

POLICY AND PROCEDURE GUIDELINE

PART 818 – Chemical Dependence Inpatient Services

This guideline is intended to support providers in the development of a Policy and Procedure Manual for Part 818 Chemical Dependence Inpatient Services. Policies and procedures should be a reflection of the philosophy and actual practices of the program. A policy and procedure manual **should not be** an exact recitation of the regulations; rather it **should be** the program's way of implementing and complying with the regulations. In doing so, a program's policy and procedure should address compliance with minimum regulatory standards and any additional aspects or nuances that the program feels are important to its operation and philosophy.

This policy and procedure guidance document will prompt programs to address and develop program operations as necessary to facilitate compliance with the Part 818 Chemical Dependence Inpatient Services regulation. Completion of a Policy and Procedure Manual does not ensure compliance with all regulatory requirements. Program staff are ultimately responsible for ensuring that program operations meet all requirements, both within the scope of the Part 818 regulation and as required by any other applicable regulation or law.

An effective Policy and Procedure Manual is clear, concise, and structured with a logical flow so that a new or veteran staff person, administrator, patient or family member, can read the manual and know:

- **For administrators:** that the manual provides the framework for how the program is to be operated to ensure compliance with regulatory requirements and maintain quality patient care, as well as indicating how all these important functions are documented (e.g., policy statements, case record documentation, forms).
- **For staff:** that the manual is a valuable tool to understand what is expected of them in their role within the program (i.e., as a counselor I do this task at this time and in this way) and what the methods of documenting these tasks are (e.g., forms, progress notes, other program related forms).
- **For patients and their family members:** what can be expected from the program when receiving services (e.g., What is the length of admission process? What are the rules I am expected to follow? What can I expect from the program?)
- **For all individuals:** the philosophy of the program; how tasks are to be completed; what resources are available if assistance and/or clarification is needed (e.g., If I have a suggestion for a change who do I talk to? Why things are done a certain way? If I feel that my rights have been violated or that the treatment is not working for me, what recourse do I have?).

A helpful way of envisioning a policy and procedure manual is to think of the questions **“why, what, how, who, and when.”**

Of these questions, **“why”** is the question that is the “foundation” for the others. It should identify the purpose of the regulatory requirement and the content to be included in such policy and procedure. There will not be a “why” delineated in each section; but it is important to think about the “why” as it should be the background for answering the other questions for each policy. To utilize an admissions policy as an example, the **“why”** (purpose) of an admissions policy might be:

“To ensure that all prospective patients in the admissions process are afforded the same services and access to admission; to identify the step-by-step process for a prospective patient being admitted into inpatient treatment programs in accordance with regulatory requirements; as well as defining the role of staff in this process and the timeframes for completion.”

Below is a description referencing each of the remaining questions (**what, how, who, and when**) using an admissions policy as an example:

What: ▪ Identifies what you expect to happen in the implementation of this process.

“Conduct an intake interview with the prospective patient to determine their need for chemical dependency services; appropriateness for this level of care; and determine if the patient meets admission criteria. Advise prospective patients of their right to voluntary participation; confidentiality as defined in 42 CFR; rules and regulations; patient rights; and inform the prospective patients of any determinations made regarding their admission.”

How: ▪ Identification of the method to be utilized to complete the admission process:

“Clinical staff will review all referral information to determine appropriateness for inpatient services. If appropriate, Clinical staff will conduct a face-to-face session; interviewing the prospective patient by asking questions regarding information reviewed from referral source and the patient’s reason for seeking treatment, including but not limited to: substance abuse history (including nicotine use), previous treatment experiences, mental health screening and other priority issues that the patient may identify. Clinical staff will complete the Initial Determination and OASAS LOCADTR form to determine the patient’s appropriateness for the inpatient level of care. Based on the information gathered during this session and referral information received, a Qualified Health Professional (QHP) will determine and document by dated signature if the prospective patient meets the admission criteria.” The intake counselor will communicate the decision regarding admission to the patient (in person) and referral source (either by phone or by mail).

Who: ▪ Identification of staff involved in the admission process and their responsibilities:

“The Administrative Assistant takes all phone calls and referral packets for prospective patients, prepares the intake packet and gives it to the intake counselor (clinical staff). The Intake Counselor reviews the information and makes any additional contacts as necessary; then calls the patient and/or referral source to set up the interview. The Intake Counselor/Clinical Staff meets with patient; gathers all required information; then discusses with QHP Level Supervisor. The QHP Level Supervisor makes the admission decision as evidenced by their signature and date on a statement regarding admission status; then assigns a primary counselor.

If admission is not appropriate and requires further referral, Intake Counselor/Clinical Staff will let the patient know regarding the decision and any referrals, The referral source will be contacted by phone and made aware of the decision not to admit. All process information will be documented in the patient case record by the staff member who provided the service.”

When: ▪ Identification of timeframes for the admission process:

“An intake session with the prospective patient will be scheduled within 24 hours of referral and/or receipt of referral information. If no space is available at the time of referral, the prospective patient’s name will be placed on a waiting list where they will be contacted as soon as space becomes available. The decision to admit is to be made at the first face-to-face pre-admission interview.

Though the questions “**why, what, how, who, and when**” help identify the elements of policy and procedure, it is not necessary for the program to write their policy and procedures exactly in this format. The completed product would most likely include an integration of all the responses to these questions and answers.

A “**Sample**” admissions policy and procedure may be developed as identified below:

Purpose: *To identify the step-by-step process for a patient to be admitted to an inpatient chemical dependency program in accordance with Part 818 regulatory requirements; as well as defining the roles of clinical and administrative staff in the process and the timeframes for completion.*

Process: *The administrative assistant receives a referral packet for prospective patients, prepares an intake packet and gives this information to clinical staff. Clinical staff will review the information and follow-up with referral contacts as necessary, then telephone the prospective patient to schedule an intake session within 24 hours.*

During the face-to-face admission session an interview of the patient takes place in which questions regarding their:

- *reason for seeking treatment;*
- *substance abuse history and previous treatment experiences;*
- *current living environment; and*
- *any other priority issues identified by the patient.*

This information along with any referral will form the basis of the admission assessment, which will include a clinical assessment of the individual’s presenting problem(s), the individual’s chemical use, abuse, dependence (including tobacco); and previous treatment history, current living environment and patient identified priority/emergency issues.

