PROPOSED RULEAMKING:
NEW PART 821

14 NYCRR Part 821
Withdrawal Management and Rehabilitation Services

821.1 Background and Intent.

The Office of Addiction Services and Supports (OASAS or the Office) oversees the quality, safety, and accessibility of addiction services for individuals across New York State. Withdrawal and stabilization services, along with inpatient rehabilitation services, are integral components of the continuum of care for individuals experiencing a substance use disorder crisis and those requiring intensive treatment following stabilization.
This Part establishes minimum standards for the provision of withdrawal management and rehabilitation services. This service continuum provides integrated withdrawal, stabilization, and rehabilitation services.

821.2 Applicability

(a) This Part applies to any person or entity organized and operating pursuant to the provisions of this Title and certified, funded or otherwise authorized by the Office to operate the following inpatient addiction service types:
   (1) programs providing medically supervised inpatient withdrawal and stabilization services;
   (2) programs authorized to provide medically managed withdrawal and stabilization services; and
   (3) any substance use disorder inpatient rehabilitation services integrated with or co-located in a general hospital, psychiatric hospital, or freestanding facility certified by the Office.

(b) Nothing in this Part shall be construed to limit the authority of a hospital licensed pursuant to Article 28 of the Public Health Law to provide withdrawal management and stabilization in a medical or surgical inpatient unit or an emergency room.

821.3 Legal Base.

(a) Section 19.07(e) of the Mental Hygiene Law (MHL) authorizes the commissioner to adopt standards including necessary rules and regulations pertaining to substance use disorder services.

(b) Section 19.09(b) of the MHL authorizes the commissioner to adopt regulations necessary and proper to implement any matter under their jurisdiction.

(c) Section 19.15 of the MHL bestows upon the commissioner the responsibility of promoting, establishing, coordinating, and conducting programs for the prevention, diagnosis, treatment, aftercare, rehabilitation, and control in the field of substance use disorder.

(d) Section 19.40 of the MHL authorizes the commissioner to issue operating certificates for the provision of substance use disorder services.

(e) Section 22.09 of the MHL directs the commissioner to designate hospitals and other appropriate facilities as providers of emergency detoxification and stabilization services for persons needing or seeking emergency treatment.

(f) Section 32.01 of the MHL authorizes the commissioner to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the MHL.

(g) Section 32.07(a) of the MHL authorizes the commissioner to adopt regulations to effectuate the provisions and purposes of Article 32 of the MHL.

(h) Section 3309 of the Public Health Law (PHL) authorizes the Department of Health (DOH) to establish standards for approval of any opioid overdose prevention program.

(i) Article 27f of the PHL defines the rules governing HIV testing and treatment in New York.

821.4 Definitions.

(a) Clinical Staff shall have the same meaning set forth in Part 800.4 of this Title.

(b) Community-based intensive inpatient withdrawal management and stabilization services means services designed for individuals who are experiencing intoxication or signs and symptoms of withdrawal that require medical monitoring but do not meet the OASAS Level of Care for Alcohol and Drug Treatment Referral Protocol 3.0 (LOCADTR, as incorporated by reference in Part 800.3 of this Title) criteria for medical management and/or co-occurring physical or psychiatric conditions that require a hospital level of care. This service is physician directed, staffed 24/7 with medical and nursing staff and includes twenty-four (24) hour emergency medical coverage.

(c) Discrete unit means an OASAS program certified pursuant to Article 32 of the MHL providing inpatient or outpatient substance use disorder treatment co-located in a facility licensed pursuant to Article 28 of the *PHL* because such facility is providing treatment due

to a consistent demand exceeding five (5) medical-surgical beds, or greater than 10% of overall patient days.

(d) Hospital-based intensive inpatient withdrawal management and stabilization services means services designed for individuals who are acutely ill from substance intoxication or withdrawal, require frequent assessment, monitoring, and treatment of withdrawal signs and symptoms by nursing or medical staff, may require medical interventions such as intravenous medication or hydration, and/or treatment of other co-occurring medical or psychiatric conditions that meet the LOCADTR criteria for medical management.

(e) Intensive inpatient means a structured, inpatient program located in a hospital or in the community that provides 24-hour supervision, medical monitoring of intoxication and withdrawal, withdrawal management and stabilization services, evaluation and treatment of medical and mental health conditions, and psychosocial treatment to individuals with substance use disorders. Intensive inpatient provides medical, nursing, and clinical care using a multi-disciplinary team and integrates standards of hospital-based and community-based inpatient care. Admission, continued stay, transfer, and discharge shall be based on clinical need and LOCADTR determination.

