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Part 822 Outpatient Services Clinical Standards

February 2020

I. **Organizational Environment: Openness, safety and respect are communicated in both physical environment and staff interactions with the Individual and/or their family.**

A. PHYSICAL ENVIRONMENT	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
Premises support an environment of safety, openness, and respect. [i] [ii]	1. All signage is positive, welcoming, helpful and respectful. 2. The premises are welcoming to individuals; there is evidence of program efforts to communicate personal value to the individual. 3. Rights and advocacy information are prominently posted. 4. In waiting rooms, offices and throughout the building, literature, photos, reading material and toys are reflective of the populations served. 5. Comfortable temperatures are maintained in all areas of the program. 6. Sign-in procedures and therapy rooms promote confidentiality. 7. Individual and group space is sufficient, comfortable, and private. 8. Records are maintained in compliance with 42 CFR and other applicable laws and regulations. 9. Medications are stored and disposed of appropriately as given in applicable laws and regulations. 10. A sufficient number of restrooms are available for use by individuals and staff. 11. Proper exit signs are visible and working with evacuation route signage posted.
B. PERSON-CENTERED CARE	
1. The program actively works to engage and appropriately retain individuals in treatment. [iii] [iv]	1. Individuals are warmly and respectfully greeted when entering the facility and throughout the duration of their treatment visit/episode. 2. Potential barriers and current difficulties in participating in treatment are identified and addressed at intake and throughout the course of treatment. 3. Service delivery reflects an understanding of the cultural perspective of the individual and/or family. 4. There is evidence of timely and appropriate follow-up on missed appointments. 5. Information is provided to individual/family about services available at the program, the treatment process, and shared decision-making. 6. Clinical Staff are aware of the likelihood of individuals having strong cravings and urges to use. With this awareness Clinical Staff assess and refer individuals for addiction medication assessment with Medical Staff, and provide counseling services which include behavioral and cognitive skill building to target urges and cravings. 7. Program makes welcoming or orientation group available to individuals and/or their families.

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STANDARDS OF CARE	CLINICAL EXPECTATION
2. The program promotes person-centered care that focuses on substance use disorder remission and/or decrease of harmful consequences of use and management of SUD as chronic illness.[v]	1. Assessments focus on individual identified areas of concern. 2. Individuals are allowed to develop goals related to decreasing symptoms they have identified as being of concern. 3. The program acknowledges that successful discharge can, in appropriate situations, include remission from SUD and/or decrease of SUD symptoms. 4. In relationships with other systems (e.g. criminal justice, child welfare) agency personnel promote an understanding that relapse occurs in the context of the treatment process and does not mean failure of treatment.
3. Program policy states that responses to relapse focus on keeping individuals engaged in treatment.[vi] [vii]	1. Program establishes process for response to relapse, which includes participation by the individual, staff (e.g. counselor) and supervisory personnel. 2. Program will evaluate individuals who are not meeting goals or experiencing repeated relapse and work to revise the treatment plan as indicated. Rather than withdraw treatment, treatment efforts should be increased to meet the needs and preferences of the individual. 3. Individual and group treatment should provide skill building including cognitive behavioral approaches, social network development, peer services (where available).
4. The program attends to the individual and family needs.[viii]	1. Flexibility in scheduling to meet the needs of individuals is in evidence. Program has evening and/or weekend hours sufficient across the week to accommodate variety in individual schedules. 2. The program assists individuals in overcoming barriers to treatment, e.g. childcare, transportation, etc. 3. Quality Improvement tools (such as surveying Perception of Care) are used and results utilized to shape program operations. 4. A notice of individual rights is provided upon admission. 5. There is evidence of a responsive complaint resolution process. 6. Information about advocates and advocacy organizations is available to individuals and families. 7. Provides family education, support and/or treatment

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5. Cultural Competence [ix] [x]	1. There is a presumption that the individuals served have a history of trauma and "universal precautions" are used in providing treatment.
	2. Individuals are asked their preferences in being addressed, e.g. Mr. Jones, Bob, etc.
	3. There is evidence that that program seeks to eliminate disparities in care for people of diverse backgrounds by:
	   a. Making all reasonable efforts to provide care in a culturally competent manner to its prevalent populations through all stages of screening, treatment, and discharge.
	   b. Ensuring that assessments capture individual/family cultural, linguistic, and literacy needs, ethnic and/or racial identification, sexual orientation, etc. and any impact on treatment.
	   c. Assigning multicultural/multilingual clinicians to individuals from matching cultural groups wherever possible.
	4. For individuals with Limited English Proficiency (LEP), the programs:
	   a. Use language translation services as needed and as required by law.
	   b. Make reasonable efforts to provide written correspondence and other documents to be used by the individual in their preferred language wherever possible.

