NEW YORK STATE

Office of Addiction Services and Supports

STATEWIDE REGIONAL OPERATIONS

Regulatory Compliance Site Review Instrument

Substance Use Disorder Opioid Treatment Programs

PRU - Recertification + Joint Site Review (QA-6CD)

(Applicable to Opioid Treatment Programs and Problem Gambling Designation)

SECTION 1: PATIENT CASE RECORDS

SECTION 2: SERVICE MANAGEMENT

SECTION 3: FACILITY REQUIREMENTS AND GENERAL SAFETY

NOTE: Pursuant to Mental Hygiene Law and the Office of Addiction Services and Supports' (OASAS) Regulations, this Site Review Instrument is designed for the express purpose of conducting OASAS regulatory compliance reviews of its certified providers. Use of this Site Review Instrument as a self-assessment tool may be a helpful indicator of a provider's regulatory compliance. However, please note that the Site Review Instrument: (1) is not the sole basis for determining compliance with OASAS' requirements; (2) does not supersede OASAS' official Regulations, and should not be relied upon as a regulatory reference in lieu of the Regulations; and (3) is subject to periodic revision without notice.

REVIEW INFORMATION

PROVIDER LEGAL NAME
PROGRAM SITE ADDRESS

CITY/TOWN/VILLAGE and ZIP	DATES OF REVIEW
REVIEW NUMBER	OPERATING CERTIFICATE NUMBER
PROVIDER NUMBER	PRU NUMBER

LEAD REGULATORY COMPLIANCE INSPECTOR
ADDITIONAL OASAS STAFF MEMBER(S) (if applicable)

SITE REVIEW INSTRUMENT INSTRUCTIONS

PATIENT CASE RECORDS INFORMATION SHEET	
Identification Number ►	Enter the Identification Number for each case record reviewed.
First Name ►	Enter the first name of the patient for each case record reviewed.
Last Name Initial ►	Enter the first letter of the last name of the patient for each case record reviewed.
Comments ►	Enter any relevant comments for each case record reviewed.

PATIENT CASE RECORDS SECTION	
Patient Record Number Column ►	Enter a ✓ or an ✕ in the column that corresponds to the Patient Record Number from the **PATIENT CASE RECORDS INFORMATION SHEET**. Enter a ✓ in the column when the program is found to be **in compliance**. ➢ For example: Consents for the release of confidential information forms *are* completed properly -- Enter a ✓ in the column. Enter an ✕ in the column when the program is found to be **not in compliance**. ➢ For example: Consents for the release of confidential information forms *are not* completed properly -- Enter an ✕ in the column.
TOTAL ►	Enter the total number of ✓'s (**in compliance**) and the total number of ✕'s (**not in compliance**) in the **TOTAL** column.
SCORE ►	Divide the total number of ✓'s (**in compliance**) by the total items scored (sum of ✓'s and ✕'s) and, utilizing the **SCORING TABLE** below, enter the appropriate score in the **SCORE** column. ➢ For example: Ten records were reviewed for Treatment/Recovery Plans. Eight records were in compliance. Divide eight by ten, which gives you 80%. Refer to the scoring table, which indicates that 80% - 89% equals a score of 2 -- Enter **2** in the **SCORE** column.

SERVICE MANAGEMENT SECTION	
YES ►	Enter a ✓ in the **YES** column when the program is found to be **in compliance**. ➢ For example: There *is* a designated area for secure storage of patient case records -- Enter a ✓ in the **YES** column.
NO ►	Enter an ✕ in the **NO** column when the program is found to be **not in compliance**. ➢ For example: There *is not* a designated area for secure storage of patient case records -- Enter an ✕ in the **NO** column.
SCORE ►	Enter **4** in the **SCORE** column when the program is found to be **in compliance**. Enter **0** in the **SCORE** column when the program is found to be **not in compliance**.

NOTE
If any question is not applicable, enter N/A in the SCORE column.

SCORING TABLE		
100%	=	4
90% - 99%	=	3
80% - 89%	=	3
60% - 79%	=	1
less than 60%	=	0

PATIENT CASE RECORDS INFORMATION SHEET

ACTIVE RECORDS

Record	Identification Number	First Name	Last Name Initial	Primary Counselor	Comments
#1					
#2					
#3					
#4					
#5					
#6					
#7					
#8					
#9					
#10					

INACTIVE RECORDS (Discharged Involuntarily)

Record	Identification Number	First Name	Last Name Initial	Primary Counselor	Comments
#1					
#2					
#3					
#4					
#5					

INACTIVE RECORDS (Discharged Successfully)

Record	Identification Number	First Name	Last Name Initial	Primary Counselor	Comments
#1					
#2					
#3					
#4					
#5					

INACTIVE RECORDS (Seen But Not Admitted)

Record	Identification Number	First Name	Last Name Initial	Comments
#1	N/A			
#2	N/A			
#3	N/A			
#4	N/A			
#5	N/A			

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
A. PRE-ADMISSION PROCEDURES												
A.1. Prior to admission, does the program verify with the **central registry** system that the prospective patient is not presently enrolled in another OTP, and is this verification documented in the clinical record? ***[822.11(a)(3)]***											✓ _____ ✕ _____	
A.2. Is there evidence that: • the program provided education about approved medications for treatment of SUD including the benefits and risks (if the patient is not already taking such medications),; • the patient's preference for or refusal of medication is documented; and • where clinically appropriate, MAT services are offered to clients regardless of their ability or willingness to engage in psychosocial treatment? **[822.7(i)(4); *MAT Standards] (NOTE: Review MAT policy to determine consistency with the MAT Standard, and procedures for: monitoring MAT only clients, program's engagement practices, and clinical appropriateness for offering MAT. A citation should be made if the evidence in the case record is not consistent with the program's MAT policy.)***											✓ _____ ✕ _____	
A.3. ➡ ***QUALITY INDICATOR*** Prior to admission (first medication dose), does a physician: • make an in-person evaluation, including a complete, fully documented physical evaluation, of the prospective patient to determine if the patient has had a physiological dependence on opioids for at least the previous 12-month period ***[822.8(e)(2)*; 42CFR Part 8.12(f)(2)]** • diagnose and document an opioid use disorder; and • determine the approved initial medication dose? ***[822.11(b)(1-4)]*** ***(NOTE: This applies to admission for methadone, only.)***											✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal			Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
A. PRE-ADMISSION PROCEDURES (cont'd)												
A.4. Does a physician (or waiver-approved practitioner) ensure that prior to treatment being initiated (first dose), that the prospective patient is provided with and signs (physical or electronic signature) an informed written consent to participate in opioid treatment and does such consent include notice of the risks and benefits of a prescribed medicine? ***[822.8(e)(3)]*** ***(NOTE: This applies to admission for methadone, only.)***											✓ _____ ✕ _____	
A.5. If the individual is determined to be one of the following priority admissions, is there evidence the individual was admitted and provided timely access to treatment services on a timely basis: • pregnant persons; • people who inject drugs; • parent(s)/guardian(s) of children in or at risk of entering foster care; • individuals recently released from criminal justice settings; • those with chronic immune defidiency; • current or past opioid dependency; and • all other individuals? ***[800.5(b); 822.8(e)]*** ***(NOTE: Review the program's policy and procedure for the determination of timely access to treatment services on a timely basis.)***											✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal			Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
A. PRE-ADMISSION PROCEDURES (cont'd)												
A.6. ➡ *QUALITY INDICATOR* Does the admission assessment include the following: • a preliminary diagnosis; • determination of appropriateness for service; • person-centered initial plan of treatment (i.e., initial services needed until the development of the treatment/recovery plan); and • the type and frequency of services needed by the patient? ***[822.5(c)]***											✓ _____ ✕ _____	
As applicable, during the admission process, is there any evidence the client was offered information about MAT (including medications for tobacco-cessation)? ***(NOTE: Refer to Opinion of Counsel dated 9/7/17)*** ***Corresponds to RO SRI Clinical Practices Question 12 - PRU completes and informs RO***											**QUESTION NOT SCORED** PLEASE PROVIDE SPECIFIC FEEDBACK REGARDING ANY RELATED ISSUES	
									Number of Applicable Questions Subtotal		Case Records Subtotal	

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
A. PRE-ADMISSION PROCEDURES (cont'd)												
Date of Birth ▶												
A.7. For prospective patients **less than 18 years of age**, does the program document: ▪ at least two prior treatment episodes within a 12-month period and a dependence on opioids; and ▪ Additionally, for prospective patients **less than 16 years of age**, does the program document prior OASAS approval? ***[822.8(e)(1); 822.8(e)(2)(ii)]***											✓ _____ ✕ _____	
A.8. Does the program conduct a screening to establish the risk of common co-occurring conditions such as Hepatitis C, the human immunodeficiency virus (HIV), sexually transmitted infections (STIs), cardiopulmonary disease, and sleep apnea? For individuals screened positive for any such conditions, is there evidence of a management plan for treatment (either onsite or referred)? ***[42 CFR Part 8.12(f)(2)]***											✓ _____ ✕ _____	
B. ADMISSION PROCEDURES												
Date of Admission ▶												
B.1. ➡ ***QUALITY INDICATOR*** Do the patient case records/documentation of admission: • include level of care determination; • include an assessment, initial services and diagnosis that form the basis of the treatment/recovery plan; • include evidence that the decision to admit was made by a clinical staff member who is a QHP working within their scope of practice, and is documented by a dated signature (physical or electronic); and • include approval of a physician, physician assistant, nurse practitioner, licensed psychologist, or licensed clinical social worker, as evidenced by a dated signature (physical or electronic**). (Note: For 4th bullet, if approval is not documented at time of review a reviewer's note should be issued in lieu of citation).** ***[822.8(b)(3)]***										✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal			Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
B. ADMISSION PROCEDURES (cont'd)												
Date of Admission ▶												
B.2. Do the patient case records contain a notation that, prior to the first treatment visit, the following information was given to and discussed with the patient, and that the patient indicated that they/them understood them: • a copy of the program's rules and regulations, including patient's rights and a summary of the Federal confidentiality requirements (i.e., HIPAA & 42 CFR) ***[822.8(a)(2); 815.5]*** ; and • that the patient was informed that admission is on a voluntary basis and that the prospective patient will be free to discharge him/herself from the outpatient program at any time? ***[822.8(b)(7)]*** • ***(NOTE: 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, continued treatment and toxicology screening. This provision shall not be construed to preclude or prohibit attempts to persuade a prospective patient to remain in the program in his/her own best interest.)***											✓ _____ ✕ _____	
B.3. Are consents for the release of confidential information forms completed properly? ***[822.8(a)(5); HIPAA; 42 CFR Part 2]*** (***Note: For each case record, review a sample of five (5) consents for the release of confidential information forms.)***											✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal			Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
B. ADMISSION PROCEDURES (cont'd)												
B.4. Is there evidence that the program orients patients at the time of admission by providing continuous education, including the following topics: • signs and symptoms of overdose, use of naloxone (prescriptions should be given to patients on entry into treatment), and when to seek emergency assistance; • the medication or modality of treatment being used, including side effects and common myths, and the expected outcomes; • the nature of various addictive disorders; • the benefits of treatment and nature of recovery process, including stages of treatment; • an OTP's guidelines, rules, regulations, fees, and billing procedures; • noncompliance and discharge procedures, including administrative withdrawal from medication; • patient rights; • confidentiality and how release of information is permitted in accordance with 42 CFR Part 2; • toxicology testing procedures; • dispensation and the appropriate storage of medications when receiving take-homes; • HIV-spectrum and other infectious diseases such as HCV, tuberculosis, and sexually transmitted infections; • potential drug interactions; • agreements needed to exchange appropriate information within the network of consultants and referral agencies in accordance with HIPAA regulations and 42 CFR Part 2; • the prescriptions drug monitoring program (PDMP), if applicable, and how the OTP utilizes it; and • central registries and how programs utilize them? ***[42 CFR § 8.12(f)(5)]*** **SCORING: If 7 or more elements are present, enter a score of "4"; if 6 or less elements are present enter a score of zero. Reviewer's note should note all missing elements.**											✓ _____ ✕ _____	

