

ALBUQUERQUE MINIMUM STANDARDS FOR SUBSTANCE ABUSE TREATMENT AND PREVENTION SERVICES



**City of Albuquerque
Department of Family and Community Services**

Division of Behavioral Health

**Revised
January 2009**

**Prepared by:
City of Albuquerque
Department of Family and Community Services
Division of Behavioral Health**

**P.O. Box 1293
Albuquerque, NM 87103
Telephone (505) 767-5821
Fax: (505) 767-5830**

TABLE OF CONTENTS

	<u>Page</u>
EXECUTIVE SUMMARY	3
Title I - MISSION STATEMENT/INTRODUCTION	4
Title II – DEFINITIONS	4
Title III – OPERATING REQUIREMENTS AND PROCEDURES	11
Evidence of Appropriate Businesses Licenses	11
Program Compliance with Health and Safety Regulations	11
Program Compliance with ADA	11
Verification of Coverage	11
Insurance	11
Governing Body	11
Licensure Requirements	12
Policies and Procedures	12
Admission Criteria	12
Discharge from Treatment	12
Clinical Supervision	12
Fiscal Management	12
Conflict of Interest	12
Personnel, Contractor, Intern and Volunteer Policies	12
Background Check	13
Client Orientation	14
Consent to Treatment	14
Drug Screening	15
HIV/HB/CV and Infectious Disease Risk Screening	15
Confidentiality of Client Records	15
Content of Client Records	15
Hours of Operation	16
Diagnostic Services	16
Treatment Services	16
Quality Assurance	17
Data	17
Emergency Response Services	17
Cultural Competency	17
Services Outside Normal Working Hours	18
Reporting Requirement for Criminal Justice System Referrals	18
Title IV – STANDARDS FOR THE OPERATION OF A CENTRAL INTAKE UNIT	19
Single Point of Entry	19
Referral	19
Request for Services	19
Hours of Operation	19
Assessment for Admission to Treatment	19
Reassessment	20
Central Record Keeping	20
Compliance with Health and Safety Regulations	21
Compliance with ADA	21
Verification of Coverage	21
Insurance	21
Licensure Requirements	22
Policies and Procedures	22

Training Policy	22
Clinical Supervision	22
Fiscal Management	22
Conflict of Interest	22
Confidentiality of Client Records	22
Client Orientation	22
Consent to Assessment	23
Governing Body	23
Personnel, Contractor, Intern and Volunteer Policies	23
Quality Assurance	24
Data	24
Emergency Response Procedures	25
Cultural Competency	25
Criminal Justice System Referrals	25
Title V – STANDARDS FOR INDIVIDUAL TREATMENT MODALITIES	26
Minimum Treatment Standards for Detoxification Programs	26
Outpatient Detoxification	26
Minimum Treatment Standards for Residential Programs	26
Minimum Treatment Standards for Non-Residential Programs	28
A. Early Intervention (Level .5)	29
B. Outpatient Treatment Programs (Level I)	29
C. Intensive Outpatient Treatment Programs (Level II.I)	30
Title VI - PREVENTION STANDARDS – DRAFT	32
Appendix A – SAMPLE PROGRAM ORIENTATION AND SAMPLE FORMS	44
Sample Program Orientation	45
Sample Individual Treatment Plan (Adult)	47
Sample Individual Treatment Plan (Adolescent)	49
Sample Case Management Services Plan	53
Sample Discharge Plan	55
Sample Clinical Progress Notes	57
Appendix B – ASAM PATIENT PLACEMENT CRITERIA	58
Level 0.5 – Early Intervention	59
Level I – Outpatient Treatment	59
Level II – Intensive Outpatient Treatment/Partial Hospitalization	60
Appendix C – EXEMPTION FROM STANDARDS: PROCEDURES AND FORM	62
Appendix D – PROGRAM DISCHARGE AND OUTCOME REPORTING	64
Appendix E – MODEL PROGRAM CONTENT	71
Appendix F – ROLES AND RESPONSIBILITIES OF CLINICAL SUPERVISION IN SUBSTANCE ABUSE TREATMENT	73
Appendix G – TREATMENT SUBSIDY VOUCHER SYSTEM DESCRIPTION	75
Appendix H – COMPUTERIZED VOUCHER SYSTEM TECHNICAL INFORMATION	79

Executive Summary

The City of Albuquerque Division of Behavioral Health administers and operates substance abuse and mental health programs that meet the needs of the citizens of Albuquerque in accordance with the following City of Albuquerque Visions and Goals.

Goal 1: Human and Family Development: People of all ages have the opportunity to participate in the community and economy and are well sheltered, safe, healthy, and educated.

Goal 2: Public Safety: Citizens are safe, feel safe and secure, and have trust and shared responsibility for maintaining a safe environment

In efforts to best accomplish these goals within the realm of substance abuse and mental health services, the City of Albuquerque, Division of Behavioral Health has developed Minimum Standards that define minimally acceptable levels of treatment and prevention services that agencies contracted to provide these services must meet. These standards known as the Albuquerque Minimum Standards for Substance Abuse Treatment and Prevention Services (Minimum Standards), is contained within this document. The applicable titles are as follows:

Title I Introduction

This section outlines the history and purpose of the Division of Behavioral Health.

Title II Definitions

This section provides applicable definitions

Title III Operating Requirements and Procedures for Substance Abuse Treatment – Common Standards

This section provides the standards necessary for the operation of a substance abuse treatment agency

Title IV Standards for the Operation of a Central Intake Unit

This section provides the standards necessary for the operation of a Central Intake Unit

Title V Standards for Individual Treatment Modalities

This section provides specific standards for the different treatment modalities funded by the City of Albuquerque

Title VI Substance Abuse Prevention Program Operating Standards – DRAFT

This section is in draft form for the Prevention Programs funded by the Division of Behavioral Health

Questions?

If there are questions regarding the applicability or interpretation of a rule, please contact your program specialist in writing.

Title I.

Mission Statement

"The Mission of the City of Albuquerque Division of Behavioral Health is to be a progressive leader in the development and implementation of a coordinated, effective continuum of substance abuse and mental health services for the people of Albuquerque."

Introduction

The Division of Behavioral Health is responsible for the design, development, management, and evaluation of substance abuse services for the City of Albuquerque. The Division oversees social service contracts for substance abuse treatment services for special populations and an outpatient voucher-based treatment system. Albuquerque's comprehensive voucher-based services system includes a thorough assessment and disposition process, provided through the Albuquerque Metropolitan Central Intake (AMCI), and a network of fee for service contracted provider agencies that offer a range of treatment modalities for both adults and adolescents.

The City, AMCI, and treatment provider agencies are collaborative partners in developing the city's system of care for substance abuse services. The City consults with AMCI and the Treatment Provider Advisory Committee on treatment system improvement and holds treatment system provider meetings on a regular basis.

The City works collaboratively with AMCI and all treatment provider agencies to ensure that they are following the Albuquerque Minimum Standards for Substance Abuse Prevention and Treatment and provides, at a minimum, annual on-site monitoring and technical assistance to all agencies to ensure they meet these standards

TITLE II. DEFINITIONS

1. **ADMISSION** means an agency's acceptance of a client for the purpose of providing services on a scheduled basis based on the agency's written criteria and standards for admission.
2. **ADOLESCENT** refers to individuals who are between the ages of 13 and 18 years old.
3. **ADVISORY COMMITTEE** is a group of service provider representatives, acting in an advisory capacity to the Division of Behavioral Health.
4. **AGENCY** means a provider of substance abuse prevention and/or treatment services that is in compliance with these Minimum Standards, and which provides services within the metropolitan area of Albuquerque.
 - (1) **Non-Profit Agency** is a 501 (c) (3) agency, as defined by the U.S Internal Revenue Service Code.
 - (2) **State or Local Government Agency** is an agency which is a unit of state or local government.
 - (3) **For-Profit Agency** is an organization that is not a non-profit corporation or unit of state or local government as defined above.
5. **AGENCY COMPONENTS** are individual parts of a program, following the levels of care established by the American Society of Addiction Medicine (ASAM), which must adhere to applicable standards under the following categories:
 - (1) **Detoxification Programs** are those that utilize medical (inpatient or outpatient) psychosocial treatment procedures and a supportive counseling regimen to assist clients in their efforts to withdraw from the physiological effects of the abuse of alcohol and mood altering drugs.

- (2) **Residential/Inpatient Programs** are those which provide a structured, live-in therapeutic environment within a hospital or non-hospital setting on a 24-hour-a-day-basis, and may include adult or adolescent residential programs, residential programs serving Women with Dependent Children or Pregnant Women and their Infants; services emphasize treatment, rehabilitation, and recovery support services and, depending upon client needs, may include formal school and adult education programs.
 - (3) **Non-residential Programs** are those which provide an outpatient therapeutic environment with a structured schedule of daily and hourly activities.
 - (4) **Outpatient Treatment** provides individual, group or family counseling for an average period of 90 to 120 days; clients are seen by appointment during scheduled operating hours with an emphasis on assessment, treatment, case management and recovery support services; services are provided in regularly scheduled sessions of usually fewer than 9 contact hours per week, but not less than once a week.
 - (5) **Intensive Outpatient** provides treatment with an intensity of nine or more hours of structured programming per week and a frequency of not less than three times per week for an average of 120 days.
 - (6) **Partial Hospitalization/Day Treatment** provides twenty or more hours of structured programming a minimum of four days per week and a minimum of five consecutive hours of service each day with emphasis on assessment, rehabilitation, treatment, and ancillary services and, depending upon client needs, may include formal school and adult education programs.
6. **ALBUQUERQUE METROPOLITAN CENTRAL INTAKE (AMCI)** is the centralized facility responsible for the assessment, diagnosis, and disposition of an applicant for purposes of referral to an appropriate substance abuse treatment provider. AMCI is also tasked with issuing the City of Albuquerque's Substance Abuse Treatment Vouchers.
7. **ASAM PPC-2R** is the American Society of Addiction Medicine Patient Placement Criteria second edition Revised.
8. **APPLICANT** is an individual seeking admission to substance abuse treatment and who is assessed for admission through Albuquerque Metropolitan Central Intake (AMCI).
9. **ASSESSMENT** is the evaluation of a client's bio-psychosocial condition as it relates to the individual's need for substance abuse treatment. The assessment includes:
 - (1) **Initial Assessment** is the initial evaluation of an applicant who is seeking admission to substance abuse treatment. For entry into the City-funded Treatment Voucher program, the initial assessment is conducted by AMCI. For entry into other City-funded treatment agencies, the initial assessment will be conducted by the agency. Regardless of which agency is administering the initial assessment, the assessment should utilize a bio-psychosocial assessment which addresses the various factors which may have contributed to the client's need for services and includes historical information, clinical impressions, and disposition on placement. The initial assessment should consist of, at a minimum, both:
 - i. A case history consists of background information on the client and includes, at a minimum, family history, educational history, record of employment, legal history, and history of chemical dependency.
 - ii. Clinical impressions consist of a statement of findings from the case history, and include a disposition on placement.

(2) **Ongoing Assessment** is the routine and periodic evaluation, conducted by the treatment program staff, of a client's continuing need for services and progress in meeting treatment plan goals and objectives.

10. BACKGROUND CHECK: A formal, national criminal background check that includes reference checks, fingerprinting, national sex offender registry check, and interviews on all individuals who work, or volunteer, directly or in proximity of children, in accordance with the New Mexico State Regulation, New Mexico Administrative Code, Title 8, Chapter 8, Part 3 – Social Services, Children, Youth and Families General Provisions, Governing Background Checks and Employment History Verification.

11. CASE MANAGEMENT is a professional helping process whereby adult and/or adolescent clients participating in a program receive non-counseling services appropriate to their needs either at the program or, if necessary, through facilitated referral. Typical case management services include such activities as helping clients to secure access to educational services, employment services, job training programs, health and welfare services and others based on the secondary needs identified in the client's initial assessment at AMCI and supplemented with other needs identified during their time in treatment. Case management services can be provided by a primary counselor, a nurse, or a position employed specifically to be a case manager.

(1) Time spent for billing for services is NOT a case management function, nor are providing reports to the court for DWI or criminal justice clients, rescheduling appointments, or other administrative activities, or dispensing medications, or writing progress notes or other documentation.

(2) (See Current Fiscal Year's Fee Schedule and *Appendix A GUIDE –SAMPLE CASE MANAGEMENT SERVICES PLAN*)

12. CASE MANAGER is a position responsible for the organization, management, and/or provision of other social services needed by substance abuse clients.

13. CHEMICAL DEPENDENCY is the use of alcohol or any other psychoactive or mood altering substance which results in alcohol abuse or alcoholism or other drug abuse or other drug addiction, which impairs the individual's health or interferes with the person's social or occupational functioning.

14. CITY is the City of Albuquerque.

15. CLIENT is any youth, adolescent, adult, or family who has applied for services, has completed the intake process, and has been accepted for treatment or prevention services.

16. CLIENT CHOICE is specific to substance abuse treatment services and is a process wherein the client chooses a treatment provider based on the AMCI assessment counselors' presentation of three treatment options, if available, that meet the appropriate level of treatment recommended for the client. No services should be denied based on client's choice of approved provider.

17. CLIENT DATA MANAGEMENT SYSTEM is the electronic system at AMCI that is comprised of the appointments application, web client system, client system, ASI, MADAD, publishing and management reports.

18. CLIENT IDENTIFYING INFORMATION is information which is created or received by a health plan, health care clearinghouse, or health care provider, transmitted in any format (oral, written, or electronic) that could potentially identify an individual as a participant in a substance abuse treatment or other behavioral health program. Protection of information is given to anyone who has applied for or been given substance abuse treatment or other behavioral health services, and anyone checking on eligibility to get into a behavioral health or substance abuse treatment program following arrest on a criminal charge. (See HIPAA Regulations and 42CFR for additional definitions)

- 19. CLINICAL SUPERVISION** is a process required for all counselors who are not independently licensed. Supervision is defined in the New Mexico Counseling and Therapy Practice Board Rules, Regulations, and Practice Act Title 16, Chapter 27, Part 19. Supervision includes, but is not limited to: oversight of assessment and diagnosis; treatment plan construction; oversight of client progress notes and other written clinical records; provision of consultation to assist treatment practitioners in best working with their clients; and may include other basic supervisory responsibilities related to job performance. (See *Appendix F – Roles and Responsibilities of Clinical Supervision in Substance Abuse Treatment*)
- 20. CLINICAL SUPERVISOR** is an individual, who by experience, training, and/or level of licensure is able to provide supervision to clinicians regarding the appropriate care and treatment of substance abuse clients. The requirements and responsibilities of a clinical supervisor are defined in the New Mexico Counseling and Therapy Practice Board Rules, Regulations, and Practice Act Title 16, Chapter 27, Part 19. Clinical Supervision requirements for social workers are found in Title 16, Chapter 63, Part 1.7A Appropriate Supervision. (See *Appendix F – Roles and Responsibilities of Clinical Supervision in Substance Abuse Treatment*)
- 21. CONFLICT OF INTEREST** is a situation that arises within nonprofit and government entities when an individual who occupies a position of authority uses the trust and responsibility invested in that position to further the individual's personal gain.
- 22. CONTINUITY OF CARE** is a process ensuring that, at any given point in time, clients being served in programs are receiving the most appropriate form of care, as their needs indicate, and that multiple services are provided in a coordinated fashion.
- 23. CONTRACT COUNSELOR** is an individual who enters into a binding agreement to perform specified services in exchange for monetary gain, under supervision of the agency with whom they are contracting.
- 24. CO-OCCURRING DISORDER** is the commonly preferred term that refers to patients who have both a mental health disorder and substance use disorder. It typically may be used interchangeably with "co-occurring disorders" or "co morbidity."
- 25. COUNSELING** is the provision of guidance and/or recommendations relative to a client's treatment goals and objectives. Counseling may be undertaken with individuals, groups, and families.
- 26. COUNSELOR** is an individual who, by virtue of training, experience in the field of chemical dependency or related area, or level of licensure is responsible for providing clinical care and guidance to clients. At minimum, the City requires an LSAT, or equivalent, to provide substance abuse treatment services and be reimbursed by the City, in accordance with the State of New Mexico Substance Abuse Counselor Act, chapter 61, Laws of 1996, HB 790: Article 9A of the New Mexico Counseling and Therapy Practice Board: section 61-9A-5, Scope of Practice.
- 27. CREDENTIALS** are the indication of a treatment provider's academically acquired and recognized licensure provided after the individual's signature on official documents. All agencies shall provide verification of Substance Abuse Licensure for staff in compliance with the State of New Mexico Substance Abuse Counselor Act, chapter 61, Laws of 1996, HB 790: Article 9A of the New Mexico Counseling and Therapy Practice Board: section 61-9A-5, Scope of Practice.

