

PART 816
SUBSTANCE USE DISORDER WITHDRAWAL AND STABILIZATION SERVICES

(Statutory Authority: Mental Hygiene Law Sections 19.09, 19.15, 19.40, 22.09)

Sec.

- 816.1 Background and intent
- 816.2 Legal base
- 816.3 Applicability
- 816.4 Definitions
- 816.5 General program standards
- 816.6 Additional requirements for medically managed withdrawal and stabilization services
- 816.7 Additional requirements for medically supervised inpatient withdrawal and stabilization services
- 816.8 Additional requirements for medically supervised outpatient withdrawal and stabilization services
- 816.9 Standards pertaining to Medicaid reimbursement
- 816.10 Savings and renewal clause
- 816.11 Severability

Section 816.1 Background and intent.

- (a) These regulations set forth minimum standards for the provision of withdrawal and stabilization services for persons suffering from acute or crisis stages of substance use disorder.
- (b) The primary function of a withdrawal and stabilization service is the medical management and treatment of acute withdrawal, resulting in a referral to an appropriate level of care. Certified providers of withdrawal and stabilization services may provide one or more of the following services as further defined in this Part:
 - (1) medically managed withdrawal and stabilization services;
 - (2) medically supervised inpatient withdrawal and stabilization services; and/or
 - (3) medically supervised outpatient withdrawal and stabilization services.
- (c) Withdrawal and stabilization services can be the first step in the recovery process and must be provided in an atmosphere which protects the patient's dignity. Therefore, it is expected that providers of withdrawal and stabilization services will establish meaningful linkages for supporting services, including appointments for admission, linkages to supportive services and those services identified by use of an Office designated level of care determination tool for the

appropriate level of care. All services shall be provided in a manner that is person centered, strength based and trauma informed.

816.2 Legal base.

- (a) Section 19.09 of the Mental Hygiene Law authorizes the Commissioner to adopt regulations necessary and proper to implement any matter under their jurisdiction.
- (b) Section 19.15 of the Mental Hygiene Law bestows upon the Commissioner the responsibility of promoting, establishing, coordinating, and conducting programs for the prevention, diagnosis, treatment, aftercare, rehabilitation, and control in the field of substance use disorder.
- (c) Section 19.40 of the Mental Hygiene Law authorizes the Commissioner to issue operating certificates for the provision of substance use disorder services.
- (d) Section 22.09 of the Mental Hygiene Law directs the Commissioner to designate hospitals and other appropriate facilities as providers of emergency detoxification and stabilization services for persons needing or seeking emergency treatment.

816.3 Applicability.

- (a) This Part applies to any person or entity organized and operating pursuant to the provisions of this Title and certified, funded or otherwise authorized by the Office to provide a substance use disorder withdrawal and stabilization service.
- (b) Nothing in this Part shall be construed to limit the authority of a hospital licensed pursuant to Article 28 of the Public Health Law to provide detoxification and stabilization in a medical/surgical bed or emergency room.

816.4 Definitions.

- (a) “Detoxification” or “detox” means a medical withdrawal and stabilization regimen under the supervision of a physician or nurse practitioner, consistent with federal authority, to reduce systematically the amount of an addictive substance on which the patient is physiologically dependent, provide reasonable control of active withdrawal symptoms and/or avert a life-threatening medical crisis related to the substance on which the patient is physiologically dependent.

(b) “Discrete unit” means an OASAS program certified pursuant to Article 32 of the Mental Hygiene Law providing inpatient or outpatient substance use disorder treatment co-located in a facility licensed pursuant to Article 28 of the Public Health Law because such facility is providing treatment due to a consistent demand exceeding five (5) medical-surgical beds, or greater than 10% of overall patient days.

(c) “Medically managed withdrawal and stabilization services” are 24/7 services designed for individuals who are acutely ill from alcohol and/or substance related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-occurring conditions. This level of care includes the forty-eight (48) hour observation bed. Individuals who have stabilized in a medically managed detoxification service may transition to a medically supervised service within the same service setting or may be transferred to another service setting.