Number of Applicable Questions Subtotal _____ Case Records Subtotal _____

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
B. ADMISSION PROCEDURES (cont'd)												
B.5. ➡ ***QUALITY INDICATOR*** Does each patient undergo a full medical examination with results of serology and other tests completed within 14 days of admission? ***[42 CFR Part 8.12(f)(2); 822.8(b)(4)]***											✓ _____ ✕ _____	
C. TREATMENT/RECOVERY PLANNING												
NOTE: 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 to reflect patient goals as appropriate.												
C.1. ➡ ***QUALITY INDICATOR*** Is a written person-centered treatment/recovery plan that begins with the assessment,incorporated into the patient record? ***[822.5(o); 822.8(h)(1)]***											✓ _____ ✕ _____	
C.2. Is there evidence that treatment/recovery plans are developed by the clinical staff member with primary responsibility for the patient (primary counselor), in collaboration with the patient and anyone identified by the patient as supportive to recovery goals? ***[822.8(h)(1)] (NOTE: If the patient 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.)***											✓ _____ ✕ _____	
C.3. Does the plan of treatment include each diagnosis identified at assessment? ***[822.8(h)(2)(i)]***											✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal		Case Records Subtotal	

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
C. TREATMENT/RECOVERY PLANNING (cont'd)												
C.4. ➡ *QUALITY INDICATOR* Does treatment planning: • address patient goals as identified through the assessment process and regularly updated as needed through progress notes; • include reference to/acknowledgement of any significant medical and psychiatric issues (including applicable medications) identified as part of the medical assessment process? • If the patient is pregnant or becomes pregnant, the treatment/recovery plan must include provisions for prenatal care or if the patient refuses or fails to obtain such care, the patient should acknowledge in writing that pre-natal care was offered, recommended, and refused. For patients who are pregnant, evidence of development of a plan of safe care was offered. ***[822.8(h)(2)(iii)(v); 822.8(l); OASAS LSB 2019-02]***										✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal		Case Records Subtotal	

STANDARDS OF CARE: Patient-Centered Plan of Treatment/Progress Notes

Exemplary

- ☐ Treatment plans reflect tailored approaches which incorporate person-centered, Strength-based, Trauma Informed, Recovery Oriented strategies.
- ☐ Strategies include evidence-based treatment approaches (CBT, Motivational Interviewing, etc.)
- ☐ Treatment plan goals, objectives, and services are linked to the measurement-based assessments, which are individualized and person-centered

Adequate

- ☐ Progress notes reflect the evolving needs of the patient and possible course of action to address those concerns
- ☐ Reflects previous goals. (although every goal does not need review at each note – reviewer notes consistency and attempts to connect goals and presenting issues.)
- ☐ The progress note includes the specific evidenced based interventions and planned next steps
- ☐ Narrative reflects collaboration/discussion with patient regarding their plan of treatment.
- ☐ Clinical observation /summation including clinical recommendations and reflect results of the service
- ☐ There is evidence that the plan of treatment is created and/or updated collaboratively by participant, clinician, and transdisciplinary team, as well as significant others involved with the participant's recovery

Needs Improvement

- ☐ Immediate Mental Health, Medical and Addiction needs that require stabilization. Have not been addressed
- ☐ MAT for OUD has not been explored
- ☐ Needs identified in the assessment are not addressed and no explanation is provided
- ☐ Plan of treatment is not documented in progress notes
- ☐ Participants unique insights /voice is not captured in counselor's reflections
- ☐ Interventions are not realistic to attain or do not reflect desired preferences or assessed needs
- ☐ Treatment plans have minimal or no evidence of addressing person centered strength based, trauma informed, recovery-oriented tenets regarding participants and families

FEEDBACK TO PROVIDER: Utilizing the Standards of Care criteria identified above, please provide specific feedback to the provider regarding whether the treatment/recovery or service plans demonstrate a patient-centered treatment approach.

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
C. TREATMENT/RECOVERY PLANNING (cont'd)												
C.5. ➡ *QUALITY INDICATOR* Is there evidence that treatment planning has occurred, with review and approval by the clinical staff person responsible for developing the plan, the patient, and the clinical supervisor? ***[822.8(h)(2)(vi)]***											✓ _____ ✕ _____	
C.6. ➡ *QUALITY INDICATOR* Is there evidence that treatment planning is addressed through the ongoing assessment process and regular progress notes? ***[822.8(i)]***											✓ _____ ✕ _____	
D. DOCUMENTATION OF SERVICE												
NOTE: For the following questions, review the progress notes that identify initial plan of services, a consistent pattern where the person's identified goals are discussed with on-going steps and progress delineated, significant areas of treatment plan are changed, and treatment services are provided as agreed upon).												
D.1. ➡ *QUALITY INDICATOR* Service delivery is documented in the patient record through regular progress notes that include, unless otherwise indicated, the type, content, duration and outcome of each service delivered to or on behalf of a patient, described and verified as follows: • be written and signed (physical or electronic signature) by the staff member providing the service; • indicate the date the service was delivered; • record the relationship to the patient's developing treatment goals described in the treatment/recovery plan; and • include,as appropriate and relevant, any recommendations, communications, or determinations for initial, continued or revised patient goals and/or treatment. ***[822.8(j)(1-4)]***										✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal			Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
D. DOCUMENTATION OF SERVICE (cont'd)												
NOTE: For the following questions, review the progress notes for the previous 30 patient visit days.												
D.2. ➡ ***QUALITY INDICATOR*** Does the patient case record demonstrate medical and treatment services consistent with the patient's treatment/recovery plan? ***[822.8(h)(2)(v)]*** ***((NOTE: This question refers to individual progress notes reflecting that treatment is progressing according to plan, and that the plan is being revised as needed via the plan portion of the notes in a way that is consistent with the issues identified.)***											✓ _____ ✕ _____	
D.3. If a patient has no contact with the program for a period of 60 days, is there documentation supporting the case record being left open? ***[822.8(r)] Note: Documentation supporting the case record being left open after 60 days would be indicating the intent of the patient returning for services.***											✓ _____ ✕ _____	
Do the individual and group counseling progress notes reflect services that are meaningful and person-centered? ***Corresponds to RO SRI Clinical Practices Question 12 - PRU completes and informs RO***											**QUESTION NOT SCORED** PLEASE PROVIDE SPECIFIC FEEDBACK REGARDING ANY RELATED ISSUES	
Where appropriate, do progress notes describe evidence-based treatment interventions specific to substance use/recovery? ***Corresponds to RO SRI Clinical Practices Question 12 - PRU completes and informs RO***											**QUESTION NOT SCORED** PLEASE PROVIDE SPECIFIC FEEDBACK REGARDING ANY RELATED ISSUES	
Where appropriate, do the charts reflect any enhanced services (e.g., (vocational/educational, financial assessment, psychiatric, peer support, etc.) were provided? ***Corresponds to RO SRI Clinical Practices Question 12 - PRU completes and informs RO***											**QUESTION NOT SCORED** PLEASE PROVIDE SPECIFIC FEEDBACK REGARDING ANY RELATED ISSUES	
Where appropriate, does the patient record/progress note reflect collaboration with other providers, family members, collateral contacts? *(individuals in support of patient's recovery goals)* ***Corresponds to RO SRI Clinical Practices Question 12 - PRU completes and informs RO***											**QUESTION NOT SCORED** PLEASE PROVIDE SPECIFIC FEEDBACK REGARDING ANY RELATED ISSUES	

Number of Applicable Questions Subtotal _____ Case Records Subtotal _____

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
E. TAKE-HOME MEDICATION												
E.1. ➡ *QUALITY INDICATOR* Does the medical director consider the following take-home criteria in determining whether a patient is responsible in handling opioid drugs for unsupervised use: • absence of recent use of drugs (opioid or non-narcotic), including alcohol; • regularity of clinic attendance; • absence of serious behavioral problems at the clinic; • absence of known recent criminal activity (e.g., drug dealing); • stability of the patient's home environment and social relationships; • length of time in comprehensive maintenance treatment; • assurance that take-home medication can be safely stored within the patient's home; and • whether the rehabilitative benefit the patient derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion? ***[822.11(c)(2); 42 CFR Part 8.12(i)(2)(i)(1)(i-viii)]*** ***(NOTE: When determining take-home schedules, the program must document sound clinical judgment that the patient is appropriate for the amount of medication dispensed. Each patient must be on a visit schedule that is most appropriate to clinical need, conducive to treatment progress, and supportive of rehabilitation. A prescribing professional may reduce a patient's visit schedule, when clinically indicated, to accommodate patient changes in need, progress, or rehabilitation.)***											✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal			Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (ACTIVE)	TOTAL	SCORE

Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
E. TAKE-HOME MEDICATION (cont'd)												
E.2. ➡ *QUALITY INDICATOR* If it is determined that a patient is responsible in handling opioid medications, beyond the single take-home dose for a day the clinic is closed (including Sundays and State and Federal holidays), are the following restrictions applied: • during the first 90 days of treatment, the take-home supply is limited to one dose per week; • in the second 90 days of treatment, the take-home supply is two doses per week; • in the third 90 days of treatment, the take-home supply is three doses per week; • in the remaining months of the first year, a patient may be given a maximum 6-day supply of take-home medication; • after 1 year of continuous treatment, a patient may be given a maximum 2-week supply of take-home medication; • after 2 years of continuous treatment, a patient may be given a maximum 1-month supply of take-home medication, but must make monthly visits? ***[822.11(c)(2); 42 CFR Part 8.12(i)(1)(3)(i-vi)]*** ***(NOTE: The above requirements pertain only to the use of methadone; take-home considerations for buprenorphine or naltrexone are not dependent on the time-in-treatment requirements. However, when determining take-home schedules for patients treated with buprenorphine, OTPs must document sound clinical judgment that the patient is appropriate for the amount of buprenorphine dispensed.)***										✓ _____ ✕ _____	Not scored at this time due to Ferderal flexibility regarding take-home
								Number of Applicable Questions Subtotal		Case Records Subtotal		

