AMENDED PART 819 EFFECTIVE OCTOBER 1, 2022

PART 819
SUBSTANCE USE DISORDER RESIDENTIAL SERVICES
(Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32.01, 32.07(a))

Section 819.1 Legal base.

(a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner to adopt standards including necessary rules and regulations pertaining to substance use disorder services.

(b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations necessary and proper to implement any matter under their jurisdiction.

(c) Section 19.40 of the Mental Hygiene Law authorizes the Commissioner of the Office to issue operating certificates for the provision of substance use disorder services.

(d) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner of the Office to adopt any regulation reasonably necessary to implement and exercise effectively the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(e) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner of the Office to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law.

819.2 Definitions

For purposes of this Part, the following definitions are applicable:

(a) Substance use disorder residential service or residential service means a substance use disorder residential service providing an array of services for persons with substance use disorders, which may be provided directly or through cooperative relationships with other community service providers.

(b) Levels of service. There are three levels of service that can be offered in a residential setting which are distinguished by the complement of services available on site as well as the functional capacity of the patient served in each setting:

(1) Intensive residential rehabilitation services means substance use disorder residential services requiring twenty four hours a day, seven days per week treatment in a structured environment for individuals whose potential for independent living in recovery is contingent upon social habilitation or rehabilitation. An integral part of this service is the case management of additional services from other providers that are needed by the resident. This level of residential service requires established written agreements with other appropriately certified providers to furnish physical and mental health treatment services, in addition to educational, social and vocational services. These services are appropriate for individuals who require substance use disorder services in a residential setting as determined by utilizing the OASAS level of care determination protocol.

(2) Community residential services means substance use disorder residential services providing supervised services to persons making the transition to independent living. Persons appropriate for this service require the support of a substance free environment while receiving either outpatient services or educational and/or vocational services. These transitional residential services are for individuals who are completing or have completed a course of treatment, but who are not ready for independent living yet due to unresolved clinical issues or unmet needs for personal, social or vocational skills development. These services are appropriate for individuals who require ongoing clinical support.

(3) Supportive living services means substance use disorder treatment services which are designed to promote independent living in a supervised setting for individuals who have completed another course of treatment, are making the transition to independent living, and whose need for services does not require staffing on site twenty-four hours a day. These treatment services are for individuals who either require a long-term supportive environment following care in another type of residential service for an undetermined length of stay, or who are in need of a transitional living environment prior to establishing independent community living.

(c) Resident, for purposes of this Part, means the individual admitted to and receiving services from the residential service provider certified pursuant to this Part.

§819.3 Standards applicable to all residential service providers.

(a) The program governing authority must approve written policies, procedures and methods governing the provision of services to residents in compliance with Office regulations and guidance which shall include a description of each service provided, including procedures for making appropriate referrals to and from other services, when necessary. These policies, procedures, and methods, shall address, at a minimum, the following:

(1) procedures and specific criteria for admission, retention, transfers, referrals, and discharge;

(2) level of care determinations utilizing the OASAS level of care determination protocol, comprehensive evaluations, treatment/recovery plans, and placement services;

(3) staffing including, but not limited to, training and the use of students, peers, and volunteers, and appropriate criminal history reviews as otherwise required by this Title;

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

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

(6) a schedule of fees for services rendered;

(7) infection control procedures;

(8) cooperative agreements with other substance use disorder treatment providers and other providers of services that the resident may need;

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

(i) education, counseling, prevention, and treatment of transmissible infections, including tuberculosis, viral hepatitis, sexually transmitted infections, HIV, and other infectious diseases, in accordance with guidance from the Office. Regarding HIV, such education, counseling, prevention and treatment shall include condom use, testing, and pre- and post-exposure prophylaxis and treatment;

(ii) the use of toxicology tests, in accordance with guidance issued by the Office;

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

(iv) if acupuncture is provided as an adjunct to the services provided by the program, it must be provided in accordance with Part 830 of this Title.

(10) procedures for the ordering, procuring, and disposing of medication, as well as the self-administration of medication;

(11) quality improvement and utilization review;

(12) clinical supervision and related procedures;

(13) procedures for emergencies;

(14) incident reporting and review in accordance with Part 836 of this Title;

(15) record keeping procedures which ensure that documentation is accurate, timely, prepared by appropriate staff, and in conformance with the federal confidentiality regulations contained in 42 Code of Federal Regulations Part 2;

(16) procedures by which required educational services are provided for school age children who are in residence as either an individual who is receiving treatment or as part of a family unit;

(17) procurement, storage, and preparation of food;

(18) record retention; and

(19) safety plan development.