(1) Examples of credentials include:

- i. Licensed Alcohol Abuse Counselor (LAAC)
- ii. Licensed Drug Abuse Counselor (LDAC)
- iii. Licensed Alcohol and Drug Abuse Counselor (LADAC)
- iv. Licensed Masters Level Social Worker (LMSW)
- v. Licensed Bachelors Level Social Worker (LBSW)
- vi. Licensed Independent Social Worker (LISW)
- vii. Licensed Professional Mental Health Counselor (LPC)

- viii. Licensed Professional Clinical Mental Health Counselor (LPCC)
- ix. Licensed Mental Health Counselor (LMHC)
- x. Licensed Professional Art Therapist (LPAT)
- xi. Licensed Substance Abuse Trainee, Intern, or Associate (LSAT) (LSAI) (LSAA)

- 28. CULTURAL COMPETENCY** means acknowledging the client's cultural strengths, values, and experiences while encouraging behavioral and attitudinal change. Treatment services that are culturally responsive are characterized by staff knowledge of the cultural language of the client, staff sensitivity to the cultural nuances of the patient population, staff backgrounds representative of the client population, treatment modalities that reflect the cultural values and treatment needs of the patient population, and representation of the patient population in decision making and policy implementation. (Cultural issues in substance abuse treatment, CSAT 1999)
- 29. DEPARTMENT** is the City of Albuquerque's Department of Family and Community Services.
- 30. DIAGNOSTIC SERVICES** are methods or tools used to determine the need for special services and may include psychosocial tests, special educational tests, and psychological and psychiatric evaluation.
- 31. DISCHARGE** is the ending of service delivery to a client by a treatment provider.
- 32. DISCHARGE OUTCOME REPORTING** is the reporting of discharge and outcome data, as required by the Division, through the AMCI electronic service entry system. This report is only required at discharge. (See *Appendix D – Program Discharge and Outcome Reporting*)
- 33. DISCHARGE PLANNING** is the process undertaken with the client prior to termination of treatment (usually 3 to 4 weeks depending on the length of treatment) to put closure on the treatment process and plan for aftercare support needed to maintain stability and sobriety and to continue meeting goals successfully.
- 34. DISCHARGE SUMMARY** is a written narrative of the client's treatment experience and includes presenting problem, agency assessment, services provided, client's attitude toward treatment, progress made and goals met, obstacles to achievement of goals and recommendations for further services.
- 35. DISPOSITION** is the written determination of appropriateness for treatment and subsequent placement referral for those clients being assessed for substance abuse treatment in accordance with the ASAM Levels of Care.
- 36. DIVISION** is the Division of Behavioral Health, Department of Family and Community Services, City of Albuquerque.
- 37. DOCUMENTATION** refers to the written record, contained in the client file, of all client contacts, progress notes, disciplinary actions, discharge summaries and other written evidence of treatment services provided.
- 38. DRUG SCREENING** is a physical test to determine the presence or absence of alcohol or other drugs in a person's system and used as part of the therapeutic process. Examples include urine screening, saliva screening, breathalyzer, etc.
- 39. EMPLOYEE** is an individual, not under contract, who is paid by an agency to perform specified services within the agency.
- 40. EXECUTIVE DIRECTOR** (or Chief Executive Officer) is an individual with full responsibility for the overall operation of an agency.
- 41. EXEMPTION** is a process whereby provider agencies may make written application for a waiver to specific Minimum Standards. Agencies requesting an exemption waiver must demonstrate that client needs and services will not be compromised. Exemptions shall be granted for a period of up to one year on a case-by-case basis. (See *Appendix C – Procedures for Application for Exemption to the Minimum Standards*).

- 42. FISCAL MANAGEMENT** are those systems and procedures that ensure the integrity of the financial functions of the agency.
- 43. GOVERNING BODY** is a group of individuals authorized to make policy decisions for the management of non-profit agencies.
- 44. INDIVIDUALIZED TREATMENT PLAN** is a written, comprehensive statement of treatment goals to be achieved by a client, the means for attaining those goals and, a delineation of the type and frequency of services to be provided and to be completed within 30 days of intake and updated as required by service level (See *Appendix A – ADULT TREATMENT PLAN FORM; ADOLESCENT TREATMENT PLAN FORM*)
- 45. LEVELS OF CARE** are the levels of care established by the American Society of Addiction Medicine (ASAM). Levels of care funded by the City include the following, and a detailed description of each of the levels can be found in Appendix B. See asam.gov for additional information.
- (1) **Level 0.5 – Early Intervention** is an organized service that may be delivered in a wide variety of settings. Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and to help the individual recognize the harmful consequences of inappropriate substance use.
 - (2) **Level I – Outpatient Treatment** encompasses organized outpatient treatment services tailored to each client’s level of clinical severity and are designed to help the client achieve changes in his or her alcohol or other drug using behaviors.
 - (3) **Level II – Intensive Outpatient Treatment/Partial Hospitalization** encompasses organized intensive outpatient treatment services including both intensive outpatient treatment (Level II.I) and partial hospitalization/day treatment (Level II.5).
- 46. LICENSED PHYSICIAN**, referenced herein as L.P. is an individual licensed to practice medicine, osteopathy, or oriental medicine, in the State of New Mexico.
- 47. MINIMUM STANDARDS** refers to the Albuquerque Minimum Standards for Substance Abuse Treatment and Prevention Services, which defines minimally acceptable levels of substance abuse treatment services established by the City for program performance within an agency.
- 48. PHYSICIAN ASSISTANT (P.A.)** is an individual licensed as a physician assistant according to the New Mexico State laws.
- 49. POLICIES AND PROCEDURES** are formal, written guidelines for governing and directing the operations of an organization.
- 50. PROGRESS NOTES** are detailed, written records of client and/or family interactions with a counselor or case manager. The written records must include the date, length of service (beginning time and ending time) of services, and signature of individual providing services, including applicable licensure. Progress notes must contain client specific information. Progress notes shall document, for all services provided to the client, information regarding attendance at and participation in therapeutic sessions, assessment of the client's progress or lack thereof toward meeting those objectives established in the treatment plan and all case management services received by the client. The progress notes should also document the date a client has disengaged from treatment, and the efforts made by the agency to re-engage the client. (*See Appendix A – SAMPLE CLINICAL PROGRESS NOTE*)
- 51. QUALITY ASSURANCE** is a systematic process that is designed to evaluate the quality of a program's services and to promote and maintain an efficient and effective service delivery system.

- 52. RECORD** refers to the written evidence concerning program or client experience and/or participation in any substance abuse program or related services, including required forms appropriately signed and dated.
- 53. SERVICE MIX** refers to those therapeutic activities consistent with the ASAM criteria, required and funded by the City of Albuquerque.
- 54. SUBSTANCE ABUSE TREATMENT** is the provision of both clinical and non-clinical services including, but not limited to, individual, group and family counseling for clients with addiction disorders.
- 55. SUSPENSION** of a contract is an action by the City that temporarily suspends city payments and/or treatment referrals under the contract, pending corrective action by the contractor or pending a decision to terminate the contract by the City.
- 56. TERMINATION** of a contract means the cancellation of City sponsorship in whole or in part, prior to the date of completion, in accordance with the terms of the agency's contract with the City of Albuquerque.
- 57. YOUTH** refers to individuals under the age of 13 years old.

TITLE III. OPERATING REQUIREMENTS AND PROCEDURES FOR SUBSTANCE ABUSE TREATMENT – COMMON STANDARDS

All treatment programs, regardless of modality or source of payment, shall abide by the following common operating requirements and procedures; City of Albuquerque funded service providers shall abide by all applicable provisions of the most current *Administrative Requirements for Contracts Awarded Under the City of Albuquerque, Department of Family and Community Services, Social Services Program*.

- 1. EVIDENCE OF APPROPRIATE BUSINESSES LICENSES.** Agencies must document all applicable business licenses including, but not limited to: City of Albuquerque, Business Registration receipt, and State of New Mexico Taxation and Revenue Department Certificate.
- 2. PROGRAM COMPLIANCE WITH HEALTH AND SAFETY REGULATIONS.** All physical facilities used by a program are required by law to be in compliance with fire and safety standards established and enforced by the State Fire Marshall, and health, safety and occupational codes enforced at the local level. The Agency must agree to be responsible for knowing and complying with all applicable fire and safety standards.
- 3. PROGRAM COMPLIANCE WITH ADA.** In providing services, programs must agree to meet all the requirements of the Americans with Disabilities Act of 1990 (ADA), and all applicable rules and regulations which are imposed directly on the Agency or which would be imposed on the City as a public entity. The Agency must agree to be responsible for knowing and complying with all applicable requirements of the ADA.
- 4. VERIFICATION OF COVERAGE.** Evidence of verification of immunities and limitations of the New Mexico Tort Claims Act Section 41-4-1, et. seq, 1978, must be provided by the program if applicable.
- 5. INSURANCE**
 - a. GENERAL LIABILITY AND PROFESSIONAL LIABILITY.** All programs not covered by Item (4) above shall maintain documentation that appropriate levels of general and professional liability coverage are in effect at the following levels:
 1. \$1,000,000 Per Occurrence
 2. \$1,000,000 Policy Aggregate
 - b. PROFESSIONAL LIABILITY INSURANCE.** Professional liability insurance in an amount not less than \$1,000,000 combined single limit of liability per occurrence with a general aggregate of \$1,000,000.
 - c. AUTOMOBILE LIABILITY INSURANCE:** An automobile liability policy with liability limits in amounts not less than \$1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. Said policy of insurance must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work, unless the City has on file written verification that the agency does not use vehicles in other than a commuting capacity.
 - d. WORKER'S COMPENSATION INSURANCE:** Workers' Compensation Insurance for its employees in accordance with the provisions of the Workers' Compensation Act of the State of New Mexico.
- 6. GOVERNING BODY:** All public and private non-profit agencies shall have a legal governing body responsible for establishing its policies, defining its services, guiding its development and assuring its accountability in the community as well as providing general oversight of programs and services provided. The agency must document that its governing body is constituted in compliance with approved bylaws and that it actively fulfills its responsibility for policy direction, including regularly scheduled meetings for which minutes are kept. The agency must verify board compliance with the City of Albuquerque "Open Meetings" ordinance.

- 7. LICENSURE REQUIREMENTS.** Each agency must ensure its staff and contractors are licensed according to applicable State of New Mexico requirements to provide services. At minimum, the City requires an LSAT, or equivalent, to provide substance abuse treatment services and be reimbursed by the City, in accordance with the State of New Mexico Substance Abuse Counselor Act, chapter 61, Laws of 1996, HB 790: Article 9A of the New Mexico Counseling and Therapy Practice Board: section 61-9A-5, Scope of Practice.
- 8. POLICIES AND PROCEDURES.** Agencies must adhere to their written policies and procedures that ensure compliance with these Minimum Standards. These policies must include those listed in the Minimum Standards.
- 9. ADMISSION CRITERIA.** Programs shall develop and utilize written criteria and standards for admission to each program component offered.
- 10. DISCHARGE FROM TREATMENT.** Programs shall develop and utilize written criteria and standards for discharge for each program component offered. Expiration of the treatment voucher prior to completion of treatment is not a clinical justification for discharge, and every effort should be made to ensure continuing treatment for the client. Discharge Standards, at minimum, must include the following:
 - (1) To ensure that when it is evident to treatment staff that a client has received optimum benefit from treatment, the client shall be discharged or referred, as appropriate.
 - (2) To ensure that in the case of a court-ordered client, the court of referral or responsible party must be notified prior to discharging the client or according to the respective court mandate, and in consideration of 42 CFR, Part II.
 - (3) To ensure that clients who have not received a face-to-face contact with the treatment program for 30 days must be discharged from the AMCI system, unless otherwise clinically justified.
- 11. CLINICAL SUPERVISION.** Provider agencies will ensure clinical supervision standards are met (See *Appendix F - Roles and Responsibilities of Clinical Supervision in Substance Abuse Treatment*).
- 12. FISCAL MANAGEMENT.** The agency must have and use a written set of systems and procedures that ensure the integrity of the financial functions of the agency, as well as ensuring the accuracy of invoicing and billing.
- 13. CONFLICT OF INTEREST.** Non-profit agencies are required to have a policy that at minimum:
 - a. Applies to the procurement and disposition of all real property, equipment, supplies and services by the contractor and to the contractor's provision of assistance to individuals, businesses, and other private entities.
 - b. Provides that no person who exercises any functions or responsibilities with respect to agency activities or who are in a position to participate in a decision making process may obtain a personal or financial interest or benefit from an agency activity, either for themselves or those with whom they have family or business ties, during their tenure or for one year thereafter.
 - c. Exception to the above policies may be allowed with the prior written approval of the Department on a case-by-case basis only after the following has been provided: (i) a disclosure of the nature of the conflict, accompanied by an assurance that there has been a public disclosure of the conflict and a description of how the public disclosure was made and (ii) an opinion by the City's attorney that the interest for which the exception is sought would not violate state or local laws.
- 14. PERSONNEL, CONTRACTOR, INTERN AND VOLUNTEER POLICIES.** Personnel policies shall be made available in writing to all employees, including contractors, interns, and volunteers. Policies shall include, but are not limited to, establishing clear lines of communication within the agency, rules governing the ethical conduct of staff, volunteers, contract workers, and/or student interns, confidentiality of information regarding clients and

client records, attendance, leave, prohibition of the use of illicit drugs and misuse of alcohol and drugs, employee grievance and non-discrimination, address performance evaluations and the criteria for such evaluations, background check requirements, and the maintenance of personnel files. The agency shall demonstrate compliance with its personnel policies. Agency policies must ensure personnel files include the minimum:

a. Personnel File – The Personnel File shall contain, at a minimum, the following:

- (1) Job Description – a description of the responsibilities of the position for which the employee is hired, including minimum qualifications and salary range.
- (2) Employee’s resume or application
- (3) Personnel Actions (hiring actions, disciplinary or probationary actions, salary increases, sick and vacation time information, etc.)
- (4) Signed Drug Free Workplace statement
- (5) Signed statement that employee has reviewed personnel policies and information.
- (6) Evidence of employee participation in City required training events.
- (7) Evidence of CPR/FIRST AID certification, as needed
- (8) Professional licensure
- (9) W-4
- (10) I-9
- (11) Background checks, as described in these Minimum Standards
- (12) Performance evaluations

b. Contractor File - The Contractor File shall contain, at a minimum, the following:

- (1) Signed contract detailing the Scope of Work, dates of service, signed and dated.
- (2) Resume
- (3) Evidence of contractor participation in City required training events.
- (4) Signed Drug Free Workplace Statement
- (5) W-9
- (6) Evidence of CPR/FIRST AID certification, as needed
- (7) Professional licensure
- (8) City of Albuquerque, Business Registration receipt, and State of New Mexico Taxation and Revenue Department Certificate
- (9) Professional liability insurance, at the appropriate levels
- (10) Background checks, as described in these Minimum Standards

c. Intern Files

- (1) Signed contract between supervising school and agency, detailing the Scope of Work, dates of service, signed and dated.
- (2) Resume.
- (3) Evidence of contractor participation in City required training events.
- (4) Signed Drug Free Workplace Statement
- (5) Evidence of CPR/FIRST AID certification, as needed
- (6) Professional licensure
- (7) Professional liability insurance, at the appropriate levels
- (8) Background checks, as described in these Minimum Standards

15. BACKGROUND CHECK: Agency standards must include a written procedure for criminal background checks to ensure a safe environment and proper protection of children under 18 years of age who are receive services from the agency. The program is responsible for conducting formal, national criminal background checks, reference checks, fingerprinting, and interviews on all individuals who work directly or in proximity of children. Any individual registered as a sex offender in any United States jurisdiction cannot be employed or serve as a volunteer.

All interns, volunteers, and student employees must also undergo the background checks. The following must be adhered to:

- a. Background checks must be conducted prior to the time of hire. If an individual has had a nationwide background check conducted in the past 180 days, evidence of such shall be sufficient for the background check.
- b. After a background check has been conducted, agency policies must include a statement specifying that any arrest, conviction or substantiated referral must be reported to the agency supervisor.
- c. The requirement for the criminal background check is in accordance with the New Mexico State Regulation, New Mexico Administrative Code, Title 8, Chapter 8, Part 3 – Social Services, Children, Youth and Families General Provisions, Governing Background Checks and Employment History Verification.