SECTION 1: PATIENT CASE RECORDS (ACTIVE)	TOTAL	SCORE

Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
F. TOXICOLOGY												
F.1. ➡ *QUALITY INDICATOR* Does the program promptly address the results of toxicology testing with patients and document both the results of toxicology tests and follow-up therapeutic interventions in the patient record? ***[42 CFR § 8.12(f)(6)]***											✓ _____ ✕ _____	
G. MEDICATION ADMINISTRATION												
G.1. ➡ *QUALITY INDICATOR* Does the initial dose of methadone not exceed 30 milligrams and the total dose for the first day shall not exceed 40 milligrams, unless the program physician documents in the patient's record that 40 milligrams did not suppress opioid abstinence symptoms? ***[42 CFR Part 8.12(h)(3)(ii)] (NOTE: In both instances, additional amounts may be given if the physician determines and immediately documents in the patient record that the initial dose is insufficient to relieve opioid withdrawal symptoms and opioid cravings.)***											✓ _____ ✕ _____	
G.2. Does the program evaluate the dosage and the patient, when a patient has missed several doses of medication? ***[42 CFR § 8.12(h)]*** ***(NOTE: Under no circumstances should standing orders be used to address these situations)***											✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal		Case Records Subtotal	

SECTION 1: PATIENT CASE RECORDS (ACTIVE)											TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	✓ = yes ✕ = no	From Scoring Table
G. MEDICATION ADMINISTRATION (cont'd)												
G.3. If a patient is prescribed FDA approved medications to treat SUD from another prescriber, is there documentation of contact with the existing program or practitioner prescribing such medications to maintain the patient on the medication? **[822.7(i)(1)]** **OR** For transfer patients, does the program continue the patient's approved medication dosage and take-home schedule unless new medical or clinical information requires medical staff to review and subsequently order a change? ***[822.8(g)(1)(v)]*** ***(NOTE: Any such changes must be explained to the patient prior to implementation and documented in the case record.)***											✓ _____ ✕ _____	
									Number of Applicable Questions Subtotal			Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (INACTIVE)						TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	✓ = yes ✕ = no	From Scoring Table
H. INVOLUNTARY DISCHARGE							
NOTE: For the following questions, review the patient records of five (5) patients who were discharged involuntarily.							
H.1. In cases of involuntary discharge, does the program director (or designee) implement the recommendation for discharge only after they/them: • reviews the recommendation to discharge to ensure that the reason(s) is fair, not arbitrary or capricious, and is serious enough to warrant discharge; • reviews and evaluates the patient's total response to treatment, in light of the recommendation to discharge; • confers with staff at a multidisciplinary meeting to discuss the patient's response to treatment and the recommendation to discharge; • confirms that, within reasonable clinical judgment, all incremental strength-based and trauma-informed interventions have been tried but without success, including consideration of transfer to another provider; and • provides a written notice to the patient that indicates the reason(s) for the recommended discharge as well as required information on how to appeal? ***[815.7(a)(1-5)]***						✓ _____ ✕ _____	
					Number of Applicable Questions Subtotal		Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (INACTIVE)						TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	✓ = yes ✕ = no	From Scoring Table
H. INVOLUNTARY DISCHARGE (cont'd)							
H.2. In cases of involuntary discharge, if the patient appeals, does the program: • meet with the patient to conduct the appeal no sooner than 24 hours after provision of the notice, to allow the patient time to seek the advice of others, if desired; • discuss with the patient the reasons to implement or rescind the recommendation to discharge; and • informs the patient in writing of the appeal decision to implement or rescind the recommendation to discharge no later than 72 hours after the appeal is made: ○ if discharge is decided after the appeal, assures that the patient receives information about treatment and referral options, and connections to such referrals if desired; ○ if rescission of the discharge is decided after the appeal, assure the patient full opportunity to continue treatment? ***[815.7(a)(6-7)]***						✓ _____ ✕ _____	
H.3. In cases of involuntary discharge, does the program ensure that no methadone dose taper shall begin until after completion of the aforesaid process and all efforts to transfer the patient to another provider of opioid full agonist medications have been exhausted? ***[815.7(b)]***						✓ _____ ✕ _____	
					Number of Applicable Questions Subtotal		Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (INACTIVE)						TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	✓ = yes ✕ = no	From Scoring Table
I. LEVEL OF CARE TRANSITION (DISCHARGE) PLANNING							
NOTE: For the following questions, review the patient records of five (5) successfully discharged patients.							
I.1. Are at least 8 random toxicology tests to be determined by the provider as clinically appropriate conducted per year? ***[822.7(f)(5)(i)]*** ***(NOTE: Applicable only for patients in receipt of methadone; otherwise, program simply shall maintain a policy on toxicology. Check for the last full year prior to the discharge date.)***						✓ _____ ✕ _____	
I.2. Is there evidence of level of care transition (discharge) planning, and does the plan include circumstances/reasons for transition? ***[822.8(a)(8)]***						✓ _____ ✕ _____	
I.3. Does the level of care transition (discharge) plan contain evidence of development in collaboration with the patient and any other collateral person(s) the patient chooses to involve? ***[822.8(r)(4)(i)]*** ***(NOTE: Collaboration can be documented via a signature or progress note.)*** ***(NOTE: If the patient 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 22.11)***						✓ _____ ✕ _____	
I.4. Is there evidence that the program continues to treat clients (including with MAT) while they are being referred to a different setting/program and while making every effort to coordinate a warm handoff to the receiving treatment team? ***[MAT Guidance]***						✓ _____ ✕ _____	
					Number of Applicable Questions Subtotal		Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (INACTIVE)						TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	✓ = yes ✕ = no	From Scoring Table
I. DISCHARGE & DISCHARGE PLANNING (cont'd)							
I.5. Do the level of care transition (discharge) plans specify: • referrals with appointment dates and times, if applicable; • all known medications, including frequency and dosage; • recommendations for continued care; and • an appointment with an appropriate provider to continue access to approved medications to treat the patient's SUD? ***[822.8(r)(4)(i-ii)]***						✓ _____ ✕ _____	
I.6. Was the level of care transition (discharge) plan reviewed and approved by the responsible clinical staff member and clinical supervisor prior to discharge? ***[822.8(r)(5)]*** ***(NOTE: This requirement does not apply to patients who stop attending, refuse continuing care planning or office-based opioid treatment, or otherwise decline to participate in the discharge planning process.)***						✓ _____ ✕ _____	
I.7. Is the portion of the level of care transition (discharge) plan, which includes referrals for continuing care, given to the patient upon discharge? ***[822.8(r)(5)]*** ***(NOTE: Documentation may be in the form of a progress note or duplicate form.)***						✓ _____ ✕ _____	
Was there a "warm hand off" for the aftercare referral? *Corresponds to RO SRI Clinical Practices Question 12 - PRU completes and informs RO*						**QUESTION NOT SCORED** PLEASE PROVIDE SPECIFIC FEEDBACK REGARDING ANY RELATED ISSUES	
				Number of Applicable Questions Subtotal		Case Records Subtotal	

SECTION 1: PATIENT CASE RECORDS (INACTIVE)						TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	✓ = yes ✕ = no	From Scoring Table
I. DISCHARGE & DISCHARGE PLANNING (cont'd)							
I.8. Is there evidence that patients and their family /significant other(s) were offered overdose prevention/education/training and a naloxone kit or prescription upon discharge? ***[822.8(r)(5)]*** ***(NOTE: The offer to Family/significant other(s) is applicable if they were involved with the patient in their treatment service.)***						✓ _____ ✕ _____	
Are the circumstances of the patient discharge clearly described in the progress notes? (Part 822 FAQ) Corresponds to RO SRI Clinical Practices Question 12 - PRU completes and informs RO						**QUESTION NOT SCORED** PLEASE PROVIDE SPECIFIC FEEDBACK REGARDING ANY RELATED ISSUES	
					Number of Applicable Questions Subtotal		Case Records Subtotal

STANDARDS OF CARE: Level of Care Transition (Discharge) Planning

Exemplary

- ☐ The agency utilizes a system to follow up with participants or other providers post-discharge and, to confirm appointment was kept, and aids in linking to new services as needed
- ☐ Where a participant is going from a bedded service to another service, a warm hand-off or peer service is utilized
- ☐ The discharge plan includes goals toward establishing meaningful engagement in community to support long-term recovery and includes-community mental health, primary care physicians, housing, employment and recovery/ wellness supports. Circumstances of discharge and efforts to re-engage if the discharge had not been planned

Adequate

- ☐ Arrangements for appropriate services (appointment dates, contact names and numbers, etc.) are made and discussed with the participant and significant others prior to planned discharge
- ☐ Discharge summaries identify services provided, the participants response, and progress toward goals
- ☐ The discharge summary and other relevant information is made available to receiving service providers prior to the participant's arrival

Needs Improvement

- ☐ Participants are discharged with no assessment of needs or plan for follow up services
- ☐ Discharge summaries are missing or do not summarize the course of treatment
- ☐ Discharge planning does not reflect participant and staff collaboration

FEEDBACK TO PROVIDER: Utilizing the Standards of Care criteria identified above, please provide specific feedback to the provider regarding whether the discharge planning protocols demonstrate a patient-centered treatment approach.