(f) Milieu staff means non-clinical personnel who are present in the therapeutic environment and responsible for supporting a safe, structured, and consistent recovery atmosphere. They facilitate activities of daily living, observe patient behaviors, model and reinforce social behaviors, provide supportive engagement, and assist clinical staff by ensuring the treatment goals are carried out within the treatment environment. They are not qualified health professionals and do not provide formal counseling or make clinical decisions.

(g) Patient means an individual admitted to or receiving services from a program certified under this Part for the purpose of receiving treatment for intoxication or withdrawal, stabilization, and/or intensive inpatient services.

(h) Peer or Recovery Support Staff means individuals with lived experience of an addiction disorder and sustained recovery who are trained to provide support, engagement, advocacy, education and linkage to resources. Peer or recovery support staff shall not be responsible for conducting clinical assessments, diagnosing conditions, or making clinical decisions, but may participate in service delivery under the supervision of a qualified health professional.

(i) Psychosocial services are services designed to promote and support the health and well-being of patients. Such services may include but are not limited to, counseling, supportive services, psychoeducation, activities, and skills building interventions.

(j) Qualified Health Professional (QHP) shall have the same meaning as set forth in Part 800.4 of this Title.

(k) *Stabilization* means addressing addiction and co-occurring medical and mental health conditions through a combination of medication management and psychosocial services

(l) Withdrawal management means a medical regimen under the supervision of a physician, nurse practitioner, or physician assistant consistent with state and federal authority, to systematically reduce the amount of a substance on which the patient is physiologically dependent, provide control of active withdrawal symptoms, and/or avert a life-threatening medical crisis related to the substance on which the patient is physiologically dependent.

821.5 General program standards.

(a) Programs may provide withdrawal management and rehabilitation services in a community or hospital-based setting. Programs must evaluate the medical and mental health treatment needs of each prospective patient based on their presentation and history to determine if the resources available to the program can provide effective and safe treatment to the prospective patient.

(1) Community-Based Withdrawal Management and Rehabilitation Service Programs.

(i) Community-based programs shall provide withdrawal, stabilization, and rehabilitation services for patients who do not meet LOCADTR criteria for medical management and/or do not have co-occurring physical or psychiatric conditions that require a hospital level of care.

(ii) Programs shall have 24/7 on site nursing staff and 24/7 availability of physicians, nurse practitioners, or physician assistants on site or on call, to medically monitor patients and provide treatment for withdrawal symptoms.

(iii) Community based programs must establish and maintain a formal agreement with local hospitals to ensure transfer and continuity of care for patients who require acute medical attention. Such agreements must specify procedures for emergency response, transition of care, and warm hand off between the program and the hospital.

(2) Hospital-Based Withdrawal Management and Rehabilitation Service Programs.

1. Hospital-based withdrawal management and rehabilitation service programs with full access to hospital resources shall provide withdrawal and stabilization services

for patients who are acutely ill due to intoxication or withdrawal and who require frequent medical monitoring and treatment for withdrawal symptoms, and/or co-occurring medical or psychiatric conditions that meet the LOCADTR criteria for medical management.

2. These programs must provide behavioral, psychosocial, and recovery-oriented support services concurrently with medical stabilization. Services must be delivered at an intensity appropriate to the individual's level of stability and functioning and must support engagement in treatment services.
3. Hospitals must utilize clinical staff, including but not limited to social workers, case managers and discharge planners, to support care coordination, transition planning, and linkage to aftercare or specialty services. Telehealth may be used to facilitate engagement with aftercare providers and support care transitions and shall not replace required rehabilitation services during hospitalization.
4. Programs shall have agreements with community-based providers to ensure continuity of care following discharge; however, such agreements shall not be a substitute for the hospital's responsibility to provide rehabilitation and transition-focused services during the hospital/inpatient stay. If programs lack the capacity to provide all services in the same physical location, they must develop and implement a hybrid service model, approved by this office, to utilize existing clinical staff, telehealth and formal community agreements as appropriate, to ensure full compliance with regulatory expectations.

(c) Satellite and Jointly Operated Programs.

(1) At the discretion of the Office, organizations operating both an inpatient rehabilitation and a withdrawal management service under the same administrative and clinical oversight may be authorized to hold a single operating certificate encompassing both services (withdrawal management and rehabilitation services), even when located at a separate location.

(2) Such programs shall operate under one governance and structure, maintain a unified clinical and administrative protocol, and ensure that transfers between sites occur as part of a single, continuous treatment episode, under one treatment and recovery care plan.