16. CLIENT ORIENTATION The program shall conduct an orientation session with the client and significant others, if applicable. The following shall be covered in orientation:

1. **Discharge Standards.** A written explanation listing all reasons for discharge, and include discharge planning for the client.
2. **Program Rules.** A written body of rules governing the rights and conduct of clients shall be established and maintained by all programs. These include rules regarding admission, discharge, expulsion, and program expectations for clients admitted to treatment as well as Disciplinary Actions for failure to conform to Program Rules including but not limited to such situations as no shows for appointments, chronically late for appointments, drinking or being intoxicated on the premises, and other behaviors against Program Rules. These rules shall be signed by each client prior to or at the time of admission to treatment.
3. **Procedures and Activities of the Treatment Program.** A written description of the operations of the program, and the types of activities offered to the client. For example, number of groups and individual sessions, types of activities.
4. **In-House Client Grievance Policies and Procedures.** This includes written procedures for reporting grievances the client may have with the treatment provider or the agency. No program shall discourage or prevent a client from contacting the State. This notification must include the telephone number to report alleged counselor abuse and complaints against the agency to the applicable State Licensing Board.
5. **Agency Responsibility To Report Abuse/Neglect.** All programs shall provide the client with written notification of their legal obligation to adhere to the New Mexico statutory requirements concerning the mandatory reporting of suspected child and elder abuse and neglect.
6. **Client Rights.** The rights of clients who are admitted to programs shall be assured and defined in each program's policies and procedures. This shall include operating standards that protect the dignity, health, and safety of clients.
7. **Confidentiality of Client Information.** A written statement that the agency provides to and explains to clients in compliance with 42CFR and HIPAA. (See *Appendix A – Sample Program Orientation*)

17. CONSENT TO TREATMENT. Any program providing treatment shall have on file:

- a. A consent for treatment for voluntary clients, signed and dated by each individual; or
- b. An order to treatment for involuntary clients.
- c. Parents/Legal Guardians have the authority to sign a consent form for treatment for their unmarried, minor unemancipated, children.

18. DRUG SCREENING. Drug screening for the detection of chemical substances (alcohol and other drugs) is performed for clinical purposes only. The manner in which drug screens are collected and the manner in which results are utilized shall be described in the program's standards and on a client consent form. Consent shall be obtained from clients for drug screening. Drug screens shall be collected in a manner that minimizes falsification. Although the City does not require it, if visual observation of urine collection takes place, the observer shall be of the same sex as the client. As applicable to the method of collection, safety measures to protect the staff shall be described in the program's policies and procedures.

19. HIV, HB/CV, AND INFECTIOUS DISEASE RISK ASSESSMENT. Each program shall maintain standards that describe the methods for assessing clients involved in high-risk behavior for communicable disease, including the human immunodeficiency virus (HIV) and hepatitis B and C virus (HB/CV). The program shall encourage persons found to be at risk or exposure to infectious diseases to submit to voluntary testing either at the facility or upon referral.

20. CONFIDENTIALITY OF CLIENT RECORDS. Every program shall maintain a record on each client, and client identifying information in a confidential manner, and secure consent for the release of client information in accordance with State and Federal Regulations (Title 42, Code of Federal Regulations, Part 2), and these Standards.

(a) Record System. All treatment programs shall include a description of their client record system in their policies and procedures. Client records shall be kept secure from unauthorized access. The policies and procedures shall include, at a minimum, requirements regarding content, organization and use of client records. All signatures shall be original as opposed to facsimile. Counselors shall have ready access to client records.

(b) Record Retention and Disposition. Medical and non-medical clinical records shall be retained for a minimum period of five (5) years following the closing of the file. Programs shall establish standards that address the appropriate disposition of closed records.

21. CONTENT OF CLIENT RECORDS. Records maintained by treatment programs shall contain the following information as required by these standards;

- a. The client name and address.
- b. Name, address and telephone number of guardian or representative, where applicable.
- c. The source of referral and relevant referral information.
- d. Signed and dated consent for treatment, or Order to Treatment for involuntary clients.
- e. Documentation of orientation to program and program rules; signed and dated by the client.
- f. Nursing assessment report for detoxification programs; signed, credentialed, and dated by the L.P., if applicable.
- g. Medical history and physical examination report; signed, credentialed, and dated by the L.P, if applicable.

- h. Psychosocial assessment (ASI or MADAD) conducted at AMCI and provided to treatment programs upon client admission to treatment, or a copy thereof.
- i. The individualized treatment plan, signed by the client and signed, credentialed, and dated by the counselor; and reviewed and signed, credentialed, and dated by the qualified clinical supervisor.
- j. Treatment plan reassessments and reviews, signed by the client and the counselor, signed, credentialed, and dated by the qualified clinical supervisor as required by these Minimum Standards
- k. Progress notes; signed, credentialed and dated by the counselor.
- l. Consent to drug screening, with information as to how the results are utilized; signed and dated by the client.
- m. A record of all recovery support and case management services.
- n. A record of medical prescriptions and administration of medication, if applicable.
- o. Consents for the release of client information, consistent with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and Sections 26-2-13(B) and 26-2-14(C), NMSA 1978 of the New Mexico Drug Abuse Act, and the Health Information Portability and Accountability Act of 1996, (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Sections 160 and 164, signed and dated by the client.
- p. Evidence of Discharge Planning
- q. Discharge Outcome Report Form

22. HOURS OF OPERATION. The hours that a program or component is in operation shall be posted in a conspicuous place within each facility or at the entrance to the facility.

23. DIAGNOSTIC SERVICES. Clients admitted to treatment shall be referred for appropriate diagnostic testing, including psychological testing and psychiatric evaluation, where indicated

24. TREATMENT SERVICES. All treatment services shall be provided under the supervision of a qualified clinical supervisor as appropriate to the counselor's level of licensure.

- a) **Counselor.** The client must have a primary counselor assigned to him/her for the duration of treatment. The name of the counselor shall be identified in the client's treatment plan.
- b) **Treatment Plan.** An individualized treatment plan for the client shall be developed in accordance with the agency's Policies and Procedures in keeping with the degree of severity or acuteness of the condition of the client. This shall include measurable goals with projected target dates, type and frequency of services and the need for continuing care after discharge. This plan shall be developed within thirty days of admission, depending on the level of care, and shall be reviewed and signed by the clinical supervisor within two weeks of completion. The Treatment Plan is updated monthly or quarterly, depending on the level of care. (See *Appendix A – Sample Standardized Forms*)
- c) **Case Management Services.** Other services that support recovery shall be provided as clinically indicated, through case management services, either directly or through referral to other agencies.

- d) **Documentation of Participation in Treatment.** Progress notes shall document all services provided to the client in detail, in written format including client and/or family interactions with a counselor or case manager. The written records must include the date, length of service (beginning time and ending time) of services, and signature of individual providing services, including applicable licensure. Progress notes must contain client specific information. Progress notes shall document, for all services provided to the client, information regarding attendance at and participation in therapeutic sessions, assessment of the client's progress or lack thereof toward meeting those objectives established in the treatment plan and all case management services received by the client. The progress notes should also document the date a client has disengaged from treatment, and the efforts made by the agency to re-engage the client.

25. QUALITY ASSURANCE. To ensure adequate client care, each agency shall have written policies and procedures for a quality assurance process, designed to evaluate the quality of care provided and to promote efficient and effective services. One staff person shall be assigned the responsibility of coordinating the quality assurance program. The quality assurance program shall be described in the program's policies and procedures and, at a minimum, shall include documentation of the following:

- a. **Planning and Evaluation.** Every program shall describe its goals and priorities in an Annual Program Plan. The Plan shall have goals and objectives to address the needs of the clients or geographic area served by the program, and documented methods for assessing progress in meeting goals and objectives. Measurable objectives shall be developed for each program goal.
- b. **Peer Review.** This involves the review of a staff member's record content by comparably trained and qualified individuals performing similar tasks. Clinical quality review should be done by a supervisory staff. Peer staffing is another recommended method of peer review.
- c. **Utilization Review.** The program shall develop and use predefined criteria to evaluate the necessity and appropriateness of services and allocated resources to ensure that the program's services are necessary, cost-efficient and effectively utilized.
- d. **Incident Reporting.** Programs and their subcontractors shall maintain a file on all incidents in accordance with the program's policies and procedures.

26. DATA. The City of Albuquerque Division of Behavioral Health through the AMCI database system collects aggregate data on all clients. These data are used to show effectiveness of services. Every agency shall participate in reporting client data and other information as requested by the City of Albuquerque.

27. EMERGENCY RESPONSE PROCEDURES.

- a. All agencies shall have standards that describe the manner in which emergencies shall be managed, such as medical emergencies, natural disasters, and other disasters. All staff/contractors shall be familiar with the procedures.
- b. All direct care staff/contractors shall be trained in cardiopulmonary resuscitation (CPR) and first aid, within three months of employment/contracting with the agency. A copy of the Training Certification must be maintained in personnel/contractor files.
- c. A staff member/contractor trained in First Aid and CPR shall be available at the program when clients are present.

28. CULTURAL COMPETENCY. All programs shall recognize and honor client's cultural customs/traditions and practices, and integrate those practices into treatment as appropriate. Every effort shall be made to provide services in the preferred language of clients. Staff shall receive regular and ongoing training to develop cultural competency through the agency.

29. SERVICES OUTSIDE NORMAL WORKING HOURS. Non-residential agencies shall provide client services at least 4 hours per week scheduled outside the hours of 9:00 A.M. and 5:00 P.M. or during the weekend to insure that all clients can access services. A notice of program operating hours shall be posted in program entrance areas.

30. REPORTING REQUIREMENTS FOR CRIMINAL JUSTICE SYSTEM REFERRALS. Treatment agencies choosing to serve criminal justice clients must comply with all reporting requirements of the criminal justice system.

Title IV. STANDARDS FOR THE OPERATION OF A CENTRAL INTAKE UNIT

Central intake services shall abide by the following operating requirements and procedures and shall abide by all applicable provisions of the most current *Administrative Requirements for Contracts Awarded Under the City of Albuquerque, Department of Family and Community Services, Social Services Program*.

- 1. SINGLE POINT OF ENTRY.** Albuquerque Metropolitan Central Intake (AMCI) shall be the system entry point for all referrals for individuals and/or families seeking admission to the City vouchered substance abuse treatment services.
- 2. REFERRAL.** AMCI will accept referrals from all sources in the greater Albuquerque, Bernalillo County area (including To'hajiilee, Corrales, Tijeras, Edgewood, and Isleta) for persons in need of substance abuse treatment services for assessment and potential referral for admission to a treatment program.
- 3. REQUEST FOR SERVICES.** AMCI shall obtain a completed Request for Services form for each applicant seeking treatment. The completed Request for Services form shall include basic identifying information, referral source, and presenting problem on each applicant. In the event that an applicant for substance abuse treatment is found to be inappropriate for admission to treatment, information relative to that decision, with the consent and upon request of the applicant, will be provided to the initial referral source.
- 4. HOURS OF OPERATION.** AMCI must provide services at least five days a week, 8 hours per day. At least 4 hours of operation must be outside of the hours of 9 a.m. to 5 p.m. The hours the program is in operation shall be posted in a conspicuous place within each facility or at the entrance to the facility.
- 5. ASSESSMENT FOR ADMISSION TO TREATMENT.** A comprehensive drug and alcohol assessment shall be completed with applicants seeking admission to treatment when applicable. Previous records from prior treatment or other necessary information*¹ may be requested with the consent of the applicant. The assessment shall include, at a minimum:
 - A. Bio-Psychosocial Assessment.** All bio-psychosocial assessments shall be conducted under the supervision of a qualified clinical supervisor as appropriate to the counselor's level of licensure. Applicants referred to residential programs, and non-residential programs, and all methadone programs shall be provided the following psychosocial assessment services:

(1) Assessment Instrument(s)

- a. Addiction Severity Index (ASI).** The Addiction Severity Index shall be the standard tool for the assessment for adults seeking substance abuse treatment services. Documentation should include: including: a statement of findings, referred to as the Summary, from the assessment based on relative to a a client's need for substance abuse treatment; a DSM IV substance abuse diagnosis if appropriate; a level of care recommendation; the disposition regarding substance abuse treatment placement if needed; and a secondary referral for other supportive services including medical if the need has been identified.

, or

- b. Modified Adolescent Drug Abuse Diagnosis (MADAD).** The Modified Adolescent Drug Abuse Diagnosis shall be the standard tool for the assessment for youth and adolescents seeking substance abuse treatment services. In this case, parent interviews should be utilized, whenever possible, to inform the need for and placement decisions in treatment services.

¹ AMCI seeks to further implement a process to obtain, when appropriate, collateral information from the referring agency relevant to the client's substance abuse and/or mental health history.

- (2) **Levels of Care.** An appropriate treatment placement, or level of care recommendation will be provided using the Appropriate **American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC)** and other information that may be helpful in determining appropriate placement or activities, including various screening tools and appropriate consents for release of information.
- (3) **Medical Health History Screen.** Applicants for treatment shall be given a Medical Health History Screen and will be referred for further medical review and laboratory testing, as appropriate, which includes HIV and other infectious disease.

B. Disposition. AMCI staff shall recommend a disposition among the following options:

- (1) **Appropriate for substance abuse treatment.** If an applicant is determined appropriate for treatment, the applicant will receive a referral to an approved provider and be given a payment voucher. The electronic record will include the specific modality, location and time of appointment if an appointment can be obtained at the time of assessment. If an appointment cannot be obtained at the time of assessment, this will be noted in the Summary and Disposition.
 - a. If a client is referred by the Criminal Justice System, a letter will be sent to the referring agency with the client's name, date of assessment, and the name of the provider to whom the client is being sent along with a release of information.
 - b. The provider to whom the client is being referred will also be sent a letter with the same information and release.
 - c. All documentation will be in the client's record.
- (2) **Not appropriate for substance abuse treatment - needs referral.** If it is evident that the applicant is not appropriate for substance abuse services, the applicant shall be referred to an appropriate agency or service in the community if other services are indicated.
- (3) **Dual diagnosis.** The applicant will be referred to a provider skilled in assessing mental illness if the applicant reveals a history of diagnosed mental illness or if the counselor believes further assessment is needed. Individuals determined to have both a diagnosed mental illness and a substance abuse problem shall be assessed for the most appropriate treatment and referred accordingly.
- (4) **Individuals needing substance abuse treatment but not meeting geographic or financial criteria for receiving a treatment voucher.** Applicants who live outside the approved geographic area and/or fail to meet the financial criteria set by AMCI are referred to appropriate agencies suitable to the applicant's needs.

C. Clinical Review and Publishing Process. Prior to making the assessment available electronically to the provider, a licensed clinician will review and approve the information placed in the electronic record. The clinician will review with the assessment counselor any areas of concern, missing data, or inconsistencies prior to "publishing" the report. The entire report is then available to the treatment provider through the electronic Client System. It is expected that the review and publishing process will be completed within 4 business days.

6. **REASSESSMENT.** If an applicant reapplies to AMCI after six (6) months from the initial assessment, he/she shall receive a full assessment at the discretion of the supervisor, based upon the triage of the client. If an applicant returns before the six (6) month period is completed, the assessment counselor will determine if a full assessment is required; otherwise, it is considered a follow-up report.
7. **CENTRAL RECORD KEEPING.** AMCI shall maintain a physical and electronic record on each client.

Multiple Enrollments: The physical file is given to medical records which merges case 2 and above files with the original file.

A. Content of Client Records. Records maintained AMCI shall contain the following information as required by these standards

- 1) The client name and address, or indication that client is homeless
- 2) Name, address and telephone number of guardian or representative, where applicable.
- 3) The source of referral and relevant referral information.
- 4) Documentation of orientation to program and program rules, Client Rights & Responsibilities; signed and dated by the client.
- 5) Medical history screening form completed by the client.
- 6) Summary and Disposition of the bio-psychosocial assessment (ASI) or the complete MADAD, signed, credentialed and dated by the counselor, conducted at AMCI and provided to treatment programs upon client admission to treatment, or a copy thereof. The full assessment is kept electronically.
- 7) Consents for the release of client information, consistent with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and Sections 26-2-13(B) and 26-2-14(C), NMSA 1978 of the New Mexico Drug Abuse Act, and the Health Information Portability and Accountability Act of 1996, (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Sections 160 and 164, signed and dated by the client
- 8) Follow up notes as applicable. Follow-up notes in the electronic record shall document all services provided by AMCI to the client to include, contacts made with outside referrals, Parole Officers, the courts, etc. Follow-up notes should be signed, credentialed, and dated, and should include the length of service provided.
- 9) Voucher Records. AMCI shall keep a record of all vouchers assigned

B. Central Data Collection. The City shall have access to summary data of applicants who are assessed, assigned a voucher, admitted for treatment, or referred to other services. A client numbering system shall be utilized to ensure confidentiality.

8. COMPLIANCE WITH HEALTH AND SAFETY REGULATIONS. All physical facilities used by AMCI are required by law to be in compliance with fire and safety standards established and enforced by the State Fire Marshall, and health, safety and occupational codes enforced at the local level. AMCI must agree to be responsible for knowing all applicable fire and safety standards.

