

# PART 818

## CHEMICAL DEPENDENCE INPATIENT REHABILITATION SERVICES

[Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32.01, 32.07(a)]

**Notice: The following regulations are provided for informational purposes only. The Office of Alcoholism and Substance Abuse Services makes no assurance of reliability. For assured reliability, readers are referred to the *Official Compilation of Rules and Regulations*.**

### Sec.

- 818.1 Legal base**
- 818.2 General service standards**
- 818.3 Admission procedures**
- 818.4 Post admission procedures**
- 818.5 Record keeping**
- 818.6 Quality improvement and utilization review**
- 818.7 Medical policy and services**
- 818.8 Staffing**
- 818.9 Severability**

### **818.1 Legal base.**

(a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt standards including necessary rules and regulations pertaining to chemical dependence services.

(b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations necessary and proper to implement any matter under his or her jurisdiction.

(c) Section 19.40 of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to issue operating certificates for the provision of chemical dependence services.

(d) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(e) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law.

### **818.2 General service standards.**

(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. These policies, procedures, and methods, which require review and approval by the governing authority, shall address, at a minimum, the following:

- (1) admission, retention and discharge, including specific criteria relating thereto, as well as transfer procedures;
- (2) level of care determinations, comprehensive evaluations, treatment plans, and placement services;
- (3) staffing plans, including the use of volunteers;
- (4) the provision of medical services, including screening and referral for associated physical or psychiatric conditions;
- (5) the determination of prices for services rendered;
- (6) infection control;
- (7) public health education and screening with regard to tuberculosis, sexually transmitted diseases, hepatitis, and HIV and AIDS prevention and harm reduction;
- (8) cooperative agreements with other chemical dependence service providers and other providers of services that the patient may need;

- (9) a requirement that if acupuncture is provided as an adjunct to the services provided by the service, it must be provided in accordance with Part 830 of this Title;
- (10) a requirement that when HIV and AIDS education, testing and counseling are provided, such services must be provided in accordance with Article 27-F of the Public Health Law and this Title;
- (11) the use of alcohol and other drug screening tests, such as breath testing, urine screening and/or blood tests;
- (12) a requirement that when chemical dependence crisis services are provided, such services must be provided in accordance with Part 816 of this Title;
- (13) medication;
- (14) quality improvement and utilization review;
- (15) clinical supervision and related procedures;
- (16) procedures for emergencies;
- (17) incident reporting and review in accordance with Part 836 of this Title;
- (18) record keeping procedures which ensure that documentation is accurate, timely, prepared by appropriate staff, and in conformance with the federal confidentiality regulations contained in 42 Code of Federal Regulations Part 2; and
- (19) personnel.

(b) An inpatient service shall have as its goals:

- (1) the promotion and maintenance of abstinence from alcohol and other mood-altering drugs or substances except those prescribed by a physician, physician's assistant, or nurse practitioner; however, if an inpatient service objects to a patient's continued use of such prescribed drugs or substances, the inpatient service shall document each of the following:
  - (i) obtain a signed consent form in accordance with the requirements of 42 Code of Federal Regulations Part 2 which authorizes the release of patient identifying information to the physician, physician's assistant, or nurse practitioner who prescribed the drug or substance to the patient ("the prescribing professional");

(ii) consult with the prescribing professional to ascertain their knowledge and awareness of the patient's history of chemical dependence, and if the prescribing professional is unaware of the patient's history of chemical dependence, inform the prescribing professional accordingly; and  
(iii) after the required consultation in (ii) above, if the prescribing professional believes that the patient should be permitted to continue to use the drug or substance, the patient must be permitted to continue to use the drug or substance;

(2) the improvement of functioning and development of coping skills necessary to enable the patient to be safely, adequately and responsibly treated in the least intensive environment; and

(3) the development of individualized plans to support the maintenance of recovery, attains self-sufficiency, and improves the patient's quality of life.

