Credo Community Center
820 Reintegration
Women's Community Residence

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Introduction

Credo Community Center's 820 Reintegration programs provide a family atmosphere that promotes independence, responsibility, and self-awareness for patients in early recovery. The Reintegration level of care provides a community living experience in a congregate setting with limited supervision and/or case management. Individuals appropriate for these services are transitioning to long term recovery from substance use disorder and independent living in the community [820.3(d)]. This environment is made possible through peer support, individual service planning, and utilizing a person-centered care approach to meet the unique needs of all patients. The program emphasizes treating the whole person to meet substance use disorder needs and physical, mental, and spiritual health.

The 820 Reintegration programs are licensed through OASAS (Office of Addiction Services and Supports) and have an average length of stay of six to twelve months for individuals aged eighteen years and older. Patients are expected to share in household duties including meal preparation, housework, outside chores, and lawn maintenance. If appropriate, patients are encouraged to become employed during their treatment episode, and are also encouraged to explore and, when ready, pursue educational/vocational opportunities that range from the Test Assessing Secondary Completion (TASC) to college or vocational training.

Daily house meetings are held Monday through Friday mornings, allowing patients to process difficulties and accomplishments in daily living to better prepare them for independence. Outpatient counseling services are mandatory for those enrolled in the program and care collaboration will occur with those involved in the patient's care.

Patients progress through the program through the engagement in their treatment plans and progress through a level system that promotes more independence and autonomy. The patient handbook outlines the components and expectations of the level system.

The program cost is covered by Public Assistance and patients who are ineligible to receive Public Assistance will be placed on a sliding fee scale. Medicaid or private insurance policies are used to cover any medical or prescription needs.

Referrals are received from a variety of sources such as outpatient clinics, other programs, legal entities, and self-referrals. Each referral receives an assessment to identify if the individual is appropriate for the reintegration level of care.

The certified bed capacity for each program may not be exceeded at any time except:

- In cases of emergency and unexpected surges in demand where no alternative options are available; and
- Failure to temporarily accept individuals into the program would jeopardize their immediate health and safety; and

- Where the excess capacity would be time limited. **[820.5(f)]**

For the Patricia Pond Hinckley 820 Reintegration Program for Women. This capacity is 15 patients.

I. Admission Policies and Procedures

A. Admission Criteria

Policy:

If determined appropriate for the patient service, the individual must also be determined to be able to achieve or maintain recovery goals with the application of patient services to be admitted. The following criteria must be met to be admitted into the program:

1. The individual must be homeless or must have a living environment not conducive to recovery.
2. The individual must be determined to need outpatient treatment services and/or other support services such as vocational or educational services, in addition to the patient services provided by the Community Residence. **[820.12(b)]**

Admissions will be prioritized in accordance with *Local Services Bulletin No. 2019-03 and 2014-11*. Refer to the Priority Admissions Policy in the Agency-Wide Policies.

Procedure:

a. After a referral is received, an assigned staff will contact the referral source to set up an admission assessment.
b. An admission assessment will be completed for the prospective client to determine if the individual meets the need of care determination and admission criteria.
c. If needed, and/or available, collateral information will be obtained to support an admission determination. This information will be recorded in a Progress/Contact Note in the EHR (Electronic Health Record).
d. Any physical documentation obtained in the process will be scanned into the EHR and verified as completely uploaded before destroying originals in accordance with the HIPAA (Health Insurance Portability and Accountability) Privacy Rule: General Information in the Agency Wide Manual.
e. The admissions assessment will be routed to a QHP (Qualified Health Professional) for review and, if appropriate, approval to admit the individual.
f. The name of the Qualified Health Professional that made the admission decision, along with the date of admission, will be documented in the case record.

B. Initial Determination

Policy:

An individual who appears at the Reintegration Element of Care seeking or having been referred for treatment for evaluation will have an initial determination made and documented in a written record by a Qualified Health Professional, or other clinical staff under the supervision of a Qualified Health Professional, which states the following:

1. That the individual needs chemical dependence services;
2. That the individual is free of serious communicable disease that can be transmitted through ordinary contact; and
3. That the individual does not need acute hospital care, acute psychiatric care, or other intensive services which cannot be provided with patient care or would prevent him from participating in a chemical dependence service. **[820.7(a)1]**

Procedure:

The determinations made pursuant to the above will be based upon service provider records, reports from other providers and/or through a verbal contact with the individual, all of which must be documented. The initial determination will be made and documented in the case record by a QHP or other clinical staff supervised by a QHP.

C. Inappropriate for Care Determination

Policy:

If the presenting individual is determined to be inappropriate for admission to the residential service, a referral to a more appropriate service must be made, unless the individual is already receiving substance use disorder services from another provider. Individuals deemed ineligible for admission must be informed of the reason. [820.7(4)(iv)]

Referrals to more appropriate service providers will be done in accordance with *Local Services Bulletin No. 2019-03 and 2014-11*. Refer to the Priority Admissions Policy.

Procedure:

If the individual is deemed inappropriate for services, unless the individual is already receiving chemical dependence services from another provider, Credo will make a referral to a more appropriate service. The reason(s) for denial of any admission to the

patient service will be provided to the individual and/or referral source and documented in a written record maintained by the program.

D. Level of Care Determination

Policy:

If an individual is determined to be appropriate for chemical dependence services, a level of care determination will be made by a clinical staff member who will be provided clinical oversight by a Qualified Health Professional. The level of care determination will be signed and dated by the clinical staff member. The level of care determined will be determined promptly and no later than one (1) day after the patient's first on-site contact with the service.

The level of care determination process will be in accord with the governing authority's policy and procedures and incorporate the use of the OASAS Level of Care for Alcohol and Drug Treatment Referral protocol (LOCADTR) or another OASAS-approved protocol. **[820.7(a)2]**

Procedure:

a. A QHP will complete a LOCADTR assessment found at: https://extrapps.oasas.ny.gov/pulic/oasas/oasas_login.html
b. A PDF of the LOCADTR results will be attached to the LOCADTR/Admission Note in the EHR within 24 hours of admission.
c. If results confirm that the client is appropriate for the Community Residence level of care, treatment will continue.
d. If results indicate that the client is not appropriate for the Community Residence level of care, see the section Inappropriate for Care Determination.
e. The LOCADTR/Admission Note will be routed to a supervisor for approval.

E. Admission Decision

Policy:

Appropriate for Care Determination
If determined appropriate for the patient service, the individual must also be determined to be able to achieve or maintain recovery goals with the application of patient services to be admitted. The following criteria must be met to be admitted into the program:

A. The individual must be homeless or must have a living environment not conducive to recovery.
B. The individual must be determined to need outpatient treatment services and/or other support services such as vocational or educational services, in addition to the

patient services provided by the Community Residence. **[820.12 (b) 1-2]**

F. Admission Assessment

Policy:

The admission assessment or decision to admit must contain a statement documenting the individual is appropriate for this level of care, identify the assignment of a named clinical staff member with the responsibility to provide orientation to the individual, and include a preliminary schedule of activities, therapies, and interventions. **[820.7(4)(v)]**

Admissions will be prioritized in accordance with *Local Services Bulletin No. 2019-03 and 2014-11*. Refer to the Priority Admissions Policy in the Agency-Wide Policies.

Procedure:

a. After a referral is received, an assigned staff will contact the referral source to set up an admission assessment.
b. An admission assessment will be completed for the prospective client to determine if the individual meets the need of care determination and admission criteria.
c. If needed, and/or available, collateral information will be obtained to support an admission determination. This information will be recorded in a Progress/Contact Note in the EHR.
d. Any physical documentation obtained in the process will be scanned into the EHR and verified as completely uploaded before destroying originals in accordance with the HIPAA Privacy Rule: General Information in the Agency Wide Manual.
e. The admissions assessment will be routed to a QHP for review and, if appropriate, approval to admit the individual.
f. The name of the Qualified Health Professional that made the admission decision, along with the date of admission, will be documented in the case record.
g. Upon admission, an initial treatment plan will be developed in collaboration with the patient that will outline activities, therapies, and interventions that will be incorporated into the patient's treatment.

G. Communicable Disease Risk Assessment

Policy:

Prior to admission, the program will conduct a communicable disease risk assessment (HIV/AIDS, tuberculosis, viral hepatitis, sexually transmitted diseases, and other communicable diseases) as well as conduct a toxicology screen if deemed clinically necessary. **[820.7(b)(1) (I-ii)]**

Procedure:

a. During the pre-admission assessment with the potential patient, the Communicable Diseases Risk Assessment Tool will be utilized to identify any concerns or needs of the patient.
    i. After admission, any needs identified in the assessment will be addressed and incorporated into the patient's treatment plan.
    ii. Program staff will coordinate with local providers and the patient to establish any necessary appointments or referrals. This information will be recorded in the patient's EHR.
b. Prior to admission to the program, a toxicology screen will be conducted according to the program's policy and procedures related to urinalysis testing or breathalyzer testing.
    i. The results of the toxicology screen will determine if the potential patient is appropriate to complete the admission process.
    ii. The results of the test that are presented as concerning to the admitting staff will be reviewed with the Outpatient Medical Director for further direction on admitting or referring the patient to a more medically appropriate level of care.
    iii. If the toxicology test results indicate it is appropriate for the patient to be admitted, the rest of the admission process will continue.

H. Admission Priorities

Policy:

This program acknowledges the need for establishing priorities for substance use disorder and mental health treatment. Therefore, the following policy aims to set guidelines by which patients will be triaged for priority admissions in accordance with Federal and State regulations.

Potential patients will be triaged in accordance with LSB 2019-03: *Requirements under the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant (Supersedes LSB 2012-01 issued 8/30/12)* and LSB 2014-11: *Admission Priority to Alcoholism and Substance Abuse Treatment Programs (Supersedes OASAS LSB 2000-04)*. This policy and procedure can be found in the agency wide manual

I. Rules and Regulations

Policy:

There must be a notation in the case record that the patient received a copy of the residential service's rules and regulations, including patient rights, and a summary of

Federal confidentiality requirements and a statement that such rules were discussed with the patient and the patient indicated that they understood them **[820.7(4)(ii)]**

Procedure:

1. During the admission process, the rules, patient rights, and regulations will be discussed with the patient.
2. The patient will review and sign the Consent to Treatment/Orientation document indicating that they understand the content.
3. The assigned staff will print the completed form and provide it to the patient.

J. Confidentiality

Policy:

All patients will be provided with information on the patient's right of privacy protection, which includes the Federal Confidentiality Laws- 42 CFR (Code of Federal Regulations) (Code of Federal Regulations) (Code of Federal Regulations); HIPAA Laws 45 CFR, and Client Rights and Responsibilities. These will be discussed with the patient, signed, and dated by them, thus attesting that the individual understands them all.

Procedure:

1. During the intake process, the assigned clinical staff will review with the patient the Patient's Right of Privacy Protection, which includes Federal Confidentiality Laws- 42 CFR; HIPAA Laws 45 CFR, and Client Rights and Responsibilities.
2. The patient will sign and date this document attesting to understanding the information. This signed document will be maintained in the patient's EHR, and a copy will be printed for the patient.