(3) Existing programs holding a separate operating certificate for Inpatient Rehabilitation Services (under Part 818 of this Title) and Withdrawal Management and Stabilization Services (under Part 816 of this Title) shall transition to a single operating certificate under this Part upon renewal, modification, or as otherwise directed by the Office.

(d) Bed capacity.

(1) Programs shall be certified pursuant to Part 810 of this Title for inpatient services for a maximum number of beds establishing their certified capacity. The level of care provided to each patient shall be determined based on clinical necessity as identified through patient-centered assessment(s) and the OASAS LOCADTR protocol, consistent with the individual's risk and resources.
(2) The certified bed capacity of each inpatient program may not be exceeded at any time except:
(i) in cases of emergency and unexpected increases in demand where no alternative options are available; and

(ii) failure to temporarily accept individuals into the program would jeopardize their immediate health and safety; and

(iii) where the excess of capacity would be time limited.

(e) Policies and procedures. The program's governing authority must approve written policies and procedures governing the provision of services in compliance with Office regulations including a description of each service provided. These policies, procedures, and methods must address, at a minimum:

(1) procedures and specific criteria for admission, retention, transfer, referrals, and discharge;

(2) procedures for level of care determinations utilizing the LOCADTR, to determine the appropriate level of care, treatment planning, and placement of services;

(3) treatment/recovery plans;

(4) staffing including, but not limited to, training and use of student interns, peers and volunteers, and compliance with Part 805 of this Title;

(5) the provision of medical services, including screening and referral procedures for associated physical conditions as needed;

(6) the provision of mental health services, including the use of OASAS-approved, validated screening instruments for co-occurring mental conditions and behavioral health risks, including suicide risk, and referral for associated mental health conditions as needed;

(7) a schedule of fees for services rendered, including a sliding scale when appropriate;

(8) infection control procedures;

(9) cooperative agreements with other providers and hospitals for services the patient may need;

(10) compliance with other requirements of applicable local, state and federal laws and regulations, OASAS guidance documents and standards of care including, but not limited to:

(i) education, counseling, prevention and treatment of transmissible infections, including viral hepatitis, sexually transmitted infections (STIs) and HIV; regarding HIV, STIs and HCV, such education, counseling, prevention and treatment shall include testing, pre-and post-exposure prophylaxis, treatment and the provision of treatment or referral to treatment as appropriate

(ii) medications and the use of medication for addiction treatment;

(iii) the use of a problem gambling screen approved by OASAS;

(11) laboratory testing, including the use of alcohol and other drug screening tests, such as breath testing and urine screening;

(12) procedures for the ordering, procuring, storing, administering and disposing of medication;

(13) quality improvement and utilization review: all programs must have a utilization review process, a quality improvement committee, and a written plan that identifies key performance measures for that program;

(14) procedures for emergencies;

(15) incident reporting, review and corrective action planning in accordance with Part 836 of this Title;

(16) record keeping procedures which ensure the documentation is accurate, timely, prepared by appropriate staff and in conformance with state and federal confidentiality rules, including 42 CFR Part 2 (as incorporated by reference in Part 800.3 of this Title);

(17) procedures whereby required educational services are provided for school age children who are in residence as either a patient or as part of a family unit;

(18) programs seeking to admit/serve individuals under the age of eighteen (18) must obtain an adolescent designation from the Office prior to admitting. Programs applying for this designation must demonstrate the capacity to provide age and developmentally appropriate services.

(19) procurement, storage, preparation of food and nutritional planning; and

(20) procedures for record retention (case records must be retained for ten years after the date of discharge or last contact, or three years after the patient reaches the age of 18, whichever time period is longer).

(f) Emergency medical kit. All programs must maintain an emergency medical kit at each certified location; such kit must include basic first aid and naloxone overdose prevention kits sufficient to meet the needs of the program and that are accessible by staff at all times and available for use during all program hours of operation. Programs must develop and implement a plan to train staff in overdose prevention education and naloxone education, including the prescribed use of naloxone, proper storage and maintenance.

(1) All staff and patients should be notified of the existence of naloxone overdose prevention kits and the authorized administering staff.

(2) Nothing in this regulation shall preclude patients from becoming authorized to access the naloxone emergency overdose prevention kits and administer naloxone, provided, however, the program director must be notified of the availability of any additional authorized users.

(g) Medical emergencies. Each withdrawal management and rehabilitation service program shall have written agreements with general hospitals for the immediate transfer of patients or prospective patients in need of acute hospital care, unless the inpatient program is co-located in a general hospital.