(c) Inpatient services shall provide, at a minimum, the following clinical services and procedures as clinically indicated and specified in the individualized treatment plan:

(1) individual and group counseling and activities therapy (a counseling group shall contain no more than 15 patients);

(2) chemical dependence awareness and relapse prevention;

(3) education about, orientation to, and the opportunity for participation in, available and relevant self-help groups;

(4) assessment and referral services for patients and significant others;

(5) HIV and AIDS education, risk assessment, supportive counseling and referral;

(6) vocational and/or educational assessment; and

(7) medical and psychiatric consultation.

(d) A provider of inpatient services may provide inpatient services to an individual who is on methadone or other approved opiate maintenance, or is being detoxified from methadone. Opiate maintenance or detoxification services must be provided through a written agreement with an appropriately certified methadone/opiate provider in accordance with applicable federal and state requirements including, but not limited to, regulations of the federal Center for Substance Abuse Treatment, the United States Drug Enforcement Administration, the New York State Department of Health, and the Office, including but not limited to Part 828 of this Title.

(e) Food and nutrition.

(1) Each facility shall provide to each patient three nutritious meals each day which furnish sufficient nutrients and calories to meet normal needs as well as the special needs of persons in recovery.

(2) The facility shall have available snacks and beverages between meals.

(3) A qualified dietician or dietetic technician shall provide menu planning services. Other suitable staff shall be responsible for the procurement of food supplies and the training and directing of food preparation and serving personnel. Copies of menus shall be kept on file for a period of one year.

(f) The certified bed capacity of each inpatient service shall not be exceeded at any time.

(g) Educational and child care services. Each inpatient service which provides services to school-age children must make arrangements to ensure the availability of required basic educational and child care services.

(h) Providers seeking Medicaid reimbursement must also comply with the requirements of Part 841 of this Title.

### **818.3 Admission procedures.**

(a) An individual who appears at the inpatient service seeking or having been referred for treatment or evaluation shall have an initial determination made and documented in a written record by a qualified health professional or other clinical staff under the supervision of a qualified health professional, which states the following:

- (1) that the individual appears to be in need of chemical dependence services;
- (2) that the individual appears to be free of serious communicable disease that can be transmitted through ordinary contact; and
- (3) that the individual appears to be not in need of acute hospital care, acute psychiatric care, or other intensive services which cannot be provided in conjunction with inpatient care or would prevent him/her from participating in a chemical dependence service.

(b) The determinations made pursuant to the above shall be based upon service provider records, reports from other providers and/or through a face-to-face contact with the individual, all of which must be documented.

(c) Level of care determination. If an individual is determined to be appropriate for chemical dependence services, a level of care determination shall be made by a clinical staff member who shall be provided clinical oversight by a qualified health professional. The level of care determination shall be signed and dated by the clinical staff member. The level of care determination shall be made promptly and in no event not later than one patient day after the patient's first on-site visit at the service

(d) The level of care determination process must be in accord with the governing authority's policy and procedures and incorporate the use of the OASAS Level of Care for Alcohol and Drug Treatment Referral Protocol (LOCADTR) or another Office-approved protocol.

(e) Prohibition against discrimination. No individual shall be denied admission to the inpatient service based solely on the individual's:

- (1) prior treatment history;
- (2) referral source;
- (3) maintenance on methadone or other medication prescribed and monitored by a physician, physician's assistant or nurse practitioner; however, if an inpatient service objects to a individual's continued use of such prescribed drugs or substances, the inpatient service shall document each of the following:

(i) obtain a signed consent form in accordance with the requirements of 42 Code of Federal Regulations Part 2 which authorizes the release of patient identifying information to the physician, physician's assistant, or nurse practitioner who prescribed the drug or substance to the individual ("the prescribing professional");

(ii) consult with the prescribing professional to ascertain their knowledge and awareness of the individual's history of chemical dependence, and if the prescribing professional is unaware of the individual's history of chemical dependence, inform the prescribing professional accordingly; and

(iii) after the required consultation in (ii) above, if the prescribing professional believes that the individual should be permitted to continue to use the drug or substance, the individual must be permitted to continue to use the drug or substance;

(4) pregnancy;

(5) history of contact with the criminal justice system;

(6) HIV and AIDS status;

(7) physical or mental disability; or

(8) lack of cooperation by significant others in the treatment process.