K. Voluntary Status Notification

Policy:

All patients shall be informed that admission to the Community Residence Program is on a voluntary basis and that a patient shall be free to discharge themselves from the service at any time. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the service of their own best interest. **[820.7(4)(iii)]**

Procedure:

1. During the admission process, the voluntary nature of the program will be discussed with the patient. For patients under an external mandate, the potential consequences for premature discharge shall be explained, but this shall not alter the voluntary

nature of admission and continued treatment.
2. The patient will review and sign the Consent to Treatment/Orientation document, which outlines the voluntary status of engaging in treatment. The patient's signature on this document will be used to indicate they understand the content.
3. The assigned staff will print the completed form and provide it to the patient.

L. Anti-Discrimination

Policy:

No patient shall be denied admission to the residential service program based solely on the individual's **[820.7(3) (I-vii)]**:

1. Prior treatment history;
2. Referral source;
3. Maintenance on MAT (Medication Assisted Treatment) or other medication prescribed and monitored by a physician, physician's assistant, or nurse practitioner; however, if a residential service objects to an individual's continued use of such prescribed drugs or substances, the program will:
    a. Obtain a signed consent form in accordance with the requirements of 42 Code of Federal Regulations (CFR) Part 2 which authorizes the release of patient identifying information to the physician, physician's assistant, or nurse practitioner who prescribed the drug or substance to the individual (the prescribing professional);
    b. Document the consultation with the prescribing professional to ascertain their knowledge and awareness of the individual's history of chemical dependence, and if the prescribing professional is unaware of the individual's history of chemical dependence, inform the prescribing professional accordingly; and
        - After the required consultation, if the prescribing professional believes that the individual should be permitted to continue to use the drug or substance, the individual must be permitted to continue to use the drug or substance;
4. History of contact with the criminal justice system;
5. HIV (Human Immunodeficiency Virus) and AIDS status;
6. Physical or mental disability; or
7. Lack of cooperation by significant others in the treatment process.

M. Disease Assessment

Policy:

After admission, the program will offer testing for viral hepatitis, HIV, sexually transmitted diseases, and any other tests or immunizations recommended by an examining physician or other medical staff member. Tuberculin testing will also be completed if clinically appropriate and if available and patients on a regimen of pre- or post-exposure prophylaxis will be permitted to continue with the regimen until consultation with a prescriber occurs. **[820.7(b)(2) (I-ii)]**

Procedure:

1. Within thirty (30) days of admission, testing will be offered and provided offsite by local providers. Tests may include but will not be limited to tuberculosis testing, sexually transmitted disease testing, EKG, and chest X-rays, as well as referrals for immunizations.
    a. Patients with positive test results will be referred as recommended by providers for follow-up care.
    b. Program staff will help coordinate care to meet the patient's medical needs.
    c. Documentation of referrals and care coordination will be maintained in the patient's EHR.
    d. Tests requested by providers will be completed and results provided to the patient as soon as possible.
2. Significant medical issues, including potential risk for communicable diseases, identified pre or post admission will be addressed in the treatment plan and all documentation will be recorded in the patient's EHR.
3. The treatment plan will include documentation of the provision for the prevention, care and treatment of HIV, viral hepatitis, tuberculosis and/or sexually transmitted diseases.
4. If a patient refuses to obtain such care, the program will have the patient acknowledge in writing that such care was offered but refused.

N. Medical and Psychiatric Screenings

Policy:

During the preadmission assessment prior to admission and the comprehensive evaluation post admission, screenings and referrals will be completed as clinically indicated for both physical and psychiatric conditions. Ongoing assessments throughout the treatment episode will be implemented as deemed clinically necessary.

If the patient has a medical history available and has had a physical examination performed within12 months prior to admission, or if the patient is being admitted directly to the residential service from another office certified program, the existing medical history and physical examination documentation may be used to comply with the requirements of this subdivision, provided that such documentation has been reviewed and determined to be current and accurate; such determination shall be dated and recorded in the patient's record.

Additionally, if the resident is admitted to an outpatient SUD (substance use disorder) clinic (CD-OP) or opioid treatment program (OTP), then within 30 days the reintegration program shall obtain the medical history, physical and treatment plan from the outpatient provider if not previously obtained. Notwithstanding the foregoing, the following shall be offered to all patients regardless of a documented history within the previous twelve (12) months: HIV and Hep-C testing. [820.7c(1)]

Procedure:

During the pre-admission assessment information will be collected utilizing the following tools:

1. Communicable Disease Risk Assessment
2. Medical Information Questionnaire
3. Patient Health Questionnaire (PHQ-9)
4. Columbia Suicide Severity Rating Scale (C-SSRS)
5. Psychosis Screening
6. Any additional collateral information from the referral source will be documented in the patient's chart. If a physical exam was received in the referral packet, this information will be reviewed to help determine if the patient is appropriate for admission to the program.

Upon admission:

A. Physical/Medical Assessments
    1. A physical exam will be scheduled within 30 days of admission if a previous exam was not completed in the past twelve months or if the information received on a previous exam is deemed not current or accurate.
    2. The physical examination will include review of any physical and/or mental limitations or disabilities which may require special services or attention during treatment.
    3. The physical exams, at a minimum, must include an investigation of:
        a. The possibility of infectious disease;
        b. Pulmonary, liver, or cardia abnormalities;
        c. Possible surgical problems;
        d. A complete blood count and differential,
        e. Routing microscopic urinalysis
        f. Physical and/or mental limitations or disabilities which may require special services or attention during treatment;
        g. Any additional laboratory tests at the request of the examining physician
    4. Patient records shall include a summary of the results of the physical examination and shall also demonstrate that appropriate medical care is recommended to any patient whose health status indicates the need for such care.

5. All patients will be established with a primary care provider that the program has an MOU with, and this provider will be utilized for ongoing medical care throughout the patient's treatment. Coordination of care will be documented in the patient's EHR.
6. Each patient will be offered the opportunity to receive HIV and Hep-C testing; this will be documented in the patient EHR.
7. The Primary Counselor will support the patient in pursuing any recommended physical health referrals during that individual's treatment episode. Appropriate releases will be in place to support care coordination.
8. All information related to a patient's medical history or care will be documented in the patient's EHR. **[820.7(c)]**

B. Psychiatric Assessments
   1. If a patient is already on psychotropic medications or is requesting a psychiatric evaluation, the assigned clinical staff member will place the appropriate referrals for these services.
   2. During the comprehensive evaluation, the following additional screening tools will be utilized:
      a. Brief Trauma Questionnaire
      b. Risk Assessment (suicidal or homicidal ideation/plan)
   3. All psychiatric records and associated documentation will be stored in the patient's EHR.

Care coordination will occur between the program and the psychiatric provider, with the appropriate releases and agreements in place, to help support the patient in addressing their psychiatric needs.

II. Post Admission Policies and Procedures

A. Comprehensive Assessment

Policy:

This program will complete a comprehensive assessment to obtain information necessary to develop an individual treatment plan. This assessment will be based on the admission's assessment, clinical interviews with the patient, and may include collateral information with significant, if possible and appropriate.

Procedure:

1. No later than seven (7) days after admission, an assigned counselor will complete the patient's comprehensive assessment which will include a

written report of findings and conclusions addressing, at a minimum, the patient's chemical use, abuse, and dependence history;

2. History of previous attempts to abstain from chemical and previous treatment experiences;
3. Comprehensive psychosocial history, including, but not limited to, the following:
    a. Legal involvement;
    b. Any additional substance uses not previously disclosed in the admission's assessment;
    c. An assessment of the patient's individual, social and educational strengths, and weaknesses, including, but not limited to, the patient's literacy level, daily living skills, and use of leisure time;
    d. A review of the patient's mental health history not otherwise disclosed on the admission's assessment;
    e. Diagnosis related to substance use.
4. The comprehensive evaluation will record the names of the staff members who participated in evaluating the individual and must be signed by the supervising QHP.
5. The Comprehensive Assessment for a patient entering directly from another OASAS licensed program or is readmitted to Credo within sixty (60) days of discharge from the program, may be reviewed, using the "Residential Comprehensive Evaluation Update Form," dated, signed, and entered the patient's EHR. The Comprehensive Evaluation Update form must be completed within 14 days of admission and signed off by the Primary Counselor and the supervising QHP.

B. Treatment Plan

Policy:

As soon as possible after admission, a patient-centered, interdisciplinary treatment/recovery plan or service plan will be developed, which includes problem formulation and short-term, measurable treatment/recovery goals and activities designed to achieve those goals. This plan should be developed in collaboration with the patient. **[820.8(a)1]**

Procedure:

a. Within three (3) days of admission, an Initial Treatment plan will be developed with the patient and will include:
    1. Documentation that the individual is appropriate for this level of care; Does this

need to be done in addition intake
2. Identify the assignment of a named clinical staff member with the responsibility to provide orientation to the patient;
3. A preliminary schedule of activities, therapies, and interventions; and
4. Inclusion of identified problems/needs with short-term measurable goals and activities to support the patient in the achievement of their goals.

b. This plan will be signed by the patient and the assigned counselor in their EHR.

C. Treatment Plan Review

Policy:

A Comprehensive Treatment Plan will be based on the Comprehensive Evaluation and shall be prepared within thirty (30) days of development of the Three-Day Service Plan. This plan will identify the needs of the resident and will consider cultural and social factors as well as the characteristics, conditions, and circumstances of each resident. For patients moving directly from one program to another or being readmitted to the same program within 60 days (about 2 months) of discharge, the existing treatment/recovery plan may be used if there is documentation that it has been reviewed and, if necessary, updated within 14 days (about 2 weeks) of transfer. **[820.8 (b)I]** The treatment plan will be reviewed and revised, if necessary, with the resident monthly. **[820.8 (a)2]**

In addition to the required periodic review, each treatment plan, once established, will be thoroughly reviewed, and updated by the responsible clinical staff member in consultation with the patient whenever a change in services occurs; all updates must be reviewed and signed by the supervisor. **[820.12(d)]**

Procedure:

Within thirty (30) days after the completion of the Three-Day Service Plan, the Comprehensive Treatment Plan will **[820.8 (b)2]**:

1. Be developed in collaboration with the patient as evidenced by the patient's signature thereon;
2. Be based on the Comprehensive Evaluation and any additional evaluation(s) determined to be required;
3. Specify goals for each problem identified;
4. Specify the objectives to be achieved while the patient is receiving services which shall be used to measure progress toward attainment of goals;
5. Include schedules for the provision of all services prescribed;
6. Identify the member of the clinical staff responsible for coordinating and managing the patient's care;

7. Include the diagnosis for which the patient is being treated; and
8. Be signed by the responsible clinical staff member and approved and signed by the supervising QHP within ten (10) days.
9. Each comprehensive plan, once established, will be reviewed, and revised every month thereafter by the responsible clinical staff member in consultation with the patient and reviewed and signed by the supervising QHP.
    a. The treatment plan will be reviewed more frequently if a change of services has been deemed necessary by the treatment team.
    b. The change of services will be reviewed with the patient and incorporated into a revised treatment plan. This plan will be signed by the patient, assigned counselor, and supervising QHP.
10. The clinical staff member will ensure that the treatment plan is included in the patient's EHR, and that all treatment is provided in accordance with the treatment plan.

Where a service is to be provided by any other service or facility off site, the treatment plan will contain a description of the nature of the service, a record that a referral for such service has been made, the results of the referral, and procedures for ongoing coordination of care.