(b) Emergency Medical Kit. Pursuant to Part 800 of this Title, all programs must maintain an emergency medical kit at each certified or funded location; such kit must include basic first aid items and naloxone emergency overdose prevention kits sufficient to meet the needs of the program. Programs must develop and implement a plan to have staff and residents, where appropriate, trained in the prescribed use of a naloxone overdose prevention kit such that it is available for use during all program hours of operation, in accordance with guidance from the Office.

(1) All staff and residents should be notified of the existence of the naloxone prevention kit and the authorized administering staff.

(2) Nothing in this Part shall preclude residents from becoming authorized in the administration of the naloxone emergency overdose prevention kit, provided, however, the program director must be notified of the availability of any additional authorized users.

(c) Medication for Addiction Treatment (MAT) for Substance Use Disorder (SUD)

(1) All programs 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.

(2) 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.

(3) 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.

(4) 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.

(5) 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.

(d) A substance use disorder residential service shall have as its goals

(1) the improvement of functioning and development of coping skills necessary to enable the resident to be treated safely, adequately and responsibly in the least intensive environment; and

(2) the utilization of individualized treatment/recovery plans to support the maintenance of recovery and the attainment of self-sufficiency, including, where appropriate, the ability to be employed functionally, and the improvement of the resident's quality of life.

(e) All residential services shall provide, either directly or through referral to appropriate agencies, habilitative and rehabilitative services consistent with identified needs and treatment/recovery plans for services for individual residents. The following services shall be provided to residents as clinically indicated:

(1) Psychosocial Treatment. Each residential service shall make available to its residents individual, group and family services as appropriate that are evidence-based, person-centered, and trauma-informed.

(i) 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 resident experience, and assessing group efficacy. These sessions shall contain no more than fifteen residents.

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

(iii) Evidence-based, person-centered, trauma informed individual, group and family counseling must be provided by a staff member operating within their scope of practice.

(iv) Family counseling services that include significant others are provided by program staff with appropriate training or by referral to community providers with this expertise.

(v) Peer support may occur in a peer group setting where the group is facilitated by residents who have greater experience or seniority within the service. Such counseling must be supervised directly by a clinical staff member in attendance.

(2) Supportive services. Each service shall ensure that a comprehensive and appropriate range of support services are available to each resident. Such services shall include, as needed and as appropriate, legal, medical, mental health, recovery, wellness, and social services, as well as vocational assessment and activities.

(3) Educational and childcare services. Each residential service that provides services to school-age children must make arrangements to ensure the availability of required educational and childcare services.

(4) Structured activity and recreation. Residents shall be afforded the opportunity to participate in recovery and wellness activities designed to develop skills to enable them to make effective use of leisure time as well as improve social skills, self esteem and responsibility.

(5) Orientation to community services. Each substance use disorder residential service shall provide orientation to, and instruction in identifying and obtaining needed community recovery and wellness services, including housing and other necessary case management services, to each resident.

(f) The certified bed capacity of each residential service may not be exceeded at any time except in cases of emergency and unexpected surges in demand where no alternative options are available, when the failure to accept individuals temporarily into the service would jeopardize their immediate health and safety, and where the excess of capacity would be time limited. Standards and procedures for such exceptions that are based upon the availability of adequate space, supplies and staff must be established with the prior approval of the Office.

(g) Food and nutrition.

(1) Intensive residential rehabilitation services shall ensure the availability of three meals each day to each resident and community residences shall ensure the availability of two meals each day to each resident. Such meals shall furnish sufficient nutrients and calories to meet normal needs as well as the special needs of persons in recovery. Supportive living services shall ensure the availability of adequate food to all participants.

(2) Intensive residential rehabilitation services and community residences shall have available snacks and beverages between meals. A qualified dietician, dietetic technician, nutritionist, or other appropriately qualified personnel working within their scope of practice shall provide menu planning services. Other suitable staff shall be responsible for the procurement of food supplies and the training and directing of food preparation and serving personnel. Copies of menus shall be kept on file for a period of one year.

(f) Safety plan development in accordance with guidance issued by the Office.

819.4 Admission procedures.

(a) Admission requirements for all programs.

(1) The admission assessment or decision to admit must include identification of initial services needed until the development of the treatment/recovery plan.

(2) Unless otherwise authorized, the program must document that the individual is determined to have a substance use disorder based on the criteria in the most recent version of the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD), as incorporated by reference in Part 800 of this Title.

(3) The decision to admit an individual 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 and include the basis for admitting the individual.

(b) Level of care determination. If an individual is determined to meet criteria for substance use disorder residential services, a level of care determination shall be made by a clinical staff member who shall be provided clinical oversight by a qualified health professional. The level of care determination shall be signed and dated by the clinical staff member. The level of care determination shall be made promptly after the individual's first on site contact with the service.