9. COMPLIANCE WITH ADA. In providing services, AMCI must agree to meet all the requirements of the Americans with Disabilities Act of 1990 (ADA), and all applicable rules and regulations which are imposed directly on the Contractor or which would be imposed on the City as a public entity. AMCI must agree to be responsible for knowing all applicable requirements of the ADA.

10. VERIFICATION OF COVERAGE. Evidence of verification of immunities and limitations of the New Mexico Tort Claims Act Section 41-4-1, et. seq, 1978, must be provided by the program if applicable.

11. GENERAL LIABILITY AND PROFESSIONAL LIABILITY. All programs not covered by (4) shall maintain documentation that appropriate levels of general and professional liability coverage are in effect at the following levels:

- \$1,000,000 Per Occurrence
- \$1,000,000 Policy Aggregate

12. LICENSURE REQUIREMENTS. AMCI must ensure its staff and contractors are licensed according to applicable State of New Mexico requirements to provide services.

- 13. POLICIES AND PROCEDURES.** AMCI must adhere to its written policies and procedures that ensure compliance with these Minimum Standards. These policies must include those listed in these Minimum Standards.
- 14. TRAINING POLICY.** AMCI will provide training as needed to its staff and employees and contractors. They are required to attend applicable City trainings and demonstrate competency.
- 15. CLINICAL SUPERVISION.** AMCI will ensure clinical supervision standards are met according to Title II of these Minimum Standards.
- 16. FISCAL MANAGEMENT.** AMCI must have and use a written set of systems and procedures that ensure the integrity of the financial functions of the agency, as well as ensuring the accuracy of invoicing and billing.
- 17. CONFLICT OF INTEREST.** AMCI must have a policy that at minimum:
- A.** Applies to the procurement and disposition of all real property, equipment, supplies and services by the contractor and to the contractor's provision of assistance to individuals, businesses, and other private entities.
 - B.** Provides that no person who exercises any functions or responsibilities with respect to agency activities or who are in a position to participate in a decision making process may obtain a personal or financial interest or benefit from an agency activity, either for themselves or those with whom they have family or business ties, during their tenure or for one year thereafter.
 - C.** Exception to the above policies may be allowed with the prior written approval of the Department on a case-by-case basis only after the following has been provided: (i) a disclosure of the nature of the conflict, accompanied by an assurance that there has been a public disclosure of the conflict and a description of how the public disclosure was made and (ii) an opinion by the City's attorney that the interest for which the exception is sought would not violate state or local laws.
- 18. CONFIDENTIALITY OF CLIENT RECORDS.** Client records and client identifying information must be maintained in a confidential manner. AMCI must secure a consent for the release of client information in accordance with State and Federal Regulations (Title 42, Code of Federal Regulations, Part 2), and these Minimum Standards.
- A. Record System.** AMCI shall include a description of their client record system in their policies and procedures. Client records shall be kept secure from unauthorized access. The policies and procedures shall include, at a minimum, requirements regarding content, organization and use of client records. All signatures shall be original as opposed to facsimile. Treatment providers authorized to access the electronic client system will have ready access to client records. The applicant's physical file will reside at AMCI in the Medical Records Department.
 - B. Record Retention and Disposition.** Medical and non-medical clinical records shall be retained for a minimum period of 5 years following the closing of the file. Programs shall establish standards that address the appropriate disposition of closed records.
- 19. CLIENT ORIENTATION** The program shall conduct an orientation with the client and significant others, if applicable. The following shall be covered in orientation:
- A.** Guidelines for Obtaining a referral to treatment
 - B.** Standards for Receiving a Voucher for treatment
 - C. Client Rights & Responsibilities.** AMCI maintains a written body of principles governing the rights and conduct of clients. These include Client Rights and program expectations for clients being assessed for treatment. This shall include operating standards that protect the dignity, health, and safety of clients.

- D. In-House Client Grievance Policies and Procedures.** AMCI will make available to any applicant information about procedures for reporting grievances the client may have with the agency. No program shall discourage or prevent a client from contacting the State. This notification must include the telephone number to report alleged counselor abuse and complaints against the agency to the applicable State Licensing Board.
- E. Agency Responsibility To Report Abuse/Neglect.** All programs shall provide the client with written notification of their legal obligation to adhere to the New Mexico statutory requirements concerning the mandatory reporting of suspected child and elder abuse and neglect.
- F. Confidentiality of Client Information.** A written statement that the agency provides to and explains to clients in compliance with 42CFR and HIPAA.
- G. Drug Screening.** Applicants shall receive written notice that treatment providers will be requesting regular drug screening, as a part of treatment received through the City’s Treatment Voucher System.

20. CONSENT TO ASSESSMENT. AMCI shall have on file:

- A.** A consent for assessment for voluntary and involuntary clients (as documented in client's file), signed and dated by each individual; or
- B.** Parents/Legal Guardians have the authority to sign a consent form for assessment for their unmarried, minor un-emancipated, children.

21. GOVERNING BODY: All public and private non-profit agencies shall have a legal governing body responsible for establishing its policies, defining its services, guiding its development and assuring its accountability in the community as well as providing general oversight of programs and services provided. The agency must document that its governing body is constituted in compliance with approved bylaws and that it actively fulfills its responsibility for policy direction, including regularly scheduled meetings for which minutes are kept. The agency must verify board compliance with the City of Albuquerque “Open Meetings” ordinance.

22. PERSONNEL, CONTRACTOR, INTERN AND VOLUNTEER POLICIES. Personnel policies shall be made available in writing to all employees, including contractors, interns, and volunteers. Policies shall include, but are not limited to, establishing clear lines of communication within the agency, rules governing the ethical conduct of staff, volunteers, contract workers, and/or student interns, confidentiality of information regarding clients and client records, attendance, leave, prohibition of the use of illicit drugs and misuse of alcohol and drugs, employee grievance and non-discrimination, address performance evaluations and the criteria for such evaluations, background check requirements, and the maintenance of personnel files. The agency shall demonstrate compliance with its personnel policies. Agency policies must ensure personnel files include the minimum:

a. Personnel File – The Personnel File shall contain, at a minimum, the following:

- (1) Job Description – a description of the responsibilities of the position for which the employee is hired, including minimum qualifications and salary range.
- (2) Employee’s resume or application
- (3) Personnel Actions (hiring actions, disciplinary or probationary actions, salary increases, sick and vacation time information, etc.)
- (4) Signed Drug Free Workplace statement
- (5) Signed statement that employee has reviewed personnel policies and information.
- (6) Evidence of employee participation in City required training events.
- (7) Evidence of CPR/FIRST AID certification, as needed
- (8) Professional licensure
- (9) W-4
- (10) I-9

- (11) Background checks, as described in these Minimum Standards
- (12) Performance evaluations

b. Contractor File - The Contractor File shall contain, at a minimum, the following:

- (1) Signed contract detailing the Scope of Work, dates of service, signed and dated.
- (2) Resume
- (3) Evidence of contractor participation in City required training events.
- (4) Signed Drug Free Workplace Statement
- (5) W-9
- (6) Evidence of CPR/FIRST AID certification, as needed
- (7) Professional licensure
- (8) City of Albuquerque, Business Registration receipt, and State of New Mexico Taxation and Revenue Department Certificate
- (9) Professional liability insurance, at the appropriate levels
- (10) Background checks, as described in these Minimum Standards

c. Intern Files

- (1) Signed contract between supervising school and agency, detailing the Scope of Work, dates of service, signed and dated.
- (2) Resume.
- (3) Evidence of contractor participation in City required training events.
- (4) Signed Drug Free Workplace Statement
- (5) Evidence of CPR/FIRST AID certification, as needed
- (6) Professional licensure, as applicable
- (7) Professional liability insurance, at the appropriate levels, as applicable
- (8) Background checks, as described in these Minimum Standards

23. QUALITY ASSURANCE. To ensure adequate client care, AMCI shall have written policies and procedures for a quality assurance program, designed to evaluate the quality of care provided and to promote efficient and effective services. One staff person shall be assigned the responsibility of coordinating the quality assurance program. The quality assurance program shall be described in the program's policies and procedures and, at a minimum, shall include documentation of the following:

- A. Planning and Evaluation.** AMCI shall describe its goals and priorities in an Annual Program Plan. The Plan shall have goals and objectives to address the needs of the clients or geographic area served by the program, and documented methods for assessing progress in meeting goals and objectives. Measurable objectives shall be developed for each program goal. Find out if there is something in existence
- B. Utilization Review.** AMCI shall develop and use predefined criteria to evaluate the necessity and appropriateness of services and allocated resources to ensure that the program's services are necessary, cost-efficient and effectively utilized.
- C. Incident Reporting.** AMCI shall maintain a file on all incidents in accordance with the program's policies and procedures as well as the policies and procedures of the University of New Mexico.

24. DATA. AMCI will maintain a comprehensive management information system that will allow provider agencies to submit client admission and discharge data. This system will also allow provider agencies to utilize voucher funds to pay for treatment, receive information from the AMCI, facilitate invoicing, and provide outcome reporting data.

AMCI will provide technical assistance to outside contractors who are providing data analysis to the City of Albuquerque. This will include verifying the validity of the reports, providing access to the data and hosting web-based management reports.

25. EMERGENCY RESPONSE PROCEDURES.

A. AMCI shall have standards that describe the manner in which emergencies shall be managed, such as medical emergencies, natural disasters, and other disasters. All staff/contractors shall be familiar with the procedures.

B. All direct care staff/contractors shall be trained in cardiopulmonary resuscitation (CPR) and first aid, within three months of employment/contracting with the agency. A copy of the Training Certification must be maintained in personnel/contractor files.

C. A staff member/contractor trained in First Aid and CPR shall be available at the program when clients are present.

26. CULTURAL COMPETENCY. AMCI shall recognize and honor client's cultural healing traditions and practices, and integrate those practices into the assessment process as appropriate. Every effort shall be made to provide services in the preferred language of clients. Staff shall receive regular and ongoing training to develop cultural competency through the assessment agency.

27. CRIMINAL JUSTICE SYSTEM REFERRALS. When serving criminal justice clients AMCI must comply to the extent possible with all reporting requirements of the criminal justice system.

TITLE V. STANDARDS FOR INDIVIDUAL TREATMENT MODALITIES

1. MINIMUM STANDARDS FOR DETOXIFICATION PROGRAMS. In addition to Common Standards, these Minimum Standards apply to Medical Detoxification Programs.

A. MEDICAL DIRECTOR. All programs that provide detoxification, residential, and medication programs, shall designate a Licensed Physician (L.P.) as a Medical Director. This person shall oversee all medical services provided by the program. The Medical Director's responsibilities shall be described in the program's standards.

B. OUTPATIENT DETOXIFICATION

(1) Delegation of Medical Functions. The L.P. may delegate medical functions to an advanced registered nurse practitioner or to a physician's assistant respectively.

(2) Medical Evaluation.

a. Medical History. A medical history shall be taken on each client within 24 hours of admission or earlier, if possible. The medical history shall be taken by a licensed registered nurse, licensed practical nurse or physician's assistant and reviewed and signed by the L.P.

b. Nursing Assessment. A nursing assessment shall be conducted upon admission. The assessment shall be performed by a registered nurse or a licensed practical nurse, under the direction of a currently licensed registered nurse. The results of the assessment shall be signed by the nurse and included in the client's record.

c. Physical Examination. A physical examination shall be conducted by an L.P. within 48 hours of admission or earlier, if possible. The examination shall consist of an investigation of organ systems for the possibility of abnormalities, dermatology problems, and infectious disease.

d. Laboratory Tests. The following laboratory tests shall be performed at the time the medical history is completed:

i. A serological test for Sexually Transmitted Diseases and a tine or Mantou test for Tuberculosis.

ii. A laboratory test on blood to determine level of liver function and urine drug screen shall be conducted as prescribed by the L.P..

iii. Female applicants shall be evaluated to determine the need for a Pap smear and C pregnancy test, and if indicated, such tests shall be performed either at the program or through referral.

iv. Other specialized testing shall be conducted on an as-needed basis. If not available at the program, referrals for those tests will be made. Such testing may include, but is not limited to, visual tests, psychiatric or psychological tests, electro-cardiogram, chest x-ray, or other tests necessary as determined by the L.P.

2. MINIMUM STANDARDS FOR RESIDENTIAL PROGRAMS. In addition to the Common Standards, these Minimum Standards apply to residential programs.

- A. Medical Director.** All programs that provide detoxification, residential, medication programs, and methadone, shall designate an L.P. as a Medical Director. This person shall oversee all medical services provided by the program. The Medical Director's responsibilities shall be described in the program's standards.
- B. Prescription Medication.** If a client must take any legally prescribed medication while at the treatment program, the program shall retain custody of the medication while the client is on site. The client shall obtain the medication as prescribed from a staff member and self-medicate under observation. The program's L.P., A.R.N.P., or P.A., shall re-examine the need for the prescription at least every 30 days. In cases where a prescription must be renewed, the L.P. shall document the reasons for renewal in the client record. Medications shall be discontinued only on the written order of the L.P. or when the effective termination date ordered by the prescribing L.P. occurs. Under no circumstances shall medication be withheld for disciplinary reasons.
- C. Fire/Exit Drills.** All residential programs shall conduct fire exit drills on a quarterly basis. Fire exit drill records shall be maintained and include the date and time of the drill and the amount of time taken for staff and clients to evacuate the facility.
- D. Client Rehabilitation And Treatment.**
- (1) Any residential program which houses male and female clients shall provide separate sleeping arrangements for these clients.
 - (2) Residential programs which houses persons under 18 years of age shall have written standards ensuring the protection and safety of those persons.
 - (3) All staff of residential programs must undergo background checks pursuant to these Minimum Standards, all staff in proximity of youths 18 years of age and younger must have a Criminal Background check.
 - (3) **Treatment Plans.** An initial treatment plan shall be developed within 5 working days of admission, in keeping with the severity or acuteness of the condition of the client. An individualized treatment plan shall be developed within 10 working days of admission. The plan shall be reassessed by the primary counselor and client at least weekly.
 - (4) **Policies and Procedures.** Each treatment agency shall develop Program Policies and Procedures for the provision of structured therapeutic activities. This shall include, at a minimum, 15 hours of individual, group, or family counseling per client per week. The balance of the treatment schedule shall include combinations of education, recreation, personal time, visitation, work experience, or other scheduled activities, appropriate for each individual client. Participation in all activities shall be documented in the client record.
 - (5) **Progress Notes.** At least once daily, progress notes shall be recorded in the client record and shall reflect progress toward meeting treatment plan objectives and/or goals.
 - (6) **Meals.** At least three nutritious meals per day shall be provided to each resident. Under no circumstances may food be withheld for disciplinary reasons. The program shall document and ensure that menus are reviewed and approved by a New Mexico registered dietitian at least annually.
 - (7) **Transportation.** Transportation services must be arranged for the clients as clinically indicated.
 - (8) **Staff Coverage.** Each program shall maintain staff coverage in compliance with the State of New Mexico regulations.

- (9) **Caseload.** No counselor may have a caseload which exceeds 15 active clients.
- (10) **Clinical Supervision.** All treatment services shall be provided under the supervision of a qualified clinical supervisor as appropriate to the counselor level of licensure.
- (11) **Discharge Plan.** The program shall develop a discharge plan as defined in these Minimum Standards.
- (12) **Aftercare Services.** All clients discharged from residential treatment shall have the opportunity to enroll in an aftercare or continuing care program, either at the residential treatment program or by referral, which could include referral to AMCI. Each program shall develop program standards for the provision of aftercare services or for referral to aftercare.

E. Residential Programs for Women with Dependent Children and Pregnant Women and Their Infants. All such residential programs shall comply with the Minimum Standards applicable to Residential Treatment Programs as shown above. In addition, the following Minimum Standards are required:

- (1) **Child and Infant Care Services** - For those residential treatment programs that serve women with dependent children or pregnant women and their infants, the programs shall develop Program policies and procedures which indicate the manner in which neonatal infant care and child care and development services will be provided. These shall include staffing patterns indicating the skill level and coverage level appropriate for the number and age of children or infants served in the program. A schedule of age-appropriate social and therapeutic activities shall be provided.
- (2) Programs serving pregnant women shall maintain dietary standards appropriate for pregnancy.
- (3) For pregnant women, the activity schedule shall reflect the recommendations made by the L.P. or physician that is providing prenatal care.

F. Social Model Residential Programs. The City of Albuquerque maintains a set of operating standards appropriate for Social Model Programs. For entities wishing to provide such services, a copy of the Social Model Program Standards are available from the Division of Behavioral Health.

3. MINIMUM STANDARDS FOR NON-RESIDENTIAL PROGRAMS. In addition to the Common Standards, these Minimum Standards apply to all nonresidential programs.

