AMENDED PART 820 EFFECTIVE OCTOBER 1, 2022

PART 820
RESIDENTIAL SERVICES
(Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32.01, 32.07(a), Public Health Law Article 27f)

Section:

Section 820.1 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 addiction 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 addiction services.

(d) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner 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) Article 27F of the Public Health Law defines the rules governing HIV testing in New York.

820.2 Applicability.

(a) This Part applies to any program certified by the office pursuant to this Part to provide residential services. These services are designed to help persons who lack a safe and supportive residential option in the community to achieve changes in their substance use disorder ("SUD") behaviors within a safe and supportive setting. Such services shall be strength based, person centered and trauma informed and may focus treatment on one or more of the following treatment/recovery elements: stabilization, rehabilitation, or community reintegration in congregate or scatter-site settings and may be provided directly on program site or through cooperative relationships with other service providers. Clinical services in residential programs are delivered on an individual or group basis in a variety of settings.

(b) Residential substance use disorder (SUD) services include medically necessary care and supportive services both on and off-site according to assessed needs including:

(1) assessment and clinical treatment/recovery plan or service plan development;

(2) skill development for coping with and managing symptoms and behaviors associated with SUDs;

(3) counseling to address a beneficiary's major lifestyle, attitudinal, and behavioral problems; and

(4) medication for addiction treatment for substance use disorder when medically necessary.

820.3 Definitions.

Unless otherwise indicated, the following terms shall be applicable to all programs certified pursuant to this Part.

(a) "Residential services" are 24/7 structured treatment/recovery services in a residential setting provided by office certified programs to persons recovering from substance use disorder. Services correspond to elements in the treatment/recovery process and are distinguished by the configuration of services, staffing patterns, degree of dysfunction of the individual served in each setting, and patient readiness to transition to a less restrictive program or element of treatment/recovery. Certified residential programs may provide residential services corresponding to one or more of the following elements of the treatment/recovery process:

(1) stabilization;

(2) rehabilitation;

(3) reintegration in congregate or scatter-site settings.

(b) “Stabilization” provides a safe environment in which a person may stabilize withdrawal symptoms, severe cravings, psychiatric and medical symptoms before referral or transition to another program or element of structured treatment/recovery. Stabilization requires the supervision of a physician and clinical monitoring.

(c) “Rehabilitation” provides a structured environment for persons whose potential for independent living is seriously limited due to significant functional impairment including social, employment, cognitive and ability to follow social norms that requires restructuring social supports and behaviors in order to develop sufficient skills; these persons require a course of rehabilitative services in a structured environment with staffing to provide monitoring and support and case management.

(d) “Reintegration” provides a community living experience in either congregate or scatter-site settings with limited supervision and/or case management; persons appropriate for these services are transitioning to long term recovery from substance use disorder and independent living in the community.

(e) “Patient” or “Resident”, for purposes of this Part, means an individual that is receiving services from a program certified pursuant to this Part.

820.4 Assignment of services.

(a) Programs will be certified for a maximum number of beds for a certified capacity. The level of care is attributed to the patient based on a patient-centered assessment and the OASAS level of care for alcohol and drug treatment referral protocol based on individual risk and resources. Programs will be certified pursuant to Part 810 of this Title for residential services and will have noted on the operating certificate each of the services (stabilization, rehabilitative and/or reintegration) approved for delivery at the certified residential site.

(b) Bed distribution will be determined by patient population demand. At any given time, the bed type is defined by the element of care to which the patient has been assigned. Distribution of bed types will not be fixed; however, the program must meet OASAS reporting requirements for transitions from one element of care to the next.

(c) All programs must submit an application with specific staffing structure, treatment approach, and other policies and procedures as requested by the Office for each element of residential services the program intends to provide. Upon approval of the application the service to be provided will be approved and designated on the residential program's operating certificate.

820.5 General program standards.

(a) Policies and procedures. The program governing authority must approve written policies, procedures, and methods governing the provision of services in compliance with office regulations including a description of each service provided. These policies, procedures, and methods must address, at a minimum:

(1) admission and discharge, including transfer and referral procedures;

(2) treatment/recovery plans, including service plans where appropriate;

(3) staffing including, but not limited to, training and use of student interns, peers and volunteers, and compliance with Part 805 of this Title;

(4) screening and referral procedures for associated physical or psychiatric 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 a resident 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) medication for addiction treatment;

(9) the use of alcohol and other drug screening tests, such as breath testing, urine screening;

(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) procedures for emergencies;

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

(14) record keeping;

(15) procedures whereby 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;

(16) procurement, storage, preparation of food and nutritional planning;

(17) records retention. Case records must be retained for ten years after the date of discharge or last contact, or three years after the patient reaches the age of 18, whichever time period is longer.