D. Case Conferences

Policy:

The case of any patient who is not responding to treatment, is not meeting goals defined in the Comprehensive Treatment Plan, including educational and vocational goals, or who is disruptive to the service, as well as failing to maintain compliance with program rules and regulations will be discussed as a Case Conference and the treatment plan revised accordingly.

Procedure:

1. The outcome of each case conference will be documented in the patient's EHR, and the treatment plan modified, if necessary, within two business days.
2. The modified document will be dated and signed by the resident and the person responsible for the staff at the Community Residence.
3. Outpatient treatment providers, referral sources and family members that the resident has identified should also be made aware of the results of these case conferences so they can adjust their treatment goals, interventions, and support if necessary.

E. Utilization Review

Policy:

The utilization review plan includes procedures for ensuring that admissions are appropriate, that retention and discharge criteria are met, and that services are appropriate. The utilization

review plan considers each resident's need for continued treatment, the extent of the resident's chemical dependence problem, and the continued effectiveness of, and progress in, treatment.

Procedure:

1. The assigned clinical staff will conduct monthly utilization reviews.
    a. All new admissions will be reviewed for appropriateness;
    b. All open cases will be evaluated at least monthly to determine if the patient should be considered for further treatment and will be completed in conjunction with treatment plan reviews; and
    c. All discharges will be reviewed to ensure that discharge criteria have been met.
2. Continued Stay
    a. The assigned clinical staff is responsible for ensuring that subsequent reviews for continued stay of all patients are conducted no later than each thirty (30) day period following the initial continued stay review, and that continued stay criteria include:
        i. Extent of the patient's chemical dependence problem;
        ii. Appropriateness of interventions; and
        iii. Effectiveness of treatment;
        iv. Review and evaluation of documentation contained in each patient's chart as appropriate
    b. If finding that a patient's continued stay is needed:
        1. Assigning a new continued stay review date, no later than thirty (30) days following the most recent review;
        2. Certify that the services continue to be needed by each patient.
    c. If finding that continued stay is unnecessary:
        1. The patient will be notified, and this will be documented in the patient's case record.
        2. Arrangements will be made for the patient to leave the program based on the recommendations of the treatment team and any tools utilized to assess the patient for appropriateness to remain in treatment.
3. Documenting of utilization reviews:
   The Program Manager is responsible for:

    a. Ensuring the date assigned for each subsequent continued stay review shall be noted in the resident's record.
    b. Ensuring all utilization reviews are documented on the Utilization Review Form in the EHR.
    c. The utilization review will also be used to conduct case conferences for residents who are not responding to treatment or not meeting their goals.

F. Transfer

Policy:

Throughout their treatment episode, patients will be routinely assessed for their appropriateness to remain at the reintegration level of care. Utilizing treatment plan reviews, utilization reviews, case conferences, and the LOCADTR, the patient's progression in treatment will be monitored. If the multidisciplinary team assesses that this level of care no longer remains appropriate or beneficial for the patient, a recommendation of a transfer to another level of care will be made.

Procedure:

a. The multidisciplinary team will assess patients at least once a month with their treatment plans and utilization reviews. If a patient is not effectively engaging in the program, case conferences will be conducted and utilized as a tool to assess if the individual is in the most beneficial level of care.
b. Any recommendation of a transfer to another level of care will be approved by the Program Director and a LOCADTR will be completed to indicate what level of care is more appropriate for the patient.
c. The results of the LOCADTR and the recommendation of the multidisciplinary team will be reviewed with the patient and if appropriate, any collaterals involved in treatment (I.e., legal entities, family members, other providers, etc.)
d. The program will facilitate the transfer process and will document this process in the patient's EHR.

G. Referral

Policy:

The program will provide necessary and appropriate referrals for all patients in the program. Referrals will be made to other providers or agencies and when able MOUs and QSOAs (Qualified Service Organization Agreement) (Qualified Service Organization Agreement) will be utilized.

Procedure:

a. Based on assessed needs through assessments completed onsite or recommendations from other providers, the program will coordinate all referrals with the patient.
b. Before any referral, appropriate releases of information will be completed with the patient's signature and approval.
c. The program will facilitate the completion of tasks for any referrals (i.e., Faxing requested forms or documentation, scheduling appointments, etc.) and will document this information in the patient's EHR.

d. Referrals made for the patient will be recorded in the patient's treatment plan by the primary counselor or other assigned staff member.

III. Discharge Policies and Procedures

A. Discharge Planning

Policy:

This Program will ensure that discharge planning is started as soon as the patient is admitted, be considered as part of the treatment planning process, and be provided by the responsible clinical staff member. The discharge plan will be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. The discharge plan shall specify needed referrals with appointment dates and times, all known medications (including frequency and dosage) and recommendations for continued care. **[820.9(c)(1)]** This plan is updated and reviewed during every treatment plan review and is a part of the treatment plan document.

The discharge plan shall be based on the individual's self-reported confidence in maintaining recovery and following an individualized reoccurrence prevention plan, an assessment of the patient's home environment, suitability of housing, vocational/educational/employment status, and relationships with significant others to establish the level of social resources available to the patient and the need for services to significant others.

No patient shall be discharged without a discharge plan completed by the Primary Counselor and reviewed by the clinical supervisor or designee prior to the patient's discharge. This does not apply to patients who leave the service without permission or otherwise fail to cooperate in the discharge planning process.

Procedure:

1. The discharge plan is completed and updated on every treatment plan in collaboration with the patient.
2. The Primary Counselor collaborates with the patient to complete a formal discharge plan.
3. The plan will include a re-occurrence prevention plan and a statement from the patient regarding their confidence in maintaining their recovery goals. It shall also include a list of resources available to them, their significant others and family members.
4. The discharge plan will include but not be limited to:
    a. Identification of continuing chemical dependence services and any other treatment, rehabilitation, self-help and vocational, educational and employment services the patient will need after discharge;
    b. Identification of specific providers of these needed services; and

c. Specific referrals and initial appointments for these needed services.

5. The plan will be signed off on by the patient, the primary counselor and the Program Director or other designee.
6. The discharge plan which includes referrals for continuing care will be given to the patient.

B. Discharge Criteria

Policy:

A patient is considered appropriate for discharge from the Community Residence and will be discharged when they meet one (1) or more of the following criteria:

a. The patient has accomplished the goals and objectives which were identified in the comprehensive treatment/service plan;
b. The patient refuses further care;
c. The patient has been referred to other appropriate treatment which cannot be provided in conjunction with the residential service;
d. The patient has been removed from the service by the criminal justice system or other legal process;
e. The patient has received maximum benefit from the service; and/or
f. The patient is disruptive to the service and/or fails to comply with the applied written behavioral standards of the facility. **[820.9(b) (1-6)]**

Procedure:

a. The Primary Counselor is responsible for the oversight of the patient's progress in treatment.
b. The Primary Counselor will coordinate with the Clinical Supervisor and Program Director to review the discharge criteria that the patient meets.
c. A discharge plan will be made according to the Discharge Planning policy.

C. Involuntary Discharge

Policy:

A patient may be asked to leave the program involuntarily for a variety of reasons, including but not necessarily limited to threatening or fighting with other residents or staff, non-compliance with rules and programming, lack of progress or motivation in treatment, and/or continued drug and/or alcohol use in program. **[820.9(a)(2)]**

Procedure:

a. All administrative discharges are reviewed and discussed with the members of the

Community Residence Treatment Team. The Program Director makes the final decision after consultation with the Director of Residential Services based on recommendations from the team.

b. If the Program Director is not present and the team feels that it is necessary to decide, the Director of Residential services should be contacted prior to any decision.
c. If a patient is being asked to leave the program against their wishes, a Discharge Against Wishes form will be completed, and the patient will be given a written statement of why they are being asked to leave treatment.
d. The patient will be discharged with all their belongings and will sign the Personal Item Inventory, and a sheet that they have received all their medications that they have taken with them.
e. The referral source and/or the legal contact will be contacted (beforehand if possible) to discuss the action taken and the reasons.
f. Outpatient service providers and/or Primary Care providers providing services to this resident will also be informed so they can adjust their services accordingly.
g. The patient's legal guardians, parents, emergency contacts, and referral sources are notified immediately of the decision to discharge.
h. The Discharge Against Wishes Letter will be scanned and maintained in the patient's chart.

Recommendations made for a patient to be discharged against their wishes will only be finalized after the Director of Residential Services or designee has completed the following:

a. Has reviewed the recommendation to discharge to ensure that the reasons are fair and serious enough to warrant discharge.
b. Ensure that a complete review has been done which evaluated the patient's response to the complete treatment episode.
c. Confirms that periodic interventions have been tried and have been unsuccessful, including the consideration of a transfer to another provider.
d. All patients will be given a written statement describing the reason for discharge and the procedure on how to appeal this decision.
e. If the patient appeals, the Program Director shall meet with the patient after a 24-hour period has passed. This time will allow the patient to seek advice and consultation from others if they wish to do so. The Director will discuss with the patient the reason to rescind or implement the recommendations to discharge.
f. The patient will be informed, in writing, of the appeal decision no later than seventy-two (72) hours after the appeal decision is made.
g. After the appeal, if the decision is to discharge, the patient will receive information about treatment and referral options.
h. If it is decided to maintain the patient in treatment after the appeal, the resident will be given the opportunity to start treatment anew. All procedures and steps taken will be documented in the patient's file. No patient shall be forced to leave the program

until the procedures listed above have been completed. No patient shall be forced to leave the program between the hours of 6 p.m. and 8 a.m. unless appropriate arrangements have been made, such as safe and appropriate transportation, travel arrangements and travel costs shall be provided or arranged for the patient as needed.

An emergency discharge may occur when a patient has been determined to be a danger to others. If this occurs, the patient will be told their right to appeal after the discharge.

D. Client Initiated Discharge

Policy:

As this program is voluntary, all patients have the right to withdraw from treatment at any time, but at admission they are asked to sign a statement (part of the Statement of Client Rights) that they will provide Credo seventy-two (72) hours' notice prior to leaving. This policy was created to provide staff time to with the individual to change their minds, refer them to another program if appropriate, or at a minimum to help them leave safely.

Procedure:

1. Staff will take the time to counsel the patient on the cost/benefit of leaving treatment. If a patient still wants to leave, they are asked to sign the Client Departure Agreement that states they understand the possible consequences of leaving treatment.
2. If the patient is willing to participate, a final discharge plan will be completed to include recommendations for further treatment needs, a record of any upcoming appointments, and a recurrence prevention plan. After signing the document, a copy will be provided to
3. The patient is asked to take all belongings and sign the Personal Item Inventory, if needed.
4. The staff signing the patient out will notify the manager or on-call staff if the patient signs out after regular business hours. The legal contact and emergency contact will be notified as soon as possible, but no later than 24 hours after discharge.

E. Client Absconsion Discharge

Policy:

When a patient has absconded from treatment and staff have been unable to contact the patient for 24 hours, the individual will be administratively discharged from the program.

This policy is to ensure the safety of patients and staff when an individual has been unaccounted for more than 24 hours. If a patient is in contact with staff after 24 hours, information will be provided to the patient to assist in safe housing as well as assistance in connecting them to appropriate care. If the patient would like to return to treatment, the Program Director, or designee, will review this request within 1 business day and a clinical assessment will be completed to identify appropriateness of returning to the program.

