Substance Abuse Treatment Services-Outpatient Standards

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
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 HRSA 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.

Virginia Ryan White Part B Service Unit Definition:
One substance abuse provider visit (in-person or virtual) per day for an uninsured client.

(An additional visit on the same date of service at a different practice/site = one unit. All categories assume one or more client encounters per day with the same practice/site = one unit.)

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 with HIV, including the following:

1.0 Intake and Eligibility

As outlined in HRSA HAB Policy Clarification Notice 21-02 Clarifications (PCN) on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02

2. **Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. **Residency:** The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

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. To be eligible for this service applicants must: a) Be diagnosed with HIV (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be 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 that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures Part B services are used as the payer of last resort and other funding sources must be vigorously pursued**.** Client must agree to participate in the insurance option that the client is eligible for and that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the Provide Enterprise® data system.	
Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.
2.0 Key Services Components and Activities (including assessment and service plan)	
Standard	**Measure**
Documentation	
2.1) All substance abuse services provided is documented in client record.	2.1) Documentation of mental health services are in client's record signed and dated.
2.2) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record and the dental agencies record must contain: • Referral; • Initial assessment;	2.2) Documentation of provided services, signed, and dated records, including referral in record.

• 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. Must sign and date all reports.	
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 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*) <u>Prior to discharge</u>: Conduct discussion with client over reasons for discharge and options for other service provisions. 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. Must return letter to provider if the client is not present to sign. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* <u>Documentation:</u> Client's record must include: a) Date services start 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.	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. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*
<u>Transfer:</u> 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. <u>Unable to Locate:</u> If client cannot be located,	Discharge summary and other records send with the patient

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. The three attempts should start no later than three months prior to the due date. 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 case closure within 30 days from the date on the letter if no appointment is schedule with the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* <u>Withdrawal from Service:</u> If client reports no need of services or not 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. <u>Administrative Discharge:</u> 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, agency leadership must review the case according to that agency's policies. Provide clients discharged for administrative reasons written notification of and reason for the discharge and notify 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	Document attempts made

days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	
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 insurance assistance staff for a period of three months despite three (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.	2.11) Documentation of case closure in client's record with clear rationale for closure.
3.0 Client Rights and Responsibilities	
Standard	**Measure**

3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the Americans with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services based on 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) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they have been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy.	3.2) Written policy on file.
3.3) Explanation of *Client's Rights and Responsibilities* is provided to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. Client responsibilities include: • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating in a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible to 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, as well as responding to phone calls and mail and • Not subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	
4.0 Grievance Process	
Standard	**Measure**

4.1) Grievance policy requires each client to sign & date indicating they have been offered: a) explanation of the policy, and b) copy of *Grievance Procedure,* and c) communication that client understands the policy. Policy shall describe the process for resolving client grievances, including the 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) Provide to each client an explanation of *Grievance Procedure*. Clients may file a grievance if denied their request for services, 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 client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
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 the grievance policy yearly with client signature.	4.4) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
5.0 Personnel Qualifications (including licensure)	
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:	5.2) Documentation of training completed in personnel file.

• Hepatitis B and C • Sexually Transmitted Diseases (including HIV) • Tuberculosis • Referral for crisis intervention policy/procedures • Confidentiality • Emergency and safety procedures • Cultural competency.	
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: a) Experience with providing services to the diverse ethnic, linguistic, sexual, or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff.	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
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.	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 compliance were applicable.	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 client'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) Store each client's file in a secure location with electronic client records 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 protected and access 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	
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 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 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. •

References

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