BHO Summary of Changes

AGENCY: Behavioral Healthcare, Developmental Disabilities & Hospitals

DIVISION: Behavioral Healthcare

RULE IDENTIFIER: 212-RICR-10-10-01

RULE TITLE: Rules and Regulations for Behavioral Healthcare Organizations

ERLID: 7819

TYPE OF FILING: Adoption with Associated Repeal

SUMMARY OF PROPOSED ACTION ON THE RULE:

By this rulemaking, the Department is proposing to:

1. Revise to comply with RICR formatting and codification guidelines. This includes minor, non-substantive corrections in spelling, grammar and formatting throughout the regulation in order to make the regulatory content fit into the RICR format and codification guidelines.

2. Behavioral Health Recovery Principles, Preface summary, Statutory Authority for Licensing, Applicability and License Required deleted and moved to §1.1 – Authority, Purpose and Applicability.

    a. Remove informational/non-regulatory language.

    b. Added new language to reflect Department priorities: §1.1.1 Philosophy of Services and Values: "*A. The organizations licensed and/or funded by the Department incorporate the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's (SAMHSA) Ten Guiding Principles of Recovery in the operation of the business. The individual served is considered an essential partner in his/her treatment and recovery path as evidenced by entries in the person-centered treatment or recovery plan.*"

    c. Added §1.2 Relevant Federal Law and Incorporated Materials to identify controlling authority.

3. In the following, section headings (e.g. § 1.02) reference the previous regulations unless noted to refer to a section in the new regulations.

4. **§1.0 Definitions**

- New reference § 1.3 Definitions, General Requirements, and Procedures
- 1.1 “Administer” - moved to §1.3.1(A)(1)
- 1.2 “Administrative Discharge” – Deleted reflecting compliance with new practice and procedures, no longer utilized.
- 1.3 “Admission” – moved to § 1.3.1(A)(2)
- 1.4 “Adverse event or incident” – Deleted definition not needed.
- 1.5 “Advocate” – moved to § 1.3.1(A)(3)
- 1.6 “Affiliation Agreement” – Deleted no longer utilized.
- 1.7 “Aftercare Plan” – Deleted definition not needed.
- 1.8 “Aggregate” – Deleted definition not needed.
- 1.9 “ANCC” – Deleted no longer utilized.
- 1.10 “ASAM-PPC” – Deleted definition not needed.
- 1.11 “Assessment” – moved to § 1.3.1(A)(4)
- 1.12 “Aversive techniques” – moved to § 1.3.1(A)(5), updated term to current practice.
- 1.13 “Behavioral Health Acute Stabilization Unit” – Deleted definition not needed.
- 1.14 “Behavioral health issue” – moved to § 1.3.1(A)(6), updated term substance use disorder (SUD).
- 1.15 “Behavioral healthcare” – moved to § 1.3.1(A)(7)
- 1.16 “Behavioral healthcare organization” – moved to § 1.3.1(A)(8), updated term substance use disorder (SUD).
- 1.17 “Behavioral management” – moved to § 1.3.1(A)(9)
- 1.18 “Behavioral management plan” – moved to § 1.3.1(A)(10)
- 1.19 “Best practice standards" – moved to § 1.3.1(A)(11)

- 1.20 “Board” – moved to § 1.3.1(A)(12)
- 1.21 “Case management” – Deleted definition not needed.
- 1.22 “Certified Co-Occurring Disorder Professional” – Deleted definition no needed.
- 1.23 “Certified Co-Occurring Disorder Professional – Diplomate” – Deleted to reflect current practice.
- 1.24 “Change in operator” – Deleted definition not needed.
- 1.25 “Change in owner” – Deleted definition not needed, not in regulations.
- 1.26 “Clinical screening” – moved to § 1.3.1(A)(13), updated term to reflect current practice, removed “via telephone”.
- 1.27 “Clinical supervision” – Deleted definition not needed.
- 1.28 “CMHC” – moved to § 1.3.1(A)(14), update term to reflect current practice.
- 1.29 “Collateral” – Deleted definition not needed.
- 1.30 “Community Psychiatric Supportive Treatment” – Deleted definition not needed.
- 1.31 “Community residence” – moved to § 1.3.1(A)(15)
- 1.32 “Community Support Professional” – Deleted definition not needed.
- 1.33 “Community Support Program” – Deleted definition not needed.
- 1.34 "Complaint" – moved to § 1.3.1(A)(16)
- 1.35 “Concern” – moved to § 1.3.1(A)(17)
- 1.36 “Continuing Care” – Deleted definition not needed.
- New language: “Co-occurring disorder” § 1.3.1(A)(18), added to reflect current practice.
- 1.37 “Counseling” – Deleted definition not needed.
- 1.38 “Courtesy dosing” – moved to § 1.3.1(A)(19)
- 1.39 “Crisis Intervention” – Deleted definition not needed.
- 1.40 “Crisis Stabilization” – Deleted definition not needed.
- 1.41 “Data Definitions” – Deleted to reflect current practice.

- 1.42 “Department” – moved to § 1.3.1(A)(20)
- 1.43 “Director” – moved to § 1.3.1(A)(21)
- 1.44 “Disaster" – Deleted definition not needed.
- 1.45 “Dispense” – moved to § 1.3.1(A)(22)
- 1.46 “Distribute” – Deleted definition not needed.
- 1.47 “Division of Behavioral Healthcare Services” – moved to § 1.3.1(A)(23)
- 1.48 “DSM” – Deleted definition not needed.
- 1.49 “Endemic” – Deleted definition not needed.
- 1.50 “Epidemic” – Deleted definition not needed.
- 1.51“Evidence-based practice” – moved to § 1.3.1(A)(24)
- 1.52 “Facility” – moved to § 1.3.1(A)(25)
- 1.53 “Family” – Deleted definition not needed.
- 1.54 “Family Psychoeducation” – Deleted definition not needed.
- 1.55 “Full-time equivalent” – moved to § 1.3.1(A)(26)
- 1.56 “Harm Reduction” – Deleted not in regulation.
- 1.57 “Health information exchange” – moved to § 1.3.1(A)(27)
- 1.58 “HIV” – Deleted definition not needed.
- 1.59 “Individual” – moved to § 1.3.1(A)(28)
- 1.60 “Informed consent” – moved to § 1.3.1(A)(29), updated term to reflect current practice, removed “situated as to be”
- 1.61 “Investigation” – moved to § 1.3.1(A)(30)
- 1.62 “Leaders” – Deleted definition not needed.
- 1.63 “Legally competent” – Deleted definition not needed.
- 1.64 “Licensed Chemical Dependency Professional” – Deleted definition not needed.