- **Outpatient Treatment** provides individual, group or family counseling for an average period of 90 to 120 days; clients are seen by appointment during scheduled operating hours with an emphasis on assessment, treatment, case management and recovery support services; services are provided in regularly scheduled sessions of usually fewer than 9 contact hours per week, but not less than once a week; if fewer or more sessions are clinically indicated for a client, this must be justified and documented in the client record.
- **Intensive Outpatient** provides treatment with an intensity of nine or more hours of structured programming per week and a frequency of not less than three times per week for an average of 120 days. If fewer or more sessions are clinically indicated for a client, this must be justified and documented in the client record.
- **Partial Hospitalization/Day Treatment** provides twenty or more hours of structured programming a minimum of four days per week and a minimum of five consecutive hours of

service each day with emphasis on assessment, rehabilitation, treatment, and ancillary services and, depending upon client needs, may include formal school and adult education programs.

A. Early Intervention (Level .5) Early Intervention/Education level of care is to explore and address problems or risk factors that are related to substance use and to help the client recognize the harmful consequences of inappropriate substance use. Each program that offers Early Intervention/Education needs to use an established and recognized curriculum.

- (1) **Service Plan.** Each client shall have an initial service plan created at the time of intake. The service plan shall be reviewed by the counselor, client and clinical supervisor, to insure compliance with the treatment program.
- (2) **Documentation of Progress.** Progress notes shall be recorded in the client record at least weekly or according to the frequency of therapeutic sessions and shall reflect progress toward meeting early intervention objectives and documentation of attendance at early intervention sessions. Progress notes shall also document missed appointments, client's effort to disengage from early intervention, and efforts made to re-engage the client. Hard copies of progress notes should be filed weekly. Undocumented services will result in repayment of invoiced services.
- (3) **Early Intervention Session.** Each client shall participate in a minimum of one education group per week. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client record.
- (4) **Case Management/Ancillary Services.** Each client shall have access to appropriate education, vocational, health, and social services as indicated in the treatment plan. If said services are not directly available through the program's case management services, referral must be made and documented.
- (5) **Referral Standards.** Every early intervention program shall have written procedures for the referral of a client to a detoxification, residential, outpatient treatment or emergency medical facility where such referral is indicated by staff evaluation of the client.
- (6) **Drug Screening.** One drug screen must be performed monthly to include an initial screen and a screen prior to discharge.
- (7) **Discharge Summary.** The program shall complete a discharge summary for each client upon discharge from early intervention services.
- (8) **Education Group Client to Staff Ratio:** These Minimum Standards require a maximum of twenty five (25) clients be facilitated by one counselor.

B. Outpatient Treatment Programs (Level I)

- (1) **Treatment Plan.** An individualized treatment plan shall be developed within 30 days of admission. For Level I, the treatment plan shall be reviewed by the counselor, client and clinical supervisor, not less than quarterly.
- (2) **Documentation of Progress.** Progress notes shall be recorded in the client record at least weekly or according to the frequency of therapeutic sessions and shall reflect progress toward meeting treatment plan objectives and documentation of attendance at therapeutic sessions. Progress notes shall also document missed appointments, client's effort to disengage from treatment, and efforts made to re-engage the client. Hard copies of progress notes should be filed weekly. Undocumented services will result in repayment of invoiced services.

- (3) **Therapeutic Session.** Each client shall participate in a minimum of one individual, group or family therapeutic session not less than once a week. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client record.
- (4) **Case Management/Ancillary Services.** Each client shall have access to appropriate education, vocational, health, and social services as indicated in the treatment plan. If said services are not directly available through the program's case management services, referral must be made and documented.
- (5) **Referral Standards.** Every outpatient program shall have written procedures for the referral of a client to a detoxification, residential or emergency medical facility where such referral is indicated by staff evaluation of the client.
- (6) **Discharge Planning.** The program must demonstrate discharge planning has occurred with clients, prior to termination of treatment to put closure on the treatment process and plan for aftercare support needed to maintain stability and sobriety, and to continue meeting goals successfully.
- (6) **Discharge Summary.** The program shall complete a clinical discharge summary for each client upon discharge from treatment.
- (7) **Group Therapy Client to Staff Ratio.** These Minimum Standards require a maximum of eight (8) clients be facilitated by one counselor. A maximum of 9-12 clients requires two facilitators.
- (8) **Education Group Client to Staff Ratio:** These Minimum Standards require a maximum of twenty five (25) clients be facilitated by one counselor.
- (9) **Required Service Mix for Outpatient (Level I).** Each program serving clients appropriate for Level I services should, *at a minimum*, adhere to the schedule shown below. Services are intended to run at least 90 days in length for the average client. The client must be provided with an Individualized Treatment Plan within 30 calendar days of admittance into the program, and then updated quarterly thereafter.
 - a. Each week, one of the following therapeutic sessions is required: individual, group, or family counseling with client, with a minimum of 2 individual sessions per month.
 - b. Case management services as clinically indicated.
 - c. One alternative group/activity every other week. (*See Appendix E – Model Program Content*)
 - d. One drug screen monthly, to include an initial screen and a screen prior to discharge.
 - e. Continue to provide services after voucher has expired, including aftercare, as necessary.

C. Intensive Outpatient Treatment Programs (Level II.I).

- (1) **Treatment Plan.** An individualized treatment plan shall be developed within 10 working days of admission. For Level II.1 clients the treatment plan shall be reviewed by the client, counselor, and supervisor not less than monthly.
- (2) **Documentation of Progress.** Progress notes shall be recorded in the client record at least weekly or according to the frequency of therapeutic sessions and shall reflect progress or lack thereof toward meeting treatment plan objectives and documentation of attendance at therapeutic sessions. Progress notes shall also document missed appointments, client's effort to disengage from treatment, and efforts made to re-engage the client. Hard copies of progress notes should be filed weekly. Undocumented services will result in repayment of invoiced services.

- (3) **Therapeutic Session.** Each client shall participate in a minimum of one individual, group or family therapeutic session three times per week. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client record.
- (4) **Case Management/Ancillary Services.** Each client shall have access to appropriate education, vocational, health, and social services as indicated in the treatment plan. If said services are not directly available through the program's case management services, referral must be made and documented.
- (5) **Referral Standards.** Every outpatient program shall have written procedures for the referral of a client to a detoxification, residential or emergency medical facility where such referral is indicated by staff evaluation of the client.
- (6) **Discharge Planning.** The program must demonstrate discharge planning has occurred with clients, prior to termination of treatment to put closure on the treatment process and plan for aftercare support needed to maintain stability and sobriety, and to continue meeting goals successfully.
- (7) **Discharge Summary.** The program shall complete a clinical discharge summary for each client upon discharge from treatment.
- (8) **Group Therapy Client to Staff Ratio.** These Minimum Standards require a maximum of eight (8) clients be facilitated by one counselor. A maximum of 9-12 clients requires two facilitators.
- (9) **Education Group Client to Staff Ratio.** These Minimum Standards require a maximum of twenty five (25) clients be facilitated by one counselor.
- (10) **Required Service Mix.** Clients that are appropriate for Level II.1 services should, *at a minimum*, adhere to the schedule shown below, ensuring that 9 or more hours of structured programming is offered per week, primarily counseling and educational activities concerning substance related issues and mental health problems. Services are intended to run at least 120 days or four months. The client must be provided with an Individualized Treatment Plan within 10 calendar days of admittance into program. Monthly treatment plan updates must occur.
 - a. One individual counseling session per week
 - b. Two group counseling sessions per week
 - c. Case management as clinically indicated.
 - d. One drug screen monthly, to include an initial screen and a screen prior to discharge
 - e. One alternative group/activity every other week (*See Appendix E – Model Program Content*)
 - f. Home visits as needed
 - g. Continue to provide services after voucher has expired, including aftercare, as
 - h. necessary
 - i. A combination of services that equal 9 or more hours of structured programming.

TITLE VI: SUBSTANCE ABUSE PREVENTION PROGRAM OPERATING STANDARDS - DRAFT

DEFINITIONS. The following terms and definitions are used in the Albuquerque Prevention Program Operating Standards:

1. **Addiction** refers to the process of chronic, compulsive behaviors most often associated with alcohol, tobacco, and other drug abuse, gambling and other compulsive behaviors.
2. **Agency** refers to any public or privately constituted organization that provides substance abuse prevention services contracted through the Division of Behavioral Health.
3. **ADA** refers to the Americans with Disabilities Act that requires accessibility of services for handicapped or otherwise disabled persons.
4. **Attendee** refers to person(s) who attend a single prevention service.
5. **ATOD** refers to alcohol, tobacco, and other drugs.
6. **Coalition** refers to those entities responsible for community organization and mobilization to prevent alcohol, tobacco, and other drug use.
7. **Division** refers to the City of Albuquerque's Division of Behavioral Health in the Department of Family and Community Services which is responsible for the financing and management of substance abuse treatment and prevention services and mental health services for the City.
8. **Early Intervention** refers to those services intended to intervene with at risk or high risk populations for the purpose of deterring or changing risk behaviors.
9. **Evidence-Based Programs** refers to those programs and services that are based in nationally recognized and researched methods and practices of service delivery that have proven to be effective with specific prevention populations.
10. **Goals** refer to broad statements, each of which targets those issues a prevention program needs to achieve in order to satisfy its mission or purpose in providing services.
11. **Objectives** refer to statements of precise and measurable results the program intends to accomplish, within the context of a specific goal, during a specific period of time.
12. **Outcomes** refer to measures that assess program effectiveness, program efficiency, determine the extent to which a program makes a difference, and/or identify interventions and activities having the greatest effect.
13. **Organization** refers to those public or private entities engaged in community services or community development that may directly or indirectly affect the nature and extent of a community's response to alcohol, tobacco, and other drug abuse and related problems and concerns.
14. **Parenting and Family Management** programs are those prevention education programs intended to aid parents and families in reducing risk factors for alcohol, tobacco, and other drug abuse and in developing knowledge and skills to combat alcohol, tobacco, and other drug abuse and related problems within the family.
15. **Participant** is an individual, group or family enrolled in a recurring prevention service.
16. **Program Plan** refers to written documentation of the intended programs, services, and/or activities that an agency/ organization/coalition intends to carry out, within a specified period of time.

17. **Recurring Prevention Program** is a planned and recurring sequence of multiple, structured activities intended to inform, educate, impart skills, deliver services, shape or influence policies, and/or provide appropriate referrals for other services, through the practice and application of recognized prevention strategies.
18. **Qualified Prevention Professional** refers to individuals who have met the training and professional experience requirements to become a Certified Prevention Specialist as established by the New Mexico Credentialing Board for Behavioral Health Professionals.
19. **Prevention Information Center** refers to an entity or organization that provides current, research-based prevention ATOD information and resource materials; information resource centers may also provide training and technical assistance services.
20. **Prevention Training** refers to the provision of structured instruction to develop professional proficiency in prevention program design, development, implementation, and evaluation.
21. **Preventive Interventions** refers to the prevention continuum as defined by the National Academy of Sciences, Institute of Medicine and includes:
 - a. **Universal Preventive Interventions** refers to those prevention services targeted to the general public, or a segment of the population, at average risk of a substance abuse disorder.
 - b. **Selected Preventive Interventions** refers to those prevention services targeted to populations whose risk of substance abuse disorder is significantly higher than average, either imminently or over a lifetime.
 - c. **Indicated Preventive Interventions** refers to those prevention services targeted to populations who display signs or symptoms of a disorder or who carry biological (and/or psychosocial) markers for a disorder.
22. **Primary Prevention** refers to prevention services that are directed to people who do not need treatment.
23. **Primary Prevention Strategies** are the six defined methods and approaches to meeting federal block grant requirements for primary prevention funding. Strategies include: Information Dissemination, Education, Alternatives, Community- Based Process, Problem Identification and Referral, and Environmental (including Enforcement and Policy strategies). (Definitions for each Strategy are contained within the Prevention Standards.)
24. **Qualified Prevention Supervisor** is a Certified Prevention Specialist who possesses sufficient working experience, knowledge, skills, and attitudes to effectively provide guidance and direction to other individuals in the practice of current prevention research, theory and best practices.
25. **Risk** refers to those factors that place individuals in situations or circumstances that may cause them to be more likely to be exposed to or involved with harmful behaviors.
 - a. **At-Risk** refers to those individuals, families, and communities in need of information about substance abuse so as to reduce or prevent the likelihood of their involvement in illegal or age inappropriate behavior concerning alcohol, tobacco or other drugs.
 - b. **High Risk** refers to individuals who are exposed to or experimenting with alcohol, tobacco, or other drugs and who possess multiple risk factors for substance abuse.
26. **Service Population** is a specific group or population to which prevention programs and activities are provided.
27. **Single Prevention Service** refers to the provision of a single, one-time prevention service.

28. **Structure** refers to those attributes that provide a framework for program activities and content based on identified needs and recognized prevention and early intervention approaches.
29. **Technical Assistance** refers to the provision of expert advice, skilled training, and general technical support to organizations and entities within and outside of the specialized substance abuse service system.
30. **Workforce Development** refers to the implementation of policies and procedures to enable prevention agencies/organizations/coalitions to recognize and foster the knowledge, skills, and attitudes necessary to effectively practice alcohol, tobacco, and other drug abuse prevention service delivery.

Scope of Prevention Programs

Prevention programs shall encompass current research, theory, and practice-based strategies and activities implemented through structured Primary Prevention services. These services are intended to preclude, forestall, or impede the development of alcohol, tobacco, and other drug abuse or misuse and their associated health and social consequences. Services shall be provided along the prevention continuum that identifies universal, selected, and indicated preventive interventions. These interventions require that prevention services be respectively tailored appropriately to persons at average risk of a substance abuse disorder, persons at significantly greater than average risk for a substance abuse disorder, and persons who may be displaying early signs and symptoms of a disorder or who carry biological markers for an alcohol, tobacco, and other drug abuse disorder.

Each agency/organization/coalition providing Primary Prevention services shall delineate the scope of services to be offered within an annual Program Plan. Such scope of services for Primary Prevention programs shall be approved by the agency's Board of Directors or Membership, and approval shall be documented in Board or Membership Meeting Minutes.

Description of Common Prevention Program Operating Standards

All programs providing Primary Prevention services funded by the City of Albuquerque shall abide by the following Common Operating Standards. Programs shall participate in reporting non-identifying participant data and other information upon request of the City. Programs unable to comply with a specific standard(s) may petition the City for an exemption to the standard(s) for a period of one year. Such exemption process shall follow policies and procedures developed and published by the Division of Behavioral Health.

A. Defined Program Content

Each agency shall provide to the Division, maintain and annually update, a Program Plan including a description of the following:

1. Service Population(s) for Primary Prevention services;
2. Specific evidence-based Primary Prevention Strategies to be employed in providing primary prevention services;
3. Program Goals;
4. Measurable Objectives;
5. Program Evaluation, including intended outcomes;
6. Policies that document compliance with ADA requirements; and
7. Policies and procedures to comply with these Standards;

B. Staffing and Staff Qualifications

1. Agencies conducting primary prevention and other community based prevention services shall provide an initial orientation within 30 days of employment, for all new employees and shall document such in the personnel record of the employee. The orientation shall include at least the following:

- (a) Acquainting staff with policies and procedures, expected codes of conduct, and expected practices for prevention staff including use of current prevention concepts and program strategies, theory, research, and evidence-based best practices findings upon which prevention services and programs of the agency are based;
 - (b) The philosophical approach to prevention service delivery, including the manner in which prevention reinforces and supports other agency services.
 - (c) Maintaining confidentiality of participant information, including a review of 42 CFR, Part II and HIPAA.
 - (d) The proper maintenance and handling of participant program records;
 - (e) Procedures to follow in the event of a medical emergency or natural disaster; and,
 - (f) The employee's specific job description and job responsibilities.
2. Individuals employed to provide primary prevention services shall meet the minimum standards for a qualified prevention specialist as determined by the Division of Behavioral Health.
 3. Each agency shall maintain and annually update a description of its agency staffing pattern, including an organizational chart showing lines of authority for prevention services.
 4. Agencies shall develop and document criteria for the qualification of individuals employed as less than half time staff and for individuals employed as consultants to provide a specific and defined prevention service(s).
 5. **Qualified Prevention Supervisor.** For agencies that conduct primary prevention services, the board of directors or agency director shall designate an individual responsible for the supervision of prevention professionals and services. Such individual shall meet the requirements for a Qualified Prevention Supervisor as defined in these standards.

C. Prevention Staff Workforce Development

1. All full and part time employees conducting prevention services as their primary job function shall have a period of up to two calendar years from the date of Standards promulgation or from their date of hire, whichever is most recent, in which to meet City of Albuquerque requirements to become a Certified Prevention Specialist.
2. Additionally, all prevention staff shall receive a minimum of 16 required hours of annual prevention continuing education and training appropriate to their responsibilities and, for full and part time employees, training consistent with City of Albuquerque training requirements; education and training shall be reflective of current theory, research and evidence-based best practices for prevention services.
3. Training may include a combination of agency based in-service training and off-site training. All training shall be documented in personnel records.

