

**PART 818**  
**SUBSTANCE USE DISORDER INPATIENT REHABILITATION SERVICES**

Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32.01, 32.07(a) and Public Health Law sections 33.09, Article 27f

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**Section 818.1 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 his or her jurisdiction.
- (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 32.01 of the Mental Hygiene Law authorizes the to adopt any regulation reasonably necessary to implement and effectively exercise 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 to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law.
- (f) Section 3309 of the Public Health Law authorizes the DOH to establish standards for approval of any opioid overdose prevention program.
- (g) Article 27f of the Public Health Law defines the rules governing HIV testing and treatment in New York.

**818.2 General program standards.**

(a) *Policies and procedures.* The program governing authority must approve written policies, procedures and methods governing the provision of strength based, person centered, trauma informed services to patients in compliance with Office regulations including a description of each service provided and a description of evidence-based practices employed in all aspects of service delivery including but not limited to group, individual and family treatment. Such policies and procedures shall address, at a minimum, the following:

- (1) procedures and specific criteria for admission, retention, transfer, referrals and discharge;
- (2) level of care determinations utilizing the OASAS level of care determination protocol, treatment/recovery plans, and placement services;
- (3) staffing, including but not limited to, training, supervision, and use of student interns, peers, and volunteers;
- (4) the provision of medical and psychiatric services, including screening and referral for associated physical or mental health conditions;
- (5) a schedule of fees for services rendered;
- (6) infection control procedures;
- (7) cooperative agreements with other substance use disorder service providers and other providers of services that the patient may need;
- (8) 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 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 of toxicology tests as clinically appropriate; and
  - (iii) medication and the use of medication for addiction treatment;
  - (iv) if acupuncture is provided it must be provided in accordance with Part 830 of this Title;
  - (v) the use of a problem gambling screen approved by OASAS.
- (9) 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; and
- (10) 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.

(b) *Program goals.* An inpatient program shall have as its goals:

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

(2) the development of individualized plans to support the maintenance of recovery, attain self-sufficiency, and improve the patient's quality of life.

(c) *Minimum services.* Inpatient programs shall provide, at a minimum, the following strength based, person centered, trauma informed services as clinically indicated and specified in the individualized treatment/recovery plan:

(1) trauma-informed individual and group counseling and activities therapy. Group counseling sessions must be structured in size and duration to maximize therapeutic benefit for each participant. Program policies must include a process for determining group size, group purpose, monitoring patient experience, and assessing group efficacy;

(2) skills to identify and manage craving and urges to use, anticipate recurrent substance use, and develop a safety plan;

(3) education about, orientation to, and the opportunity for participation in, available and relevant self-help groups and other forms of peer support;

(4) assessment and referral services for patients and significant others;

(5) HIV education, risk assessment, supportive counseling and referral:

(i) offer viral hepatitis testing; testing may be done on site or by referral;

(ii) offer HIV testing; testing may not be conducted without patient written informed consent except in situations specifically authorized by law; testing may be done on site or by referral; individuals on a regimen of pre- or post-exposure prophylaxis, must be permitted to continue the regimen until consultation with the prescribing professional occurs;

(6) vocational and/or educational assessment; and

(7) medical and psychiatric consultation.

(d) *Medication for Addiction Treatment.*

(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.

(e) *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 and naloxone emergency overdose prevention kits sufficient to meet the needs of the program. Programs must develop and implement a plan to have staff trained in the prescribed use of a naloxone overdose prevention kit such that it is available for use during all program hours of operation.

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

(2) Nothing in this regulation shall preclude patients 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.

(f) *Food and nutrition.* (1) Each facility shall provide to each patient three (3) nutritious meals each day which furnish sufficient nutrients and calories to meet normal needs as well as the special needs of persons in recovery.

(2) The facility shall have available snacks and beverages between meals.

(3) A dietician or dietetic technician acting 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.

(g) *Certified capacity.* The certified bed capacity of each inpatient program shall not be exceeded at any time except with the written approval of the Office.

- (h) *Educational and child care services.* Each inpatient program which provides services to school-age youth must make arrangements to ensure the availability of required basic educational and child care services.
- (i) *Medicaid.* Providers seeking Medicaid reimbursement must comply with the requirements of this Part and Part 841 of this Title.
- (j) *Medical emergencies.* Each inpatient program shall have written agreements with general hospitals for the immediate transfer of patients or prospective patients in need of acute hospital care, unless the inpatient program is co-located in a general hospital.
- (k) *Telehealth.* Services may be delivered using telehealth consistent with Part 830 of this Title.