- 1.65 “Licensed Chemical Dependency Clinical Supervisor” – Deleted definition not needed.
- 1.66 “Licensed clinician or practitioner” – Deleted definition not needed.
- 1.67 “Licensed independent clinician or practitioner” – moved to § 1.3.1(A)(31)
- 1.68 “Medical detoxification” – moved to § 1.3.1(A)(32), updated term ‘abuse’ to ‘misuse’ to reflect current practice.
- 1.69 “Medically supervised withdrawal” – moved to § 1.3.1(A)(33)
- New language “Mental health professional” § 1.3.1(A)(34) added to reflect current practice.
- 1.70 “Mental Health Psychiatric Rehabilitative Residence” – Deleted definition not needed.
- 1.71 “Minor/child” – moved to § 1.3.1(A)(35)
- 1.72 “Opioid treatment program” – moved to § 1.3.1(A)(36), updated to add ‘methadone’ to reflect current practice.
- 1.73“Orientation” – moved to § 1.3.1(A)(37)
- 1.74 “Outcome” – moved to § 1.3.1(A)(38)
- 1.75 “Outpatient detoxification” – moved to § 1.3.1(A)(39)
- 1.76 “Peer support” – Deleted definition not needed.
- New language: "Person-centered plan" § 1.3.1(A)(40), added to reflect current practice.
- 1.77 “Physical examination” – moved to § 1.3.1(A)(41), updated to add ‘chest x-ray’ to reflect current practice.
- 1.78 “Pre-Crisis Treatment Plan” – Deleted definition not needed.
- 1.79 “Premises” – moved to § 1.3.1(A)(42)
- 1.80 “Primary Provider” – Deleted definition not needed.
- 1.81 “Priority population” – moved to § 1.3.1(A)(43)
- 1.82 “Program” – moved to § 1.3.1(A)(44)
- 1.83 “Provider” – moved to § 1.3.1(A)(45)

- 1.84 “Provisional Chemical Dependence Professional” – Deleted definition not needed.
- 1.85 “Provisional Certified Co-Occurring Disorder Professional” – Deleted definition not needed.
- New language “Qualified mental health professional” § 1.3.1(A)(46) added to reflect current practice.
- 1.86 “Recovery” – moved to § 1.3.1(A)(47)
- 1.87 “Recovery principles” – Deleted definition not needed.
- 1.88 “Register” – Deleted definition not needed.
- 1.89 “Rehabilitation service” – moved to § 1.3.1(A)(48)
- 1.90 “Residential services” – moved to § 1.3.1(A)(49)
- 1.91 “Restraint” – moved to § 1.3.1(A)(50), updated term to reflect current practice.
- 1.92 “Rhode Island Consumer System of Care” – Deleted no longer a program/service.
- 1.93 “Seclusion” – moved to § 1.3.1(A)(51)
- 1.94 “Service area” – moved to § 1.3.1(A)(52)
- 1.95 “Services” – moved to § 1.3.1(A)(53)
- 1.96 “Shall” – Deleted definition not needed.
- 1.97 “Significant others” – moved to § 1.3.1(A)(54)
- 1.98 “Staff” – moved to § 1.3.1(A)(55), updated to reflect current practice, added ‘includes, but is not limited to’, deleted independent contractor.
- 1.99 “Stakeholder” – Deleted definition not needed.
- 1.100 “State opioid treatment authority” – moved to § 1.3.1(A)(56), updated term to reflect current practice.
- 1.101 “Supported Employment” – Deleted not regulated by Department.
- 1.102 “Supported Employment Professional” – Deleted not regulated by Department.
- 1.103 “Treatment" or “Care” – Deleted definition not needed.
- 1.104 “Validate” – Deleted definition not needed.

5. **§ 2.1** moved to § 1.3.3(B) and amended because it was duplicative.

6. **§ 2.1.1 to 2.2.12** was deleted to reflect current practice.

7. **§ 2.2** moved to § 1.3.3(C) and amended to align with the Licensing regulations.

8. **§§ 2.2.1 to 2.2.7** was amended to cite the current general law for CMHCs in § 1.4.1(B) and to define and describe current services in §1.6.7, § 1.6.7(A) and (B), §1.6.10(A) and (B), § 1.6.11.

9. **§ 2.3** moved to § 1.3.3(D).

10. **§ 2.4** was deleted because it was duplicative of what is in the Licensing regulations.

11. **§ 2.5** was deleted and updated to reflect current statutory references in § 1.6.14(A)(1) Medication Assisted Treatment and §1.2(A) and (B) Relevant Federal Law.

12. **§ 2.6** was deleted and updated to reflect current statutory references in § 1.6.14(A)(1) Medication Assisted Treatment and §1.2(A) and (B) Relevant Federal Law.

13. **§ 2.7** was deleted and updated to describe the specific services required in § 1.6.11(A).

14. **§ 3.0 Rules Governing Practices and Procedures** was deleted in its entirety and new language was added in §1.3.2(B) to conform with the mandated EOHHS appeal process in 210-RICR-10-05-2.

15. **§ 4.0 Leadership and Organization Planning** was deleted and new language was added to reflect current practice in §1.4.1 Provider Governance:

"A. Organizations shall meet all requirements established in Subchapter 00 Part 1 of this Chapter.
B. Entities designated by the Director as a CMHC shall adhere to R.I. Gen. Laws §§ 40.1-8.5-2(3); 40.1-8.5-4; 40.1-8.5-5 and 40.1-8.5-7, 40.1-5.4-1; 40.1-5.4-4; and 40.1-5.4-5, which define the organizational structure, board governance structure, board membership duties and services required of a CMHC."

16. **§ 5.0 Financial Management** was deleted because it was duplicative of the language in the Licensing regulations and to eliminate redundancies. 212-RICR-10-00-01.

17. **§ 6.0 Direction of Services.** §§ 6.1, 6.1.1, 6.7 and 6.7.1 were deleted because the language was non-regulatory. §§ 6.2, 6.3, 6.4, 6.5 and 6.6 were moved to Licensing regulations to eliminate redundancies, Provider Governance. 212-RICR-10-00-01

18. **§ 7.0 Leadership's Role in Performance Improvement** was deleted and moved to Licensing regulations, Provider Governance, to eliminate redundancies. 212-RICR-10-00-01

19. **§ 8.0 Human Resources** was deleted and moved to Licensing regulations § 1.2.6 to eliminate redundancies and added new language in § 1.4.2 that is BHO specific practice:

"B. The organization shall have a policy relating to treatment of employees during periods of behavioral health crises.
C. Clinical and administrative leaders shall define, for their areas of responsibility, the qualifications and competencies of staff needed to fulfill the organization's mission.
1. Staff qualifications shall be commensurate with job responsibilities and applicable licensure, law, regulation, registration and/or certification.
D. The organization shall provide professional development opportunities to all staff that maximize individual cultural competencies.
E. The organization shall have recruitment and retention policies to increase the number of personnel who reflect the cultural diversity of the communities in which the BHO provides services.
F. The organization shall have policies for recruiting leadership that is culturally representative of the individuals served by the organization.
G. The organization shall have policies and procedures to address requests by persons served for a change of provider, clinician or service."

20. **§ 9.0 Staff Competency and Training.** § 9.1 was moved to § 1.6. §§ 9.2 and 9.3 were moved to Licensing regulations to eliminate redundancies 212-RICR-10-00-01. § 9.4 was moved to § 1.6. § 9.5 was moved to § 1.6. §§ 9.6, 9.7 and 9.8 were deleted and moved to Licensing regulations § 1.26 Personnel to eliminate redundancies. §§ 9.9, 9.10, 9.11 were moved to §§ 1.6 and updated to reflect current credentials and licensure requirements. §§ 9.12, 9.13, 9.13.1, 9.14, 9.15, 9.16 were deleted to remove the 50% ratios in licensure and credentialing. New language added to reflect current practice in § 1.6 Services and Programs:

"A. All organizations licensed by the Department to provide services and programs will have staff with appropriate training, education, experience, credentials and licenses to deliver the services and programs covered in this Part.
B. Direct Service Staff
1. All staff providing direct services in licensed behavioral health organizations who are not licensed independent practitioners will receive clinical supervision.
2. Hours of supervision will be pro-rated for actual hours worked each month.
3. Licensed staff - all professionally licensed staff who provide a clinical or medical service, and are not independent practitioners, except nurses in an OTP who have no counseling responsibilities, will receive supervision on a regular and predictable schedule that occurs at least monthly with preference for a minimum of four (4) hours

of clinical supervision per month (pro-rated for part-time clinicians), that will consist of no less than one (1) hour of individual supervision. Each month the remaining three (3) hours of clinical supervision may be in a group setting.

4. Staff without a license - All direct service staff who do not have a professional license, except those who work the third shift in a residential program, will receive supervision on a regular and predictable schedule that occurs at least monthly with preference for a minimum of four (4) hours of clinical supervision per month (pro-rated for part-time direct service staff) of which at least two (2) hours will be individual clinical supervision. Each month the remaining two (2) hours of documented clinical supervision may be in a group setting.