SECTION 1: PATIENT CASE RECORDS (INACTIVE)						TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	✓ = yes ✕ = no	From Scoring Table
J. MONTHLY REPORTING							
J.1. Are the admission dates reported to OASAS consistent with the admission dates (date of the first medication dose) recorded in the patient case records? ***[810.14(e)(7)]***						✓ ____ ✕ ____	
J.2. Is the discharge disposition reported to OASAS consistent with documentation in the patient case records? ***[810.14(e)(7)]***						✓ ____ ✕ ____	
J.3. Are the discharge dates reported to OASAS consistent with the discharge dates (date of last face-to-face contact) recorded in the patient case records? ***[810.14(e)(7)]***						✓ ____ ✕ ____	
					Number of Applicable Questions Subtotal		Case Records Subtotal

SECTION 1: PATIENT CASE RECORDS (SEEN BUT NOT ADMITTED)						TOTAL	SCORE
Patient Record Numbers ▶	#1	#2	#3	#4	#5	✓ = yes ✕ = no	From Scoring Table
K. SEEN BUT NOT ADMITTED							
NOTE: For the following questions, review completed assessments of five (5) individuals who were assessed, but not admitted to the Opioid Treatment Program.							
K.1. Do the patient case records contain the name of the physician (authorized QHP) who made the **decision not to admit** as documented by their dated signature (physical or electronic)? ***[822.8(a)(3)(iii-iv); 822.8(b)(5)]***						✓ ____ ✕ ____	
K.2. ➡ ***QUALITY INDICATOR*** In cases where an individual is deemed ineligible for admission, is there: • documentation that the individual was informed of the reason(s); and • if applicable, a referral to an appropriate program? ***[822.8(b)(5)]***						✓ ____ ✕ ____	
K.3. Is there evidence that the program does not summarily exclude individuals from being admitted because of polysubstance use, discontinuance of MAT, nor administratively discharge clients solely on the basis of continued substance use and/or polydrug use? ***[822.8(b)(6); MAT Standards] ? (NOTE: If there is evidence of exclusion, a citation should be made)***						✓ ____ ✕ ____	
K.4. Is there evidence the program does not exclude admission to the program solely because the client is on another medication that confers increased risk of overdose or other adverse outcome? **[822.8(b)(6); 815.5(a)(21); MAT Standards]** ***(NOTE: If there is evidence of exclusion, a citation should be made).***						✓ ____ ✕ ____	
					Number of Applicable Questions Subtotal		Case Records Subtotal
					Number of Applicable Questions Total		Case Records Total

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE

A. POLICIES AND PROCEDURES/ADMINISTRATION			
A.1. Does the program register with the Drug Enforcement Agency (DEA), do they have certification by the Center for Substance Abuse Treatment (CSAT) and are they accredited by a federally approved accrediting body (TJC; CARF)? ***[822.3(a)]*** ***(NOTE: Copies of registration, certification and accreditation are required by OASAS.)***			
A.2. ➡ ***QUALITY INDICATOR*** Has the program made any change to their written policies, procedures, or methods since the last OASAS recertification review? If so: a. Do those changes comport with **822.7**?	a.		
b. If so, has the program communicated and educated those changes to staff and/or clients?	b.		
c. In all instances, did the reviewed case records reflect the above written policies and procedures?	c.		
A.3. Problem Gambling Designation Only Does the program demonstrate methods governing the provision of Problem Gambling services to patients in compliance with Office regulations including a description of each service provided which address, at a minimum: a. Standards of conduct for staff related to providing clinical treatment, self-help support or any other professional service in another independent program, community and/or private practice setting ***[857.7(a)(1)]***	a.		
b. Provisions to admit without a full diagnosis for a gambling disorder; ***[857.7(a)(2)]***	b.		
c. Services must include financial counseling and planning (on site or by referral) ***[857.7(a)(3)]***	c.		
B. MEDICATION SECURITY			
B.1. ➡ ***QUALITY INDICATOR*** Is access to controlled substances, including approved medications, limited to authorized persons (e.g., medical staff) in accordance with applicable state and federal law? ***[822.11(d)(1)]***			
B.2. Are areas where controlled medication stocks are maintained, dispensed, or administered physically separated and secure from patient areas in accordance with applicable state and federal law? ***[822.11(d)(1)]***			
B.3. Does the program have a perpetual and accurate inventory of all in-stock medications including controlled substances as: • every dose administered or dispensed is captured electronically or recorded on an administration sheet at the time the medication is administered or dispensed and recorded on the patient's individual medication dose history • the qualified person administering or dispensing the medication either signs or initials each notation • if initials are used, the fill signature of the qualified person administering or dispensing the medication appears at the bottom of each page of the medication sheet • the number of dispensed medication doses is totaled in milligrams on a daily basis; and • programs must calibrate their medication-dispensing instruments according to the manufacturer recommendations to ensure accurate patient dosing and medication tracking? ***[42 CFR § 8.12 (g)]*** ***(NOTE: Any theft or loss of approved medications must be immediately reported in accordance with applicable state and federal law.)***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
B. MEDICATION SECURITY (cont'd)			
B.4. Does the program purge drug containers immediately after administration by rinsing, inversion, or by an acceptable alternative method that must effectively prevent the accumulation of residual medication? ***[822.11(d)(2)]***			
B.5. Does the program ensure that medication containers used in the program or for take-home medications are child resistant, and destroyed and not reused? ***[822.11(d)(2)]***			
B.6. Does the program have a process to dispose of controlled substances consistent with state and federal licenses? ***[10 NYCRR Part 80.51]***			
B.7. Does the program utilize options to dispose of controlled substances in a manner that does not have a negative environmental impact when possible (e.g., take back programs, reverse distributor arrangements) ? ***[10 NYCRR Part 80.51]***			
C. MEDICATION ADMINISTRATION			
C.1. Is methadone administered or dispensed only in oral form and formulated in such a way as to reduce its potential for abuse? ***[42 CFR Part 8.12(h)(3)(i)]*** ***(NOTE: OTPs should dispense dry medication diskettes or tablets in one single bottle to patients who report to the clinic once or twice per month and receive 15-30 day supplies of medication.)***			
C.2. ➡ ***QUALITY INDICATOR*** Do medical staff directly observe medication administration on-site or ingestion until the medication dissolves in the mouth? ***[TIP 63; pages 183, 227, 307]***			
C.3. If applicable, does the program receive prior OASAS approval for split medication doses? ***[822.11(b)(3)]*** ***(NOTE: An individual exemption is required.)***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
D. QUALITY IMPROVEMENT/UTILIZATION REVIEW			
D.1. ➡ ***QUALITY INDICATOR*** Does the provider have a: • utilization review process; • quality improvement committee; and • written plan that identifies key performance measures? ***[822.7(c)]*** ***BASIC Joint Review:*** *PRU completes this question* ***ADMINISTRATIVE Joint Review:*** *Corresponds to RO SRI Administrative Section 1 Question 9 - RO completes and informs PRU*			
D.2. Are any multi-disciplinary team meetings documented as follows: • date; • attendance; • cases reviewed; and • recommendations? ***[822.8(k)]*** ***(NOTE: The multi-disciplinary must include one CASAC, one QHP in a discipline other than alcoholism and substance abuse counseling, and where applicable, one medical staff member).*** (***If the treatment service has a gambling designation on their operating certificate, the multi-disciplinary team must include Qualified Problem Gambling Professional (QPGP)*** *Corresponds to RO SRI Clinical Practices Question 12 - PRU completes and informs RO*			
D.3. Does the program leadership demonstrate a systematic process for assigning individuals to clinicians, based on clinician experience, skill, training, and background? ***[822.7(k)(5)]; [822 Clinical Standards (A)(II)(4)(1)]***			
D.4. Is there evidence of a systematic process, and the concomitant policies and procedures to monitor, review, and track clinician caseloads by size, complexity of individuals and other factors? ***[822.7(k)(5); 822 Clinical Standards (A)(II)(4)(2)]***			
D.5. Does the program consider intensity of treatment in determining caseload, as evidenced by program staff who are responsible for individuals receiving a high intensity of services or who have high severity of symptoms having lower caseloads than staff who are responsible for lower severity and intensity of services? ***[822.7(k)(5); 822 Clinical Standards (A)(II)(4)(3)]***			
D.6. Is there evidence of methods of reviewing staffing sufficiency, including quality indicators (treatment plans on time, individuals are seen regularly, perception of care indicators, staff reports, etc.) that would trigger a staff caseload review? ***[822.7(j)(5); 822 Clinical Standards (A)(II)(4)(4)]***			
D.7. Do productivity standards exist that allow for appropriate clinical care and address fiscal viability? ***[822.7(k)(5); 822 Clinical Standards (A)(II)(4)(5)] (NOTE: Request documentation supporting evidence of the productivity standards e.g. Policy, Quality Improvement Plan).***			
E. OPERATIONAL REQUIREMENTS			
E.1. Is there a designated area provided for locked storage and maintenance of patient case records? ***[814.4(c)(3)]*** ***(NOTE: Federal Regulation 42 CFR § 2.16(a) states that records must be kept in a secure room, locked file cabinet, safe or other similar container.)***			
E.2. **For programs with a Problem Gambling Designation**: Are case records of patients admitted for a primary problem gambling concern, without a secondary SUD diagnosis, stored separately from case records of patients admitted for a primary, or secondary, SUD diagnosis? ***[(857.5(d)(2)]*** ***(NOTE: for Electronic Health Records – case records are only accessible to those working within the Problem Gambling Designation)***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
E. OPERATIONAL REQUIREMENTS (cont'd.)			
E.3. ➡ ***QUALITY INDICATOR*** Does the provider maintain an emergency medical kit at each certified location which includes: • basic first aid supplies; and • naloxone emergency overdose prevention kits in a quantity sufficient to meet the needs of the program? ***[822.7(b)(1); OASAS Local Services Bulletin No. 2020-02]*** *Corresponds to RO SRI Program Environment Question 8 - RO completes and informs PRU*			
E.4. Has the provider developed and implemented a plan to have staff trained in the prescribed use of a naloxone emergency overdose prevention kit such that it is available for use during all program hours of operation? ***[822.7(b)(1)]*** *Corresponds to RO SRI Program Environment Question 9 - RO completes and informs PRU*			
E.5. Has the provider notified all staff and patients of the existence of the naloxone emergency overdose prevention kit and the authorized administering staff? ***[822.7(b)(2)]*** *Corresponds to RO SRI Program Environment Question 9 - RO completes and informs PRU*			
E.6. Has the program developed necessary procedures, including disaster plans, to assure continuous services in emergencies or disruption of operations in accordance with OASAS guidelines and accreditation standards? ***[822.7(d)]***			
E.7. Does the program operate at least six days per week? ***[822.7(m)]***			
E.8. Does the program: • provide flexible dosing hours that meet patient needs, providing access for clients with varying schedules; and give patients an appointment for all visits, including medication dispensing, which allow for program operation with limited wait times? ***[822.7(m)]***			
E.9 Does the program maintain the command and control document, with either the Board Chair or CEO signature, and a log, with Executive Director signature, acknowledging the annual review of Emergency Preparedness protocols? ***[OASAS Local Service Bulletin 2019-05]*** ***(NOTE: the command and control document is generated by the respective organization with the signature of either the Board Chair and or CEO affirming review and approval of Emergency Preparedness protocols.)***			
F. MONTHLY REPORTING			
F.1. ➡ ***QUALITY INDICATOR*** Have data reports (*PAS-44N, PAS-45N & PAS-48N*) been submitted to OASAS timely and reflect accurate admission and discharge transactions? ***[810.14(e)(7)]*** ***(REVIEW GUIDANCE: Prior to on-site review, obtain a copy of the Client Roster-Admissions, Client Roster-Discharges and MSD Program History Reports from the OASAS Client Data System. Review these documents to determine timeliness (Admissions/PAS-44N must be submitted within 30 days of the admission date; Discharges/PAS-45N must be submitted within 35 days of the date last treated; Monthly Service Delivery reports/PAS-48N must be submitted by the 10th day of the month following the report month) of data submission and overall consistency for the previous six months. Additional location information should also be included. While on-site, compare the total number of active patients, as stated on the Client Roster Report, to the actual number of active patients, as indicated by the program administrator.***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
G. STAFFING [Complete Personnel Qualifications Work Sheet]			
G.1. ➡ *QUALITY INDICATOR* Is the **clinical director** of the program who is responsible for the daily activities and supervision of services provided, a QHP who has at least three years of full-time clinical experience in the substance use disorder field, one of which was supervisory, prior to appointment? ***[822.7(k)(1)]*** ***(NOTE: An OTP may have a part-time on-site clinical director only if the OTP is part of a multiple OTP system or part of a larger health, mental health or substance use disorder service. Such an OTP must designate and assign all clinical director responsibilities to another staff member qualified and capable of completing all duties.)***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