(h) Food and Nutrition. Each program shall provide to each patient three (3) nutritious meals each day which furnish sufficient nutrients and calories to meet normal needs as well as the special needs of persons in recovery, as well as snacks and beverages available between meals. A dietician or dietetic technician working within their scope of practice shall provide menu planning services, and other suitable staff shall be responsible for the procurement of food supplies and the training and directing of food preparation and serving personnel.

(i) Recordkeeping and reporting.

(1) All programs must maintain individual case records for each patient served. These records must, at a minimum, include the information required in this Part, as well as the source of referral, documentation of any case conferences or case reviews, reports of other evaluations and case consultations, medical orders (if applicable), and consent forms.

(2) Statistical information shall be reported to the Office on prescribed forms as required and in accordance with any data reporting required by the Office.

(j) Programs must implement policies and procedures, in accordance with Part 815 of this Title, to prevent and address the presence of items that create an unsafe environment in a manner that is trauma informed, person centered, respectful of patient and visitor dignity, and that reasonably balances the well-being, health, and safety of all patients in the program.

821.6 Services.

(a) Minimum program standards:

(1) Minimum services. Withdrawal management and rehabilitation service programs shall provide 24/7 medical monitoring and nursing care, and a minimum of twenty (20) hours per week of structured clinical services. Clinical services shall include medical, psychiatric and psychosocial services delivered using a strength-based, person-centered, trauma-informed approach.

(2) Programs shall recognize that during the initial stabilization period, patients may not be able to fully participate in structured services. Services shall be modified based on the patient's ability to participate. Clinical engagement and supportive psychosocial interventions shall be provided consistent with patient needs.

(b) Programs shall provide the following services:

(1) Withdrawal Management and Stabilization.

(i) All providers certified under this Part must develop and implement written withdrawal management and stabilization protocols that are consistent with the following criteria, and in accordance with guidance from the Office:

(a) objective monitoring;

(b) safety;

(c) involvement of medical and nursing professionals;

(d stabilization on medication for addiction treatment;

(e) patient comfort;

(f) level of care assessment; and

(g) transition to continued care.

(2) Providers of withdrawal management and stabilization services must obtain and maintain approval of policies, procedures, and medical protocols for withdrawal management from the OASAS Division of Medicine, Psychiatry, and Nursing (DMPN) by submitting their withdrawal management protocols for review and approval by DMPN and attesting that their protocols meet the criteria identified herein and in guidance issued by

the Office when seeking new certification for, or continued operation of, withdrawal management and stabilization services.

(i) Medical protocols are subject to review by OASAS at any time.

(ii) Medical protocols not in compliance with this Part and guidance issued by the Office and/or do not meet the standard of care for withdrawal management and stabilization services may result in corrective and/or disciplinary action in accordance with this Title.

(c) Medication for addiction treatment.

(1) All programs shall maintain a patient with substance use disorder on approved medication, including those federal Food and Drug Administration (FDA) approved medications to treat substance use disorder, if deemed clinically appropriate and in collaboration with the patient's existing provider, and with patient consent, in accordance with federal and state rules and guidance issued by the Office. The program shall document such contact with the existing program or practitioner prescribing such medications.

(2) To facilitate access to full opioid agonist medication for opioid use disorder for patients who are maintained on such medication at the time of admission or who elect to initiate such medication during admission, the program shall develop a formal agreement with at least one OASAS licensed, certified or other authorized outpatient program that provides FDA-approved medications for the treatment of opioid use disorder, including but not limited to Opioid Treatment Programs (OTPs), to facilitate patient access to full opioid agonist medication, if clinically appropriate. Such agreements shall address the program and the OTP's responsibilities to facilitate patient access to such medication in accordance with guidance issued by the Office.

(3) The program shall provide FDA-approved medications to treat substance use disorder to an existing patient or prospective patient seeking admission to an Office certified program in accordance with all federal and state rules and guidance issued by the Office.

(4) The program shall provide education to an existing patient or prospective patient with substance use disorder about FDA-approved medications for the treatment of substance use disorder if the patient is not already taking such medications, including the benefits and risks. The program shall document such discussion and

the outcome of such discussion, including a patient's preference for or refusal of medication, in the patient's record.

(5) All programs shall provide overdose prevention education and naloxone education and training to a patient or prospective patient, and their significant other(s).

(6) The program shall ensure that the patient's discharge plan includes an appointment with a treatment provider or program that can continue the medication post-discharge.