D. Materials Review

1. All written and/or audio visual prevention materials shall be reviewed annually by staff and by a peer review or advisory board to assure that it is culturally relevant, age appropriate and current.

2. Each agency/organization/coalition that conducts classroom or group educational programs shall use a structured curriculum for prevention education, based on current alcohol, tobacco, and other drug abuse research and evidence-based best practice findings.
3. The Division of Behavioral Health shall periodically review prevention materials used by the provider to assure consistency with current prevention research.

E. Referral Resource.

Each agency shall maintain a current data base of information and referral resources on ATOD, substance abuse services, and prevention and treatment resources for their community or service area. Such information shall be conspicuously posted and publicly distributed through such means as internet, mailings, flyers, public services announcements, and related activities.

F. Record of Activities.

Each agency/organization/coalition conducting primary prevention services shall maintain a record of all prevention activities provided in accordance with the described Program Content. In addition, each agency/organization/coalition shall provide a description of how activities provided meet the specific needs of the individual, group or community organization served. Records shall, at a minimum, include but are not limited to:

1. Record of presenters and participants involved in Primary Prevention services; date(s) of presentations or service provision;
2. Number of participants and demographic characteristics of participants, including but not limited to:
 - a. age;
 - b. race/ethnicity;
 - c. gender;
 - d. service population; and
 - e. such other information as may be requested by the Division.
3. Consent for participation or for release of information, if needed;
4. Record of all program topics and activities;
5. Copies of programmatic materials;
6. Other prevention management information;
7. Copies of program evaluations.

G. Quality Assurance and Improvement

1. Each agency/organization/coalition shall maintain an on-going prevention quality assurance and improvement program including, but not limited to, program evaluation, adherence to program operating standards, demonstration of fiscal and programmatic accountability, and such other requirements as may be determined by the Division.
2. Programs shall evaluate the effectiveness of their services, utilizing criteria and tools such as consumer satisfaction surveys, participant evaluations, consumer awareness of substance abuse problems, knowledge of resources and services, and utilization of services. Program evaluation shall include the development and reporting of outcome measures related to demonstration of risk reduction and positive individual and/or community behavioral change.

Primary Prevention Service Standards.

Primary Prevention services shall be provided for the general population as well as for youth and adults who may be at risk for substance abuse, but who are not necessarily in need of treatment services. Agencies/organizations/coalitions shall have the capability to provide and shall provide one or more of the following services:

I. Information Dissemination Strategy

Information Dissemination services include those activities which provide awareness and knowledge of the nature and extent of alcohol, tobacco, and other drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of activities conducted and methods used for this strategy include, but are not limited to the following:

- * Clearinghouse/information resource center(s)
- * Resource Directories
- * Media Campaigns
- * Brochures, pamphlets, newsletters
- * Radio/TV public service announcements
- * Speaking engagements
- * Health fairs/health promotion
- * Information and referral services

Each agency/organization/coalition providing Information Dissemination services shall provide to the Division, initially and annually, a description of the following:

A. Service Population. The service population shall include, but is not limited to: the general population; youth and adults who are at risk for a substance abuse problem; families or friends, or both, of persons at risk for a substance abuse problem; school students and school officials; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, businesses, state and municipal governments and related community organizations; or, employers of persons at risk for a substance abuse problem.

B. Service Provision. Each agency/organization/coalition providing Information Dissemination services must provide a structured program of services consistent with the defined Strategy and the identified service population(s). At a minimum, information dissemination shall include current legal, physiological, psychological, and pharmacological facts regarding alcohol, tobacco, and other drug use, abuse, or dependency, as well as information relevant to individuals, parents, families, schools, and communities at risk for substance abuse and related health and social problems. Programs offered under this Strategy shall meet the following standards:

1. Agencies providing prevention public information shall utilize education and/or information dissemination services to foster public attitudes and personal practices that discourage substance abuse and reduces risk factors associated with substance abuse and the health and social problems that accompany the disorder. They shall provide basic substance abuse information and how-to information regarding prevention techniques;
2. Agencies shall use and make available current, culturally relevant, and age appropriate, written materials including, but not limited to, brochures, pamphlets, newsletters, and other appropriate print materials intended to inform individuals, families, schools, and communities about the nature and scope of ATOD use including primary prevention, intervention, and treatment services;
3. Agencies/organizations/coalitions shall use and make available current, culturally relevant, and age appropriate audio visual materials including, but not limited to, films, tapes, public service announcements, and other materials concerning substance abuse primary prevention, intervention, and treatment services;
4. Current and factual information and materials shall be made available in support of Division priorities for prevention activities; such priorities will be identified by the Division and included in requests for proposals for professional services or contracts as appropriate;

5. Agencies/organizations/coalitions shall develop criteria for the selection and referral of knowledgeable speakers skilled in current prevention issues and topics, to convey information to all levels of the service area concerning substance abuse prevention services and issues;
6. Agencies operating as an Information Resource Center shall provide a comprehensive program of written and audio visual primary prevention information and materials to be developed and/or disseminated throughout the City.
7. Agencies/organizations/coalitions conducting information dissemination services shall document coordination with other community resources providing prevention services.

II. Education Strategy

ATOD Prevention Education involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator and/or facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision making, refusal skills, critical analysis, and systematic judgment abilities. Examples of activities conducted and methods used for this strategy include, but are not limited to the following:

- *Classroom and/or small group sessions (all ages)
- * Parenting and family management classes
- * Peer leader/helper programs
- * Education programs for youth groups
- * Children of substance abusers groups

A. Service Population. The service population shall include, but is not limited to, persons, both at-risk and high risk, for substance abuse; families or friends, or both, of persons at risk for a substance abuse problem; school students and school officials; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, businesses, state and municipal governments and related community organizations; or, employers of persons at risk for a substance abuse problem.

B. Service Provision. Each provider of Education services shall maintain a culturally relevant, age appropriate, and structured program of services consistent with the defined Program Content and this Strategy. Programs offered under this Strategy shall meet the following standards:

1. Agencies/organizations/coalition that provide youth education or adult education programs relative to ATOD prevention and related health and social consequences of such shall be provided by a structured program using recognized curricula, concerning the prevention of alcohol, tobacco, and other drug abuse;
2. Agencies/organizations/coalitions providing parenting education and family management classes, or other comparable activities provide such programs to aid parents and families to reduce risk factors for substance abuse and to develop knowledge and skills to combat substance abuse within the family. Such services shall utilize current prevention research and best practices to equip parents and families to prevent or delay experimentation, and to prevent abuse and dependency.
3. Educational resource services for parent support groups, youth groups, community organizations, and other prevention programs shall be provided in a manner consistent with current research, theory and best practices.
4. Structured training events, training of trainers, or community education events concerning activities conducted under this Strategy shall be provided by qualified prevention staff and shall incorporate current research, theory and best practices including youth and adult learning theory and the use of demonstrated effective training techniques.

5. All appropriate youth, parent, family, community education and training services provided under this Strategy shall be documented in program records as described in these standards.
6. Agencies providing education services shall document coordination with other community resources providing prevention services.

III. Alternatives Strategy

Alternatives provide for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and would, therefore, minimize or obviate resort to the latter. Examples of activities conducted and methods used for this strategy include, but are not limited, to:

- * Community service activities
- * Youth/adult leadership activities
- * Community drop-in centers
- * Alcohol and drug free social and recreational events

A. Service Population. The service population shall include but is not limited to, persons who are at risk for ATOD use or abuse; families or friends, or both, of persons at risk for a substance abuse problem; school students and school officials; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, businesses, state and municipal governments and related community organizations; or employers of persons at risk for a substance abuse problem.

B. Service Provision. Each provider of Alternative services shall maintain a culturally relevant, age appropriate, and structured program of services consistent with the defined Program Content and this Strategy. Programs offered under this Strategy shall meet the following standards:

1. Each provider conducting programming under the Alternatives Strategy shall develop a plan that describes the on-going and structured activities and events that will provide the opportunity for youth and adults to participate in programs and activities that specifically exclude the use of alcohol, tobacco, and other drugs. These shall include strategies for providing structured activities over a specified period of time to individuals or groups identified as subject to specific risk factors for substance abuse.
2. Prevention technical assistance and support services conducted for alcohol, tobacco, and other drug free social and recreational events and activities shall incorporate current research, theory, and best practices.
3. Structured training events, training of trainers, or community education events concerning Alternative activities shall be provided by a qualified prevention specialist and shall incorporate current research, theory, and best practices including learning theory and use of demonstrated effective training techniques.
4. Community drop-in center services operated under this Strategy shall provide posted hours of operation, provide supervision by staff or volunteers who have received training in the management of the center; shall have written and posted rules and regulations governing the conduct of persons participating in center activities; and, shall have a structured program of activities and events intended to offer youth or adults a gathering place free of alcohol, tobacco, and other drug use.
5. Agencies/organizations/coalitions providing Alternative programs shall document coordination with other community resources to provide prevention services.

IV. Problem Identification and Referral Strategy

Problem Identification and Referral aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those who have indulged in the first use of illicit drugs in order to assess if their behavior can be

reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include but are not limited to:

- * Employee Assistance Programs
- * Student Assistance Programs
- * DWI/DUI Educational Programs

A. Service Population. The service population shall include, but is not limited to, persons who are at risk for substance abuse; families or friends, or both, of persons at risk for a substance abuse problem; school students and school officials; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, businesses, state and municipal governments and related community organizations; or, employers of persons at risk for a substance abuse problem.

B. Service Provision. Each provider conducting Problem Identification and Referral services shall develop a schedule of on-going, culturally relevant, age appropriate and structured activities appropriate to the defined Program Content. Such services shall meet the following standards:

1. Agencies/organizations/coalitions conducting Employee Assistance Programs shall provide relevant activities such as training and consultation, provision of written materials or other literature, group discussion and information about prevention or treatment resources to assist persons for whom alcohol, tobacco and other drug abuse may be interfering with their employment;
2. Providers of DUI/DWI educational programs must meet standards to be determined by the Division.
3. Agencies/organizations/coalitions conducting problem identification and referral services shall document coordination with other community resources providing prevention services.

V. Community Based Process Strategy

Community Based Process aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco, and other drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building and networking. Examples of activities conducted and methods used for this strategy include but are not limited to:

- * Accessing services and funding
- * Community Teams
- * Community Team Activities
- * Training
- * Technical Assistance

A. Service Population. The service population shall include, but is not limited to, persons at risk for substance abuse; community groups mobilizing to combat substance abuse, including civic and volunteer organizations; churches, schools, businesses, state and municipal governments and related community organizations.

B. Service Provision. Each provider shall conduct Community Based Process activities that are structured, that document specific services provided related to the defined Program Content, and that demonstrate community mobilization and community coordination. Agencies conducting Community Based Process services shall meet the following standards:

1. Structured community mobilization or community development services shall be based on current research, theory, and best practices; such services shall be for the purpose of meeting the defined program content and the intent of this Strategy.

2. Agencies/organization/coalitions providing community mobilization services shall develop policies and procedures for recruiting and training coalition or task force members.
3. Training shall be provided by a Qualified Prevention Specialist and shall reflect current prevention theory, research, and best practices, in particular as they pertain to community mobilization activities as described under this Strategy and in these standards.
4. Program records shall document the provision of at least an annual orientation for coalition members to maintain their knowledge of current prevention theory, research, and best practices, particularly as they pertain to community mobilization activities.
5. Coalitions shall develop and document an annual Program Plan that identifies the priority prevention activities and programs for that coalition;
6. Agencies/organizations/coalitions shall conduct and document evaluation of community mobilization activities based on their Program Plan, and shall include programs and activities undertaken including process and outcome measures for those programs and activities.
7. If appropriate, agencies/organizations/coalitions conducting community mobilization activities shall develop written policies and procedures relative to the recruiting and hiring of staff qualified in current community mobilization techniques and strategies.
8. Agencies/organizations/coalitions conducting prevention technical assistance services shall provide for the development, maintenance, and enhancement of the substance abuse related efforts of community organizations and individuals involved in substance abuse programming.
9. Agencies/organizations/coalitions conducting prevention technical assistance services shall provide services that are designed to increase the effectiveness of other change agents to influence individuals, families, schools and communities to make appropriate decisions regarding substance abuse.
10. Agencies/organizations/coalitions shall document all technical assistance contacts and activities according to record keeping requirements described in the Standards.
11. Agencies/organizations/coalitions conducting Community Based Process services shall document coordination with other community resources to conduct prevention activities in the community served.

VI. Environmental Strategy

The Environmental strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives.

Two sub-sets of this Strategy include Changing Institutional or Organizational Policies and Changing Law Enforcement and Regulatory Attention to ATOD use. Examples of activities conducted and methods used for this strategy shall include but are not limited to:

- * Environmental consultation to communities
- * Preventing underage sale of tobacco and tobacco products
- * Preventing underage alcoholic beverage sales
- * Establishing ATOD free policies
- * Changing environmental codes, ordinances, regulations, and legislation
- * Public policy efforts which may include:

Influencing enforcement of laws
Influencing legislation - federal, state and local level
Regulate liquor industry
Taxation initiatives

A. Service Population. The service population shall include, but is not limited to, persons at risk for substance abuse; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, schools, businesses, state and municipal governments, and related community and youth organizations;

B. Service Provision. Each agency/organizations/coalition conducting Environmental Services shall provide structured activities consistent with the defined Program Content and this Strategy. Providers of Environmental strategies shall meet the following standards:

1. Agencies/organizations/coalitions providing environmental consultation and resources to inform and advise ATOD policies in schools, businesses, and other community organizations shall reflect current research, theory and evidence-based, best practices.
2. Agencies/organizations/coalitions shall be equipped to provide technical assistance to community organizations or coalitions that have Environmental strategies within their Program Plans.
3. Agencies/organizations/coalitions providing services to educate or inform vendors of alcohol or tobacco products relative to sale of such to minors, shall provide documentation of the structure used to implement the educational program intended to reduce the sale of alcohol or tobacco products to underage youth.
4. Agencies/organizations/coalitions providing public policy campaigns intended to impact environmental efforts, shall develop such campaigns to reflect current prevention theory, research, and best practices.
5. Agencies/organizations/coalitions providing services under the Environmental Strategy shall document coordination of such services with other community prevention activities.

Early Intervention Program Operating Standards

Early Intervention services shall be provided for those youth and adults who may possess multiple risk factors for substance abuse and related problem behaviors. Early intervention program operating standards establish a minimum set of standards for the performance of services that are intended to work with high risk populations in need of concrete intervention to prevent experimentation with alcohol, tobacco and other drug abuse and/or to reduce or reverse multiple risk factors; Programs provided as Early Intervention Services include, but are not limited to: Student Assistance Programs; Before and After School Programs; Parent Skill Training Programs; and Drop-Out Prevention Programs. Agencies shall have the capability to provide and shall provide one or more of the following services

Student Assistance Programs

Agencies conducting Student Assistance Programs shall provide relevant activities such as training and consultation, provision of brochures or other literature, group discussion, and information about prevention or treatment resources, or other appropriate information for school age youth for whom substance abuse may be interfering with their school performance; services shall be included as appropriate for school faculty and administrators.

Before and After School Programs

Agencies conducting Before and After School Programs shall provide relevant activities such as training and consultation, provision of brochures or other literature, group discussion, and information about prevention or treatment resources, or other appropriate information for school age youth for whom substance abuse may be

interfering with their school performance; services shall be included as appropriate for school faculty and administrators.

Parent Skill Training

Agencies conducting Parent Skills Training shall utilize recognized training methods and curricula. Programming shall be culturally appropriate and provide parents with basic information about alcohol, tobacco and other drugs. Programming shall include but is not limited to activities such as: parenting classes; family communication skills; discipline strategies, and related activities.

Drop Out Prevention Programs

Agencies conducting Drop Out Prevention Programs shall utilize recognized and research-based approaches appropriate for the age and cultural background of program participants. Programs will offer a combination of individual and group counseling, family counseling, academic skill building, and behavior management with the overall goal of assisting youth who are at risk for school dropout to remain in school.