6. Information Sharing [xi]	1. Individual is informed of what to expect in terms of the assessment and treatment process throughout their involvement with the program. 2. The program has procedures, policies and clearly delineated protocols in place which describe and support the importance of appropriate information sharing within the agency and with outside agencies, families, and other collaterals in providing coordinated services for recipients. 3. Individuals are fully informed upon admission of the program's privacy policies, including circumstances where written consent is not required or when information can be released without prior consent. 4. The value of sharing information with other parties is discussed and the individual's consent is sought and documented as appropriate. 5. There is evidence of sharing treatment information in order to better integrate services for individuals, particularly at admission, discharge, or periods of crisis or hospitalization, and for individuals with mental health concerns.

STANDARDS OF CARE	CLINICAL EXPECTATION
7. Communication with Families/Other Significant People [xii]	1. Families or significant others have all information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis. 2. Staff can explain the parameters and policies concerning confidentiality, including the ability to receive information from family and others. 3. Clinicians seek to identify others involved in the individual's care and recovery and discuss benefits of their involvement with the individual. 4. There is documentation of efforts to communicate in person or by telephone with significant others involved in the individual's treatment and recovery as appropriate.
8. Every individual has one clinical staff person who provides individual counseling and coordinates the treatment plan. [xiii]	1. Each individual is assigned a primary clinician at the time of admission. 2. Individual choice is considered in primary clinician characteristics and special training or focus. Ongoing therapeutic alliance is monitored. 3. Individuals are given appropriate opportunities to process changes of clinician
9. The Program has a process to re-engage individuals who have left treatment prematurely. [xiv]	1. When individuals discontinue, refuse services, or are lost to contact, a review of the individual's history, current circumstances and degree of risk is conducted. 2. Efforts to re-engage are commensurate with the degree of risk assessed. 3. Reviews include contact with significant others/collaterals when appropriate and available. 4. Reviews are in consultation with the clinical supervisor or team prior to the case being closed. 5. When possible, written correspondence indicates that the individual is encouraged and welcome to re-engage in services at any time in the future.

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II. Clinical Administration and Staffing: the program has qualified staff who provide program services based on the needs of the populations served.

A. CLINICAL STAFF/TRAINING	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
1. Medical direction is provided by an Addiction Medicine certified physician who oversees all aspects of treatment.	**1. Medical Direction is provided by a physician who has the following characteristics: waiver to prescribe buprenorphine (or obtains waiver to do so within 4 months of hire) and one or more of the following a) certification by the American Society of Addiction Medicine, b) boarded by the American Board of Addiction Medicine and/or c) board certification in Psychiatry with added qualification of certification in Addiction Psychiatry.** 2. Provides supervision of all medical staff. (may delegate supervision of administrative tasks such and time and attendance, scheduling of call, etc. to someone in administration, HR or another appropriate individual, but clinical supervision and supervision of case management must be done by the medical director) 3. Functions as part of the treatment team, providing a leadership role or deferring when appropriate to the other experts on the team. 4. Ensures that all treatment is within best practices and meets established clinical standards 5. Provides leadership, along with other professionals in establishing treatment and standards of care within the institution 6. Provides consultation to staff regarding medical issues and medications 7. Prescribes and/or approves any medications that are given to patients within the facility. Again this approval/prescription is done within best practices and is *individualized for each patient*. The process may be done through other prescribers such as other physicians, nurse practitioners, physician assistants, but the Medical Director ensures that standards and philosophy are consistent and appropriate 8. Consults with other specialists and refers as indicated 9. Ensures that admission work, laboratory work, ongoing care is timely and appropriate. Provides and/or supervises all medical care that patients receive 10. Is involved in the hiring process of medical staff and approves of the clinical expertise of these new hires or develops a plan to ensure that standards clinical expertise is upheld 11. Assists staff that s/he supervises in developing plans for ongoing professional development

