Preferred Provider Substance Use Disorder Treatment Standards

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DEPARTMENT OF HEALTH

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I. Introduction

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

The ***Treatment Standards*** are subject to change. Notification of changes will be included within the summary of changes table at the end of this document.

II. Definitions

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

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

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

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

CO-OCCURRING DISORDERS: The coexistence of both a substance use disorder and another condition (often inferred to be a mental health condition but can also be a physical health condition). Co-occurring disorders are common among people in treatment.

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

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

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

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

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

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

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

DISCHARGE SUMMARY: a clinical report prepared by a health professional at the conclusion of an episode of care. It is often the primary mode of communication between the organization and transitioning providers.

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

DSM-5: The abbreviation for *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* which is a manual that helps clinicians and researchers define and classify mental health and substance use disorders. In addition to defining and explaining conditions, the DSM-5 organizes conditions into groups.

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

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

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

GRIEVANCE: An expression of dissatisfaction about any matter.

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

ICD-10: A diagnostic and procedure coding system endorsed by the World Health Organization (WHO).

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

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

INTENSIVE OUTPATIENT PROGRAM (IOP): ASAM Level 2.1 states that intensive outpatient programs are 9- 19 hours (6 or more hours for adolescents) of structured programming per week, consisting primarily of individual, group, and family counseling, medication management, and education about substance-related and mental health problems. The patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the patient is stable and requires only maintenance monitoring. (Services provided outside the primary program must be tightly coordinated.)

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

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

MEDICATION FOR OPIOID USE DISORDER (MOUD): Refers to specific FDA-approved drugs for opioid use disorder treatment such as buprenorphine, methadone, or injectable naltrexone (for opioid use disorder).

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA): part of the United States Department of Labor that is tasked with ensuring safe and healthful working conditions for workers by setting and enforcing standards and by providing training, outreach, education and assistance.

OFFICE-BASED OPIOID TREATMENT (OBOT): A team of health care professionals providing ongoing care for patients receiving MOUD that is comprised of a designated Provider who is the prescribing OBOT physician and the team of collaborating health and substance use disorder professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services. Provider practice for prescribing buprenorphine as established by the Drug Abuse and Treatment Act of 2000. In Vermont, OBOTs are often referred to as "Spokes". An OBOT may be a preferred provider, an individual provider practice or several providers practicing as a group.

OFFICE OF PROFESSIONAL REGULATION (OPR): is a division of the Office of the Secretary of State that supports boards and advisor groups that oversee licensure of 50 professions.

OPIOID TREATMENT PROGRAM (OTP): A regional center providing comprehensive substance use disorder treatment, Health Home, and rehabilitation services for individuals receiving methadone maintenance treatment, and dispensed buprenorphine to clinically complex individuals. In Vermont, OTPs are often referred to as "Hubs".

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

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

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

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

PREFERRED PROVIDER: A provider who has obtained certification pursuant to the Vermont Substance Use Disorder Treatment Certification Rule.

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

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

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

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

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

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

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

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

RESIDENTIAL WITHDRAWAL MANAGEMENT SERVICES: ASAM Level 3. 7 - WM: Medically Monitored Inpatient Withdrawal Management is an organized service delivered to patients whose withdrawal signs and symptoms are sufficiently severe enough to require 24-hour inpatient care by medical and nursing professionals, which provides for 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. These programs must comply with the requirements of ASAM Criteria, Third Edition.

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

SCHEDULE OF FEES: Maximum rate charged for specific services.

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

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

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

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

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

TRANSITION: When a person begins to receive services from a different provider or organization that will assist in managing their care.

TRAUMA: Chronic conditions that are complications from a traumatic event(s).

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

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

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

VERMONT OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (VOSHA): A division of the Vermont Department of Labor that protects the health and safety of working Vermonters.

VOLUNTEER: A non-paid employee.

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

III. General Program Standards

All Providers seeking certification must be in compliance with the General Program Standards (Sections 1-20). Population and Core Specialty Program Standards (residential, IOP, etc.) must additionally comply with the corresponding standards outlined in Sections 21 through 28.

1.0Certification Procedure and Review

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

2.0Leadership and Governance

- **2.1** The Preferred Provider has a leadership and governance structure.
  - **2.1.1** The Provider identifies those responsible for leadership and governance.
- **2.2** Governance is ultimately responsible for the safety and quality of care, treatment, or services.
  - **2.2.1** Governance defines in writing its responsibilities.
- **2.3** The governance meets regularly and is open to staff, if requested.
- **2.4** The Provider has an organizational chart that reflects current staffing.
  - **2.4.1** The organizational chart is made available to all staff and members of the governing body.

3.0Planning

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

3.2.2 The Provider has a written plan to address the national standards for Culturally and Linguistically Appropriate Services (CLAS) that are updated when the CLAS standards are updated.

4.0 Fiscal Management

4.1 The Preferred Provider must have fiscal management practices and internal controls that demonstrate the following:

4.1.1 Medicaid certification.

4.1.2 A publicly available fee schedule.

4.1.2.1 Written policies and procedures describing eligibility for and implementation of a sliding fee schedule.

4.1.3 Comprehensive internal monitoring of billing, expenditures, and revenues by person served, by staff, by service, by program, and by service provider, in accordance with generally accepted accounting principles (GAAP).

4.1.3.1 Must establish and maintain effective internal control over the state and federal funding to provide reasonable assurance that funds are managed in accordance with the intent of the funding.

4.1.3.2 Internal controls must be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States and the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

4.1.4 Practices that ensure that the organization's budget utilization matches the funding source, provider agreements, and payer of last resort requirements.

4.1.4.1 Policies and procedures which outline that Medicaid program is the payer of last resort, and that if another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment.

4.1.5 The Provider uses a formal written procedure to prepare a revenue and expense budget.

4.1.6 Retention of records schedule that adheres to provider agreements as well as state and federal regulations and process for maintaining, storing, and accessing those records for a minimum of three years unless stricter timelines apply.

5.0 Human Resources

The Provider has a written non-discrimination policy.

5.1 The policy addresses non-discrimination on the basis of:

5.1.1 Race.

5.1.2 Religion.

5.1.3 Gender.

5.1.4 Ethnicity.

5.1.5 Age.
5.1.6 Disabilities or health conditions.
5.1.7 Sexual orientation.
5.1.8 Real or perceived HIV status.

5.2 The Provider has a code of ethics, which governs the behavior of all staff, including business practices.
5.2.1 There are procedures for investigating and acting upon violations, including reporting to authorities as warranted.

5.3 The Preferred Provider has policies that require staff responsible (as per their job descriptions) for substance use disorder counseling to:
5.3.1 Be licensed in Vermont to provide substance use disorder treatment, or:
5.3.1.1 Have or acquire an Addiction Apprentice Professional (AAP) certificate through Office of Professional Regulation within 180 days of hire, or
5.3.1.2 Have alcohol and drug abuse counselor (ADC) certificate, or
5.3.1.3 Possess a Master's degree, be rostered with the Vermont Office of Professional Regulation, and be actively fulfilling the required number of hours of supervised work experience providing alcohol/drug counseling commensurate with their degree, as outlined by the Vermont Office of Professional Regulation.
5.3.2 If the non-licensed staff does not meet this requirement, they must cease providing direct services.

5.4 The Provider must have policies and procedures for conducting background checks on personnel in compliance with state and federal laws, including Medicaid regulations.

5.5 The Provider must have and make available to all employees a personnel policy and procedures manual.
5.5.1 The personnel policies and procedures manual must include, at a minimum, information on employee:
5.5.1.1 Recruitment, hiring, benefits, and promotion;
5.5.1.2 Training and development;
5.5.1.3 Safety and health;
5.5.1.4 Assistance programs;
5.5.1.5 Disciplinary systems and practices;
5.5.1.6 Grievance mechanisms;
5.5.1.7 Wages, hours, and salary administration;
5.5.1.8 Rules of conduct;
5.5.1.9 Code of ethics;
5.5.1.10 Performance appraisals;
5.5.1.11 Equal employment opportunity (EEO) and affirmative action policies;
5.5.1.12 Confidentiality;
5.5.1.13 Methods and procedures for supervision including supervision of clinical staff.
5.5.2 There is written and dated documentation in the personnel record that the staff person has reviewed the personnel policies and procedures.

5.5.3 There is written and dated documentation that the personnel policies and procedures are reviewed and updated (as necessary).

5.5.4 There is a mechanism for notifying all employees of changes in personnel policies and procedures, which is documented.

5.6 Each employee must be oriented to all policies and procedures pertinent to their job description.

5.6.1 There is written and dated documentation, signed by the employee, in the personnel file, that they have received this orientation.

5.6.2 The orientation must include receipt of and discussion about federal confidentiality regulations, 42 CFR Part 2 and as amended.

5.6.3 There is written and dated documentation, signed by the employee, that they agree to abide by the federal confidentiality regulations, 42 CFR Part 2 and as amended.

5.6.4 The orientation must include evidence that the staff member has completed a training on documentation policies and procedures that is inclusive of the items outlined in Section 12.0.

5.7 The Provider has a job description for each staff position that contains information on:

5.7.1 The written job descriptions contain information on the:

5.7.1.1 Credentials and/or licensure required;

5.7.1.2 Duties and responsibilities;

5.7.1.3 Minimum levels of education and training required;

5.7.1.4 Related work experience required;

5.7.1.5 Reporting and supervisory responsibilities;

5.7.1.6 Salary range of the position.

5.7.1.7 Performance criteria.

5.7.2 Changes in the duties and responsibilities of positions are reflected in revisions and updates of job descriptions.

5.7.3 There is dated documentation in the personnel file, signed by the employee, that a copy of the current job description has been provided to him/her.

5.8 A personnel record is maintained for each member of the staff.

5.8.1 The personnel record contains documentation of the employees' training and credentialing documents.

5.8.2 The personnel record contains signed and dated documentation of the employees' performance appraisals.

5.8.3 Employees may access their own personnel records for review and comment.

5.8.4 Personnel records are stored, maintained, and utilized in such a way as to protect employee confidentiality.

5.9 Performance appraisals are conducted using pre-established performance criteria based on the specific responsibilities of the position as stated in the job description.

5.9.1 Performance objectives established in the previous period must be evaluated.

5.9.2 Dated performance appraisals are conducted for each staff person at least annually.

5.9.3 There is dated documentation, in the personnel record, the staff have reviewed, signed, and discussed their performance appraisals with their supervisor.

5.9.4 Performance appraisals must document deficient performance and establish a plan to address the deficiencies.

5.10 The Provider has policies and procedures for the supervision of all individuals providing direct services.

5.10.1 The policies and procedures must require clinical supervision of any clinical or direct service personnel that provides substance use disorder services by a qualified licensed professional at a minimum of twice a month and pursuant to requirements outlined by the Office of Professional Regulation.

5.11 Ongoing supervision of clinical or direct service personnel is documented.

5.12 The Provider has a written and dated policy and procedure for employees who have problems that interfere with acceptable job performance.

5.13 Students, interns, or volunteers are to be held to the standards outlined by this section.

5.14 Trainings with approved continuing education credits in substance use disorder services are made available to employees who provide billable substance use disorder services.

6.0 Risk Management

6.1 The Provider must implement a risk management plan, which includes:

6.1.1 Explanation of extent to which the continuity of care can be maintained during unforeseen events.

6.1.2 Emergency preparedness procedures.

7.0 Accessibility

7.1 The Provider must make accommodations for individuals with language barriers or with special needs per American Disability Act (ADA) Federal guidelines.

8.0 Health and Safety

8.1 The Provider must implement an infection control policy in compliance with OSHA/VOSHA and Vermont Department of Health regulations that include the prevention of transmission of tuberculosis and that address the following:

8.1.1 Screening individuals and identifying those individuals who are at risk of becoming infected.

8.1.2 Testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment for the individual.

8.1.3 Appropriate medical evaluation and treatment for individuals infected with mycobacteria tuberculosis.

8.1.4 Identification of those individuals who are at high risk of becoming infected.

8.1.5 Counseling individuals with respect to tuberculosis.
8.1.6 Case management activities to ensure that individuals receive such services.
8.1.7 Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR Part 2.
8.1.8 For persons denied admission to the program on the basis of lack of capacity, the program refers such persons to other providers of tuberculosis services.