Other Evidence Based Early Intervention Strategies

Agencies may also conduct other Evidence Based Early Intervention Strategies that have been documented, through recognized research, to be a program or array of services that effectively impacts populations at high risk for alcohol, tobacco, and/or other drug abuse. Agency operating plans must document that early intervention programming is based on recognized research, best practices, and/or an evidence based model of programming. Recognized sources of evidence based early intervention programs for ATOD problems include, but are not limited to, the Substance Abuse and Mental Health Services Administration, the National Institute on Drug Abuse, the National Institute on Alcoholism and Alcohol Abuse, the National Institute on Mental Health

**APPENDIX A –SAMPLE PROGRAM ORIENTATION
AND SAMPLE FORMS**

SAMPLE PROGRAM ORIENTATION

Date: _____ Program Name: _____

Client Name _____ Client Number: _____

As a part of participating in this Treatment Program, it is important that you understand how the program operates and what is expected of you while you are in treatment here. To help you to get the most out of treatment, we will provide the following:

Program Rules

Insert agency specific rules here that include rights and conduct of clients, rules regarding admission, discharge, expulsion, and program expectations for clients admitted to treatment as well as Disciplinary Actions for failure to conform to Program Rules including but not limited to such situations as no shows for appointments, chronically late for appointments, drinking or being intoxicated on the premises, and other behaviors against Program Rules. These rules shall be signed by each client prior to or at the time of admission to treatment.

Primary Counselor

You will be assigned a Primary Counselor who will help you develop a Treatment Plan, and who will work with you to meet the goals of your plan.

Individual Counseling

You will have the opportunity to receive individual counseling sessions with your Primary Counselor.

Group Counseling

You may have the opportunity to join other clients who are working on issues or concerns similar to yours in group counseling sessions.

Significant Other/ Family Counseling

To help you establish or maintain good family relations family and/or couples counseling may be provided.

Ancillary Services

Depending upon your individual needs, you may be scheduled to participate in any of a variety of rehabilitative support services intended to help you in achieving and sustaining recovery from substance abuse. These services will be explained by your Primary Counselor and/or Case Manager.

Discharge Planning

When you have received maximum benefit from treatment, your Primary Counselor will work with you to process closure with the treatment received, review progress made, and to plan for continued sobriety/maintenance for the future. This can include relapse planning, safety plans, AA, identifying goals for the future, etc.

Aftercare/Continuing Care

To assist in preventing relapse, you and your Primary Counselor may feel it would be beneficial to schedule you for Aftercare Services.

Discharge Standards

Insert any applicable discharge standards not covered in the above categories.

Client Rights

Insert agency specific client rights in this section. Sample client rights include the following:

As a client of this agency, you have the right to:

1. confidentiality under federal and state laws relating to the receipt of services
2. be informed of the various steps and activities involved in received services
3. humane care and protection from harm, abuse and neglect.

4. make an informed decision whether to participate in the program or refuse participation.

Client Grievance Procedure Insert agency specific client grievance procedure. This must include the phone number for the all applicable state licensing boards. Sample client grievance procedure: If a client has a grievance with a staff member, or feels their rights have been violated, the client must speak with the Program Director regarding these situations and may be asked to put the complaint in writing. The Program Director will then determine if action should be taken. If the client believes the actions taken were not sufficient, you may contact the New Mexico Counseling and Therapy Practice Board at (505) 476-4606; the Board of Social Work Examiners at (505) 476-4890 or the Board of Psychologist Examiners at (505)476-4960.

Agency Responsibility To Report Abuse/Neglect By New Mexico law, this agency is required to report suspected child and elderly abuse and neglect. Elderly abuse is reported to the Division of Health Improvement, Incident Management Bureau and to CYFD. Suspected child abuse and neglect is reported to Child Protective Services.

Sample Individual Treatment Plan

Treatment Program: _____ **Date:** _____

Client: _____ **Update:** _____
Counselor: _____

Client ID No. _____ **Initial Assessment Date:** _____

DSM-IV Primary Diagnosis (Axis I): _____

ASI & Severity Ratings Profile

<u>Domain</u>	<u>Rating (0-9)</u>	<u>Problem Statement From ASI/Target Goal #(as per attached page)</u>
Medical	_____	_____
Employment/Support	_____	_____
Family/Social	_____	_____
Psychiatric	_____	_____
Interpersonal	_____	_____
Legal	_____	_____
Alcohol	_____	_____
Drug	_____	_____
ADL	_____	_____

Treatment Goals Page 2: Must be Initialed and Dated by client and counselor prior to final signatures on face page.

Problem Referred: _____

Problem Deferred: _____

Identified Client Reinforcers: _____

Client's Participation in Treatment Planning Process: _____

Other's Participation in Treatment Planning Process: _____

Client Signature _____ **Date** _____

Counselor Signature _____ **Date** _____

Reviewed by: _____ **Date** _____

Treatment Goals: Please Initial and Date- Client _____ Counselor _____

Target Problem #1: _____ **Domain:** _____

Goal: _____

Objective A: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Objective B: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Target Problem #2: _____ **Domain:** _____

Goal: _____

Objective A: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Objective B: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Target Date Resolution Date

Target Problem #3: _____ **Domain:** _____

Goal: _____

Objective A: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Objective B: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Target Problem #4: _____ **Domain:** _____

Goal: _____

Objective A: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Objective B: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Client Signature

Date

Counselor Signature

Date

Reviewed by:

Date

Sample Adolescent Individual Treatment Plan

Treatment Program _____ Date: _____

Client _____ Update: _____

Counselor _____

Client ID No. _____ Initial Assessment Date: _____

DSM-IV Primary Diagnosis: (optional) _____

MADAD & Severity Ratings Profile Ratings

Domain	Ratings (0-9)	Problem Statement from MADAD /Target Problem #(Page 2)
Medical	_____	_____
School	_____	_____
Employment	_____	_____
Social	_____	_____
Family	_____	_____
Psychological	_____	_____
Legal	_____	_____
Alcohol	_____	_____
Drug	_____	_____

Treatment Goals Page 2: Must be Initialed and Dated by client and counselor prior to final signatures on face page.

Problem Referred: _____

Problem Deferred: _____

Identified Client Reinforcers: _____

Client's Participation in Treatment Planning Process: _____

Other's Participation in Treatment Planning Process: _____

Client Signature _____ Date _____

Counselor Signature _____ Date _____

Reviewed by: _____ Date: _____

Treatment Goals: Please Initial and Date- Client _____ Counselor _____

Target Problem #1: _____ **Domain:** _____

Goal: _____

Objective A: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Objective B: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Target Problem #2: _____ **Domain:** _____

Goal: _____

Objective A: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Objective B: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Target Date Resolution Date

Target Problem #3: _____ **Domain:** _____

Goal: _____

Objective A: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Objective B: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Target Problem #4: _____ **Domain:** _____

Goal: _____

Objective A: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Objective B: _____

Target Date Resolution Date

Intervention #1: _____

Intervention #2: _____

Client Signature

Date

Counselor Signature

Date

Reviewed by:

Date

Treatment Plan Instructions

FACE SHEET:

1. **Client Identifying Information:** Enter the agency name, plan date, client name, primary counselor name, client identification number (provided by AMCI) and the initial assessment date (provided by AMCI). If this is an updated Individual Treatment Plan add the update date.
2. **DSM-IV Primary Diagnosis:** Review and indicate the diagnosis assigned by the AMCI assessor and any modifications that are appropriate.
3. **ASI or MADAD & Severity Ratings Profile:** Enter the Interviewers Severity Ratings Profile for each Domain from the Addiction Severity Index (ASI) or the Modified Adolescent Drug Abuse Diagnosis (MADAD). Write down the identified problems (or enter none if there are no problems in a domain) in the nine areas evaluated by AMCI in the ASI. Or MADAD. Identify the number of each target goal (on the Treatment Goals Pages) that will be worked on by your agency to resolve the problem identified in each domain by AMCI in the ASI or MADAD.
4. **Problems Referred:** Identify any problems in the nine domains evaluated by AMCI in the ASI that are not being addressed by your agency but are being referred to another agency for resolution. Identify who the problem was referred to.
5. **Problems Deferred:** Identify any problems in the nine domains evaluated by AMCI in the ASI or MADAD that are being delayed (for example: because other problems have to be resolved first) until later in the client's course of treatment with your agency.
6. **Identified Client Reinforcers:** Identify the positive reinforcements the client, agency, other interested participants have agreed to use to keep the client motivated to make the behavioral changes needed to resolve the targeted problems.
7. **Clients Participation in Treatment Planning Process:** What did the client contribute to make this treatment plan a collaborative process between the client, agency and other interested participants.
8. **Others Participation in Treatment Planning Process:** What did the other interested participants contribute to make this treatment plan a collaborative process between the client, agency and other interested participants.
9. **Contract Signatures:** The client and the primary counselor sign the treatment plan to indicate what the counselor and client agree to work on during the course of treatment. The clinical supervisor signs in the "reviewed by" space to certify that the treatment plan is clinically sound and that it can be realistically completed using the clinical expertise and treatment capabilities available within the agency.

TREATMENT GOAL PAGES (Modify as appropriate and use as many as needed to cover the treatment goals, client objectives, and agency interventions):

10. **Treatment Goals:** Client and Counselor initial to certify that both agree to the problem statements, treatment goals, client objectives, and agency interventions that follow.
11. **Target Problems:** List the major problems (identified in the ASI or MADAD) resulting from the client's use of alcohol and/or drugs that the client and agency agree to work on and assign a number.
12. **Domain:** Identify the ASI or MADAD domain of the specific target problems that will be worked on by your agency.
13. **Goal:** Identify to what degree the target problem will be resolved before the client is successful discharged from the program. (Describes how **to identify and measure** a successful treatment outcome for the client).
14. **Objective:** Write a statement of what the **client will do** to reach the identified goal.

15. **Intervention:** Write a statement of what services or actions the agency will provide to assist the client to obtain their objective.
16. **Target Date:** Specify a planned date by which the agency will provide the intervention.
17. **Resolution Date:** Enter the actual date when the client and agency both agree the agency intervention has accomplished the assistance the client needed to obtain their objective.

SAMPLE CASE MANAGEMENT SERVICES PLAN

Date: _____

The following Services are recommended for: _____.

Client name

SERVICES:

NOTES/SCHEDULE:

<input type="checkbox"/> Psychological Testing	<hr/>
<input type="checkbox"/> Psychological Consultation	<hr/>
<input type="checkbox"/> Referral for Psychiatric/Medical Evaluation	<hr/>
<input type="checkbox"/> Education Services	
<input type="checkbox"/> Technical/Vocation Institute	<hr/>
<input type="checkbox"/> GED Classes	<hr/>
<input type="checkbox"/> Tutoring/ESL	<hr/>
<input type="checkbox"/> Community College	<hr/>
<input type="checkbox"/> University	<hr/>
<input type="checkbox"/> Job Training	<hr/>
<input type="checkbox"/> NM Dept. of Labor	<hr/>
<input type="checkbox"/> JTPA	<hr/>
<input type="checkbox"/> Other	<hr/>
<input type="checkbox"/> Other	<hr/>
<input type="checkbox"/> Employment Services	
<input type="checkbox"/> Vocational Assessment	<hr/>
<input type="checkbox"/> Vocational Counseling	<hr/>
<input type="checkbox"/> Job Development	<hr/>
<input type="checkbox"/> Other	<hr/>
<input type="checkbox"/> Child Care	

<input type="checkbox"/>	Head Start	_____
<input type="checkbox"/>	Office of Child Development	_____
<input type="checkbox"/>	Other	_____
<input type="checkbox"/>	Housing Assistance	
<input type="checkbox"/>	Albuquerque Housing Services	_____
<input type="checkbox"/>	Homeless Shelter	_____
<input type="checkbox"/>	Shelter for Victims of Domestic Violence	_____
<input type="checkbox"/>	TANF/Medicaid Eligibility	_____
<input type="checkbox"/>	Transportation Assistance	_____
<input type="checkbox"/>	Albuquerque Transit Dept.	_____
<input type="checkbox"/>	Medical Services	_____
<input type="checkbox"/>	New Mexico Public Health Clinics	_____
<input type="checkbox"/>	Community-based Clinics	_____
<input type="checkbox"/>	Legal Services	_____
<input type="checkbox"/>	Other	_____

Comments:

Client Signature **Date**

Counselor Signature **Date**

Sample Discharge Plan

Client Name _____ DOB _____ ID# _____
Client Address _____ City/State/Zip _____
Program Name _____ Phone _____
Date of Admission _____ Date of Discharge _____ Counselor _____
Last Face-to-Face Contact: _____

Type of Treatment/Level of Care: ___ Outpatient (Level .5) ___ Outpatient (Level I)
___ Intensive Outpatient (Level II.I) ___ Day Treatment (Level II.5)
___ Outpatient Medication Maintenance (Level I) ___ OMM (Level II) – remove what we don't pay for

This plan is a road map to help you transition from active treatment to maintain your recovery. You and your counselor will work together to complete this plan prior to discharge.

Reason for Client Discharge

Presenting Problems: _____

Problems Addressed: _____

Agency Interventions: _____

Services Provided/Referrals Made/Case Management Provided:

Progress made during treatment: _____

Goals Met: _____

Client's level of participation _____

Continuing goals: _____

APPENDIX B

**ASAM PATIENT PLACEMENT CRITERIA
SECOND EDITION – REVISED**

See asam.gov for additional information

ASAM PATIENT PLACEMENT CRITERIA

Level 0.5 – Early Intervention

Early intervention is an organized service that may be delivered in a wide variety of settings. Early Intervention Services are designed to explore and address problems that appear to be related to substance use and to help the individual recognize the harmful consequences of inappropriate substance use.

Length of Service

Length of service at Level 0.5 varies according to: (a) an individual's ability to comprehend the information provided and use that information to make behavior changes and avoid problems related to substance use or (b) the appearance of new problems that require treatment at another level of care.

Level I – Outpatient Treatment

Level I encompasses organized outpatient treatment services, which may be delivered in a wide variety of settings. In Level I programs, addition treatment staff, including addiction-credentialed physicians, provide professionally directed evaluation, treatment and recovery services. Such services are provided in regularly scheduled sessions of (usually) fewer than nine contact hours a week. The services follow a defined set of policies and procedures or clinical protocols.

Level I services are tailored to each patient's level of clinical severity and are designed to help the patient achieve changes in his or her alcohol or other drug-using behaviors. Treatment thus must address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or to impair the individual's ability to cope with major life tasks without the non-medical use of substances.

Level I services are appropriate in several different situations:

- Level I may be the initial level of care for a patient whose severity of illness warrants this intensity of treatment. Such a patient should be able to complete professionally directed addiction treatment at this level, thus using only one level of care, unless (a) an unanticipated event causes a change in his or her level of functioning, leading to a reassessment of the appropriateness of this level of care, or (b) there is recurring evidence of the patient's inability to use this level of care (such as repeated episodes of drinking or non-medical drug use even after the treatment plan has been reviewed and revised).
- Level I may represent a "step down" from a more intensive level of care for a patient whose progress warrants such a transfer, assuming that he or she meets Level I placement criteria.
- Level I may be used for a patient who is in the early stages of change and who is not yet ready to commit to full recovery (Dimension 4 issues). For such a patient, placement in a more intensive level of care is apt to lead to increased conflict, passive compliance or even leaving treatment.

The relationship between the severity of illness and the intensity of treatment is more clearly seen in Dimensions 1, 2, and 3. On the other hand, increasing the intensity of services solely because of Dimension 4 issues may be counterproductive. An alternative approach is to use Level I services to engage the resistant individual in treatment. If this approach proves successful, the patient may no longer require a higher intensity of service, or may be able to better use such services.

Length of Service

Duration of treatment varies with the severity of an individual's illness and his or her response to treatment.

Co-Occurring Mental and Substance Related Disorders

Level I services are appropriate for clients with co-occurring mental and substance related disorders if:

- I. The clients' disorders are of *moderate severity* (dimension three is very stable or the patient is receiving concurrent mental health monitoring) and have responded to more intensive treatment services. The mental disorders have resolved to an extent that addiction treatment services are assessed as potentially beneficial. However, ongoing monitoring of the patient's mental status is required.
2. The clients' disorders are of *high severity* (dimension four indicates a high resistance to change but patient is stable in the other dimensions) and are persistent but have stabilized to such an extent that integrated mental health and addiction treatment services are assessed as potentially beneficial. Patients who have severe and persistent mental disorders may not have been able to achieve sobriety or to maintain abstinence for a significant period of time (months) in the past; nevertheless, they are appropriately placed at Level I because they need engagement strategies and intensive case management.

Level II - Intensive Outpatient Treatment/Partial Hospitalization

Level II encompasses intensive outpatient treatment services, which may be delivered in a wide variety of outpatient or partial hospitalization settings. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. For appropriately selected patients, Level II programs provide essential education and treatment services, and allow patients to apply their newly acquired skills in "real world" environments.

Level II programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services. They provide comprehensive biopsychosocial assessments and individualized treatment plans that are developed in consultation with the patient. Such plans include problem formulation, treatment goals and measurable treatment objectives. In addition, the programs have active affiliations with other levels of care and can help the patient access support services such as childcare, vocational training and transportation.

Beyond the essential services, many Level II programs provide psychopharmacological assessment and treatment and have the capacity to effectively treat patients who have complex co-occurring mental and substance-related disorders.