(c) The level of care determination process must be in accordance with the governing authority's policy and procedures and incorporate the use of the OASAS Level of Care for Alcohol and Drug Treatment Referral Protocol (LOCADTR) or another Office-approved protocol.

(d) Prohibition against discrimination. Individuals that meet level of care criteria for residential services, in accordance with this Part, may not otherwise be denied admission in accordance with the provisions of Part 815 of this Title.

(e) Admission criteria. To be admitted for residential services, the individual must be determined to have recovery goals with the application of residential services and meet the admission criteria identified in this Part for the applicable level of service.

(f) If the individual does not meet admission criteria for residential services, unless the individual already is receiving substance use disorder treatment services from another provider, a referral to a service that can meet the individual's treatment needs shall be made. The reasons for denial of any admission to the residential service must be provided to the individual and documented in a written record maintained by the residential service.

(g) There must be a notation in the resident's record that they received a copy of the residential service's rules and regulations, including resident rights and a summary of federal confidentiality requirements, and a statement that notes that such rules were discussed with the resident, and that the resident indicated that they understood them.

(h) All prospective residents shall be informed that admission is on a voluntary basis and that a resident shall be free to discharge themselves from the service at any time. For prospective residents under an external mandate, the potential consequences for premature discharge shall be explained, including that the external mandate does not alter the voluntary nature of admission and continued treatment. This provision shall not be construed to preclude or prohibit attempts to persuade a resident to remain in the service in their own best interest.

819.5 Post admission procedures.

(a) As soon as possible after admission, if not completed already, all programs must:

(1) offer viral hepatitis testing (testing may be done by referral);

(2) offer HIV testing (testing may not be conducted without a resident's written informed consent in accordance with public health law and may be done on site or by referral). Residents on a regimen of pre- or post- exposure prophylaxis must be permitted to continue the regimen until consultation with the prescribing professional occurs.

(3) Screen for co-occurring mental health conditions and behavioral health risks, including suicide risk, using validated screening instruments approved by the Office.

(4) If clinically appropriate, all programs must:

(i) conduct a blood-based tuberculosis test (testing may be done on site or by referral with results as soon as possible after testing); residents with a positive test result should be referred for further tuberculosis evaluation;

a. an intradermal PPD may be placed in those circumstances when a blood-based tuberculosis test cannot be performed unless the patient is known to be PPD positive;

*b.*PPD placement may done on site with medical staff interpreting the results or by referral with results as soon as possible after testing

(ii) offer testing for other sexually transmitted infections (testing may be done on site or by referral);

(iii) offer immunizations either on site or by referral;

(iv) offer pregnancy tests to persons of childbearing potential (testing may be done on site or by referral);

(v) provide or recommend any other tests the examining physician or other medical staff member working within their scope of practice deems necessary including, but not limited to, an ECG, a chest X-ray or other diagnostic tests.

(5) As soon as possible after testing, programs must review and discuss any blood, urine, and skin test results, ECG results, chest X-ray results, or other diagnostic test results where applicable with the residents.

(6) Any significant medical issues, including risk of transmissible infections, identified prior to or after admission must be addressed in the treatment/recovery plan and documented in the resident's record. Treatment/recovery plans must include provisions for the prevention, care, and treatment of HIV, viral hepatitis, tuberculosis, sexually transmitted infections, and other infectious diseases when present. If a resident chooses not to obtain such care and treatment, the provider must

have the resident acknowledge in writing that such care and treatment were offered and declined.

(b) Comprehensive evaluation.

(1) The goal of the comprehensive evaluation shall be to obtain information from the resident and other sources, including family members and significant others if possible and where appropriate, that is necessary to develop an individualized, person-centered treatment/recovery plan.

(2) No later than fourteen days after admission, staff shall complete the resident's comprehensive evaluation which shall include a written report of findings and conclusions addressing, at a minimum, the resident's:

(i) identifying and emergency contact information;

(ii) the source of referral, date of commencing service, and name of the clinical staff member with primary responsibility for the resident;

(iii) both recent and history of substance use;

(iv) substance use disorder treatment history;

(v) comprehensive psychosocial history, including, but not limited to the following:

(*a*) legal history;

(*b*) transmissible infection risk assessment (HIV, tuberculosis, viral hepatitis, sexually transmitted infections, and other transmissible infections) ;

(*c*) an assessment of the resident's individual, social and educational strengths and limitations, including, but not limited to, the resident's literacy level, daily living skills and use of leisure time;

(*d*) the resident's current medical conditions, current mental health conditions, past medical history, past mental health history, and an assessment of the resident’s risk of harming self or others.

(3) The comprehensive evaluation must include diagnoses, 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).