8.2 The Provider has procedures for addressing critical incidents that include:
8.2.1 Reporting.
8.2.2 Remedial action.
8.2.3 Timely debriefings.
8.2.4 The following incidents:
8.2.4.1 Serious Illness.
8.2.4.2 Injuries.
8.2.4.3 Deaths.
8.2.4.4 Alleged or confirmed abuse or neglect.
8.2.4.5 Medical errors.
8.2.4.6 Communicable diseases.
8.2.4.7 Infection control.
8.2.4.8 Aggression or violence.
8.2.4.9 Use and unauthorized possession of a weapon.
8.2.4.10 Vehicular accidents.
8.2.4.11 Bio-hazardous accidents.
8.2.4.12 Suicide or attempted suicide.
8.2.4.13 Unauthorized use and possession of legal or illegal substances.
8.2.4.14 Sexual abuse/assault.
8.2.4.15 Abduction.
8.2.4.16 Security breaches.
8.2.4.17 Other sentinel events.

8.3 Each Provider must define sentinel events for its own purposes and must communicate this definition throughout the organization.

8.4 The following critical incidents must be reported using the DSU designated form to the DSU Clinical Services Director within 24 hours of staff knowledge of the event.
8.4.1 Serious illness and/or injuries resulting in medical care as a result of services delivered or on the premises.
8.4.2 Death.
8.4.3 Alleged or confirmed assault, including sexual assault by staff or by other.
8.4.4 Medical errors.
8.4.5 Medication errors that require intervention or monitoring.
8.4.6 Unlawful activity perpetrated on property by staff or by others.
8.4.7 Any incident, marked by seriousness or severity, that is likely to result in attracting negative public attention, or lead to claims or legal action against the State or the reporting entity.

8.5 The Provider's policies and procedures for addressing at a minimum for the DSU reportable critical incidents must include:
- 8.5.1 Conducting timely, thorough, and credible root cause analysis.
- 8.5.2 Development of an action plan designed to implement improvements to reduce risks.
- 8.5.3 Implement improvements and monitor the effectiveness of those improvements.

8.6 There are policies and procedures for the handling of both licit and illicit drugs brought into the Provider by both persons served and personnel.

9.0 Quality Assurance and Performance Improvement

9.1 The Provider has clear documentation of the methods to collect data on all persons served.

9.2 At a minimum, data about all persons served must be collected:
- 9.2.1 At intake.
- 9.2.2 At discharge.
- 9.2.3 For each service rendered.

9.3 The data must be used to inform and link to the Provider's:
- 9.3.1 Strategic plan.
- 9.3.2 Quality improvement plan.

9.4 The Provider maintains and implements a quality improvement plan and documents actions toward the areas shown to need improvement.

9.5 The quality improvement plan:
- 9.5.1 Defines the quality improvement structure and procedures.
- 9.5.2 Is informed by data and outcomes.
- 9.5.3 Incorporates measurable goals and objectives.
- 9.5.4 Incorporates performance indicators:
  - 9.5.4.1 Service access.
  - 9.5.4.2 How well did we do it?
  - 9.5.4.3 Is anyone better off?

10.0 Rights of the Person Served

10.1 Rights of the person served must be communicated to the person served:
- 10.1.1 In a manner the person served understands.
- 10.1.2 Prior to the beginning of service delivery or at the initiation of service delivery.
- 10.1.3 When informed consent is not possible due to the inability of the person served to understand his/her rights in the treatment process, documentation of this factor appears in the client record.

10.2 The Provider's policies promote the following rights of the persons served:
- 10.2.1 Confidentiality of information.
- 10.2.2 Privacy.
- 10.2.3 Freedom from:
  - 10.2.3.1 Abuse.
  - 10.2.3.2 Financial or other exploitation.

10.2.3.3 Retaliation.
10.2.3.4 Humiliation.
10.2.3.5 Neglect.
10.2.4 Access to:
10.2.4.1 Information pertinent to person served in a timely manner in order to facilitate their decision-making.
10.2.4.2 Their record.
10.2.4.3 Their treatment plan.
10.2.4.4 Participate in developing their individualized treatment plan.
10.2.5 Informed consent or refusal regarding:
10.2.5.1 Service delivery
10.2.5.2 Release of information
10.2.5.3 Concurrent services
10.2.5.4 Involvement in human subject research projects, if applicable.
10.2.6 Access or referral to:
10.2.6.1 Self-help support services
10.2.6.2 Advocacy support services
10.2.7 Adherence to human subject research guidelines and ethics when persons served are involved, if applicable.
10.2.8 Investigation and resolution of alleged infringement of rights.
10.2.9 Other legal rights.

10.3 The Provider demonstrates:
10.3.1 Knowledge of the legal status of the persons served.

10.4 The Provider must implement procedures that conform to Vermont Medicaid's grievance process and administrative rules.

10.5 The Provider has policies and procedures allowing persons served to review their medical record.

10.6 The Provider has policies and procedures regarding the use of current clients as paid or voluntary staff that ensure:
10.6.1 Employment must be in accordance with local, state, and federal laws and regulations.
10.6.2 Employment at prevailing fair market rates.

11.0 Levels of Care: Structure and Staffing

11.1 The Preferred Provider will be authorized to provide only the specific levels of care and associated services, at specific sites, approved and certified by DSU. Authorization will be considered for the following levels of care:
11.1.1 Withdrawal management (non-medical),
11.1.2 Outpatient care,
11.1.3 Intensive outpatient care,
11.1.4 Residential care.

11.2 Staffing requirements are in accordance with the ASAM Criteria and are determined by the level of care being provided.

11.3 Each level of care:
11.3.1 Documents the following parameters regarding its scope of services:

11.3.1.1 Setting.
11.3.1.2 Support systems.
11.3.1.3 Staffing.
11.3.1.4 Therapies.
11.3.1.5 Assessment.
11.3.1.6 Treatment Planning.
11.3.1.7 Documentation.

11.4 Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed publications, clinical practice guidelines, and/or expert professional consensus.

11.5 Services must be designed and implemented to:
- 11.5.1 Support the recovery, health, and well-being of the persons or family served.
- 11.5.2 Reduce symptoms and needs and build resilience.
- 11.5.3 Restore and/or improve functioning.
- 11.5.4 Support the integration of persons served into the community.

11.6 The level of care offers, either in-house or through referral of available local support, one or more of the following:
- 11.6.1 Peer support.
- 11.6.2 Local advocacy groups.
- 11.6.3 Self-help groups.

11.7 As appropriate, families are:
- 11.7.1 Encouraged to participate in educational programs offered by the Provider.
- 11.7.2 Invited to participate in clinical programs or services with the person served, with consent or legal rights.

11.8 The Provider implements policies and procedures that address:
- 11.8.1 The handling of items brought into the Provider by personnel and persons served that include:
  - 11.8.1.1 Illegal drugs.
  - 11.8.1.2 Legal drugs.
  - 11.8.1.3 Prescription medication.
  - 11.8.1.4 Weapons.
- 11.8.2 The prohibition of the use of tobacco products on the facility grounds and in vehicles owned and operated by non-residential organizations.

11.9 The Provider has information available identifying other social service providers who offer related or ancillary services that supplement the principal services of the Provider.
- 11.9.1 Collaborate with community elder care providers (e.g. area agencies on aging, SASH programs, home health agencies, etc.) in improving mental health and substance use disorder services for the elderly.

11.10 Providers providing child and adolescent substance use disorder treatment should make the necessary steps to ensure care is:
- 11.10.1 Coordinated with family, school, community, behavioral health and physical health, and is developmentally, cognitively, and culturally

appropriate; and with a workforce knowledgeable about child and adolescent substance use disorder treatment.

11.10.2 Developmentally appropriate substance use disorder treatment services that address child and adolescent treatment to effectively engage and treat these groups, and evidence based or emerging practice when possible.

12.0 Documentation

12.1 The Preferred Provider has policies and procedures that define the format and content of records for persons served.

12.1.1 The record must contain:

12.1.1.1 Information collected at admission includes name, address, date of birth, and gender of the person served.

12.1.1.2 Name and contact information for the persons served, family, and any legal authorized representative.

12.1.1.3 The preferred language and any special communication needs of the individual served.

12.1.1.4 The reason(s) for admission for care.

12.1.1.5 Assessment and reassessments.

12.1.1.6 Allergies.

12.1.1.7 Diagnosis established during treatment.

12.1.1.8 Consultant reports.

12.1.1.9 Observations relevant to care.

12.1.1.10 The response to care.

12.1.1.11 Progress notes.

12.1.1.12 Medications ordered or prescribed.

12.1.1.13 Medication administered, including dose, strength, and route.

12.1.1.14 Adverse drug reactions.

12.1.1.15 Treatment plan and revisions.

12.1.1.16 Orders for tests and their results.

12.1.1.17 Advanced directives (including when appropriate for youth).

12.1.1.18 Informed consent.

12.1.1.19 Documentation of consent by the person served, guardian, or legal authority as applicable for admission, treatment, continuing care, or research.

12.1.1.20 Discharge summary.

12.1.1.21 Transition plan.

12.1.1.22 Sign-offs by the person served that is mandated by these standards.

12.2 The Provider has a system to protect client records from inappropriate disclosure, and the system:

12.2.1 Complies with all applicable State and Federal laws and regulations, including 42 CFR Part 2.

12.2.2 Includes provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure.

12.3 The Provider is in compliance with data and documentation requirements outlined in any grant award from DSU and/or pertinent state or federal regulations.

12.4 The Provider has a policy and procedure for closing, storing, and destroying person served identifying information that is in compliance with both Federal and State requirements.

12.5 Documentation of services provided must be legible, of sufficient clarity, sufficient clinical content (minimum required content is specified for each service) and abide by Medicaid documentation expectations to ensure eligibility for payment.

12.6 All clinical and support notes must include:

12.6.1 Identification of the person served such as name, identification number, and date of birth.

12.6.2 Date the service was rendered.

12.6.3 Specific title or code of the service rendered.

12.6.4 Location in which the service occurred.

12.6.5 Amount of time it took to deliver the service.

12.6.6 Reference to the treatment goal for the service.

12.6.7 Summary of the service rendered with appropriate clinical content.

12.6.8 Specific plan for ongoing treatment.

12.6.9 Name, title, credentials, and signature(s) of the clinician(s). If not required by the Provider, qualifications, degrees and titles must be on file at the Provider and made available.

12.7 Each reimbursed service must be documented in the person's served clinical record.

12.8 Providers requesting and demonstrating appropriate safeguards for use of computer-generated signatures may use electronic signature technology. Policies should be in compliance with Federal law 42 CFR Part 2.

13.0 Screening and Access

13.1 The Preferred Provider has screening/eligibility policies and procedures that:

13.1.1 Define:

13.1.1.1 How screening is conducted.

13.1.1.2 Eligibility for services.

13.1.1.3 How admissions are prioritized and conducted.

13.1.1.3.1 Prioritization for treatment is as follows:

13.1.1.3.1.1 Pregnant women who use substances intravenously

13.1.1.3.1.2 Pregnant women who use substances

13.1.1.3.1.3 People who use substances intravenously

13.1.1.3.1.4 All other people who use substances.

13.1.1.4 Exclusionary or ineligibility criteria.

13.1.2 Address acceptance and refusal of referrals from outside agencies.
13.1.3 Outline treatment of pregnant women through:
13.1.3.1 Compliance with a forty-eight (48) hour time limit within which screening and eligibility determination for a pregnant woman is identified and shared with those seeking services and/or the referring agency as clinically appropriate.
13.1.3.2 Referral to DSU when the Provider has insufficient capacity to provide services to any pregnant women who seek the services from the Provider.
13.1.3.2.1 Any Provider refusing services to a pregnant woman due to insufficient capacity must refer those people to DSU's Clinical Services Director within forty-eight (48) hours.