5. Direct service staff who work the third shift in a residential program will receive a minimum of one (1) hour of clinical supervision each month, at least thirty (30) minutes of which will be individual clinical supervision.

6. All clinical supervision will relate to the service the staff person is providing and will be documented.

C. Clinical Supervisors

1. Staff providing clinical supervision will have, at a minimum, the following qualifications with education, credential, license, and experience relevant to the service they are supervising:

a. Licensed Independent Practitioner; or

(1) These licenses include Licensed Marriage and Family Therapist (LMFT), Licensed Independent Clinical Social Worker (LICSW), Medical Doctor (MD) and Licensed Ph.D., Licensed Nurse Practitioner (LNP), and Advanced Practice Registered Nurse (APRN).

b. Licensed Chemical Dependency Clinical Supervisor (LCDCS) with experience providing substance use counseling and delivering clinical supervision focused on the clinical skills and competencies for persons providing counseling; or

c. Licensed Chemical Dependency Professional or Certified Alcohol and Drug Counselor who has completed a Department approved course in clinical supervision; Certified Co-Occurring Disorder Professional-Diplomate, Certified Advanced Alcohol and Drug Counselor, Certified Co-Occurring Disorder Professional or

(1) The Certified Co-Occurring Disorder Professional-Diplomate, Certified Co-Occurring Disorder Professional and Provisional Certified Co-Occurring Disorders Professional credentials issued by the Rhode Island Certification Board have been discontinued. Individuals with the credential may renew or recertify this credential but no new credentials will be issued. The Certified Alcohol and Drug Counselor and Certified Advanced Alcohol and Drug Counselor credentials contain the co-occurring competencies.

d. Clinician with relevant Master's Degree and license and, at least, two (2) years full time experience providing relevant behavioral health services; or

e. Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services."

21. **§ 10.0 Management of the Environment of Care** was deleted to eliminate redundancies in the Licensing regulations. New § 1.4.4 cites to the Licensing regulations. 212-RICR-10-00-01.

22. § 11.0 Management of Information. §§ 11.1 to 11.9 were deleted because the language is non-regulatory. §§ 11.10, 11.11, 11.12 and 11.18 were moved to §§ 1.4.5 (B), (C) (D) and (E), respectively. §§ 11.13 to 11.17 were deleted because the language was non-regulatory and to eliminate redundancies in the Licensing regulations. 212-RICR-10-00-01

23. § 12.0 Surveillance, Prevention and Control of Infection was deleted because it was duplicative of the language in the Licensing regulations **§** 1.27(A).

24. § 13.0 Performance Improvement was deleted because the language was non-regulatory and updated language is contained in Licensing regulations to reflect current practice.

25. § 14.0 Research was deleted and updated in § 1.4.6 adding new language to reflect current practice:

"A. In the event that research, experimentation, or clinical trials involving human subjects is to be conducted, the organization must adhere to the following guidelines and to all applicable state and federal laws and regulations.
1. A proposal outlining the research, experimentation, or clinical trial must be submitted to an organizational review board formally comprised of individuals who have expertise in research protocols, privacy and confidentiality, as it relates to research convened by the Department and approved through the organizational review process. The proposal shall include:
a. The purpose of the study, the treatment proposed and its relation to the organization's mission statement and values;
b. A description of the benefits expected;
c. A description of the potential discomforts and/or risks that could be encountered;
d. A full explanation of the procedures to be followed;
e. The criteria for inclusion and exclusion;
f. The process to be used to explain the procedures to the subject of the study, experiment, or clinical trial;
g. The authorization form is to be a consent to participate in the research, experimentation, or clinical trial;
h. The methods of addressing any potential harmful consequences with respect to an individual's right to privacy, confidentiality, and safety.
2. The authorization form shall include a description of all the elements described in § 1.4.6(A)(1) of this Part and:
a. The name and credentials of the person who supplied the information;

b. The signature and date of such person;
c. The process for the subject to withdraw at any point, without compromising his or her access to the organization's services;
d. The participant's signature indicating willingness to participate.
3. If research is proposed in conjunction with a university or college, the organization shall be required to provide documentation verifying that the research has been reviewed by the university's human subject review committee."

26. **§ 15.0 Rights of Persons Served and Responsibilities of Behavioral Healthcare Organizations** was moved to Licensing regulations § 1.3.1 Participant's Rights; § 15.4 was incorporated into Research § 1.4.6 and updated in § 1.3.2(B), § 1.5.1 Protection of Rights: Human Rights Officers to reflect current practice and new language was added to harmonize BHO and DDO practice in § 1.5.3 Grievance Procedure:

"A. Every BHO shall establish an accessible grievance procedure.
B. The grievance procedure shall be presented to every person served in a manner consistent with the person's learning style and be conspicuously posted in the BHO. The notice of grievance procedure shall include the name and contact information for organizations that provide free legal assistance.
C. The person served shall be entitled to initiate a grievance. It shall be the duty of the BHO to encourage and assist the person in exercising his or her rights.
D. The person served shall initiate the grievance by filing for a grievance with the director of the BHO. The director shall forthwith forward a copy of the grievance form to the HRO.
E. The director of the BHO, or his or her designee, with the assistance of the HRO, or his or her designee, shall investigate the grievance and issue a written decision to the person within ten (10) business days of receipt of the grievance. The written decision shall include a copy of the grievance, a list of persons interviewed in the investigation, the steps taken to resolve the grievance, and the conclusion of the BHO director or his or her designee.
F. The HRO, or his or her designee, shall, if necessary, assist the person in requesting a review.
G. If the person is not satisfied with the outcome of the grievance proceedings, the person may file for an administrative hearing in accordance with the Appeals Process and Procedures for EOHHS Agencies and Programs, 210-RICR-10-05-2."

27. **§ 16.0 Rights of Persons Served in Residential Programs** was moved in its entirety to § 1.5.

28. **§ 17.0 Confidentiality** was deleted as duplicative of §1.2 and new language added to identify controlling authority in §1.5.2:

"All persons served have the right to have their records kept confidential pursuant to the applicable federal and state laws and regulations."

29. **§ 18.0 Protection of Rights: Human Rights Officers** was moved in its entirety to § 1.5.1.

30. **§ 19.0 Concern and Complaint Resolution Procedure** was harmonized with the grievance procedure in the DDO regulations and new language added in § 1.5.3 Grievance Procedure: See item 26 above.

31. **§ 20.0 Organization Ethics** was deleted and moved to Licensing regulations § 1.21(C) Provider Governance to eliminate redundancies.

32. **§ 21.0 Behavioral Management** was moved in its entirety to § 1.5.4.

33. **§ 22.0 Seclusion and Restraint** was amended and new language reflecting current practice added in § 1.5.5:

"A. Seclusion, chemical restraint, and mechanical restraint, as defined in this Part, are prohibited in all BHOs.
B. Physical restraint as defined in this Part may be used only when there is an imminent risk of danger to an individual or others and no other safe and effective intervention is possible. Nonphysical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response.
1. When physical restraint is used, it shall be applied in a manner that minimizes the possibility of physical injury or mental distress to the individual.
a. Only approved physical restraining procedures that have been developed by a nationally recognized organization shall be used.
b. The individual served shall not be placed in a prone restraint, as prohibited by R.I. Gen. Laws § 42-158-4.
c. The individual shall be removed from restraint as soon as the threat of harm has been safely minimized.
C. The individual and, if appropriate, the individual's family shall participate with staff who were involved in the episode in a debriefing about each episode of restraint.
D. The use of physical restraint must be recorded in the individual's treatment record by a staff member who was present at the time of the restraint.
E. Every use of restraint shall be recorded and reported as an adverse event to the Department's Office of Quality Assurance.
1. The organization shall collect data on the use of restraint in order to monitor and improve its performance and report it to the Department's Office of Quality Assurance."