(4) The comprehensive evaluation shall bear the names of the clinical staff members who evaluated the resident and must be signed (physically or electronically) and dated by the qualified health professional responsible for the evaluation.

(c) Medical history and physical examination. Providers shall make every effort to execute appropriate consents to obtain and share medical information with the resident’s other medical providers as appropriate.

(1) Residents who do not have an available medical history and have not had a physical examination performed within the last 12 months prior to admission must have a medical history recorded, and a physical examination performed and documented in the resident’s record by a physician, physician assistant, or a nurse practitioner working within their scope of practice within forty five days after admission. The physical examination may include

but shall not be limited to the investigation of, and if appropriate, screenings for infectious diseases; pulmonary, cardiac or gastrointestinal abnormalities; and physical, neurological, and/or psychological limitations or disabilities which may require special services or attention during treatment. The physical examination shall also include the following laboratory tests:

([a]i) complete blood count and differential;

([b]ii) routine and microscopic urinalysis;

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

(iv) pregnancy test for persons of childbearing potential;

(v) blood-based tuberculosis test

(*a*) an intradermal PPD may be placed in those circumstances when a blood-based tuberculosis test cannot be performed, with the results interpreted by the medical staff working within the scope of their practice unless the resident is known to be PPD positive;

(vi) any other tests the examining physician or other medical staff members working within their scope of practice deem to be necessary, including, but not limited to, an ECG, a chest X-ray, or other diagnostic tests.

(2) If the resident has a medical history available and has had a physical examination performed within 12 months prior to admission, or if the resident has been admitted directly to the residential service from another substance use disorder service authorized by the Office, the existing medical history and physical examination documentation 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. Notwithstanding the forgoing, the following shall be offered regardless of a documented history within the previous twelve months: HIV and viral hepatitis testing.

(i) 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, physician assistant, or nurse practitioner working within the scope of their practice determine that the elements of the existing medical history and/or physical examination and/or results of laboratory and other diagnostic tests require reevaluation based on the clinical judgment of the examining physician or other medical staff;

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

(3) Resident records shall include a summary of the medical history and the results of the physical examination, laboratory tests, and other diagnostic tests and shall also demonstrate that appropriate medical care, including mental health care, is recommended to any resident who needs such care.

(d) After the comprehensive evaluation is completed, a resident shall be retained in such treatment if the resident has a diagnosis of a substance use disorder in accordance with the most

recent edition of the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD) and continues to meet the admission criteria required by this Part.

(e) If the comprehensive evaluation indicates that the resident needs services beyond the capacity of the residential service to provide either alone or in conjunction with another program, referral to appropriate services shall be made. Identification of such referrals and the results of those referrals to identified program(s) shall be documented in the resident record.

([e]f) If a resident is referred directly to the residential service from another service certified by the Office, or is readmitted to the same service within sixty (60) days of discharge, the existing level of care determination and comprehensive evaluation may be used, provided that the documentation has been reviewed and, if necessary, updated within fourteen (14) days of transfer.

(g) Treatment/recovery plan. A person-centered, initial treatment/recovery plan addressing the resident's individual needs must be developed within three days of admission, or readmission, to the substance use disorder residential service. The treatment/recovery plan shall be developed by the clinical staff member with primary responsibility for the resident ("the responsible clinical staff member") in collaboration with the resident and anyone identified by the resident as supportive of their recovery goals. This initial treatment/recovery-plan must contain a statement which documents that the resident meets admission criteria for this level of care, identifies the assignment of a named clinical staff member with the responsibility to provide orientation to the resident, and includes a preliminary schedule of activities, therapies and interventions.

(h) A treatment/recovery plan, based on the admitting evaluation, shall be prepared within thirty days of development of the initial treatment/recovery plan to meet the identified needs of the resident, and shall take into account cultural and social factors as well as the particular characteristics, conditions and circumstances of each resident. For residents moving directly from one substance use disorder service 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 the resident's goals as appropriate.

([h]i) The treatment/recovery plan shall:

(1) be developed by the responsible clinical staff member(s) in collaboration with the resident and anyone identified by the resident as supportive of their recovery goals;

(2) be based on the admitting evaluations specified above and any additional evaluation(s) the resident has received or is determined to be required;

(3) specify measurable treatment goals for each problem identified;

(4) specify the objectives that shall be used to measure progress toward attainment of goals;

(5) include schedules for the provision of all services prescribed; where a service is to be provided by any other service or facility offsite, the treatment/recovery plan must contain a description of the nature of the service, a record that referral for such service has been made, the results of the referral, and procedures for ongoing care coordination and discharge planning;

(6) identify the responsible clinical staff for coordinating and managing the resident's treatment, who shall approve and sign (physically or electronically) such;

(7) reference any significant medical and mental health issues, including applicable medications, identified as part of the medical assessment process;