13.2 Each individual who requests and is in need of treatment for intravenous substance use is admitted to a program no later than:
13.2.1 14 days after making the request for admission to such a program; or
13.2.2 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request.
13.2.3 If a person cannot be located for admission into treatment or, if a person refuses treatment, such persons may be taken off the waiting list and need not be provided treatment within 120 days. For example, if such persons request treatment later, and space is not available, they are to be provided interim services, placed on a waiting list and admitted to a treatment program within 120 days from the latter request.

13.3 When screening is conducted the Provider must:
13.3.1 Utilize evidence-based tools as clinically appropriate.
13.3.2 Document each person's eligibility.
13.3.3 Identify potential alternative treatment sources when services cannot be provided.
13.3.4 Include an interview with the person to be served or referral source.
13.3.5 Ensure that screening tools used are uniformly administered and personnel are trained to use the tools prior to administration.
13.3.6 Collaborate with community screeners to identify high-risk populations (e.g. older adults or individuals involved with child welfare) and triage appropriately.

13.4 When appropriate, the Provider has a policy and procedure for offering interim services that address, at a minimum, the following:
13.4.1 Counseling and education about HIV and tuberculosis, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and tuberculosis does not occur.
13.4.2 Referral for HIV or tuberculosis treatment services, if necessary.
13.4.3 Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women.
13.4.4 That special attention is given to the following groups:

13.4.4.1 Pregnant women who use substances.
13.4.4.2 Women who use substances and who have dependent children.
13.4.4.3 People who use substances intravenously.
13.4.4.4 People who use substances and have HIV or tuberculosis.

13.5 If, within the course of a screening, an individual is in crisis:

13.5.1 It is documented.

13.5.2 The following topics are addressed:

13.5.2.1 Suicide risk.
13.5.2.2 Danger to self or others.
13.5.2.3 Urgent or critical medical condition(s).
13.5.2.4 Immediate threats.

13.6 The Provider utilizes procedures with written and standardized admission criteria for each level of care offered by the Provider.

13.6.1 The admission criteria are publicly available to person served, staff, and community.

13.6.2 The procedure includes criteria for determining that the level of care is appropriate to the needs of the person served.

13.6.3 The procedure addresses acceptance and refusal of referrals from outside agencies.

13.7 The provider makes the availability of services and the fact that pregnant women receive preference publicly available, according to section 13.1.1.3.1.

13.8 All persons served receive an orientation. For individuals not continuously in treatment, providers must have a policy that discusses the frequency of which an orientation must occur.

13.8.1 There is written and dated documentation signed by the person served that the orientation occurred.

13.8.2 The orientation includes an explanation of the Provider's policies relating to treatment of the person served:

13.8.2.1 Philosophy and goals.
13.8.2.2 Confidentiality policies including 42 CFR Part 2 limitations and requirements.
13.8.2.3 Consent to treatment.
13.8.2.4 Rules governing conduct.
13.8.2.5 Transitions between levels of care criteria and procedures.
13.8.2.6 Hours of services and access to after-hour services, as appropriate.
13.8.2.7 Costs, fees and payment responsibility.
13.8.2.8 Mandated reporting laws.

13.8.3 The orientation includes an explanation of:

13.8.3.1 Rights and responsibilities of the persons served.
13.8.3.2 Grievance procedures.
13.8.3.3 The Provider's health and safety policies regarding:

13.8.3.3.1 Use of tobacco products.
13.8.3.3.2 Legal or illegal substances brought into the program.
13.8.3.3.3 Prescription medication brought into the program.

13.8.3.3.4 Weapons brought into the program.

13.8.3.4 The Provider's rules and expectations of the persons served, which identifies the following:

13.8.3.4.1 Any restrictions the Provider may place on the person served.

13.8.3.4.2 Event, behaviors, or attitudes and their likely consequences.

13.8.3.4.3 Means by which the person served may regain rights or privileges that have been restricted.

13.8.3.5 A written description of:

13.8.3.5.1 How the person-centered treatment plan will be developed.

13.8.3.5.2 The person's participation in goal development and achievement.

13.8.3.5.3 Expectations for legally required appointments, sanction, or court notification.

14.0 Assessment

14.1 The Preferred Provider has policies and procedures for obtaining a person served assessment and the establishment of a diagnosis.

14.1.1 The policy and procedure requires that a written assessment:

14.1.1.1 Be completed by qualified personnel trained in the applicable tools, tests, instruments, prior to administration, and signed off by a licensed professional.

14.1.1.2 Document the risk ratings across all six dimensions in the ASAM Criteria to determine the appropriate level of care.

14.1.1.3 Address use of appropriate assessment measurement tools as it applies to presenting diagnosis.

14.1.1.4 Be completed, verified by dated signature, within the following time frames:

14.1.1.4.1 For outpatient and intensive outpatient served programs, by the end of the third (3rd) clinical visit. For OTPs a clinical visit is defined as a scheduled meeting with a case manager or licensed professional.

14.1.1.4.2 For residential substance use disorder treatment, by the end of the sixth (6th) day.

14.1.1.5 The assessment must be conducted in a manner that is sensitive to a history of possible sexual abuse or domestic violence and should not lead to retraumatization.

14.1.1.5.1 Unless contraindicated, the assessment should include trauma sequelae.

14.1.1.6 Family functioning and strengths must be assessed.

14.1.1.7 Barriers to treatment participation and necessary accommodations must be assessed.

14.2 The assessment includes an evaluation of the following areas:

14.2.1 Presenting problem(s)
14.2.2 Mental health status including:
14.2.2.1 Suicide risk.
14.2.2.2 Personal Safety.
14.2.2.3 Risk to others.
14.2.3 The relationship between substance use disorder and criminal activity.
14.2.4 Substance use history including tobacco or tobacco-derived products and other addiction disorders, as clinically appropriate.
14.2.5 Previous substance use disorder and mental health services including diagnostic and treatment histories.
14.2.6 Physical health information including:
14.2.6.1 Health history and current health needs.
14.2.6.2 Medication history and current use profile.
14.2.6.3 Known allergies.
14.2.6.4 Advance directives.
14.2.7 Family/Interpersonal history.
14.2.7.1 Staff routinely follow up on questions such as 'do you have children within your care' by asking about and recording the names and dates of birth of any children.
14.2.7.2 Who children are living with and who has custody.
14.2.7.3 Parent/guardian's current contact with children, including current visitation plan, if any.
14.2.7.4 Parent/guardian's desired contact with children if contact is limited.
14.2.7.5 If parent/guardian is involved with the Department for Children and Families (DCF), staff should make every effort to obtain name and phone number of the DCF social worker and explain the importance of establishing productive, ongoing partnerships with DCF, including sharing information about parental treatment, and developing shared treatment and service plans.
14.2.8 Cultural considerations.
14.2.9 Educational/Employment history.
14.2.10 Legal history and current involvement with criminal justice system.
14.2.11 History of trauma that is experienced and/or witnessed.
14.2.12 Current level of behavioral, cognitive, and emotional functioning.
14.2.13 Person's strengths, needs, abilities, and preferences.

14.3 Assessments for each child and adolescent must be age, gender, developmentally and culturally specific, and include information on:
14.3.1 Developmental history, including developmental age factors, motor development, and functioning.
14.3.2 Medical history and physical health history.
14.3.3 Treatment history.
14.3.4 School history, including information on special education services provided.
14.3.5 Intellectual functioning.

14.3.6 Family relations.
14.3.7 Social functioning/interactions with peers.
14.3.8 Environmental surroundings (home and community).
14.3.9 Alcohol and drug use disorder history.
14.3.10 Criminal justice involvement.
14.3.11 Parental/guardian custodial status when applicable.
14.3.12 When applicable, parents'/guardians':
14.3.12.1 Ability/willingness to participate in services.
14.3.12.2 Strengths.
14.3.12.3 Preferences.

14.4 The assessment process results in a written and dated document that includes:
14.4.1 Interpretive summary.
14.4.2 DSM-5 Diagnosis or ICD-10 diagnostic code.
14.4.3 Identification of any co-occurring disorders, including eating disorders.
14.4.4 ASAM Level of Care review and justification.
14.4.5 Treatment recommendations.

14.5 If the person served has received an assessment from a Preferred Provider or licensed professional in the previous twelve months and a full assessment is not clinically necessary, the treating Provider is encouraged to do an addendum. The addendum should include:
14.5.1 ASAM Level of Care review and justification.
14.5.2 Mental health exam.
14.5.3 DSM-5 diagnosis or ICD-10 diagnosis.
14.5.4 Changes to any section 14.2 listed above since the last assessment.
14.5.5 A copy of assessment from the provider or program in the medical record.
14.5.6 Signature of qualified professional and dated by staff completing addendum assessment and signed off by licensed professional.
14.5.7 Updates to treatment recommendations.

14.6 The Provider must have a policy and associated procedures stating:
14.6.1 How the Provider regularly screens, assesses, and treats using clinical practice guidelines for tobacco cessation including:
14.6.1.1 Counseling.
14.6.1.2 Utilization of FDA-approved nicotine replacement products or medications, as appropriate.
14.6.2 How the Provider promotes no cost state resources.

15.0 Case Management

15.1 All Preferred Providers must provide case management services, as appropriate, that provide goal-oriented and individualized support focused on improving self-sufficiency for the person served through assessment, planning, linkage, advocacy, coordination, and monitoring. Case management must be flexible and must be driven by the unique needs of the client.
15.1.1 Based on the needs of the persons served, case management includes:
15.1.1.1 Outreach to encourage participation.

15.1.1.2 Coordination of, or assistance with, crisis intervention, as appropriate.
15.1.1.3 Optimizing resources and opportunities through community linkages.
15.1.1.4 Assistance with and linkages to:
15.1.1.4.1 Accessing transportation.
15.1.1.4.2 Securing housing.
15.1.1.4.3 Exploring employment or meaningful activities.
15.1.1.4.4 Securing childcare and assistance with school enrollment of children.
15.1.1.4.5 Health insurance and maintaining insurance coverage.
15.1.1.4.6 Life skills education.
15.1.1.4.7 Skill development services.
15.1.1.4.8 Social Services.
15.1.1.4.9 Child Welfare System.
15.1.1.4.10 Schools.
15.1.1.4.11 Caregivers (including foster care or kin), if children are not in their birth parent's custody.
15.1.1.4.12 Financial services.
15.1.1.4.13 Legal services.
15.1.1.4.14 Criminal justice system staff.
15.1.1.4.15 Medical services.
15.1.1.5 Care coordination with primary care provider to ensure effective planning and communication.

15.1.2 It is the expectation that the Provider must secure and document a 42 CFR Part 2 Compliant Release of Information from the person served in order to coordinate care. When a Release of Information exists, communication is documented.

16.0 Person-Centered Treatment Plan

16.1 There is written and dated documentation that each person served receives a person-centered treatment plan that is:
16.1.1 Developed with the person served and with the involvement of family or legal guardian of the person served, when applicable and permitted.
16.1.2 Based on the assessment.
16.1.3 Recognizes the persons' strengths, needs, abilities, preferences.
16.1.4 Formed with knowledge of the persons' cultural considerations.

16.2 For those served who remain in treatment with the Provider, the plan must be completed, dated, and signed by:
16.2.1 The end of the fourth (4th) visit (for outpatient, IOP, and OTPs programs. For OTPs a visit is defined as a scheduled meeting with a case manager or licensed professional.
16.2.2 The end of the seventh (7th) day (for all residential programs).
16.2.3 The end of the fourth (4th) visit .

16.3 The Plan includes the following components:

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

16.3.2 For each goal, there are treatment objectives that are:

16.3.2.1 Specific to the person served.

16.3.2.2 Measurable.

16.3.2.3 Achievable.

16.3.2.4 Realistic.

16.3.2.5 Time specific and time limited.

16.3.3 Treatment objectives must identify the specific interventions, modalities, or services including:

16.3.3.1 Frequency of the intervention.

16.3.3.2 The staff responsible for helping to accomplish the objective.

16.4 The person served must sign and date a statement, included in the treatment plan, indicating that they have reviewed, participated in the development of, and understand the treatment plan.