(b) Emergency medical kit. All programs must maintain an emergency medical kit at each certified 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 and residents, where appropriate, trained in overdose prevention education and naloxone education including the prescribed use of naloxone which shall be available for use during all program hours of operation.

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

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

(c) Utilization review and quality improvement. All programs must have a utilization review process, a quality improvement committee, and a written plan that identifies key performance measures for that particular program.

(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) Services. All residential programs shall make available, either directly or through referral to appropriate agencies, the following services as clinically and programmatically indicated:

(1) Supportive services: availability of a range of support services appropriate to resident needs including legal, mental health, and social services, vocational assessment and counseling.

(2) Educational and child care services: availability of required educational and childcare services in each program which provides services to school-age children.

(3) Structured activity and recreation: opportunities for residents and family members, where appropriate, to participate in activities designed to foster effective use of leisure time, to improve social skills, develop self-esteem and encourage personal responsibility.

(4) Orientation to community services: orientation for each resident including advice and instruction in identifying and obtaining needed community services such as housing and other necessary case management services.

(5) Medication for addiction treatment, consistent with this Part and guidance issued by the Office.

(6) Overdose prevention education and naloxone education and training and a naloxone kit or prescription, consistent with guidance issued by the Office.

(f) Certified capacity. The certified bed capacity of each residential program may not be exceeded at any time except:

(1) in cases of emergency and unexpected surges in demand where no alternative options are available; and

(2) failure to temporarily accept individuals into the program would jeopardize their immediate health and safety; and

(3) where the excess of capacity would be time limited.

(g) Recordkeeping and reporting. (1) All residential services must maintain individual case records for each resident served. These 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.

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

820.6 Staffing.

(a) Any residential program of 10 beds or more shall have a full-time program director who is a qualified health professional as defined in Part 800 of this Title. The program director shall have at least five years of full-time work experience in SUD, or related treatment field, prior to appointment as program director. A residential program with fewer than 10 beds shall have a similarly qualified program director who shall serve on at least a part-time basis.

(b) General and clinical staffing. (1) General and clinical staffing shall be on-site or on-call sufficient to meet the emergent needs of the resident population receiving services in a particular treatment element. Staff may be either specifically assigned to the residential service or may be part of the staff of the facility or program within which the residential service is located. However, if the staff is part of the general facility or program staff, they must have specific

training and experience in the treatment of chemical use, abuse and dependence specific to the services provided.

(2) Applicable only to stabilization and rehabilitation services, staff "sufficient to meet the emergent needs of the resident population" shall include:

(i) registered nurse and weekend nursing staff sufficient to resident need, on-site daily and to supervise LPN;

(ii) LPN available on-site daily for support to residents for support and documentation of self-medication;

(iii) physician, nurse practitioner and or physician assistants to meet the medical assessment and treatment needs of each resident. Each service shall have identified a medical director whose qualifications and responsibilities are defined in Part 800 of this Title;

(iv) psychiatrist and/or psychiatric nurse practitioner to evaluate all residents who have a history of mental health disorder or who are exhibiting symptoms of a mental health disorder.

(v) LMSW/LCSW/LMHC or family therapist in sufficient numbers to provide psychotherapy to all residents who are in need of such services in a frequency sufficient to meet the assessed need;

(vi) clinical staff in sufficient numbers to serve as the primary counselors. Each resident shall be assigned a clinical staff member as his/her primary counselor to provide individual counseling and treatment/recovery plan preparation, monitoring and review;

(vii) CASACs, CASAC-T and other clinical and milieu staff in sufficient numbers to facilitate activities of daily living, community meetings, engagement, carry out of treatment planning in milieu; at least one CASAC available at all times to intervene to help provide therapeutic interactions to foster residents' social, cognitive and behavioral skill development. CASAC staff will provide supervision of milieu staff;

(viii) milieu staff all shifts in sufficient numbers available within the community to model and provide pro-social behavioral interventions at all times. Milieu staff are included in the treatment planning process and are aware of the treatment goals of each resident; they will carry out activities that will support goal attainment through the natural interactions within the milieu.