(8) include each diagnosis for which the resident is being treated;

(9) be reviewed, approved, signed (physically or electronically), and dated by the supervisor of the responsible clinical staff member within seven (7) days after the finalization of the treatment/recovery plan. If the supervisor of the responsible clinical staff member is not a qualified health professional, another qualified health professional must be designated to sign (physically or electronically) the plan; and

(10) Pregnancies. Treatment/recovery plans must include provisions for prenatal care for all residents who are pregnant or become pregnant. If a pregnant resident chooses not to obtain such care, the provider must have the resident acknowledge in writing that prenatal care was offered, recommended, and declined. The program should offer to develop a plan of safe care with the resident and anyone identified by the resident, and such offer should be noted in the resident's record.

(11) Transmissible infections. Treatment/recovery plans must include provisions for the prevention, care, and treatment of HIV, viral hepatitis, tuberculosis, and/or sexually transmitted infections when present. If a resident chooses not to obtain such care and treatment, the provider must have the resident acknowledge that such care and treatment were offered, recommended, and declined.

(j) Treatment according to the treatment/recovery plan. The responsible clinical staff member shall ensure that the treatment/recovery plan is included in the resident record and that all treatment is provided in accordance with the treatment/recovery plan.

(1) If, during the course of treatment, revisions to the treatment/recovery plan are determined to be clinically necessary, a multidisciplinary case conference will be held with the resident to determine what revisions to the treatment plan are needed to help the resident achieve their goals.

(k) Progress notes.

(1) Progress notes shall be written, signed (physically or electronically) and dated by the responsible clinical staff member or another clinical staff member familiar with the resident's care no less often than once every two weeks. Progress towards all treatment/recovery plan goals that are made during the two-week period must be documented in the applicable progress note.

(2) Progress notes shall provide a chronology of the resident's progress related to the goals established in the treatment/recovery plan and be sufficient to delineate the course and results of treatment. The progress notes shall indicate the resident's participation in all significant services that are provided.

(l) Resident deaths. If a resident dies while in active treatment any known details must be documented in the resident record.

(m) Discharge planning. Discharge planning shall begin upon admission and shall be considered part of the treatment/recovery planning process. The plan for discharge shall be developed by the responsible clinical staff member in collaboration with the resident and anyone the resident identifies as supportive of their recovery. If the resident is a minor, the discharge plan must also be developed in consultation with their parent or guardian, unless the minor is being treated without parental consent as authorized by Section 22.11 of the Mental Hygiene Law. Information pertaining to testing and treatment of sexually transmitted infections including HIV cannot be shared with the minor resident's parent or guardian without the resident's consent in accordance with applicable laws and regulations.

(1) A resident discharged from the program must be discharged for a documented reason. Residents discharged involuntarily must be discharged consistent with Part 815 of this Title.

(2) The discharge plan shall be based on the resident's self-reported confidence in their recovery and following an individualized recovery support plan, an assessment of the resident's home environment, suitability of housing, vocational/educational/employment status, and relationships with significant others to establish the level of social resources available to the resident and the need for services to significant others. In accordance with guidance and standards issued by the Office, the discharge plan shall include but not be limited to:

(i) identification of continuing substance use disorder services, medical and mental health services, rehabilitation, recovery, wellness, and vocational, educational and employment services the resident will need after discharge;

(ii) identification of specific providers of these needed services; and

(iii) specific referrals with appointment dates and times for any needed services;

(iv) identification of the type of residence that the resident will need after discharge;

(v) prescriptions and/or other arrangements to ensure access to medications including medications for addiction treatment for substance use disorders; and

(vi) overdose prevention education, naloxone education and training, and a naloxone kit or prescription for the resident and their family/significant other(s).

(n) No resident shall be discharged without a discharge plan that has been reviewed and approved by the responsible clinical staff member and the clinical supervisor or designee prior to the discharge of the resident. The portion of the discharge plan that includes referrals for continuing care shall be given to the resident upon discharge. Documentation detailing why a discharge plan was not provided to the resident prior to discharge must be placed in the resident record if the resident did not receive the plan.

(o) Discharge criteria. A resident shall be appropriate for discharge from the residential service and shall be discharged when they meet one or more of the following criteria:

(1) the resident has accomplished the goals and objectives which were identified in the treatment/recovery plan;

(2) the resident declines further care;

(3) the resident has been referred to other treatment that meets their individual needs and cannot be provided in conjunction with the residential service;

(4) the resident has been removed from the service by the criminal justice system or other legal process;

(5) the resident has received maximum benefit from the service; and/or

(6) the resident does not adhere to the written behavioral standards of the facility, provided that the resident is offered a referral and connection to another treatment program. A discharge for behavioral reasons with an offer of a referral and connection to another treatment program shall occur only after the program has utilized interventions to help the resident manage their behavior in a manner consistent with the written behavioral standards of the facility, and in accordance with guidance from the Office.