(f) Admission criteria. To be admitted for inpatient services, an individual shall:

(1) be 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:

(i) the individual has accessed a less intensive level of care and has failed to remain abstinent;

(ii) the individual's environment is not conducive to recovery;

(iii) 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

(iv) the individual lacks judgment, insights and motivation such as to require 24 hour supervision.

(g) If the individual is deemed inappropriate for inpatient services, unless the individual is already receiving chemical dependence services from another provider, a referral to a more appropriate service shall be made. The reasons for denial of any admission to the inpatient service must be provided to the individual and documented in a written record maintained by the inpatient service.

(h) If determined appropriate for the inpatient service, the individual shall be admitted. The decision to admit an individual shall be made by a staff member who is a qualified health professional authorized by the policy of the governing authority to admit individuals. The name of the qualified health professional that made the admission decision, along with the date of admission, must be documented in the case record.

(i) There must be a notation in the case record that the patient received a copy of the inpatient service's rules and regulations, including patient rights and a summary of federal confidentiality requirements, and a statement that notes that such rules were discussed with the patient, and that the patient indicated that he/she understood them.

(j) All patients shall be informed that admission is on a voluntary basis and that a patient shall be free to discharge him or herself from the service at any time. For patients under an external mandate, the potential consequences for premature discharge shall be explained, but this shall not alter the voluntary nature of admission and continued treatment. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the service in his or her own best interest.

#### **818.4 Post admission procedures.**

(a) Comprehensive evaluation.

(1) The goal of the comprehensive evaluation shall be to obtain that information necessary to develop an individual treatment plan.

- (2) The comprehensive evaluation shall obtain that information necessary to determine whether a diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office approved protocol is indicated.
- (3) Each comprehensive evaluation shall be based, in part, on clinical interviews with the patient, and may also include interviews with significant others, if possible and appropriate.
- (4) No later than three days after admission, staff shall complete the patient's comprehensive evaluation which shall include a written report of findings and conclusions addressing, at a minimum, the patient's:
- (i) chemical use, abuse and dependence history;
  - (ii) history of previous attempts to abstain from chemicals and previous treatment experiences;
  - (iii) comprehensive psychosocial history, including, but not limited to, the following:
    - (A) legal involvements;
    - (B) HIV and AIDS, tuberculosis, hepatitis or other communicable disease risk assessment;
    - (C) relationships with, history of the use of chemicals by, and the impact of the use of chemicals on, significant others;
    - (D) an assessment of the patient's individual, social and educational strengths and weaknesses, including, but not limited to, the patient's literacy level, daily living skills and use of leisure time;
    - (E) the patient's medical history, mental health history, current status, and the patient's lethality (danger to himself/herself or to others) assessment; and
    - (F) a specific diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office approved protocol.

(5) The comprehensive evaluation shall include an identification of initial services needed, and schedules of individual and group counseling to address the needed services until the development of the comprehensive treatment plan. The initial services shall be based on goals the patient identifies for treatment and shall include chemical use and any other priority issues identified in the admission assessment.

(6) The comprehensive evaluation shall bear the names of the staff members who participated in evaluating the individual and must be signed by the qualified health professional responsible for the evaluation.

(b) Medical history.

(1) For those patients who do not have available a medical history and no physical examination has been performed within 12 months, within three days after admission the patient's medical history shall be recorded and placed in the patient's case record and the patient shall receive a physical examination by a physician, physician's assistant, or a nurse practitioner. The physical examination may include but shall not be limited to the investigation of, and if appropriate, screenings for infectious diseases; pulmonary, cardiac or liver abnormalities; and physical and/or mental limitations or disabilities which may require special services or attention during treatment. The physical examination shall also include the following laboratory tests:

(a) complete blood count and differential;

(b) routine and microscopic urinalysis;

(c) if medically or clinically indicated, urine screening for drugs;

(d) intradermal PPD, given and interpreted by the medical staff unless the patient is known to be PPD positive;

(e) or any other tests the examining physician or other medical staff member deems to be necessary, including, but not limited to, an EKG, a chest X-ray, or a pregnancy test.

