NEW YORK STATE | Office of Addiction Services and Supports

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Required Problem Gambling Standards for programs seeking certification under Title 14 NYCRR 824 – Specialized Services

The following requirement applies only to programs seeking OASAS certification to deliver problem gambling treatment services under the authority of Title 14 NYCRR part 824. As part of the Part 824 application process, entities must adhere to:

1. The requirements below.
2. The provisions and operations standards in Title 14 NYCRR Part 857.
   AND;
3. It is the applicant's responsibility to review all applicable operating regulations to ensure the proposed action(s) is in accord with regulatory standards and to receive approval by the appropriate local governmental unit.

General program standards

A. Programs must comply with OASAS clinical standards https://oasas.ny.gov/system/files/documents/2020/07/clinical-standards-for-oasas-certified-programs.pdf

B. Policies and procedures. The program sponsor must approve written policies, procedures, and methods governing the provision of services to patients in compliance with Office regulations including a description of each service provided. These policies, procedures, and methods must address, at a minimum:

(1) admission and discharge, including specific criteria relating thereto, as well as transfer and referral procedures;

(2) provisions to admit without a full diagnosis for a gambling disorder;

(3) treatment/recovery planning documented within assessment and progress notes;

(4) services to be provided by contract or subcontract including methods for coordinating service delivery and a description of core groups offered and procedures for coordinating group, individual, and family treatment;

(5) reporting and record keeping;

(6) a schedule of fees for services rendered;

(7) compliance with other requirements of applicable local, state and federal laws and regulations, OASAS guidance documents and standards of care

(8) staffing, including but not limited to, training and use of student interns, peers and volunteers;

(9) Standards of conduct for staff related to providing clinical treatment, self-help support or any other professional service in another independent program, community and/or private practice setting;

(10) Group counseling. Group counseling sessions must be structured in size and duration to maximize therapeutic benefit for each participant. Program policies must include a process for determining group size, group purpose, monitoring patient experience, and assessing group efficacy

C. Continuous services. Programs must develop necessary procedures, including disaster plans, to assure services in emergencies or disruption of operations in accordance with Office guidelines and accreditation standards.

D. Incident Reporting (Part 836) Programs must develop necessary policies and procedures in accordance with OASAS guidelines and regulations.

F. Tobacco Free-Policy (Part 856) Programs must develop necessary policies and procedures in accordance with OASAS guidelines and regulations.

I. Staffing. Program must ensure sufficient staffing for patient needs. Each program must provide documented clinical supervision and ensure and document a plan for staff training based on individual employee needs.

(1)A Medical consultant who is licensed and registered to practice through the NYS Education Department and has documented education, training and/or experience in gambling addiction should be available to consult when clinically needed This may include a physician, psychiatric nurse practitioner, psychiatrist, or registered physician's assistant. The Medical consultant may be a contracted consultant and provide the following:

(i) medical services provided by or arranged for by the provider;

(ii) oversight of the development and revision of [medical] policies, procedures and ongoing training for matters including, but not limited to, [such as routing] routine medical care, specialized services, specialized medications, and medical and psychiatric emergency care, screening for, and reporting of, communicable diseases and infection in accordance with law, public health education including prevention and harm reduction;

(iii) collaborative supervision with the program director of non-medical staff in the provision of addiction services;

(iv) assisting in the development of necessary referral and linkage relationships with other institutions and agencies

(v) ensuring program compliance with all federal, state and local laws/ regulations

2) A clinical director who acts as the clinical lead for the program and is a Qualified Problem Gambling Professional (QPGP).

3) Programs may utilize peers, volunteers and student interns. Such peers, volunteers or student interns must receive supervision, training, or didactic education consistent with their assigned tasks and the services they are expected to provide.

Patient Records/Treatment Planning

Admission requirements applicable to all programs:

(1) The treatment/recovery plan: 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 patient record and is regularly updated with progress notes

(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;

(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) 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 other behavioral health providers;

(vi) be reviewed and-approved by the clinical staff person responsible for developing the plan, the patient and the clinical supervisor.

(vii) Minor patients: If the patient is a minor, the treatment/recovery plan must also be developed in consultation with the patient's parent or guardian unless the minor is being treated without parental consent as authorized by Mental Hygiene Law section 22.11.

(9) Continuing review of treatment/recovery plans. The treatment/recovery plan must be reviewed through the ongoing assessment process and regular progress notes.

(10) Progress Notes. Progress notes are intended to document the patient's clinical status. Service delivery should be documented in the patient record through regular progress notes that include, unless otherwise indicated, the type, content, duration and outcome of each service delivered to or on behalf of a patient, described and verified as follows:

(1) be written and signed (physical or electronic signature) by the staff member providing the service;

(2) indicate the date the service was delivered;

(3) record the relationship to the patient's developing treatment plan; and

(4) include, as appropriate and relevant, any recommendations, communications, or determinations for initial, continued or revised patient goals and/or treatment.

(11) The program's clinical team shall meet on a regularly scheduled basis for the purpose of reviewing a sample of cases for the purpose of clinical monitoring of practice. This meeting shall be documented as to date, attendance, cases reviewed and recommendations.

(12) Communicable disease. Treatment/recovery plans must include provisions for the prevention, care and treatment of HIV/AIDS, viral hepatitis, tuberculosis and/or sexually transmitted diseases when present. If a patient refuses to obtain such care, the provider must have the patient acknowledge in writing that such care was offered, recommended, and refused.

(13) Confidentiality. Patient records maintained by the program are confidential and may only be disclosed consistent with the Health Insurance Portability and Accountability Act (HIPAA).

(14) Records retention. Patient records must be retained for six (6) years after the date of discharge or last contact, or three (3) years after the patient reaches the age of eighteen, whichever time period is longer.

(15) Patient deaths. If a patient dies while in active treatment any known details must be documented in the patient record.

(16) Documentation of Services. Unless otherwise indicated, the type, content, duration and outcome of each service delivered to or on behalf of a patient must be documented in the patient's case record, described and verified as follows:

(1) be written and signed (physical or electronic signature) by the staff member providing the service;

(2) indicate the date the service was delivered;

(3) record the relationship to the patient's developing treatment goals described in the treatment/recovery plan;

(4) include any recommendations, communications, or determinations for initial, continued or revised patient goals and/or treatment.

(16) Transition or discharge criteria.

(i) Patients having no contact or intent to continue accessing services from a program should be discharged after a period not exceeding sixty (60) days unless reason for continuing treatment past that period is identified and documented in the patient record.

(ii) Individuals entering treatment should progress by meeting treatment milestones including: engagement; goal setting; and attainment of patient-centered goals. If an individual leaving treatment expresses a preference for a level of care or services that preference should be included in the patient record.

(iii) Individuals who are discharged involuntarily must be discharged consistent with Part 815 of this Title.

(v) No patient may be discharged without a plan which has been previously reviewed and approved by a clinical staff member and the clinical supervisor. This requirement does not apply to patients who stop attending, or otherwise fail to cooperate. That portion of the transition plan which includes referrals for continuing care must be given to the patient prior to leaving the program. The patient, and their family/significant other(s).