(p) A discharge summary which includes the course and results of treatment must be prepared and included in each resident's record within thirty (30) days of discharge.

819.6 Record keeping.

(a) Substance Use Disorder residential services must maintain individual [case] records for each resident served. These resident records must, at a minimum, include the information required in this Part, as well as the source of referral, documentation of any case conferences or case reviews, reports of other evaluations and case consultations, medical orders, if applicable, and consent forms.

(1) the resident record shall include documentation that the resident and their family/significant other(s) were offered overdose prevention education, naloxone education and training, and a naloxone kit or prescription.

(i) documentation should include the reasons why overdose prevention education, naloxone education and training, and a naloxone kit or prescription were not offered, if applicable, or the reasons why the resident and their family members/significant other(s) declined overdose prevention education, naloxone education and training, and a naloxone kit or prescription.

(b) Resident records maintained by substance use disorder residential services are confidential and only may be disclosed consistent with the Health Insurance Portability and Accountability Act (HIPAA) and the federal regulations governing the confidentiality of patient/resident records as set forth in 42 Code of Federal Regulations Part 2 and other applicable law.

(c) Any medical and/or mental health treatments provided, including medications, shall be maintained in accordance with the requirements of federal and state law and approved policies and procedures.

(d) All medical or psychiatric services provided must be provided pursuant to the orders of a physician, physician assistant, or nurse practitioner working within their scope of practice.

(e) In the event that more than one substance use disorder service is offered by a facility, the resident record shall identify the service in which the resident is participating currently.

(f) Statistical information shall be reported to the Office as required and on the prescribed forms therefor.

819.7 Quality improvement and utilization review.

(a) Each substance use disorder residential service shall establish and implement a quality improvement plan and utilization review plan in accordance with this section. The utilization review requirement may be met by the following:

(1) the service may perform its utilization review process internally; or

(2) the service may enter into an agreement with another organization, competent to perform utilization review, to complete its utilization review process.

(b) The utilization review plan shall include procedures for ensuring that admissions are based on the program's admission criteria that retention and discharge criteria are met, and that services are appropriate. The utilization review plan shall consider each resident's need for continued treatment, the severity of the resident's substance use disorder(s), and the continued effectiveness of, and progress in, treatment.

(c) Each residential service shall establish a written quality improvement plan in accordance with this section.

(1) The quality improvement plan shall identify clinically relevant quality indicators that are based upon professionally recognized standards of care. This process shall include but not be limited to:

(i) no less than quarterly self-evaluations which may include an independent peer review process as discussed below, to ensure compliance with applicable regulations and performance standards;

(ii) findings of other management activities, including but not limited to; utilization reviews, incident reviews, and reviews of staff training, development and supervision needs;

(iii) surveys of resident satisfaction; and

(iv) analysis of treatment outcome data.

(2) The residential service shall prepare an annual report and submit it to the governing authority. This report shall document the effectiveness and efficiency of the service in relation to its goals and indicate any recommendations for improvement in its services to residents, as well as recommended changes in its policies and procedures.

(3) The purpose of independent peer review is to review the quality and appropriateness of residential services. The review is to focus on such services and the substance use disorder service system rather than on the individual practitioners. The intent of the independent peer review process is to improve continuously the residential services provided to individuals with substance use disorders.

819.8 General staffing.

(a) General Staffing Requirements.

(1) Former residents. Staff members shall not be former residents who recently have received treatment in the program and/or who have completed the program less than one year prior to their employment application, per guidance and standards issued by the Office.

(2) Adequate coverage. There shall be sufficient staff to ensure that there is adequate coverage of all critical tasks necessary to the safe care of residents in the program, per guidance and standards issued by the Office.

(i) Residents in the program shall not be asked or required to perform staff duties. For valid therapeutic reasons and when included in the treatment/recovery plan, residents may be asked to perform certain duties under the direct supervision of staff members, in accordance with guidance and standards issued by the Office.

(*a*) Residents shall not operate motor vehicles belonging to the program under any circumstances.

(*b*) Residents shall not serve as overnight awake staff.

(ii) Programs shall have arrangements with outside entities such as staffing agencies to ensure adequate staffing coverage during times of staff shortages.

(b) Staff may be assigned either specifically to the substance use disorder residential service or may be part of the staff of the facility within which the substance use disorder residential service is located. However, if these staff members are part of the general facility staff, they must have specific training and experience in the treatment of substance use disorders specific to the services provided. The percentage of time that each shared staff is assigned to the substance use disorder residential service must be documented.