(ix) at least two staff per overnight shift, one of which must be a clinical staff member;

(x) vocational counselor;

(xi) case manager to develop the treatment/recovery plan and to meet regularly to identify needs and progress.

(3) All residential services shall have sufficient clinical staff that have been trained in, and are designated by the clinical supervisor to perform, the following tasks:

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

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

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

(4) 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 non-treatment functions and to optimize operational efficiency.

(c) Clinical supervision. (1) Each residential 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.

(2) All 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 as defined in Part 800 of this Title with at least three years of clinical experience in substance use disorder treatment.

(3) 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.

(4) All clinical staff should be provided with and document training, including but not limited to, crisis interventions, working with special populations, medication assisted treatment, trauma informed care, quality improvement, agency policies and procedures. Additional subject areas appropriate for training may from time to time be identified by the Office.

(d) Health coordinator. 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 (including pre-and post-exposure

prophylaxis), tuberculosis, viral hepatitis, sexually transmitted infections and other transmissible infections.

(e) Volunteers, peers, students or trainees. A residential service may utilize volunteers, peers, students or trainees, on a salaried or non-salaried basis if such volunteers, peers, students or trainees are provided close professional staff supervision and necessary didactic education from both internal and external sources, and comply with the requirements of Part 805 where appropriate.

820.7 Admission, screening and assessment.

(a) Admission procedures. (1) Initial determination. An individual seeking residential services shall have an initial determination based upon face-to-face contact plus any other available records and made by a qualified health professional or other clinical staff under the supervision of a qualified health professional; such determination shall document in writing that:

(i) the individual appears to be in need of substance use disorder services; and

(ii) the individual appears to be free of serious transmissible infection which can be transmitted through ordinary contact; and

(iii) the individual appears to not need acute hospital care, acute psychiatric care, or other intensive services which cannot be provided in conjunction with residential services or would prevent him/her from appropriate participation in a residential service.

(2) Level of care determination. If the initial determination indicates the person is appropriate for residential services, a level of care determination shall be made by a clinical staff member supervised by a qualified health professional no later than 24 hours after the resident's first on-site contact with the program. The level of care report generated by the level of care protocol must be documented in the resident patient record. To be admitted for residential services at the appropriate level of care the individual must meet the level of care protocol criteria for the residential services and must be provided the services which match the resident's need for either stabilization, rehabilitative, or reintegration services.

(3) No individual may be denied admission to a program consistent with Part 815 of this Title.

(4) Decision to admit; notice to residents. (i) If determined appropriate for the residential service, the individual shall be admitted. The decision to admit shall be included in the resident

case record, dated and signed by a staff member who is a qualified health professional authorized by program policies to admit individuals; and

(ii) there must be a notation in the resident patient record that the resident received a copy of the residential service's rules and regulations, including resident rights, a summary of Federal confidentiality requirements, and a statement that such rules were discussed with the resident and the resident indicated that he/she understood them; and

(iii) all residents shall be informed that admission is on a voluntary basis and that a resident is free to discharge him or herself from the service at any time.

(iv) If the presenting individual is determined to be inappropriate for admission to the residential service, a referral to a more appropriate service must be made, unless the individual is already receiving substance use disorder services from another provider. Individuals deemed ineligible for admission must be informed of the reason.

(v) The admission assessment or decision to admit must 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.

(b) Assessment. (1) Prior to admission, all programs must:

(i) conduct a transmissible infection risk assessment (HIV, tuberculosis, viral hepatitis, sexually transmitted infections, and other transmissible infections);

(ii) conduct a toxicology screen as clinically appropriate or required by Federal law.

(2) As soon as possible after admission, for all residents, programs must:

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

(ii) offer HIV testing; 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.

(3) If clinically indicated, as soon as possible after admission, 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 and referrals for immunization; 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.

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

(5) Any significant medical issues, including risk for transmissible infections, identified prior to or after admission must be addressed in the treatment/recovery plan and documented in the patient case record. Treatment/recovery plans must include provisions for the prevention, care and treatment of HIV, viral hepatitis, tuberculosis and/or sexually transmitted infections. If a resident refuses to obtain such care, the provider must have the resident acknowledge in writing that such care was offered but refused.

