Memphis TGA Ryan White Part A & MAI Substance Abuse-Outpatient Standards of Care

PURPOSE

The purpose of the Ryan White Part A and MAI Substance Abuse- Outpatient Standards of Care is to ensure that uniformity of service exists in the Memphis Transitional Grant Area (TGA) such that the consumers of a service receive the same quality of service regardless of where or by whom the service is provided. Standards will be used as contract requirements, in program monitoring, and in quality management. If an agency is unable to meet a particular standard, the agency must document why the standard was unable to be met and explain the steps it is taking to meet that standard.

The purpose of substance abuse outpatient services is to address and stabilize substance abuse issues so that a person is able to engage in and maintain participation in HIV medical care.

DEFINITION

Substance Abuse Services- Outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel. This includes but is not limited to psychiatrists, psychologists, licensed clinical social workers and licensed alcohol and drug abuse counselors. This service provides clients with HIV/AIDS regular, ongoing alcohol and drug/ substance abuse monitoring and counseling on an individual and group basis in a state licensed outpatient setting.. This does not include case management services or time spent in therapy discussing case management issues such as Medicaid disability/ eligibility, housing, resource identification and/or referral, financial concerns, transportation, and other community level service needs.

STANDARDS DEVELOPMENT PROCESS

These standards were developed through extensive background research on standards of care, a review of existing standards from other Ryan White Part A Eligible Metropolitan Areas (EMA) and TGAs, meetings of the Evaluation and Assessment Committee of the Memphis TGA Ryan White Planning Council and meetings with the Ryan White Part A Grantee

APPLICATION OF STANDARDS

The standards apply to all agencies that are funded to provide Substance Abuse Outpatient Services through Ryan White Part A or MAI within the Memphis TGA. These standards should be used in combination with the Universal Standards of Care that apply to any agency or provider funded to provide any Ryan White Part A and/or MAI service.

Revision Approved by Memphis Area Ryan White Planning Council 9/22/10

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Standard	Measure/Method
I. Policies and Procedures	
A. See Universal Standards of Care for detailed information.	
II. Program Staff	
A. Agency must ensure that direct treatment and/or rehabilitation services are provided by qualified alcohol and drug abuse personnel. Qualified Alcohol and Other Drug Abuse Personnel refers to persons who meet the criteria described in items (a), (b) and (c) as follows: a. Currently meet one (1) of the following conditions: 1. Licensed or certified by the State of Tennessee as a physician, registered nurse, practical nurse, clinical or counseling psychologist, psychological examiner, social worker, alcohol and other drugs of abuse counselor, teacher, professional counselor, or marital and family therapist, or if there is no applicable licensure or certification by the state has a bachelor's degree or above in a behavioral science or human development related area; OR 2. Actively engaged in a recognized course of study or other formal process for meeting criteria of part (1) of item (a) above, and directly supervised by a staff person who meets criteria in part (1) of item (a) above, who is trained and qualified as described in items (b) and (c) below, and who has a minimum of two (2) years experience in his/her area of practice; and b. Are qualified by education and/or experience for the specific duties of their position; and c. Are trained in alcohol or other drug specific information or skills. (Examples of types of training include, but are not limited to, alcohol or other drug specific in-services, workshops, substance abuse schools, academic coursework and internships, field placement, or residencies).	• Policies and procedures on file • Documentation in staff files
B. A physician must be employed or retained by written agreement to serve as medical consultant to the program.	• Documentation in staff file OR • Documentation of consultant agreement on file

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A. Staff is trained and knowledgeable about HIV/AIDS, the affected communities and available resources. Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications as well as substance abuse, including cognitive impairment and generally accepted treatment modalities and practices.	• Documentation of training on these topics • Documentation of participation of all staff involved in delivering Part A services
B. Staff is appropriately certified or licensed as required by the state or local government for the provision of services.	• Documentation in personnel records
III. Access to Services	
A. See Universal Standards of Care for detailed information.	
IV. Eligibility Determination/Intake/Screening	
A. Provider determines client eligibility for services	•
V. Assessment	
A. Agency assures that after each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.	• Policy and procedure on file describing the assessment process • Documentation in client file
B. The facility must document that the following assessments are completed prior to the development of an Individual Program Plan (IPP); re-admission assessments must document the following information from the date of last service: ✓ Assessment of current functioning according to presenting problem, including history of the presenting problem; ✓ Basic medical history, including drug usage, a determination of the necessity of a medical evaluation, and a copy, where applicable of the results of the medical evaluation ✓ Screening to identify service recipients who are at high risk for infection with TB according to TB Guidelines, including documentation of the service recipient's risk level, and if applicable, a tuberculin skin test or equivalent, the	• Documentation in client file