(c) Staff Training. Each residential program must provide clinical supervision and ensure and document that all clinical staff have training plan based on individual employee needs. Such training may be provided directly or through outside arrangements and must be provided at least every one year. Training must be ongoing and documented in each employee's personnel record. Training in suggested relevant topics includes, but it not limited to:

(1) substance use disorders;

(2) evidence-based, trauma-informed, and person-centered individual, group and family counseling;

(3) child abuse and domestic violence;

(4) therapies and other activities supportive of recovery;

(5) co-occurring disorders;

(6) transmissible infections such as tuberculosis, sexually transmitted infections, viral hepatitis, HIV;

(7) infection control procedures;

(8) clinical supervision;

(9) quality improvement;

(10) vocational rehabilitation and employment preparation services;

(11) cultural diversity and cultural competence;

(12) tobacco use disorder;

(13) problem gambling;
(14) community based recovery supports and services**;**
(15) trauma-informed care;
(16) medications for addiction treatment;
(17) overdose prevention education;
(18) naloxone and naloxone administration; and
(19) agency policies and procedures.

(d) All substance use disorder residential services shall identify a clinical supervisor who shall be responsible for the day-to-day clinical operation of each residence and provide routine supervision for the staff. The clinical supervisor shall be a qualified health professional with at least three years of administrative and clinical experience in substance use disorder residential services.

(e) All substance use disorder residential services shall have sufficient clinical staff who have received training in, and are designated by the clinical supervisor to perform, the following tasks:

(1) evaluation of resident needs, development and implementation of individualized treatment/recovery plans for each resident, including individual, group and family counseling;

(2) participation with staff and, as necessary, other services and agencies to assure the development, management and implementation of comprehensive services for each resident, reflecting substance use disorder treatment needs and other habilitation or rehabilitation needs; and

(3) preparation and maintenance of case records for each individual resident.

(f) At least twenty-five per cent of all clinical staff members shall be qualified health professionals.

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

(h) There shall be sufficient staff available to ensure that the space and equipment of the service is clean and maintained in working order to minimize the need for treatment staff to perform nontreatment functions and to optimize operational efficiency.

(i) Clinical staff members who are not qualified health professionals shall have qualifications appropriate to their assigned responsibilities as set forth in the service's personnel policies and shall be subject to appropriate professional staff supervision and continuing education and training.

(j) In addition to staffing requirements of this Part, a residential service may utilize volunteers, students or trainees, on a salaried or non-salaried basis if such volunteers, students or trainees are provided close professional staff supervision and necessary didactic education from both internal and external sources.

819.9 Additional requirements for intensive residential rehabilitation.

(a) Admission criteria. In addition to the admission criteria applicable to residential services generally, an individual admitted to intensive residential rehabilitation services must meet the following criteria:

(1) The individual must have demonstrated an inability to participate in treatment outside of a twenty-four hour setting as indicated by one or more of the following:

(i) recent unsuccessful attempts at abstinence; or

(ii) substantial limitations in functional skills evidencing the need for extensive habilitation or rehabilitation in order to achieve lasting recovery in an independent setting.

(b) Clinical services. Intensive residential services are required to provide a minimum of forty hours per week within a structured therapeutic environment, consisting of the services identified in Section 819.4 of this Part and include the following:

(1) Rehabilitation and/or habilitation services.

(i) Each service shall ensure that a comprehensive and appropriate range of rehabilitative services are available to each resident. Such services include, but are not limited to:

(*a*) vocational services such as vocational assessment, job skills training, and employment readiness training;

(*b*) educational remediation services; and

(*c*) life, parenting and social skills training.

(ii) These services may be provided directly by the service or by referral.

(iii) These services shall be reflected in the resident's comprehensive treatment/recovery plan and the resident's progress shall be documented in the resident’s record.

(2) Personal, social, and community skills training and development. Residents shall receive training in community and adult living skills, as needed by each individual. Such skill development shall include, but is not limited to, social interaction and leisure activities.

(c) Comprehensive treatment/recovery plan update.

(1) Each comprehensive plan, once established, must be reviewed and revised at least every three months thereafter by the responsible clinical staff member in consultation with the resident and reviewed and signed (physically or electronically) by the supervisor.

(2) A summary of the resident's progress in each of the specified goals shall be prepared and documented in the resident's record as part of the plan update.

(d) Staffing.

(1) Each residential facility shall have a full-time on-site Director whose duties shall include overseeing the day-to-day operations of the service.

(2) There shall be sufficient staff available to all residents at all times. During late evening and night shifts, there shall be at least one responsible staff person awake and on duty.