An Initial Determination and OASAS LOCADTR form will be completed to assess the individual’s need for chemical dependency services; functioning; determine the prospective patients’ appropriate level of care; and determine the appropriateness for admission. Prospective patients will be advised of their voluntary participation, Federal confidentiality requirements as defined in 42 CFR, rules and regulations of the program and patient rights. All of this information will be documented in the patient case record.

Based on the information gathered via interview, referral information, and any other collateral contact the QHP determines if the patient meets the following admission criteria:

The patient is unable to participate in, or comply with, treatment outside of a 24 hour structured treatment setting, based on one or more of the following factors:

- *the individual has accessed a less intensive level of care and has failed to remain abstinent;*
- *the individual’s environment is not conducive to recovery;*
- *the individual has physical or mental complications and co morbidities requiring medical management which may include, but not be limited to, psychiatric and/or developmental disability conditions; pregnancy; moderate to severe organ damage; or other medical problems that require 24 hour observation and evaluation; or*
- *the individual lacks judgment, insights and motivation such as to require 24-hour supervision?*

The responsible QHP signs off on the admission decision, as evidenced by their signature and date; then assigns a primary counselor. Unless further consultation or consideration is needed, the Intake Counselor will inform the patient regarding admission at the conclusion of the face-to-face admission assessment visit.

If admission is not appropriate and requires further referral, Intake Counselor/Clinical Staff will let the patient know at the session and provide information regarding the decision and any referrals. The referral source will be contacted by phone to be apprised of the decision. The clinical staff member who provided the service will

document all process information in the patient case record.

The above “**Sample**” Admissions Policy example is but one of many ways of writing up this policy. What is important to remember is that the policy does cover regulatory requirements and answers the “**why, what, how, who, and when**” questions of **your** particular program.

In the subsequent pages, programs will find a comprehensive outline to assist in assessing how their policies and procedures reflect regulatory requirements in every day practice. Existing programs are encouraged to use this guide either to evaluate their current policy and procedure manual and new programs may utilize it as a guideline for developing their baseline policies, procedures and methods.

If you have further questions regarding the development of policies and procedures, please contact the OASAS Technical Assistance Unit at technicalassist@oasas.ny.gov .

Guidelines for Regulatory Content in Policies and Procedures

Please remember for policies, procedures and methods to be effective, they must reflect the actual practice of the program; be written in a language that can be understood by all; and be a document subject to changes and revisions as the nature of the program changes. Policies and Procedures should address compliance with minimum regulatory standards, but are most effective when they reflect the full range of the program’s philosophy and practice, including elements beyond regulatory compliance. For programs that are overseen by a governing authority, it is required that the authority approves all policies, procedures and methods. It is suggested that programs document this practice, where applicable. Again, the following information is for guidance purposes only, not for direct quotation.

General Program Standards 818.2

(a) The governing authority shall determine and establish written policies, procedures and methods governing the provision of services to patients which shall include a description of each service provided, including procedures for making appropriate referrals to and from other services, when necessary.....

- What:
- Is the description of the governing authority (e.g., Board of Directors, Managing Partners) of the program?
 - Is the make-up of the governing authority?
 - Is the description of any subcommittees that report to the governing authority related to drafting, revising or amending the program’s policies and procedures?
 - Is the description of how the governing authority operates (e.g., meetings, reporting structure, leadership, interaction with sub-committees)?
 - Types of services are provided (e.g., counseling, outreach)?
- How:
- Are decisions made (e.g., first by recommendation of subcommittee or program staff)?
 - Are policies and procedures developed (i.e., first by recommendation of subcommittee or program staff)?
 - Does the governing authority ensure that the philosophy of the program is applied when developing the program’s policies and procedures?
- Who:
- Serves on the governing authority (e.g., Board of Directors, Managing Partners) of the program?
 - Serves on sub-committees of the governing authority?
 - Reviews and revises policies and procedures?
 - Recommends services, which the program should provide?
 - Decides on services the program provides?
 - Recommends what the mission of the program should be?
 - Decides on the philosophy, mission/vision of the program?

- When:
- How often does the governing authority meet to address policy and procedure issues?
 - How often are policies and procedures reviewed and updated? By the full Board? By subcommittees of the Board?

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| Application: | <ul style="list-style-type: none"> ▪ Written document outlining the above information. ▪ Roster of Board Members. ▪ Listing of Sub-committees. ▪ Minutes of meetings. |
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Admission 818.2(a)(1); 818.3(e)(1-8)

- What:
- Is the step-by-step process for a patient to move from intake to admission?
 - Is the process for identification of admission criteria both regulatory and specific to the programs guidelines?
 - Is the process for informing a patient regarding voluntary participation in treatment, patient rights, Federal Confidentiality Requirements, and program rules and regulations?
 - Is the process regarding any special populations served and protocols utilized with these population groups?
 - Is the process regarding that if the patient is a minor, parental/guardian consent for treatment is necessary? (Without parental/guardian consent for treatment, admission must be in accordance with Mental Hygiene Law Section 22.11.)
 - Are the guidelines regarding prohibition against discrimination per Federal Law and a non-discrimination statement (i.e., A statement that persons cannot be denied admission based **solely** on the given areas.) *[Note: Policies that make declarative statements might be viewed as discriminatory. For example, a statement that a program “won’t admit patients with severe psychiatric disorders” would be unwise. It is better to indicate how having a psychiatric disorder would preclude a patient from actively benefiting from treatment. Psychiatric disorders alone should not be a reason to deny admission. However, if the patient’s psychiatric disorder is to such an extent that they could not function at an inpatient chemical dependence level of care, this would be a reasonable non-admit. Be cautious and clear as to under what circumstances someone would not be admitted to your program.]*
- How:
- Are forms, tools and concepts used to determine if patients are appropriate for admission and to provide required information?
 - Is it documented that a patient met the admission criteria to be admitted to the inpatient level of care?
 - Is treatment of a minor handled in accordance with Mental Hygiene Law Section 22.11?
- Who:
- Conducts the intake interview with the patient and informs them of required information?
 - Is involved in making the admission decision?
 - What qualifications must the person have to make the admission decision?
 - Informs the patient regarding the admission decision and documents it in the case record?
 - Informs the referral source regarding the decision to admit or not to admit?
- When:
- Is the timeframe for the admissions process and providing pertinent information to the patient and the referral source?

