Substance Abuse Outpatient Care

Health Resources & Services Administration (HRSA) Definition: Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pre-treatment/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 an allowable under this services category only when it is included in a documented Treatment Plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Syringe access services are allowable to the extent they comport with current appropriation laws and applicable Health and Human Services (HHS) guidance, including Health Resources and Services Administration (HRSA) or the HIV/AIDS Bureau (HAB)-specific guidance.

Eligibility: Client shall meet eligibility requirements as defined in the System-Wide Standards of Care.

1.0 Agency Policies and Procedures

The Agency shall have Policies and Procedures to ensure the services are accessible to all eligible clients. The Agency's policy and procedures shall ensure compliance with the following Standards:

1.0 Agency Policies and Procedures

	Standards		Measures
1.1	Comply with Florida Administrative Code Chapter 65D-30 and Chapter 397 of Florida Statutes.	2.1	Current licensure displayed. Staff resume, license, and certifications on file.

2.0 Scope of Service

Agency shall comply with all of the requirements outlined in this Standard of Care unless otherwise specified in their contract.

2.0 Scope of Service

	Standards		Measures
2.1	Outpatient Substance Abuse services include the following: • Biopsychosocial Assessments • Treatment Plan development • Treatment Plan review • Urine Drug Screening Psychotherapeutic Treatment to include: • Individual sessions • Group sessions • Case consultations • Crisis intervention • Referral for Psychiatric Evaluation and Treatment • Other services as deemed clinically appropriate	2.1	Documentation in client clinical record
2.2	Biopsychosocial assessment should be completed within two visits, but no longer than 30 days. Biopsychosocial assessment will include at a minimum: • Presenting problem • History of the presenting illness or problem • Psychiatric history;	2.2	Completed assessment, signed and dated by the licensed professional in client clinical record. If assessment is not completed in 30 days, reason for delay to be documented in progress notes.

	• Trauma history; • Medication history; • Alcohol and other drug use history; • Relevant personal and family, medical history; • Mental health status exam; • Cultural influences; • Educational and employment history; • Legal history; • General and HIV related medical history; • Medication adherence; • HIV risk behavior and harm reduction; • Summary of findings; • Diagnostic formulation; • Current risk of danger to self and others; • Social support and functioning, including client strengths/weaknesses, coping mechanisms and self-help strategies; • Domestic violence/abuse history; and treatment recommendations and/or plan.		
2.3	A Biopsychosocial update is ongoing and driven by client's needs, when client's status has changed significantly or when client has left and re-entered treatment. A Biopsychosocial update is required to be completed at least every six months.	2.3	Progress notes or new assessment demonstrating update in client clinical record.

2.4	Assessments and updated assessment completed by unlicensed providers shall be co-signed by licensed clinical supervisor.	2.4	Co-signature on file in client clinical record.
2.5	All clients must be under the care of a physician within the past twelve (12) months. Clients who are out of care must be referred for medical care within 10 business days.	2.5	Documentation in client file of receiving medical care in past year or current referral.
2.6	An individualized Treatment Plan shall be developed with the participation of the client within (30) days of identifying the needs and it should be centered and consistent with the client's identified strengths, abilities, needs and preferences. If the client is under the age of 18 the client's parent or legal guardian/custodian shall be included in the development of the individualized Treatment Plan.	2.6	Documentation in client clinical record. The Treatment Plan shall have client's signature or his/her legal representative's signature as well as the licensed professional signature. If the Treatment Plan is not completed in 30 days, reason for delay must be documented in progress notes. If the client's age or clinical condition precludes participation in the development of the Treatment Plan, an explanation must be provided in the Treatment Plan. If a Treatment Plan for a client under the age of 18 does not include the client's parent or legal guardian/custodian signature an explanation must be provided in the progress note.
2.7	The Treatment Plan shall contain all of the following components: • The client's diagnosis code (s) consistent with assessment(s)	2.7	The Treatment Plan in the client's clinical record reflects all required components.

