Substance Abuse Treatment Services-Outpatient Standards[i]

Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening;
- Assessment;
- Diagnosis; and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA or HAB-specific guidance.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people living with HIV, including the following:

1.0 Intake and Eligibility

National Monitoring Standards: Eligibility determination process requiring documentation in client medical records of low-income status and eligibility based on a specified percent of the FPL and proof of an individual's HIV-positive status, residency. Determination and documentation of client eligibility every six months.[ii]

Health Resources and Services Administration (HRSA), the funder for Ryan White HIV Services, prohibits continued HIV services, including medications to clients who are not recertified for eligibility of services by their specified date; therefore, if a client has not completed their annual certification or recertification at six months they may not be eligible for Ryan White services.[iii]

Standard	Measure
Referral	
1.1) Self-referral or referral for Substance Abuse Services by a Part B provider is documented prior to initiation of the service.	1.1) Documentation of referral for outpatient substance abuse services is present in the client's record, signed and dated.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services is determined.	1.2) Documentation of the client's eligibility is present in the client's record.
1.3) 1.3) To be eligible for this service applicants must: a) Be diagnosed with HIV b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Ryan White Part B is the payer of last resort and other funding sources must be vigorously pursued. Providers are responsible to ensure that clients are screened and deemed ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third party payers such as private and commercial insurance plans, and other payers. e) Provide recertification every six months with proof of income, changes in insurance coverage, or any changes in residency f) **Client eligibility ensures Part B services are used as the payer of last resort.** Client must agree to participate in the insurance option client is eligible and that best meets the client's medical needs regardless of preference. *Note:* The Part B Program is the payer of last resort. This is interpreted as "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by another payment source.[iv] Apply through the VDH Central Office or through agency's eligibility services	1.3) Documentation is present in files that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status (gap of services) e) Recertification for continued eligibility for Part B services every six months f) Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

Intake	
1.4) Eligibility screening and intake to be completed within 15 days of initial contact with client.	1.4) Documentation of intake and eligibility screening in client record signed and dated by the provider.
Recertification	
1.5) Client must be recertified every six months to continue to receive Ryan White services. There is no grace period.	1.5) Documentation of recertification of the client's eligibility every six months is present in the client's record.
2.0 Key Services Components and Activities (including assessment and service plan) ***Substance Abuse Treatment Services (Outpatient) support eligible activities, including: a) Pre-treatment/recovery readiness programs, b) Harm reduction c) Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse, d) Outpatient drug-free treatment and counseling, e) Opiate Assisted Therapy, f) Neuro-psychiatric pharmaceuticals, g) Relapse prevention, and h) Limited acupuncture services with a written physician referral. Services are provided on an outpatient basis only.[v] Documentation that the use of funds for acupuncture services is: a) limited through some form of defined cap; b) Acupuncture is not the dominant treatment modality.[vi]***	
Standard	**Measure**
Documentation	
2.1) All substance abuse services provided is documented in client record.	2.1) Documentation of mental health services is in client's record signed and dated.
2.2) When a third party provides service, the sub-recipient must maintain a client record. At a minimum, the third party's record must contain: • Referral; • Initial assessment; • Individualized treatment plan, including treatment modality and frequency and quantity of treatments; • Documentation of all contacts & dates of service; • Reassessment of treatment plan to include monitoring and assessment of client progress; • Referrals and follow-ups; and • Discharge plan. All reports must be signed and dated.	2.2) Signed, dated reports located in the client's record at the third party's office.
Assessment/Service Plan/Provision of Services	

2.3) An initial substance abuse assessment of client's needs to be completed within 10 days of initial contact with client and prior to the initiation of the service plan. Assessment to include: • Substance use history and current status • Medical history and current health status • Availability of food, shelter, transportation, financial resources • Support system • Legal issues/custody status • Mental health status and co-existing conditions.	2.3) Documentation of assessment in client's record signed and dated.
2.4) If substance abuse serves are deemed appropriate, a substance abuse treatment plan is developed within 15 days within date of the initial assessment to include: • Diagnosed condition • Treatment modality (individual or group) • Treatment goals • Start date for services • Projected end date for services • Recommended number of sessions • Reassessment dates of client progress. *Note:* Substance abuse services must be provided by or under the supervision of a physician or other qualified/licensed personnel. (*See section 5.0 Personnel Qualifications)*	2.4) Documentation of treatment plan in client's record signed and dated.
2.5) A complete psychosocial assessment will be completed. Results of the assessment will be used to complete the treatment plan as necessary.	2.5) Documentation of complete psychosocial assessment in client's record signed and dated.