A. CLINICAL STAFF/TRAINING	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
	12. May provide or arrange for ongoing education for all staff, in collaboration with other leadership of the facility 13. Along with other clinical and administrative staff, ensures to the best of her or his ability that all discharges are within minimum standards of safety, even if they are not recommended such as AFA or Administrative discharges.
2. Clinical Supervision is provided regularly to all staff working in a clinical capacity with patients. [xv] [xvi]	1. Clinical supervision by appropriate leadership staff occurs on a regular basis for all clinicians. All such supervision is documented. 2. The frequency of supervision is increased for new vs. experienced staff. 3. Provision is made for prompt supervision in times of crisis or increased need, clinicians demonstrate knowledge of the method to request "ad hoc" supervision, and there is evidence that this method has been used. 4. Issues or needs identified related to staff performance are addressed in supervision, training, or by other identified methods. 5. Regularly scheduled clinical in-service training is provided by the program and staff attendance is documented. 6. Required staff clearances are maintained. 7. Staff licenses, credentials, and registrations are current. 8. For state-operated programs, mandatory annual cultural and linguistic training is conducted.
3. Programs must have policies and procedures to ensure that individuals are receiving care from a competent staff person, working within their scope of practice, who has the required experience, training, and supervision to provide such services. [xvii]	Please consult the following: OASAS Scope of Practice Guidelines and/or NYS Office of Professions

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A. CLINICAL STAFF/TRAINING	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
4. The agency has a clear policy and procedures for assignment of cases and monitoring of caseload size to ensure that all clients can expect quality treatment. [xviii]	1. Program leadership can demonstrate a systematic process used to assign individuals to clinicians. Such decisions are based on clinician experience, skill, training, and background. 2. A systematic process, and the concomitant policies and procedures to monitor, review, and track clinician caseloads by size, complexity of individuals and other factors can be demonstrated. 3. The program considers intensity of treatment in determining caseload. Program staff who are responsible for individuals receiving a high intensity of services or who have high severity of symptoms should have lower caseloads than staff who are responsible for lower severity and intensity of services. 4. Policies and procedures should include methods of reviewing staffing sufficiency including quality indicators (treatment plans on time, individuals are seen regularly, perception of care indicators, staff reports, etc.) that would trigger a staff caseload review. 5. Productivity standards that allow for appropriate clinical care and address fiscal viability are established. 6. Sufficient prescriber coverage is available to meet the needs of individuals without undue delay, or a process is in place to assure individuals have access to prescription services when needed. 7. The program systematically recruits staff to better meet the clinical and other needs of the population served (for instance, bilingual staff of staff with particular expertise or training).
5. Training is promoted by the agency and regular training opportunities are accessible. [xix] [xx]	1. Co-occurring Disorders: Clinicians are adequately trained to provide services to individuals who meet primary SUD admission criteria but also have a co-occurring mental health disorder that does not interfere with their ability to participate in the program. 2. Clinical Risk Management: All new staff receive training in Clinical Risk Management regarding the definition of incidents and reporting procedures for incidents. They are informed about the Incident Review Committee (IRC) process and the importance of risk management in maintaining safety and improving services. This training includes training on professional role and boundaries of clinical staff. 3. Medication Assisted Treatment: Staff is trained in identifying individuals who may benefit from an assessment for potential addiction medication use.

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A. CLINICAL STAFF/TRAINING	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
6. Care provided is consistent with the scientific literature and is responsive to the unique needs of each individual. [xxi] [xxii] [xxiii]	The program has trained staff in and implements evidence based practices including at least 2 of the following: (a) Cognitive Behavioral Therapy (b) Motivational Interviewing (c) Functional Family Therapy (d) Contingency Management (e) Twelve Step Facilitation (f) Behavioral Couples Therapy (g) Dialectical Behavioral Therapy (h) Matrix Model (i) Trauma Informed Care (j) Others approved by the Office.
Services	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
1. The program offers a menu of treatment services that are appropriate to the needs of the population served.	1. There is evidence that the program provides all required services and approved optional services in a consistent and clinically appropriate manner. 2. Optional Services (and appropriate staff, if necessary) are added if the program identifies a need among its population, for example, a criminal justice or trauma track. 3. Administration identifies and utilizes mechanism(s) for ensuring that appropriate services are provided to each individual based on current clinical need and documented processes (for instance, UR). 4. Appropriately, trained and credentialed/licensed staff provide all services, including services provided at integrated OMH/OASAS/DOH program sites. 5. Documented procedures for identifying, monitoring, and re-assessing individuals receiving medication assisted treatment only, are known and adhered to by program staff.