(d) Psychosocial Services.

(1) Intensive inpatient providers shall offer structured programming which includes individual, group, and family counseling, and activities to educate and promote skills necessary to manage cravings, urges to use, and to anticipate the possible recurrence of substance use.

(2) Programs must integrate patients into psychosocial services upon admission while providing flexibility and respite to patients whose symptoms prevent them from engaging in structured programming.

(3) All patients shall have daily contact with their primary clinician, or designee, to provide support and counseling. Contacts may be provided on an individual basis or in a group setting.

(4) Programs shall offer a variety of group counseling sessions and activities which must be structured in size and duration to maximize therapeutic benefit for each participant. Program policies must include a process for determining group size, group purpose, monitoring patient experience, and assessing group efficacy.

(e) *Peer or Recovery Support Services*.

(1) Peer or recovery support services shall be offered to support engagement and retention. Staff shall meet with newly admitted patients when it is clinically appropriate for the patient to begin receiving peer support services. Peers shall work collaboratively with clinical and milieu staff to support treatment and recovery goals and support care coordination and discharge.

821.7 Staffing.

(a) General Staffing

(1) Staff may be specifically assigned to the withdrawal management and rehabilitation service or may be part of the staff of the facility or program within which the service is located. However, if the staff is part of the general facility or program staff, they must have training and experience in the treatment of substance use disorders specific to the services provided. Staffing shall reflect the medical, nursing, counseling, and recovery support needs of individuals and shall ensure access to both medical and behavioral health services.

(2) At least 50 percent of all clinical staff shall be QHPs as defined in Part 800 of this Title. CASAC Trainees may be counted towards satisfying the 50 percent requirement provided, however, such individuals shall not be considered QHPs for any other purpose under this Part.

(b) Supervision and training. Each program must provide clinical supervision and document a plan for staff training based on individual employee needs. Subject areas appropriate for training shall be identified by the Office.

(c) Withdrawal management and rehabilitation services staff shall have regular, scheduled, and documented training in the following subject areas, or as determined by the Office:

(1) diagnosing substance-related and addictive disorders;
(2) signs and symptoms of withdrawal from all classes of substances;
(3) complications of withdrawal from all substance classes;
(4) medications for addiction treatment, including during pregnancy;
(5) infection control;
(6) mental health conditions, including screening;

(7) public health education and screening with regard to tuberculosis, sexually transmitted infections, viral hepatitis, and HIV prevention and harm reduction; and
(8) certification in cardiopulmonary resuscitation (CPR) from the American Red Cross, the American Heart Association or an equivalent nationally recognized organization.

(d) Medical and Nursing Staff. Medical and nursing staff shall have primary responsibility for coordinating medical care including, but not limited to, physical examinations, prescribing and administering medications, and monitoring and treating withdrawal symptoms.

(1) Each service shall have a medical director, as defined in Part 800 of this Title, who oversees the development and revision of medical policies, procedures and

ongoing training for matters such as routine medical care, specialized services, medical and psychiatric emergency care, and supervision of medical staff.

(2) The medical director may also serve as medical director of another service which is provided by the facility.

(3) A physician, nurse practitioner, or physician assistant working within their respective scopes of practice must be on site or on call at all times.

(4) There must be a physician, nurse practitioner, or physician assistant working in their respective scopes of practice on site to perform the patients' initial medical histories and physical examinations, and to perform follow-up physical examinations as medically indicated.

(5) Programs shall have physicians, nurse practitioners, or physician assistants working within their respective scopes of practice available on-site or through telehealth, pursuant to Part 830 of this Title and designated by the Office, to provide urgent or routine medical care, other than initial medical histories, initial physical examinations, and follow-up physical examinations as medically indicated, which must be performed on site.

(6) There shall be a psychiatrist or psychiatric nurse practitioner available in sufficient hours on site or by telehealth to evaluate all patients who have a history of mental health disorder or who are exhibiting symptoms of a mental health disorder.

(7) There shall be at least one full-time registered nurse on site 24/7 and additional registered nurses and licensed practical nurses, sufficient to provide the services required. Such personnel shall be on-site and available to all patients at all times.

(e) Program director. There shall be a director of the program who is a QHP with at least three (3) years-experience in the provision of substance use disorder services, and at least two (2) additional years of supervisory experience prior to appointment as director.

(f) Clinical staff.