(3) In addition to the twenty four hour per day, seven day per week coverage, all intensive residential rehabilitation services shall have sufficient staff to ensure that counseling and rehabilitation services are available and responsive to the needs of each resident. An intensive residential rehabilitation service will have no less than one clinical staff member for every fifteen residents.

(4) For those residential rehabilitation services that serve children, at least one clinical staff member with training and experience in childcare shall be available.

819.10 Additional requirements for community residential services.

(a) Admission criteria. In addition to the admission criteria applicable to residential services generally, an individual admitted to community residential services must meet the following criteria:

(1) The individual must be homeless or must have a living environment not conducive to recovery.

(2) The individual must be determined to need outpatient treatment services and/or other support services such as vocational or educational services, in addition to the residential services provided by the community residence.

(b) Clinical services.

(1) In addition to the service elements required of all residential services, community residential services are required specifically to provide a structured therapeutic environment designed to facilitate the individual's progress toward recovery from a substance use disorder(s).

(2) The service shall maintain a focus on the development and improvement of the skills necessary for recovery.

(3) Specific services to be provided shall include the following:

(i) Each community residential service shall ensure that its residents have access to evidence-based, person-centered, and trauma-informed individual, group and family counseling services as needed and appropriate.

(ii) Each community residence shall have written referral agreements with one or more substance use disorder outpatient services to provide outpatient treatment services, as necessary.

(iii) The community residence shall ensure that such services are integrated with the recovery and wellness activities and services provided by the residence and incorporated in the individual's service plan.

(iv) Each community residence shall ensure that a comprehensive and appropriate range of rehabilitative procedures are available to each resident. Such services include but are not limited to:

(*a*) vocational services such as vocational assessments;

(*b*) job skills training, and employment readiness training;

(*c*) educational remediation; and

(*d*) life, parenting and social skills training.

(4) Rehabilitation services may be provided directly by the service or by referral.

(5) Rehabilitation services shall be identified in the resident's comprehensive treatment/recovery plan.

(6) Personal, social, and community skills training and development. Residents shall receive training in community living skills and adult living skills as needed by each resident. Such skill development shall include, but is not limited to, a program of social interaction and leisure activities.

(c) Treatment/recovery plan review.

(1) Each treatment/recovery plan, once established, must be reviewed completely and revised at least every three months thereafter by the responsible clinical staff member in consultation with the resident and reviewed and signed by the supervisor.

(2) Any resident who is having challenges meeting agreed upon goals defined in the treatment/recovery plan shall be engaged in a case conference with members of the multidisciplinary team who will collaborate with the resident to create revisions to the treatment/recovery plan that meet the resident's treatment needs

(d) Staffing.

(1) Each community residence shall have a full time house manager responsible for the day-to-day operation of the service.

(2) There shall be staff on site twenty-four hours per day, seven days per week.

(3) All community residential services shall have sufficient staff to insure that supportive and rehabilitation services are available and responsive to the needs of each resident. In addition to the twenty-four hours a day coverage, community residential services will have at least one clinical staff member for every fifteen residents.

819.11 Additional requirements for supportive living services.

(a) Admission criteria. In addition to the admission criteria applicable to residential services generally, an individual admitted to a supportive living service must meet the following criteria:

(1) the individual requires support of a residence that provides a substance-free environment;

(2) the individual requires the peer support of fellow residents to maintain abstinence;

(3) the individual does not require twenty-four hour a day on-site supervision by clinical staff; and

(4) the individual exhibits the skills and strengths necessary to maintain recovery and readapt to independent living in the community while receiving the minimal clinical and peer support provided by this residential environment.

(b) Clinical services. There shall be scheduled clinical interaction at least one time per week designed to support residents in their efforts to readapt to independent living in the community while maintaining their recovery and wellness.

(c) Treatment/recovery plan review. Each treatment/recovery plan, once established, must be reviewed at least every six months thereafter, at which time the progress toward accomplishing the goals and objectives is reviewed. Any resident who is having challenges meeting agreed upon goals described in the treatment/recovery plan shall be engaged in a case conference where members of the multidisciplinary team will collaborate with the resident to create revisions to the treatment/recovery plan.

(d) Staffing. Supportive living services shall be staffed as follows:

(1) there shall be at least one full-time equivalent clinical staff member for each fifteen residents; and

(2) there shall be sufficient clinical staff members to ensure at least one visit to each supportive living service once per week, in order to assure the proper maintenance of the living site and that residents are maintaining an environment and schedule appropriate to and supportive of each-resident's independent living; and

(3) there shall be sufficient clinical staff members to ensure that each resident is contacted personally at least once a week by staff to assure safety, adherence to the established service plan and support for daily independent living, through guidance, training, and assistance, as necessary.

819.12 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 which can be given effect without the invalid provisions or applications, and to this end the provisions of this Part are declared to be severable.