(c) Medical history. (1) 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 is being admitted directly to the residential service from another office certified SUD program, the existing medical history and physical examination documentation may be used to comply with the requirements of this subdivision, provided that such documentation has been reviewed and determined to be current and accurate; such determination shall be dated and recorded in the resident record. Notwithstanding the foregoing, the following shall be offered to all patients regardless of a documented history within the previous twelve (12) months: HIV and HCV testing.

(2) Stabilization services. (i) Within 24 hours after admission, programs providing stabilization services must complete a general assessment which identifies immediate problem areas, substantiates appropriate resident placement and is signed by a qualified professional. If withdrawal symptoms or other potentially life threatening behavior or conditions are present, the patient must be assessed immediately for safety by a medical staff person who is working within the scope of practice. A physician must be available by phone at all times to respond to immediate crises.

(ii) Within 24 hours after admission programs providing stabilization services must conclude a medical assessment and, if necessary, a full physical no later than 7 days after admission. All residents shall receive a physical exam by a physician, physician's assistant or nurse practitioner if they do not have available a medical history and no physical examination

has been performed within the prior 12 months. Residents who have a medical history shall receive an evaluation within 7 days.

(3) Rehabilitation services. Within seven days after admission, programs providing rehabilitation services must conclude a medical assessment and, if necessary, a full physical no later than 45 days after admission. All residents shall receive a physical exam by a physician, physician's assistant or a nurse practitioner if they do not have available a medical history and no physical examination has been performed within the prior 12 months. Residents who have a medical history shall receive an evaluation within 21 days.

(4) Reintegration services. (i) Residents admitted to reintegration services should have an identified primary care physician (PCP) in the community and have a physical exam if one has not been completed within the prior 12 months, or, if the resident is admitted to an outpatient SUD clinic [~~(CD-OP)~~] or opioid treatment program (OTP), then within 30 days the reintegration program shall obtain the medical history, physical and treatment plan from the outpatient provider.

(ii) The physical examination shall include review of any physical and/or mental limitations or disabilities which may require special services or attention during treatment.

820.8 Treatment/recovery plan development and review.

(a) Programs providing residential services for any or all elements of care must:

(1) as soon as possible after admission, develop a patient-centered, interdisciplinary person centered treatment/recovery plan, which includes problem formulation and short-term, measurable treatment/recovery goals and activities designed to achieve those goals. This plan should be developed in collaboration with the resident; and

(2) review and revise, if necessary, the treatment/recovery plan or service plan in collaboration with the resident monthly (rehabilitation and reintegration) and weekly (stabilization) after admission and document accordingly.

(b) Treatment/recovery plan. (1) Each resident must have a written person-centered treatment/recovery plan, or a service plan where appropriate, developed by the responsible clinical staff member and resident as soon as possible after admission. Standards for developing a treatment/recovery plan include, but are not limited to:

(i) for residents moving directly from one program to another, or being readmitted to the same program within 60 days of discharge, the existing treatment/recovery plan may be used if there is documentation that it has been reviewed and, if necessary, updated within 14 days of transfer;

(ii) if the resident is a minor, the treatment/recovery plan must also be developed in consultation with his/her parent or guardian unless the minor is being treated without parental consent as authorized by Mental Hygiene Law section 22.11.

(2) The treatment/recovery plan must:

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

(ii) address resident 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 resident and primary counselor;

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

(iv) be reviewed and approved by the supervisor of the responsible clinical staff member within 10 days after the finalization of the treatment/recovery or service plan. If the supervisor of the responsible clinical staff member is not a qualified health professional (QHP), another QHP must be designated to sign (physical or electronic signature) the plan; and

(v) include schedules for the provision of all services prescribed; where a service is to be provided by any other service or facility 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, the results of the referral, and procedures for care coordination and discharge planning.

(c) Treatment according to the treatment/recovery plan. (1) The responsible clinical staff member shall ensure that the treatment/recovery plan is included in the resident record and that all treatment and services are provided in accordance with the treatment/recovery plan.

(2) Progress notes. (i) Progress notes shall be written, signed and dated by the responsible clinical staff member on a frequency appropriate to the element of care and consistent with policies and procedures and must include all clinical and milieu services delivered and the response of the resident to treatment. All individual and medical contacts for

the purpose of assessing, diagnosing or treating the resident shall be documented in the resident record by the staff member delivering the service(s).