34. § 23.0 Clinical Screening was amended, new language added in § 1.6.1 to eliminate non-regulatory and overly prescriptive language.

35. § 24.0 Biopsychosocial Assessment was amended, new language added in § 1.6.2 to eliminate non-regulatory language and update current licensing and credential requirements.

36. § 25.0 Treatment Plan was amended, new language added in § 1.6.3 to reflect current industry standards as "person-centered" treatment plans and eliminate non-regulatory language.

37. § 26.0 Treatment Plan Review was amended, new language added in § 1.6.4 to reflect current industry standards as "person-centered" and eliminate non-regulatory language.

38. § 27.0 Progress Notes was amended in § 1.6.5 to eliminate non-regulatory language.

39. § 28.0 Discharge Summary and Aftercare Plan was amended in § 1.6.6 Transition/Discharge Summary and Aftercare Plan to reflect current industry standards to include ICD codes for coding services and eliminate non-regulatory language.

40. § 29.0 Emergency, Crisis Intervention, and Crisis Stabilization Services was amended, new language added in § 1.6.7(A) to eliminate non-regulatory language.

41. § 30.0 Medication and Laboratory Services was moved to § 1.6.8.

42. § 31.0 General Outpatient Services was amended in §1.6.7(B) to eliminate non-regulatory language.

43. § 32.0 Services for Persons with Co-occurring Disorders: Integrated Co-Occurring Treatment was amended in § 1.6.9 to: remove the 50% ratio required by § 32.2.1(A), add a requirement to check the PDMP generally before prescribing medications, require a pregnancy test for all women of childbearing age, and update staffing and qualification requirements to reflect current practice, as follows:

"5. Staffing and Qualifications. The following qualifications are recommended for staff providing co-occurring clinical services:
a. Dual licensure in mental health and addictions; or
b. Certified Co-Occurring Disorder Professional-Diplomate or Certified Advanced Alcohol and Drug Counselor; or
c. Certified Co-Occurring Disorder Professional or Certified Alcohol and Drug Counselor."

44. § 33.0 Case Management and Community Psychiatric Supportive Treatment was amended in § 1.6.10(A) to reflect current industry practice and minimum qualifications, as follows:

"2. Staffing
a. All staff providing case management services will receive appropriate training on case management specific to supported employment and substance use.
b. Staff providing case management services will have a minimum of an Associate's Degree in a relevant human service field.
c. Clinical supervisors of case management or CPST services shall have, at a minimum, the qualifications listed in § 1.6 of this Part; or a Bachelor's Degree in a relevant human service field and have a minimum of three (3) years full time experience providing behavioral healthcare services to the population served."

45. § 34.0 Intensive Outpatient Services was amended in § 1.6.7(C) to eliminate non-regulatory language.

46. § 35.0 Rhode Island Assertive Community Treatment (RIACT-1) was amended in § 1.6.11(B) to eliminate non-regulatory language, update eligibility criteria, staffing, hours of operation for all services except crisis and clarify delivery of services to reduce the level of burden on the provider to meet staffing percentage thresholds and reflect current practice, as follows:

"B. RI Assertive Community Treatment (ACT)
1. The Department will establish guidelines for fidelity for ACT programs. Until those guidelines are developed, the IHH-ACT manual will act as best practice guidelines for implementation of ACT.
2. Admission/Eligibility Criteria. Clients eligible for ACT services will meet diagnostic and functional criteria established by the Department.
a. Diagnostic eligibility:
(1) Schizophrenia
(2) Schizoaffective Disorder
(3) Schizoid Personality Disorder
(4) Bipolar Disorder
(5) Major Depressive Disorder, recurrent
(6) Obsessive-Compulsive Disorder
(7) Borderline Personality Disorder
(8) Delusional Disorder
(9) Psychotic Disorder.
b. Functional Eligibility: Clients with a Daily Living Assessment of Functioning (DLA) score of <3.0 are eligible for ACT services.
3. ACT team is mobile and delivers the following core ACT services in the community (further description is in the IHH-ACT manual):
a. Service Coordination/Case Management;

b. Crisis Assessment and Intervention to be provided 24 hours a day/7 days a week/365 days a year;
c. Symptom Assessment and Management;
d. Medication Prescription, Administration, Monitoring and Documentation;
e. Co-Occurring Substance Use Disorder Services;
f. Work-Related Services;
g. Activities of Daily Living/ADL's;
h. Social/Interpersonal Relationship and Leisure-Time Skill Training;
i. Peer Support Services;
j. Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:
(1) Medical and dental services;
(2) Safe, clean, affordable housing;
(3) Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance);
(4) Social service;
(5) Transportation;
(6) Legal advocacy and representation;
(7) Education, Support, and Consultation to Clients' Families and Other Major Supports.
4. Required Staffing Model per 100 clients:

TITLE	*FTE*
Program Director (LICSW, LMHC, LMFT, LCDP, RN)	*1*
Registered Nurse	*2*
Master's Level Clinician	*1*
Vocational Specialist (BA level)	*1*
Substance Use Disorder Specialist (BA level)	*2*
CPST Specialist	*4*
Peer Specialist	*1*
Psychiatrist	*.75*
Total staff on team	*12.75*

5. Staff Composition Variances

a. Any requests for variance in staffing composition, whether position or qualifications, must be submitted in writing to the Department's licensing unit for approval.
6. Discharge Criteria. Discharge from the ACT program can be based on the following criteria:
a. when clients and program staff mutually agree to the discharge;
b. termination of services and transfer to a different level of care (IHH or GOP). This shall occur when clients:
(1) Have successfully reached individually established goals for discharge, and when the client and program staff mutually agree to the termination of services.
(2) DLA results indicate need for higher or lower level of care.
(3) Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the client.
(4) Do not participate in any services for a period of ninety (90) days, despite documented efforts to engage in treatment."

47. § 36.0 Rhode Island Assertive Community Treatment-II (RIACT-II) was deleted because the services are no longer offered.

48. §§ 37.1 to 37.2 and 37.5 to 37.7, Community Integration Programs & Services, were deleted because the language is non-regulatory. § 37.0 was amended in § 1.6.10(B). §§ 37.3 and 37.4 were amended in § 1.6.10(A) to reflect current practice.

49. § 38.0 Rhode Island Consumer System of Care was deleted because the services are no longer offered. § 38.4 was amended in §§ 1.6.12(B), (C) and (D) to reflect current practice, as follows:

"B. MHPRR Mental Health Psychiatric Rehabilitative Residences (MHPRR). Basic Mental Health Psychiatric Rehabilitative Residence (MHPRR) is a congregate licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing. This population includes individuals with refractory psychosis; dual diagnosis (individuals with developmental disabilities and mental health issues); addiction and mental health issues (co-occurring disorders), who cannot be treated in the community through outpatient supports. A physician must authorize all MHPRR services, based on the Psychiatric Rehabilitative Residence Individual Care Checklist.

1. The provider must provide staff on site coverage 24-hours a day/7 days a week as long as there are client(s) physically present in the residence.

a. Availability of 1:1 staffing when a resident is in crisis.

b. The minimum standard staffing pattern of direct care staff to residents approved by the Department is:

(1) Staffing can be based on the acuity of residents in the household. Preference is for one (1) direct care staff to eight (8) residents during periods when residents are awake (1:8).

(2) Direct care staff to resident ratio is at minimum one (1) to sixteen (16) between the hours of 11pm and first shift (1:16).

(3) The Department reserves the right to require the BHO to have increased staffing levels based upon health and safety needs.

c. At least one (1) staff person trained in CPR.