Procedure:

1. After a patient has been unaccounted for 24 hours, the responsible clinical staff will close the chart in the electronic health record. The patient's emergency contact will be notified of the discharge. The patient's belongings will be secured, and the bedroom searched in accordance with the Securing Patient Bedrooms Policy.
2. If a patient contacts after 24 hours, information will be provided about safe housing and outpatient maintenance services. If the patient has requested to return to the program for continued treatment, they will be instructed to contact the Program Director and this request will be reviewed within 1 business day and the patient will be notified of the decision.

F. Discharge Summary

Policy:

A discharge summary which includes the course and results of care will be completed and must address and measure progress toward attainment of treatment goals. The discharge summary shall be prepared by the Primary Counselor and included in each patient's record within thirty (30) days of discharge. Both the Primary Counselor and the supervisor will sign off on the discharge summary. **[820.9(c)(5)]**

Procedure:

a. Within thirty (30) days of the patient being discharged from program, a discharge summary will be completed in the patient's EHR.
b. The discharge summary will include the following information:
    a. Reason for discharge
    b. Further clinical or treatment recommendations
    c. Treatment plan outcomes
    d. Medical Updates
    e. Referral information
    f. Housing assessment
    g. Employment and financial information
    h. Medications at discharge
c. The summary will be reviewed by a supervisor for final approval and signed by the

assigned counselor and supervisor.

IV. Program Services and Care Coordination Policies and Procedures

A. Services

Policy:

This reintegration residential service will ensure that its patients have access to individual, group, and family counseling services as needed and appropriate. The program will provide, either directly or through referral to appropriate agencies, habilitative and rehabilitative services consistent with identified needs and plans for services for individual residents; this will include written referral agreements with one or more SUD outpatient providers for the provision of outpatient treatment services. These services will be integrated with the activities and services provided by the program and incorporated into the comprehensive treatment plan. The program will ensure that a comprehensive and appropriate range of services are available to each patient and will include at minimum:

a. vocational services such as vocational assessment;
b. job skills training, and employment readiness training;
c. educational remediation; and
d. life, parenting, and social skills training.

Services may be provided directly by the program or by referral and will be identified in the patient's treatment plan. Patients will receive training in community living skills, personal hygiene, and personal care skills as needed. Such skill development will include a program of social interaction and leisure activities. **[820.12(c) (1-5)]**

Procedure:

a. Based on needs identified in the Comprehensive Evaluation, support services will be recommended for patients, and appropriate referrals will be made.
    1. With appropriate releases in place, on-going coordination of care will occur between providers.
    2. On-going assessment of and referral for needed support services will continue during treatment plans reviews.
b. Individual and group counseling as outlined by the treatment plan will be provided by a clinical staff member.
c. On-site group therapy sessions shall contain no more than 15 people.
d. Family and support delegate services will be provided in accordance with Family

Involvement and Support Delegates policy in the Agency Wide Manual.

1. Patients will be referred to outpatient services with on-going collaboration between the service providers. Outpatient services will provide individual, group and family counseling to include mental health services as needed or requested by the patient.
2. Patients will be provided opportunities to participate in rehabilitative services and structured activities designed to develop skills to enable them to make effective use of leisure time as well as improve social skills, self-esteem, and responsibility. Integration of services with the activities and services provided by the residence will be incorporated into the resident's individual service plan/treatment plan.
    i. Patients will be encouraged to participate in activities offered by the program.
    ii. Patients will be provided information regarding community resources that will support them in their treatment and recovery.
    iii. Patients will be provided with training in community living skills, personal hygiene, and personal care skills as needed.
3. The program will provide orientation, advice, and instruction in identifying and obtaining needed community services, including housing and other necessary case management services, to each resident.
    i. All Care Management referrals will be documented in the electronic health record (EHR). Clinical staff at the Community Residence will record updates during Treatment Plan reviews noting if a referral was made, the nature of the referral, description of the services provided, the results and if care coordination will continue.
    ii. Case Management services are provided by case managers of Credo Community Center's Ancillary Services or another provider who provides Health Home Care Management services.

B. Patient Programming and Rules

Policy:

The structure of the patient's schedule and program rules are outlined in the patient handbook. Each patient is provided a copy of the handbook upon admission.

C. HIV/AIDS Education, Counseling, Prevention, and Testing

Policy:

All staff will receive initial and annual in-service training on HIV confidentiality, high-risk behaviors, HIV updates, and agency policy and procedures. All patients in the program will

receive HIV education as a component of their treatment, by introducing HIV aspects in educational groups or during individual sessions.

Procedure:

1. Training records will be completed, and copies placed in the personnel records. All staff completing such training will sign the HIV in-service training record for employees.
2. Training is provided by AIDS Community Resources personnel based in Syracuse and Watertown.
3. All patients will sign agency HIV policy forms at admission outlining the information available after admission and their rights regarding HIV testing and/or HIV-related records.
4. AIDS Community Resources personnel also provide patients with annual training about safer sex, AIDS updates, and confidentiality.
5. All patients will receive education classes at the Outpatient Clinic. These classes will include TB, STD's, hepatitis, HIV and AIDS prevention as well as harm reduction. Patients will be directed to clinics or agencies that provide testing.

D. The use of Medication Assisted Treatment

Policy:

This program will provide residential services to an individual on methadone or other approved opiate maintenance or detoxified from methadone. Opiate maintenance or detoxification services may be provided through a written agreement with an appropriately certified methadone/opiate provider in 6 accordance with applicable Federal and State requirements including, but not limited to, regulations of the Federal Center for Substance Abuse Treatment, the United States Drug Enforcement Administration, the New York State Department of Health, and the office, including but not limited to Part 822 of this Title **[820.5(d)]**

Procedure:

1. During the pre-admission screening, the patient will be asked about a current MAT prescription.
    a. If the patient is currently on MAT and is appropriate for admission to the program, a referral to the agency's Opioid Treatment Program (OTP) will be made by the staff conducting the screening.
    b. If the patient is not currently on MAT but discloses a desire to be on MAT upon entering the program, a referral to the agency's Opioid Treatment Program will be made by the staff conducting the screening.
2. After admission, the program will coordinate with the patient, their outpatient

counselor, and the OTP to support the patient in effectively engaging in MAT services.
3. Any coordination of care will be documented in the patient's chart and added to their treatment plan.

E. Self-Help Meetings

Policy:
Patients are encouraged to attend self-help meetings of their choosing both during and after treatment. Meetings are held regularly in the community and can be found in various locations several times a day. Residents attend meetings to experience a different level of recovery and commitment and to build a support network for their recovery.

Procedure:
1. Upon admission, or at any point in treatment, patients have the option to sign a request to do step work form which outlines their ability to request assistance with resources for self-help related activities and information.
2. Treatment plans will not require that a patient attend specified self-help meetings such as Alcoholics Anonymous or Narcotics Anonymous.
    a. A patient may request to identify an objective related to attending self-help on their treatment plan; this will always be at the discretion of the resident.
    b. Participation in self-help meetings may at times be required by a resident's legal entity; however, the option of which meeting to attend will be left up to the resident.
    c. The following guidance from OASAS LSB No. 2014-22: Impact of Federal Court Decision Concerning Alcoholics Anonymous on Government Funded Providers will be taken into consideration when making treatment recommendations to patients:
        i. must not require that a patient attend A.A.
        ii. must not provide staff supervision of any meetings of A.A.
        iii. must not compel the reading, listening, or viewing of written, audio, or visual material developed by A.A.
        iv. may suggest that individuals receiving services participate in A.A.
        v. may require that a patient attend recovery support groups in the community, if the patient has the option of choosing attendance of activities that are of a non-religious nature.
        vi. may request a patient read, listen to or view materials

developed by A.A., as part of an introduction to available resources, if the materials are not limited to A.A.

vii. may make space available to A.A. for holding meetings, if the space is available to other groups as well.

F. Community Service/Restitution/Child Support

Policy:

Patients are provided with the opportunity to be involved in community service projects. These opportunities teach them teamwork, community spirit and the positive feeling of "giving back" among other things. Also, patients are supported in meeting other financial obligations such as restitution or child support.

Procedure:

1. Community Service, as ordered by the court as part of a sentence, will be coordinated with clinical staff. Probation officers are informed that community service is being done. Patients will be provided with log forms to record their volunteer hours which can be submitted to their legal entities and maintained as part of their EHR.
2. Restitution payments, as ordered by the court as part of a sentence, can be arranged on a limited basis if a patient is receiving personal needs money from DSS (Department of Social Service) (Department of Social Service) monthly. This payment arrangement is established by the patient.
3. Child Support payments should be made by patients, if possible, while they are in treatment. Payment arrangements will be coordinated through DSS and will often result in the funds being deducted from their personal needs assistance checks.

G. Care Coordination

Policy:

The purpose of care coordination is to provide patients with the appropriate services to best aid them in their treatment and recovery. Primary Counselors will coordinate with other treatment providers and legal entities to provide wrap-around care for patients. Referrals will be made as needed to link clients to services in the community.

Procedure**:**

a. All care coordination will be documented in a patient's treatment plan, which is in the electronic health record.
b. The assigned clinical staff will update the treatment plan at least every 30 days (about 4 and a half weeks) and will include if a referral was made and the nature of the referral. Documentation of the description of the services provided by the referral, results of the referral, as well as if care coordination will continue will be recorded in the medical information of the patient chart.

H. Cooperative Agreements

Policy:

This program will have cooperative agreements with other chemical dependence service providers and other providers of services a patient may need; **[820.5(a)7]**. The Corporate Compliance Department will ensure that the appropriate type of agreement is in place so that only necessary information is disclosed.

Procedure:

1. The program will ensure cooperative agreements are made with local chemical dependence services providers, medical providers, psychiatric care providers and any other providers connected to patient care.
2. The cooperative agreements will be overseen by the Corporate Compliance Department and routinely reviewed to ensure agreements are up-to-date and relevant.

V. Program Policy and Procedures

A. Toxicology

Policy:

This program follows the agency wide policy and procedures for toxicology screenings. This policy can be found in the agency-wide manual.

B. Patient under the Influence/Positive Drug Test

Policy:

If there is a concern for a resident who may be intoxicated or under the influence of a substance the staff on duty must take the following steps which will include the use of universal precautions.

Procedure:

1. Ask the resident to come into a private office to remove them from the rest of the house.
2. Ask them if they are under the influence of a substance; an answer of yes or no has no authority on conducting the next step if staff's discretion deems the sobriety status questionable.
3. Administer the proper testing devices (breathalyzer/Alco-sensor, urine screen kits for chemicals such as morphine, THC, cocaine, and amphetamines). If the resident refuses to take the test they will be reminded that they agreed to random testing via the intake contract, and it could result in discharge from our facility should they refuse to comply. If a relief staff is on duty and the resident refuses the test the staff must monitor the individual for the evening, keeping him on the couch for the night, and documenting all events that transpire. The relief staff will also call the On-Call Manager to keep them informed of the events. Depending on the testing results, it may be appropriate to send the resident to the emergency room for observation. This decision should be made after speaking with the On-Call Manager. The resident will then be evaluated by the daytime staff in the morning dependent on the test results and condition of the individual.
4. If testing comes back negative, document exactly what had happened, why there was suspicion of use and photocopy the test results. It may also need to be shipped to a lab for further review if staff deems status is still questionable. Due to some substances not appearing on testing kits, if a resident presents with concerning behaviors or appears to be under the influence, the decision to have the resident under staff observation will still be made with support of the Program Manager or if after hours, the On-Call Manager.
5. If testing is positive for any substance, the On-Call Manager will be notified, and the On-Call Medical contact will also be notified to receive further direction (i.e., receive medical attention). If medical attention is not required, the resident will remain under direct staff observation until the Treatment Team can convene to review the resident's treatment needs.
6. A contact note will be placed in the resident's Electronic Health Record indicating the concern about the resident being under the influence and outlining the action steps taken to ensure the resident's safety. Additionally, an Incident Report form must be completed, and an alert sent to the Program Director.