Application:	<ul style="list-style-type: none"> ▪ Specific forms in patient case record form (e.g., Initial Determination, LOCADTR, ASAM, Admissions decision). ▪ Appropriate sign off's. ▪ All required patient notifications (e.g., rights and responsibilities, Federal confidentiality guidelines, voluntary participation). ▪ Parental consent for the treatment of a minor.
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Retention 818.2(a)(1)

- What:
 - Are the retention criteria?
 - Determines if patient still meets the criteria for the inpatient level of care and admission criteria?

- How:
 - Are forms, tools and concepts used to determine if the patient continues to need the level of care?
 - Is this determination documented in the patient case record?

- Who:
 - Among the staff makes this determination?
 - What are their qualifications?

- When:
 - How often is retention criteria reviewed, and with how many case records?

Application:	<ul style="list-style-type: none"> ▪ Utilization Review information in the patient case record. ▪ Documented in the Treatment Plan review.
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Discharge 818.2(a)(1)

- What:
 - Are the guidelines that identify how discharge planning is implemented?
 - Are the elements of the Discharge Plan and Discharge Summary?
 - Are the discharge criteria?

- How:
 - Is the discharge planning process implemented at admission and included as part of the treatment planning process?
 - Is the determination made that the patient is ready to be discharged?
 - Are forms, tools and concepts used to develop a Discharge Plan?
 - Does the patient receive the required portion of the Discharge Plan?
 - Is this documented in the patient case record?
 - Is the Discharge Summary completed?
 - Are involuntary discharges (i.e., due process) handled?

- Who:
 - Is responsible for developing the Discharge Plan?
 - Is responsible for approving the Discharge Plan?
 - Is responsible for developing the Discharge Summary?

- When:
 - Does the Discharge Plan have to be approved?
 - Does the patient receive the appropriate portion of the Discharge Plan?
 - Is the Discharge Summary completed?

Application:	<ul style="list-style-type: none"> ▪ Documentation of the discharge process in the case record (e.g., case conference notes, progress notes leading up to discharge decision, Treatment Plan review indication). ▪ Discharge Plan and Discharge Summary in case record. ▪ Appropriate and required signatures on all paperwork.
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Transfer Procedures 818.2(a)(1)

- What: ▪ Are the guidelines for the process and under what conditions/situations a patient transitions from one program to another?
- How: ▪ Is the clinical justification, summary of progress and date of admission to new program documented?
 ▪ Is the Treatment Plan revised?
- Who: ▪ Documents the above information?
 ▪ Approves and signs the revised Treatment Plan?
- When: ▪ What are the required timeframes?

Application:	▪ Progress note in patient case record documenting the required information. ▪ Treatment Plan revision.
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Level of Care Determination 818.2(a)(2)

- What: • Is the process for gathering information needed to determine the level of care the patient needs?
 • Type of information is gathered to make the determination?
 • Tool is used for level of care determination (i.e. LOCADTR, ASAM, other office-approved protocol)?
 • Are the staff qualifications needed to make this decision?
- How: • Is the information gathered?
 • How is the level of care documented?
- Who: • Makes the determination?
- When: • Is the level of care determination made?
 • Is the required timeframe for completion?

Application:	• A completed LOCADTR, ASAM form, or other office-approved tool is located in the case record. • Appropriate staff signatures at given timeframes on the document used.
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Comprehensive Evaluations 818.2(a)(2)

- What: ▪ Is the process for gathering information necessary to determine a substance abuse related diagnosis, and obtain information necessary to develop a patient-centered and individualized initial services plan and on-going plan of treatment?
 ▪ Type of information is gathered as required by regulations/program needs?
- How: ▪ Is the information gathered?
 ▪ Is the Comprehensive Evaluation documented?
- Who: ▪ Conducts the Comprehensive Evaluation?
 ▪ Reviews the Comprehensive Evaluation?
 ▪ Is the QHP responsible for the Comprehensive Evaluation?
- When: ▪ Is the Comprehensive Evaluation conducted?
 ▪ Are the required timeframes for completion?

Application:	<ul style="list-style-type: none"> ▪ Comprehensive Evaluation forms or other evaluation forms containing required information included in the patient case record. ▪ Progress note documenting sessions where Comprehensive Evaluation was being completed. ▪ Appropriate signatures on all required information.
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Treatment Plan 818.2(a)(2)

- What:
- Is the purpose of the Treatment Plan(s) (preliminary and comprehensive) including the use of goals, objectives, methods, services and target dates?
 - Are the areas that must be addressed in each?
 - Are the options (e.g., goal, defer, not applicable) for addressing a functional area?
 - Is the aftercare plan?
- How:
- Is the Treatment Plan developed?
 - Where does the information for the plan come from?
 - Is the Treatment Plan documented?
 - Does the patient and if applicable patient's family/parents participate in the development of the Treatment Plan?
 - Is collaboration documented?
 - Are Treatment Plans reviewed and approved?
 - Is collaboration of care with other programs documented?
- Who:
- Is responsible for the development of the Treatment Plan?
 - Needs to review and approve the Treatment Plan?
- When:
- Does the Treatment Plan(s) need to be completed?
 - Does the Treatment Plan need to be reviewed and approved by the Physician?

Application:	<ul style="list-style-type: none"> ▪ Treatment Plan form/documentation that covers all required elements in patient case record. ▪ Signatures and dates as required. ▪ Documentation of patient collaboration.
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Treatment Plan Review 818.2(a)(2)

- What:
- Is the process for the review of the Treatment; its effectiveness and need for updating and/or change?
- How:
- Is the review process completed?
 - Is the Treatment Plan review documented, including summary of progress, completion of goals, addition of goals and objectives?
 - If the patient is not responding to treatment, how this is addressed?
 - Is patient and if applicable family/parent collaboration/consultation documented?
- Who:
- Is responsible for completing the Treatment Plan review?
 - According to regulation and program philosophy, needs to sign off on the Treatment Plan review?
- When:
- How often should the Treatment Plan be reviewed?