16.5 The counselor must sign and date the treatment plan upon its completion.

16.6 Person-centered treatment plans are reviewed and updated by the clinician and the person served as verified by a signed and dated plan no less frequently than:

16.6.1 When there are significant changes in a person's life.

16.6.2 When there are changes to the treatment modality, frequency and/or amount of treatment services.

16.6.3 When there is a transition between levels of care. When people are receiving services from the OTPs (hubs), within the first year of service people must receive updated plans quarterly. After receiving services for one year, people must receive updated plans bi-annually.

16.7 If the clinician signing the treatment plan is a non-licensed clinician, AAP, or CADC, the treatment plan must be cosigned by:

16.7.1 A LADC of at least one year full-time professional experience working as such, and who is licensed and in good standing in the state of practice; or

16.7.2 An independent clinical social worker, psychologist, marriage and family therapist, or clinical mental health counselor, licensed and in good standing in Vermont or a foreign jurisdiction acceptable to the OPR Director, who has completed addiction counseling training consistent with the OPR Licensing Rules and has accrued at least one year of full-time addiction counseling experience or its part-time equivalent; or

16.7.3 An allopathic or osteopathic physician certified in addiction medicine by the American Society of Addiction Medicine, the American Osteopathic Association, the American Board of Psychology and Neurology, or an equivalent certifying body approved by the OPR Director.

16.8 Clients must be offered a copy of their treatment plan and each update thereof.

16.9 After each billable service there must be documentation supporting continued need for services based on clinical necessity, including the following:
- 16.9.1 Dated progress notes that link to the treatment plan;
- 16.9.2 Updates or modifications to treatment plan;
- 16.9.3 Interventions provided and person served response;
- 16.9.4 Printed staff name and signature or electronic equivalent.

17.0 Transition Plan

17.1 The Preferred Provider has policies and procedures on persons served who are transitioning or are discharged from the Provider.
- 17.1.1 The policy states that persons served must participate in the development of their transition plans as early as possible in the person-centered treatment planning and service delivery process.

17.2 There must be entered into the person served record a discharge summary within seven (7) days following discharge signed and dated by the clinician, which includes:
- 17.2.1 Date of admission and discharge.
- 17.2.2 Presenting condition.
- 17.2.3 Description of the services provided.
- 17.2.4 Description of progress toward treatment goals and objectives.
- 17.2.5 Reason for discharge/ transition.
- 17.2.6 Identification of unmet needs and recommended services and supports after discharge.
- 17.2.7 Medications prescribed by the Provider during the episode of care.
- 17.2.8 Final diagnosis.
- 17.2.9 Dated signature of the staff completing the discharge summary.

17.3 The written transition plan is developed and:
- 17.3.1 Is prepared to ensure seamless transition when a person served is transferred to another level of care or prepares for a planned discharge.
- 17.3.2 Identifies the person's need for a recovery support system or other types of service that will assist in continuing the recovery and community integration.
- 17.3.3 Includes referral information made for additional services such as appointment dates, times, contact name, telephone number, and location.
- 17.3.4 Includes recommendations for self-help and contact information for local peer recovery support services.
- 17.3.5 Must include the signature of the person served and/or their legal guardian as applicable.

17.4 For transitions between levels of care and/or Providers:
- 17.4.1 Counselors ensure successful transition between clinically appropriate levels of care.
- 17.4.2 Referring Providers must provide the receiving Provider the most recent assessment upon receipt of a signed release of information.

17.5 Upon discharge, when person served has given documented consent, the Provider, when prescribing medications, must document coordination of care with the Primary Care Provider and/or external prescribing professional regarding, at a minimum, what medications are being prescribed and for what diagnoses.

18.0 Medication Monitoring and Management

18.1 All medications are administered in accordance with accepted and statutory clinical practice under the authority of a prescribing professional.

18.2 A list of clinical staff members authorized by the Preferred Provider and by law to administer or dispense medications is maintained and updated as needed.

18.3 Self-administration of medication is permitted only when specifically ordered by the responsible prescribing professional.

18.4 Drugs and prescriptions brought into the Provider for the person served are neither administered nor made available for self-administration unless they are identified by the Provider and approved by the responsible prescribing professional.

18.5 Medication errors and adverse drug reactions are documented in the person served record and reported to the responsible prescriber upon discovery.

18.6 The Provider has policies and procedures regarding pharmaceutical practices.

18.6.1 Providers will offer a pregnancy test before implementation of medication for opioid use disorder.

18.6.2 Treatment for pregnant people receiving methadone or other approved controlled substances from a Preferred Provider licensed to provide medication for opioid use disorder treatment will be based on up-to-date clinical best practices

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

19.0 Crisis Management

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

IV. Specialty Program Standards

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

20.0 Medications for Opioid Use Disorder

Preferred Providers who administer medication assisted treatment for opioid use disorders must also conform to current Vermont Department of Health Medication-Assisted Treatment for Opioid Use Disorder Treatment Rules established under the authority of 18 VSA Chapter 92.

21.0 Intensive Outpatient Treatment (IOP)

21.1 In IOP treatment the person served and/or family members are provided at least nine (9) (if serving adults) and six (6) (if serving adolescents) but not more than nineteen (19) direct contact hours a week in accordance with ASAM criteria.

21.2 IOP's will provide two (2) or more of the following services per week:

- **21.2.1** Individual counseling.
- **21.2.2** Group counseling.
- **21.2.3** Family counseling.
- **21.2.4** Case management.

21.3 IOP's must:

- **21.3.1** Offer education on wellness and recovery.
- **21.3.2** Have direct affiliation with (or close coordination through direct referral to) more and less intensive levels of care and supportive housing services.
- **21.3.3** Coordinate treatment with other services when consent of the person served is documented.
- **21.3.4** Secure psychiatric and/or medical consultation by telephone within twenty-four (24) hours and within seventy-two (72) hours in person.
- **21.3.5** Arrange medical, psychological, psychiatric, laboratory, and toxicology services through consultation or referral.
- **21.3.6** Utilize a planned format of therapies, delivered on an individual and group basis and adapted to the client's developmental stage and comprehension level.

21.4 Clinical appropriateness for admission to an IOP is determined utilizing assessment protocols identified in these standards and can be justified based upon ASAM Criteria for level 2.1.

21.5 The Preferred Provider has a written description of the mission, policies, and procedures of its IOP.

- **21.5.1** Follow the standards outlined in Section 14.0 regarding assessments.
- **21.5.2** Follow the standards outlined in Section 16.0 regarding person-centered treatment plans.

Treatment Standards for ASAM Level 3.2-WM Clinically Managed Residential Withdrawal Management Substance Use Disorder Treatment Services

22.0 ASAM Level 3.2-WM Clinically Managed Residential Withdrawal Management Substance Use Disorder Treatment Services

22.1 Preferred Providers who provide ASAM Level 3.2-WM clinically managed residential withdrawal management substance use disorder treatment services must:

- **22.1.1** Provide services in a trauma-informed, gender-responsive environment that is safe, calm, welcoming and friendly and be able to justify the clinical necessity of services to include:
  - **22.1.1.1** Specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems.
  - **22.1.1.2** Have affiliations with other levels of care.
  - **22.1.1.3** Have the ability to arrange for appropriate laboratory and toxicology tests.
- **22.1.2** Have protocols in place should a client's condition deteriorate and appear to need medical or nursing interventions. These protocols are:
  - **22.1.2.1** Developed and supported by a physician knowledgeable in addiction medicine.
  - **22.1.2.2** Used to determine the nature of the medical or nursing intervention that may be required and include:
    - **22.1.2.1.1** The condition nursing and physician care is warranted.
    - **22.1.2.1.1** When transfer to a medically monitored facility or acute care hospital is necessary.
- **22.1.3** Have a staffing structure that includes:
  - **22.1.3.1** Appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for client observation and supervision, determination of appropriate level of care, and facilitation of the client's transition to continuing care.
  - **22.1.3.2** All clinicians who assess and treat clients are able to obtain and interpret information regarding the needs of these clients including:
    - **22.1.3.2.1** Signs and symptoms of alcohol and other drug intoxication and withdrawal.
    - **22.1.3.2.2** Appropriate treatment and monitoring of alcohol and other drug intoxication and withdrawal and how to facilitate entry into ongoing care.
  - **22.1.3.3** Staff who are appropriately licensed and credentialed and policies and procedures in place, if facility supervised self-administered medications, and assure that clients are taking medications according to physician prescription and legal requirements.
- **22.1.4** Offer the following therapies:
  - **22.1.4.1** A range of cognitive, behavioral, medical, mental health, and other services on an individual or group basis that enhance the client's understanding of addiction, the completion of the withdrawal management process (if necessary), and referral to an appropriate level of care for continuing treatment, is adapted to the client's developmental stage and level of comprehension, understanding, and physical abilities.
  - **22.1.4.2** Interdisciplinary individualized assessment and treatment.
  - **22.1.4.3** Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases).

22.1.4.4 Services to families and significant others.

22.1.5 Follow the standards outlined in Section 14.0 regarding assessments.

22.1.6 Follow the standards outlined in Section 16.0 regarding person-centered treatment plans.

22.1.7 Document:

22.1.7.1 The implementation of the treatment plan and the client's response to treatment, as well as subsequent amendments to the plan within progress notes.

22.1.7.2 Withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed.

22.1.8 Discharge clients only when one of the following criteria are met:

22.1.8.1 Withdrawal signs and symptoms are sufficiently resolved that the client can be safely managed at a less intensive level of care; or,

22.1.8.2 The client's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) or other comparable standardized scoring system, such that transfer to a more intensive level of withdrawal management service is indicated; or,

22.1.8.3 The client is unable to complete withdrawal management at the current level of care, despite an adequate trial.

22.1.9 Offer a pregnancy test before initiation of pharmacological intervention.

22.1.10 Make available to the person served a description of the treatment services, including treatment services provided evenings and weekends.

22.1.11 Assign a primary clinician who will follow the client's progress during withdrawal management. Such assignment must be documented in the clinical record.

22.1.12 Establish written admission, continuing care, and discharge criteria.

22.1.13 Have policies and procedures that address:

22.1.13.1 Leaving treatment against the advice of the staff, which includes:

22.1.13.1.1 The person served must be informed (and documented) of the risks of leaving treatment prematurely.

22.1.13.1.2 The person must be provided a list of possible danger signs (including withdrawal) that are specific to the person.

22.1.13.1.3 The person must sign an "Against Medical Advice Form".

22.1.13.1.4 The signature must be witnessed by a staff member.

22.1.13.1.5 If the person served refuses to sign the "Against Medical Advice Form" the Provider staff must document this on the aforementioned form and sign the form.

22.1.13.2 The consequences of the use of alcohol and other drugs by the person served while in residential treatment.

22.1.13.3 The persons served having access to:

22.1.13.3.1 Visitation in a space that allows for private conversation.

22.1.13.3.2 The right to send and receive mail.

22.1.13.3.3 Reasonable access to electronic mail.

22.1.13.3.4 Telephone access with the right and capacity to conduct private telephone conversation.

22.1.13.3.5 Means to secure personal property and retrieve property in the event of an unexpected discharge.

22.1.13.3.6 Separate sleeping areas for the persons served based on gender, age, and needs.

22.1.14 Provide and have procedures for the following if the Provider manages medications for persons served:

22.1.14.1 Compliance with all applicable laws and regulations pertaining to medications and controlled substances.

22.1.14.2 Documentation or confirmation of informed consent for each medication prescribed, when possible.

22.1.14.3 Integrating any prescribed medications into a person's treatment plan, including, if applicable special dietary restrictions or needs associated with medication use.

22.1.14.4 Identification, documentation, and required reporting, including to the prescribing professional:

22.1.14.4.1 Of any medication reactions experienced by the person served.

22.1.14.4.2 Of medication errors, as appropriate.

22.1.14.5 Policies and procedures regarding medication errors and drug reactions as part of the quality monitoring and improvement system.