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A. CLINICAL STAFF/TRAINING	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
2. The program has the ability to respond promptly to crisis and has a clear policy and procedure for responding to crisis. [xxiv] [xxv]	1. The program has the ability to accommodate crisis intakes and walk-ins during normal program hours. 2. There is a plan in place that results in contact with a licensed/credentialed professional by individuals and their collaterals who need assistance when the program is not in operation. 3. The primary clinician at the program is informed on the next business day of information from clinicians providing after hours services. 4. During intake, after-hours contact is explained to all individuals, and significant others where appropriate, along with an information packet describing the services offered by the program. This information is also posted onsite and reviewed with the individual throughout the course of care. 5. The program demonstrates consistent follow-up on crisis calls received. 6. Staff is trained in the agency policy and can identify where the policy can be found and the procedures to be followed in a crisis.
3. Medication Assisted Treatment is available as appropriate to the client population. [xxvi] [xxvii] [xxviii]	Program has policies and procedures regarding: 1. Assessment for addiction medication needs; 2. Provision of addiction medications. 3. The training and utilization of opioid overdose prevention kits for staff, family, significant others.
4. There are clear policies and procedures for Clinical Risk Management [xxix]	1. The IRC reviews incidents, makes recommendations, and ensures implementation of action plans with the program's administrator. 2. The IRC membership composition is appropriate; members meet qualifications and are properly trained. 3. The program compiles and analyzes incident data for the purpose of identifying and addressing possible patterns and trends. 4. The program identifies, tracks, monitors, assesses, and re-assesses the treatment of at-risk and high-need individuals. 5. Staff receive follow-up training for Risk Management on an annual basis. 6. The program routinely uses staff debriefings to discuss critical incidents, the causes and possible changes needed to procedures. 7. For at-risk and high-need individuals, an updated risk assessment is completed prior to a planned discharge.

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C. QUALITY IMPROVEMENT	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
Quality Improvement is a continuous and on-going process. [xxx] [xxxi]	Policies and procedures include: 1. Program utilizes Plan-Do-Study ACT cycles, NIATx model or other recognized quality improvement methods as appropriate. 2. Program ensures that all staff participate in metric understanding, adoption and promulgation. 3. Program participates in OASAS recognized continuous quality improvement initiatives such as Peer Review. 4. Program understands and distinguishes process based and outcome based measures and incorporates necessary metrics in ongoing program development. 5. Program includes appropriate measures to ensure data collection and reporting is of the highest caliber to ensure appropriate baselines are determined and benchmarks set, attained and maintained. 6. Program identifies and pursues metric adoption and integration in all necessary levels of the program operations. 7. Quality Improvement is shown to be integral and linked to individual outcomes, program success, and risk mitigation (both fiscal and clinical).

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III. Clinical Practice: Elements of person-centered care and appropriate staffing will be applied in the program's provision of services.

A. PREADMISSION SERVICES	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
A prospective individual or family member receives prompt response to a treatment inquiry and the program has the capacity to meet urgent needs. [xxxii]	1. Calls, walk-ins or referrals for service are reviewed for risk by appropriately trained staff. Mechanisms are in place for alerting clinical staff when risk is identified. 2. Individuals referred from inpatient or crisis service settings, or those at high-risk receive initial assessment within 24 hours. 3. Individuals who are not in immediate crisis are offered an assessment within 5 business days of first contact.
B. ASSESSMENT AND EVALUATION	

1. Admission assessment process is responsive and coordinated.[xxxiii] [xxxiv]	1. To support early engagement, admission Assessment appointments are:
	   • Scheduled as soon as possible, but within at least 5 business days from first contact.
	   • Conducted as individual sessions.
	2. A single clinician oversees the assessment process with the individual integrating and utilizing information gathered by other staff members (e.g. nurse, vocational/employment, psychiatrist).
	3. There is evidence of effective "hand-off" of individual information and the individual between clinicians during both the assessment and the admission process.
	4. Individuals whose mental health service needs exceeds the provider's ability to respond, are referred to the appropriate mental health services. Both agencies facilitate care coordination to address both SUD and mental health concerns.

