

## Substance Abuse Services (Outpatient) 2009-2010

**Definition of Service:** Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e. alcohol and/or legal and illegal drugs) in an outpatient setting, rendered or under the supervision of a physician, or by other qualified staff. (HRSA definition)

**Objectives for Service:**

- To provide substance abuse medical treatment and/or substance abuse counseling services.
- To ensure that clients have access to quality services through experienced and trained staff.
- To refer to a licensed medical provider for psychotropic medicine management.

STANDARD	MEASURE
<b>Service Standards:</b>	
The client's eligibility for Ryan White Part B services is determined before services are initiated.	Documentation of the client's eligibility is present in the client's record.
The client is referred by a Ryan White Part B Provider is made to initiate substance abuse treatment. The client may self-refer.	Documentation of the referral or form is present in the client's record. If self-referred, documentation of the initial contact is present in the client's record, signed and dated.
Provider must identify the therapeutic framework/model used to provide interventions for the client.	Description of the therapeutic framework/model used must be in the policy manual of the agency and is available for review.
Providers comply with state and federal (HIPAA) confidentiality statutes.	A written statement regarding confidentiality is signed by each employee and available for review. Services are provided in accordance with confidentiality (HIPAA) statutes.

<p><b>Assessment:</b></p> <p>An initial assessment of each client must be conducted <b>within 10 days of initial contact</b> before the initiation of substance abuse treatment. The substance abuse assessment will include the following:</p> <ol style="list-style-type: none"> <li>1) Substance abuse history and current status</li> <li>2) medical history and current health status</li> <li>3) availability of food, shelter, transportation, financial resources</li> <li>4) support system</li> <li>5) legal issues/custody status</li> <li>6) mental health status, co-existing conditions</li> <li>7) emergency contact information</li> <li>8) communication with collateral service providers with informed consent, as applicable</li> </ol>	<p>Documentation of the assessment <b>within 10 days of initial contact</b> with signature/credentials and date must be present in the client's record to support need for substance abuse treatment.</p>
<p><b>Treatment Plan:</b></p>	
<p>Provider will determine if client is appropriate for individual or group therapy.</p>	<p>Documentation of this determination and rationale must be in the client's record.</p>
<p>An individualized plan of care (treatment plan) will be developed in collaboration with the client and the substance abuse counselor. The client is offered a copy of this plan.</p>	<p>Documentation of the completed plan will be present in the client's record, signed and dated by the client and the substance abuse counselor. If client declines a copy, documentation is present in the client's record.</p>
<p>The plan of care must use evidence based interventions and include the following:</p> <ol style="list-style-type: none"> <li>1) contain measurable treatment goals</li> <li>2) time frames</li> <li>3) outcome assessment</li> <li>4) risk reduction to prevent HIV transmission</li> </ol>	<p>Documentation of the plan of care is present in the client record, signed and dated, with evidence-based interventions.</p>
<p>Progress notes should include type of service provided, frequency of service, type of contact (face to face, phone, e-mail).</p>	<p>Progress notes are signed and dated by the support staff and present in the client's record.</p>
<p>Follow-up visits to provide or monitor treatments and assess progress towards treatment goals will be determined by the licensed substance abuse professional.</p>	<p>Documentation of the plan of care and the follow up visits will be recorded in the client's record and signed and dated</p>
<p><b>Psychotropic Drugs:</b></p>	
<p>The monitoring of psychotropic drugs where applicable must be documented in the client's record. Documentation must include assessment of and education on medication side effects.</p>	<p>Documentation of the Medications list, assessment for side effects, and education must be present, signed and dated in the client's record.</p>

<b>Reassessment:</b>	
The plans of care must be reassessed at a minimum of <b>every 90 days</b> .	Documentation of the plan of care reassessment <b>every 90 days</b> signed and dated must be both client and provider present in the client's record.
<b>Referrals:</b>	
The provider discusses with client support services available and makes appropriate referrals.	Documentation of this discussion and referrals made along with follow up that appropriate outcomes occurred must be in the client's record.
If the provider is unable to meet the needs of the client, a referral will be made to the appropriate substance abuse professional or an appropriate referral to necessary services.	Documentation of this referral will be present on the client's record.
<b>Discharge:</b>	
The client and the provider should discuss follow up/after care.	Documentation of the follow up/after care must be signed and dated by the therapist and client and be present in the client's record.
The provider and client should discuss plans for discharge after treatment goals are reached or services are no longer needed.	Documentation of the discharge plan must be signed and dated by the therapist and client and be present in the client's record.
<b>Qualifications:</b>	
All substance abuse treatment providers possess and maintain licenses, and/or certifications as required by the Commonwealth of Virginia.	Copies of licenses and/or certifications are available for review.
<b>Annual Training Requirement:</b>	
All providers must complete 2 hours of continuing education in HIV/AIDS annually.	Documentation of completion of the continuing education must be kept in the licensed substance abuse professional personnel file.
<b>Third Party Payer:</b>	
When the agency is a third-party provider, the subcontractor maintains a client record to provide adequate documentation on the record for accountability of primary medical care provided by payee.	At a minimum, the third payer's record must contain a statement(s) of: <ol style="list-style-type: none"> <li>1. Referral</li> <li>2. Initial assessment</li> <li>3. Individualized treatment plan</li> <li>4. Notes of all contacts and dates of service</li> <li>5. Reassessment of treatment plan</li> <li>6. Referrals and follow-ups</li> <li>7. Discharge plan</li> <li>8. All reports must be signed and dated.</li> </ol>
<b>Qualifications of Third-Party Payer:</b>	
All substance abuse treatment providers possess and maintain licenses, and/or certifications as required by the Commonwealth of Virginia.	Copies of licenses and/or certifications are available for review.