(1) Programs shall employ a sufficient number of clinical staff to serve as primary counselors. A clinical staff member assigned as a primary counselor must be a QHP, or, if not credentialed or licensed, must work under the supervision of a QHP. The primary counselor is responsible for managing and coordinating the patient's care, including but not limited to counseling, development of the treatment and recovery plan, care coordination, discharge planning, and ongoing monitoring and review of treatment progress. Each patient shall be assigned to a primary counselor based on individual needs, preferences and clinical complexity.

(2) Clinical staff members who are not QHPs shall have qualifications appropriate to their assigned responsibilities as set forth in the service's personnel policies and shall be subject to appropriate professional staff supervision and continuing education and training.

(3) CASACs, CASAC-Ts and other clinical staff must be in sufficient numbers to facilitate psychosocial services in the milieu; at least one CASAC must be available at all times to intervene and help provide therapeutic interactions to foster patients' social, cognitive and behavioral skill development. (4) All withdrawal management and rehabilitation services shall have sufficient clinical staff that have been trained in, and are designated by the clinical supervisor to perform, the following tasks:

(i) evaluation of patient needs, development and implementation of individualized treatment/recovery plans for each patient, including individual, group and family counseling;

(ii) participation with staff and, as necessary, other services and agencies to ensure the development, management and implementation of comprehensive services for each patient, reflecting both substance use issues and other habilitation or rehabilitation needs; and

(iii) preparation and maintenance of case records for each patient.

(g) Additional Required Staff.

(1) *Peer or Recovery Support Staff* must be available in sufficient numbers to support consistent engagement, promote retention in services, assist with care coordination and discharge planning and facilitate warm hand offs to community-based providers.

(2) Milieu staff must be present on all shifts and available within the treatment environment to model and reinforce pro-social behaviors. Milieu staff shall be familiar with each patient's treatment goals and are responsible for supporting goal attainment through routine interactions and structured or unstructured activities within the milieu. Milieu staff must be supervised by a QHP.

(3) Programs shall maintain overnight staffing patterns that assure safe and efficient care. At a minimum, there must be both a clinical and nursing staff and a CASAC on site during all overnight hours, in sufficient numbers to meet patient needs.

(4) Programs shall maintain sufficient staff to ensure that all space and equipment are clean and in working order, to minimize the need for clinical staff to perform non-treatment functions and to support operational efficiency.

(5) Volunteers, interns, students and trainees may be utilized on a salaried or non-salaried basis in addition to required staffing. Such personnel must receive close professional supervision and appropriate education or training from internal and/or external sources, and their roles and supervision arrangements shall be documented in program policy.

(5) Each inpatient program shall designate a qualified individual to serve as Health Coordinator. The Health Coordinator shall ensure the provision of education, risk reduction, counseling and referral services related to HIV, tuberculosis, hepatitis, sexually transmitted infections, and other communicable conditions.

(6) There shall be at least one clinical staff member, as defined in Part 800 of this Title, designated to provide activities therapy.

821.8 Admission Procedures.

(a) Admission requirements for all programs. Admission shall be based upon a diagnosis of substance use disorder pursuant to the most recent edition of either the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), or the International Classification of Diseases (ICD), as incorporated by reference in Part 800.3 of this Title.

(1) The initial assessment and decision to admit must include an initial treatment plan, documented in the admission note, that identifies the services needed until the development of the treatment /recovery plan as required in Section 821.10.

(2) The decision to admit an individual must be made by a clinical staff member who is a QHP with diagnostic privileges and must be documented by the dated signature (physical or electronic signature) of the QHP and include the basis for admitting the patient.

(3) An individual who appears at the inpatient program for treatment or evaluation shall have an initial determination made and documented in a written record by a QHP with diagnostic privileges, or other clinical staff under the supervision of a QHP with diagnostic privileges, which states that the individual appears to not need acute hospital care, acute psychiatric care, or other intensive services which cannot be provided in conjunction with inpatient care or which would prevent them from participating in substance use disorder treatment.

(b) Level of care determination. If an individual is determined to be appropriate for substance use disorder treatment services, a level of care determination utilizing the OASAS LOCADTR protocol, shall be made by a clinical staff

member. The level of care determination shall be made no later than twenty-four (24) hours after the patient's admission to the program.

(c) Prohibition against discrimination.

(1) No individual shall be denied admission to the inpatient program consistent with the provisions in Part 815 of this Title.

(2) All prospective patients must be informed that admission to a program is on a voluntary basis, and a prospective patient is free to discharge themselves from the service at any time. 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 and continued treatment.

(d) Admission Procedures.

