NEW YORK STATE | Office of Addiction Services and Supports

ANDREW M. CUOMO
Governor

ARLENE GONZÁLEZ-SÁNCHEZ, M.S., L.M.S.W.
Commissioner

June 21, 2021

Re: Part 825 treatment planning

Dear Providers,

Effective August 2, 2021, amended regulations will be implemented for all outpatient programs certified pursuant to 14 NYCRR Part 822. The new Part 822 makes substantial changes to the way in which treatment planning and supervision occur in the outpatient system. Consistent with these changes, the following guidance may be used by any programs certified pursuant to 14 NYCRR Part 825 (OASAS host model) until such time as Part 825 is amended.

Provisions of Part 825 identified below may be waived and replaced using the provisions and guidance for treatment planning and supervision in accordance with Part 822. Additional guidance on treatment planning may be found on the OASAS website.

Providers will be required to submit the **Request for Waiver from OASAS Regulations (PAS-10)** application as well as (1) their updated agency policies and procedures, (2) an agency implementation plan to address staff training on the new regulatory requirements and (3) a timeline for implementation.

Questions should be directed to **Legal@oasas.ny.gov** or **PICM@oasas.ny.gov.**

Sincerely,

Trisha Schell-Guy
General Counsel

- **General Service Standards for Substance Use Disorder (Part 822)**
- **Part 822 Regulations Discussion and Q+A Session**, 1/27/21
- **Overview of Part 822 Regulation** 4/14/21
- **Part 822 FAQs** – March 2021
- **Part 822 Side By Side**
- **Updates to Part 822 Outpatient Programs**,
- **Early Treatment Engagement Using Person Centered Care**,
- **Treatment Planning in Person Centered Care Practice**

Current Part 825 Treatment Planning	**New Part 822 Updated Treatment Planning**
825.7(b) Patient participation in treatment planning shall be documented by the signature of the patient or the signature of the person who has legal authority to consent to care on behalf of the patient or, in the case of a child, the signature of a parent, guardian, or other person who has legal authority to consent to health care on behalf of the child, as well as the child, where appropriate, provided, however, that the lack of such signature shall not constitute noncompliance with this requirement if the reasons for non-participation by the patient are documented in the treatment plan.	822.8(h) (h) Treatment/recovery plan. (1) Each patient must have a written person-centered treatment/recovery plan developed by the clinical staff person with primary responsibility for the patient, in collaboration with the patient and anyone identified by the patient as supportive to recovery goals. The treatment/recovery plan begins with the assessment incorporated into the patient record and is regularly updated with progress notes.
825.7(c)(1) (c) Each patient must have a written patient-centered treatment plan developed by the responsible clinical staff member and patient. Standards for developing a treatment plan include, but are not limited to: (1) For mental health or substance use disorder behavioral care host models, treatment plans shall be completed no later than 30 days after admission. For primary care host models, treatment plans shall be completed no later than 30 days after the decision to begin any mental health and/or substance use disorder services beyond pre-admission services.	Treatment planning shall be conducted in the manner and timeframe as indicated in the guidance for Part 822 programs.
825.7(c)(4) (4) For patients moving directly from one program offered by an integrated services provider to another program offered by the same provider, whether or not it is a program approved to provide integrated services, the existing treatment plan may be used if there is documentation that it has been reviewed and, if necessary, updated within 14 days of transfer.	822.8(h)(1)(ii) (ii) Immediate transfer: For patients moving directly from one program to another, the existing treatment/recovery plan may be used if there is documentation that it has been reviewed and, if necessary, updated to reflect patient goals as appropriate

825.7(e)(1)-(8) (e) The treatment plan shall include identification and documentation of the following: (1) patient-identified problem areas specified in the admission assessment; (2) treatment goals for these problem areas (unless deferred); (3) objectives that will be used to measure progress toward attainment of treatment goals and target dates for achieving completion of treatment goals; (4) methods and treatment approaches that will be utilized to achieve the goals developed by the patient and primary counselor; (5) schedules of individual and group counseling; (6) each diagnosis for which the patient is being treated at the program; (7) descriptions of any additional services (e.g., vocational, educational, employment) or off-site services needed by the patient, as well as a plan for meeting those needs; and (8) the signature of the qualified health professional, or other licensed individual within his/her scope of practice involved in the treatment and responsible for review of treatment plan.	822.8(h)(2) (2) The treatment/recovery plan must: (i) include the assessment, which identifies each diagnosis for which the patient is being treated; (ii) be incorporated into the patient record through regular progress notes, including initial services to be offered prior to completion of the initial assessment; (iii) address patient goals as identified through the assessment process and regularly updated as needed through progress notes; 23 (iv) identify a single member of the clinical staff responsible for coordinating and managing the patient's treatment who shall approve and sign (physical or electronic signature) such plan; (v) [include] reference to any significant medical and psychiatric issues, including all medications, by acknowledging review of medical/psychiatric assessment and progress notes, as well as coordination with mental and psychiatric providers [identified as part of the assessment process and updated mediations as issued by the appropriate medical staff]; and (vi) be reviewed and approved by the clinical staff person responsible for developing the plan, the patient and the clinical supervisor.
825.7(f) (f) All treatment plans shall be reviewed and updated as clinically necessary based upon the patient’s progress, changes in circumstances, the effectiveness of services, and/or other appropriate considerations. Such reviews shall occur no less frequently than every 90 days, or by the next occasion where a service is to be provided to the patient, whichever shall be later.	822.8(i) (i) Continuing review of treatment/recovery plans. The treatment/recovery plan must be reviewed through the ongoing assessment process and regular progress notes.
825.7(g)(1)-(4) (g) Treatment plan reviews shall include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate. The periodic review of the	822.8(k) (k) The program’s multidisciplinary team, as defined in Part 800 of this Title, shall meet on a regularly scheduled basis for the purpose of reviewing a sample of

treatment plan shall include the following: (1) assessment of the progress of the patient in regard to the mutually agreed upon goals in the treatment plan; (2) adjustment of goals and treatment objectives, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate; (3) an evaluation of physical health status; and (4) the signature of the qualified health professional, or other licensed individual within his/her scope of practice, involved in the treatment and responsible for review of the treatment plan.	cases for the purpose of clinical monitoring of practice. This meeting shall be documented as to date, attendance, cases reviewed and recommendations.