(d) “Medically supervised inpatient withdrawal and stabilization services” means services for the treatment of moderate withdrawal symptoms and non-acute physical or psychiatric complications. This service is physician directed and staffed 24/7 with medical staff and includes twenty-four (24) hour emergency medical coverage. Medically supervised withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or substances, who are experiencing or who are expected to experience withdrawal symptoms that require medical oversight. Individuals who have stabilized in a medically managed or medically supervised inpatient withdrawal service may transition to a medically supervised outpatient service.

(e) “Medically supervised outpatient” means services appropriate for persons who are suffering from mild to moderate withdrawal or persons experiencing non-acute physical or psychiatric complications associated with their substance use disorder and who are unable to detox on their own without withdrawal complications, but who retain a stable living environment.

(f) “Observation bed” means a service providing intensive assessment and treatment of withdrawal where the patient has continuous periodic evaluation for up to forty-eight (48) hours. The care given in an observation bed is a medically managed level of care.

816.5 Standards applicable to all withdrawal and stabilization services.

(a) Services applicable to all levels of care. Medically supervised withdrawal services provide assessment, medical supervision of intoxication and withdrawal conditions, pharmacological services, individual and group counseling, level of care determination, and referral to other appropriate services.

(b) *Screening, linkages and referral.* (1) All providers of withdrawal and stabilization services must provide onsite medical, mental health and substance use disorder services as well as screening, linkages and referral to other specialized providers of physical and behavioral health services if such services cannot be provided by the withdrawal and stabilization program.

(2) All providers must develop referral sources and keep updated lists of regional programs which provide treatment and recovery services at all levels of care.

(3) All providers must provide screening and referral for specialized physical conditions and/or mental health conditions.

(4) All providers shall provide overdose prevention education and naloxone education and training to a patient or prospective patient, and their significant other(s), in accordance with guidance issued by the Office. Providers shall make a naloxone kit or prescription available to all patients or prospective patients and develop a safety plan with the patient as needed.

(c) *Policies and procedures.* The program governing authority must approve written policies, procedures and methods governing the provision of services in compliance with Office regulations and guidance, including a description of each service provided. Such policies and procedures must include, at a minimum, the following:

(1) procedures and specific criteria for admission, retention, level of care transition(s), referrals and discharge;

(2) level of care determinations utilizing a tool approved by OASAS to determine the appropriate level of care, treatment/recovery plans, and placement services;

(3) staffing for sufficient coverage and task designation; at least 50% of all clinical staff must be qualified health professionals as defined in Part 800 of this Title;

(4) the provision of medical services, including screening and referral for associated physical conditions;

(5) the provision of mental health services, including the use of OASAS approved, validated screening instruments for co-occurring mental health conditions and behavioral health risks, including suicide risk, and referral for associated mental health conditions;

(6) the provision of evidence-based SUD treatment services that are person-centered, strength-based and trauma-informed;

(7) procedures for the coordination of care with other service providers including transfers, emergency care and transport;

(8) a schedule of fees for services rendered;

(9) infection control procedures;

(10) cooperative agreements with other SUD treatment service providers or other providers of services that a patient may need;

(11) compliance with other requirements of applicable local, state, and federal laws and regulations, OASAS guidance documents and standards of care regarding, but not limited to:

(i) education, counseling, prevention and treatment of transmissible infections, including tuberculosis, viral hepatitis, sexually transmitted infections and HIV; regarding HIV, such education, counseling, prevention and treatment shall include condom use, testing, pre- and post-exposure prophylaxis and treatment;

(ii) the use toxicology tests consistent with OASAS guidance;

(iii) medication and the use of medication for addiction treatment;

(iv) medication policies must ensure the appropriate continuation of medically appropriate and lawfully prescribed medication(s) taken by the patient prior to admission;

(12) record keeping procedures which ensure that documentation is accurate, timely, prepared by appropriate staff, and in conformance with state and federal confidentiality rules including 42 CFR Part 2;

(13) utilization review and quality improvement. All programs must have a utilization review process, a quality improvement process, and a written plan that identifies key performance measures;

(14) medical and nursing procedures consistent with professional practice;

(15) pharmacological services including storage and dispensing of medication pursuant to applicable state and federal regulations;

(16) laboratory testing protocols, including alcohol screening and toxicology tests, such as breath tests and urine screening;

(17) toxicology policy;

(18) incident reporting and review in accordance with this Title; and

(19) screening of patients and visitors and the disposal of any items that create an unsafe environment;

(i) programs must implement policies and procedures to prevent and address the presence of items that create an unsafe environment in a manner that is trauma-informed, person-centered, respectful of patient and visitor dignity, and that reasonably balances the well-being and the health and safety of all patients in the program.