Application:	<ul style="list-style-type: none"> ▪ Documentation (e.g., Treatment Plan review form, progress note that gives required information). ▪ Updated goals/objectives/dates where appropriate. ▪ Appropriate signatures. ▪ Demonstration of patient collaboration.
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Placement Services 818.2(a)(2)

- What:
 - Is the process to determine the most appropriate type of services utilizing specific patient characteristics, conditions, or services?
 - Is the process to develop a written list (i.e., specific program names and contact information) of what other programs have been identified to use under the specified circumstances (e.g., emergency, detoxification, vocational/educational)?
 - Is the process of coordinating these programs with those identified providers?

- How:
 - Is the need for placement determined?
 - Is the placement and placement follow-up documented?
 - Does the program communicate patient information with other programs?
 - Does the program receive information from other programs?
 - Does the program document Qualified Service Agreements or Cooperative Agreements with the other specified providers?
 - Is coordination documented?
 - Are consents for release of confidential information obtained?

- Who:
 - Makes the determination?
 - Approves the placement?
 - Are the agencies to which your program refers?
 - Are the staff member(s) who make referrals?
 - Are the staff member(s) who obtain releases?
 - Is the staff member who provides on-going communication and/or coordination?

- When:
 - Are the timeframes or places in the treatment process where decisions for placement are made?
 - Turnaround time for specific services?
 - Is the timeframe for coordination of care with other programs?

Application:	<ul style="list-style-type: none"> ▪ Written list of providers in policy and procedure manual. ▪ Cooperative agreements with providers. ▪ Documentation in the patient case record that supports need for and process of placement/referral. ▪ Documentation in the patient case record of coordination with the other programs (e.g., coordination of care plan, progress notes, case conference). ▪ Appropriate consent of release forms.
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Staffing 818.2(a)(3), 818.8(c-p)

Personnel 818.2(a)(19)

- What:
- Is the process for ensuring that job descriptions, performance evaluations, promotions, qualifications, disciplinary actions, hiring, maintenance of licenses/credentials and staff development/training is in accordance with regulation?
 - Are the staffing plans, including the **use of volunteers**?
 1. What are the actual titles within the program and what are their functions/responsibilities?
 2. Who provides supervision for staff and volunteers?
 3. What are volunteers allowed to do?
 4. How are volunteers apprised of 42CFR/HIPAA requirements?
 - Is the process for ensuring that the full complement of staff, clinical, medical, etc. is in accordance with regulation?
 - Is the documentation for employee time, scheduling and staffing assignments?
 - Is the process for appropriate documentation of staff-to-patient ratio?
 - Is the guideline regarding the requirements of the Health Insurance Portability and Accountability Act (HIPAA), as well as federal confidentiality requirements (i.e., Title 42 of the Code of Federal Regulations, Part 2)?
 - Are the limited situations under which student interns may conduct individual and group counseling sessions?
 - Is the process for ensuring the provision of close professional staff supervision and didactic education, both internal and external?
 - Is the plan used to cover counseling staff and clinical staff on-site requirements?
 - Is the schedule for staff training both regulatory required and otherwise?
 - Is the plan for providing activities therapy?

- How:
- Are staffing guidelines developed and determined?
 - Are volunteers utilized?
 - Are volunteers supervised?
 - Is time and scheduling documented?
 - Are staff made aware of their responsibilities under 42CFR and HIPAA?
 - Are staff trained?
 - Are medical and mental health issues covered by staffing?
 - Is activities therapy provided?
 - Are menus developed?

- Who:
- Supervises staff and volunteers?
 - Develops and updates the Human Resources policies and manual?
 - Determines staffing guidelines?
 - Serves as the Health Coordinator?
 - Provides psychiatric or psychological services, if necessary?
 - Provides medical services?
 - Provides staff training?
 - Provides activities therapy?
 - Develops menus?

- When:
- Are staff made aware of Human Resources policies and updates?
 - Are Human Resources policies and manual reviewed?
 - Are work schedules posted?

Application: (verified through Personnel Qualification Worksheet, schedules, timesheets)	<ul style="list-style-type: none"> ▪ Human Resources Handbook. ▪ Documentation that the Director of the program has proper certification and work experience. ▪ Documentation that the Medical Director has proper licensure and certification. ▪ Documentation that at least 50% of all counselors are QHP's. ▪ Documentation that at least 50% of all clinical staff are QHP's. ▪ Documentation that the service has a qualified dietician or dietetic technician on staff to provide menu planning services. ▪ Documentation for appropriate psychological or psychiatric staff if severe mental disorders or mental illness is being addressed in the program. ▪ Documentation of at least one full-time registered nurse. ▪ Documentation that a licensed practical nurse, registered nurse, physician's assistant, and/or nurse practitioner are available to patient at all times to provide required services. ▪ Documentation that the counselor-to-patient ratio is within regulatory limits (Verified through active roster, CDS Report, and Personnel Qualification worksheet).
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Provision of Medical Services 818.2(a)(4)

- What:
- Is the process for medical services to be provided?
 - Is the screening process for physical or psychiatric conditions?
 - Is the referral process, if applicable?
 - Is the process for ensuring that any medical procedures required must be provided in accordance with Federal and State law and that all medical services must be provided pursuant to a physician's, registered physician assistant's or nurse practitioner's order?
 - Is the process for follow-up?
- How:
- Are screenings performed?
 - Are referrals made?
 - Are screenings/referrals documented?
 - Is follow-up conducted?
- Who:
- Performs the screenings?
 - Makes the referrals?
 - Conducts follow-up?
- When:
- Are these screenings performed?
 - Does follow-up take place?

Application:	<ul style="list-style-type: none"> ▪ A statement in the policy and procedure manual that outlines the provision of medical services. ▪ Documentation of such services in the patient case record that reflects these policies and procedures (e.g., progress notes, screening forms).
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Determination of prices for services 818.2(a)(5)

- What:
- Is the process for determining fees for each of the services provided (e.g., sliding scale, contract rate, deficit funded)?
 - Is the process for patients who refuse to pay for services rendered?
 - Is the process for ensuring that the program will not add additional charges to patients for services paid by Medicaid?

- How:
- Are fees collected?
 - Is information regarding billing communicated to patients?
 - Are fee agreements documented?
 - Are sliding scale fees calculated?
 - Is the patient's ability to pay determined?
- Who:
- Makes the fee determination?
 - Communicates the determination to the patient?
- When
- Is the fee for service determined and discussed with the patient?
 - Is the determination made?
 - Is the determination communicated to the patient?