	• Individualized, strength-based goals and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences and needs expressed by the client • The treatment modality (group or individual) • Measurable objectives with target completion dates identified for each goal • The start date of services, recommended number of sessions, frequency and duration of each service for the six month duration of the Treatment Plan (e.g., four units of therapeutic behavioral on-site services, two days per week for six months). It is not permissible to use "As Needed", "PRN" or the client will received a service "X to Y times per week". • The date of the re-assessment. • Projected treatment end date		
2.8	Treatment Plan is signed by a licensed professional.	2.8	Treatment Plan in client's clinical record is signed and dated by a licensed professional.
2.9	A formal review of the Treatment Plan with the client shall be conducted at least every six months. The Treatment Plan should be reviewed more often when significant changes occur.	2.9	Documentation of the formal Treatment Plan review with the client shall be in the client's clinical record within the specified time frame.
2.10	Activities, notations of discussions, findings, conclusions and recommendations shall be documented during the Treatment Plan review. Any modifications or	2.10	Written documentation must be included in the client's clinical record upon completion of the Treatment Plan review activities.

additions to the Treatment Plan must be documented based on the results of the review. The Treatment Plan review shall contain the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client's progress toward meeting individualized goals and objectives
- Client's progress towards meeting individualized discharge criteria
- Updates to after care plan
- Findings
- Recommendations
- Dated signature of the client
- If client is under 18 dated signature of the client's parent, or legal guardian/custodian
- Signatures of the treatment team members who participated in review of the plan

Treatment Plan review completed by unlicensed providers shall be co-signed by a licensed clinical supervisor.

If the Treatment Plan review process indicates the goals and objectives have not been met, documentation shall reflect the treatment team's re-assessment of services and justification if no changes are made.

2.11	A periodic re-evaluation of the Treatment Plan shall be completed at least monthly and is amended based on life changes or client's circumstances.	2.11	Documentation in client's clinical record reflects re-evaluation on a monthly basis.

3.0 Discharge

Client who are no longer engaged in Outpatient Substance Abuse services or have achieved self-sufficiency should have their cases closed based on the criteria and protocol outlined in the client Treatment Plan and the Agency's Policies and Procedures Manual.

3.0 Discharge

	Standards		Measures
3.1	Upon termination of services, client's case shall be closed and a discharge summary completed within 30 days of last contact with Clinical Supervisor approval. For face-to-face discharge, clients shall receive a discharge plan which has been approved by a Clinical Supervisor.	3.1	Documentation of discharge summary & Clinical Supervisor's approval in client's clinical record. For face-to-face discharge, document is signed by the client and the Clinical Supervisor.
3.2	Discharge summary should include the following: reason for closure, outline available resources and follow up instructions; signed by the mental health provider and the clinical supervisor.	3.2	A copy of the signed discharge summary including all required components is included in client's clinical record.
3.3	Cases may be closed when the client: • Has achieved all goals listed on the Treatment Plan; • Has become ineligible for services;	3.3	Documentation of reasons for case closure in client's clinical record.

	• Is deceased; • No longer needs the service • Decide to discontinue the service; • The service provider is unable to contact the client thirty (30) days after expired eligibility; or • Is found to be improperly utilizing the service or is asked to leave the program.		
3.4	All discharged clients shall be offered an exit interview via one of the following: • Face-to-face visit; • Telephone call; or • Written communication **Note: When the treating provider is not able to conduct an exit interview, reason must be documented in the record**	3.4	Documentation of an exit interview being offered shall be recorded in client's clinical record. If an exit interview was not completed the reason must be included.
3.5	All attempts to contact the client and notification about case closure shall be communicated to the referral source and Clinical Supervisor.	3.5	Documentation of attempts to contact clients and communication about case closure with the referral source and Clinical Supervisor shall be in the client's clinical record.