
# Standards for OASAS Certified Programs

## Introduction

The purpose of this document is to provide guidance to programs implementing updated OASAS regulations and should be used collaboratively with other OASAS guidance provided herein and on the website. Questions should be directed to Legal@oasas.ny.gov and PICM@oasas.ny.gov.

OASAS programmatic regulations have been revised in accordance with the following principles:

- Addiction is a chronic disease: These regulations support treatment of addiction as a chronic disease that may have exacerbations and remissions over a lifetime. Programs can increase and decrease intensity as needed and monitor individuals in need of infrequent contact through continuing care.

- Promote clinical quality: The regulations are focused on minimal requirements that promote patient safety. Programs are responsible for ensuring consistency with clinical standards of care and developing policies and procedures consistent with the standards.

- Removal of stigmatizing language: Revisions support OASAS' goal to unify all outpatient programs into one regulation, utilize gender neutral language and replace terms (such as reoccurrence rather than relapse, opioid full agonist rather than methadone) to promote accurate and respectful terminology.

- Recovery is the goal. Treatment goals should focus on impairment and distress caused by substance use. A person may be in remission from their substance use disorder and still use substances. Individuals should meet milestones in treatment established in the treatment/recovery plan. The treatment plan goal is the person achieving recovery; it is for the patient to determine what recovery is and how it is defined.

## Medication Assisted Treatment (MAT)

The following should be considered and incorporated in program policy and procedures:

All outpatient programs:

- Rapid access to MAT. Admission to MAT services should happen immediately, once a determination is made that MAT is a viable treatment option. This includes same day admissions for all outpatient clinics.
- Clients should be educated on and provided access to all MAT options. In accordance with person centered care, a client should be educated on all MAT options to treat their

substance use disorder. A client should be able to access all available MAT options, either directly from their treatment program, or via linkage agreement with another treatment program (e.g., access to methadone from a partnering Opioid Treatment Program (OTP).

- Administrative discharges that involve a tapering of MAT services should only be done in extreme instances where clinic staff and/or patient safety is potentially in jeopardy. Administrative discharge / administrative taper should not be done exclusively based on poor engagement in treatment services (e.g., patient not participating in counseling) or continued substance use. An administrative medication taper should ideally be conducted on-site but if not indicated, then it is the responsibility of the program to refer for an off-site administrative taper to be done.
- Diversion Control Plan (DCP): A DCP is required in all outpatient programs. Policies and procedures that address the programs' DCP must, at minimum, include the following:
    - Prescribing practices that reduce diversion potential.
    - Demonstration on how the program will ensure rapid access to MAT services while simultaneously ensuring that diversion risk is minimized. The DCP should include activities that the program has adopted to ensure diversion does not occur.
    - Clinically justified use of toxicology screens as part of a DCP.
    - Other mechanisms, such as: pill counts, where appropriate recall of medication, street loitering patrols, etc. should be included as part of a DCP policy(s) / procedure(s).
- MAT services should be offered, or medication continued, regardless of a person's full engagement in treatment services (such as counseling services). A person should not be discharged from care and/or be denied access to MAT solely because of continued substance use or because they are not fully engaging in other treatment services.

Programs providing opioid full agonist medication (previously known as Opioid Treatment Programs or OTPs):

- Guest dosing: Guest dosing must be provided for patients that require medication based on travel or medical reasons that displace the person from their home clinic. Guest dosing is a Medicaid reimbursable service. If the patient is uninsured, then a sliding scale fee should be provided that is based on a person's ability to pay.
- Residential services: Linkage agreement should be established with all applicable community based residential service programs to continue opioid full or partial agonist medication for individuals admitted to those services to ensure continuity of care. Residential programs may either bring patients to the home OTP (or to the OTP that is guest dosing) to pick up their medication or establish a plan for residential program staff to pick up a patient's medication on their behalf (i.e., designated other or third party).
- Scheduled dosing: Scheduled dosing procedures should be in place to include scheduled blocks of time that should not exceed thirty (30) minute bands. These scheduling blocks should minimize the number of people in and around the clinic at the same time, with the intent to reduce waiting time for dosing. They must be spaced throughout the day to accommodate the daily number of expected individuals, and ideally, be available in the afternoon and/or evening hours. Not all patients will be able to successfully adhere to a scheduled dose schedule; for instance, patients who are transported to and from the clinic

or patients with medical conditions where adherence to a scheduled time is not possible should be permitted flexibility and this should be documented in the patient's record. Scheduled dosing is a person-centered approach to care, minimizes chaos in waiting areas, permits patients greater access to nursing staff while medication administration is occurring, and reduces risk of potential diversion and loitering.