Application:	<ul style="list-style-type: none"> ▪ Copy of sliding scale table in case record. ▪ Copy of financial agreement in case record.
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Infection Control: 818.2(a)(6)

- What:
- Is the guideline regarding the implementation of universal precaution practices (e.g., hand washing, sharp containers, blood and body fluid spills)?

****Please note for providers that are part of larger health care agencies such as hospitals, using the hospital infection control procedures is acceptable, providing that it is applicable for site specific issues (i.e., situations that are likely to occur in an inpatient setting).***

- How:
- Are the guidelines implemented?
 - Are infection control incidents reported?
- Who:
- Reports and documents infection control incidents?
 - Reviews all infection control related incidents for the program as a whole?
 - Is qualified to respond to infection control incidents?
- When:
- Is the timeframe for responding?
 - Is the timeframe for documenting?
 - Is the timeframe for follow-up?

Application:	<ul style="list-style-type: none"> ▪ Reports in incident report log as appropriate. ▪ Documentation of in-service training on Infection Control.
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**Public Health Education and Screening 818.2(a)(7); 818.7(a)(4)
 HIV/AIDS education, testing and counseling 818.2(a)(10); 818.2(c)(5)
 Health Coordinator 818.8(p)**

- What:
- Is the process of providing education and screening for communicable diseases (e.g., TB, STD's, Hepatitis; and HIV & AIDS prevention and harm reduction)?
 - Is the process for ensuring that staff members and patients are provided with public health education regarding communicable diseases?
 - Is the process for ensuring that if HIV and AIDS education, testing and counseling are provided, such services must be provided by qualified individuals and in accordance with Article 27-F of the Public Health Law?

- How:
- Is screening provided?
 - Is education provided, and in what format?
 - Is Prevention and Harm Reduction information for HIV/AIDS provided?

- Who:
- Provides the screening?
 - Provides the education?
 - Does the program designate as the staff member who is qualified to ensure public health education and screening (i.e., Health Coordinator)?
 - Is responsible for the policies and procedures regarding Public Health Education?

- When:
- Is screening conducted?
 - Is education provided?

Application:	<ul style="list-style-type: none"> ▪ Documentation of education and/or screening in the patient case record (e.g., progress note, screening form). ▪ Documentation of staff training regarding communicable diseases.
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Cooperative Agreements 818.2(a)(8), 818.7(b)

- What:
- Are the service(s) and service type(s) with which the program has entered into cooperative agreements and are they in accordance with regulation?
 - Are the specific agreements with a general hospital(s) for the provision, transfer of patients in need of acute hospital care?

- How:
- Is the decision to acquire a cooperative agreement made?
 - Are cooperative agreements obtained?
 - Are cooperative agreements documented?

- Who:
- Makes the decision to obtain a cooperative agreement?
 - Does the actual foot work to get the cooperative agreement?
 - Approves cooperative agreements?

- When:
- Are cooperative agreements reviewed and updated?

Application:	<ul style="list-style-type: none"> ▪ Actual cooperative agreements with other providers.
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Alcohol and Other Drug Screening Tests 818.2(a)(11)

- What:
- Is the process utilized for the collection, storage and processing of urine specimens or other methods utilized by the program to conduct toxicology testing?
 - Are the various screening tests utilized (e.g., blood alcohol content, urine screening)?
 - Is the process for ensuring that the results of all toxicology testing are included in patient case records?
 - Are the cut-off levels for positive BAC's that would require emergency response/immediate intervention?

- How:
- Are screens conducted?
 - What screening tools are used for drug use?
 - Are toxicology results documented?
 - Are positive toxicology results dealt with?
 - Are staff trained in drug screening procedures?
 - Are results documented?

- Who
- Administers drug screens?
 - Documents drug screen results?
- When:
- And under what circumstances are drug screens administered?
 - Is the breathalyzer tester calibrated?

Application:	<ul style="list-style-type: none"> ▪ Toxicology results in the patient case record. ▪ Progress notes documenting the need or circumstances around screening.
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Medication 818.2(a)(13)

- What:
- Are the guidelines regarding the proper storage, inventory, use and disposal of medications, emergency medical supplies and equipment, if applicable?
 - Is the process regarding the prescribing/dispensing/administering and maintaining documentation of medications and medication samples, if applicable?
 - Is the process regarding medication assisted treatment provided by the program (e.g., procedure for determining need, monitoring the use of the particular addiction medicine)?
 - Is the process for ensuring that if the program does store medication, it is in accordance with Article 33 of the Public Health Law at section 3341 and Part 80 rules and regulations on Controlled substances in NYS at section 80.46?
 - If the program does not prescribe addiction medicine, what is the process for collaborating with the provision of such services by another provider?
- How:
- Does program store medications?
 - Does the program supervise and or/administer medications?
 - Is medication storage and distribution documented?
 - Is medication administration documented?
- Who:
- Is responsible for the storage and distribution of medication?
 - Prescribes medication and under what circumstances?
- When:
- Are the timeframes associated with the storage and distribution of medication?

Application:	<ul style="list-style-type: none"> ▪ Medication Logs. ▪ Medication disposal logs. ▪ Progress notes indicating any patient involvement in medication or medication assisted treatment. ▪ Appropriate locked storage for medication.
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Quality Improvement and Utilization Review 818.2(a)(14), 818.6(b), 818.6(c)(1)(i-iv), 818.6(c)(2)

- What:
- Is the description of how the Quality Improvement Plan fits into the program's overall philosophy of treatment?
 - Are the required elements to conduct quality improvement identified in regulation?
 - Is the process to ensure that the Quality Improvement Plan includes :
 - Mission and goals of the program (i.e., What are you trying to achieve?); Where do you want to go)?
 - Methods for collection and review of performance and outcome data (i.e., What information is collected?; How is it collected)?
 - Methods for tracking specific outcomes over time (e.g., retention rate

after assessment; lost to contact discharges, return for treatment within 1 year)?

- Methods for gathering information from UR, incident reviews, staffing needs assessments, compliance reviews, audits and other activities?
- Plans and recommendations for areas of need identified in the above gathered information?
- A definition of Utilization Review including the required elements of utilization review process as identified in regulation?
- Is the process for submission of an annual report to the governing authority, which documents effectiveness and efficiency and provides recommendations for improvement in services to patients and recommended changes to policies and procedures?