(2) If the patient has a medical history available and has had a physical examination performed within 12 months prior to admission, or if the patient is being admitted directly to the inpatient service from another chemical dependence service authorized by the Office, the existing medical history and physical examination documentation may be used to comply with the requirements of this Part, provided that such documentation has been reviewed and determined to be current and accurate.

(3) Patient records shall include a summary of the results of the physical examination and shall also demonstrate that appropriate medical care is recommended to any patient whose health status indicates the need for such care.

(c) After the comprehensive evaluation is completed, a patient shall be retained in such treatment only if the patient:

(1) has a diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or other Office approved protocol;

(2) continues to meet the admission criteria in this Part;

(3) is free of serious communicable diseases that can be transmitted through ordinary contact with other patients;

(4) has no medical or surgical condition or mental disability requiring acute care in a general or psychiatric hospital;

(5) is not in need of medically managed detoxification; and

(6) can benefit from continued treatment in an inpatient service.

(d) If the comprehensive evaluation indicates that the individual needs services beyond the capacity of the inpatient service to provide either alone or in conjunction with another program, referral to appropriate services shall be made. Identification of such referrals and the results of those referrals to identified program(s) shall be documented in the patient record.

(e) If a patient is referred directly to the inpatient service from another service certified by the Office, or is readmitted to the same service within sixty days of discharge, the existing level of care determination and comprehensive evaluation may be used, provided that documentation is maintained demonstrating a review and update.

(f) Treatment plan. A comprehensive written individual treatment plan (“the treatment plan”) shall be developed and implemented within seven days after admission to meet the identified needs of the patient in the major functional areas of addiction, physical health and mental health. In addition, the treatment plan shall meet identified needs in other functional areas (i.e., social, emotional, familial, educational, vocational, legal) which are deemed clinically appropriate to address during the patient’s stay at the inpatient service. The treatment plan shall take into account cultural, linguistic, and social factors as well as the particular characteristics, conditions and circumstances of the patient.

(g) The treatment plan shall take into account cultural and social factors as well as the particular characteristics, conditions and circumstances of the patient. For patients transferring directly from one chemical dependence service to another, an updated treatment plan shall be acceptable.

(h) The patient shall be included and actively participate in the treatment planning process.

(i) The treatment plan shall:

- (1) be developed in collaboration with the patient as evidenced by the patient's signature thereon;
- (2) be based on the admitting evaluations specified above and any additional evaluation(s) determined to be required;
- (3) specify short term goals which can be achieved while the patient is in the service;
- (4) prescribe an integrated service of therapies, activities and interventions designed to meet goals;
- (5) specify schedules for the provision of all services prescribed;
- (6) identify a single member of the clinical staff responsible for coordinating and managing the patient's treatment (“the responsible clinical staff member”);

(7) include the diagnosis for which the patient is being treated;

(8) be reviewed, signed and dated by the responsible clinical staff member and reviewed and approved by the multidisciplinary team, as documented by their dated signatures; and

(9) be reviewed, signed and dated by the physician within ten days of admission.

(j) Where a service is to be provided by any other service or facility off site, the treatment plan must contain a description of the nature of the service, a record that referral for such service has been made, and the results of the referral.

(k) Treatment according to the treatment plan. The responsible clinical staff member shall ensure that the treatment plan is included in the patient record and that all treatment is provided in accordance with the individual treatment plan.

(l) If, during the course of treatment, revisions to the treatment plan are determined to be clinically necessary, the treatment plan shall be revised accordingly by the responsible staff member.

(m) The case of any patient who is not responding to treatment, is not meeting goals defined in the comprehensive treatment plan, or is disruptive to the service must be discussed at a case conference by the multi-disciplinary team, and the treatment plan revised accordingly.