22.1.14.6 Actions to follow in case of emergencies related to the use of medication, including ready access to the telephone number of a poison control center by Provider staff.

22.1.14.7 Availability of the medical resources for consultation during hours of operation.

22.1.14.8 Maintains up to date documentation in the person served record of all medications, prescriptions, and non-prescriptions, used by the person that includes:

22.1.14.8.1 Name of the medication.

22.1.14.8.2 Dosage, including strength or concentration.

22.1.14.8.3 Frequency.

22.1.14.8.4 Instructions for use, including administration route.

22.1.14.8.5 For prescription medications:

24.1.14.8.5.1 Prescribing professional and phone number.

24.1.14.8.5.2 Dispensing pharmacy and contact information.

22.1.14.8.6 Policies and procedures that address:

24.1.14.8.6.1 Storage, including handling of medication requiring refrigeration or protection from light.

24.1.14.8.6.2 Safe handling.

24.1.14.8.6.3 Packaging or labeling.

24.1.14.8.6.4 Safe disposal.

24.1.14.8.6.5 Maintenance of an adequate supply of the medication for the persons served.

24.1.14.8.6.6 Documentation of medication use.

22.1.15 Coordinate services, as needed, with the physician providing primary care needs.

22.1.16 Qualified staff receives and records verbal orders for medication, laboratory test, or dietary needs.

22.1.17 The Provider has identified in policy and procedures the staff that is authorized to receive and record verbal orders in accordance with laws and regulations.

22.1.17.1 Documentation of verbal orders includes the date and the names of staff, who gave, received, recorded, and implemented the orders.

22.1.17.2 Verbal orders must be authenticated within seven (7) days.

22.1.18 The Provider is encouraged to maintain tobacco-free campus status, if already established, or work toward reducing smoking on campus through:

22.1.18.1 Promoting healthy break options.

22.1.18.2 Discouraging patients, family members and other visitors from bringing tobacco products, substitutes (e-cigarettes and other vaping devices), and paraphernalia to the facility.

22.1.18.3 Supporting staff to quit or reduce tobacco use.

Treatment Standards for ASAM Level 3.7-WM Medically Monitored Inpatient Withdrawal Management Substance Use Disorder Treatment Services

23.0 ASAM Level 3.7-WM Medically Monitored Inpatient Withdrawal Management Substance Use Disorder Treatment Services

23.1 Preferred Providers who provide ASAM Level 3.7-WM Medically Monitored Inpatient Withdrawal Management substance use disorder treatment services must:

23.1.1 Provide services in a trauma-informed, gender-responsive environment that is safe, calm, welcoming and friendly and be able to justify the clinical necessity of services to include:

23.1.1.1 Specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems.

23.1.1.2 The availability of medical nursing care and observation as warranted, based on clinical judgment.

23.1.1.3 Direct affiliations with other levels of care.

23.1.1.4 The ability to arrange for appropriate laboratory and toxicology tests.

23.1.2 Have protocols in place should a client's condition deteriorate and appear to need medical or nursing interventions. These protocols are:

23.1.2.1 Developed and supported by a physician knowledgeable in addiction medicine.

23.1.2.2 Used to determine the nature of the medical or nursing intervention that may be required and include:

23.1.2.2.1 The conditions where nursing and physician care is warranted.

23.1.2.2.2 When transfer to a medically monitored facility or acute care hospital is necessary.

23.1.3 Have a staffing structure that includes:

23.1.3.1 Physicians (or physician extenders) who are available 24 hours a day by phone and are available to assess clients within 24 hours of admission (or earlier, if medically necessary), and are available to provide on-site monitoring of care and further evaluation on a daily basis.

23.1.3.2 A registered nurse or other licensed and credentialed nurse to conduct a nursing assessment on admission.

23.1.3.3 A nurse who is responsible for overseeing the client's progress and medication administration on an hourly basis, if needed.

23.1.3.4 Appropriately licensed and credentialed staff to administer medications in accordance with physician orders.

23.1.3.5 Qualified staff who provide a planned regimen of 24-hour, professional directed evaluation, care, and treatment services for clients and their families.

23.1.3.6 An interdisciplinary team of appropriately trained clinicians to assess and treat the clients and to obtain and interpret information regarding the client's needs. The number and disciplines of team members are appropriate to the range and severity of the client's needs.

23.1.4 Offer the following therapies:

23.1.4.1 A range of cognitive, behavioral, medical, mental health, and other services on an individual or group basis that enhance the client's understanding of addiction, the completion of the withdrawal management process (if necessary), and referral to an appropriate level of care for continuing treatment, adapted to the client's

developmental stage and level of comprehension, understanding, and physical abilities.

23.1.4.2 Multidisciplinary individualized assessment and treatment.

23.1.4.3 Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases).

23.1.4.4 Services to families and significant others.

23.1.5 Follow the standards outlined in Section 14.0 regarding assessments.

23.1.6 Follow the standards outlined in Section 16.0 regarding person-centered treatment plans.

23.1.7 Document:

23.1.7.1 The implementation of the treatment plan and the client's response to treatment, as well as subsequent amendments to the plan within progress notes.

23.1.7.2 Withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed.

23.1.8 Discharge clients only when one of the following criteria are met:

23.1.8.1 Withdrawal signs and symptoms are sufficiently resolved that the client can be safely managed at a less intensive level of care; or,

23.1.8.2 The client's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) or other comparable standardized scoring system, such that transfer to a more intensive level of withdrawal management service is indicated.

23.1.9 Offer a pregnancy test before initiation of pharmacological intervention.

23.1.10 Make available to the person served a description of the treatment services, including treatment services provided evenings and weekends.

23.1.11 Assign a primary clinician who will follow the client's progress during withdrawal management. Such assignment must be documented in the clinical record.

23.1.12 Establish written admission, continuing care, and discharge criteria.

23.1.13 Have policies and procedures that address:

23.1.13.1 Leaving treatment against the advice of the staff, which includes:

23.1.13.1.1 The person served must be informed (and documented) of the risks of leaving treatment prematurely.

23.1.13.1.2 The person must be provided a list of possible danger signs (including withdrawal) that are specific to the person.

23.1.13.1.3 The person must sign an "Against Medical Advice Form".

23.1.13.1.4 The signature must be witnessed by a staff member.

23.1.13.1.5 If the person served refuses to sign the "Against Medical Advice Form" the Provider staff must document this on the aforementioned form and sign the form.

23.1.13.2 The consequences of the use of alcohol and other drugs by the person served while in residential treatment.

23.1.13.3 The persons served having access to:

23.1.13.3.1 Visitation in a space that allows for private conversation.

23.1.13.3.2 The right to send and receive mail.

23.1.13.3.3 Reasonable access to electronic mail.

23.1.13.3.4 Telephone access with the right and capacity to conduct private telephone conversation.
23.1.13.3.5 Means to secure personal property.
23.1.13.3.6 Separate sleeping areas for the persons served based on gender, age, and needs.

23.1.14 Provide and have procedures for the following if the Provider manages medications for persons served:
23.1.14.1 Compliance with all applicable laws and regulations pertaining to medications and controlled substances.
23.1.14.2 Documentation or confirmation of informed consent for each medication prescribed, when possible.
23.1.14.3 Integrating any prescribed medications into a person's treatment plan, including, if applicable special dietary restrictions or needs associated with medication use.
23.1.14.4 Identification, documentation, and required reporting, including to the prescribing professional:
23.1.14.4.1 Of any medication reactions experienced by the person served.
23.1.14.4.2 Of medication errors, as appropriate.
23.1.14.5 Policies and procedures regarding medication errors and drug reactions as part of the quality monitoring and improvement system.
23.1.14.6 Actions to follow in case of emergencies related to the use of medication, including ready access to the telephone number of a poison control center by Provider staff.
23.1.14.7 Availability of the medical resources for consultation during hours of operation.
23.1.14.8 Maintains up to date documentation in the person served record of all medications, prescriptions, and non-prescriptions, used by the person that includes:
23.1.14.8.1 Name of the medication.
23.1.14.8.2 Dosage, including strength or concentration.
23.1.14.8.3 Frequency.
23.1.14.8.4 Instructions for use, including administration route.
23.1.14.8.5 For prescription medications:
23.1.14.8.6 Prescribing professional and phone number.
23.1.14.8.7 Dispensing pharmacy and contact information.
23.1.14.8.8 Policies and procedures that address:
23.1.14.8.9 Storage, including handling of medication requiring refrigeration or protection from light.
23.1.14.8.10 Safe handling.
23.1.14.8.11 Packaging or labeling.
23.1.14.8.12 Safe disposal.
23.1.14.8.13 Maintenance of an adequate supply of the medication for the persons served.
23.1.14.8.14 Documentation of medication use.

23.1.15 Coordinate services, as needed, with the physician providing primary care needs.
23.1.16 Qualified staff receives and records verbal orders for medication, laboratory test, or dietary needs.

23.1.17 The Provider has identified in policy and procedures the staff that is authorized to receive and record verbal orders in accordance with laws and regulations.

23.1.17.1 Documentation of verbal orders includes the date and the names of staff, who gave, received, recorded, and implemented the orders.

23.1.17.2 Verbal orders must be authenticated within seven (7) days.

23.1.18 The Provider is encouraged to maintain tobacco-free campus status, if already established, or work toward reducing smoking on campus through:

23.1.18.1 Promoting healthy break options.

23.1.18.2 Discouraging patients, family members and other visitors from bringing tobacco products, substitutes (e-cigarettes and other vaping devices), and paraphernalia to the facility.

23.1.18.3 Supporting staff to quit or reduce tobacco use.

Treatment Standards for ASAM Level 3.1 Clinically Managed Low-Intensity Residential Substance Use Disorder Treatment Services

24.0 ASAM Level 3.1 Clinically Managed Low-Intensity Residential Substance Use Disorder Treatment Services

24.1 Preferred Providers who provide ASAM Level 3.1 clinically managed low-intensity residential substance use disorder treatment services must:

24.1.1 Provide services in a trauma-informed, gender-responsive environment that is safe, calm, welcoming and friendly and be able to justify the clinical necessity of services to include:

24.1.1.1 Telephone or in-person consultation with a physician (or physician extender) and emergency services, available 24 hours a day, seven (7) days a week.

24.1.1.2 Direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services.

24.1.1.3 The ability to arrange for needed procedures (including laboratory and toxicology tests) as appropriate to the severity and urgency of the client's condition.

24.1.1.4 The ability to arrange for pharmacotherapy for psychiatric or medications for use in the treatment of substance use disorders.

24.1.2 Have a staffing structure that includes:

24.1.2.1 Allied health professional staff, such as counselor aides or group living workers, on-site 24 hours a day or as required by licensing regulations.

24.1.2.2 Clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions.

24.1.2.3 A team comprised of appropriately trained and credentialed medical, addiction, and mental health professionals.

24.1.2.4 A physician or physician extender to review admission decisions to confirm clinical necessity of services.

24.1.3 Offer the following therapies:

24.1.3.1 Services designed to improve the client's ability to structure and organize the tasks of daily living and recovery.

24.1.3.2 Planned clinical program activities (constituting at least five hours per week of professional directed treatment) designed to stabilize and maintain stability of the client's substance use disorder symptoms, and to help develop and apply recovery skills, adapted to the client's developmental stage and level of comprehension, understanding, and physical abilities.

24.1.3.3 Addiction pharmacotherapy.

24.1.3.4 Random drug screening to monitor and reinforce treatment gains, as appropriate to the client's person-center treatment plan.

24.1.3.5 Motivational enhancement and engagement strategies appropriate to the client's stage of readiness to change.

24.1.3.6 Counseling and clinical monitoring to assist the client with successful initial involvement or reinvolvement in regular, productive daily activity and, as indicated, successful reintegration into family living.

24.1.3.7 Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases).
24.1.3.8 Regular monitoring of the client's medication adherence.
24.1.3.9 Recovery support services.
24.1.3.10 Services for the client's family and significant others, as appropriate.
24.1.3.11 Opportunities for the client to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage their addictive disorder.