- How:
- Is Quality Improvement practiced in the organization?
 - Does the committee collect patient satisfaction information as well as treatment outcome data and use both types of information to determine program performance documented?
 - Is the process of Utilization Review conducted in the organization?
 - Does the committee determine what elements are to be included in the annual report?

- Who:
- Is on the Quality Improvement Committee
 - Participates in the Quality Improvement process either formally or informally?
 - Makes decision for action on the QI Committee's reports or recommendations?
 - Reviews the charts for utilization review?
 - Develops and submits the annual report to the governing authority?

- When:
- Is the timeframe of quality improvement activities (e.g., QI team must meet at least quarterly, annual review of Quality Improvement Plan)?
 - Is the timeframe for submission of annual report to the governing authority?
 - Is the timeframe for conducting Utilization Review (e.g., monthly, quarterly)?

- | | |
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| Application: | <ul style="list-style-type: none">▪ Quality Improvement Committee Meetings Minutes.▪ Annual Report.▪ Utilization Review Committee Meeting Minutes.▪ Documentation in the patient case record that demonstrates that utilization review was conducted on the patient case record (e.g., utilization review form with appropriate elements). |
|--------------|---|

Clinical Supervision 818.2(a)(15)

- What:
- Is the type and frequency of clinical supervision that is provided to clinical staff?
 - Are the qualifications of the clinical supervisor and title of person(s) identified to supervise staff?
 - Are the guidelines regarding the documentation of clinical supervision?

- How:
- Is supervision provided (e.g., one-on-one, group, peer)?
 - Is supervision documented?
 - Is the content of clinical supervision (e.g., case review, professional development) identified?

- Who:
- Provides supervision and what are their qualifications?
 - Receives supervision?
 - Supervises the Clinical Supervisor?

When: ▪ How often and for how long is supervision provided?

Application:	▪ Written Policy and Procedure in Manual. ▪ Supervision notes. ▪ Staff meeting notes.
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Procedures for Emergencies 818.2(a)(16)

What: ▪ Is the guideline regarding staff actions required in handling emergencies that might be reasonably expected?
▪ Is the reporting structure for communication about emergencies?
▪ Is the definition of an emergency; what emergencies might be more likely to occur than others?
▪ Are the cooperative agreements with local hospitals and the 911 reporting systems?

How: ▪ Are staff expected to respond to emergencies (i.e., what are the specific steps for the different types of emergency)?
▪ Are emergencies documented and reported?
▪ Are emergencies reviewed by upper level management?
▪ Are staff trained in emergency management?

Who: ▪ Are the specific staff members responsible for handling specific types of emergencies (e.g., medical staff for medical emergencies, counselors for grief counseling)?
▪ Reviews emergencies and how they are handled?

When: ▪ Are the timeframes for responding to and reporting an emergency?

Application:	▪ Incident reports. ▪ Fire drill logs. ▪ Documentation of staff training on emergencies.
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Incident Reporting and Review 818.2(a)(17); 836.5(a) & 836.5(b)(1-8)

What: ▪ Constitutes a reportable incident and serious reportable incident? [Note: Refer to list that includes, but is not limited to, the Part 836 regulations along with and in addition to program defined serious reportable incidents.]
▪ Is the guideline regarding the reporting of patient deaths? [Note: Reporting must be in accordance with OASAS Local Services Bulletin --1999-04.]
▪ Is the guideline regarding the completion of documentation, including incident reports?
▪ Staff are responsible for reviewing incidents?
▪ Is the procedure for communicating the results of the review back to the line staff?
▪ Is the make-up of the Incident Review Committee?

How: ▪ Are incidents reported and documented?
▪ Organizationally, how are reports reviewed?
▪ Are patient deaths recorded and reported?

Who: ▪ Is responsible for writing incident reports?
▪ Reviews incidents?
▪ Makes decisions to change policies and procedures based on incident

occurrence?

- Implements corrective actions based on incident occurrence?
- Contacts OASAS?

When:

- What is the timeframe for reporting different levels of incidents?
- Timeframes for organizational review of incidents and incident reports?

Application:

- Incident reporting log.
- Incident Review Committee Minutes.
- Communication log.
- Staff Training in Incident Reporting.
- Progress notes.
- Incident reporting forms.

**Record keeping and confidentiality 818.2(a)(18), 814.3(7),818.5(b), 42CFR 2.31; 42CFR 2.16(a)
Documentation 818.4(n)(1-2)**

What:

- Standard forms are used for record keeping Identification of standard forms used for record keeping (e.g., LOCADTR, ASAM, Model Case Record forms)?
- Are the documentation requirements/practices for each type of service provided (e.g., assessment, individual/group counseling, etc.) and any forms used for such documentation?
- Is the process for ensuring that patient case records include the components required in regulation?
- Are the guidelines to ensure the accountability, safety, security and confidentiality of any case records removed from the certified location for a limited time?
- Is the process to ensure that patient case records are kept confidential in accord with Federal confidentiality regulations?
- Ensures locked storage and maintenance of patient case records?
- Ensures that the program's Consent for Release forms contain all the regulatory required elements as given in the above-cited regulations?

How:

- Are the program's case records organized (e.g., easily understood order, format)?
- Are records stored?
- Is information provided to other agencies?
- Is the quality and compliance level of documentation evaluated/assured?
- Are staff trained in documentation?

Who:

- Is responsible for the case record, including completion of consent for release forms?
- Is responsible for transporting records when necessary?
- Is responsible for reviewing documentation for completeness and compliance?
- Is responsible for training staff in documentation?

When:

- Is the timeframe for progress note completion?
- Is the timeframe for keeping the case record open for individuals who have been screened but not admitted, as well as for patients who have been lost to contact?
- Are the retention timeframes for documentation in accordance with regulation?
- And how often is case record documentation reviewed for accuracy?

Application:

- A well organized patient case record.
- A secure room where patient case records are kept.

- Accurately filled out Consent for Release forms.
- Forms and documentation appropriate to services provided.