STANDARDS OF CARE: Clinical Supervision

Clinical Supervision should address the following:

- Person-Centered Care
- Trauma Informed practices
- Strength Based services
- Recovery Oriented Systems of Care
- Evidenced Based Practices
- Diagnostic assessment
- Evaluation
- Intervention
- Referral
- Individual substance use disorder counseling
- Group substance use disorder counseling
- Crisis management

Exemplary

- ☐ Clinical Supervision should be provided by staff with appropriate levels of training and education who are strength-based and trauma informed, and possess demonstrated experience in delivering chemical dependency treatment services for each element of care
- ☐ Individual and group supervision sessions result in the identification of individual and agency-wide training needs, policy and procedure reviews, etc.
- ☐ The agency demonstrates an ongoing training program in evidence-based **practices** (EBPs), and most staff have received training in one or more EBPs
- ☐ All clinicians will have completed FIT or equivalent training to address co-occurring needs of the population

Adequate

- ☐ Clinical supervision by appropriate leadership staff on a regular basis for all clinicians is provided and documented
- ☐ The frequency of supervision is dependent upon the acuity of service
- ☐ The frequency of supervision is increased for new vs. experienced staff.
- ☐ Provision is made for prompt supervision in times of crisis or increased need, clinicians demonstrate knowledge of the method to request ad hoc supervision, and there is evidence that this has been used
- ☐ Issues or needs identified related to staff performance are addressed in supervision, training, or by other methods
- ☐ Regularly scheduled clinical in-service training is provided by the agency and staff attendance is documented

Needs Improvement

- ☐ Clinical supervision is not provided on a regular basis (per policy)
- ☐ All clinicians, regardless of experience, have the same level of supervision.
- ☐ Supervisory sessions appear to deal more with administrative than clinical matters
- ☐ Clinical supervision occurs only in groups, not individually
- ☐ There is minimal evidence of staff training
- ☐ No performance evaluation system or other methods to assess and evaluate staff performance are evident

FEEDBACK TO PROVIDER: Utilizing the Standards of Care criteria identified above, in conjunction with the clinical supervision policy, supervision minutes, and staff interviews, please provide specific feedback to the provider regarding whether clinical supervision is provided appropriately.

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
G. STAFFING (cont'd) [Complete Personnel Qualifications Work Sheet]			
G.2. ➡ ***QUALITY INDICATOR*** Is the **medical director** of the program a physician licensed and currently registered as such by the New York State Education Department and has at least one year of education, training, and/or experience in substance use disorder services? ***[822.7(k)(2); 800.4(h)(1)]*** **►►►RED FLAG DEFICIENCY if no physician on staff.◄◄◄**			
G.3. Does the **medical director** have overall responsibility for: • medical services provided by the program; • oversight of the development and revision of policies, procedures and ongoing training; • collaborative supervision with the program director of non-medical staff in the provision of substance use disorder services; • supervision of medical staff in the performance of medical services; • assistance in the development of necessary referral and linkage relationships with other institutions and agencies; and • to ensure the program complies with all federal, state and local laws and regulations? ***[800.4(h)(1)(i-vi)]*** ***(NOTE: Documentation might be found in job description, policies and procedures, supervision minutes, etc.)***			
G.4. ➡ ***QUALITY INDICATOR*** Does the **medical director** hold • a board certification in addiction medicine from a certifying entity appropriate to their primary or specialty board certification and; • a Federal DATA 2000 waiver (buprenorphine-certified)? ***[800.4(h)(2)]*** ***(NOTE: Physicians may be hired as probationary medical directors if not so board certified but must obtain board certification within four (4) years of being hired.)***			
G.5. Do **all doctors, physician assistants and nurse practitioners** employed hold a Federal DATA 2000 waiver (buprenorphine-certified)? ***[800.6(d)]***			
G.6. Are medical staff trained in emergency response treatment and have they completed regular refresher courses/drills on handling emergencies? ***[822.7(k)(3)(i)]***			
G.7. ➡ ***QUALITY INDICATOR*** Does the program have at least the equivalent of two full-time on-site nurses for up to 300 patients, one of whom is a registered nurse (or nurse practitioner)? ***[822.7(k)(3)(iv)]***			
G.8. If the program is approved to serve more than 300 patients, is there one additional full-time nurse for each additional 150 patients or part thereof? ***[822.7(k)(3)(iv)]***			
G.9. Is there a nurse present at all times when medication is being administered? ***[822.7(k)(3)(iv)]*** ***(NOTE: A registered nurse or nurse practitioner must be present or immediately available by telephone when services are provided by a licensed practical nurse.)***			
G.10. Is there an individual on staff designated as the **health coordinator**, to ensure the provision of education, risk reduction, counseling, and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases? ***[822.7(k)(4)]*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 8 - RO completes and informs PRU*			
G.11. Is there an individual on staff designated as the **Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) liaison?** ***[822.7.(l)(6); OASAS Local Services Bulletin 2019-07]***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
G. STAFFING (cont'd) [Complete Personnel Qualifications Work Sheet]			
G.12. Is sufficient prescriber coverage available to meet the needs of individuals without undue delay, or a process is in place to assure individuals have access to prescription services when needed? ***[800.6(a)]***			
G.13. ➡ ***QUALITY INDICATOR*** Is there at least one full-time qualified health professional (QHP) on staff who is a Credentialed Alcoholism and Substance Abuse Counselor (CASAC)? ***[822.7(k)(6)]***			
G.14. ➡ ***QUALITY INDICATOR*** Is there at least one full-time qualified health professional (QHP) on staff, qualified in a discipline other than substance use disorder counseling, other than a CASAC? ***[822.7(k)(6)]***			
G.15. ➡ ***QUALITY INDICATOR*** Are at least 50 percent of all clinical staff qualified health professionals (QHPs)? ***[822.7(k)(7)]*** ***(NOTE: CASAC Trainees (CASAC-T) may be counted towards satisfying the 50 percent requirement however such individuals may not be considered qualified health professionals for any other purpose under this Part.)***			
G.16. Are Certified Recovery Peer Advocates: • appropriately certified; and • supervised by a clinical staff member who is a QHP? ***[822.7(l)(3)]*** ***(NOTE: Peer Advocates must be certified by the NY Certification Board*** http://www.asapnys.org/ny-certification-board or https://nycb.certemy.com**)**			
G.17. If the program employs security staff who are not clinical staff, does the program ensure that the security staff: • are not involved in clinical services; • receive training on confidentiality of patient information; and • adhere to such federal confidentiality laws? ***[822.7(l)(4)]***			
►►► THE FOLLOWING ADDITIONAL STAFFING QUESTIONS APPLY TO DESIGNATED PROBLEM GAMBLING SERVICES ONLY ◄◄◄			
G.18. ➡ ***QUALITY INDICATOR*** **For Programs with a Problem Gambling Designation,** is the Clinical Supervisor a Qualified Problem Gambling Professional (QPGP)? ***[857.7 (b)(2)(i)]*** ***(NOTE: If the Clinical Supervisor is not a QPGP, request documentation confirming: 1) the Clinical Supervisor is pursing the QPGP, 2) notification was provided to Regional Office of non-compliance, 3) direct clinical staff is receiving supervision approved by OASAS (another clinical supervisor that meets the QPGP criteria either from an OASAS provider or the New York Council on Problem Gambling Clinical Supervision group). If the documentation is provided, acknowledge it in the citation and if it cannot be provided indicate this in the citation.)***			
G.19. ➡ ***QUALITY INDICATOR*** **For Programs with a Problem Gambling Designation,** are all counselors providing direct problem gambling treatment QPGP? ***[857.7(b)(2)(ii)]***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
G. STAFFING (cont'd) [Complete Personnel Qualifications Work Sheet]			
G.20. ➡ ***QUALITY INDICATOR*** **<u>For Programs with a Problem Gambling Designation,</u> i**s there documentation that all clinical staff receive training on problem gambling and gambling disorder? ***[857.7 (b)(2)(iii)]***			
G.21. ➡ ***QUALITY INDICATOR*** **<u>For Programs with a Problem Gambling Designation,</u>** is there documentation that all QPGP have received ten (10) hours of advanced problem gambling clinical training within the past three years? ***[857.7 (b)(2)(iv)]***			
H. SERVICES			
H.1. Is there documentation that the program directly provides the following: • admission assessment, including, if clinically indicated, a screen for problem gambling; • treatment/recovery planning and review; • trauma-informed individual and group counseling; • medication for addiction treatment; • toxicology testing; • post-treatment planning; • medication administration and observation; • medication management; • brief intervention and brief treatment; • collateral visits; • complex care coordination; • outreach; • peer support services; • overdose prevention education and naloxone education & training; and • safety plan development? **[*822.7(f)(1-15)]*** ***(NOTE: Each program must conduct toxicology tests to be determined by the provider as clinically indicated, in addition to the Federal OTP requirements.)***			
I. JUSTICE CENTER (For the following 2 questions, review a sample of 5 applicable program employees)			
I.1. Does the provider have documentation that all employees have read and understand the *Code of Conduct for Custodians of People with Special Needs* as attested by signature and date upon hiring and on an annual basis? ***[836.5(e)]*** ***(NOTE: Check all attestations subsequent to the prior recertification review date; a copy should be maintained in the employee personnel file.)*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 8 - RO completes and informs PRU*			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
I. JUSTICE CENTER (cont'd)			
I.2. ➡ ***QUALITY INDICATOR*** For all employees hired **after July 1, 2013 OR subsequent to the prior recertification review date** who have the potential for regular and substantial unrestricted and unsupervised contact with patients/residents, did the provider maintain: • an *Applicant Consent Form for Fingerprinting for OASAS Criminal Background Check* (TRS-52) signed and dated by the applicant? ***[805.5(d)(3)]*** • documentation verifying that the Staff Exclusion List was checked? ***[702.5(b)]*** • documentation verifying that the Statewide Central Register was checked? ***[Social Services Law 424-a(b)]*** • documentation verifying that a criminal background check was completed? ***[805.7(c)]*** ***(NOTE: All hospital-based Article 28 providers are exempt from these requirements.)*** *Corresponds to RO SRI Incident Reporting, Justice Center & Patient Advocacy Question 2 - RO completes and informs PRU*			
J. COMMUNITY RELATIONS/DIVERSION CONTROL			
J.1. ➡ ***QUALITY INDICATOR*** Has the program developed and implemented a community relations plan that describes actions responsive to reasonable community needs? ***[822.7(e)]*** ***(NOTE: Such community relations plans may include, but not be limited to, formation of community patrols to ensure that patients are not loitering, and formation of a Community Committee that meets regularly to discuss actions to improve community relations.)***			
J.2. ➡ ***QUALITY INDICATOR*** Has the program developed and implemented a diversion control plan (DCP) which: • includes specific measures to reduce the possibility for diversion of controlled substances from legitimate treatment use; and • assigns specific responsibility to the medical and administrative staff of the OTP for carrying out the diversion control measures and functions described in the DCP? ***[800.6(e)]***			
K. INCIDENTS/INCIDENT REPORTING			
K.1. ➡ ***QUALITY INDICATOR*** Does the program have an incident management plan which incorporates the following: • identification of staff responsible for administration of the incident management program; • provisions for annual review by the governing authority; • specific internal recording and reporting procedures applicable to all incidents observed, discovered or alleged; • procedures for monitoring overall effectiveness of the incident management program; • minimum standards for investigation of incidents; • procedures for the implementation of corrective action plans; • establishment of an Incident Review Committee; • periodic training in mandated reporting obligations of custodians and the Justice Center code of conduct; and • provision for retention of records, review and release pursuant to Justice center regulations and Section 33.25 of Mental Hygiene Law? ***[836.5(b)(1-9)]*** ***SCORING: If all elements are present, enter a score of "4"; if one or two elements are missing, enter a score of "2"; if three or more elements are missing, enter a score of "0".*** *Corresponds to RO SRI Incident Reporting, Justice Center & Patient Advocacy Question 1 - RO completes and informs PRU*			
K.2. Does the provider maintain documentation of the required quarterly reports from the Incident Review Committee which compile the total number of incidents by type and its findings and recommendations? ***[836.5(f)(8)]*** *Corresponds to RO SRI Incident Reporting, Justice Center & Patient Advocacy Question 5 - RO completes and informs PRU*			
Number of Applicable Questions Subtotal		Service Management Subtotal	