(d) *Medical Protocols for Withdrawal Management.* (1) Providers of withdrawal management and stabilization services must develop and implement written withdrawal management and stabilization protocols that are consistent with the following criteria, in accordance with guidance from the Office:

(i) objective monitoring;

(ii) safety;

(iii) involvement of medical professionals;

(iv) stabilization on medication for addiction treatment;

(v) patient comfort;

(vi) level of care assessment; and

(vii) transition to continued care.

(2) Providers of withdrawal management and stabilization services must obtain and maintain approval of medical protocols for withdrawal management from the OASAS Chief Medical Officer (CMO) or CMO designee by attesting that their protocols meet the criteria identified herein and in guidance issued by the Office when seeking new certification for, or continued operation of, withdrawal management and stabilization services.

(i) Medical protocols are subject to review at any time by OASAS.

(ii) Medical protocols not in compliance with this Chapter and guidance issued by the Office and/or do not meet the standard of care for withdrawal management and stabilization services may result in corrective and/or disciplinary action in accordance with this Title.

- (e) *Co-location.* Substance use disorder withdrawal and stabilization services may be co-located with other substance use disorder services to ensure improved coordination of care and linkage.
- (f) *Capacity.* Capacity approved by the Office may not be exceeded at any time except with written permission from the Office.
- (g) *Emergency medical kit.* Each program shall maintain an emergency medical kit in accordance with the provisions of Part 800 and applicable guidance.
- (h) *Admission requirements for all programs.* (1) Admission shall be based upon a diagnosis of substance use disorder pursuant to the most recent edition of either the Diagnostic and Statistical Manual of the American Psychiatric Association, or the International Classification of Diseases.
- (2) A level of care determination must be made using the OASAS level of care assessment tool as defined in Part 800 of this Title and documented in the patient record.
- (3) The admission assessment or decision to admit must include identification of initial services needed until the development of the treatment/recovery plan.
- (4) An individual who presents to the withdrawal and stabilization service seeking or having been referred for treatment or assessment shall have an initial determination made and documented in a written record by a qualified health professional, or other clinical staff under the supervision of a qualified health professional, which states that:
- (i) the individual appears to be in need of withdrawal and stabilization services; and
 - (ii) the individual appears to be free of serious transmissible infections that could be transmitted through ordinary contact; and
 - (iii) the individual appears not to need acute hospital care, acute psychiatric care, or other intensive services which cannot be provided in conjunction with withdrawal and stabilization services or which would prevent them from participating in substance use disorder treatment.
- (5) Each person admitted to the withdrawal and stabilization service must receive a medical evaluation as soon as possible, but no later than the first twenty-four (24) hours.
- (6) Decision to admit, notice to patient.
- (i) If determined appropriate for withdrawal and stabilization services, the patient shall be admitted, consistent with Part 815 of this Title.

(ii) The decision to admit a patient must be made by a clinical staff member who is a qualified health professional and must be documented by the dated signature (physical or electronic) of the qualified health professional working within their scope of practice and include the basis for admitting the patient;

(iii) there must be a notation in the patient record that the patient received a copy of the withdrawal and stabilization service's rules and regulations, including patient's rights, a summary of federal confidentiality requirements, and a statement that such rules were discussed with the patient and the patient indicated that they understood them;

(iv) all patients shall be informed that admission is voluntary and that a patient shall be free to discharge themselves from the service at any time, provided however, this provision shall not preclude or prohibit attempts to persuade a patient to remain in the service in their own best interest.

(a) For prospective or admitted patients under an external mandate, the potential consequences for premature discharge must be explained, including that the external mandate does not alter the voluntary nature of admission, continued treatment, and toxicology screening.

(b) Any patient who desires to leave the service should be offered a physical examination as soon as possible by medical personnel of the service.