Positive breathalyzer results on a resident should be monitored twice per hour to determine if a BAC is going up or down. This monitoring will determine what types of action the staff must take. If the BAC continues to rise, On-Call Medical will be notified and provide

directions of next steps.

C. Patient Reoccurrence

Policy:

If a patient tests positive for the use of any mood-altering substances or admits to use of these substances, the resident's Primary Counselor is responsible for ensuring the case is reviewed by the treatment team. No patient will be discharged from the program without notice or without a discharge plan in place due to positive test results or admission of substance use. Every case will be handled individually.

Procedure:

1. A safety plan, including supervision needs, will be completed with the patient upon notice of a re-occurrence or positive drug test. This plan will include the level of supervision required to support the patient. The plan will remain in place until a case conference and treatment plan revision are complete.
2. The case conference will be completed within 24 business hours, and the treatment team will establish:
    a. if any further safety plan is required, and
    b. if a LOCADTR needs to be completed to assess for a potential higher level of care. If the re-occurrence is on a weekend, staff will make a safety plan with the support of the on-call manager and on-call medical (if currently under the influence).
3. Based on the treatment team discussion, LOCADTR results, and any coordination of care a decision will be made for the patient to remain in treatment or to be referred to a higher level of care.
4. If the patient remains in treatment, the treatment plan will be revised to address their needs and outline the safety plan, if needed.
5. If the patient were to be recommended for a higher level of care, the already established safety plan will be reviewed and modified as needed until the patient is transferred.

D. House Checks

Policy:

Staff will conduct hourly house checks. These house checks will be used to obtain a head count of all patients and ensuring the safety of clients during the check; staff will have visual of clients during the house checks (unless patient is in the bathroom, in this case patient will verbalize their presence in the bathroom).

NARCAN kits and gloves will be kept in a pouch that must be taken by the staff completing the house checks. If a NARCAN kit or pair of gloves are used during that house check, the staff who used the items are responsible for restocking the pouch. If a NARCAN kit is used and needs to be replaced, the supervisor needs to be notified immediately. Pouches will be stored in the medication offices, so they are easily accessible.

Procedure:

1. Once every clock hour (checks do not have to be completed every 60 minutes but rather once per clock hour), staff will account for the number of clients onsite and offsite. Patients offsite are logged in the sign-out book.
2. Staff will log the number of patients onsite and offsite in the house check logbook. This logbook will also record if any patient is unaccounted for and the total number of patients in the program. Staff will document the time the in-house check was completed and initial that they completed the check.
    a. Any patient unaccounted for during a house check will try to be contacted for their whereabouts. If contacted, staff will coordinate a plan with the patient to return to the program.
    b. If the patient cannot be reached, the procedure for an absconded patient will be followed. See agency wide manual for policy and procedure related to a missing patient.
3. The Program Manager will review the logbook weekly to identify any missed house checks. A random camera review of weekly house checks will be conducted, and the Program Manager will address any missed house checks or misrepresented documentation in the logbook with the appropriate staff.
4. The Program Manager will retain the review records to be made available for the Director of Residential Services and the Director of Corporate Compliance.

E. Person and Property Searches

Policy:

Upon admission, all residents and their belongings will be searched for contraband to ensure safety for the community. Contraband is considered any item that can result in serious harm to the life, safety, health, and/or welfare of individuals, including weapons or substances of abuse with the potential to result in overdose. This may include psychoactive substances that are not prescribed and/or kept per medication policies, weapons, items that pose a fire hazard, etc. Once a resident is admitted into the residence, they will participate in confidential routine contraband searches of their person (in a designated area), belongings, and bedroom. Routine property searches will also be conducted.

Staff will encourage accountability, integrity, and growth with residents by supporting their disclosure of any contraband. Staff will provide a therapeutic environment in which residents can process the ways they can support both their own health and safety and that of the program.

All searches will be conducted utilizing universal precautions, as outlined in the Personal Protective Equipment Section of the Agency Wide Manual. Person and belonging searches will be conducted by staff within view of a camera. Under no circumstances will a physical search of their person be conducted. Bedroom searches will be conducted by two staff members. Staff will be provided with training on how to conduct searches at the time of hire and two times per year thereafter.

Procedure:

Prior to starting any search, staff must put on PPE (Personal Protective Equipment) appropriate to the task and COVID-19. Staff shall not reach into any area that is not visible to avoid accidental needle sticks and use a flashlight for dim areas.

Searches Upon Admission:
Upon admission, patients, and if present support members of the patient's community will be provided with information regarding screening and search procedures. Information relating to search policy and procedure will be provided within the program manuals found on the Credo Community Center website or at the request of the participant or their family members. Clients will be informed that the program operates under an open-door policy which allows for any community member to report concerns or information regarding suspected or known contraband within the facility. To search for contraband upon admission, staff will ask the resident to empty and display the contents of their pockets and then inspect all belongings being brought into the residence. If contraband is found during admission, the staff person will collect it, store it in a secure area, and notify the Program Director. Any contraband found on a resident during an admission search does not need to be recorded in an Incident Report or a Justice Center Report.

Searches After Admission:
Once an individual is admitted into the residence, to ensure the overall safety of the house, they will be subject to routine searches of their person, belongings, and bedroom. Bedroom searches will be conducted by two staff members. The property will also be routinely swept for contraband.

Routine searches of their person and belongings will occur when:

1. Returning from an approved pass,
2. Returning from a weekend pass,
3. Returning from being off-site or outside of the residence

4. A resident's behavior indicates the individual may be intoxicated or under the influence of a substance. If at any point the act of conducting a search poses a threat to the safety of staff or clients, reach out to the site manager or on-call manager for further directions before proceeding.

Searches of the person and belongings will include a random selection of the client:

1. Emptying and displaying the contents of their pockets,
2. Pulling up sleeves and pant legs.
3. Unrolling of pant and/or shirt cuffs.
4. Removing outerwear for inspection (i.e., hats, jackets, sweatshirts, shoes).
5. Patting themselves down, loosely shaking their clothing.
6. Opening mouth, moving tongue side to side, and pulling back cheeks
7. Emptying the contents of personal items being brought into the house (bags, envelopes, wallets, etc.). Staff members will visually inspect the contents.

If person searches have been conducted and the results are negative yet program staff or the community have concerns that a resident(s) has contraband in the facility, alternative methods may be implement including but not limited to:

- A plan of observation of the client created in coordination with the program manager or the manager on-call which may include one-to-one staff to participant observation.
- Involvement of the community in processing instances of contraband that create an unsafe environment.
- Limitations on privileges for participant(s) or groups who have contraband into the facility or have no reported known instances of contraband.
- Establishment of a safety plan
- Utilization of the multidisciplinary team to provide clinical interventions.
- I will collaborate with referring or mandating agencies to formulate a strategy that may include discharge from a congregate care environment.
- Capitalizing on therapeutic alliances to maximize opportunities for disclosure and removal of contraband.

Search of a resident's bedroom will occur:

- Routinely
- When a resident's behaviors indicate the individual may be intoxicated

or under the influence of a substance.

Search of a resident's bedroom will include:

- Under, between and in the mattress and box springs
- In and under drawers
- Boxes and bags
- Picture frames
- Containers/bottles
- Ceiling tiles
- Clothing
- Any space that could be used to hide contraband

All bedroom searches will be conducted by two staff members. If a search is deemed necessary during a single coverage shift, the staff member will either restrict the resident from entering their room unless accompanied by the staff member or the search will be conducted with a second staff member participating virtually through a teleconferencing platform that meets minimum required confidentiality requirements (i.e., Skype for Business, Microsoft Teams).

If contraband is found on the resident's person, in their belongings, or in their bedroom, the staff person will collect it, store it in a secure area, and notify the site manager or, if after hours, the On-Call Manager. If contraband is found during a bedroom search and the resident is not present, the resident will be informed of the finding as soon as possible. The treatment team will review the situation, and a case conference will be completed in the EHR documenting what was found and outline the treatment plan inclusive of progressive behavioral inventions for this resident which may include discharge for specific items that pose an immediate and potentially lethal threat to participants. Individuals found to be in possession of contraband will be provided with opportunities by staff to take accountability within the community and will be provided therapeutic support. If no contraband is found, the date, time, extent, and results of the search shall still be documented.

<u>Routine Property Sweeps:</u>

Routine sweeps of the property will be conducted for contraband and unintended access points at least once per week (varying shifts), and will include:

- Enclosed outdoor spaces (trash cans, sheds, planters, etc.),
- The perimeter of the property,
- Other areas where contraband could be hidden to include agency vehicles,
- Doors are secured; and
- Screens are intact and closed.

Any contraband found on a resident, in their belongings, or during a bedroom search or

property sweep will be recorded in an Incident Report. A Justice Center Report will be filed if the contraband was found in conjunction with another Justice Center reportable event (see Incident Management Section of the Agency Wide Manual). If there is an identifiable client associated with the contraband, this will be documented in the client's EHR. Staff will coordinate with the Program Director to dispose of the contraband. If contraband is found during a property sweep, the area it was found will be monitored more frequently via camera and in person to try to identify its source. A maintenance request must be submitted for repair of any deficiencies identified in the property.

Compliance audits of searches will be completed routinely using video footage. Person searches will be reviewed quarterly with each member of staff as a training and compliance tool. House checks will be reviewed weekly via video footage and feedback will be incorporated into training opportunities and supervision sessions. Program Managers or their designee will be responsible for reviewing the person who searches logbook weekly to identify any non-compliance with documenting the return of the client to the program and the results of the person's search. Staff will be met with as needed to address any non-compliance with this policy.

E. Person & Room Search Staff Trainings

Policy:

Search training will be conducted for all staff members during on-boarding and annually. Training will focus on modeling person-centered, trauma-informed principles that protect the emotional safety of residents. Training regarding screening and search practices will include safe and person-centered alternatives to invasive searches when staff have suspicion of or concern for contraband.

Procedure:

Training will include:

- Information regarding intake procedures from the first contact with the client and referral source, including providing information on allowable items, prohibited items and those items considered to be contraband.
- Information on procedures for trauma-informed searches after a participant returns to the facility from an off-site location.
- Information on procedures for room monitoring, from everyday observation to specific searches for cause.
- Information about intake procedures from the first contact with the participant and referral source, including providing information on allowable items, prohibited items and those items considered to be contraband.
- Information on procedures for trauma-informed searches after a

participant returns to the facility from an offsite location.

- Information on procedures for room monitoring, from everyday observation to specific searches for cause.
- Information on modeling and safeguard trauma-informed principles as they provide for the emotional safety of participants.
- Information on behavioral and community interventions that staff are expected to utilize for all participants' behavior, including the possession of contraband, that is harmful and/or potentially dangerous to the community.
- Information on the use of community as method, will include:
    - Use of community rules and norms to address concerns, the understanding that the living environment is a place of safety, and use of fellowship to promote a reduction of contraband.
    - Use of staff within the facility to promote trust, safety, and a comfortable emotional tone through informal interactions with participants and to model facility norms.
- Information on the importance of behavioral modelling as a staff member, including a prohibition against contraband.
- Information on the use of strategies to encourage integrity and accountability within the program.