(ii) 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/recovery.

(iii) The progress notes shall indicate the resident's participation in all significant services provided.

820.9 Discharge.

(a) Discharge planning. (1) Discharge planning shall begin as soon as the resident is admitted. Individuals entering treatment should progress by meeting treatment milestones including: stabilization; engagement; goal setting; remission of substance use disorder; and attainment of goals supporting recovery. Individuals should be considered for discharge once they have stabilized, met remission criteria for substance use disorder, and attained the support necessary to support long term remission.

(2) An individual discharged from a program must be discharged for a documented reason. Individuals discharged involuntarily must be discharged consistent with Part 815 of this Title.

(3) Patients and significant other(s) shall be offered overdose prevention education and naloxone education and training and a kit or prescription for naloxone.

(4) Programs shall develop a safety plan in collaboration with the patient.

(b) Discharge criteria. A resident shall be appropriate for discharge from the residential service and shall be discharged when he or she meets one or more of the following criteria:

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

(2) the resident refuses further care;

(3) the resident has been referred to other appropriate treatment which 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 is disruptive to the service and/or fails to comply with the reasonably applied written behavioral standards of the facility.

(c) Discharge plan. (1) A discharge plan must be developed in collaboration with the resident and any collateral person(s) the resident chooses to involve. The discharge plan shall specify needed referrals with appointment dates and times, all known medications (including frequency and dosage) and recommendations for continued care.

(2) The discharge plan must include an appointment with a community-based provider to continue approved medications for substance use disorder treatment.

(3) If the resident is a minor, the discharge plan must also be developed in consultation with his or her parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law section 22.1; information pertaining to testing and treatment of sexually transmitted infections including HIV, cannot be shared with the minor patient's parent or guardian without the patient's consent, in accordance with applicable laws and regulations.

(4) No resident may be discharged without a discharge plan which has been reviewed and approved by the responsible clinical staff member and the clinical supervisor prior to the discharge. This requirement does not apply to residents who stop attending, refuse continuing care planning, or otherwise fail to cooperate. That portion of the discharge plan which includes referrals for continuing care must be given to the resident upon discharge.

(5) Residents should be discharged to the level of care indicated by the level of care protocol and may be moved between services within the residential program as long as the program is approved to provide the service and the resident meets the level of care for that service. Clinical staff should utilize the level of care protocol whenever a change in level of care is considered.

(6) No later than 30 days after discharge, a discharge summary must be finalized and included in each resident's record. The discharge summary must address and measure progress toward attainment of treatment goals.

820.10 Additional requirements for stabilization in a residential setting.

(a) Stabilization services are appropriate for residents who present with mild withdrawal or expected withdrawal and psychiatric symptoms that cause acute impairment; medical conditions, emotional or cognitive impairment that can be managed in a residential setting where medical staff are available on an on-call basis. Stabilization services may be provided by any certified provider of residential services designated by the office to provide stabilization services.

(1) Residential providers will be required to have medication management protocols, approved by the OASAS Medical Director, to qualify to provide stabilization services.

(2) All programs offering stabilization services shall have ancillary withdrawal and addiction medication management available as clinically indicated.

(b) Staffing. (1) In addition to staffing required of all residential services pursuant to section 820.6 of this Part, stabilization services approved by the office must provide medical staff, as defined in Part 800 of this Title, on site or on-call, and staff available sufficient to meet the emergent needs of the resident population including any or all of the staff identified in Section 820.6(b)(2) of this Part. The percentage of time that each shared staff is assigned to the residential service must be documented.

(c) Services. In addition to the required services for all residential programs, stabilization services must include:

(1) Medical assessment of the SUD symptoms and medical treatment of mild to moderate withdrawal symptoms, urges and cravings using a protocol approved by the OASAS Medical Director.

(2) Medical assessment of physical and mental health conditions and medical treatment to stabilize these conditions.

(3) Psychiatric assessment and medication management of co-occurring psychiatric conditions which can be managed within the residential setting.

(4) Psychosocial interventions which teach skills for coping with urges, craving, impulsive behavior and cognitive distortions in thinking, motivational interviewing techniques to engage the resident in treatment.