(7) If the medical personnel determine upon examination that such patient does not pose a danger to themselves or other persons because they are not incapacitated by a substance(s) to a degree that they may endanger themselves or other persons, or that there is no need for medical or psychiatric intervention, the patient and their family/significant other shall receive the following prior to leaving the program:

(i) education about the medical consequences of untreated substance(s) withdrawal.

(ii) instructions for obtaining emergency medical care for substance(s) withdrawal, should such care be necessary;

(iii) prescriptions for all medications, including medications for addiction treatments for substance use disorder(s);

(iv) referrals to ensure ongoing access to medications, including medication for addiction treatment for substance use disorder(s); and

(v) overdose prevention education, naloxone education and training, and a naloxone kit or prescription regardless of substance use disorder diagnosis.

(a) the patient record must document that the patient, and their family/significant other(s) were provided education about the medical consequences of untreated substance(s) withdrawal, instructions for obtaining emergency medical care for substance(s) withdrawal, prescriptions and/or other arrangements to ensure access to medications, including medication for addiction treatment for substance use disorder(s), and overdose prevention education, naloxone education and training, and a naloxone kit or prescription consistent with this Part.

(b) The patient record must document the reasons why education about the medical consequences of untreated substance(s) withdrawal, instructions for obtaining emergency medical care for substance(s) withdrawal, prescriptions and/or other arrangements to ensure access to medications, including medication for addiction treatment for substance use disorder(s), and overdose prevention education, naloxone education and training, and a naloxone kit or prescription were not offered, if the program is unable to provide these services or if the patient declines these services.

(8) If an individual does not meet admission criteria for the withdrawal and stabilization service, a referral to a service that can meet the individual's treatment needs must be made, unless the individual is already receiving substance use disorder services from another provider. Individuals who do not meet admission criteria shall be informed of the reason.

(9) The admission assessment or decision to admit shall contain a statement documenting the individual is appropriate for this level of care, identify the assignment of a named clinical staff member with the responsibility to provide orientation to the individual, and include a preliminary schedule of activities, therapies and interventions.

(i) *Initial assessment.* (1) Except as otherwise provided in paragraph (2) of this subdivision, an initial assessment must be conducted by a clinical staff member.

(2) The initial assessment must be completed within twenty-four (24) hours of admission and shall include whatever relevant information is necessary to develop an individualized, person-centered, interdisciplinary treatment/recovery plan. The initial assessment shall comprise of a written report of findings and conclusions and shall include the names of any staff or other persons participating in the assessment.

(3) The initial assessment shall include:

- (i) the patient's identifying and emergency contact information; and
- (ii) the patient's history and recent use of substances, substance use disorder treatment history, medical history, psychiatric history, high risk behaviors, mental status, living arrangements, level of self-sufficiency, supports, and barriers to treatment services; and
- (iii) any information concerning a medical or psychological condition that may affect communication or other functioning; and
- (iv) transmissible infection risk assessment (HIV, tuberculosis, viral hepatitis, sexual transmitted infections, and other transmissible infections).

(4) If the patient had previously been admitted to the same service within thirty (30) days of the current admission, the previous assessment may be utilized, provided that such documentation has been reviewed and determined to be current and accurate.

(5) Except for patients admitted to a medically supervised outpatient service, no patient may be continued in the withdrawal and stabilization service longer than seven (7) days after admission unless there is a reasonable probability that discharge criteria will be met within an additional seven (7) days. Current evidence must document a level of instability requiring continued stay for adjustment of medication or attainment of a level of stability to enable functioning outside a structured setting; and one of the following:

- (i) there is medical evidence of moderate to severe organ damage related to substance use; or
- (ii) the patient is pregnant and continued stay is necessary to ensure stabilization and/or complete[ed] referral to continuing treatment; or
- (iii) there is evidence of other medical complications warranting continued care in a withdrawal and stabilization service.