2. The provider must abide by the Policy and Procedure for MHPRR (Group Home) priority list process.

3. The service elements offered by a residential program include the following based on each resident's individualized recovery-focused, person-centered plan:

a. Mental health therapeutic and rehabilitative services for the resident to attain recovery;

b. Medication prescription, administration, education, cueing and monitoring;

c. Educational activities (appropriate to age and need);

d. Menu planning, meal preparation and nutrition education;

e. Skill training regarding health and hygiene;

f. Budgeting skills training and/or assistance;

g. Community and daily living skills training;

h. Community resource information and access;

i. Transportation;

j. Social skills training and assistance in developing natural social support networks;

k. Cultural/spiritual activities;

l. Counseling: Individual, group and family;

m. Social casework: Client-based advocacy; linkage to outside service providers; monitoring the use of outside services; individualized person-centered planning and skill teaching; income maintenance; and medical care assistance;

n. Limited physical assistance as required: Mobility; assistance with non-injectable medications; dressing; range-of-motion exercises; transportation; and household services; and

o. A comprehensive person-centered treatment plan shall be completed with each resident and, as appropriate, his or her family within thirty (30) days of admission. The treatment plans and treatment plan reviews of each resident of a MHPRR program must be signed by the psychiatrist who is treating the resident.

p. If a comprehensive medical history and physical examination have been completed within sixty (60) days before admission to the program, a durable, legible copy of this report may be used in the treatment record as the physical assessment. If not, a physical health assessment, including a medical history and physical examination, shall be completed by a qualified medical, licensed, independent practitioner, within thirty (30) days after admission to a residential program.

4. In addition, each residential program shall provide the following for its residents:

a. A homelike and comfortable setting;

b. Opportunities to participate in activities not provided within the residential setting;

c. Regular meetings between the residents and program personnel;

d. A daily schedule of activities;

e. Sleeping arrangements based on individual need for group support, privacy, or independence, as well as, the individual's gender and age; and

f. Provisions for external smoking areas, quiet areas, and areas for personal visits

5. Environment of Care

- ***a.*** *The maximum capacity that can be located in one facility is sixteen (16) beds.*

- ***b.*** *There should be no more than two (2) clients in one (1) room. Exceptions to this policy require prior approval of the Department and are limited to allowing one (1) room to have three (3) clients.*

C. Specialized Mental Health Psychiatric Rehabilitative Residence

1. Specialized Mental Health Psychiatric Rehabilitative Residence is a congregate licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing for populations with complex co-occurring conditions in which the clients receive a wide range of care management, co-occurring treatment of

substance use and mental health, psychiatric rehabilitation and individual care services. A physician must authorize all MHPRR services, based on the Psychiatric Rehabilitative Residence Individual Care Checklist. Specialized services are meant to address populations that are difficult to maintain in traditional group home settings including: clients with co-occurring substance use and mental health disorders, those stepping down from Eleanor Slater Hospital, clients who are self-injurious or have personality disorders, and transitional-aged youth.

2. The provider must follow the policies, procedures, protocols as described in Basic MHPRR, § 1.6.12(B) of this Part.

D. Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-A)

1. Supportive Mental Health Psychiatric Rehabilitative Residence Apartment Is a licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing for clients to receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services in an apartment setting. A physician must authorize all MHPRR services, based on the Psychiatric Rehabilitative Residence Individual Care Checklist.

2. The Provider must follow the policies, procedures, protocols as described in Basic MHPRR, § 1.6.12 (B) of this Part.

a. In all cases, response time to any individual unit (e.g. bedroom or apartment) will be no greater than five (5) minutes.

3. Clients eligible for this program do not require constant staff supervision, but do require availability of staff to respond quickly to meet needs.

4. Clinical Supervisors of residential staff shall have at a minimum, the qualifications defined in § 1.6(C)(1) of this Part. Direct service staff in residential programs shall have the qualifications relevant to the service they are providing."

50. § 39.0 Supported Housing Services was deleted because it is no longer regulated by the Department.

51. § 40.0 Residential Services was amended to reflect current practice in:
§ 1.6.12(A) Behavioral Health Stabilization Unit to eliminate § 40.30, the typical length of stay, because it was non-regulatory.
§ 1.6.12(B) Mental Health Psychiatric Rehabilitative Residence (MHPRR) to divide multiple levels of care based on acuity and specialized services provided; § 40.4 Physical Health Assessment and § 40.4.1 Comprehensive Medical History and Physical

Examination were combined and the time frame was extended from thirty (30) days to sixty (60) days to reflect current practice. § 40.5 treatment plan time frame was extended from seven (7) days to thirty (30) days and add new staffing language to reflect current practice:

"1. The provider must provide staff on site coverage 24-hours a day/7 days a week as long as there are client(s) physically present in the residence.
a. Availability of 1:1 staffing when a resident is in crisis.
b. The minimum standard staffing pattern of direct care staff to residents approved by the Department is:
(1) Staffing can be based on the acuity of residents in the household. Preference is for one (1) direct care staff to eight (8) residents during periods when residents are awake (1:8).
(2) Direct care staff to resident ratio is at minimum one (1) to sixteen (16) between the hours of 11pm and first shift (1:16).
(3) The Department reserves the right to require the BHO to have increased staffing levels based upon health and safety needs.
c. At least one (1) staff person trained in CPR."

§ 1.6.12(F) Substance Use Disorder was amended to clarify the levels of care to conform with industry standards as follows:

"F. Residential Programs for Substance Use Disorders
1. The provider must utilize the ASAM Patient Placement Criteria https://www.asam.org/resources/the-asam-criteria/about to determine the appropriate level of residential care and be able to provide the array of services based on the appropriate placement level, including medication assisted treatment options.
a. Biopsychosocial assessments must be completed forty-eight (48) hours after admission.
b. Justification for the selection of the ASAM level of care must be validated within the diagnostic summary of the assessment.
c. The individual's treatment team must complete a person-centered (treatment) plan. In addition, the following requirements related to the person-centered (treatment) plan must be met:
(1) A review of the person-centered plan for each person served in a residential treatment program shall occur at least once a month and documented in the treatment file.
2. The program provides active treatment seven (7) days a week based on the needs of persons served in each of the following areas:
a. Individual counseling/therapy;
b. Group counseling/therapy;
c. Family/support system counseling/therapy;
d. Relapse prevention/crisis preparation work.

3. The residential treatment program shall provide a suitable service array for the ASAM level of care as described below. The minimum requirements for each level are described below.

a. Level 3.5 Clinically Managed, High-Intensity Residential provides a structured, therapeutic community environment focused on addressing life skills, reintegration into the community, employment, education, and recovery.

(1) The organization must have the ability to provide an appropriate service array for clients meeting 3.5 ASAM level criteria.

(2) The service array will consist of at least twelve (12) clinical services per week including individual, group and family counseling based on the client's need.

b. Level 3.3 Short-Term, Clinically Managed, Medium-Intensity is a non- acute residential level of care that focuses on stabilization, integration, employment, education, and recovery. A component of treatment may focus on habilitation due to discharge from institutional level of care.

(1) The organization must have the ability to provide an appropriate service array for clients meeting 3.3 ASAM level criteria.

(2) The service array will provide at least twelve (12) clinical services per week including individual, group and family counseling, based on the client's need.

c. Level 3.1 Clinically Managed, Low-Intensity Residential Services

(1) The organization must have the ability to provide an appropriate service array for clients meeting 3.1 ASAM level criteria.

(2) The service array will include at least five (5) clinical services (one (1) hour per week of clinical treatment and four (4) group and/or family sessions) per week including individual, group and family, based on the client's need.