F. Securing Patient Rooms

Policy:

Credo Community Center's Community Residences will secure client bedrooms until the time that they can be searched and cleaned by staff in the cases that a client leaves unexpectedly and does not return to the program or when a client is discharged from the program.

Procedure:

In the case that a client is unaccounted for more than 8 hours, their bedroom will be secured until there is more than one staff member on shift to obtain the client's personal items and search their bedroom for contraband. When there is sufficient staffing to complete a search, a search will be done and logged as completed. The client's items will be packed and stored in a locked area until the client returns, or other arrangements have been made for the client's personal belongings to be picked up. If the bedroom that needs to be secured has more than one occupant, other sleeping arrangements will be made for those clients for no more than one night.

When a client is discharged from the program, their room will be immediately secured until it can be searched and cleaned; this will be no more than 24 hours after the discharge. If the

bedroom that needs to be secured has more than one occupant, other sleeping arrangements will be made for those clients for no more than one night.

All search procedures will be conducted according to the Searches Policy and Procedure.

G. Storing Patient Belongings

Policy:

Upon admission, all the patient's belongings will be searched by a staff member. The patient will be provided with their belongings and any luggage or storage containers they have brought will be stored in the attic labeled with their name. Patients will be permitted to have a bookbag or other small bag for day-to-day needs that can be kept in their bedrooms.

Procedure:

After a patient's belongings have been searched by a staff member, the luggage (or any other storage containers) will be searched by an additional staff before being labeled and placed in the attic. Patients can obtain their luggage (or other storage containers) upon discharge. Any contraband found during the admission process does not require a Justice Center report and will be disposed of according to policy.

Patients will be informed at admission that they can maintain a bookbag or other small bag for day-to-day needs and this will also be searched in accordance with the Searches Policy.

I. Contraband Storage and Removal

Policy:

Contraband found during person, room, or property searches or turned in to staff by a patient will be secured and stored or removed according to procedure. Any contraband found during a person, room, or property search will have an incident report and if need, a Justice Center report, completed according to agency wide policy.

Procedure:

1. If the item is legal, but not allowed in the program:
    a. Sharps: Wearing PPE, dispose of needles and blades in a red medical waste bucket.
    b. All other items:
        i. Confiscate the item(s)
        ii. Inform the client that the item(s) will be locked in storage and returned upon discharge.

iii. Store the item(s) as follows: OBJ
    1. Document the confiscated item(s) in the client's chart using a Progress/Contact Note.
    2. Place the item(s) in a Zip Lock baggy or other appropriate container labeled with the client's name.
    3. Place the baggy/container in the "belonging bin" that is in the site's assigned locked storage area.

2. If the item is illegal:
    a. Illegal drugs or unidentifiable substance:
        i. Request police to pick it up with two staff present.
        ii. Document the pick-up in the client's chart using a Progress/Contact Note. Indicate the officer's badge number and department.
    b. Prescription medication:
        i. Dispose of it according to the Medication Disposal Policy.

J. Infection Control Procedures

Policy:

This program will follow the agency's policy and procedure related to Infection Control Procedures found in the Agency Wide Manual.

K. Procurement, Storage, Preparation of Food and Nutritional Planning

Policy:

This program shall ensure the availability of two (2) meals each day to each resident. Such meals shall provide sufficient nutrients and calories to meet normal needs and those in recovery. Furthermore, the residence shall have snacks and beverages available between meals. Copies of menus shall be kept on file at the residence for one (1) year.

Procedure:

1. Kitchen Hygiene and Menus
    a. Hands will be washed each time entering kitchen before preparing any food items.
    b. Plastic gloves will always be worn while preparing and serving food.
    c. Hands must be washed after using the restroom and before re-entering the kitchen.
    d. Menus will be posted weekly.
2. Food Preparation and Storage
    a. All foods will be checked for spoilage before being prepared for a meal or snack: Cans with dents or bulges will be discarded; Jars cracked or discolored, or foul-

smelling food inside will be discarded; Produce shall be free of bugs, sand and dirt; Meat with odor and discoloration will be discarded.

b. All fresh vegetables will be washed before preparation.
c. A three-day supply of food shall be kept in storage.
d. All frozen meat items will be thawed in the refrigerator.
e. Food items when prepared for a meal will be kept at the proper temperature: Cold items - 32 to 40 degrees; and hot items - 160 degrees.
f. All foods will be covered and placed in proper serving pans and dishes before being put in the refrigerator.
g. Left-over foods will be covered, dated, and labeled and placed in the refrigerator immediately after the meal.
h. All leftover food items should be used within a seventy-two (72) hour period.
i. Foods will be stored together with like items (fresh produce, frozen foods, etc.).
j. All dry goods will be stored on shelves 12" up off the floor and 6" from the wall.
k. All frozen or refrigerated items need to be put away immediately upon receipt.

3. Food Purchasing
   a. A designated staff member is responsible for ordering food after taking an inventory of current products.
   b. The Community Residences utilize Food Bank and other local retailers to purchase food for residents.
   c. When items are delivered, they will be verified as being received before signing the receipt. If items listed on the delivery receipt are not included in the shipment, it should be indicated on the receipt. Some items may be substituted for like items in the shipment.
   d. The original invoice will be forwarded to the Finance Department for payment.
4. Supplemental Nutrition Assistance Program (SNAP) Benefits
   1. Most residents are eligible for SNAP when they enter the program. The Finance Department keeps a copy of the resident benefit list which states who is eligible to receive SNAP. The SNAP benefit cards are sent to the Main Office and are kept track of by the Finance Department.
   2. An assigned staff member assists the residents in applying for SNAP upon admission. The Community Residence has a DSS representative for the residence that oversees the new intake applications for DSS including SNAP.
   3. SNAP benefits are distributed through one access account as staff shop for food for the house. Residents are not responsible for their own food purchasing in the program and, therefore, will not possess any SNAP benefits until discharge.
   4. After shopping, all receipts will be placed in the outgoing mailbox to be sent to the Finance Department who will balance the SNAP account at the end of each month.

L. Tobacco

Policy:

This program supports and enforces a tobacco free policy. Smoking is not allowed in agency vehicles or on Credo Community Center property. Any type of tobacco paraphernalia is also prohibited. All staff, patients, and visitors will be notified of this policy and signs are posted conspicuously on the program's property. The program is committed to addressing tobacco use just as any other substance abuse or dependence is addressed.

Procedure:

1. During the comprehensive assessment, tobacco use is reviewed. If the patients are interested in receiving Nicotine Replacement Therapy (NRT) to help with nicotine withdrawal or cravings, then staff will coordinate a referral to a provider.
2. Tobacco use will be reflected in the patient's diagnosis.
3. If a visitor uses tobacco products on the property, they are asked to stop immediately. The policy is reinforced with them and the reasons why this policy exists are explained. Visitors will be informed that continuous violations of this policy could result in being unable to be onsite.

M. Patient Personal Leave

Policy:

Patients in need of personal leave due to an emergency at home such as death or serious illness can make a request to staff to be reviewed by the treatment team. If the decision must be made immediately, the Program Manager must be consulted prior to departure. When a resident is going home for a visit, the Probation Officer or legal must be notified of the arrangements.

Procedure:

1. A patient requesting unplanned personal leave will notify staff as soon as possible.
2. Staff will review the situation and the patient's safety plan during personal leave. The plan will be provided to the Program Manager for approval or revision.
3. For extended periods of leave of absence from the program will be reviewed by the treatment team to determine if the absence can be accommodated by the program or if the patient needs to be

discharged from the program due to being unable to maintain their bed for an extended period. This decision will be provided to the patient for them to determine if they would like to move forward with the leave of absence.

4. All decisions will be documented in the patient's EHR.

N. Transportation

Policy:

Patients are to be transported in agency vehicles and all vehicles and traffic laws apply to all drivers and passengers. Seat belts must be used by all individuals using the agency vehicles. There is no smoking in any of the vehicles. Residents are never to operate agency vehicles. One staff member is never permitted to transport patients alone.

Procedure:

1. Any time a staff member takes a vehicle, the mileage must be logged at the beginning and end of the trip. This logbook is maintained in the vehicle. Completed sheets will be turned into the Program Manager.
2. Any time the gas tank is less than half full at the end of use, the person using the van is responsible to fill the tank before returning it to the house. The gas card will be kept with the vehicle keys and all receipts need to be labeled with the program's name and handed in to the Finance Department.
3. Any vehicle concerns should be immediately communicated to the Program Manager.

O. Key Procedure

Policy:

The following guidelines are supplemental to the Credo Key Control Policy and Procedure found in the Agency-Wide Policies and Procedures.

All keys are kept in the designated area in the staff office. Staff must sign out any vehicle keys to keep track of the keys' whereabouts and sign back in upon their return. If an employee leaves the residential facility without returning a key, they may be required to return it immediately rather than waiting until their next shift to work.

Procedure:

1. Specific assigned staff may be provided with select keys to maintain. Any key provided to a member of staff will be documented on a form and maintained by the Program Manager.
2. Keys that are maintained onsite will be transitioned between staff during shift changes.
3. All office doors will be locked when a staff member is not in the office.
4. If keys go missing, the Program Manager will be alerted immediately.
5. Vehicle keys will be signed in and out using the vehicle sign out logbook. All completed sheets will be handed in to the Program Manager and maintained onsite for at least one year.

P. Client Satisfaction

Policy:

Perception of Care Surveys will be completed quarterly by the patients. Each program will establish a Patient Quality Assurance (QA) Committee consisting of 2-3 patients voted on by their peers. The purpose of this committee is to examine the day-to-day workings of the program and make suggestions and changes when needed regarding rules, areas of program, etc. The Director of Residential Services will meet quarterly with the QA Committee and a staff member to review the results and provide the program with formal recommendations.

Procedure:

1. An assigned staff will provide the patients with the surveys to complete each quarter. The surveys will be collected and turned into the Residential Administrative Assistance for data collection.
2. The Administrative Assistant will give the survey results to the Director of Residential Services. The Director will contact each program to establish a meeting to review the survey results.
3. The Director of Residential Services assigned staff members and patient QA Committee will review the results of the surveys and establish formal recommendations of changes that will be presented to the program's treatment team by the assigned staff. Recommendations will be implemented as able in the programs.

Q. Census Reporting

Policy:

Monthly program census reporting (PAS-48) is due to OASAS by the 10th of every month and is completed by the Program Manager or designee. All admission forms (PAS -44) are completed and filed by the staff member completing the admission. All discharge forms (PAS-45) are completed by the patient's Primary Counselor.

Procedure:

1. The assigned staff will complete the PAS 44 and PAS 45 forms within 24 hours of admission and discharge, respectively. The completed forms will be turned in to the Program Manager.
2. The Program Manager or designee will input the PAS form information into the OASAS database.
3. Completed PAS forms will be scanned and stored in the patient's EHR.
4. The Program Manager will input the PAS 48 information into the OASAS database by the 10th of each month.