Monthly Reporting 810.14(e)(6)

- What:
- Is the process for ensuring that program admission and discharge records agree with the information contained in the most recent CDS program report?
 - Is the process for ensuring that program census numbers (as determined by current client roster) match up with the most recent CDS program report?
- How:
- Are admission and discharge numbers reported to OASAS?
 - Are the program's patient roster maintained?
- Who:
- Fills out PAS form and submits to OASAS?
 - Keeps track of patient roster?
- When:
- Are CDS reports submitted?

- Application:
- Current program CDS Report matches Current program Roster within reason.

Tobacco-Free Services 856.5(a)(1-9)

- What:
- Written Policy and Procedure that includes the program's Philosophy on Tobacco Use and its impact on Chemical Dependency Treatment, along with incorporating the following information:
 - A comprehensive plan to address tobacco and integrate it into the context of treating all other substance use disorders.

Communication:

- A statement which references the program's mission statement?
- A statement that patients, family members, and visitors are prohibited from bringing tobacco products and/or paraphernalia (e.g., pipes, rolling paper) to the service site?
- A process for informing patients, staff, volunteers, and visitors of the tobacco-free policy?
- A policy that reflects the program's intent to appropriate treatment to all persons in need of alcohol and drug addition, while administering an appropriate tobacco-free program?
- A definition of what constitutes the program property that will be tobacco-free (e.g., buildings, parking lot, driveway, cars, vans)?

Staff Guidelines:

- A statement that communicates the parameters of the tobacco-free policy for all staff?
 1. A statement that reflects the importance for all staff to be familiar with the tobacco-free policy and understand the importance of addressing tobacco.
 2. A statement that all staff are prohibited from using tobacco products what at work and during work hours?
 3. A statement that addresses staff violations consistent with the program's employment procedures?

Patients/Treatment:

- A statement of how patient tobacco use will be addressed in treatment including specific modalities of treatment?
- A statement outlining the step-by-step process that occurs when a patient either relapses on tobacco or refuses to stop using (i.e., should include patient discharge criteria and the parameters around the use of discharge for patients who either have multiple relapses or generally refuse to follow the tobacco-free policy of the program)?
- A statement explaining the use of nicotine replacement therapy (NRT) and how to access medication?

Training/Resources:

- A statement describing training provided to all staff on tobacco use and nicotine dependence?
- A statement describing new staff orientation and integration of the tobacco-free policy?
- A statement describing tobacco/nicotine prevention/education programs available to patients, staff, volunteers, and others (i.e., specific programs that you intend to run to assist people in become tobacco-free)?

How:

- Is the above information communicated to patients, family members, staff, and others?
- Is training provided?
- Is prevention/education provided?
- Are you connecting tobacco free to recovery?

Who:

- Will oversee the implementation of the tobacco free policy?
- Informs the patients of the tobacco-free policy and resources?
- Informs family members, visitors, and others of the tobacco-free policy and resources?
- Informs staff about the tobacco-free policy and resources?
- Addresses patient relapse?
- Addresses staff continued tobacco use or noncompliance?
- Provides the above trainings?
- Monitors the facility for signs of tobacco use?
- Monitors compliance?
- Will assess and make adjustments as necessary?

When:

- Are patients informed of the tobacco-free policy and resources?
- Are family members, visitors, or others informed of the tobacco-free policy and resources?
- Are staff informed of the tobacco-free policy and resources?
- And how often are trainings on tobacco use and nicotine dependence provided?
- What are the timeframes for addressing patient relapse or refusal to comply with tobacco-free guidelines?
- What are the timeframes for addressing staff non-compliance with tobacco-free guidelines?
- What is the frequency of assessment and adjustment of the tobacco-free policies and procedures?

Application:

- Comprehensive written policy in the Policy and Procedure Manual.
- Evidence of tobacco integration in language.
- Evidence of tobacco policy understanding and integration to the overall

- mission of the program.
- Evidence that NRT is being used properly.
- Evidence of tobacco use and nicotine being addressed in patient case records.
- Documentation of staff and/or patient violations of the policy being addressed as per the guidelines given in the Policy and Procedure Manual.
- Absence of evidence of tobacco use in the facility (e.g., no cigarette butts, boxes, excessive matches).
- Training schedule and curriculums addressing tobacco use and nicotine dependence.
- Documentation in personnel files indicating staff attendance of trainings.

Patient Rights (815.4(a), 815.4(a)(1, 5, 6),

- What:
- Are the standards governing staff conduct to ensure the protection of patient rights and to ensure the communication of such standards, rights and responsibilities to patients?
 - Are the procedures to help patients follow their Treatment Plan; such as policies and procedures specifying standards and expectations for patient conduct, to achieve goals consistent with the plan, and consequences for failing to meet goals, including conduct which may result in discharge?
 - Are the policies and procedures that address patient behavior with timely and appropriate incremental interventions designed to assist patients in responding positively to treatment?
 - Is the procedure for ensuring periodic reviews for quality improvement with respect to patient concerns and complaints, changes in regulatory requirements, or other factors, no less frequently than once every two years?
 - Is the procedure for ensuring that documentation of all such reviews is kept?
- How:
- Are staff trained in appropriate care to ensure patient rights are guarded?
 - Are patients informed of the patient rights policy and the connection to their treatment?
 - Are patient concerns and complaints addressed?
 - Are patient rights issues and information documented?
- Who:
- Provides staff training?
 - Provides patients with information regarding their rights?
 - Provides oversight and review of patient right's complaints or grievances?
- When:
- How often are patient rights policies reviewed?
 - How often are patient's rights training held?
 - Is the timeframe for the grievance process?
 - Are patients informed of their rights?

- Application:
- Written Policy and Procedure.
 - Supervisory documentation of oversight of staff conduct in terms of assuring patient rights.
 - Documentation in Patient Case Records of clinical steps taken to help patients to meet their goals and expectations.
 - Documentation in Patient Case Records of steps taken to address when goals and expectations are not met, especially if such conduct could lead to discharge.
 - Staff Training Log.
 - Patient Interviews.
 - Staff Interviews.
 - Patients Rights information in case record.
 - Grievance/complaint logs.