**818.3 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);

(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 signature) of the qualified health professional and include the basis for admitting the patient.

(4) An individual who appears at the inpatient program seeking or having been referred for treatment or evaluation 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 the individual appears to not need acute hospital care, acute psychiatric care, or other intensive services which cannot be provided in conjunction with inpatient care or which would prevent them from participating in substance use disorder treatment.

(b) *Level of care determination.* If an individual is determined to be appropriate for substance use disorder treatment services, a level of care determination utilizing the OASAS level of care determination protocol, shall be made by a clinical staff member. The level of care determination shall be made no later than twenty-four (24) hours after the patient's first on-site visit to the program.

(c) *Prohibition against discrimination.* (1) No individual shall be denied admission to the inpatient program consistent with the provisions in Part 815 of this Title

(2) All prospective patients must be informed that admission to a program is on a voluntary basis and a prospective patient is free to discharge themselves from the service at any time. For prospective 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 and continued treatment.

(d) *Admission criteria.* (1) If the individual is deemed inappropriate for inpatient services, unless the individual is already receiving substance use disorder treatment services from another provider, a referral and connection to a more appropriate service shall be made. The reasons for a denial of admission must be provided to the individual and documented in a written record maintained by the program.

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

#### **818.4 Post-admission procedures.**

(a) *Post-admission.* (1) As soon as possible after admission, for all patients, all programs must:

(i) offer viral hepatitis testing; testing may be done on site or by referral;

(ii) offer HIV testing; testing may not be conducted without patient written informed consent except in situations specifically authorized by law; testing may be done on site or by referral; individuals on a regimen of pre- or post-exposure prophylaxis, must be permitted to continue the regimen until consultation with the prescribing professional occurs.

(2) If clinically indicated, all programs must:

(i) conduct an intradermal skin or blood-based Tuberculosis test; testing may be done on site or by referral with results as soon as possible after testing; for patients with a positive test result, refer the patient for further tuberculosis evaluation.

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

(iii) provide or recommend any other tests the examining physician or other medical staff member deems to be necessary including, but not limited to, an EKG, a chest X-ray, or a pregnancy test.

(3) As soon as possible after testing programs must explain any blood and skin test results to the patient.

(b) *Initial evaluation.* (1) The goal of the initial evaluation, to be completed within twenty-four (24) hours of admission, shall be to obtain whatever relevant information is necessary to develop an individualized patient-centered treatment/recovery plan. The initial evaluation shall comprise a written report of findings and conclusions and shall include the names of any staff or other persons participating in the evaluation.

(2) *Initial services.* The initial evaluation shall include an identification of initial services needed, and schedules of individuals and group counseling to address the needed services until the development of the treatment plan. The initial services shall be based on goals the patient identifies for treatment.

(c) *Medical history.* (1) For those patients who do not have available a medical history and no physical examination has been performed within twelve (12) months, within three (3) days after admission the patient's medical history shall be recorded and placed in the patient's case record and the patient shall receive a physical examination by a physician, physician's assistant, or a nurse practitioner. The physical examination may include but shall not be limited to the investigation of, and if appropriate, screenings for infectious diseases; pulmonary, cardiac or liver abnormalities; and physical and/or mental limitations or disabilities which may require special services or attention during treatment. The physical examination shall also include the following laboratory tests:

(i) complete blood count and differential;

(ii) routine and microscopic urinalysis;

(iii) if medically or clinically indicated, urine screening for drugs;

(iv) intradermal PPD, given and interpreted by the medical staff unless the patient is known to be PPD positive;

(v) or any other tests the examining physician or other medical staff member deems to be necessary, including, but not limited to, an EKG, a chest X-ray, or a pregnancy test.

(2) If the patient has a medical history available and has had a physical examination performed within twelve (12) months prior to admission, or if the patient is being admitted directly to the inpatient 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.

(3) Patient records shall include a summary of the results of the physical examination and shall also demonstrate that appropriate medical care is recommended to any patient whose health status indicates the need for such care.

(d) *Referral and connection.* (1) If the initial evaluation indicates that the individual needs services beyond the capacity of the inpatient program to provide either alone or in conjunction with another program, referral and connection to appropriate services shall be made. Identification of such referrals and connections and the results of those referrals to identified program(s) shall be documented in the patient record.

(2) If a patient is referred directly to the inpatient program from another program certified by the Office, or is readmitted to the same program within sixty (60) days of discharge, the existing level of care

determination and evaluation or treatment/recovery plan may be used, provided that documentation is maintained demonstrating a review and update.