(6) *Medical History and Physical Examination.*

(i) A medical history shall be taken, and a physical examination performed by a physician, physician assistant, or nurse practitioner within twenty-four (24) hours of admission. The physical examination will include but shall not be limited to the investigation of, and if appropriate, screenings for transmissible infections; pulmonary, cardiac or liver abnormalities; and physical and/or psychological conditions or limitations which may require special services or

attention during treatment. The physical examination shall also include the following laboratory tests:

(a) complete blood count and differential;

(b) routine and microscopic urinalysis, as clinically indicated, and in accordance with guidance from the Office;

(c) if medically or clinically indicated, urine toxicology test;

(d) blood-based tuberculosis test;

(1) an intradermal PPD may be given in those circumstances when a blood-based tuberculosis test cannot be performed; this test is given and interpreted by the medical staff unless the patient is known to be PPD positive;

(e) pregnancy test for persons of child-bearing potential; or

(f) any other tests the examining physician, physician assistant, nurse practitioner or other medical staff member deems to be necessary, including, but not limited to, an ECG or a chest X-ray.

(ii) If a medical history has been taken and a physical examination has been performed within the last twenty-four (24) hours, the existing medical history and physical examination documentation, including the results of laboratory and other diagnostic tests, for the patient may be used to comply with the requirements of this Part, provided that such documentation has been reviewed and determined to be current and accurate.

(a) A focused medical history shall be taken and/or physical examination shall be performed and/or laboratory tests and other diagnostic tests shall be ordered if the examining physician or other medical staff determine that elements of the existing medical history and/or physical examination and/or the results of laboratory and other diagnostic tests require reevaluation based on the clinical judgment of the examining physician or other medical staff.

(b) A focused medical history and/or physical examination shall be performed and/or laboratory, and other diagnostic tests shall be ordered if the patient has a physical complaint(s) that was not addressed in the existing medical history and /or physical examination, and/or the patient has a new physical complaint(s) that has developed since the existing medical history was taken and existing physical examination was performed.

(iii) Patient records shall include a summary of the results of the physical examination, laboratory test, and other diagnostic tests and shall also demonstrate that appropriate medical care, including psychiatric care, is recommended to any patient whose health status indicates the need for such care.

(j) *Initial Services*

(1) The initial assessment shall include an identification of initial withdrawal and stabilization intervention services needed, and schedules of individual and group counseling to address the needed services until the development of the treatment/recovery plan. The initial services shall be based on the withdrawal protocols that may be needed as well as the goals the patient identifies for treatment.

(2) *Medication for Addiction Treatment (MAT) for Substance Use Disorder (SUD)*

(i) The program shall maintain a patient with substance use disorder on approved medication, including those federal Food and Drug Administration (FDA) approved medications to treat substance use disorder, if deemed clinically appropriate and in collaboration with the patient's existing provider, and with patient consent, in accordance with federal and state rules and guidance issued by the Office. The program shall document such contact with the existing program or practitioner prescribing such medications.

(ii) To facilitate access to full opioid agonist medication for patients who are maintained on such medication at the time of admission or who choose to start such medication during admission, the program shall develop a formal agreement with at least one Opioid Treatment Program (OTP) certified by the Office to facilitate patient access to full opioid agonist medication, if clinically appropriate. Such agreements shall address the program and the OTPs responsibilities to facilitate patient access to such medication in accordance with guidance issued by the Office.

(iii) The program shall provide FDA approved medications to treat substance use disorder to an existing patient or prospective patient seeking admission to an Office certified program in accordance with all federal and state rules and guidance issued by the Office.

(iv) The program shall provide education to an existing patient or prospective patient with substance use disorder about approved medications for the treatment of substance use disorder if the patient is not already taking such medications, including the benefits and risks.

The program shall document such discussion and the outcome of such discussion, including a patient's preference for or refusal of medication, in the patients record.

(v) The program shall ensure that the patient's discharge plan includes an appointment with a treatment provider or program that can continue the medication post-discharge.

(3) Psychosocial Treatment Requirements.

(i) Group and individual psychosocial treatment modalities must be offered.

(ii) These interventions must be evidenced-based, trauma-informed, person-centered, and individualized to the needs of the patient per the clinical assessment, in accordance with guidance and standards from the Office.