820.11 Additional requirements for rehabilitation services in a residential setting.

(a) Rehabilitation services are appropriate for individuals who do not have significant withdrawal symptoms, are free of severe cravings to use substances and, if present, psychiatric and medical conditions are stable. Individuals have functional impairment in cognitive, emotional regulation, social and role functioning.

(b) Staffing. In addition to staffing required of all residential services pursuant to section 820.6 of this Part, rehabilitation services approved by the Office must provide medical staff, as defined in Part 800 of this Title, on site or on-call, and staff available sufficient to meet the emergent needs of the resident population including any or all of the staff identified in section 820.6(b)(2) of this Part. The percentage of time that each shared staff is assigned to the residential service must be documented.

(c) Services. In addition to the services required of all residential programs, rehabilitation services must provide:

(1) individual, group and family counseling as appropriate to patient needs; provided by clinical staff as clinical staff are defined in Part 800 of this Title.

(i) a group therapy session shall contain no more than 15 persons;

(ii) family counseling services include services to significant others;

(iii) 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 directly supervised by a clinical staff member in attendance;

(iv) multi-family group counseling and psycho-education;

(2) medical assessment of physical and mental health conditions and medical treatment to enable the patient to manage chronic health and mental health conditions including treatment of physical health conditions that are routine;

(i) psychiatric assessment and medication management of co-occurring psychiatric conditions which can be managed within the residential setting;

(ii) psycho-social interventions which teach skills for coping with urges, craving, impulsive behavior and cognitive distortions in thinking, motivational interviewing techniques to engage the patient in treatment;

(iii) planned interactions with patients within the milieu intended to build social, emotional, and behavioral functioning including: increased empathy, successful social

interactions, increase in self-efficacy, confidence, control over impulses, managing of urges and cravings to use and the skill in use of social supports available within the community.

820.12 Additional requirements for community reintegration services in a residential setting.

(a) Resident profile. Reintegration services are provided in a supervised congregate or scattered site setting to persons making the transition into the community. Persons appropriate for this service are stable in SUD, psychiatric and medical conditions and have adequate functioning in cognitive, emotional regulation, social and role functioning.

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

(1) the individual must be homeless or must have a living environment not conducive to recovery; and

(2) the individual must be determined to need outpatient treatment services and/or other support services such as vocational or educational services.

(c) Services. (1) In addition to services required of all residential services, reintegration residential services are specifically required to provide a structured therapeutic environment designed to facilitate the individual's progress toward recovery from SUD and maintain a focus on the development and improvement of the skills necessary for recovery.

(2) Services to be provided shall include the following:

(i) each reintegration residential service shall ensure that its residents have access to individual, group and family counseling services as needed and appropriate;

(ii) each reintegration residential service shall have written referral agreements with one or more SUD outpatient services to provide outpatient treatment services, as necessary;

(iii) the reintegration residential service shall ensure that such services are integrated with the activities and services provided by the residence and incorporated in the individual's comprehensive service plan;

(iv) each reintegration residential service shall ensure that a comprehensive and appropriate range of services are available to each resident. Such services include but are not limited to:

(a) vocational services such as vocational assessment;

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

(c) educational remediation; and

(d) life, parenting and social skills training.

(3) Services may be provided directly by the service or by referral.

(4) Services shall be identified in the resident's service plan.

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

(3) Programs shall ensure access to medication for addiction treatment.

(d) Service plan review. In addition to the required periodic review, each service plan, once established, must be thoroughly reviewed and updated by the responsible clinical staff member in consultation with the resident whenever a change in services requires; all updates must be reviewed and signed by the supervisor.

(e) Staffing. (1) Each reintegration residential service shall have a full time manager responsible for the day-to-day operation of the service.

(2) For community reintegration services in a congregate setting, there shall be staff on site twenty-four hours per day, seven days per week.

(3) All reintegration residential services shall have sufficient staff to insure that supportive services are available and responsive to the needs of each resident.

(4) For community reintegration services in a scattered site setting, there shall be sufficient clinical staff members to ensure at least one visit to each resident 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 recovery and independent living.

820.13 Standards pertaining to Medicaid reimbursement.

(a) Services must be delivered in accordance with the signed treatment/recovery plan, this Part and Part 841 of this Title.

(b) Non-covered services. Components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary, are not eligible for Medicaid reimbursement.

820.14 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.