**818.5 Treatment / recovery plan.**

(a) *Treatment / recovery plan.* (1) Each patient must have a written person-centered treatment/recovery plan developed by clinical staff and patient no later than seven (7) calendar days after admission. Standards for developing a treatment/recovery plan include, but are not limited to:

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

(3) For patients moving directly from one program to another, the existing treatment/recovery plan may be used if there is documentation that it has been reviewed and, if necessary, updated within twenty-four (24) hours of transfer.

(b) *Treatment/recovery plan.* The treatment/recovery plan must:

(1) include each diagnosis for which the patient is being treated;

(2) address patient identified problem areas specified in the admission assessment and concerns which may have been identified subsequent to admission, and identify methods and treatment approaches that will be utilized to achieve the goals developed by the patient and primary counselor;

(3) identify a single member of the clinical staff responsible for coordinating and managing the patient's treatment who shall approve and sign (physical or electronic signature) such plan; and

(4) be reviewed, signed and dated by the physician within ten (10) days of admission.

(5) Where a service is to be provided by any other program off site, the treatment/recovery plan must contain a description of the nature of the service, a record that referral for such service has been made, and the results of the referral.

(c) *Continuing review of the treatment/recovery plan.* (1) The clinical staff shall ensure that the treatment/recovery plan is included in the patient record and that all treatment is provided in accordance with the individual treatment/recovery plan.

(2) If, during the course of treatment, revisions to the treatment/recovery plan are determined to be clinically necessary, the plan shall be revised accordingly by the clinical staff member.

(d) *Progress notes.* A progress note shall be written, signed and dated by the clinical staff member or another clinical staff member familiar with the patient's care no less often than once per week. Such progress note shall provide a chronology of the patient's participation in all significant services provided, 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 treatment/services.

(e) *Discharge and planning for level of care transitions.* (1) The discharge planning process shall begin as soon as the patient is admitted and shall be considered a part of the treatment planning process. The plan for discharge and level of care transitions shall be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. If the patient is a minor, the discharge plan must also be developed in consultation with the patient's parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law Section 22.11.

(2) Discharge 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 attained skills in identifying and managing cravings and urges to use substances, stabilized psychiatric and medical conditions, and has identified a plan for returning to their community;

(ii) the patient has received maximum benefit from the service provided by the program; or

(iii) the individual is disruptive and/or fails to comply with the program's written behavioral standards, provided that the individual is offered a referral and connection to another treatment program and discharge is otherwise in accordance with Part 815 of this Title.

(3) No patient shall be discharged without a discharge plan which has been completed and reviewed by the multi-disciplinary team prior to the discharge of the patient. This review may be part of a regular treatment/recovery plan review. The portion of the discharge plan which includes the referrals for continuing care shall be given to the patient upon discharge. This requirement shall not apply to patients who leave the program without permission, refuse continuing care planning, or otherwise fail to cooperate.

(4) The discharge plan shall be developed by the clinical staff member, who, in the development of such plan, shall consider the patient's self-reported confidence in maintaining their health and recovery and following an individualized safety plan. The clinical staff member shall also consider an assessment of the patient's home and family environment, vocational/educational/employment status, and the patient's relationships with significant others. The purpose of the discharge plan shall be to establish the level of clinical and social resources available to the individual post-treatment and the need for the services for significant others. The plan shall include, but not be limited to, the following:

(i) identification of any other treatment, rehabilitation, self-help and vocational, educational and employment services the patient will need after discharge;

(ii) identification of the type of residence, if any, that the patient will need after discharge;

(iii) identification of specific providers of these needed services;

- (iv) specific referrals and initial appointments for these needed services;
  - (v) the patient, and their family/significant other(s) shall be offered naloxone education and training and a naloxone kit or prescription; and
  - (vi) an appointment with a community based provider to continue access to medication for addiction treatment.
- (5) A discharge summary which includes the course and results of care and treatment must be prepared and included in each patient's case record within twenty (20) days of discharge.

**818.6 Patient Records.**

(a) *Patient Records.* (1) Inpatient programs must maintain individual patient records for each patient served. Patient records maintained by inpatient programs are confidential and may only be disclosed in accordance with federal regulations regarding the confidentiality of records related to persons receiving treatment for substance use disorder as set forth in 42 Code of Federal Regulations Part 2, or other applicable state and federal laws.