- Certified capacity: Patients being dispensed a buprenorphine product are not counted as part of a program's certified capacity. It is recommended that all programs should apply for a capacity lift rather than develop a waitlist.

**Toxicology Screening/Testing**

Toxicology screens should be used as a clinical tool rather than a surveillance mechanism. The results should be used to inform the treatment plan. Results should be discussed with the patient from a supportive, clinical perspective, as opposed to a punitive one. Additionally, program staff should be trained to understand toxicology results including, the difference between a screening and a confirmatory test. All toxicology that is ordered or performed on site should be conducted per local, state, and federal rules and regulations. Policies pertaining to toxicology screening/testing should include the reason for the test, how it will be used, general plan for ongoing testing including frequency, conditions for a confirmatory test, randomness, and substances to be screened.

Per federal regulation, programs providing opioid full agonist medication must conduct, at minimum, eight toxicology tests annually of all patients who are receiving either opioid full agonist or opioid partial agonist medication.

**Psychosocial Counseling**

Guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA)[1]acknowledges that there is an intrinsic psychosocial component within the medical management buprenorphine prescribers provide which benefits patients. Many patients are likely to benefit from counseling at some point in their treatment for Opioid Use Disorder (OUD). SAMHSA's guidance regarding counseling notes that prescribers should "offer referrals for adjunctive counseling and recovery support services as needed." The guidance further states that "patients who were not interested in adjunctive addiction or mental health counseling during induction may become receptive to it when they are feeling more stable."

As referenced in guidance issued from OASAS and the NYS Department of Health (DOH)[2] programs should ensure immediate and continued access to buprenorphine, even for patients who are unwilling or unable to participate in counseling or other formal psychosocial services. The program should continue to keep the individual engaged in care and offer the full range of services available. In order to continue treatment with psycho-social supports for individuals

[1] Substance Abuse and Mental Health Services Administration. Medications to Treat Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63. https://store.samhsa.gov/system/files/sma18-5063fulldoc_0.pdf

[2] Implementing Transmucosal Buprenorphine for Treatment of Opioid Use Disorder: https://www.oasas.ny.gov/legal/documents/BestPractices.pdf

who are not interested in engaging in traditional programming, programs are encouraged to consider engaging the client in family sessions, individual sessions even if they are brief, and peer support services.

Group Counseling:

- The purpose of group counseling is to attain knowledge, gain skills and change attitudes about addiction to achieve and maintain recovery from addiction. Individuals also gain direct support, learn to communicate with others, and gain a sense of belonging to the group through the common goals of recovery.

- The current regulations do not specify a requirement limiting the size of an outpatient group. It is the responsibility of the program and group leaders to assure that the needs of each patient are being met, that the size of the group allows for adequate interaction of members and that the goals of the group can be attained.

- The counselor focuses on both process (how the group is communicating and inter-relating) and content (what is being discussed/addressed) to fully realize the therapeutic value of group counseling. Group size determinations should conform to evidence and best practice guidance, such as SAMHSA TIP 41. Groups have different purposes and size should be determined based on the goals and methods employed to reach the goals. For example, best practice is to limit therapy groups to less than 10 members in a closed group (new members cannot join); while psycho- educational groups may have up to 20 members. Group size, whether a group is open/or closed, facilitated by a single clinical staff, or a dyad of staff, should be clinically determined.

**Intensive Outpatient Services**

The amended outpatient regulation now allows for more flexibility in providing intensive outpatient services. This recognizes that some individuals will benefit from the intensive three-hour block of services less than three times per week, as was previously required. This change also allows for up to one hour of the intensive outpatient service to be delivered by a certified peer.