4. Staffing

a. Services are provided by a coordinated treatment team that includes a qualified behavioral health practitioner who coordinates the plan of the person serviced at a minimum.

b. All non-licensed direct-care staff are required to be moving toward a certification as a Certified Advanced Alcohol and Drug Counselor (CAADC) Certified Alcohol and Drug Counselor (CADC) or at the least as a Provisional Alcohol and Drug Counselor (PADC).

c. The program provides on-site personnel support twenty-four (24) hours day/ seven (7) days a week with assigned and trained residential personnel to meet the following staff/consumer engagement ratios:

(1) The minimum standard staffing pattern of direct care staff to residents approved by the Department is:

(AA) One (1) direct care staff to eight (8) residents during periods when residents are awake (1:8). Staffing can be increased based on the acuity of the residents in the household

(BB) Direct care staff to resident ratio is at minimum one (1) to twenty (20) overnight (1:20).

(2) The provider may submit an interim staffing plan to the Department in the event the direct care staff to resident ratio is not met.

5. Organizations that provide substance use services will have policies and procedures for urine drug testing (UDT). These policies will be made available to the persons served and will include the following provision:
a. Individuals may, at their own expense, have drug tests confirmed.
b. UDT need to be clinically appropriate and trauma informed.
c. Random UDT will be conducted on a routine basis.
6. Residential Programs that Serve Minors. Residential programs that service minors, in addition to the licensing standards listed above, must follow these additional standards.
a. Substance Abuse residential programs that serve minors will provide staffing that allows for constant adult supervision at all times, including the following:
(1) The minimum standard staffing pattern of direct care staff to residents approved by the Department is:
(AA) One (1) direct care staff to eight (8) residents during periods when residents are awake (1:8). Staffing can be increased based on the acuity of the residents in the household
(BB) Direct care staff to resident ratio is at minimum one (1) to twenty (20) overnight (1:20).
(2) The provider may submit an interim staffing plan to the Department in the event the direct care staff to resident ratio is not met.
b. Residential programs that serve minors for more than thirty (30) days, will provide, or arrange through school districts, an academic and physical education program for each minor within fourteen (14) days of his or her admission.
c. Residential facilities and treatment services for minors will be separate from those provided for the adult population, except for the following minors:
(1) Pregnant minors
(2) Children of adults undergoing residential treatment.
d. Parental consent will be required for all minors treated in substance abuse residential programs, except as otherwise provided by R.I. Gen. Laws § 14-5-4.
e. Programs providing services to minors will comply with R.I. Gen. Laws § 11-9-13 pertaining to the purchase, sale, or delivery of tobacco products to persons under the age of eighteen (18).
f. Residential programs will have a written policy regarding staff responsibilities when a minor is absent without permission. The policy will include:
(1) Immediate notification of the parent(s) or legal guardian(s);
(2) Immediate notification of the proper legal authorities; and
(3) Documentation in the minor's treatment record of the elopement and of the appropriate notifications as they were completed."

52. § 41.0 Community Support Programs was deleted because the language was non-regulatory.

53. § 42.0 Family Psychoeducation was deleted because it is no longer regulated by the Department.

54. § 43.0 Outpatient Detoxification Services was moved to §1.6.13(B).

55. § 44.0 Medical Detoxification Services was moved to § 1.6.13(A).

56. § 45.0 Opioid Treatment Programs was amended in §1.6.14(A) to remove non-regulatory language, align "take home privileges" to reflect federal statute and regulation as cited in § 1.2 Relevant Federal Law. New language in 1.6.14(B) added Health Homes to reflect current practice.

"1.6.14 Medication Assisted Treatment

A. Opioid Treatment Program (OTP)

1. This section applies to all opioid treatment and maintenance programs that administer or dispense methadone and other approved medication as maintenance or detoxification treatment to a person dependent on opioids. Programs shall reference the State Methadone Treatment Guidelines/ TIP1 (Treatment Improvement Protocol Series/CSAT) and Buprenorphine Treatment Guidelines. Programs must also comply with the Pharmacy Statute, R.I. Gen. Laws Chapter 5-19.1, Uniform Controlled Substance Act, R.I. Gen. Laws Chapter 21-28, Drug Abuse Control Act, R.I. Gen. Laws Chapter 21-28.2, and Drug Abuse Reporting Act, R.I. Gen. Laws Chapter 21-28.3.

2. OTPs shall use only opioid replacement treatment medications that are approved by the Food and Drug Administration, and the federal Food, Drugs, and Cosmetic Act (21 U.S.C. § 355) for use in the treatment of opioid use disorder.

3. All federal laws and regulations that pertain to the handling of any opioid replacement medication shall apply in these regulations.

4. All OTPs shall be open seven (7) days per week - or have the capacity to arrange for dispensing medication(s) to clients on Sundays and holidays should the program be closed or have reduced hours. The State Opioid Treatment Authority must be notified by email in cases of emergency closing due to weather-related or other emergent conditions.

5. Staffing

a. The program director of the OTP, or his or her designee, shall assign the treatment of persons served according to best practice standards and ensure appropriate rehabilitative and nursing services are provided.

b. Each OTP shall have a designated medical director who has the responsibility for administering all medical services. He or she shall:

(1) Be licensed to practice medicine in Rhode Island;

(2) Have RIDOH Controlled Substance Registration; and

(3) Be DEA registered.

c. The medical director or other authorized OTP physician shall assume the following responsibilities:

(1) Evaluate each person to determine and to document his or her current physiological opioid addiction;

(2) Conduct the required physical evaluation and document the medical history for each person served;

(3) Ensure that the appropriate laboratory studies have been performed; and

(4) Document and sign or counter-sign all medical orders.

d. Clinical staff caseloads should not exceed an average staff to client ratio of 1:60.

(1) The provider shall submit an interim staffing plan to the Department in the event the clinical staff to client ratio is not met.

6. Each OTP shall have written policies and procedures describing admission requirements, to include:

a. Documentation of a one (1) year history of opioid addiction for persons eighteen (18) years of age and over. Exceptions may be granted by the program physician for applicants who have been released from prison or from chronic care facilities, are HIV positive, are pregnant, and/or have previously been treated for opioid addiction.

b. The OTP must verify a minimum of two (2) prior short-term detoxifications or drug free treatment episodes in a twelve (12) month period for individuals under eighteen (18) years of age and must obtain parental or legal guardian's consent.

c. No person under sixteen (16) years of age may be admitted to an OTP unless the program has received prior written approval of the admission from the State Opioid Treatment Authority.

d. All women of childbearing potential shall be tested for pregnancy:

(1) Before admission to an OTP;

(2) Before any detoxification or medically supervised withdrawal is initiated; and

(3) Medical staff shall document test results in the woman’s treatment record.

e. A physical health assessment, including a medical history and physical examination, shall be completed within the first twenty-four (24) hours of a person’s admission to the program and shall include:

(1) Possible infectious diseases, including human immunodeficiency virus (HIV), tuberculosis (TB), viral hepatitis and sexually transmitted diseases (including syphilis);

(2) Pulmonary, liver and cardiac abnormalities;

(3) Dermatological and neurological consequences of addiction; and

(4) Possible concurrent surgical problems.

7. Programs are required to check the DOH Prescription Drug Monitoring Program 216-RICR-20-20-3 for each new admission, in accordance with R.I. Gen. Laws § 21-28-3.32 for each new admission and at each annual physical.

8. Prior to an individual's admission to an OTP, the following information shall be entered into the Department's BHOLD system:

a. The individual's initials (first, middle, last);

b. Date of birth;

c. Last four (4) digits of the person's Social Security number;

d. Anticipated date of admission; and

e. Gender.

9. If the BHOLD system is inoperable, prior to admitting any individual, the OTP shall contact each of the other OTPs in Rhode Island to verify that the individual is not receiving services from another OTP.

a. The documentation of these contacts shall be noted in the individual's treatment record and the OTP shall submit the individual's data to the BHOLD system as soon as it is operable.

10. Person-Centered (Treatment) Planning

a. An initial person-centered plan shall be completed within the ninety (90) days of each person's admission to the OTP reflecting patient/client goals and method for measuring these goals that meets criteria set out in Department service guidelines for person-centered (treatment) planning.

b. Person-centered plans shall be reviewed, revised, and updated every six (6) months.

c. A new person-centered plan shall be developed at least once every twelve (12) months.

d. The type and number of counseling sessions received by each individual in the program shall be based on a clinical assessment of the person's service needs and goals as formulated in the person's plan.

e. Rehabilitative counseling services (individual, group, and family) shall be provided by OTP staff and shall be consistent with the individual's person- centered plan. A minimum of one (1) session per month is required. The type and number of counseling sessions received by each individual in the program shall be based on a clinical assessment of the person's service needs and goals as formulated in the person's treatment plan. Minimum requirements for the scheduling of counseling sessions are as follows:

(1) A minimum of one (1) hour of individual counseling must be offered monthly (in one (1) or two (2) sessions) and shall be documented in the individual's treatment record for the first year of treatment.

(2) Individuals admitted to long-term detoxification services must be offered least two (2) hours of individual counseling each month.

(3) Individuals admitted to short-term detoxification services must be offered a minimum of four (4) hours of individual counseling each month.

(4) Following an individual's detoxification, medical and clinical staff shall determine and document in the person's treatment plan, the type and frequency of counseling necessary to be offered.

(5) After the first year of treatment, each person who is participating in group counseling, on at least a monthly basis, shall be offered a minimum of one (1) hour of individual counseling every ninety (90) days.

(6) Each individual, who is not participating in group counseling, shall be offered at least one (1) hour of individual counseling every thirty (30) days.

(7) An individual who has initiated medically supervised withdrawal shall be re-evaluated to determine the frequency of counseling sessions to be offered and that evaluation and subsequent changes to the individual's treatment shall be documented in his or her record.

11. Medical Services and Care Coordination

a. An OTP must maintain a Diversion Control Plan to ensure quality care while minimizing the diversion of an opioid replacement medication from treatment to illicit use.

b. The following shall be confirmed and documented prior to the initiation of take-home privileges:

(1) The individual shall receive instructions regarding safety;

(2) Such instructions shall include but not be limited to, child safety measures and the storage of medications; and

(3) The individual shall obtain an agency approved locked box for storage of take-home medication.

c. Each OTP is required to have a Disaster Response policy for each location which should include a coordination of emergency care plan with other OTPs and other necessary facilities to ensure medication delivery in the event of an emergency.

d. The OTP shall have a written policy describing procedures to be implemented when a person served needs "Courtesy Dosing" while enrolled in an approved treatment program.

(1) Arrangements for "Courtesy Dosing" shall be made in advance, consistent with federal standards.

e. Each OTP shall have policies and procedures regarding the discontinuation of any opioid replacement medication that include, at a minimum, the following:

(1) The OTP physician shall approve all requests for voluntary withdrawal from an opioid replacement medication.

(2) All withdrawal schedules shall be determined on an individual basis and each individual's progress shall be monitored by OTP staff.

(3) Withdrawal schedules shall adhere to proper medical guidelines without consideration of financial concerns.

f. Medical care, including referral for necessary medical service, and evaluation and follow-up of patient complaints must be compatible with current and prevailing community standards of medical practice.

g. All patients must receive a medical examination at least annually.

h. All other medical procedures performed at the time of admission shall be reviewed by the medical staff on an annual basis, and all clinically indicated tests and procedures shall be repeated.

i. Medical staff shall record the results of this annual medical examination and review of patient medical records in each patient's record.

j. When an individual is transferred to another program within the organization, the individual's treatment record with completed up-to-date documentation shall be transferred to the receiving program.

12. The OTP shall have written policies and procedures regarding drug testing.

a. All drug testing screen results shall be documented in the person's treatment record.

b. Required drug tests include screening for the following substances: opiates, methadone, cocaine, benzodiazepines, and substances prevalent in the community as determined by the OTP and the Department. Any additional drug tests ordered at the discretion of the program shall be specific to the individual's treatment needs.

13. The OTP drug testing policy and procedure shall be approved by the designated State Opioid Treatment Authority.

14. Random drug testing shall be conducted as clinically indicated, but no less than eight (8) times/year while an individual remains in treatment.

15. Specimens shall be collected in a manner that minimizes falsification and shall be stored in a secure place to avoid substitution.

a. Testing facilities shall be licensed by RIDOH pursuant to R.I. Gen. Laws Chapter 23-16.2 and qualified to do drug testing.

b. Results of drug testing shall not be used in a punitive manner, but rather, shall serve as one factor in making treatment decisions.

c. Each OTP shall have its own protocol regarding the increased frequency of drug testing.

16. A physician shall determine, and document in writing, the initial dose and schedule to be followed for each individual admitted to the OTP.

a. Initial doses of methadone shall not exceed thirty (30) milligrams and the total dose for the first twenty-four (24) hours shall not exceed forty (40) milligrams, unless the

program physician documents in the individual's treatment record that forty (40) milligrams did not suppress opiate abstinence symptoms.

17. The OTP shall develop and implement the following drug dispensing and administering procedures:

a. A standardized method that includes the use of identification by photograph shall be implemented to properly identify each individual before any opioid replacement treatment medication is dispensed. A dose shall not be administered or dispensed until an individual is identified and assessed to be medically and clinically appropriate.

b. The prescribed drugs shall only be administered and dispensed by licensed professionals authorized by law and regulations to do so.

c. Each opioid replacement treatment medication used by the OTP shall be administered and dispensed in accordance with its approved product labeling.

d. Methadone shall be dispensed in oral form in one dose per container when liquid form is dispensed and in a multiple dose container when tablets are used. Buprenorphine shall be dispensed in accordance with product packaging.

18. OTPs shall develop policies and procedures that ensure compliance with federal and state regulations before take-home medication privileges are granted. In addition, prior to advancement to a new take-home phase, programs are required to review, for compliance purposes, the DOH Prescription Drug Monitoring Program 216-RICR-20-20-3 in accordance with R.I. Gen. Laws § 21-28-3.32. The policies and procedures shall, at a minimum, include the following:

a. A take-home schedule that is consistent with Federal Certification Standards in 42 C.F.R. Part 8.

b. Take-home containers shall be labeled with the following:

(1) Individual's name;

(2) Name and amount of medication;

(3) Directions for use, including route of administration;

(4) Date issued and date medication is to be taken;

(5) Program name and address;

(6) Program's telephone number.

c. Childproof caps shall be used on all take-home bottles of opioid replacement medication.

d. The OTP physician shall document in the treatment record the rationale for authorizing take-home privileges.

e. The individual shall return all take-home containers on their next day of program attendance. Prior to the person receiving his or her subsequent dose, bottles shall be inspected to ensure that they are coming from the appropriate person during the appropriate time-period.

f. Take-home privileges are not allowed during long or short-term opioid detoxification.

19. An OTP shall not admit a person for more than two (2) detoxification treatment episodes in one (1) year. Individuals with two (2) or more unsuccessful detoxification episodes shall be evaluated by the OTP physician for other forms of treatment.