(n) Documentation of treatment. A progress note shall be written, signed and dated by the responsible clinical staff member or another clinical staff member familiar with the patient's care no less often than once per week. This progress note shall provide a chronology of the patient's progress related to the initial services provided or the goals established in the treatment plan and be sufficient to delineate the course and results of treatment/services. The progress note shall indicate the patient's participation in all significant services that are provided.

(o) Discharge Criteria. A patient shall be appropriate for discharge from the inpatient service, and shall be discharged, when he or she meets one or more of the following criteria:

- (1) the patient has accomplished the goals and objectives which were identified in the individual treatment plan;
- (2) the patient refuses further care;
- (3) the patient has been referred to other appropriate treatment which cannot be provided in conjunction with the inpatient service;
- (4) the patient has been removed from the service by the criminal justice system or other legal process;
- (5) the patient has received maximum benefit from the service; or
- (6) the individual is disruptive to the service and/or fails to comply with the services reasonably applied written behavioral standards.

(p) Discharge planning. The discharge planning process shall begin as soon as the patient is admitted to the inpatient service and shall be considered a part of the treatment planning process. The discharge plan shall be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. If the patient is a minor, the discharge plan must also be developed in consultation with his or her parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law Section 22.11.

(q) No patient shall be discharged without a discharge plan which has been completed and reviewed by the multi-disciplinary team prior to the discharge of the patient. This review may be part of a regular treatment plan review. The portion of the discharge plan which includes the referrals for continuing care shall be given to the patient upon discharge. This requirement shall not apply to patients who leave the inpatient service without permission, refuse continuing care planning, or otherwise fail to cooperate.

(r) The discharge plan shall be developed by the responsible clinical staff member, who, in the development of such plan, shall consider the patient's self-reported confidence in maintaining abstinence and following an individualized relapse prevention plan. The responsible clinical staff member shall also consider an assessment of the patient's home and family environment, vocational/educational/employment status, and the patient's

relationships with significant others. The purpose of the discharge plan shall be to establish the level of clinical and social resources available to the patient upon discharge from the inpatient service and the need for the services for significant others. The discharge plan shall include, but not be limited to, the following:

- (1) identification of continuing chemical dependence services and any other treatment, rehabilitation, self-help and vocational, educational and employment services the patient will need after discharge;
- (2) identification of the type of residence, if any, that the patient will need after discharge;
- (3) identification of specific providers of these needed services; and
- (4) specific referrals and initial appointments for these needed services.

(s) A discharge summary which includes the course and results of care and treatment must be prepared and included in each patient's case record within twenty days of discharge.

#### **818.5 Record keeping.**

(a) Inpatient services must maintain individual case records for each patient served. These records must, at a minimum, include the information required in this Part, as well as the source of referral, documentation of case conferences, reports of other evaluations and case consultations, medical orders, and consent forms.

(b) Patient records maintained by inpatient services are confidential and may only be disclosed in conformity with federal regulations on the confidentiality of alcohol and drug abuse patients records as set forth in 42 Code of Federal Regulations Part 2, or other applicable law.

(c) Any medical procedures required, including use of any medication, as well as the policies and procedures approved by the governing authority, shall be in accord with the requirements of federal and state law.

(d) All medical services provided must be provided pursuant to physicians, physician assistants, or nurse practitioner's order.

(e) In the event that more than one chemical dependence service is offered by a facility, the patient record shall be easily identifiable according to the service in which the patient is currently participating.

(f) There shall be a single individual patient record for each person admitted to the inpatient service which shall include:

- (1) identifying information about the patient and his or her family;
- (2) the source of referral, date of commencing service and name of primary counselor;
- (3) the admission diagnosis, including chemical dependence-related, medical, and psychiatric diagnoses in official nomenclature with associated diagnostic codes;
- (4) reports of all evaluations performed, including findings and conclusions;
- (5) reports of all examinations performed, including but not limited to X-rays, clinical laboratory tests, clinical psychological tests, electroencephalograms, and psychometric tests;
- (6) the written and signed individual treatment plan, including all reviews and updates;
- (7) progress notes informative of the patient's condition and response to treatment, written and signed by staff members;
- (8) summaries of case conferences, treatment plan updates, and special consultations held;
- (9) dated and signed prescriptions or orders for all medications with notation of termination dates;
- (10) the discharge plan;
- (11) any other documents or information regarding the patient's condition, treatment, and results of treatment; and
- (12) signed forms consenting to treatment and for obtaining or releasing confidential information in accordance with 42 Code of Federal Regulations Part 2 or other applicable law.