24.1.4 Follow the standards outlined in Section 14.0 of the General Program Standards regarding assessments.
24.1.5 Follow the standards outlined in Section 16.0 of the General Program Standards regarding person-centered treatment plans.
24.1.6 Document the implementation of the treatment plan and the client's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan (at specified times) within progress notes.
24.1.7 Perform a physical examination within a reasonable time, as defined in the policy and procedure manual, and as determined by the client's medical condition.
24.1.8 Ongoing discharge and transition/continuing care planning.
24.1.9 Offer a pregnancy test before initiation of pharmacological intervention.
24.1.10 Make available to the person served a description of the treatment services, including treatment services provided evenings and weekends.
24.1.11 Assign a primary clinician who will follow the client's progress. Such assignment must be documented in the clinical record.
24.1.12 Establish written admission, continuing care, and discharge criteria.
24.1.13 Have policies and procedures that address:
24.1.13.1 Leaving treatment against the advice of the staff, which includes:
24.1.13.1.1 The person served must be informed (and documented) of the risks of leaving treatment prematurely.
24.1.13.1.2 The person must be provided a list of possible danger signs (including withdrawal) that are specific to the person.
24.1.13.1.3 The person must sign an "Against Medical Advice Form".
24.1.13.1.4 The signature must be witnessed by a staff member.
24.1.13.1.5 If the person served refuses to sign the "Against Medical Advice Form" the Provider staff must document this on the aforementioned form and sign the form.
24.1.13.2 The consequences of the use of alcohol and other drugs by the person served while in residential treatment.
24.1.13.3 The persons served having access to:
24.1.13.3.1 Visitation in a space that allows for private conversation.
24.1.13.3.2 The right to send and receive mail.
24.1.13.3.3 Reasonable access to electronic mail.
24.1.13.3.4 Telephone access with the right and capacity to conduct private telephone conversation.

24.1.13.3.5 Means to secure personal property.

24.1.13.3.6 Separate sleeping areas for the persons served based on gender, age, and needs.

24.1.14 Provide and have procedures for the following if the Provider manages medications for persons served:

24.1.14.1 Compliance with all applicable laws and regulations pertaining to medications and controlled substances.

24.1.14.2 Documentation or confirmation of informed consent for each medication prescribed, when possible.

24.1.14.3 Integrating any prescribed medications into a person's treatment plan, including, if applicable special dietary restrictions or needs associated with medication use.

24.1.14.4 Identification, documentation, and required reporting, including to the prescribing professional:

24.1.14.4.1 Of any medication reactions experienced by the person served.

24.1.14.4.2 Of medication errors, as appropriate.

24.1.14.5 Policies and procedures regarding medication errors and drug reactions as part of the quality monitoring and improvement system.

24.1.14.6 Actions to follow in case of emergencies related to the use of medication, including ready access to the telephone number of a poison control center by Provider staff.

24.1.14.7 Availability of the medical resources for consultation during hours of operation.

24.1.14.8 Maintains up to date documentation in the person served record of all medications, prescriptions, and non-prescriptions, used by the person that includes:

24.1.14.8.1 Name of the medication.

24.1.14.8.2 Dosage, including strength or concentration.

24.1.14.8.3 Frequency.

24.1.14.8.4 Instructions for use, including administration route.

24.1.14.8.5 For prescription medications:

24.1.14.8.6 Prescribing professional and phone number.

24.1.14.8.7 Dispensing pharmacy and contact information.

24.1.14.8.8 Policies and procedures that address:

24.1.14.8.9 Storage, including handling of medication requiring refrigeration or protection from light.

24.1.14.8.10 Safe handling.

24.1.14.8.11 Packaging or labeling.

24.1.14.8.12 Safe disposal.

24.1.14.8.13 Maintenance of an adequate supply of the medication for the persons served.

24.1.14.8.14 Documentation of medication use.

24.1.15 Coordinate services, as needed, with the physician providing primary care needs.

24.1.16 Qualified staff receives and records verbal orders for medication, laboratory tests, or dietary needs.

24.1.17 The Provider has identified in policy and procedures the staff that is authorized to receive and record verbal orders in accordance with laws and regulations.

24.1.17.1 Documentation of verbal orders includes the date and the names of staff, who gave, received, recorded, and implemented the orders.

24.1.17.2 Verbal orders must be authenticated within seven (7) days.

24.1.18 The Provider is encouraged to maintain tobacco-free campus status, if already established, or work toward reducing smoking on campus through:

24.1.18.1 Promoting healthy break options.

24.1.18.2 Discouraging patients, family members and other visitors from bringing tobacco products, substitutes (e-cigarettes and other vaping devices), and paraphernalia to the facility.

24.1.18.3 Supporting staff to quit or reduce tobacco use.

Treatment Standards for ASAM Level 3.3 Clinically Managed High-Intensity Residential Substance Use Disorder Treatment Services

25.0 ASAM Level 3.3 Clinically Managed High-Intensity Residential Substance Use Disorder Treatment Services

25.1 Preferred Providers who provide ASAM Level 3.3 clinically managed high-intensity residential substance use disorder treatment services must:

25.1.1 Provide services in a trauma-informed, gender-responsive environment that is safe, calm, welcoming and friendly and be able to justify the clinical necessity of services to include:

25.1.1.1 Telephone or in-person consultation with a physician (or physician extender) and emergency services, available 24 hours a day, seven (7) days a week.

25.1.1.2 Have direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services.

25.1.1.3 Medical, psychiatric, psychological, laboratory, and toxicology services, available through consultation or referral, as appropriate to the severity and urgency of the client's condition.

25.1.2 Have a staffing structure that includes:

25.1.2.1 Physicians or physician extenders, and appropriately credentialed mental health and substance use disorder treatment professionals.

25.1.2.2 Allied health professional staff, such as counselor aides or group living workers, on-site 24 hours a day or as required by licensing regulations. One or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day.

25.1.2.3 Clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions. Staff must have specialized training in behavior management techniques.

25.1.3 Offer the following therapies:

25.1.3.1 Daily clinical services to improve the client's ability to structure and organize the tasks of daily living and recovery. Family services are provided and are designed to accommodate cognitive limitations.

25.1.3.2 Planned clinical program activities designed to stabilize and maintain stability of the client's substance use disorder symptoms, and to help develop and apply recovery skills.

25.1.3.3 Random drug screening to monitor and reinforce treatment gains, as appropriate to the client's person-center treatment plan.

25.1.3.4 A range of cognitive, behavioral, and other therapies on an individual or group basis, medication education and management, educational groups, and occupational or recreational activities, adapted to the client's developmental stage and level of comprehension, understanding, and physical abilities.

25.1.3.5 Counseling and clinical monitoring to assist the client with successful initial involvement or reinvolvement in regular, productive daily activity and, as indicated, successful reintegration into family living.

25.1.3.6 Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases).
25.1.3.7 Regular monitoring of the client's medication adherence.
25.1.3.8 Daily scheduled professional addiction and mental health treatment services, designed to develop and apply recovery skills.
25.1.3.9 Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
25.1.3.10 Clinical and didactic motivational interventions appropriate to the client's stage of readiness to change, designed to facilitate the client's understanding of the relationship between their substance use disorder and attendant life issues.
25.1.3.11 Services for the client's family and significant others, as appropriate.

25.1.4 Follow the standards outlined in Section 14.0 of the General Program Standards regarding assessments.
25.1.5 Follow the standards outlined in Section 16.0 of the General Program Standards regarding person-centered treatment plans.
25.1.6 Document the implementation of the treatment plan and the client's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan (at specified times) within progress notes.
25.1.7 Perform a physical examination performed within a reasonable time, as defined in the policy and procedure manual, and as determined by the client's medical condition.
25.1.8 Ongoing discharge and transition/continuing care planning.
25.1.9 Offer a pregnancy test before initiation of pharmacological intervention.
25.1.10 Make available to the person served a description of the treatment services, including treatment services provided evenings and weekends.
25.1.11 Assign a primary clinician who will follow the client's progress. Such assignment must be documented in the clinical record.
25.1.12 Establish written admission, continuing care, and discharge criteria.
25.1.13 Have policies and procedures that address:

25.1.13.1 Leaving treatment against the advice of the staff, which includes:

25.1.13.1.1 The person served must be informed (and documented) of the risks of leaving treatment prematurely.
25.1.13.1.2 The person must be provided a list of possible danger signs (including withdrawal) that are specific to the person.
25.1.13.1.3 The person must sign an "Against Medical Advice Form".
25.1.13.1.4 The signature must be witnessed by a staff member.
25.1.13.1.5 If the person served refuses to sign the "Against Medical Advice Form" the Provider staff must document this on the aforementioned form and sign the form.

25.1.13.2 The consequences of the use of alcohol and other drugs by the person served while in residential treatment.
25.1.13.3 The persons served having access to:

25.1.13.3.1 Visitation in a space that allows for private conversation.
25.1.13.3.2 The right to send and receive mail.
25.1.13.3.3 Reasonable access to electronic mail.
25.1.13.3.4 Telephone access with the right and capacity to conduct private telephone conversation.
25.1.13.3.5 Means to secure personal property.
25.1.13.3.6 Separate sleeping areas for the persons served based on gender, age, and needs.

25.1.14 Provide and have procedures for the following if the Provider manages medications for persons served:
25.1.14.1 Compliance with all applicable laws and regulations pertaining to medications and controlled substances.
25.1.14.2 Documentation or confirmation of informed consent for each medication prescribed, when possible.
25.1.14.3 Integrating any prescribed medications into a person's treatment plan, including, if applicable special dietary restrictions or needs associated with medication use.
25.1.14.4 Identification, documentation, and required reporting, including to the prescribing professional:
25.1.14.4.1 Of any medication reactions experienced by the person served.
25.1.14.4.2 Of medication errors, as appropriate.
25.1.14.5 Policies and procedures regarding medication errors and drug reactions as part of the quality monitoring and improvement system.
25.1.14.6 Actions to follow in case of emergencies related to the use of medication, including ready access to the telephone number of a poison control center by Provider staff.
25.1.14.7 Availability of medical resources for consultation during hours of operation.
25.1.14.8 Maintains up to date documentation in the person served record of all medications, prescriptions, and non-prescriptions, used by the person that includes:
25.1.14.8.1 Name of the medication.
25.1.14.8.2 Dosage, including strength or concentration.
25.1.14.8.3 Frequency.
25.1.14.8.4 Instructions for use, including administration route.
25.1.14.8.5 For prescription medications:
25.1.14.8.6 Prescribing professional and phone number.
25.1.14.8.7 Dispensing pharmacy and contact information.
25.1.14.8.8 Policies and procedures that address:
25.1.14.8.9 Storage, including handling of medication requiring refrigeration or protection from light.
25.1.14.8.10 Safe handling.
25.1.14.8.11 Packaging or labeling.
25.1.14.8.12 Safe disposal.
25.1.14.8.13 Maintenance of an adequate supply of the medication for the persons served.
25.1.14.8.14 Documentation of medication use.

25.1.15 Coordinate services, as needed, with the physician providing primary care needs.

25.1.16 Qualified staff receives and records verbal orders for medication, laboratory tests, or dietary needs.

25.1.17 The Provider has identified in policy and procedures the staff that is authorized to receive and record verbal orders in accordance with laws and regulations.

25.1.17.1 Documentation of verbal orders includes the date and the names of staff, who gave, received, recorded, and implemented the orders.

25.1.17.2 Verbal orders must be authenticated within seven (7) days.

25.1.18 The Provider is encouraged to maintain tobacco-free campus status, if already established, or work toward reducing smoking on campus through:

25.1.18.1 Promoting healthy break options.

25.1.18.2 Discouraging patients, family members and other visitors from bringing tobacco products, substitutes (e-cigarettes and other vaping devices), and paraphernalia to the facility.