(1) There must be a notation in the case record that the patient received a copy of the inpatient program's rules and regulations, including patient rights and a summary of federal confidentiality requirements, and a statement that notes that such rules were discussed with the patient, and that the patient indicated that they understood them.

(2) Upon admission, all patients shall be presumed to be in a stabilization phase. The duration of stabilization shall be based on individual clinical need. Engagement, monitoring, and supportive interventions shall be provided regardless of the patient's ability to fully participate in structured services.

(3) Referral and connection. If the initial evaluation indicates that the individual needs services beyond the capacity of the program, and the individual is not already engaged in addiction treatment services, the program shall ensure referral and connection to appropriate services. All referrals, connections, and the outcome of those referrals shall be documented in the patient record. If admission is denied, the program shall provide the individual with the reason for denial.

821.9 Post Admission Procedures.

(a) Post admission.

(1) As soon as possible after admission, all patients must be offered:

(i) viral hepatitis testing on site or by referral;

(ii) HIV testing on site or by referral;

(2) If clinically indicated all programs must:

(i) offer testing for other sexually transmitted infections on site or by referral;

(ii) conduct a blood-based tuberculosis test on site or by referral; an intradermal Purified Protein Derivative (PPD) test may be given in those circumstances when a blood-based tuberculosis test cannot be performed; this test is administered and interpreted by medical staff, unless the patient is known to be PPD positive.

(b) Nursing Assessment. A nursing assessment shall be completed upon admission, including an assessment of withdrawal symptoms, in accordance with the program's medical withdrawal protocols.

(c) Medical History and Physical Examination:

(1) A medical history and physical examination shall be completed by a physician, nurse practitioner, or physician assistant, working within their respective scopes of practice, within twenty-four (24) hours of admission.

(2) If a medical history and physical examination were completed within the seventy-two (72) hours prior to admission, the existing medical history and physical examination, including laboratory and diagnostic test results, may be used to comply with the requirements of this Part, provided that such documentation is reviewed and determined to be current and accurate.

(3) If the patient presents with new physical complaints or conditions that were not addressed in the existing history, physical examination, or laboratory or diagnostic tests a focused medical history shall be taken, or a focused physical examination shall be performed, or other laboratory or other diagnostic tests shall be ordered. .

(4) The physical examination shall include, but shall not be limited to, evaluation of and appropriate screenings for:

(i) infectious diseases;

(ii)major organ system abnormalities;

(iii) physical or mental conditions or disabilities that may require special services or attention during treatment.

(5) The admitting physician, nurse practitioner, or physician assistant shall determine which admission laboratory tests are medically necessary. Tests may include but are not limited to:

(i) complete blood count and differential;

(ii) electrolytes, blood glucose, liver and kidney function;
(iii) routine and microscopic urinalysis;
(iv) drug screening tests;
(v) pregnancy test for individuals of child-bearing potential; or
(vi) any other tests the physician, nurse practitioner, physician assistant or other medical staff member deems necessary, including, but not limited to, an electrocardiogram or chest x-ray

(d) Psychiatric evaluation. For patients with identified or possible mental health treatment needs, a psychiatric evaluation shall be completed by a psychiatrist or a psychiatric nurse practitioner within seven (7) days of admission, or sooner if clinically indicated.

(e) Clinical Assessment and Documentation.

(1) A clinical assessment shall be completed as soon as possible but no later than 72 hours after admission, by clinical staff functioning within their scope of practice, incorporating findings from medical, nursing, and psychiatric evaluations (when applicable), and shall inform the development of the treatment/recovery plan.

(2) Patient records shall include:
(i) the medical history and findings of the physical examination,
(ii) laboratory and other diagnostic tests results,
(iii) nursing assessment,
(iv) psychiatric evaluations (when applicable) and
(v) the clinical assessment, including an assessment of patient needs and a plan for medical, clinical, and psychiatric care as indicated.

(f) If a patient is referred directly to the inpatient program from another program certified by the Office or is readmitted to the same program within sixty (60) days of discharge, the existing level of care determination and evaluation or treatment/recovery plan may be used, provided that documentation is maintained demonstrating a review and update.

821.10 Treatment/recovery plan development and review.

(a) A treatment/recovery plan must be developed by the primary counselor assigned to the patient and approved by their supervisor as soon as possible but no later than five days after admission, as evidenced by time and date stamped signatures, which may be physical or electronic. If the supervisor is not available, another QHP must be designated to provide a physical or electronic signature. The plan must also be:

(1) created in collaboration with the patient;

(2) reviewed with the patient.