2. The admission assessment is based on a person-centered interview, is strength-based and considers a full range of functioning. [xxxv]	Complete admission assessments include the following: • A clinical assessment of the individual's presenting problem(s); • Individual identified priority/emergency issues; • The individual's chemical use (including tobacco), SUD criteria met, and previous treatment history; • An assessment of mental health history, mental status, current symptoms, and functioning; • An assessment of family, friend, and/or community supports; • Identified other strengths, i.e. employment,

A. PREADMISSION SERVICES	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
	- Identification of coping skills and triggers relevant to the presenting problem(s); - A determination that the individual has a substance use disorder based on the most recent version of the DSM or ICD; - Identification of other involved providers and services; - Information regarding criminal history or other law enforcement or court action; - An assessment of risk of harm to self or others based on the policy and procedure of the program.
3. Medication Assisted Treatment available for all individuals seeking treatment services. [xxxvi]	1. Individuals are evaluated by medical staff to determine benefit and/or need for medication assisted treatment for withdrawal management/maintenance. 2. All individuals are provided education regarding medication assisted treatment, and where appropriate offered the option of being evaluated by medical staff for such treatment. 3. Medication Assisted Treatment need is assessed throughout the course of treatment, particularly for individuals who experience strong urges or cravings to use, or have a history of strong urges or cravings leading to relapse.

4. Physical Health needs of the individual are adequately addressed during the assessment process with care coordination being offered as needed.[xxxvii]	1. Health History includes:
	   a. Information about withdrawal symptoms including protracted withdrawal, urges and cravings to use substances, withdrawal history;
	   b. A symptom checklist,
	   c. Evaluation of current physical health providers (primary care physician, other health providers),
	   d. Identification of known current and past medical conditions.
	2. Health information is reviewed by a physician, nurse practitioner, registered nurse, or physician's assistant, who then document the review and any potential impact this information has on diagnosis and treatment, as well as any need for additional health services or referrals.
	3. In all cases where there are health needs care should be coordinated.
	4. In cases of significant health and SUD needs, a health home referral or connection to existing health home care coordinator should be made.

5. The clinician should seek Information from other available sources, e.g. family	1. Assessment seeks to identify significant others as well as past and current service providers/agencies involved with the individual, e.g. courts, DSS, schools, etc. in addition to SUD services.

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A. PREADMISSION SERVICES	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
members, significant others, and recent service providers where appropriate.[xxxviii]	2. With appropriate consent, family and significant others are contacted to participation in the assessment. 3. For children and adolescents, assessment should always include input from parents or other caregivers, or there is documentation regarding why there has been no contact. 4. There is documentation that recent providers of SUD service(s) have been contacted to obtain discharge summaries and other pertinent information.

6. Assessment is an ongoing process and should be continued in individual sessions consistent with person-centered care and strengths-based recovery orientation to care. [xxxix]	1. Ongoing evaluation should include history and current status, needs, goals, and desires in the following areas:
	    a. Individual and family current strengths, supports, and stressors;
	    b. Physical/mental status;
	    c. Trauma history;
	    d. Perception of own risks and safety;
	    e. Criminal Justice involvement;
	    f. Family/significant others, finances, housing;
	    g. Social functioning, peer supports and community involvement;
	    h. Education, employment, and other community roles;
	    i. Housing needs;
	    j. Literacy needs and translation services;
	 2. Continuous assessment is needed to develop and maintain an active, appropriate treatment/recovery plan.

7. Toxicology testing is a routine part of SUD treatment that is used to inform the treatment plan. Results are used in a manner consistent with person-centered care principles.	1. Clinical staff should understand issues related to the use of toxicology reports within the context of the broader treatment episode including: • Use of clinically appropriate terms, for example "positive result" rather than "dirty"; • Skills in reporting the results; • Use of results within the context of the treatment plan and patient goals and objectives; • Use of results to support recovery in a non-punitive manner; and • Use of both positive and negative results to support and encourage recovery goals. 3. Toxicology screening is both an assessment and treatment tool. The results of toxicology screening provide valuable information on the likelihood that the patient either used or didn't use the substances screened. How the results

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A. PREADMISSION SERVICES	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
	will be used therapeutically is related to the goals of the patient and the purpose of the test. 3. Presenting the results to the patient, whether they are positive or negative, is often empowering for the patient, as long as the practitioner uses sound patient centered clinical technique. The clinician should review toxicology results with the patient whether they are positive or negative and use the results in a way that is consistent with the treatment plan, or in a way that modifies the treatment plan to support recovery.
C. TREATMENT/RECOVERY PLAN	
STANDARDS OF CARE	**CLINICAL EXPECTATION**
1. Every individual has a person-centered treatment/recovery plan. [xl]	1. Treatment/recovery plan goals, objectives, and services are clearly linked to the comprehensive assessment and discharge criteria that are individualized and person-centered. 2. An assessment of the individual's risk and resources consistent with LOCADTR to support the level of care placement. 3. Measurable and attainable steps toward the achievement of goals are identified with target dates. 4. The plan includes the specific interventions and services that will be utilized, the clinician(s) providing services, and the frequency of services. 5. The treatment/recovery plan includes discharge criteria that are clearly identified within the treatment plan, updated as needed, and reflect desired accomplishments of the individual.
2. Treatment/Recovery plan is an active and person-centered process including active and ongoing reappraisal of goals.	1. Review of the treatment/recovery plan includes an assessment of progress on each goal. 2. Treatment/Recovery plan reviews indicate the individual's input on progress, current needs, strengths, and services. For children; caregiver, significant others and/or family input is included. 3. Clinicians routinely evaluate and address changes in functioning, circumstances, and risk factors related to treatment goals.

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3. When an individual is not responding to current treatment the plan will be discussed and revised with the individual and the treatment approach adjusted. [xli xlii xliii]	Adjustments should be in consultation with the individual and may consider any of the following: (a) A change in the intervention including a change from one approach (e.g. Cognitive Behavioral Treatment) to another approach (e.g. Twelve Step Facilitation). (b) A change in the modality of treatment – group, individual, family, etc. (c) Increase in supports including peer and HCBS services. (d) Increase (or decrease) in intensity of services. (e) Medical Staff assessment, including assessment for MAT. (f) Change in family involvement in treatment including an increase in family counseling. (g) Exploration with the individual about his/her understanding of what is or is not working. (h) Consider mental health symptoms, psychiatric assessment and treatment. (i) Develop holistic approaches that make sense to the individual and their family. (j) Using LOCADTR reassess for change in individual's level of care. (k) Adjustment in goals to better align with individual perspective. (l) Trauma assessment for trauma informed plan and specific trauma interventions including DBT, Trauma focused group etc. (m) Change in primary clinician may be considered where therapeutic alliance is not well-established.

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4. Discharge begins at admission and includes a chronic condition management approach to long-term recovery.	1. Arrangements for appropriate services (appointment dates, contact names, and numbers, etc.) are discussed and made with the individual and their significant others prior to the planned discharge date. Documentation of this information will be included in the individual's case record. Where an individual is going from a bedded service to another service, a warm hand-off or peer service is considered where possible.
	2. The treatment plan includes goals toward establishing meaningful engagement in community to support long-term recovery and includes-housing, employment and recovery support.
	3. Discharge summaries identify:
	   a. Individual's response to treatment;
	   b. Progress toward goals;
	   c. Circumstances of discharge; and
	   d. Efforts to re-engage if the discharge had not been planned.
	4. When the provider is known, the discharge summary and other relevant information is made available to receiving service providers prior to the individual's arrival or within two weeks of discharge whichever comes first.

5. Substance Use Disorder is a chronic disease and in most cases needs to be managed over the life of the individual.	The program policy and procedures reflects an understanding of the chronic nature of Substance Use Disorder.
	
	1. Treatment/recovery plans reflect skill building needed to sustain long term health including, but not limited to, emotional, mental, and spiritual.
	2. Treatment encompasses and includes identification and involvement of community and family supports.
	3. Continuing Care is offered at the program in support of the on-going needs of the person after the goals of active treatment have been obtained if:
	   a. Management on medication if the individual cannot access medication management in an office based setting, or if accessing office based treatment is not the most clinically appropriate.
	   b. The individual is interested in and in need of periodic ongoing follow-up to monitor recovery.
	   c. The individual has a history of relapse and is in need of long term support for recovery.

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