R. Visitors

Policy:

All visitors at the community residence need to sign in and out for their visit. Patients are not permitted to have visitors in their bedrooms and all visits will occur in the main communal area of the house or in the yard within staff view. Visitors need to be pre-approved by clinical staff before coming onsite.

Procedure:

1. All visitors to the facility will receive an orientation to the facility, including rules about contraband.
2. All visitors will be provided an explanation of the search procedures that they will be required to follow:
   - Searches of pockets
   - Searches of packages
   - Searches of bags
3. All visitors will be requested to leave personal belongings in their personal vehicles or locked in a staff office while visiting.

VI. Medication Policies and Procedures

A. Ordering, Procuring, and Self-Administration of Medication

Policy:

Upon admission, patients are required to turn in all medications. Medications (prescribed or over the counter) are maintained under double lock and key in the medication administration office. Medication cabinets are always locked. All medications must be prescribed by a physician and over-the-counter medications need to be signed by a primary care physician. Narcotic drugs are strongly discouraged, unless necessary.

Medication shall be distributed daily as ordered by the prescribing physician. Patients must self-administer their own medications. Patients are responsible for taking the appropriate dosage(s) of medication in accordance with the prescriber's orders. This activity shall be monitored by an appropriately trained staff member and documented as noted in the procedure.

When a patient takes suboxone, they shall be monitored throughout the self-administration process until the medication is absorbed under the tongue.

Every staff person will be given a thorough orientation regarding medication policies and the administering of medications; orientation will be completed by an RN (Registered Nurses). Staff will sign off that they have been properly oriented and understand the medication policies and procedures. Refresher training will be completed annually for all staff responsible for dispensing medications.

Procedure:

Oversight of Self-Administration of Medications:

1. Each patient will come to the office to receive their medications.
2. Only one patient will be allowed in the office at a time to ensure privacy and confidentiality.
3. A professionally trained staff member will retrieve the medication box from the medication cabinet. The box must be double checked by checking the patient's name on the box to ensure that it belongs to the resident in the office.
4. Once it has been determined it is the right medication for the right patient by utilizing the 5 Rights, the following procedure will be followed:
    a. Double check the patient's name, dosage of medication and time to be given before handing it to the resident.
    b. Hand the patient each medication packet or bottle separately.
    c. Supervise the patient as they "pop" out the pill or remove it from the container. For medications that are in bubble packs, pills should be dispensed directly into the cup. Medications should not be dispensed into the hand.
    d. Ask patients to dispense all medications into one clear cup, as able. Dispensing all medications, instead of one (1) medication at a time, reduces the risk of "cheeking" a medication. If their medications are too numerous or too large, the resident may dispense only one (1) medication at a time in the cup. Prior to the patient taking the medication, staff will double check that the appropriate number of pills are in the cup. Patients should have their hands clear of the cup except for when dispensing medications in the cup.

e. Observe the patient taking the medication. Each patient must bring water with them and take a drink after consuming each pill. Patients will take an additional drink of water and swish around their mouth; they will complete this twice. Staff will ask the patient to open their mouth and move their tongue to make sure the medication has been swallowed. This process will ensure that patients are not "cheeking" medications.
f. Sign the Medication Administration Record (MAR) or document in the EHR that the medication has been taken. Also document the time, dosage and running totals for all medications, and then sign them in the appropriate place (signatures must be legible).
g. Note any deviation from the prescribed dose and/or frequency in the MAR. Follow the Incident Reporting and Medication Errors policy.

OTC meds shared by the program will be handed to the patient with a disposable glove. The patient will take the directed amount of medication and place it in the cup.

The oversight of the medications will be completed by an assigned staff person who will be responsible for coordinating with the patient to refill medications, assist in speaking with the provider for new prescriptions, and ensure that policy and procedures are being followed. In the case of medication errors, an incident report will be filed in the EHR, and the Program Director will be notified.

B. <u>Medications on Home Pass</u>

<u>Policy:</u>

This program allows and encourages patients, when appropriate, to leave the residence for extended periods of time which allows for them to have the complete oversight of their medications. When preparing for a patient to go on pass each of these steps must be followed.

<u>Procedure:</u>

Credo staff will pull the medication sheet(s), pharmacy medication education sheets (if available) and medications prior to the resident leaving. Staff will compare the medication information to the resident medication sheet for proper identification.

1. Staff will review the "Five Rights" of medication administration, side effects and any special precautions with the resident to assure understanding of medication.
2. The resident will perform a demonstration of the "Five (5) Rights" satisfactorily before being given the medication(s) and the educational sheets if needed. Medications shall remain in their original container and given to the resident.
3. The resident will follow the "Five (5) Rights" of medication

administration when taking their medication during supervised or unsupervised passes as follows,

a. The "Five Rights":
    i. The right person
    ii. The right medication
    iii. The right dosage
    iv. The right route
    v. The right time

Upon returning to the residence, the medications will be counted by the staff and residents. Any discrepancy will be documented and addressed clinically with the resident.

C. Medication Disposal

Policy:

A Medication Disposal System will be used in residential facilities to destroy medication no longer needed by a patient. The Medication Disposal System will be maintained within a locked cabinet and is not to be removed from the medication office, except for when the container is full according to New York State disposal guidelines and the container itself is being disposed of. A record of destroyed medicines will be recorded on a Medication Disposal Sheet and maintained by the Program Director in the medical office and preserved for five (5) years. No controlled medications shall be disposed of in the Medication Disposal System. For controlled medications, see the Controlled Medication Destruction policy and procedure. See a list of controlled medications here: https://www.deadiversion.usdoj.gov/schedules/).

Procedure:

Medications that must be disposed of because of a medication change or an unplanned discharge will be destroyed as follows:

1. Discontinued Medication: The staff member who becomes aware that a medication has been discontinued for a patient is the person responsible for carrying out the following steps by the end of their shift.
    a. Print the confirmation/direction from the provider that the medication is to be discontinued.
    b. Write the patient's client ID on the printed confirmation/direction.
    c. Remove the medication from the patient's medicine bin and remove the MAR from the medication binder. Document on the MAR the date the

medication was discontinued and the name of the prescriber who discontinued the medication (i.e., "Discontinued per (Provider name) on (date). Initial this documentation on the MAR.

d. Affix the printed confirmation/direction to the medication container by staple or tape.
e. Place the medication in the discontinued medicine cabinet.
f. Place the MAR in the patient's "to be scanned folder" for uploading into the patient's electronic health record.
g. Document in the shift note that the medication has been discontinued and who ordered the discontinuation.

2. Unplanned Discharge: When a client leaves the program against clinical advice without their medication(s), the staff member who becomes aware that the patient has left is responsible for carrying out the following steps by the end of their shift:
    a. Remove the non-controlled medication(s) from the patient's medicine bin and remove the MAR(s) from the patient's binder.
    b. Place the non-controlled medication(s) in a bag, and write on the bag or affix the following information to the bag by staple, tape, or writing directly on the bag:
        i. Client ID
        ii. Date of discharge
        iii. Date 61 days (about 2 months) beyond the discharge date
        iv. Date 70 days (about 2 and a half months) beyond the discharge date
        v. Place the bag of medication(s) in the discontinued medicine cabinet.
        vi. Place the MAR(s) in the patient's "to be scanned folder" for uploaded into the patient's electronic health record.
        vii. Document in a shift note that the medication has been stored in the "discontinued medication" cabinet and why.

ADD DISPOSAL FOR CONTROLLED MEDS

3. Disposal: Once a week the Program Manager, or in their absence the Director of Residential Services, along with another employee will destroy medicines in the Discontinued Medicine Cabinet. All medications in the cabinet will be reviewed and destroyed as follows:
    a. Discontinued Medicine: Compare each printed confirmation/direction of discontinuation with the medicine container to ensure the correct medicine is going to be destroyed (right client, right medication, right dose, clear direction to have discontinued use).
    b. Unplanned Discharge: Clients have 60 days (about 2 months) from the date of discharge to collect their belongings, including medications, from

the program; Therefore, these medications will be stored in the discontinued medicine cabinet for that time. The medications will be disposed of no sooner than the 61st day after discharge and no later than the 70th day from discharge.

c. Complete the Medication Disposal Sheet for each medication that is appropriate for disposal, to include:
    i. Client ID
    ii. Medication
    iii. Reason for discontinuation
    iv. The count of pills remaining or approximate volume remaining for liquids or creams
d. Initials of both staff members who reviewed the medications for destruction as an attestation that the action is appropriate and documentation is accurate.
e. With both staff still present, empty the medication from its container into the Medication Disposal System container per the directions on the container which will cause the medication to be unrecoverable.
f. Remove any patient identifying information from the empty medication containers prior to discarding. Any labels or boxes with patient identifying information must be placed in the shred bin.
g. When the Medication Disposal Sheet is full, it shall be scanned into the residence's Team site in the Medication Disposal Sheet folder in the Leadership channel.

VII. Emergency Policies and Procedures

A. Medical Emergencies

Policy:

All patient medical emergencies will be addressed with immediate attention. Staff are trained in CPR, First Aid, and NARCAN and have basic skills in assessing patient emergencies. Staff will use on-call medical professionals' support to establish a plan of care for any medical needs.

Procedure:

1. Any patient with serious health concerns or who has been seriously injured must be transported to the emergency room by staff or the rescue squad. All residences are staffed with personnel trained in First Aid and CPR, but it is policy to always err on the side of safety when evaluating a patient's need for additional care.

2. Emergency contacts are informed of the circumstances and are provided updates as needed regarding patient care.
3. Staff will arrange to transport the patient back to the program after being discharged from the hospital or if the staff is limited, a cab will be sent to transport the patient.
4. All injuries and trips to the emergency room require an incident report to be completed.
    a. Injuries resulting from staff/program inaction or negligence must be reported to the Justice Center.
    b. Injuries that result in requiring medical attention need to be reported to the Justice Center.

Upon return from the hospital, the discharge paperwork will be uploaded into the medical portion of the patient's EHR. The Program Director will help facilitate any follow-up care that is recommended.

B. Emergency Evacuation

Policy:

Fire drills are conducted at least twice per month. Patients are given an orientation to the procedure, expectations, exits, etc. upon admission. Staff are provided individual orientation to the fire system upon hire.

Procedure:

1. The fire alarm system is hooked directly into NCC Systems. When a fire or smoke alarm is set off for any reason, NCC Systems is contacted automatically and in turn calls the Sheriff's Department to dispatch the fire department.
2. Staff and patients are to evacuate the house immediately upon the fire alarm.
3. The staff on duty is to take the Sign In/Sign Out book upon exiting the building and go directly to the predetermined meeting and perform a headcount of patients and staff.
4. Documentation of the dates, times, and results of the drills are provided to the Program Manager and stored for review in the compliance audit binder.

Exit Route Signs
Maps are located on every floor of the residential programs depicting the locations and routes of exits, and the placement of the extinguishers.

Fire Extinguishers
The extinguishers are monitored monthly by the site manager or designee and checked yearly by the Watertown Fire Department for pressure and refreshed as needed. All staff receive annual training in the use of fire extinguishers.

Intercom System
There is an intercom system on every floor of the house for communication in case of an emergency. These units are to always be connected to power and used only for emergencies.