25.1.18.3 Supporting staff to quit or reduce tobacco use.

Treatment Standards for ASAM Level 3.5

Clinically Managed High-Intensity Residential Substance Use Disorder Treatment Services (Adult Criteria)

Clinically Managed Medium-Intensity Residential Substance Use Disorder Treatment Services (Adolescent Criteria)

26.0 ASAM Level 3.5 Clinically Managed High-Intensity Residential Substance Use Disorder Treatment Services

26.1 Preferred Providers who provide ASAM Level 3.5 clinically managed high-intensity residential substance use disorder treatment services must:

26.1.1 Provide services in a trauma-informed, gender-responsive environment that is safe, calm, welcoming and friendly and be able to justify the clinical necessity of services to include:

26.1.1.1 Telephone or in-person consultation with a physician (or physician extender) and emergency services, available 24 hours a day, seven (7) days a week.

26.1.1.2 Direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services.

26.1.1.3 Arranged medical, psychiatric, psychological, laboratory, and toxicology services, as appropriate to the severity and urgency of the client's condition.

26.1.2 Have a staffing structure that includes:

26.1.2.1 Licensed or credentialed clinical staff who work with the allied health professional staff in an interdisciplinary team approach.

26.1.2.2 Allied health professional staff on-site 24 hours a day or as required by licensing regulations. One or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day.

26.1.2.3 Clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions. Staff must have specialized training in behavior management techniques.

26.1.3 Offer the following therapies:

26.1.3.1 Daily clinical services to improve the client's ability to structure and organize the tasks of daily living and recovery, and to develop and practice prosocial behaviors. Family services are provided and are designed to accommodate cognitive limitations.

26.1.3.2 Planned clinical program activities designed to stabilize and maintain stability of the client's substance use disorder symptoms, and to help develop and apply recovery skills.

26.1.3.3 Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the client's person-center treatment plan.

26.1.3.4 A range of evidence-based cognitive, behavioral, and other therapies on an individual or group basis, medication education and management, addiction pharmacotherapy, educational skill building groups, and occupational or recreational activities, adapted to the client's developmental stage and level of comprehension, understanding, and physical abilities.

26.1.3.5 Counseling and clinical monitoring to promote successful initial involvement or reinvolvement in regular, productive daily activity and, as indicated, successful reintegration into family living.

26.1.3.6 Motivational enhancement and engagement strategies appropriate to the client's stage of readiness to change.

26.1.3.7 Counseling and clinical interventions to facilitate teaching the client the skills needed for productive daily activity and, as indicated, successful reintegration into family living.

26.1.3.8 Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases).

26.1.3.9 Monitoring of the client's medication adherence.

26.1.3.10 Planned clinical activities to enhance the client's understanding of substance use and/or mental health disorders.

26.1.3.11 Daily scheduled professional addiction and mental health treatment services, designed to develop and apply recovery skills.

26.1.3.12 Planned community reinforcement designed to foster prosocial values and milieu or community living skills.

26.1.3.13 Services for the client's family and significant others, as appropriate.

26.1.3.14 If serving adolescents, providers must offer:

26.1.3.14.1 Educational services in accordance with local regulations and are designed to maintain the educational and intellectual development of the adolescent and, when indicated, to provide opportunities to remedy deficits in the educational level of adolescents who have fallen behind because of their involvement with substance use.

26.1.3.14.2 Trained clinicians provide daily clinical services to assess and address the adolescent's withdrawal status and service needs. Such clinical services may include nursing or medical monitoring, use of medications to alleviate symptoms, individual or group therapy specific to withdrawal, and withdrawal support.

26.1.4 Follow the standards outlined in Section 14.0 of the General Program Standards regarding assessments.

26.1.5 Follow the standards outlined in Section 16.0 of the General Program Standards regarding person-centered treatment plans.

26.1.6 Document the implementation of the treatment plan and the client's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan (at specified times) within progress notes.

26.1.7 Perform a physical examination performed within a reasonable time, as defined in the policy and procedure manual, and as determined by the client's medical condition.

26.1.8 Ongoing discharge and transition/continuing care planning.

26.1.9 The following additional items if serving adolescents:

26.1.9.1 An initial withdrawal assessment, including a medical evaluation and referral within 48 hours preceding admission (or if a step down from another residential setting, within 7 days preceding admission).

26.1.9.2 Daily withdrawal monitoring assessments.

26.1.9.3 Ongoing screening for medical and nursing needs, with such medical and nursing services available as needed through consultation or referral.

26.1.10 Offer a pregnancy test before initiation of pharmacological intervention.
26.1.11 Make available to the person served a description of the treatment services, including treatment services provided evenings and weekends.
26.1.12 Assign a primary clinician who will follow the client's progress. Such assignment must be documented in the clinical record.
26.1.13 Establish written admission, continuing care, and discharge criteria.
26.1.14 Have policies and procedures that address:
26.1.14.1 Leaving treatment against the advice of the staff, which includes:
26.1.14.1.1 The person served must be informed (and documented) of the risks of leaving treatment prematurely.
26.1.14.1.2 The person must be provided a list of possible danger signs (including withdrawal) that are specific to the person.
26.1.14.1.3 The person must sign an "Against Medical Advice Form".
26.1.14.1.4 The signature must be witnessed by a staff member.
26.1.14.1.5 If the person served refuses to sign the "Against Medical Advice Form" the Provider staff must document this on the aforementioned form and sign the form.
26.1.14.2 The consequences of the use of alcohol and other drugs by the person served while in residential treatment.
26.1.14.3 The persons served having access to:
26.1.14.3.1 Visitation in a space that allows for private conversation.
26.1.14.3.2 The right to send and receive mail.
26.1.14.3.3 Reasonable access to electronic mail.
26.1.14.3.4 Telephone access with the right and capacity to conduct private telephone conversation.
26.1.14.3.5 Means to secure personal property.
26.1.14.3.6 Separate sleeping areas for the persons served based on gender, age, and needs.
26.1.15 Provide and have procedures for the following if the Provider manages medications for persons served:
26.1.15.1 Compliance with all applicable laws and regulations pertaining to medications and controlled substances.
26.1.15.2 Documentation or confirmation of informed consent for each medication prescribed, when possible.
26.1.15.3 Integrating any prescribed medications into a person's treatment plan, including, if applicable special dietary restrictions or needs associated with medication use.
26.1.15.4 Identification, documentation, and required reporting, including to the prescribing professional:
26.1.15.4.1 Of any medication reactions experienced by the person served.
26.1.15.4.2 Of medication errors, as appropriate.
26.1.15.5 Policies and procedures regarding medication errors and drug reactions as part of the quality monitoring and improvement system.

26.1.15.6 Actions to follow in case of emergencies related to the use of medication, including ready access to the telephone number of a poison control center by Provider staff.

26.1.15.7 Availability of the medical resources for consultation during hours of operation.

26.1.15.8 Maintains up to date documentation in the person served record of all medications, prescriptions, and non-prescriptions, used by the person that includes:

26.1.15.8.1 Name of the medication.

26.1.15.8.2 Dosage, including strength or concentration.

26.1.15.8.3 Frequency.

26.1.15.8.4 Instructions for use, including administration route.

26.1.15.8.5 For prescription medications:

26.1.15.8.6 Prescribing professional and phone number.

26.1.15.8.7 Dispensing pharmacy and contact information.

26.1.15.8.8 Policies and procedures that address:

26.1.15.8.9 Storage, including handling of medication requiring refrigeration or protection from light.

26.1.15.8.10 Safe handling.

26.1.15.8.11 Packaging or labeling.

26.1.15.8.12 Safe disposal.

26.1.15.8.13 Maintenance of an adequate supply of the medication for the persons served.

26.1.15.8.14 Documentation of medication use.

26.1.16 Coordinate services, as needed, with the physician providing primary care needs.

26.1.17 Qualified staff receives and records verbal orders for medication, laboratory tests, or dietary needs.

26.1.18 The Provider has identified in policy and procedures the staff that is authorized to receive and record verbal orders in accordance with laws and regulations.

26.1.18.1 Documentation of verbal orders includes the date and the names of staff who gave, received, recorded, and implemented the orders.

26.1.18.2 Verbal orders must be authenticated within seven (7) days.

26.1.19 The Provider is encouraged to maintain tobacco-free campus status, if already established, or work toward reducing smoking on campus through:

26.1.19.1 Promoting healthy break options.

26.1.19.2 Discouraging patients, family members and other visitors from bringing tobacco products, substitutes (e-cigarettes and other vaping devices), and paraphernalia to the facility.

26.1.19.3 Supporting staff to quit or reduce tobacco use.

Treatment Standards for ASAM Level 3.7

Medically Monitored Intensive Inpatient Substance Use Disorder Treatment Services (Adult Criteria)

Medically Monitored High-Intensity Inpatient Substance Use Disorder Treatment Services (Adolescent Criteria)

27.0 ASAM Level 3.7 Medically Monitored Intensive Inpatient Residential Substance Use Disorder Treatment Services

27.1 Preferred Providers who provide ASAM Level 3.7 medically monitored intensive inpatient residential substance use disorder treatment services must:

27.1.1 Provide services in a trauma-informed, gender-responsive environment that is safe, calm, welcoming and friendly and be able to justify the clinical necessity of services to include:

27.1.1.1 Physician monitoring, nursing care, and observation are available. A physician (or physician extender) is available to assess the client in person within 24 hours of admission and thereafter as medically necessary.

27.1.1.2 A registered nurse conducts an alcohol or other drug-focused nursing assessment at the time of admission. An appropriately credentialed and licensed nurse is responsible for monitoring the client's progress and for medication administration.

27.1.1.3 Additional medical specialty consultation, psychological, laboratory, and toxicology services are available on-site, through consultation or referral.

27.1.1.4 Coordination of necessary services or other levels of care are available through direct affiliation or referral processes.

27.1.1.5 Psychiatric services are available on-site through consultation or referral when a presenting issue could be attended to at a later time. Such services are available within 8 hours by telephone or 24 hours in person.

27.1.2 Have a staffing structure that includes:

27.1.2.1 An interdisciplinary staff who are able to assess and treat the client and to obtain and interpret information regarding the client's psychiatric and substance use or addictive disorders.

27.1.2.2 Clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use and other behavioral health disorders, and with specialized training in behavior management techniques and evidence-based practices. The staff is able to provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment services (including administration of prescribed medications).

27.1.3 Offer the following therapies:

27.1.3.1 Daily clinical services (provided by an interdisciplinary treatment team) assess and address the client's individual needs. Clinical services may involve appropriate medical and nursing services, individual, group, family, and activity services. Family services are provided and are designed to accommodate cognitive limitations.

27.1.3.2 Planned clinical program activities designed to stabilize the acute addictive and/or psychiatric symptoms and are adapted to the client's level of comprehension.

27.1.3.3 Counseling and clinical monitoring to promote successful initial involvement or reinvolvement in, and skill building for, regular, productive daily activity and, as indicated, successful reintegration into family living.

27.1.3.4 Random drug screening to monitor drug use and reinforce treatment gains, as appropriate to the client's person-center treatment plan.

27.1.3.5 A range of evidence-based cognitive, behavioral, and other therapies on an individual or group basis, medication education and management, addiction pharmacotherapy, educational skill building groups, and occupational or recreational activities, adapted to the client's developmental stage and level of comprehension, understanding, and physical abilities.

27.1.3.6 Regular monitoring of the client's medication adherence.

27.1.3.7 Planned clinical activities to enhance the client's understanding of substance use and/or mental health disorders.

27.1.3.8 Daily scheduled professional addiction and mental health treatment services, designed to develop and apply recovery skills.

27.1.3.9 Planned community reinforcement designed to foster prosocial values and milieu or community living skills.

27.1.3.10 Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases).

27.1.3.11 Evidence-based practices, such as motivational enhancement strategies and interventions appropriate to the client's stage of readiness to change, designed to facilitate the client's understanding of the relationship between substance use disorder and attendant life issues.

27.1.3.12 Daily treatment services to manage acute symptoms of the client's biomedical, substance use, and/or mental health disorder.