(k) 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 plan begins with the assessment incorporated into the patient record and is regularly updated with progress notes. The plan must be completed within twenty-four (24) hours of admission and shall be based on the initial assessment conducted. The plan shall:

(i) be developed by the responsible clinical staff member(s), in collaboration with the patient and anyone identified by the patient as supportive to recovery and signed and dated by all parties when completed and agreed upon;

(ii) provide goals for the outcome of treatment, the protocols to be followed for medical withdrawal and the clinical care services to be provided;

(iii) be updated as appropriate and as required by the level of care should additional problems requiring immediate treatment be identified;

(iv) reflect coordination of medical, psychiatric, substance use care, and/or the provision of other services provided concurrently either directly or through a secondary provider;

(v) be incorporated in the patient's case record along with written orders, prescriptions and the provision of withdrawal and stabilization services; and

(vi) include provisions for prenatal care for all patients who are pregnant. If a pregnant patient refuses or does not obtain such care, the provider must have the patient acknowledge in writing that prenatal care was offered, recommended, and refused. The program should also offer

to develop a plan of safe care with the patient and anyone identified by the patient and such offer should be noted in the patient record.

(2) *Continuing review of treatment/recovery plan.*

The clinical staff shall ensure that all treatment is provided in accordance with the individual treatment/recovery plan. The treatment/recovery plan must be reviewed through the ongoing assessment process and regular progress notes. Revisions to the treatment/recovery plan shall be reflected in the patient's progress notes, signed and dated by the responsible clinical staff.

(3) Progress Notes. Progress notes are intended to document the patient's clinical status. Such progress notes shall provide a chronology of all significant withdrawal, stabilization and SUD services delivered to the patient, their progress related to the initial services or the goals established in the treatment/recovery plan and be sufficient to delineate the course and results of treatments/services. 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 treatment/service delivered to or on behalf of a patient, described and verified as follows:

(i) be written, signed (physically or electronically) and dated by the clinical staff member or another clinical staff member familiar with the patient's care.

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

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

(iv) include all individual, medical, and psychiatric contacts for the purpose of assessing, diagnosing, or treating the patient.

(v) Unless additional requirements apply to specific levels of withdrawal and stabilization services, progress notes shall be documented no less often than once per shift for the first five (5) days and no less often than once per day thereafter.

(vi) If a patient's condition necessitates more frequent documentation, the appropriate staff must document the provision of those services and/or care in the patient's progress notes.

(vii) 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 cases for the purpose of clinical monitoring of practice. This meeting shall be documented as to date, attendance, cases reviewed and recommendations.

(1) *Discharge and planning for level of care transitions.* (1) Discharge and planning for level of care transition shall commence upon admission and shall be considered part of the treatment/recovery planning process. The plan for discharge or level of care transition shall be developed by the clinical staff member(s) with primary responsibility for the patient in collaboration with the patient and anyone identified by the patient as supportive to recovery. Planning must provide a framework for a long-term, patient-driven treatment/recovery plan and link the patient to appropriate level of care transition services to support the plan; and include detailed information on referral and plan specifics. No patient shall be discharged until the plan is complete and identifies a staff member assigned to follow up on referrals. Documentation detailing why a discharge or level of care transition plan was not provided to the patient must be placed in the medical record, if the patient did not receive a plan.

(2) Discharge and/or level of care transitions should occur when:

(i) the patient meets criteria documented by the OASAS level of care determination protocol for an alternate level of care and has been medically withdrawn from a substance(s) they are physiologically dependent on, has been stabilized on a medication(s) for addiction treatment if such treatment(s) were initiated during admission, has co-occurring medical and/or psychiatric symptoms that have been stabilized, and has developed a discharge or level of care transition plan;

(ii) the patient and the medical and clinical staff agree that the patient has received maximum benefit from the withdrawal and stabilization services provided by the program; or

(iii) the patient does not adhere to the program's written behavioral standards, provided that the patient is offered a referral and connection to another treatment program.

(a) discharge for behavioral reasons with a referral and connection to another treatment program shall only occur after the program has utilized behavioral interventions to help the patient manage their behavior in a less disruptive manner and discharge must be consistent with the provisions of Part 815 of this Title.

(3) The plan shall include, but not be limited to at least the following:

(i) an evaluation of the patient's living arrangement, level of self-sufficiency and available support systems;

(ii) identification of substance use disorder treatment and other services the patient will need after discharge including alternative medical and mental health providers; and

(iii) a list of current medications.

(a) A member of the clinical and medical staff who participated in preparing the plan, and the patient, shall sign and date the plan upon its completion. Except for medically monitored withdrawal and stabilization services, the program physician shall also sign and date the plan.