2.6) Substance abuse services, provided as group or individual sessions, should be specific to individual client needs. Progress notes should be completed for every counseling session and include: • Session date and duration • Focus of session and observations • Assessment and interventions • Newly identified issues/goals • Client's responses to interventions and referrals.	2.6) Documentation of substance abuse services provided in client's record signed and dated.
2.7) Treatment options shall be a joint decision between the client and provider and should address the full spectrum of substance use. Services are limited to the following: • Pre-treatment/recovery readiness programs • Harm reduction • Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse • Outpatient drug-free treatment and counseling • Opiate Assisted Therapy • Neuro-psychiatric pharmaceutical • Relapse prevention • Limited acupuncture services. *Note:* For any client receiving acupuncture services, a written referral from the primary care provider must be in the client file.	2.7) Documentation of treatment modalities employed in client's record signed and dated. If provided, referral for services in client's record signed and dated.
2.8) Treatment plan is reviewed at least every 12 sessions and modified as appropriate.	2.8) Documentation of review and update of treatment plan as appropriate signed and dated.
2.9) Refer client to other medical, mental health and other services as appropriate, e.g. psychiatric services, mental health services, in-patient hospitalization, case management.	2.9) Documentation of referrals made and status of outcome in client's record.

Transition and Discharge	
2.10) Client discharged when substance abuse (outpatient) services are no longer needed, goals have been met, upon death or due to safety issues. (*see 2.11*) Prior to discharge: Reasons for discharge and options for other service provision should be discussed with client. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter must be sent to client's last known address. If client is not present to sign for the letter, it must be returned to the provider. Documentation: Client's record must include: a) Date services began b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable Transfer: If client transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made.	2.10) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable.

Withdrawal from Service: If client reports that services are no longer needed or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the client's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, the case must be reviewed by leadership according to that agency's policies. Clients who are discharged for administrative reasons must be provided written notification of and reason for the discharge, and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart.	
Case Closure	
2.11) Case will be closed if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the mental health assistance staff for a period of three months despite three	2.11) Documentation of case closure in client's record with clear rationale for closure.

(3) documented attempts to contact client; g) Can no longer be located; h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits pattern of abuse as defined by agency's policy. j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or k) Is deceased.	
3.0 Client Rights and Responsibilities ***National Monitoring Standards: Provision of Part B funded HIV primary medical care and support services, to the maximum extent, without regard to either: the ability of the individual to pay for such services, or the current or past health conditions of the individuals served.***[vii]	
Standard	**Measure**
3.1) Services are available and accessible to any individual who meets program eligibility requirements. All providers shall be in compliance with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the American's with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services on the basis of the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	3.1) Written eligibility requirements and non-discrimination policy on file.
3.2) Clients Rights and Responsibilities policy exists which requires each client to sign & date a form indicating they has been offered: a) explanation of the policy, and	3.2) Written policy on file.

b) copy of *'Client's Rights and Responsibilities* and to communicate patient's understanding of the policy.	
3.3) Explanation of *Client's Rights and Responsibilities* is provided to each patient. Client rights include: o Be treated with respect, dignity, consideration, and compassion; o Receive services free of discrimination; o Be informed about services and options available. o Participate in creating a plan of services; o Reach an agreement about the frequency of contact the client will have either in person or over the phone. o File a grievance about services received or denied; o Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; o Voluntary withdraw from the program; o Have all records be treated confidentially; Have information released only when: o A written release of information is signed; o A medical emergency exists; o There is an immediate danger to the client or others; o There is possible child or elder abuse; or o Ordered by a court of law. Client responsibilities include: o Treat other clients and staff with respect and courtesy; o Protect the confidentiality of other clients; o Participate in creating a plan of service; o Let the agency know any concerns or changes in needs;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by patient and located in patient's record.