**Peer Support Services**

Peer Support Services are now a required service from all certified outpatient programs.[3] Peer services have proven both effective and integral to ensuring individuals are engaged and maintained in addiction treatment services. Additional guidance is available regarding the provision of peer support services including who may provide reimbursable peer services and how such services must be documented for reimbursement.[4]

As programs are building capacity to deliver peer services, it is important to remember that clients may not be admitted to two outpatient programs at one time. If a client requires peer

[3] 14 NYCRR Part 822.7(g)(12)

[4] Peer Support Services in Outpatient Clinical Settings: https://www.oasas.ny.gov/recovery/documents/OASASPeerGuidanceFINAL5-6-19.pdf

support services and your agency does not offer those services, it may be appropriate to transfer the client to another program that will better serve their needs.

In limited circumstances until January 1, 2020, where an outpatient program is not able to provide peer support services, that program may contract with another outpatient program for the provision of peer support services. The program employing the peer cannot bill independently and must be paid by the contracting program through a collaborative agreement. Programs are expected to use the resources provided to integrate peer services into their outpatient programs.

**Screening and Zero Suicide Protocol**

Suicide is a significant public health problem that disproportionately affects individuals with substance use disorders. Since substance use is the second highest risk factor for suicide, implementing suicide safer care protocols in the addiction treatment system. All OASAS-certified programs should have evidence-based suicide safer care protocols in place to address suicide risk in the individuals in their care. The Office of Mental Health, in collaboration with OASAS, developed suicide safer care protocols for addiction treatment providers. All staff in OASAS-certified treatment programs should be routinely trained in suicide safer care based on their roles in the program.

All OASAS-certified programs are expected to be screening individuals entering treatment with the Modified Mini Screen (MMS) to identify potential co-occurring disorders. Should an individual respond "yes" to question #4 of the MMS, OASAS recommends screening with the Columbia-Suicide Severity Rating Scale (C-SSRS) screening version or another approved, evidence-based screen for suicide risk. The C-SSRS can be completed by any clinician. Individuals who screen at risk on the C-SSRS should then receive a C-SSRS comprehensive assessment or another approved evidence-based suicide risk assessment by a licensed clinician trained to use the assessment tool and working within his/her scope of practice. If an individual is assessed to have imminent risk of suicide, refer to a Comprehensive Psychiatric Emergency Program (CPEP), if available, or Psychiatric Emergency Department. If imminent risk is not present, but the assessment identifies a level of risk, refer to a trained, licensed mental health clinician within the program or to an outside mental health agency.

**Transition Planning/ Post-Treatment Planning (formerly discharge planning)**

Addiction is a chronic long-term disease that requires ongoing management. Providers should consider, as part of transition planning, how clients will meet social determinants including: housing, employment and ongoing recovery support from the initial assessment and through ongoing treatment.

**Delivering Trauma Informed Care**

Programs should assume that all individuals seeking treatment have been exposed to some traumatic event and that many meet the criteria for post-traumatic stress disorder. Programs should develop policies and procedures that are consistent with research and clinical consensus around trauma informed care including in TIP 57.

**Recertification Reviews**

All services that moved from “optional” to “required” under Part 822.7 will not be scored during recertification review until January 2020. New site review instruments will be posted on the OASAS website.

**Additional Resources for Certified Programs:**

Preadmission Services Guidance
http://webdev.oasas.ny.gov/ManCare/documents/PREADMISSIONSERVICESGUIDANCE.pdf

In-community Services Guidance:
https://www.oasas.ny.gov/ManCare/documents/ServicesintheCommunity.pdf

Continuing Care Guidance:
https://www.oasas.ny.gov/ManCare/documents/ContinuingCareGuidance.pdf

Person Centered Care Guidance
https://www.oasas.ny.gov/ManCare/documents/OASASPerson-CenteredCareGuidance.pdf

Peer Support Services Guidance
https://www.oasas.ny.gov/recovery/documents/OASASPeerGuidanceFINAL5-6-19.pdf

NY Suicide Prevention Center
https://www.preventsuicideny.org/providers-health-care-systems/

Center for Practice Innovations (CPI) at Columbia Psychiatry, NYS Psychiatric Institute training
https://rfmh.csod.com/client/rfmh/default.aspx