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
L. TOBACCO-USE IN ADULT SERVICES (TOBACCO-LIMITED or TOBACCO-FREE)			
L.1. Does the **tobacco-limited program** (if applicable) have written policies and procedures, approved by the program sponsor, which address: • defines the parts of the facility and vehicles where tobacco use is not permitted; • defines designated areas on facility grounds where limited use of certain tobacco products by patients is permitted in accordance with guidance issued by the Office and Public Health Law Section 1399-O; • use of nicotine delivery systems by patients shall not be permitted; • use of tobacco products and/or nicotine delivery devices by family members and other visitors shall not be permitted in the facility, on facility grounds or in facility vehicles; • limits tobacco products that patients can bring, and that family members and other visitors can bring to patients admitted to the program to closed and sealed packages of cigarettes; • requires all patients, staff, volunteers, and visitors be informed of the tobacco-limited policy including posted notices and the provision of copies of the policy; • establishes a policy prohibiting staff and volunteers from using tobacco products or nicotine delivery systems when they are on the site of the program, from purchasing tobacco products or nicotine delivery systems for, or giving tobacco products or nicotine delivery systems to patients, and from using tobacco products or nicotine delivery systems with patients; • describes employee assistance programs and other programs that will be made available to staff who want to stop using tobacco products, nicotine delivery systems, or other nicotine containing products; • establishes evidence-based harm reduction and cessation treatment modalities for patients who use tobacco products or nicotine delivery systems, in accordance with guidance from the Office; • establishes a policy prohibiting patients from using tobacco products during program hours except for the limited use of certain tobacco products in designated areas of the facility grounds at designated times, in accordance with guidance issued by the Office; • describes required annual training for staff, including clinical, non-clinical, administrative and volunteers about tobacco products, nicotine dependence, and tobacco use disorder that is sufficient for the program to operate a holistic approach to tobacco use disorder that is evidenced in progress notes, policies and procedures, perception of care, and outcomes; • describes tobacco and nicotine prevention and education programs made available by the service to patients, staff, volunteers and others; • establishes procedures, including a policy to address patients who continue to use or return to use of tobacco products or nicotine delivery systems. ***[856.5(a)]*** ***NOTE: Tobacco-limited services must submit an attestation form to the Office of the Chief Medical Officer attesting that their tobacco-limited policies and procedures meet the criteria outlined in Tobacco-Limited Services guidance.*** ***SCORING: If all elements are present, enter a score of "4"; if one or two elements are missing, enter a score of "2"; if three or more elements are missing, enter a score of "0".*** *Corresponds to RO SRI Program Environment Question 2 - RO completes and informs PRU*			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
L. TOBACCO-USE IN ADULT SERVICES (TOBACCO-LIMITED or TOBACCO-FREE) (cont'd)			
L.2. Does the **tobacco-free** program (if applicable) have written policies and procedures, approved by the program sponsor, which address: • defines the parts of the facility and vehicles where tobacco use is not permitted; • requires all patients, staff, volunteers, and visitors be informed of the tobacco free policy including posted notices and the provision of copies of the policy; • establishes a policy prohibiting staff and volunteers from using tobacco products or nicotine delivery systems when they are on the site of the program, from purchasing tobacco products or nicotine delivery systems for, or giving tobacco products or nicotine delivery systems to patients, and from using tobacco products or nicotine delivery systems with patients; • describes employee assistance programs and other programs that will be made available to staff who want to stop using tobacco products, nicotine delivery systems, or other nicotine-containing products; • establishes evidence-based harm reduction and cessation treatment modalities for patients who use tobacco products or nicotine delivery systems, in accordance with guidance from the Office • prohibits patients, family members and other visitors from bringing tobacco products and paraphernalia to the program; • describes required annual training for staff, including clinical, non-clinical, administrative and volunteers about tobacco products, nicotine dependence, and tobacco use disorder that is sufficient for the program to operate a holistic approach to tobacco use disorder that is evidenced in progress notes, policies and procedures, perception of care, and outcomes; • describes tobacco and nicotine prevention and education programs made available by the service to patients, staff, volunteers and others; establishes procedures, including a policy to address patients who continue to use or return to use of tobacco products or nicotine delivery systems. ***[856.5(a)]*** *Corresponds to RO SRI Program Environment Question 2 - RO completes and informs PRU*			
L.3. Does the program adhere to each of its tobacco-limited or tobacco-free policies, as identified above? ***[856.5(a)]*** *Corresponds to RO SRI Program Environment Question 2 - RO completes and informs PRU*			
M. GAMBLING-FREE SERVICES			
M.1. For Programs with a Problem Gambling Designation, does the program have written policies and procedures and methods approved by the program sponsor, which: • Define the facility, vehicles and grounds which are gambling-free; • Prohibit patients, family members, vendors, or other visitors from participating in any gambling activity while at the service; • Require all patients, staff, volunteers, and visitors be informed of the gambling-free policy including posted notices and the provision of copies of the polices; • Prohibit staff from participating in any gambling activity while at work, during work hours; • Prohibit any participation in any type of gambling activity on an electronic device, including, smart phone or computer while at the service, on the grounds, or in a Provider's vehicle. • Establish a gambling free policy for staff while they are on the site of the service; • Establish gambling free activity policies for the facility which includes not promoting or participating in any gambling activities as a recreational activity for patients and staff; • Describe training on gambling, gambling disorder and its relationship to substance use disorder that includes the prevention of gambling disorders, potential relapse triggers, and cross-addiction to staff including clinical, non-clinical, prevention, administrative and volunteers; • Describe gambling prevention and education materials made available by the facility to patients, staff, volunteers and others; • Establish procedures for service and/or referral to assist patients who are identified either through screening or self-report a potential gambling problem; and • Describe local community linkages for the prevention, treatment and recovery of gambling disorder if said facility does not provide the service directly. ***[OASAS Local Services Bulletin No. 2019-01]*** ***[SCORING: If all elements are present, enter a score of "4"; if one or two elements are missing, enter a score of "2"; if three or more elements are missing, enter a score of "0".]***			
M.2. Does the program adhere to each of its gambling-free policies, as identified above? ***[OASAS Local Services Bulletin No. 2019-01]***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
N. PATIENT RIGHTS POSTINGS			
N.1. ➡ ***QUALITY INDICATOR*** Are statements of patient rights and participant responsibilities, including the toll-free hotline numbers of the Justice Center Vulnerable Persons' Central Register **[1-855-373-2122]** and the OASAS Patient Advocacy **[1-800-553-5790]** posted prominently and conspicuously throughout the facility? ***[815.4(a)(2)]*** ***(NOTE: Part 815 includes statements of patient rights and participant responsibilities based upon Sections 815.5 and 815.6. and must be readily accessible and easily visible to all patients and staff. Justice Center and Patient Advocacy postings that do not stand out or that blend in with other postings do not suffice as prominently posted. For hospital-owned and/or hospital-affiliated programs, these postings can be the same as what hospitals are required to post; however, such postings need to include the Justice Center and OASAS as additional contacts.)*** *Corresponds to RO SRI Program Environment Question 7 - RO completes and informs PRU*			
N.2. Is there at least one prominent posting that includes the name and contact information of the clinic director/program director of the OASAS-certified program? ***[815.4(a)(2)]*** ***(NOTE: This posting can be separate from or together with the statements of patient rights and patient responsibilities and the OASAS 800 phone number in the question immediately above. Unlike the above question, this posting can be in only one place as long as it is prominently posted such as upon immediately entry to a facility or behind a receptionist desk.)*** *Corresponds to RO SRI Program Environment Question 7 - RO completes and informs PRU*			
O. PRIORITY OF ADMISSIONS			
►►► THE FOLLOWING QUESTION APPLIES TO ALL PROVIDERS; ◄◄◄			
O.1. Does the program have written policies and procedures, approved by the program sponsor, which establish immediate admission preference in the following order: • pregnant persons; • people who inject drugs; • parent(s)/guardian(s) of children in or at risk of entering foster care; • individuals recently released from criminal justice settings; • those with chronic immune defidiency; • current or past opioid dependency; and • all other individuals? ***[800.5(b); 822.8(e)]*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 1-7 - RO completes and informs PRU*			
P. SAPT BLOCK GRANT REQUIREMENTS (IF APPLICABLE)			
►►► THE FOLLOWING QUESTIONS APPLY TO OASAS-FUNDED PROVIDERS ONLY; IF NOT FUNDED, ALL QUESTIONS ARE TO BE MARKED "N/A" ◄◄◄			
These requirements apply to OASAS-funded providers ONLY. OASAS annually receives Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funding. To maximize use of this resource, OASAS requires all funded services to address the following SAPT Block Grant service requirements either directly or through arrangement with other appropriate entities. QUESTIONS FROM PROVIDERS SHOULD BE DIRECTED TO THE APPROPRIATE REGIONAL OFFICE.			
P.1. For an OASAS-funded provider, does the program have written policies and procedures, approved by the governing authority, which address outreach to pregnant and parenting persons and persons who inject drugs? ***[45 CFR Part 96]*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 1-7 - RO completes and informs PRU*			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
P. SAPT BLOCK GRANT REQUIREMENTS (cont'd) (IF APPLICABLE)			
P.2. For an OASAS-funded provider that treats persons who inject drugs, does the program have a written policy to: • admit individuals in need of treatment not later than 14 days after making a request; OR • admit individuals within 120 days if interim services are made available within 48 hours? ***[45 CFR Part 96]*** ***(NOTE: Interim services includes counseling and education about HIV, TB, risks of needle sharing, risks of transmission, steps that can be taken to ensure HIV and TB transmission does not occur and referral for HIV and TB services.)*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 1-7 - RO completes and informs PRU*			
P.3. For an OASAS-funded provider that treats persons who inject drugs and/or pregnant persons and persons with dependent children (including persons attempting to regain custody of their children), does the program have a written policy to: • maintain a wait list and ensure clients are admitted or transferred as soon as possible (unless treatment is refused, or they cannot be located); and • maintain contact with individuals on wait list? ***[45 CFR Part 96]*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 1-7 - RO completes and informs PRU*			
P.4. For an OASAS-funded provider that treats pregnant persons and persons with dependent children (including persons attempting to regain custody of their children), does the program have a written policy to: • refer pregnant persons to another provider when there is insufficient capacity to admit; and • within 48 hours, make available interim services (counseling and education about HIV, TB, risks of needle sharing, referral for HIV and TB services if necessary, counseling on the effects of alcohol and other drug use on the fetus and a referral for prenatal care) if a pregnant persons cannot be admitted due to lack of capacity? ***[45 CFR Part 96]*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 1-7 - RO completes and informs PRU*			
P.5. For an OASAS-funded provider that treats pregnant persons and persons with dependent children (including persons attempting to regain custody of their children), does the program have a written policy to: • admit both parents and their children (as appropriate); • provide or arrange for primary medical care, prenatal care, pediatric care (including immunizations); • provide or arrange for childcare while the parents are receiving services; • provide or arrange for gender-specific treatment and other therapeutic interventions; • provide or arrange for therapeutic interventions for children in custody of parents in treatment; and • provide or arrange for case management and transportation services to ensure parents and their children can access treatment services? ***[45 CFR Part 96]*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 1-7 - RO completes and informs PRU*			
P.6. For an OASAS-funded provider which self-identify themselves as a religious organization/faith-based program, does the program have a written policy to: • prohibit State Aid funding for activities involving worship, religious instruction or proselytization; and • include outreach activities that does not discriminate based on religion, religious belief, refusal to hold a religious belief or refusal to participate in a religious practice? ***[45 CFR Part 96]*** *Corresponds to RO SRI Initial Intake & Priority Admissions Question 1-7 - RO completes and informs PRU*			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

