Substance Abuse Services (Residential) Standards

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

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

RWHAP funds may not be used for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license.

Virginia Ryan White Part B Service Unit Definition:
30 days or less residential substance abuse service = one unit.

(Residential treatment program must comply with HAB PCN #16-02 Substance Abuse Services - Residential definition and program 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 persons 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 by a Part B provider for Substance Abuse Services (Residential) is documented prior to initiation of the service.	1.1) Appointment documented to attend Substance Abuse Services (Residential) is present in the client's record.
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	
Standard	**Measure**
2.1) Services to be provided by or under the supervision of a physician, or other qualified personnel, with appropriate and valid licensure and certification by the State in which the services are provided.	2.1) Documentation of provider licensure or certifications as required by the State in which service is provided. Provide assurance that all services are provided in a short-term residential setting.
2.2) Services to be provided in accordance with a treatment plan.	2.2) Maintain program files that document: • That all services provided are allowable

	under this service category • The quantity, frequency, and modality of treatment services.
2.3) Detoxification to be provided in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of a hospital).	2.3) Services are provided in accordance with a written treatment plan. Maintain client records that document: • The date treatment begins and ends • Individual treatment plan • Evidence of regular monitoring and assessment of client progress. Assurance that services are provided only in a short-term residential setting.
Assessment/Service Plan/Provision of Services	
2.4) 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.	2.4) Documentation of assessment in client's record signed and dated.
2.5) If substance abuse serves are deemed appropriate, a substance abuse treatment plan is developed within 30 days 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	2.5) Documentation of treatment plan in client's record signed and dated.

• Reassessment dates of client progress. *Note:* Substance abuse services must be provided by or under the supervision of a physician or other qualified/licensed provider. *(See 5.0 Personnel Qualifications)*	
2.6) A complete psychosocial assessment will be completed. Results of the assessment will be used to complete the treatment plan as necessary.	2.6) Documentation of complete psychosocial assessment in client's record signed and dated.
2.7) Service plan is reassessed every 90 days for progress and to identify emerging needs.	2.7) Documentation of review and update of the plan, as appropriate, signed and dated by staff. Progress notes should include documentation that a copy of the service plan was provided to the client.
2.8) 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.	2.8) Documentation of mental health services provided in client's record signed and dated.
2.9) 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	2.9) Documentation of treatment modalities employed in client's record signed and dated. If provided, referral for acupuncture services in client's record signed and dated.

• 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.	
2.10) Treatment plan is reviewed at least every 12 sessions and modified as appropriate.	2.10) Documentation of review and update of treatment plan as appropriate signed and dated.
2.11) Refer client to other medical, mental health and other services as appropriate, e.g., psychiatric services, mental health services, in-patient hospitalization, case management.	2.11) Documentation of referrals made and status of outcome in client's record.
Transition and Discharge	
2.12) Client discharged when Virginia Substance Use (Residential) services are no longer needed, goals have been met, upon death, or due to safety issues. (*see 2.13*) <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. If client is not present to sign for the letter, return to the provider. **Exception: If the client has noted during the intake or at any other time to the VA MAP staff that sending mail is not permitted, no letter will be sent. If this is the case, VDH 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	2.12) 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.*

e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable. <u>Transfer:</u> If client transfers to another location (state), 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, 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 longer needing services 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 understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. <u>Administrative Discharge:</u> Discharge clients	

who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. 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 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	
2.13) 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 (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;	2.13) Documentation of case closure in client's record with clear rationale for closure.

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	
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 any service on the basis of 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; • 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. 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;	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.

• 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 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 requires each client to sign & date indicating they have been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and c) communication of client'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) Provide explanation of *Grievance Procedure* to each client. 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 of 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 client's 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: • Hepatitis B and C • Sexually Transmitted Diseases • 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 2 hours of continuing education in HIV/AIDS treatment or care annually.	5.3) Documentation of training complete in personnel file
5.4) A substance use disorder treatment supervisor shall be a Certified Clinical Supervisor.	5.4) Documentation of certification in personnel file.
5.5) A written policy regarding regular supervision of all licensed staff will be in place.	5.5) Documentation of supervision according to agency policy.
5.6) 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.	5.6) 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 prioritized; b) Capacity of staff, including volunteers and board, to design, provide and evaluate culturally and linguistically appropriate services; and 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.	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 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	
Standard	**Measure**
8.1) Measure and report client health outcomes using Substance Abuse Services approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of persons with HIV and receiving Substance Abuse 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 Services, regardless of age, who will have an HIV viral load lesser than 200 copies/mL at last HIV viral load test during the measurement year.

References

HRSA HAB Policy Clarification Notice 16–02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds. (2018, October 22). HRSA Ryan White HIV/AIDS Program. Retrieved August 18, 2022, from https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

HRSA HAB Policy Clarification Notice 21–02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertification Requirements. (2021, October 18). HRSA Ryan White HIV/AIDS Program. Retrieved August 19, 2022, from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf

Monitoring Standards for Ryan White B Grantees: Fiscal – Part B. (2013, April). HRSA Ryan White HIV/AIDS Program. Retrieved August 19, 2022, from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/fiscal-monitoring-partb.pdf

National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B. (2013, April). HRSA Ryan White HIV/AIDS Program. Retrieved August 19, 2022, from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/universal-monitoring-partab.pdf

National Monitoring Standards for Ryan White Part B Grantees: Program – Part B. (2013, April). HRSA Ryan White HIV/AIDS Program. Retrieved August 19, 2022, from

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/program-monitoring-partb.pdf

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. (n.d.). Think Cultural Health. Retrieved August 19, 2022, from https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf