SA Outpatient Clinical Tool.

1. SA Outpatient 65D-30.0042.1 Pertaining to Screening; If the screening is not completed by a qualified professional, then it shall be countersigned and dated by a qualified professional.

2. SA Outpatient 65D-30.0042.1, a. Pertaining to Screening; Determination of Need and Eligibility for Placement. The condition and needs of the individual shall dictate the urgency and timing of screening; screening is not required if an assessment is completed at time of admission. All individuals presenting for services, voluntarily or involuntarily, shall be evaluated to determine service needs and eligibility for placement or other disposition. The person conducting the screening shall document the rationale for any action taken and the validated tool used for service determination.

3. SA Outpatient 65D-30.0042.1, b. Pertaining to Screening; Consent for Drug Screen. If required by the circumstances pertaining to the individual's need for screening, or dictated by the standards for a specific component, individuals shall give informed consent for a drug screen.

4. SA Outpatient 65D-30.0042.1, c. Pertaining to Screening; Consent for Release of Information. Consent for the release of information shall include information required in 42 Code of Federal Regulations, Part 2, and may be signed by the individual only if the form is complete.

5. SA Outpatient 65D-30.0042.1, d. Pertaining to Screening; Consent for Services. A consent for services form shall be signed by the individual prior to or upon placement, with the exception of involuntary placements.

6. SA Outpatient 65D-30.0042.2. Pertaining to Assessment. This requirement applies to addictions receiving facilities, detoxification, intensive inpatient treatment, residential treatment, day or night treatment with community housing, day or night treatment, intensive outpatient treatment, outpatient treatment, and methadone medication-assisted treatment for opioid addiction. Individuals shall undergo an assessment of the nature and severity of their substance use disorder. The assessment shall include a physical health assessment and a psychosocial assessment.

7. SA Outpatient 65D-30.0042.2, a (2.c). For day or night treatment with community housing, day or night treatment, intensive outpatient treatment, and outpatient treatment, a medical history shall be completed within 30 calendar days prior to or upon placement. The medical history shall be completed by the individual or the individual's legal guardian.

8. SA Outpatient 65D-30.0042.2, b, (1.a). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of Emotional or mental health.

9. SA Outpatient 65D-30.0042.2, b, (1.b). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of the level of substance use impairment.

10. SA Outpatient 65D-30.0042.2, b, (1.c). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of family history, including substance use by other family members.

11. SA Outpatient 65D-30.0042.2, b, (1.d). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of the individual's substance use history, including age of onset, choice of drugs, patterns of use, consequences of use, and types and duration of, and responses to, prior treatment episodes

12. SA Outpatient 65D-30.0042.2, b, (1.e). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of educational level, vocational status, employment history, and financial status.

13. SA Outpatient 65D-30.0042.2, b, (1.f). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of social history and functioning, including support network, family and peer relationships, and current living conditions.

14. SA Outpatient 65D-30.0042.2, b, (1.g). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of past or current sexual, psychological, or physical abuse or trauma.

15. SA Outpatient 65D-30.0042.2, b, (1.h). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of the individual's involvement in leisure and recreational activities.

16. SA Outpatient 65D-30.0042.2, b, (1.i). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of cultural influences.

17. SA Outpatient 65D-30.0042.2, b, (1.J). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of spiritual or values orientation.

18. SA Outpatient 65D-30.0042.2, b, (1.k). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of legal history and status.

19. SA Outpatient 65D-30.0042.2, b, (1.l). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include the individual's history as determined through an assessment of the individual's perception of strengths and abilities related to the potential for recovery.

20. SA Outpatient 65D-30.0042.2, b, (1.m). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include a clinical summary, including an analysis and interpretation of the results of the psychosocial assessment.

21. SA Outpatient 65D-30.0042.2, b, (1.n). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include documentation of determination of placement utilizing a validated tool used for service determination.

22. SA Outpatient 65D-30.0042.2, b, (1.o). Pertaining to the Psychosocial Assessment. The psychosocial assessment shall include documentation of appropriateness of level of care countersigned by the qualified professional or clinical supervisor.

23. SA Outpatient 65D-30.0042.2, b, (2.e). For intensive outpatient treatment and outpatient treatment, the psychosocial assessment shall be completed within 30 calendar days of placement. Any psychosocial assessment that is completed within 30 calendar days prior to placement may be accepted by the provider placing the individual.

24. SA Outpatient 65D-30.0042.2, b, (3). The psychosocial assessment shall be completed by clinical staff and signed and dated. If the psychosocial assessment was not completed initially by a qualified professional, the psychosocial assessment shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion. (Inmate Substance Abuse Programs operated by or under contract with the Department of Corrections or the Department of Management Services shall conduct the review and sign-off within 30 calendar days.)

25. SA Outpatient 65D-30.0042.2, b, (4). In instances where an individual is readmitted to the same provider for services within 180 calendar days of discharge, a psychosocial assessment update shall be conducted, if clinically indicated. Information to be included in the update shall be determined by the qualified professional. A new assessment shall be completed on individuals who are readmitted for services more than 180 calendar days after discharge. In addition, the psychosocial assessment shall be updated annually for individuals who are in continuous treatment for longer than one (1) year.

26. SA Outpatient 65D-30.0042.2, b, (5.a.). Regarding Individuals Who Are Referred or Transferred. A new psychosocial assessment does not have to be completed on individuals who are referred or transferred from one (1) provider to another or referred or transferred within the same provider if the provider meets at least one (1) of the following conditions: (I) The provider or component initiating the referral or transfer forwards a copy of the psychosocial assessment information prior to the arrival of the individual; (II) Individuals are referred or transferred directly from a specific level of care to a lower or higher level of care (e.g., from detoxification to residential treatment or outpatient to residential treatment) within the same provider or from one (1) provider to another; or (III) The individual is referred or transferred directly to the same level of care (e.g., residential level 1 to residential level 1) either within the same provider or from one (1) provider to another.

27. SA Outpatient 65D-30.0042.2, b, (5.b.). In the case of referral or transfer from one (1) provider to another, a referral or transfer is considered direct if it was arranged by the referring or transferring provider and the individual is subsequently placed with the provider within seven (7) calendar days of discharge. This does not preclude the provider from conducting an assessment.

28. SA Outpatient 65D-30.0042.2, b, (5.b.). The following are further requirements related to referrals or transfers:(I) If the content of a forwarded psychosocial does not comply with the psychosocial requirements of this rule, the information will be updated, or a new assessment will be completed; (II) If an individual is placed with the receiving provider later than seven (7) calendar days following discharge from the provider that initiated the referral or transfer, but within 180 calendar days, the qualified professional of the receiving provider will determine the extent of the update needed; and (III) If an individual is placed with the receiving provider more than 180 calendar days after discharge from the provider that initiated the referral or transfer, a new psychosocial assessment must be completed.

29. SA Outpatient 65D-30.0042.2, c. Co-occurring Mental Illness and Other Needs. The assessment process shall include the identification of individuals with mental illness and other needs. Such individual shall be accommodated directly or through referral. A record of all services provided directly or through referral shall be maintained in the individual's clinical record.

30. SA Outpatient 65D-30.0043.1 Pertaining to Criteria and Operating Procedures. Providers shall have operating procedures that clearly state the criteria for admitting, retaining, transferring, and discharging individuals. This includes procedures for implementing these placement requirements.

31. SA Outpatient 65D-30.0043.2 Individuals must be assessed prior to admission to determine level of service need and choice of the individual. If the provider completing the assessment does not offer the service needed, the provider must refer the individual to the assessed level of care.

32. SA Outpatient 65D-30.0043.3,a. A primary counselor shall be assigned to each individual. This standard does not apply to detoxification and addictions receiving facilities.

33. SA Outpatient 65D-30.0043.3,b. Each individual served must receive an orientation to the program at the time of admission and upon request. The orientation shall be in a language the individual or his or her representative understands. The individual's acknowledgement of the orientation and receipt of required information must be documented in the clinical record.

34. SA Outpatient 65D-30.0043.3,b (1). Pertaining to orientation. A description of services shall be provided.

35. SA Outpatient 65D-30.0043.3,b (2). Pertaining to orientation. A copy of the individual's rights pursuant to Chapter 397, Part III, F.S. shall be provided.

36. SA Outpatient 65D-30.0043.3,b (3). Pertaining to orientation. A summary of the facility's admission and discharge policies shall be provided.

37. SA Outpatient 65D-30.0043.3,b (4). Pertaining to orientation. A copy of the service fee schedule, financial responsibility policy, and applicable fees shall be provided.

38. SA Outpatient 65D-30.0043.3,b (5). Pertaining to orientation. Written rules of conduct for individual's served which shall be reviewed, signed, and dated shall be provided.

39. SA Outpatient 65D-30.0043.3,b (6). Pertaining to orientation. A copy of the grievance process and procedure shall be provided.

40. SA Outpatient 65D-30.0043.3,b (7). Pertaining to orientation. General information about infection control policies and procedures shall be provided.

41. SA Outpatient 65D-30.0043.3,b (8). Pertaining to orientation. Limits of confidentiality shall be provided.

42. SA Outpatient 65D-30.0043.3,b (9). Pertaining to orientation. Information on parental or legal guardian's access to information and participation in treatment shall be provided.

43. SA Outpatient 65D-30.0043.3,b (10). Pertaining to orientation. Information regarding advance directives which delineate the facility's position with respect to the state law and rules relative to advance directives shall be provided.

44. SA Outpatient 65D-30.0043.4. Pertaining to Transfer and Discharge. Providers must ensure safe and orderly transfers and discharges in accordance with the facility's policies and procedures and in compliance with 42 CFR.

45. SA Outpatient 65D-30.0044.1, a. Pertaining to the Treatment Plan. Each individual shall be afforded the opportunity to participate and be actively engaged in the development and subsequent review of the treatment plan. The treatment plan shall be signed and dated by the person providing the service and by the individual. If the treatment plan is completed by other than a qualified professional, the treatment plan shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion. A written treatment plan shall be completed on each individual. The treatment plan shall include;

a. Goals and related measurable behavioral objectives to be achieved by the individual.
b. The tasks involved in achieving those objectives.
c. The type and frequency of services to be provided, and the expected dates of completion.

46. SA Outpatient 65D-30.0044.1. a (1). For long-term outpatient methadone detoxification and methadone medication-assisted treatment for opioid addiction, the treatment plan shall be completed prior to or within 30 calendar days of placement.

47. SA Outpatient 65D-30.0044.1. a (6). For intensive outpatient treatment and outpatient treatment, the treatment plan shall be completed prior to or within 30 calendar days of placement.

48. SA Outpatient 65D-30.0044.1. a (8). For providers that are licensed for multiple program components and deliver a continuum of care, any change in level of care requires a treatment plan review or treatment plan update.

49. SA Outpatient 65D-30.0044.1. a (8,b). Pertaining to Treatment Plan Reviews. Treatment plan reviews shall be completed with each individual and shall be signed and dated by the individual within 30 calendar days of the completion of the treatment plan. The treatment plan must be reviewed when clinical changes occur and as specified in subparagraphs 65D-30.0044(1)(b)1.-4., F.A.C. If the treatment plan reviews are not completed by a qualified professional, the review shall be countersigned and dated by a qualified professional within five calendar days of the review.

50. SA Outpatient 65D-30.0044.1. a (8,b,4). Pertaining to Treatment Plan Reviews. For methadone medication-assisted treatment for opioid addiction and long-term outpatient methadone detoxification, treatment plan reviews shall be completed every 90 calendar days for the first year and every 6 months thereafter.

51. SA Outpatient 65D-30.0044.1. a (8,b,5). Pertaining to Treatment Plan Reviews. For outpatient treatment, treatment plan reviews shall be completed every 90 calendar days for the first year and every six (6) months thereafter.

52. SA Outpatient 65D-30.0044.1. a (8, c). Pertaining to Progress Notes. Progress notes shall be entered into the clinical record documenting an individual's progress or lack of progress toward meeting treatment plan goals and objectives. When a single service event is documented, the progress note must be signed and dated by the person providing the service and shall include the credentials of the person who signed the notes. When more than one (1) service event is documented, progress notes may be signed by any clinical staff member assigned to the individual.

53. SA Outpatient 65D-30.0044.1. a (8, c, 3). Pertaining to Progress Notes. For intensive outpatient treatment and outpatient treatment, progress notes shall be recorded at least weekly or, if contact occurs less than weekly, notes will be recorded according to the frequency of sessions.

54. SA Outpatient 65D-30.0044.2. Pertaining to Ancillary Services. Ancillary services shall be provided directly or through referral in instances where a provider cannot or does not provide certain services needed by an individual. The provision of ancillary services shall be based on individual needs as determined by the treatment plan and treatment plan reviews. In cases where individuals need to be referred for services, the provider shall use a case management approach by linking individuals to needed services and following-up on referrals. All such referrals shall be initiated and coordinated by the individual's primary counselor or other designated clinical staff who shall serve as the individual's case manager. A record of all such referrals for ancillary services shall be maintained in the clinical record, including whether or not a linkage occurred or documentation of efforts to confirm a linkage when confirmation was not received.

55. SA Outpatient 65D-30.0044.3, a. Pertaining to the Prevention Plan. For individuals receiving indicated prevention services as described in paragraph 65E-14.021(4)(v), F.A.C., a prevention plan shall be completed within 45 calendar days.

56. SA Outpatient 65D-30.0044.3, Prevention plans shall include goals and objectives designed to reduce risk factors and enhance protective factors.

57. SA Outpatient 65D-30.0044.3, The prevention plan shall be signed and dated by staff who developed the plan and signed and dated by the individual.

58. SA Outpatient 65D-30.0044.3, b. Pertaining to the Intervention Plan. For individuals involved in intervention on a continuing basis, an intervention plan shall be completed within 45 calendar days.

59. SA Outpatient 65D-30.0044.3, b, Intervention plans shall include goals and objectives designed to reduce the severity and intensity of factors associated with the onset or progression of substance use.

60. SA Outpatient 65D-30.0044.3, b, The intervention plan shall be reviewed and updated at least every 60 days.

61. SA Outpatient 65D-30.0044.3, b, The intervention plan shall be signed and dated by staff who developed the plan and signed and dated by the individual.

62. SA Outpatient 65D-30.0044.3, c. Pertaining to Summary Notes. Summary notes shall be completed in indicated prevention and intervention services where clinical records are required.

63. SA Outpatient 65D-30.0044.3, Summary notes shall contain information regarding an individual's progress or lack of progress in meeting the conditions of the prevention or intervention plan described in paragraphs (3 ,a) and (3, b).

64. SA Outpatient 65D-30.0044.3, c, Summary notes shall be entered into the individual's clinical record at least weekly for those weeks in which services are scheduled.

65. SA Outpatient 65D-30.0044.3, c, Each summary note shall be signed and dated by staff delivering the service.

66. SA Outpatient 65D-30.0044.4, a. Pertaining to the Discharge Summary. A written discharge summary shall be completed for individuals who complete services or who leave prior to completion of services.

67. SA Outpatient 65D-30.0044.4,The discharge summary shall include a summary of the individual's involvement in services, the reasons for discharge, and the provision of and referral to other services needed by the individual following discharge, including aftercare.

68. SA Outpatient 65D-30.0044.4,The discharge summary shall be completed within 15 business days and signed and dated by a primary counselor.

69. SA Outpatient 65D-30.0044.2, b. Pertaining to the Transfer Summary. A transfer summary in accordance with policies and procedures shall be completed immediately for individuals who transfer from one (1) component to another within the same provider and shall be completed within 5 calendar days when transferring from one (1) provider to another.

70. SA Outpatient 65D-30.0044.2, An entry shall be made in the individual's clinical record regarding the circumstances surrounding the transfer and that entry and transfer summary shall be signed and dated by a primary counselor within 15 days.

71. SA Outpatient 65D-30.0044.3, The prevention plan shall be reviewed and updated every 60 calendar days from the date of completion of the plan.