SECTION 2: SERVICE MANAGEMENT	YES	NO	SCORE
Q. RESIDENTIAL OTP REQUIREMENTS (IF APPLICABLE)			
►►► THE FOLLOWING QUESTIONS APPLY TO RESIDENTIAL OTPs ONLY; OTHERWISE, ALL QUESTIONS ARE TO BE MARKED "N/A" ◄◄◄			
Q.1. Does the **Residential OTP** provide at least 40 hours per week of required clinical services within a structured therapeutic environment? ***[819.9 (b)]*** ***(NOTE: The provider should indicate which activities are considered clinical in nature.)***			
Q.2. Does the **Residential OTP** have written policies and procedures, approved by the governing authority, which address's clinical supervision and related procedures? ***[819.3 (a)(12)]***			
Q.3. Does the **Residential OTP** have written policies and procedures, approved by the governing authority, which address procedures for emergencies? ***[819.3 (a)(13) OASAS Local Services Bulletins 2019-05 & 2019-06]***			
Q.4. Does the **Residential OTP** have written policies and procedures, approved by the governing authority, which address procedures for the ordering, procuring, and disposing of medication, as well as the self-administration of medication? ***[819.3 (a)(10); OASAS Local Services Bulletin 2022-01]***			
Q.5. Does the **Residential OTP** ensure that the following services are available either directly or by referral, as clinically indicated: • counseling (Evidence-based, person-centered, trauma informed individual, group and family counseling as appropriate)? • supportive services (legal, mental health, social services, vocational assessment and counseling as appropriate)? • educational and childcare services (for residential services that provide services to school-age children)? • structured activity and recreation (activities designed to improve leisure time skills, social skills, self-esteem and responsibility)? • orientation to community services (identifying and obtaining housing and other case management services)? ***[819.3(e)(1-5)]***			
Q.6. If the **Residential OTP** is engaged in the storage, possession or dispensing of controlled substances by non-medical personnel, do they have prior approval and licensure by the New York State Department of Health (NYSDOH) as an Institutional Dispenser? ***[OASAS Local Services Bulletin 2022-01]***			
R. RESIDENTIAL OTP REQUIREMENTS (IF APPLICABLE)			
►►► THE FOLLOWING QUESTIONS APPLY TO RESIDENTIAL OTPs ONLY; OTHERWISE, ALL QUESTIONS ARE TO BE MARKED "N/A" ◄◄◄			
R.1. Is there a full-time on-site Director whose duties shall include overseeing the day-to-day operations of the **Residential OTP**? ***[819.9(d)(1)]***			
R.2. Is there Is there at least one responsible staff person awake and on during late evening and night shifts at the **Residential OTP**? ***[819.9(d)(2)]***			
R.3. Is there sufficient staff to ensure that counseling and rehabilitation services are available and responsive to the needs of each resident. ***[(819.9(d)(3)]***			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

Number of Applicable Questions Total _____ Service Management Total _____

SECTION 3: FACILITY REQUIREMENTS AND GENERAL SAFETY	YES	NO	SCORE
A. FACILITY REQUIREMENTS			
A.1. Is the facility maintained: ▪ in a state of repair which protects the health and safety of all occupants; and ▪ in a clean and sanitary manner? ***[814.4(a)]*** ***(NOTE: This question refers to the facility's overall condition. The facility should be maintained in a condition that provides a safe environment which is conducive to recovery; however, the results of single or isolated minor facility maintenance issues should not be the basis for a citation.)*** • **Serious Facility Issue – CITATION ISSUED; Provider must submit acceptable CAP to receive Operating Certificate.** o *Examples: inoperable fire alarm; broken boiler; blocked egress; inoperable toilet; mold or mildew; etc.* • **Minor Facility Issue – REVIEWER'S NOTE ISSUED; Provider must submit acceptable CAP to receive Operating Certificate.** o *Examples: poor lighting; threadbare carpet; broken outlet covers; holes in wall; inadequate furnishings; etc.* • **Facility Recommendation – RECOMMENDATION NOTE ISSUED; Provider must work with Regional Office to address recommendation.** o *Examples: eventual replacement of boiler or roof; construction; etc.*			

Number of Applicable Questions Subtotal _____ Service Management Subtotal _____

STANDARDS OF CARE: Physical Environment

Exemplary

- ☐ Premises support a trauma informed environment that promotes emotional and physical safety, openness, and respect. (i.e., consciousness of male to female ratios, quiet space)
- ☐ The environment is welcoming and attractive (for example: comfortable furniture, beverages in the waiting area, up to date reading materials, and decorated offices) to the age groups and cultural groups served at the facility
- ☐ The premises are decorated and furnished in a welcoming manner specific to the prevalent cultural groups served at the facility
- ☐ A waiting area is available for children/families
- ☐ The program has materials promoting recovery and sharing success stories available in the waiting area
- ☐ Outcomes from Participant Satisfaction surveys, suggestion boxes and complaints are displayed prominently including the actions taken by the provider to improve services based on participant feedback

Adequate

- ☐ The premises are maintained in a clean condition and are welcoming
- ☐ Individual counseling space and group rooms ensure confidentiality
- ☐ A sufficient number of restrooms are available for use by recipients and staff
- ☐ Participant living space - square footage; is responsive to the participants medical, mental health, physical status, and gender identification
- ☐ Comfortable temperatures are maintained in all areas of the clinic
- ☐ In waiting rooms, offices and throughout the building, literature, photos, reading material and toys are reflective of the populations served. These materials should be up to date, maintained and safe

Needs Improvement

- ☐ The premises need extensive maintenance to ensure a comfortable place to receive services
- ☐ Literature, photos, reading material and toys are not reflective of the population served and those using the waiting area
- ☐ Negative messages such as "all cell phones will be confiscated" or "no packages can be dropped off for participants in treatment" are posted in the waiting and reception areas
- ☐ The physical plant cannot contain the staff and participants in the space allocated. (i.e., insufficient group rooms, lack of privacy, etc.)

FEEDBACK TO PROVIDER: Utilizing the Standards of Care criteria identified above, please provide specific feedback to the provider regarding whether the premises support a trauma informed environment that promotes safety, openness, and respect.