(b) The plan shall be discussed with the patient, given to the patient upon discharge and with appropriate patient consent, the plan, including level of care transition planning, shall be forwarded to any subsequent service providers. The patient and their family/significant other(s) shall be offered overdose prevention education, naloxone education and training, and a naloxone kit or prescription.

(c) For a patient transitioning directly from a withdrawal and stabilization service to another service within the same facility, a transfer plan may take the place of a discharge plan. To ensure sufficient information is available to the new service, a transfer plan must include information about the patient's immediate needs, medical and psychiatric diagnoses, medications and plan for meeting those needs.

(m) *Patient records.* (1) Providers must keep individual patient records for each patient admitted. These records must include, at a minimum, all information and documentation required in this Part, including but not limited to:

(i) identifying information about the patient and their family;

(ii) the source of referral, date of commencing service, and names of clinical staff who have primary responsibility for the patient's care;

(iii) a notation that the patient received a copy of the program's rules and regulations, including patient's rights consistent with Part 815 of this Title and a summary of the federal confidentiality requirements, that such rules and regulations were discussed with the patient, including their ability to designate individuals to be notified in case of an emergency, and that the patient indicated they understood them;

(iv) the admission diagnosis, including substance-related, medical, and psychiatric diagnoses in official nomenclature with associated diagnostic codes in the most recent version of the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD);

(v) any clinical and non-clinical documentation or determination applicable to the delivery of withdrawal and stabilization treatment services for a patient and/or supporting the patient's evolving recovery treatment/recovery plan;

(vi) the individual treatment/recovery plan and all reviews and updates thereto through progress notes;

(vii) reports of all assessments performed, including findings and conclusions;

(viii) reports of all examinations performed, including but not limited to X-rays and/or other imaging studies, clinical laboratory tests, clinical psychological tests, electroencephalograms, and psychometric tests

(ix) documentation of public health education and screening with regard to tuberculosis, sexually transmitted infections, hepatitis, and HIV prevention and harm reduction.

(x) summaries of case conferences, and special consultations held.

(xi) dated and signed prescriptions or orders for all medications with notation of termination dates;

(xii) documentation that the patient, and their family/significant other(s), were offered overdose prevention education, naloxone education and training and a naloxone kit or prescription;

(xiii) documentation should include, if applicable, the reasons why overdose prevention education, naloxone education and training, and/or a naloxone kit or prescription were not offered or the reasons why the patient declined overdose prevention, naloxone education and training and/or a naloxone kit or prescription.

(xiv) the discharge plan;

(xv) any other documents or information regarding the patient's condition, treatment, and results of treatment; and

(xvi) signed forms consenting to treatment and for obtaining or releasing confidential information in accordance with 42 Code of Federal Regulations Part 2 or other applicable law.

(2) Patient records shall be maintained, shared with other clinical staff involved in the treatment of a patient and with professional staff or other providers involved in the care of such patient, and released in accordance with state and federal laws and regulations governing confidentiality.

(n) *Staffing.* (1) Staff may be either specifically assigned to the withdrawal and stabilization service or may be part of the staff of the facility within which the service is located, provided that:

(i) they have specific training in the diagnosis and treatment of substance use disorder, including person-centered, trauma-informed principles; and

(ii) the service identifies and documents the percentage of time each shared staff member is assigned to each service.

(2) A withdrawal and stabilization service shall have regular, scheduled, and documented training made available in the following subject areas, or as determined by the Office:

(i) diagnosing substance use disorder and other addictive disorders;

(ii) signs and symptoms of withdrawal from all classes of substances;

(iii) complications of withdrawal from all classes of substances;

(iv) public health education and screening with regard to tuberculosis, sexually transmitted infections, viral hepatitis, and HIV prevention and harm reduction, and,

(v) certification in cardiopulmonary resuscitation from the American Red Cross, the American Heart Association or an equivalent nationally recognized organization within one year of hire, to be renewed as needed.

(3) Each service shall have a qualified individual designated as the Health Coordinator to ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV, tuberculosis, viral hepatitis, sexually transmitted infections, and other transmissible infections.

(4) Clinical staff shall have primary responsibility for implementing the treatment/recovery plan.