Standard	Measure/Method
results of the tuberculin skin test, the date and result of a chest x-ray, and any drug treatment for TB; ✓ Assessment information, including employment and educational skills; financial status; emotional and psychological health; social, family and peer interaction; physical health; legal issues; community living skills and housing needs; and the impact of alcohol and/or drug abuse or dependency in each area of the service recipient's life functioning; and ✓ A six (6) month history of prescribed medications, over the counter medications used frequently, and alcohol or other drugs, including patterns of specific usage for the past thirty (30) days	
VI. Care Plan	
A. A written Plan of Care must be developed prior to the initiation of services with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.	• Policy on file describing the development of written plan of care
B. An Individual Program Plan (IPP) must be developed and documented for each service recipient within thirty (30) days of admission or by the end of the third face-to-face treatment contact with qualified alcohol and drug abuse personnel, whichever occurs first, and must include: ✓ The service recipient's name ✓ The date of the IPP's development ✓ Standardized diagnostic formulation(s) including, but not limited to, the current Diagnostic and Statistical Manual (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) and ASAM PPC ✓ Specified service recipient problems which are related to specified problems	• Documentation in client file

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and which are to be addressed within the particular service/program component ✓ Interventions addressing goals ✓ Planned frequency of contact ✓ Signatures of appropriate staff; and ✓ Documentation of the service recipient's participation in the treatment planning process.	
VII. Service Coordination/Treatment/ Referral	
A. Agency staff acts as a liaison between the client and other service providers to support coordination, encouragement to seek and/or maintain involvement in primary medical care, and delivery of high quality care, providing appropriate referrals and contacts. For those clients not in primary medical care, agency staff notes progress toward linking the client into primary medical care.	• Policies and procedures on file • Documentation that staff receive and are trained on referral and coordination policies and procedures • Client records document attempted referrals and contacts and referral results, including progress/results of efforts to link client into primary medical care and other core and support services
B. Provision of all Ryan White Part A funded services is documented.	• Documentation of services provided, with dates, in client records
C. Agency must maintain linkages with one or more residential facilities and appropriate community based programs, and be able to refer or place clients in a residential program, in collaboration with the patient, his/her case manager and primary care physician when that is found to be appropriate.	• Policies and procedures on file • Documentation of agreement with
VIII. Monitoring/ Reassessment/ Termination of Treatment Plan	
A. Staff should keep progress notes which include written documentation of progress or changes occurring within the IPP must be made in the individual service recipient record for each treatment contact.	• Documentation in client file
B. The facility must review and, if indicated, revise the IPP at least every ninety (90) days. The revision shall document any of the following which apply: ✓ Change in goals and objectives based upon service recipient's documented	• Documentation in client file

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progress or identification of any new problems ✓ Change in primary counselor assignment ✓ Change in frequency and types of services provided; and ✓ A statement documenting review and explanation if no change are made in the IPP	
C. Reassessment is an ongoing process that may occur throughout the process of receiving this service. At least once annually the client must complete a reassessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase. Reassessment must occur at the time the IPP monitoring. Reassessment includes the following elements: ✓ Updating signatures and/or documentation from intake and Screening to include confidential releases, eligibility requirements and contractual agreements per stated standards ✓ Updating assessment per stated standards ✓ Updating/ revising written plan of care per stated standards ✓ Communication with client regarding services ✓ Entries in the written plan of care ✓ Client acknowledgment of changes resulting from the reassessment	• Documentation in client file
D. Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff.	• Documentation in client file as appropriate • Policy on file
E. Conditions which result in a client's termination from services may include: • Attainment of goals • Non-compliance with stipulations of written plan' • Change in status which results in program ineligibility • Client desire to terminate services • Death	• Documentation in client file as appropriate • Policy on file
VI. Client Rights and Responsibilities	
A. See Universal Standards of Care for detailed information.	