(g) Disclosure of HIV and AIDS related information contained in a patient's record shall be made in accordance with the Public Health Law, other applicable state and federal statutes and regulations, and subject to the additional disclosure requirements of 42 Code of Federal Regulations Part 2.

(h) Statistical information shall be reported to the Office as required and on the prescribed forms therefor.

### **818.6 Quality improvement and utilization review.**

(a) Each inpatient service shall establish and implement a quality improvement plan and utilization review plan in accordance with this section. The utilization review requirement may be met by the following:

(1) the service may perform its utilization review process internally; or

(2) the service may enter into an agreement with another organization, competent to perform utilization review, to complete its utilization review process.

(b) The utilization review plan shall include procedures for ensuring that admissions are appropriate, that retention and discharge criteria are met, and that services are appropriate. The utilization review plan shall consider each patient's need for continued treatment, the extent of the patient's chemical dependence problem, and the continued effectiveness of, and progress in, treatment.

(c) Each inpatient service shall establish a written quality improvement plan in accordance with this section.

(1) The quality improvement plan shall identify clinically relevant quality indicators that are based upon professionally recognized standards of care. This process shall include but not be limited to:

(i) no less than quarterly self-evaluations, which may include an independent peer review process as discussed below, to ensure compliance with applicable regulations and performance standards;

(ii) findings of other management activities, including but not limited to; utilization reviews, incident reviews, and reviews of staff training, development and supervision needs;

(iii) surveys of patient satisfaction; and

(iv) analysis of treatment outcome data.

(2) The inpatient service shall prepare an annual report and submit it to the governing authority. This report shall document the effectiveness and efficiency of the inpatient service in relation to its goals and indicate any recommendations for improvement in its services to patients, as well as recommended changes in its policies and procedures.

(3) The purpose of independent peer review is to review the quality and appropriateness of treatment services. The review is to focus on treatment services and the substance abuse service system rather than on the individual practitioners. The intent of the independent peer review process is to continuously improve the treatment services to chemically dependent individuals.

### **818.7 Medical policy and services.**

(a) The medical director shall, as appropriate:

(1) oversee the development and revision of medical policies, procedures and ongoing training for matters such as routine medical care, specialized services, and medical and psychiatric emergency care;

(2) advise the director of the inpatient service regarding medical and related problems;

(3) assist in the development of necessary referral and linkage relationships with other institutions and agencies including, but not limited to, general or special hospitals and nursing homes, health-related facilities, home health agencies, hospital outpatient departments, diagnostic and treatment facilities, laboratories and related resources;

(4) oversee the development of policies and procedures to ensure the provision of routine services, including but not limited to, means for the prompt detection and referral of health problems through adequate medical surveillance and regular examination as needed, implementation of medical orders regarding treatment of medical conditions and reporting of communicable diseases and infection in accordance with law;

(5) oversee the establishment of policies and procedures for public health education and screening for all patients regarding tuberculosis, sexually transmitted diseases, hepatitis and HIV and AIDS prevention and harm reduction.

(b) Each inpatient service shall have written agreements with general hospitals for the immediate transfer of patients or prospective patients in need of acute hospital care, unless the inpatient service is provided by a general hospital.

### **818.8 Staffing.**

(a) The general severity of the condition of the population served, including comorbid conditions, complications and general functioning, may indicate the need for staff in addition to those listed below.

(b) Staff may be either specifically assigned to the inpatient service or may be part of the staff of the facility within which the inpatient service is located. However, if these staff members are part of the general facility staff, they must have specific training and experience in the treatment of alcoholism, substance abuse and/or chemical dependence specific to the services provided. The percentage of time that each shared staff is assigned to the inpatient service must be documented.