(5) Medical staff shall have primary responsibility for coordinating medical care including, but not limited to, physical examination, prescription, dispensing, and/or administration of medications, observation of symptoms, and vital signs and the provision of nursing care.

(6) Additional staffing requirements specific to the type of withdrawal and stabilization service provided pursuant to applicable sections of this Part.

816.6 Additional requirements for medically managed withdrawal and stabilization services.

(a) Unless otherwise authorized medically managed withdrawal and stabilization services, as defined in this Part, shall only be provided in facilities certified by the Office and licensed by the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law.

(b) *Required services.* Medically managed services must provide, at a minimum, all of the following services:

(1) medical management of acute intoxication and withdrawal conditions;

(2) an observation period for up to forty-eight (48) hours of admission. Patients found to be stable and able to step-down to a lower level of care shall be transferred within or to another facility, with specific discharge instructions, as soon as possible;

(3) medically supervised inpatient withdrawal services.

(c) *Staffing.* (1) The medical director of a medically managed withdrawal and stabilization service, whether full or part time, may also serve as director of another service provided by the same program governing authority.

(2) A physician must be on duty or on call at all times.

(3) There must be a physician, nurse practitioner and/or physician assistant under the supervision of a physician, on-site sufficient hours to perform the initial medical history and physical examination of all patients and to prescribe any and all necessary medications necessary to ensure safe withdrawal.

(4) There shall be registered nursing personnel immediately available to all patients at all times. Nursing services shall be under the direction of a registered nurse who has at least one year of experience in the nursing care and treatment of substance use disorders and related medical and psychiatric illnesses.

(5) There shall be sufficient hours of psychiatric provider time to meet the assessment and treatment needs of those patients with other psychiatric disorders in addition to substance use disorders.

(6) There shall be sufficient clinical staff both to maintain a ratio of one counselor for each 10 beds and be scheduled to be available for one and one-half shifts, seven (7) days per week.

(7) One of the full time equivalent qualified health professionals employed by the service shall be designated to provide discharge and treatment/recovery planning to persons admitted to the service.

816.7 Additional requirements for medically supervised inpatient withdrawal and stabilization services.

(a) Medically supervised withdrawal services can be delivered only by a provider of services certified by the Office to provide a continuum of care encompassing: residential, inpatient or outpatient substance use disorder treatment services in order to ensure appropriate continuation in treatment.

(b) Each inpatient medically supervised withdrawal service shall have a director who is a qualified health professional with at least two years of full-time clinical work experience in the treatment of substance use disorder prior to appointment. The director may also serve as director of another service provided by the same governing authority.

816.8 Additional requirements for medically supervised outpatient withdrawal and stabilization services.

(a) Unless otherwise authorized by the Office medically supervised outpatient services may be delivered only by an OASAS certified provider of residential, inpatient and outpatient services in order to assure appropriate continuation in treatment.

(b) *Required services.* (1) All providers of outpatient medically supervised services must, at a minimum, provide the following services in addition to those otherwise required by this Part:

(2) patients must be seen by the physician, nurse practitioner, physician assistant or registered nurse daily unless otherwise specified by the physician based on the patient's physical and psychiatric conditions; and

(3) The provider of services must provide or make available a twenty-four (24) hour telephone crisis line.

(c) *Staffing.* (1) Each outpatient medically supervised service shall have a service director who is a qualified health professional as defined by this Title. Such service director shall have at least two years of full-time work experience in the substance use disorder treatment field prior to

appointment as service director and may also serve as director of another service provided by the same program governing authority.

(2) Counselors. In every program there must be an adequate number of counselors sufficient to carry out the objectives of the program and to assure the outcomes of the program are addressed. The Office shall review factors in determining whether the program's outcomes are being addressed, which may include but shall not be limited to: (i) retention of patients in treatment; (ii) patients' stability and progress in treatment.

(3) Progress notes shall be documented no less often than once per visit.

816.9 Standards pertaining to Medicaid reimbursement.

Medicaid reimbursement shall be provided in accordance with the provisions of 14 NYCRR Part 841.

816.10 Severability.

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part that can be given effect without the invalid provisions or applications, and to this end the provisions of this Part are declared to be severable.