C. E-Finds Tracking System

Policy:

The purpose of the Evacuation of Facilities in Disaster Systems (e-FINDS) Tracking System is to create a common platform among New York State providers for sharing patient and resident location information in the case of an emergency or natural disaster during which clients must be relocated to a different facility for safety. This system helps track each patient's movements between facilities and is used by both the evacuating and receiving facilities with a scanner and multiple bracelets, each with a unique barcode. During an evacuation of a Credo facility, a bracelet will be given to each client and patients will be registered, to the extent feasible, prior to moving to another facility. Credo will also accept clients from other facilities during an emergency, when it is determined to be feasible.

Procedure:

The following procedure shall be followed to ensure patient safety and tracking during an evacuation.

1. Each Credo residential facility will have at least two staff trained in e-FINDS.
2. The Program Director of each program will serve as the e-FINDS administrator and is responsible for the storage and maintenance of the e-FINDS scanner and bracelets and ensuring that the scanner is effectively working through testing on a quarterly basis.
3. The Program Director is additionally responsible for ensuring that there are enough tracking bracelets onsite at any given time to provide one to every client in the program in case of an evacuation.
4. During an evacuation or when receiving clients, the appropriate section of the e-FINDS Quick Reference Guide will be followed by the Administrator. The e-FINDS Quick Reference Guide includes directions for the following:
    a. Getting Started
    b. Open e-FINDS
    c. Evacuating Facility: Registers Multiple Patient/Resident
    d. Evacuating Facility: Register Patient/Resident with Scanner
    e. Evacuating Facility: Updates Multiple Patient/Resident
    f. Evacuating Facility: Generates Barcoded PDF Log OR Up loadable Barcode Spreadsheet
    g. Evacuating Facility: Uploads Multi Patient/Resident File

h. Shelter-in-Place (SIP)
i. Quick Search
j. Receiving Facility: Updates Patient/Resident with Scanner
k. Receiving Facility: Updates Patient/Resident without Scanner

5. The information in the database will be reviewed by a second responsible member of staff and then utilized to track and coordinate appropriate care for clients.
6. Clients shall not remove their bracelet until they return to their home facility.

VIII. Record Keeping Policies and Procedures

A. Record Keeping

Policy:

This program will maintain individual case records for each patient served. These records will, at a minimum, include the information required in Part 820, as well as the source of referral, documentation of any case conferences or case reviews, reports of other evaluations and case consultations, medical orders, if applicable, and consent forms. Patient records maintained by the program are confidential and may only be disclosed in conformity with Federal regulations relating to the confidentiality of records as set forth in 42 CFR Part 2 and other applicable law. The assigned Primary Counselor and Program Director are responsible for the oversight and management of the patient's case record. **[820.5(g)]**

Procedure:

1. A patient's case record will be opened upon referral to the program.
2. The Primary Counselor and Program Director will be responsible for ensuring that all documentation is accurate, timely, and signed as appropriate.
3. All paper documentation will be scanned and uploaded into the patient's record.

The Program Director is responsible for closing out the patient's record after discharge.

B. Record Retention

Policy:

All patient records will be maintained and retained in the electronic health record.

Procedure:

A. Upon receipt of a referral, a chart will be opened in the electronic health record.

B. This chart will be used during the patient's treatment episode(s) and will retain all information related to the patient's treatment.
C. All patient records shall be stored and accessed in accordance with the agency-wide privacy and security policies. This includes retention for at least ten (10) years.

IX. Staffing and Staff Training Policies and Procedures

A. Staffing

Policy:

This reintegration residential service will have a full-time manager responsible for the day-to-day operation of the service and staff will be onsite twenty-four hours per day, seven days per week. There will be sufficient staff to ensure that supportive services are available and responsive to each resident's needs. Staff may be either specifically assigned to the residential service or may be part of the staff of the facility or program within which the residential service is located. However, if the staff is part of the general facility or program staff, they must have specific training and experience in the treatment of chemical use, abuse, and dependence specific to the services provided. **[820.12(e)1-3]**

As this residential program will have more than 10 beds, there will be a full-time program director who is a qualified health professional as defined in Part 800 of this Title. The program director shall have at least five years of full-time work experience in SUD, or related treatment field, prior to appointment as program director. **[820.6(a)]**

A clinical supervisor will be responsible for the day-to-day clinical operation of each residence and provide routine supervision for the staff. The clinical supervisor shall be a qualified health professional as defined in Part 800 of this Title with at least three years of clinical experience in chemical dependence treatment. **[820.6(c)2]**

Clinical staff members who are not qualified health professionals will have qualifications appropriate to their assigned responsibilities as set forth in the agency's personnel policies and will participate in professional staff supervision and continuing education and training. **[820.6(c)3]**

This residential service will have a qualified individual designated as the health coordinator who will ensure the provision of education, risk reduction, counseling, and referral services to all residents regarding HIV and AIDS (including pre-and post-exposure prophylaxis), tuberculosis, viral hepatitis, sexually transmitted diseases, and other communicable diseases. **[820.6(d)]**

There will be enough staff available to ensure that the service's space and equipment is clean and maintained to minimize the need for treatment staff to perform non-treatment functions and to optimize operational efficiency. **[820.6(b)4]**

This program may utilize volunteers, peers, students, or trainees, on a salaried or non-salaried basis if such volunteers, peers, students, or trainees are provided close professional staff supervision and necessary didactive education from both internal and external sources and comply with the requirements of Part 805 where appropriate. **[820.6(e)]** The agency wide manual further outlines how volunteers, peers, students, or trainees may be utilized in the program.

B. Staff Supervision and Training

Policy:

This program will provide clinical supervision and document a plan for staff training based on individual employee needs. Subject areas appropriate for training will be identified by the Office. A clinical supervisor will be responsible for the day-to-day clinical operation of each residence and provide routine supervision for the staff. The clinical supervisor shall be a qualified health professional as defined in Part 800 of this Title with at least three years of clinical experience in chemical dependence treatment. **[820.6(c)1]**

This residential services will have sufficient clinical staff that have been trained in, and are designated by the clinical supervisor to perform, the following tasks: (I) evaluation of resident needs, development and implementation of individualized treatment/recovery plans for each resident, including individual, group and family counseling; (ii) participation with staff and, as necessary, other services and agencies to assure the development, management and implementation of comprehensive services for each resident, reflecting both chemical dependence issues and other habilitation or rehabilitation needs; and (iii) preparation and maintenance of case records for each individual resident. **[820.6(b)3]**

All clinical staff will be provided with and document training, including but not limited to, crisis interventions, working with special populations, medication assisted treatment, trauma informed care, quality improvement, and agency policy and procedures. **[820.6(b)4]**

Procedure:

1. Regular supervision is provided to each staff member. Supervision provides direction and support to answer questions and solve problems.
2. Supervisors operate under the open-door policy so that if questions or concerns arise between scheduled supervision sessions, the employee is welcome to ask for time.
3. The supervisor is responsible for ensuring supervision happens.

4. Supervisors will schedule routine and ongoing training for staff through available formats (in-person, online, etc.). Supervisors will coordinate with staff to support attendance and completion of the training. For additional information related to training, refer to the agency wide manual.

X. Financial Policies and Procedures

A. Schedule of Fees for Services Rendered

Policy:

This program is considered a Congregate Care Level II program by the Department of Social Services. Patients will not be refused treatment due to an inability to pay for services. Credo will accommodate low-income patients' ability to pay at the time of the initial fee assessment, when the patient's financial situation changes and if at any time, they request a re-assessment.

Procedure:

a. The prospective patient is asked to present their financial information during their initial appointment.
    1. During the referral assessment, all residents are asked about their financial status to include any assets.
    2. Referrals that have SSI, SSD, or other income or assets will be provided with a payment agreement once information about their finances have been received and reviewed by the finance office.
b. Prospective patients will be advised during their initial contact with the agency that the Credo Community Center Residential programs are fees for service programs. The prospective patient will also be advised what the monthly fee for service at the residential program will be.
c. To maximize all available revenue and to continue opportunities for sound clinical practice, Credo will develop fair and equitable fee setting and legal collection policies and procedures that integrate clinical and fiscal goals as per Local Services Bulletin No. 2002-02: Patient Fees. Patients will be provided with a copy of Credo's fee policy at their admission.
d. All patients applying for services must comply with the reasonable requests of Credo to establish their ability to pay.
    1. Self-pay fees are to be all inclusive and related to the cost of overall services.
    2. Patients without insurance coverage during their assessment or treatment must apply for medical assistance through Medicaid or an Insurance Navigator. Credo will make all reasonable efforts to assist patients in obtaining health

insurance.

3. For patients not eligible for health insurance, a sliding scale fee will be calculated on their ability to pay. If a patient refuses to cooperate with efforts to determine their ability to pay, the patient will be charged and is responsible for paying Credo's self-pay fee schedule. If the patient refuses to pay at any time no matter the applied fee schedule, Credo reserves the right to deny assessment and treatment.

e. Outpatient patients with health insurance are responsible for paying the assigned co-pay, deductible, and co-insurance at time of service. Opioid Treatment Program patients are responsible for paying the assigned co—pay or co-insurance once weekly for dispensation services only. If a patient has health insurance but is unable to pay the co-pay, deductible, or co-insurance, the patient may request to be considered for the sliding fee scale.
f. The Sliding Fee Schedule Discount Program is calculated using the Federal Poverty Guidelines with a percentage applied to the New York State APG (Ambulatory patient groups) rates for services.

Patients have a right to receive a written summary or copies of their bills and payments upon request.

B. Personal Needs Allowance

Policy:

Monies received from DSS for individuals to be used for the patients' personal spending are deposited in an agency account designated for that purpose. An account of each patient's resources is kept by the Finance Department and personal needs checks are provided to the patients once a month. Fees accrued on behalf of the patient will be deducted from this account.

Procedure:

1. On admission, the resident reviews and signs off on the Personal Needs Agreement and an assigned staff member will meet with the patient to complete the paperwork required to apply for Temporary Assistance through their home county DSS.
2. The Program Manager is alerted to funds available for patients for personal needs and will coordinate with a staff member approved to write checks to them. Any fees that Credo has accrued on behalf of the patient will be deducted from their personal needs' checks (i.e., pharmacy copays, lock box payments from the OTP, etc.). The patient will be made aware of these fees if they occur.

3. Patients will be provided with a check around the 15th of each month with money available. Copies of all checks are maintained onsite and sent to the Finance Department.
4. If a patient has money left in their personal needs account and they successfully complete the program, that money is theirs to keep. The Finance Department will make it available to them within thirty (30) days.
5. If a patient has money left in the account but leaves the program unsuccessfully, DSS requires it to be refunded to them.

XI. Cooperative Agreements Policy and Procedure

A. Cooperative Agreements

Policy:

This program will have cooperative agreements with other chemical dependence service providers and other providers of services a patient may need; **[820.5(a)7]**. The Corporate Compliance Department will ensure that the appropriate type of agreement is in place so that only necessary information is disclosed.

Procedure:

A. The program will ensure cooperative agreements are made with local chemical dependence services providers, medical providers, psychiatric care providers and any other providers connected to patient care.
B. The cooperative agreements will be overseen by the Corporate Compliance Department and routinely reviewed to ensure agreements are up-to-date and relevant.

XII. Quality Improvement and Incident Management Policies and Procedures

A. Quality Improvement

Policy:

This program adheres to the agency wide policy and procedure related to Quality Improvement. Please refer to the agency wide manual.

B. Incident Reporting and Review

Policy:

This program will follow the agency wide policy and procedures for incident reporting and review. Please refer to the agency wide manual.