27.1.3.13 Services for the client's family and significant others, as appropriate.

27.1.3.14 If serving adolescents, providers must offer:

27.1.3.14.1 Educational services in accordance with local regulations and are designed to maintain the educational and intellectual development of the adolescent and, when indicated, to provide opportunities to remedy deficits in the educational level of adolescents who have fallen behind because of their involvement with substance use.

27.1.3.14.2 An interdisciplinary team provides daily clinical services to assess and address the adolescent's withdrawal status and service needs.

27.1.3.14.3 Frequent nurse monitoring of the adolescent's progress in withdrawal management and medication administration is available, if needed.

27.1.4 Follow the standards outlined in Section 14.0 of the General Program Standards regarding assessments.

27.1.5 Follow the standards outlined in Section 16.0 of the General Program Standards regarding person-centered treatment plans.

27.1.6 Document the implementation of the treatment plan and the client's response to therapeutic interventions for all disorders treated, as well as

subsequent amendments to the plan (at specified times) within progress notes.

27.1.7 Perform a physical examination, performed by a physician within 24 hours of admission, or review and update by a facility physician within 24 hours of admission of the record of a physical examination conducted no more than 7 days prior to admission.

27.1.8 Ongoing discharge and transition/continuing care planning.

27.1.9 The following additional items if serving adolescents:

- 27.1.9.1 An initial withdrawal assessment within 24 hours of admission, or earlier if clinically warranted.
- 27.1.9.2 Daily nursing withdrawal monitoring assessments and continuous availability of nursing evaluation.
- 27.1.9.3 Daily availability of medical evaluation, with continuous on-call coverage.

27.1.10 Offer a pregnancy test before initiation of pharmacological intervention.

27.1.11 Make available to the person served a description of the treatment services, including treatment services provided evenings and weekends.

27.1.12 Assign a primary clinician who will follow the client's progress. Such assignment must be documented in the clinical record.

27.1.13 Establish written admission, continuing care, and discharge criteria.

27.1.14 Have policies and procedures that address:

- 27.1.14.1 Leaving treatment against the advice of the staff, which includes:
  - 27.1.14.1.1 The person served must be informed (and documented) of the risks of leaving treatment prematurely.
  - 27.1.14.1.2 The person must be provided a list of possible danger signs (including withdrawal) that are specific to the person.
  - 27.1.14.1.3 The person must sign an "Against Medical Advice Form".
  - 27.1.14.1.4 The signature must be witnessed by a staff member.
  - 27.1.14.1.5 If the person served refuses to sign the "Against Medical Advice Form" the Provider staff must document this on the aforementioned form and sign the form.
- 27.1.14.2 The consequences of the use of alcohol and other drugs by the person served while in residential treatment.
- 27.1.14.3 The persons served having access to:
  - 27.1.14.3.1 Visitation in a space that allows for private conversation.
  - 27.1.14.3.2 The right to send and receive mail.
  - 27.1.14.3.3 Reasonable access to electronic mail.
  - 27.1.14.3.4 Telephone access with the right and capacity to conduct private telephone conversation.
  - 27.1.14.3.5 Means to secure personal property.
  - 27.1.14.3.6 Separate sleeping areas for the persons served based on gender, age, and needs.

27.1.15 Provide and have procedures for the following if the Provider manages medications for persons served:

27.1.15.1 Compliance with all applicable laws and regulations pertaining to medications and controlled substances.
27.1.15.2 Documentation or confirmation of informed consent for each medication prescribed, when possible.
27.1.15.3 Integrating any prescribed medications into a person's treatment plan, including, if applicable special dietary restrictions or needs associated with medication use.
27.1.15.4 Identification, documentation, and required reporting, including to the prescribing professional:
27.1.15.4.1 Of any medication reactions experienced by the person served.
27.1.15.4.2 Of medication errors, as appropriate.
27.1.15.5 Policies and procedures regarding medication errors and drug reactions as part of the quality monitoring and improvement system.
27.1.15.6 Actions to follow in case of emergencies related to the use of medication, including ready access to the telephone number of a poison control center by Provider staff.
27.1.15.7 Availability of medical resources for consultation during hours of operation.
27.1.15.8 Maintains up to date documentation in the person served record of all medications, prescriptions, and non-prescriptions, used by the person that includes:
27.1.15.8.1 Name of the medication.
27.1.15.8.2 Dosage, including strength or concentration.
27.1.15.8.3 Frequency.
27.1.15.8.4 Instructions for use, including administration route.
27.1.15.8.5 For prescription medications:
27.1.15.8.6 Prescribing professional and phone number.
27.1.15.8.7 Dispensing pharmacy and contact information.
27.1.15.8.8 Policies and procedures that address:
27.1.15.8.9 Storage, including handling of medication requiring refrigeration or protection from light.
27.1.15.8.10 Safe handling.
27.1.15.8.11 Packaging or labeling.
27.1.15.8.12 Safe disposal.
27.1.15.8.13 Maintenance of an adequate supply of the medication for the persons served.
27.1.15.8.14 Documentation of medication use.
27.1.16 Coordinate services, as needed, with the physician providing primary care needs.
27.1.17 Qualified staff receives and records verbal orders for medication, laboratory test, or dietary needs.
27.1.18 The Provider has identified in policy and procedures the staff that is authorized to receive and record verbal orders in accordance with laws and regulations.
27.1.18.1 Documentation of verbal orders includes the date and the names of staff who gave, received, recorded, and implemented the orders.
27.1.18.2 Verbal orders must be authenticated within seven (7) days.

27.1.19 The Provider is encouraged to maintain tobacco-free campus status, if already established, or work toward reducing smoking on campus through:

27.1.19.1 Promoting healthy break options.

27.1.19.2 Discouraging patients, family members and other visitors from bringing tobacco products, substitutes (e-cigarettes and other vaping devices), and paraphernalia to the facility.

27.1.19.3 Supporting staff to quit or reduce tobacco use.

Summary of Updates

Date	Section Information	Section Number
7/1/2025	Removed definition of “aftercare”	Definitions
7/1/2025	Replaced “aftercare providers” with “transitioning providers” in the discharge summary definition.	Definitions
7/1/2025	Added “transition” definition.	Definitions
7/1/2025	Replaced DSU with VDH.	Throughout
7/1/2025	Changed timeline of CLAS plan to be updated when CLAS standards are updated.	3.2.2
7/1/2025	Removed reference to the federal poverty index.	4.1.2
7/1/2025	Added standard for provider to have policies describing eligibility for and implementation of the sliding fee schedule.	4.1.2.1
7/1/2025	Changed pronouns	5.6
7/1/2025	Added training documents to be maintained in personnel records.	5.8.1
7/1/2025	Specified that trainings with CEUs should be made available to staff providing billable SUD services.	5.14
7/1/2025	Added standard that requires that medical error that require intervention or monitoring be reported to VDH.	8.4.5
7/1/2025	Replaced “aftercare” with “transition”.	12.1.21
7/1/2025	Included timeline for completion of assessment for OTPs (no change in requirement, was previously standards 14.1.1.5.0)	14.1.1.4.1
7/1/2025	Renamed “short-term residential” to “residential substance use disorder treatment”.	14.1.1.4.2
7/1/2025	Replaced “parent” with “parent/guardian”.	14.2.7
7/1/2025	Removed standard that required prenatal exposure information within the assessment (previously standard 14.3.9)	
7/1/2025	Included nicotine cessation medications as appropriate.	14.6.1.2
7/1/2025	Included timeline for completion of person-centered treatment plan for OTPs (no change in requirement, was previously standards 16.2.3).	16.2.1
7/1/2025	Changed pronouns.	16.4
7/1/2025	Replaced “aftercare plan” with “transition plan”	17.0
7/1/2025	Specified that IOP programming must adhere to ASAM criteria.	21.1
7/1/2025	Removed gender-specific reference.	22.1.9 23.1.9 24.1.9 25.1.9 26.1.10 27.1.10
7/1/2025	Reworded standard to promote healthy break options.	22.1.18.1

		23.1.18.1 24.1.18.1 25.1.18.1 26.1.19.1 27.1.19.1
1/1/2024	Changed “ADAP” to “DSU”	Throughout
1/1/2024	Added definition for co-occurring disorders	Definitions
1/1/2024	Added definition for discharge summary	Definitions
1/1/2024	Added definition for DSM-5	Definitions
1/1/2024	Added definition for ICD-10	Definitions
1/1/2024	Clarified definition for medication	Definitions
1/1/2024	Removed definition for MAT (hub) and MAT (spoke)	Definitions
1/1/2024	Added definition for OSHA	Definitions
1/1/2024	Added language to OBOT	Definitions
1/1/2024	Added definition for OPR	Definitions
1/1/2024	Added definition for OTP	Definitions
1/1/2024	Removed definition for short-term residential	Definitions
1/1/2024	Changed term from utilization review to utilization management	Definitions
1/1/2024	Added definition for VOSHA	Definitions
1/1/2024	Changed language about frequency of governance meetings and ensuring accessibility to meetings by staff.	2.3
1/1/2024	Removed some specific requirements related to strategic plans.	3.2.1
1/1/2024	Specified that fee schedule should be publicly available.	4.1.2
1/1/2024	Added additional language regarding internal controls.	4.1.3
1/1/2024	Removed requirement for providers to identify funds to DSU.	4.1.4
1/1/2024	Added language regarding budget utilization.	
1/1/2024	Added language regarding record retention.	
1/1/2024	Included health conditions included on non-discrimination.	5.1.1.6
1/1/2024	Clarified that supervision must be clinical in nature and adhere to OPR requirements.	5.10.1
1/1/2024	Added additional description about what elements should be included in a risk management plan.	6.1
1/1/2024	Specified that critical incidents should be reported to DSU within 24 hours of knowledge of event.	8.4
1/1/2024	Removed introduction paragraph.	9.0
1/1/2024	Specified that provider must have documentation methods to collect data on all persons served.	9.1

1/1/2024	Removed some of the requirements for quality improvement plans.	9.4
1/1/2024	Clarified language regarding the use of current clients as paid or voluntary staff.	10.6
1/1/2024	Removed MAT as a level of care.	11.1
1/1/2024	Removed language specific to Drug Court Programs and Public Inebriate Programs.	
1/1/2024	Included reference to federal regulations with documentation requirements.	12.3
1/1/2024	Included reference to Medicaid regulations with documentation requirements.	12.5
1/1/2024	Clarified prioritization of populations language.	13.1.1.3
1/1/2024	Identified older adult as a high-risk population.	13.3.6
1/1/2024	Clarified language around crisis screening.	13.5
1/1/2024	Increased the number of days to complete an assessment for short-term residential programs to the end of the 6th day and removed specific mention of long-term residential.	14.1.1.4
1/1/2024	Included "other addiction disorders, as clinically appropriate."	14.2.4
1/1/2024	Removed the requirement for spiritual beliefs to be included in the assessment.	
1/1/2024	Changed language to "no cost state resources" instead of specifying certain tobacco cessation programs.	14.6.2
1/1/2024	Clarified that case management should include assistance with as well as linkages to other services.	15.1.1.4
1/1/2024	Removed repetitive language related to case management.	15.0
1/1/2024	Changed timeframe for residential programs so that treatment plans must be completed by the end of the 7th day.	16.2.2
1/1/2024	Added language that references the administrative rules regarding updates to treatment plans within the hub setting.	
1/1/2024	Added reference to OPR licensing rules.	16.7.2
1/1/2024	Changed "medication assisted treatment" to "medication for opioid use disorder" and removed language specific to pregnant women and added reference to clinical best practice.	18.6
1/1/2024	Changed "medication assisted treatment" to "medication for opioid use disorder" and updated language about the administrative rule change.	20.0

1/1/2024	Added language for persons served to be able to retrieve property in the event of an unexpected discharge.	22.1.13.3
1/1/2024	Removed requirement to ensure that children have care and supervision if parent/guardian seeks withdrawal management services.	22.1.18
1/1/2024	Removed requirement to ensure that children have care and supervision if parent/guardian seeks withdrawal management services.	23.1.18
1/1/2024	Replaced “anti-addiction” with “for the use in the treatment of substance use disorders”.	24.1.1.4