(c) Each inpatient program must provide clinical supervision and ensure and document that all clinical staff have a training plan based on individual employee needs. Such training may be provided directly or through outside arrangements and must be provided at least every three years. Training must be ongoing and documented in each employee's personal record. Training may include, but is not limited to, the following areas:

- (1) chemical dependence;
- (2) individual, group and family counseling;
- (3) child abuse and domestic violence;

- (4) therapies and other activities supportive of recovery
- (5) co-occurring disorders;
- (6) communicable diseases such as tuberculosis, sexually transmitted diseases, hepatitis, HIV/AIDS;
- (7) infection control procedures;
- (8) clinical supervision;
- (9) quality improvement;
- (10) vocational rehabilitation and employment preparation services;
- (11) cultural diversity and cultural competence;
- (12) tobacco dependence;
- (13) problem gambling; and
- (14) community based recovery supports and services.

(d) There shall be a director of the inpatient service who is a qualified health professional with at least three years experience in the provision of alcoholism, substance abuse, and/or chemical dependence services, and at least two additional years of supervisory experience prior to appointment as director.

(e) There shall be a medical director who will supervise and direct all medical staff and all medical services provided at the inpatient service. The medical director shall have at least one year of education, training, and/or experience in alcoholism, substance abuse or chemical dependence services. The medical director may also serve as a physician of another service which is provided by the facility.

(f) Inpatient services which admit and provide treatment for individuals with severe mental disorders or mental illness in addition to their chemical dependence shall have a psychologist or psychiatrist, and other appropriate clinical and/or medical staff, available for a sufficient number of hours each week to provide evaluation, treatment, and supervision of other services for these patients.

(g) Inpatient services which provide treatment for persons with coexisting medical conditions in addition to their dependence shall have an appropriately qualified physician, physician's assistant, or nurse practitioner for a sufficient number of hours each week to provide evaluation, treatment and supervision of other services.

(h) There shall be at least one full-time registered professional nurse and additional licensed practical nurses, registered nurses, registered physician's assistants, and nurse practitioners sufficient to provide the services required. Such personnel shall be available to all patients at all times.

(i) There shall be at least one clinical staff member designated to provide activities therapy.

(j) There shall be at least one counselor for every eight patients, at least 50 percent of whom shall be qualified health professionals. Counseling staff shall be scheduled for a minimum of one and one-half shift five days per week, and one shift per day for the remaining two days per week.

(k) There shall be clinical staff available to all patients at all times. During late evening and night shifts, there shall be at least two clinical staff members on duty. This staff shall be awake at all times, make frequent rounds and be available to patients who awaken during the night.

(l) There shall be sufficient clinical staff to achieve an overall ratio of at least the following:

(1) if the service has 80 patients or more, one full time equivalent staff for each four patients;

(2) if the service has between 31 and 79 patients, at least one full time equivalent staff for each three and one-half patients; and

(3) if the service has 30 or fewer patients, at least one full time equivalent staff for each three patients.

(m) There shall be sufficient staff available to ensure that the inpatient service and all equipment utilized therein is maintained in such a manner as to provide patients with a clean and safe environment.

(n) In addition to staffing requirements of this Part, an inpatient service may utilize volunteers, students and trainees, on a salaried or no salaried basis. Such personnel shall be provided close professional staff supervision and appropriate education from both internal and external sources.

(o) (1) At least 50 percent of all clinical staff shall be qualified health professionals. Individuals who qualify as a CASAC Trainee pursuant to Part 853 of this chapter may be counted towards satisfying the 50 percent requirement; however, CASAC Trainees may not be considered qualified health professionals for any other purpose under this chapter.

(2) Clinical staff members who are not qualified health professionals shall have qualifications appropriate to their assigned responsibilities as set forth in the inpatient service's written personnel policies, shall be subject to appropriate staff supervision, and shall receive regular and continuing education and training.

(p) Each inpatient service shall have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases.

#### **818.9 Severability.**

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provision or applications of this Part which can be given effect without the invalid provision or applications, and to this end the provisions of this Part are declared to be severable.