OASAS FUNDED PROVIDERS ONLY

SAPT Block Grant Requirements: 45 CFR Part 96

PRIORITY OF ADMISSION

- What: ▪ Is the process for ensuring that preference in admission to treatment is given in the following order:
1. Pregnant injecting substance users,
 2. Pregnant substance users,
 3. Injecting substance users; then
 4. All other individuals?
- How: ▪ Does the program determine if patients meet this criterion?
- Does the program manage the patient intake process so that there is adequate space for someone who meets the criteria for preferential admission?
- Who: ▪ Makes the decision if the person meets the criteria?
- When: ▪ Are the timeframes for patients who meet these criteria to be given intake appointments and subsequently admitted into the program?

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| Application: | ▪ Written Policy outlining the above.
▪ Questions in pre-admissions screening that determine if patients meet the above criteria. |
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OUTREACH

- What: ▪ Is the process for outreach to pregnant and parenting women; and injecting drug users?
- Under what circumstances?
- How: ▪ Does the program conduct outreach?
- Does the program decide to continue or stop outreach?
- Who: ▪ Decides to conduct outreach?
- Provides the outreach?
- When: ▪ Is the Outreach provided and for how long?

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| Application: | ▪ Written statement of regarding Outreach.
▪ Screening form, checklist, or questionnaire to determine if outreach is needed.
▪ Documentation in case record of outreach and its results. |
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INTERIM SERVICES

- What: ▪ Is the process for ensuring that:
1. Injecting drug abusers will be admitted no later than 14 days from requesting treatment; OR
 2. Injecting drug abusers will be admitted within 120 days if interim services (counseling/education about HIV, TB, risks and steps to prevent transmission) are made available within 48 hours?
- How: ▪ Are these decisions made and documented?
- Are interim services provided?

- Are decisions to provide interim services made?

- Who:
- Decides on either admission or provision of interim services?
 - Provides interim services?

- When:
- In the process will interim services be given?
 - Is the timeframe for evaluating the continued need for interim services or for space availability for admission?

- Application:
- Written statement regarding Interim Services.
 - Listing of available Interim Services.
 - Description of Interim Services.

WAIT LIST

- What:
- Is the process for ensuring that a wait list is maintained for injecting drug abusers and/or pregnant women and women with dependent children and ensure patients are admitted or transferred as soon as possible?
 - Is the process of maintaining contact with individuals on the wait list?

- How:
- Is this information gathered and documented?
 - Does the program stay in contact with patients on the wait list?
 - Does the program arrange for the earliest admission?
 - Does the program decide to transfer patients and where?

- Who:
- Who makes the decision on the wait list admissions?
 - Who makes the decision to transfer the patient to another program?
 - Who makes contact with the patients on the wait list?

- When:
- When would the decision to transfer take place?
 - Is the timeframe for someone remaining on the wait list until being transferred to another program?

- Application:
- Written policy for the wait list process.
 - A wait list.
 - Referral source list for when services cannot be provided in a timely fashion.
 - Documentation in the patient case record of wait list status and/or transfer/referral.
 - Documentation of contact with patient while on wait list.

REFERRAL

- What:
- Is the process for ensuring that there is a referral policy when there is insufficient capacity to admit?
 - Is the process for ensuring the provision of interim services within 48 hours when admission is not possible for capacity reasons?

- How:
- Does the program determine that there is insufficient capacity to admit?
 - Does the program inform the patient about the inability to admit, interim services, and when there is capacity to admit?
 - Are interim services provided?

- Who:
- Informs the patient regarding their status?
 - Provides the interim services?

When: ▪ Is the referral to interim services made?

Application:	<ul style="list-style-type: none">▪ Written statement on capacity limits.▪ Policy on providing interim services.▪ Documentation in case record of interim services and notifications to the patient regarding their status.
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WOMEN AND CHILDREN

What: ▪ Is the process for ensuring that the program admits women and their children as appropriate?
▪ Is the process to provide or arrange for primary medical care, prenatal and pediatric care (including immunizations)?
▪ Is the process to provide childcare while the women are receiving services?
▪ Is the process to provide or arrange for gender-specific treatment and other therapeutic interventions?
▪ Is the process to provide or arrange for therapeutic interventions for children in custody of women in treatment?
▪ Is the process to provide or arrange for case management and transportation services to ensure women and children can access treatment services?

How: ▪ Does the program determine if the women and their children are appropriate for admission?
▪ Is primary medical care, prenatal and pediatric care provided?
▪ Is childcare provided while the women are receiving services?
▪ Are therapeutic interventions for children provided?
▪ Are case management and transportation services provided?

Who: ▪ Provides the services listed above?

When: ▪ Are these services provided?

Application:	<ul style="list-style-type: none">▪ Admission documentation for women and children.▪ Cooperative Agreements or Qualified Service Organization Agreements with primary medical, prenatal, and pediatric care providers.▪ A supervised area for children to wait while mother receives services.▪ Documentation of therapeutic interventions provided for children.▪ A staff person who provides case management services.▪ Documentation of case management services in patient case record.
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SELF-IDENTIFIED RELIGIOUS ORGANIZATION/FAITH-BASED PROGRAMS

What: ▪ Is the process for ensuring prohibition of the use of State Aid for activities involving worship, religious instruction or proselytization?
▪ Is the process for ensuring that outreach activities do not discriminate based on religion, religious belief , refusal to hold such belief of participate in religious practice?

How: ▪ Does the program determine the appropriate use of State Aid?
▪ Does the program determine that outreach activities do not discriminate based on the above criteria?

Who: ▪ Makes these determinations?

When: ▪ Is the timeframe for making determinations?

Application:	▪ Statement in Policy and Procedure Manual. ▪ Documentation of where State Aid is used. ▪ Documentation that outreach activities are open to all.
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Acupuncture (If Applicable) **830.5(b)(1); 830.4(b); 830.6(a)(1-2);**

What: ▪ Is the process for ensuring that the program maintains compliance with the Part 830 regulations in the provision of Acupuncture Services?

How: ▪ Is it determined that a patient needs acupuncture?
▪ Are acupuncture services documented (e.g., Treatment Plan, Comprehensive Evaluation, progress notes)?
▪ Is appropriate supervision provided and documented?

Who: ▪ Provides acupuncture services to the patient?
▪ Supervises the provision of acupuncture services?

When: ▪ Are acupuncture services provided?
▪ Is the need for the continuation of acupuncture services reviewed?

Application:	▪ Documentation of acupuncture services in the patient case record. ▪ Supervision notes for acupuncture service providers. ▪ License or certificate for acupuncture service providers.
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