(2) There shall be a single individual patient record for each person admitted to the inpatient program which shall include, at a minimum:

- (i) identifying information about the patient and their family;
- (ii) the source of referral, date of commencing service and name of primary counselor;
- (iii) the admission diagnosis, including substance use related, medical, and psychiatric diagnoses in official nomenclature with associated diagnostic codes;
- (iv) reports of all evaluations performed, including findings and conclusions;
- (v) reports of all examinations performed, including but not limited to X-rays, clinical laboratory tests, clinical psychological tests, electroencephalograms, and psychometric tests;
- (vi) the written and signed individual treatment/recovery plan, including all reviews and updates;
- (vii) progress notes informative of the patient's condition and response to treatment, written and signed by staff members;
- (viii) summaries of case conferences, treatment plan updates, and special consultations held;
- (ix) dated and signed prescriptions or orders for all medications with notation of termination dates;
- (x) the discharge plan;
- (xi) any other documents or information regarding the patient's condition, treatment, and results of treatment; and

(xii) 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.

(b) *Disclosures.* Disclosure of HIV related information contained in a patient's record shall be made in accordance with the Article 27f of the Public Health Law, other applicable state and federal statutes and regulations, and subject to the additional disclosure requirements of 42 Code of Federal Regulations Part 2.

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

### **818.7 Staffing.**

(a) *Medical Director and medical staff.* (1) The medical director, as defined in Part 800 of this Title, shall oversee the development and revision of medical policies, procedures and ongoing training for matters such as routine medical care, specialized services, and medical and psychiatric emergency care, and supervision of medical staff.

(2) Programs providing treatment for persons with co-existing medical or psychiatric conditions in addition to their substance use disorder shall have an appropriately qualified physician, physician's assistant, nurse practitioner, psychiatrist or psychologist on-site or through telepractice, pursuant to Part 830 of this Title, providing coverage as adequate and necessary to provide evaluation, treatment and supervision of such other services for these patients.

(3) There shall be at least one full-time registered professional nurse and additional licensed practical nurses, registered nurses, registered physician's assistants, and nurse practitioners sufficient to provide the services required. Such personnel shall be available to all patients at all times.

(4) The medical director may also serve as a physician of another service which is provided by the facility.

(b) *Staff sharing.* Staff may be either specifically assigned to the inpatient service or may be part of the staff of the facility within which the inpatient 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 disorder specific to the services provided. The percentage of time that each shared staff is assigned to the inpatient service must be documented.

(c) *Supervision and training.* Each program must provide clinical supervision and ensure and document a plan for staff training based on individual employee needs. Subject areas appropriate for training shall be identified by the Office.

(d) *Program director.* There shall be a director of the program who is a qualified health professional with at least three (3) years-experience in the provision of substance use disorder services, and at least two (2) additional years of supervisory experience prior to appointment as director.

(e) *Other clinical staff.* (1) At least 50 percent of all clinical staff shall be qualified health professionals as defined in Part 800 of this Title. CASAC Trainees may be counted towards satisfying the 50 percent requirement provided, however, that such individuals shall not be considered qualified health professionals for any other purpose under this Part.

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

(3) There shall be at least one clinical staff member, as defined in Part 800 of this Title, designated to provide activities therapy;

(4) There shall be at least one counselor for every eight (8) patients, at least 50 percent of whom shall be qualified health professionals. Counseling staff shall be scheduled for a minimum of one and one-half shifts five days per week, and one shift per day for the remaining two days per week;

(5) There shall be clinical staff available to all patients at all times. During late evening and night shifts, there shall be at least two clinical staff members on duty. This staff shall be awake at all times, make frequent rounds and be available to patients who awaken during the night;

(6) There shall be sufficient clinical staff, allocated based on clinical demands of each shift, to achieve an overall program ratio of at least the following:

(i) if the program has 80 patients or more, one full time equivalent staff for each four (4) patients;

(ii) if the program has between 31 and 79 patients, at least one full time equivalent staff for each three and one-half patients; and

(iii) if the program has 30 or fewer patients, at least one full time equivalent staff for each three patients.

(g) *Additional required staff.* (1) Maintenance and security. There shall be sufficient staff available to ensure that the inpatient program and all equipment utilized therein is maintained in such a manner as to provide patients with a clean and safe environment.

(2) Volunteers and interns. In addition to staffing requirements of this Part, an inpatient service may utilize volunteers, students and trainees, on a salaried or non-salaried basis. Such personnel shall be provided close professional staff supervision and appropriate education from both internal and external sources.

(3) Health coordinator. Each inpatient program 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 patients regarding HIV, tuberculosis, hepatitis, sexually transmitted infections, and other transmissible infections.

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