(3) If the patient is a minor, the treatment/recovery plan must also be developed in consultation with the parent or guardian unless services are provided without parental consent pursuant to MHL 22.11.

(b) The treatment/recovery plan must be based on the patient's presenting problem and patient-directed goals, with recommendations/input from the multidisciplinary treatment team,

(c) Standards for treatment/recovery plan development shall include, but are not limited to, the following:

(1) for patients transferring directly from another program or readmitted to the same program within sixty (60) days of discharge, the existing treatment/recovery plan may be utilized if documentation confirms that it has been reviewed and, if necessary, updated within fourteen (14) days of transfer;

(2) if the patient is a minor, the treatment/recovery plan must be developed in consultation with the parent or guardian unless the minor is receiving services without parental consent pursuant to Mental Hygiene Law section 22.11.

(d) At a minimum, the treatment/recovery plan must include the:

(1) diagnosis for which the patient is being treated; and

(2) patient-driven goals and or needs, treatment methods to achieve such goals, and preliminary discharge plan.

(e) The primary counselor must ensure that the treatment/recovery plan is included in the patient record and updated through progress notes, in collaboration with the patient, on a weekly basis. The primary counselor must ensure that all treatment is provided in accordance with the individual treatment/recovery plan.

(f) Progress notes. Progress note shall provide a chronology of the patient's participation in all services provided, their progress related to the goals established in the treatment/recovery plan and be sufficient to delineate the course and results of treatment/services.

821.11 Discharge.

(a) Discharge and Level of Care Transition Planning.

(1) Discharge planning process shall begin at admission and be integrated into the treatment planning process. The discharge/transition plan must be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. If the patient is a minor, the discharge plan must also be developed in consultation with the parent or guardian unless services are provided without parental consent pursuant to MHL Section 22.11.

(2) Clinical and peer/recovery support staff in collaboration with the treatment team shall work to provide warm handoffs or other transitional services such as follow up to ensure a seamless transition in care.

(3) Discharge should occur when:

(i) the patient meets criteria established under the OASAS LOCADTR protocol for an alternate level of care,

(ii) patient's medical and psychiatric conditions are stable,

(iii) patient is stabilized on medication for addiction treatment if such treatment was initiated during the treatment episode,

(iv) patient has attained skills in identifying and managing cravings and urges,

(v) patient has developed a plan for returning to the community or transitioning to further care; or

(vi) the patient and the program staff agree that the patient has received maximum benefit from the services provided by the program; or

(vii) the patient does not adhere to the program's written behavioral standards, provided that a referral and connection to another treatment program is offered and discharge is otherwise in accordance with Part 815 of this Title, and if possible, without creating an unsafe environment. Discharge for behavioral reasons with referral and connection to another treatment program shall occur only after the program has utilized incremental, strength-based, and trauma-informed interventions to help the patient manage their behavior in a less disruptive manner.

(3) No patient shall be discharged without a discharge plan reviewed by the multidisciplinary team prior to the discharge. This review may occur as part of a regularly scheduled treatment/recovery plan review. Referrals for continuing care shall be provided to the patient upon discharge, except when the patient leaves

without permission, refuses continuing care planning, or otherwise fails to cooperate

(4) The discharge plan must be developed by the primary counselor, or designee, in conjunction with the patient and must consider:

(i) the patient's self-reported confidence in maintaining their health and recovery and (ii) an assessment of the patient's home and family environment and relationships with significant others.

(5) The purpose of the discharge plan is to determine available post-treatment clinical and social supports and to identify service needs of significant others. The plan shall include, but not be limited to, the following:

(i) identification of required treatment, rehabilitation, self-help and vocational, educational, and employment services post-discharge;

(ii) identification of the type of residence needed post-discharge, if any;

(iii) identification of specific providers of such services;

(iv) specific referrals and initial appointments for needed services including medication providers for continuing MAT;

(v) a list of current medications;

(vi) recurrence prevention plan

(vii) harm reduction methods and resources.

(viii) suicide prevention safety plan, as clinically indicated.

(ix) the patient, and as appropriate, their family/significant other(s), shall be offered harm reduction education and strategies, including but not limited to overdose prevention education and naloxone education and training, and the provision of a naloxone kit or prescription.

(6) A discharge summary documenting the course of treatment must be prepared and included in the patient record within twenty (20) days of discharge.

821.12 Standards pertaining to Medicaid reimbursement.

Providers seeking Medicaid reimbursement must comply with this Part and Part 841 of this Title.

821.13 Severability.

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part which can be given effect without the invalid provision or applications, and to this end the provisions of the Part are declared to be severable.