20. The following security requirements shall be met:

a. Access to electronic alarm areas where drug stock is maintained shall be limited to a minimum number of authorized personnel. Each employee shall have his or her own individual code, which shall be erased upon the employee's termination. A list shall be maintained that identifies all persons with access to the stock/safe and dispensing station and the type of access each has.

b. All stored controlled substances (powdered, liquid, tablet and reconstituted) shall be clearly labeled with the following information:

(1) Name of substance;

(2) Strength of substance;

(3) Date of reconstitution;

(4) Lot number;

(5) Reconstituted expiration date or manufacture date, whichever is earlier.

c. All stored poured doses shall have the following information:

(1) Name of substance;

(2) Strength of substance;

(3) Date of reconstitution;

(4) Lot number; and

(5) Reconstituted expiration date or manufacture date.

d. Containers shall be kept covered and stored in the appropriate locked safe with access limited through an electronic alarm system that conforms with the U.S. Drug Enforcement Administration (DEA) requirements in 21 C.F.R. Part 21 and 21 C.F.R. § 1301.71.

e. Following the initial opioid replacement treatment medication inventory at each OTP, an authorized licensed staff member shall conduct a bi-annual written inventory and document the results. The record shall be maintained for a period of two (2) years. The inventory shall contain:

(1) Name and address of the OTP;

(2) Date of inventory;

(3) Opening or closing of business day;

(4) Quantity of opioid replacement treatment medications on hand, amount used, and amount received;

(5) Total of all medications accounted for;

(6) Signature of person performing the inventory and a co-signature.

f. The Department shall be notified of any occurrence of theft, suspected theft, or any loss of any opioid replacement treatment medication. The form, authorized by the Department for reporting adverse events/incidents, shall be completed for each occurrence and shall be sent to the Department, along with a photocopy of DEA form 106.

g. OTPs shall have quality control procedures to track and trend all spillages of any medication.

h. The disposal of unused controlled substances shall be done in accordance with procedures provided by DEA Regulations, 21 C.F.R. § 1307.22, and the RIDOH.

21. All pharmacists employed by an OTP shall be licensed in Rhode Island and must be authorized by the organization to dispense all opioid replacement treatment medications used by the program.

22. Clinical laboratories provided on the premises of the organization shall be licensed by RIDOH subject to the provisions of R.I. Gen. Laws Chapter 23-16.2. Testing not performed on the premises shall be performed by facilities licensed in accordance with R.I. Gen. Laws Chapter 23-16.2 or by a hospital laboratory in accordance with R.I. Gen. Laws Chapter 23-17.

23. All organizations shall provide HIV and Hepatitis C information and offer a referral for HIV testing for persons served who engage in related high-risk behaviors.

a. All testing pursuant to this section, conducted by an organization, shall be performed in accordance with R.I. Gen. Laws § 23-6.3-7 and § 23-6.3-8, except where federal confidentiality laws may supersede. The identity of the individuals tested under this section shall be maintained only at the site where the sample is drawn and shall not be released except as otherwise provided.

b. Each person who is offered a test and counseling shall be provided with an "Informed Consent Form" in accordance with R.I. Gen. Laws § 23-6.3-3, which he or she shall sign and date in acknowledgment of the offer, unless consent is agreed to be provided verbally.

c. All persons tested under this section shall be provided pre-test and post-test counseling in accordance with regulations adopted by the DOH and by R.I. Gen. Laws Chapter 23-6.3. All persons providing the pre-and/or post-test counseling must have completed the training provided by the DOH, Office of Sexually Transmitted Disorders and HIV, or an equivalent course.

B. Opioid Treatment Program (OTP) Health Homes provide integrated behavioral and physical health care services to individuals with an opioid use disorder. OTPs administer or dispense medications approved by the federal Food and Drug Administration (FDA) as maintenance or detoxification treatment to a person dependent on opioids. It provides, when appropriate or necessary, a comprehensive range of medical and rehabilitative services; is approved by the State authority and the SAMHSA; and is registered with the Drug Enforcement Administration to use opiate replacement therapy for the treatment of opioid use disorder. A Health Home is the fixed point of responsibility to provide person-centered care; providing timely post discharge follow-up, and improving patient health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers, of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, provision of preventative and education services around self-care and wellness.

1. OTP Health Homes shall meet all requirements § 1.6.14(A) of this Part.

2. OTPs must offer and provide Health Home services to clients who meet eligibility requirements.

3. Admission Criteria: Patients with opioid dependence who meet state and federal criteria for Methadone Maintenance Treatment and are currently receiving financial support through Medicaid.

4. The following are the Health Home Service Provision requirements:

a. Have a physician(s) assigned for the purpose of Health Home team participation to each individual receiving OTP Health Home services;

b. Conduct wellness interventions as indicated based on individuals' level of risk and willingness to participate;

c. Maintain a Memorandum of Understanding (MOU) with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking Emergency Department services that might benefit from a connection with an OTP Health Home provider;

d. Maintain a contract(s) or MOU(s) with Federal Qualified Healthcare Centers (FQHCs) and/or primary care centers in the OTP area;

e. Coordinate care for Health Home participants among the OTP and primary and specialty care providers, including mental health treatment providers. This may include development of data sharing system that includes Electronic Medical Record (EMR) expansion, use of Direct Messaging through the State's Health Information Exchange to help safeguard privacy of this information and assure compliance with all related state and federal confidentiality regulations;

f. Use health information technology to link services, facilitate communication among team members, and between the health team and individual and family caregivers, and providing feedback to practices, as feasible and appropriate;

g. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease-management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;

h. Develop treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;

i. Monitor individual and population health status and service use to determine adherence to or variance from treatment guidelines;

j. Develop and disseminate reports that indicate progress toward meeting outcomes for patient satisfaction, health status, service delivery and costs;

k. Agree to convene regular, ongoing and documented internal health home team meetings with all relevant providers to plan and implement goals and objectives of practice transformation; and

l. Provide multiple contacts as needed for a team of 125 patients. Contacts can include phone contact, such as coordinating care with other providers and support systems, as well as direct contact with the client.

5. Care Coordination:

a. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

b. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and other substance use disorders;

c. Coordinate and provide access to mental health and other substance abuse services;

d. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings;

e. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families, and referrals through the RIDOH Chronic Disease Self-Management Programs;

f. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;

g. Coordinate and provide access to long-term care supports and services;

h. Develop and implement a person-centered plan of care that is flexible and integrates all clinical and non-clinical healthcare related needs and services;

i. Ensure that all services, including mental health treatment, are coordinated across provider settings;

j. OTPs, in review of their Policies and Procedures, shall update all relevant Policies and Procedures to reflect Health Homes;

k. Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the plan of care, as necessary. All relevant information is to be obtained and reviewed by the team;

l. Facilitate timely and effective transitions from inpatient and long-term care settings to the community, as appropriate;

m. Health Home providers shall identify hospital liaisons to assist in the discharge planning of individuals, existing OTP patients and new referrals, from inpatient settings to OTPs and mental health treatment, if indicated;

n. Care coordination may also occur when transitioning an individual from a jail/prison setting into the community;

o. A member of the team of health professionals provides care coordination services between hospitals and community services;

p. Team members collaborate with physicians, nurses, social workers, discharge planners and pharmacists as needed to ensure that a person-centered plan of care has been

developed, and work with family members and community providers to ensure that the plan is communicated, adhered to and modified as appropriate;

q. Provide assistance to individuals to identify and develop social support networks;

r. Provide assistance with medication and treatment management and adherence, to include referrals for mental health vocational and counseling services;

s. Connection to peer advocacy groups, wellness centers, National Alliance on Mental Illness (NAMI), RICARES, family psycho-educational programs, etc.;

t. Provide Individual and family support services to assist individuals to access services that shall reduce barriers to treatment and improve health outcomes. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills; and

u. Referral to primary and or specialty care as requested by physician.

6. Discharge Criteria. An individual shall be deemed ready for discharge if one of the following exists:

a. The individual voluntarily elects to terminate participation;

b. The goals and objectives of the person-centered plan have been met and a referral is coordinated to a willing community-based physician; or

c. The individual is not benefitting from the treatment and requires a higher level of care."

57. § 46.0 Overdose Prevention and Education was amended in § 1.6.15 to remove non-regulatory language.