○ Make and keep appointments, or when possible, phone to cancel or change an appointment time; ○ Stay in contact with the agency by informing the agency of change in address and phone number, respond to phone calls and mail ○ Avoid to subject the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	
4.0 Grievance Process	
Standard	**Measure**
4.1) Grievance policy exists which requires each client to sign & date form indicating they has been offered: a) explanation of the policy, and b) copy of *Grievance Procedure* and to communicate patient's understanding of the policy. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.	4.1) *Written grievance procedure on file*, available in languages and formats appropriate to populations served.
4.2) Explanation of *Grievance Procedure* is provided to each client. Clients may file a grievance if their request for services is denied or if they have any complaint or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by Client and located in patient's record.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status and resolution.
4.4) Review of grievance policy yearly with client signature.	4.4) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record.
5.0 Personnel Qualifications (including licensure) ***National Monitoring Standards: Substance abuse treatment (outpatient) services are provided by or under the supervision of a physician or other qualified/licensed personnel. Documentation of appropriate and valid licensure and certification as required by the State. Acupuncture provider has appropriate State license and certification.***[viii]	

Standard	Measure
5.1) All substance abuse (outpatient) service providers and substance abuse counselors will have appropriate and valid licensure/certification as required by the Commonwealth of Virginia.	5.1) Copy of current licensure and/or certification in personnel file.
5.2) Newly employed substance abuse professionals must complete orientation within 90 days of hire and include training on: • Hepatitis B and C • Sexually Transmitted Diseases (including HIV) • Tuberculosis • Referral for crisis intervention policy/procedures • Confidentiality • Emergency and safety procedures • Cultural competency.	5.2) Documentation of training completed in personnel file.
5.3) All substance abuse professionals must complete two (2) hours of continuing education in HIV/AIDS treatment or care annually.	5.3) Documentation of training complete in personnel file.
5.4) A written policy regarding regular supervision of all licensed staff will be in place.	5.4) Documentation of supervision according to agency policy.
5.5) The provider agency must be a licensed facility with outpatient substance use treatment designation and must comply with the rules and standards established by DBHDS.	5.5) Agency will have documentation on site that license is current for the physical location of the treatment facility.
6.0 Cultural and Linguistic Competency	
Standard	**Measure**
6.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: • Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; • Capacity of staff, including volunteers and Board, to design, provide and evaluate	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.

culturally and linguistically appropriate services; • List of cultural competency trainings completed by staff.	
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.[ix]	6.2) Culturally and linguistically appropriate materials and signage accessible.
7.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	7.1) Written Client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	7.2) Current *Release of Information Form* signed and dated by client and provider representative and located in patient's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months from date of signature.
7.3) Each client file is stored in a secure location. Electronic patient records are protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access is limited to appropriate personnel.
7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
8.0 Quality Management ***National Monitoring Standards: Implement a Clinical Quality Management Program (CQM) to include: a) written QM plan; b) quality expectations for providers and services; c) method to report and track expected outcomes; d) monitoring of provider compliance with HHS treatment guidelines and Part B Program's approved Standards of Care.***[x]	
Standard	**Measure**
8.1) Measure and report client health outcomes using Substance Abuse Treatment (Outpatient) measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of people living with HIV and receiving Substance Abuse Treatment (Outpatient) Services, regardless of age, who will have at least two care markers in

	a 12 month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program living with HIV and receiving Substance Abuse Treatment (Outpatient) Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

[i] HRSA/HAB Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice #16-02 (Revised 10/22/18).
[ii] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p. 23.
[iii] HRSA/HAB Ryan White HIV/AIDS Program Services: Clarifications on Ryan White Program Eligibility Determinations and Recertification Requirements Policy Clarification Notice #13-02
[iv] Public Health Service Act; Sections 2605(a)(6), 2617 (b) (7) (F), 2664 (f) (1), and 2671 (i).
[v] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p. 23.
[vi] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p. 24.
[vii] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), pp. 61-62.
[viii] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p. 22.
[ix] National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Available at: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf
[x] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p. 71.