SECTION 3: FACILITY REQUIREMENTS AND GENERAL SAFETY	YES	NO	SCORE
A. FACILITY REQUIREMENTS (cont'd)			
A.2. Are current and accurate facility floor plans maintained on site and, upon request, provided to OASAS? ***[814.5(b)]*** ***(NOTE: Part 820 Reintegration Scatter-Site Housing and Part 819 Supportive Living Apartments are exempt from this requirement.)***			
A.3. Do all spaces where counseling occurs afford privacy for both staff and patients? ***[814.4(c)(1)]*** ***(NOTE: With or without the use of sound generating devices, voices should not be transmitted beyond the counseling space.)*** ***(NOTE: Part 820 Reintegration Scatter-Site Housing and Part 819 Supportive Living Apartments are exempt from this requirement.)***			
A.4. Are separate bathroom facilities made available to afford privacy? ***[814.4(c)(2)]*** ***(NOTE: Part 820 Reintegration Scatter-Site Housing and Part 819 Supportive Living Apartments are exempt from this requirement.)***			
A.5. Is there a separate area available for the proper storage, preparation and use or dispensing of medications, medical supplies and first aid equipment? ***[814.4(c)(6)]*** ***(NOTE: Storage of all medications must be provided for in accordance with the requirements set forth in Title 21 of the Code of Federal Regulations, section 1301.72, and Title 10 NYCRR, section 80.50. Syringes and needles must be properly and securely stored.)*** ***(NOTE: Part 820 Reintegration Scatter-Site Housing and Part 819 Supportive Living Apartments are exempt from this requirement.)***			
B. GENERAL SAFETY			
B.1. Are fire drills conducted at least quarterly for each shift (i.e., three shifts per quarter) at times when the building is occupied **OR** for programs certified by OASAS and co-located in a general hospital, as defined by Article 28 of the Public Health Law, did they follow a fire drill schedule established and conducted by the hospital? ***[814.4(b)(1)]*** ***(NOTE: Part 820 Reintegration Scatter-Site Housing and Part 819 Supportive Living Apartments are exempt from this requirement.)***			
B.2. Is a written record maintained on-site indicating: ▪ the time and date of each fire drill; ▪ the number of participants at each drill; and ▪ the length of time for each evacuation? ***[814.4(b)(1)(i)]*** ***(NOTE: Part 820 Reintegration Scatter-Site Housing and Part 819 Supportive Living Apartments are exempt from this requirement.)***			
B.3. Are fire regulations and evacuation routes posted in bold print on contrasting backgrounds and in conspicuous locations and do they display primary and secondary means of egress from the posted location? ***[814.4(b)(1)(ii)] (NOTE: Part 820 Reintegration Scatter-Site Housing and Part 819 Supportive Living Apartments are exempt from this requirement.)***			
B.4. Is there at least one communication device (e.g., telephone, intercom) on each floor of each building accessible to all occupants and identified for emergency use? ***[814.4(b)(2)]***			
B.5. Is there documentation of annual training of all employees in the classification and proper use of fire extinguishers and the means of rapid evacuation of the building? ***[814.4(b)(3)]*** ***(NOTE: Such training must be maintained on site for review.)***			

Number of Applicable Questions Subtotal		Facilities Subtotal	

SECTION 3: FACILITY REQUIREMENTS AND GENERAL SAFETY	YES	NO	SCORE
B. GENERAL SAFETY (cont'd)			
Maintenance and testing of hard wired (permanently installed) fire alarm systems, fire extinguishers, and heating systems must be conducted by a certified vendor; documentation must be maintained on-site.			
B.6. Is there documentation maintained of annual inspections and testing of the fire alarm system (including battery operated smoke detectors and sprinklers)? ***[814.4(b)(4)]*** ►►►**RED FLAG DEFICIENCY if Fire Alarm System is not operational at the time of the review.**◄◄◄			
B.7. Is there documentation maintained of annual inspections and testing of fire extinguishers? ***[814.4(b)(4)]***			
B.8. Is there documentation maintained of annual inspections and testing of emergency lighting systems? ***[814.4(b)(4)]***			
B.9. Is there documentation maintained of annual inspections and testing of illuminated exit signs? ***[814.4(b)(4)]***			
B.10. Is there documentation maintained of annual inspections and testing of environmental controls (e.g., HEPA filter)? ***[814.4(b)(4)]***			
B.11. Is there documentation maintained of annual inspections and testing of heating and cooling systems conducted? ***[814.4(b)(4)]***			

Number of Applicable Questions Subtotal		Facilities Subtotal	

Number of Applicable Questions Total		Facilities Total	

QUALITY INDICATOR COMPLIANCE SCORE WORKSHEET			Enter Quality Indicator Total Score on the Level of Compliance Determination Schedule.		
Section 1: Resident Case Records			**Section 2: Service Management**		
QUESTION #	**ISSUE**	**SCORE**	**QUESTION #**	**ISSUE**	**SCORE**
1 ► A.3.	physician evaluation – opioid use disorder		**1► A.2**	Policies and Procedures updated since last visit	
2 ► A.6.	admission assessment information		**2 ► B.1.**	access only by authorized staff	
3 ► B.1.	QHP – admission decision and approved by MD, PA, NP, etc		**3 ► C.2.**	observe and verify ingestion	
4 ► B.5.	physical exam – admission		**4 ► D.1.**	UR, QI, key performance measures	
5 ► C.1.	initial plan of treatment		**5 ► E.3.**	first-aid kit with naloxone emergency overdose kit	
6 ► C.4.	treatment planning addresses patient goals, medical and psychiatric issues and provisions for pre-natal care.		**6 ► F.1.**	monthly reporting	
7 ► C.5.	treatment planning approval clinical staff, patient, clinical supervisor		**7 ► G.1.**	QHP clinical director (part-time if <100)	
8 ► C.6.	treatment planning through ongoing assessment and regular progress notes		**8 ► G.2.**	Medical Director is physician **[RED FLAG]**	
9 ► D.1.	progress notes – documentation		**9 ► G.4.**	Medical Director has DATA 2000 waiver	
10 ► D.2.	services consistent with treatment plan		**10 ► G.7.**	equivalent of 2 FT nurses; at least 1 RN	
11 ► E.1.	take home - minimum criteria		**11 ► G.13.**	FT QHP who is a CASAC	
12 ► E.2.	take home – timeframes/doses		**12 ► G.14.**	FT QHP other than a CASAC	
14 ► F.1.	positive toxicology properly addressed		**13 ► G.15.**	50 percent QHPs or CASAC-Ts	
14 ► G.1.	Initial medication dosage		**14 ► I.2.**	Justice Center background checks	
15 ► K.2.	ineligible individuals - reason and referral		**15 ► J.1.**	Community Relations Plan	
			16 ► J.2.	Diversion Control Plan	
# of questions ►		**Quality Indicator Total Score ►**	**17 ► K.1.**	incident management plan	
			18 ► N.1.	patient rights postings	
			Additional Quality Indicators ► Problem Gambling Designation Services		
			19 ► G.18.	Clinical Supervisor (QPGP)	
			20 ► G.19.	counselors providing direct gambling treatment (QPGP)	
			21 ► G.20.	all clinical staff receive gambling training	
			22 ► G.21.	QPGP ten hours advanced problem gambling clinical training	
			# of questions ►	**Quality Indicator Total Score ►**	

LEVEL OF COMPLIANCE DETERMINATION SCHEDULE

OVERALL COMPLIANCE SCORES

	SCORE		# OF QUESTIONS		FINAL SCORE
Patient Case Records ►		÷		=	
Service Management ►		÷		=	
Facilities/Safety ►		÷		=	

QUALITY INDICATOR COMPLIANCE SCORES

	SCORE		# OF QUESTIONS		FINAL SCORE
Patient Case Records ►		÷		=	
Service Management ►		÷		=	

LOWEST OVERALL or QUALITY INDICATOR COMPLIANCE SCORE ►

LEVEL OF COMPLIANCE SCORING DETERMINATION

The Level of Compliance Rating is determined by **EITHER** the lowest of the Overall and Quality Indicator Final Scores **OR** a Red Flag Deficiency (automatic six-month conditional Operating Certificate)

LEVEL OF COMPLIANCE DETERMINATION TABLE

0.00 – 1.75 = NONCOMPLIANCE
1.76 – 2.50 = MINIMAL COMPLIANCE
2.51 – 3.25 = PARTIAL COMPLIANCE
3.26 – 4.00 = SUBSTANTIAL COMPLIANCE

RED FLAG DEFICIENCY

Please check if there is a RED FLAG DEFICIENCY in the following area(s):

☐ No Physician on staff (Section 2; G.2.)
☐ Fire Alarm not operational (Section 3; B.6.)

VERIFICATION

Regulatory Compliance Inspector	Date	Regulatory Compliance Inspector signature indicates that all computations in the Instrument and scores on this page have been verified. Supervisor or Peer Reviewer signature indicates verification of all computations on this page.
Supervisor or Peer Reviewer	Date	

INSTRUCTIONS FOR PERSONNEL QUALIFICATIONS WORKSHEET

Employee Name -- Employee Title ▶	Enter employee name and present title or position, including the clinical director and medical director. (example: **Roberta Jones – Clinical Director; Dr. Carol Granger – Medical Director; Joe Smith – Counselor Assistant**)
Number of Weekly Hours Dedicated to this Operating Certificate ▶	Enter the number of the employee's weekly hours that are dedicated to this Operating Certificate. (example: **35 hours, 40 hours, 5 hours**)
Work Schedule ▶	Enter the employee's typical work schedule for this outpatient program. (example: **Mon,Wed,Fri 8am-5pm; Thu-Sun 11pm-7am; per diem**)
Education ▶	Enter the highest degree obtained or the highest grade completed. (example: **MSW; Associate's; GED**)
Experience ▶	List general experience and training in substance use disorder services. (example: **3 yrs. CD Counseling; 14 yrs. in Addictions or Substance Use Disorder field**)
Hire Date ▶	Enter the date the employee was hired to work for this provider.
SUD Counselor Scope of Practice ▶	Enter the code for the Career Ladder Counselor Category for each employee. **A** = Counselor Assistant **B** = CASAC Trainee **C** = Provisional QHP **D** = CASAC **E** = CASAC Level 2 **F** = QHP (other than CASAC) **G** = Advanced Counselor **H** = Master Counselor
QHP ▶	Enter a check mark (✓) if the employee is a Qualified Health Professional (QHP).
License/Credential # -- Expiration Date ▶	Enter License and/or Credential number and expiration date, if applicable. (example: **CASAC #1234 – 09/30/22; CASAC Trainee #123 – 07/15/19; LCSW #321 – 11/15/20; MD #7890 – 06/30/21**)

WHEN COMPLETED, PLEASE REMEMBER TO SIGN AND DATE THE ATTACHED FORM(S)

MAKE AS MANY COPIES AS NECESSARY

PERSONNEL QUALIFICATIONS WORKSHEET

PROVIDER LEGAL NAME

Employee Name / Employee Title	Number of Weekly Hours Dedicated to this Operating Certificate	Work Schedule	Education	Experience	Hire Date	SUD Counselor Scope of Practice (ENTER CODE)	QHP	License/Credential # / Expiration Date	Verified (Office Use Only)
									☐ Code ☐ JC ☐ Credential
									☐ Code ☐ JC ☐ Credential
									☐ Code ☐ JC ☐ Credential
									☐ Code ☐ JC ☐ Credential
									☐ Code ☐ JC ☐ Credential
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									☐ Code ☐ JC ☐ Credential
									☐ Code ☐ JC ☐ Credential
									☐ Code ☐ JC ☐ Credential

I hereby attest to the accuracy of the above stated information and verify that each staff member meets the requirements for the level they are functioning in. Filing a false instrument may affect the certification status of your program and potentially result in criminal charges.

PROVIDER REPRESENTATIVE	DATE	LEAD REGULATORY COMPLIANCE INSPECTOR	DATE