Some programs also can provide overnight housing for patients who have problems related to family environment or transportation but who do not need the supervision or 24-hour access to services afforded by a Level III program. Such structured day and evening treatment programs "unbundle" actual clinical treatment from "around the clock" supervised living environments that include overnight housing.

Increasingly, distinctions are made among various subtypes of Level II programs. Criteria are offered here for two variations: Intensive Outpatient (Level II.1) and Partial Hospitalization/Day Treatment (Level II.5) programs. However, only Level II.1 is a covered service in the City's treatment system.

Treatment Levels Within Level II

Level II.1: Intensive Outpatient Treatment. Intensive outpatient programs (IOPs) generally provide 9 or more hours of structured programming per week, consisting primarily of counseling and education about substance-related and mental health problems. The patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the patient is stable and requires only maintenance monitoring. (Services provided outside the primary program must be tightly coordinated.)

Intensive outpatient treatment differs from partial hospitalization (Level II.5) programs in the intensity of clinical services that are directly available. Specifically, most intensive outpatient programs have less capacity to effectively treat patients who have substantial unstable medical and psychiatric problems that do partial hospitalization programs.

Level II.5: Partial Hospitalization/Day Treatment Programs. Partial hospitalization programs generally feature 20 or more hours of clinically intensive programming per week, as specified in the patient's treatment plan. Level II.5 partial hospitalization/day treatment programs typically have direct access to psychiatric, medical and laboratory services, and thus are better able than Level II.1 programs to meet needs identified in Dimensions 1, 2, and 3 which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting.

Patients who meet Level III criteria in Dimensions 4, 5, or 6 and who otherwise would be placed in a Level III program may be considered for placement in a Level II.5 program if the patient resides in a facility that provides 24-hour support and structure and that limits access to alcohol and other drugs, such as a correctional facility or other licensed health care facility or a supervised living situation.

Length of Service

Duration of treatment varies with the severity of the patient's illness and his or her response to treatment.

Co-Occurring Mental and Substance-Related Disorders

The services of a Level II treatment program are appropriate for patients with co-occurring mental and substance-related disorders if the mental health and addiction treatment services are integrated into the intensive outpatient or partial hospitalization program. Such patients require active mental health services, which should be delivered through Level II.1 Dual Diagnosis Capable or Dual Diagnosis Enhanced Programs.

There are other levels of treatment modalities beyond what is defined in this document. Only those modalities accepted for funding through the City's substance abuse treatment system have been discussed here. Other modalities can be found in the ASAM Patient Placement Criteria, Second Edition-Revised.

Appendix C

PROCEDURES FOR APPLICATION FOR EXEMPTION TO THE MINIMUM STANDARDS FOR SUBSTANCE ABUSE TREATMENT AND PREVENTION SERVICES

From time to time, substance abuse treatment and prevention agencies may not be able to comply with a particular section of the Minimum Standards for Substance Abuse Treatment and Prevention Services. The City of Albuquerque, Department of Family and Community Services (City), Division of Behavioral Health (DBH), has developed procedures, described below, for programs to apply for an exemption to the specific section of the Standards that they are unable to meet.

Application for Exemption

Treatment programs wishing to request an exemption from a specific section of the Standards must complete the *Application for Exemption* form in as much detail as possible. *Applications for Exemption* will be reviewed and considered by the **Division of Behavioral Health**. In some instances, it may be requested that a representative of the applicant program provide additional information.

Exemption Decision

Following Division of Behavioral Health review, programs will be notified in writing of the City's decision concerning the requested exemption. All decisions are the purview of the City and are final. Exemptions granted are good for the current fiscal year. However, the City reserves the right to monitor and inspect programs to determine that exemptions are not interfering with appropriate client services. Should a determination be made that the exemption is interfering with quality service provision, the City reserves the right to rescind the exemption.

**APPLICATION FOR EXEMPTION
ALBUQUERQUE MINIMUM STANDARDS FOR
SUBSTANCE ABUSE TREATMENT AND PREVENTION SERVICES**

City of Albuquerque
Department of Family and Community Services
Division of Behavioral Health

P.O. Box 1293
Albuquerque, NM 87103
767-5838/Fax:767-5830

To the Division of Behavioral Health:

_____ is requesting an exemption from the
(Name of treatment program)
Albuquerque Minimum Standards for Substance Abuse Treatment and Prevention Services
relative to Section _____.
(Section # & page #)

**Please provide a detailed explanation of why the program is unable to comply with the Standards;
attach additional pages as needed.**

Our agency is unable to comply with this specific section of the Standards because:

As an alternative, our program intends to address the intent of the Standards as closely as possible by
(Please explain your alternative plans to address the intent of the Standards. Attach additional pages as needed)

If you have questions or need additional information, please contact: _____
(Name of Director)

Agency Address Phone # Date

Appendix D

PROGRAM DISCHARGE AND OUTCOME REPORTING

The City of Albuquerque collects data to determine the effectiveness of its voucher-based substance abuse program. The City has developed a Discharge and Outcomes Report Form to collect information on clients' outcomes using several indicators, including length of stay in treatment, arrests/criminal justice involvement, education, employment, housing, living conditions, primary health care, and discharge status. The initial data will be extracted from the ASI assessment completed at the beginning of a client's entry into the voucher-based substance abuse system. Thus, treatment providers will not have to collect initial outcome data. However, treatment provider agencies will be required to collect outcomes data at a client's Discharge from the program. The Discharge and Outcomes Report Form, which has been developed as an online web-based form, must be completed when billing for services at discharge.

1. A completed Discharge and Outcomes Report Form must be kept in the client's file to document the outcome report service billing.
2. The form should be completed by treatment staff with the client present, as part of a treatment session at DISCHARGE. If a client has completed his/her treatment program, the Discharge and Outcomes Report Form should be completed with the client present to obtain the best information possible from the client when the client is being discharged. However, if a client is being discharged because the client never showed up for services, dropped out, is incarcerated, or is deceased, the client's assigned counselor must complete the Discharge and Outcomes Report Form.
3. The Discharge Summary billing will be linked to the entry of the Discharge and Outcomes Report Form. When the form is completed, a link or reminder will "pop up" to prompt the user to enter the discharge service billing. If the form is not completed and entered, the billing for the discharge summary will not be accepted.
4. The form must be completed and entered by the 15th of the following month for vouchered clients that have been discharged in the previous calendar month. The data must be entered before 12:00 Midnight. The system will not allow for entry after midnight. Example: For the Outcome Report period for the month of July 2007, the data must be entered by 12:00 midnight on August 15th. Please plan accordingly.
5. A fee of \$5.00 will be paid for each discharge report form entered into the Web-based system.

**City of Albuquerque Voucher Program
FY09 DISCHARGE AND OUTCOMES REPORT FORM**

All sections of the Outcomes Report form must be completed.

Section 1: CLIENT & PROGRAM INFORMATION		
1. Client Name:	2. Client ID #:	3. Level of Care:
4. Name of Treatment Provider:	5. Name of Primary Counselor:	6. Date of Admission: (MM/DD/YYYY)
7. Date of Last Contact: (MM/DD/YYYY)	8. Report Completed By:	
This will be completed through the AMCI Service Entry Data	a. Treatment staff with client	<input type="checkbox"/>
	b. Treatment Staff Only	<input type="checkbox"/>

Section 2: DISCHARGE STATUS: Indicate the client's status for each indicator.

1. Date of Discharge: ____/____/____ (MM/DD/YYYY)

2. Identify the type of discharge (choose one only)

<input type="checkbox"/> a. Completed Treatment	<input type="checkbox"/> h. Non-compliance w/agency policies
<input type="checkbox"/> b. Court Ordered Treatment Sessions Completed	<input type="checkbox"/> i. Administrative discharge
<input type="checkbox"/> c. Voucher funds expended	<input type="checkbox"/> j. Incarcerated
<input type="checkbox"/> d. Voucher funds expended/Client still in treatment	<input type="checkbox"/> k. Deceased
<input type="checkbox"/> e. Terminated Services - Dropped Out	<input type="checkbox"/> l. Client received alternative funding
<input type="checkbox"/> f. Terminated Services - Lost Contact	<input type="checkbox"/> m. Client changed program or provider
<input type="checkbox"/> g. Client moved out of area	

3. Clinical Recommendations - The client has a need:
Code: 1=Yes 2 = No 3 = Not Applicable 4 = Unknown

a. For further treatment services?
If yes, describe: _____

b. For additional recovery support services?
If yes, describe: _____

c. The client is participating in an aftercare program? (aftercare means a client attends scheduled sessions following a formal discharge from treatment for the purpose of relapse prevention)
If yes, describe: _____

Section 3. Indicate the client's status for each outcome indicator.

Code: 1=YES 2=NO 3=Not Applicable 4=UNKNOWN

1. Arrest History/Criminal Justice Involvement

a. New Arrests/Criminal Involvement at time of discharge

2. Education Status

a. Enrolled in GED Program	<input type="checkbox"/>
b. Enrolled in Vocational or Education Program	<input type="checkbox"/>
c. Completed GED program	<input type="checkbox"/>
d. Completed Vocational or Education program	<input type="checkbox"/>

-
- 3. Employment Status
 - a. Full time
 - b. Part time
 - c. Unemployed
 - d. Not in labor force

 - 4. Housing Status
 - a. Homeless - no fixed address
 - b. Independent living - private dwelling home, self-supported or non-supervised group home
 - c. Lived in shared housing - temporary (friends, family)
 - d. Lived in a Controlled Environment (Jail, Residential Treatment Program, Detox Program, etc.)

 - 5. Living Conditions Status - Client is Living:
 - a. With Family (sexual partner and children)
 - b. With sexual partner alone
 - c. With children alone
 - d. With parents
 - e. Alone
 - f. With friends/relatives
 - g. Lived in a Controlled Environment

 - 6. Primary Health Care
 - a. Primary Care Provider
(Client has access to primary health care services)

Discharge and Outcomes Report Form
Instructions: Question by Question

Section 1: Client & Program Information (Questions 3 through 7, will be automatically entered by the AMCI Web-Based Data Collection System when either the client name or ID number is entered.)

1. Client's name
2. Client's identification number
3. Level of Care to which the client was admitted
4. Name of Treatment Agency
5. Name of Primary Counselor/Therapist
6. Date the client was admitted to your program
7. Date of the last face-to-face contact with the client.
8. At discharge, mark the appropriate box. Report is completed by:
 - a. Treatment Staff with Client, with the treatment staff asking the questions, **as part of a treatment session, with the client present.** (A maximum of 2 units of Individual Counseling can be billed to complete the form, in addition to the \$5.00 allocated to enter the discharge and outcomes data into the web-based data collection system.)
 - b. Treatment Staff Only, if the form is completed by treatment staff without the client being present. This would occur only when the agency has lost contact with the client for 30 days, and the client must be discharged. (A maximum of \$5.00 has been allocated to enter the discharge and outcomes data into the web-based data collection system.)

Section 2: Discharge Information (completed at time of discharge)

1. Date the client was discharged from your program. The Discharge and Outcomes Report Form must be completed within 30 days of the last face-to-face service provided or within 30 days from the last face-to-face client contact if the agency has lost contact with the client. The Discharge and Outcomes Report Form should also be completed when the client is leaving the system because of treatment completion.
2. Type of Discharge. Check the box that most appropriately describes the reason for the discharge.
 - a. Completed treatment. The client has successfully met required treatment goals and treatment sessions (as specified in the treatment plan), has a relapse prevention plan and/or aftercare plan, if applicable. The client may have been advised to continue in aftercare on a self pay or other payment basis.
 - b. Court ordered treatment sessions completed. The client has completed the required number of sessions (as per court order) and has met required court mandated treatment goals. The client has been advised to continue in treatment as further treatment is needed and voucher funds have not been expended.
 - c. Voucher funds expended. The client has expended the voucher funds available and is unable to self-pay even with a sliding fee scale. The agency has completed a discharge summary.
 - d. Voucher Funds Expended/Client Still in Treatment. The client has expended the voucher funds available, and the agency has completed a discharge summary, but the client continues to participate in treatment services and/or aftercare services.

- e. Terminated Services – Dropped Out. The client has voluntarily dropped out of treatment against the recommendation of the treatment counselor, and the agency has completed a discharge summary.
- f. Terminated Services – Lost Contact. The agency has lost contact with the client and has documented efforts to re-engage the client through phone calls or mailings and the agency has completed a discharge summary.
- g. Client moved out of area. Clients must be residents of Bernalillo County. The client has moved out of Bernalillo County and no longer qualifies for services. The agency has completed a discharge summary.
- h. Non-compliance with agency policies. The agency has discharged a client due to non-compliance with agency policies regarding treatment or program rules (threats or violence against staff, other clients, etc.), which have been documented within a completed discharge summary.
- i. Administrative Discharge. The client has been administratively discharged as the client has not accessed services for 30 days and the agency has not completed a discharge summary. The agency will be asked to complete a discharge summary.
- j. Incarcerated. The client is in jail or prison, and the agency has completed a discharge summary.
- k. Deceased. The client has died, and the agency has completed a discharge summary.
- l. Client received alternative funding. The client has secured funding for treatment services other than through the City of Albuquerque and client has decided to voluntarily leave treatment through the City’s system. An example is a client has received funds (Medicare, Medicaid) to enter an in-patient treatment program. The agency has completed a discharge summary.
- m. Client changed program or provider. The client has decided to seek treatment through another agency in the City’s voucher-based system other than the agency he/she was initially referred to. The original agency must release the client by completing a discharge summary form.

3. Clinical Recommendations – The client :

- a. Needs further treatment services? 1 – Yes, 2 - No, 3 - Not applicable, 4 - Unknown. If the answer is “Yes,” please provide a brief description of the services needed.
- b. Needs additional recovery support services? 1 – Yes, 2 - No, 3 - Not applicable, 4 - Unknown. If the answer is “Yes,” please provide a brief description of the recovery support services needed.
- c. Is participating in an aftercare program? (Aftercare participation means a client attends scheduled sessions following a formal discharge from treatment for the purpose of relapse prevention) 1 – Yes, 2 - No, 3 - Not applicable, 4 - Unknown. If the answer is “Yes,” please provide a brief description of the aftercare program.

Section 3. Starting FY09, outcome codes 3 = Not Applicable and 4 = Unknown will no longer be a valid answer for Discharge Type a, b, c, d, h, l, or m. Only Discharge Type e, f, g, j, or k, will ALLOW selection of outcome codes 3 = Not Applicable or 4 = Unknown.

For each of the outcome status indicators listed, enter the appropriate codes: 1= Yes, 2 = No, 3 = Not Applicable and 4 = Unknown

1. Arrest History/Criminal Justice Involvement:

a. The client has new arrests or criminal justice involvement while in treatment? This would include new probation or parole violations. Enter 1 for “yes” (if the client has new arrests or charges in the last 30 days); enter 2 for “no” (if the client does not have new arrests or charges in the last 30 days); 3 for “not applicable;” or 4 for “unknown.”

2. Education:

a. The client is enrolled in a GED program?

Enter 1 for “yes” if the client is enrolled in such a program; enter 2 if the client is not enrolled in a program; enter 3 if “not applicable;” or enter 4 if “unknown.”

b. The client is enrolled in a vocational or education program?

This would include enrollment for job skills training at places such as the State Department of Vocational Rehabilitation or attending technical-vocational programs offered at educational institutions such as Central New Mexico Community College. Enter 1 for “yes” if the client is enrolled in such a program; enter 2 if the client is not enrolled in a program; enter 3 if “not applicable;” or enter 4 if “unknown.”

c. The client completed a GED Program.

Enter 1 for “yes” if the client completed a GED program; enter 2 if the client did not complete a program; enter 3 if “not applicable;” or enter 4 if “unknown.”

d. The client completed a vocational or education program?

This includes completion of job skills training at places such as the State Department of Vocational Rehabilitation or completion of technical-vocational programs offered at educational institutions such as Central New Mexico Community College. Enter 1 for “yes” if the client has completed such a program; enter 2 if the client has not completed a program; enter 3 if “not applicable;” or enter 4 if “unknown.”

3. Employment:

a. Full time: Enter 1 for “yes” if the client is employed on a full time basis (35 hours or more per week, includes members of the uniformed services); enter 3 if “not applicable;” or enter 4 if “unknown.”

b. Part time: Enter 1 for “yes” if the client is employed on a part time basis (35 hours or less per week); enter 3 if “not applicable;” or enter 4 if “unknown.”

c. Unemployed: Enter 1 for “yes” if the client is not working full or part time but is looking for work during the past 30 days, or on layoff from a job; enter 3 if “not applicable;” or enter 4 if “unknown.”

d. Not in Labor Force: Enter 1 for “yes” if the client is not looking for work during the past 30 days, or a student, homemaker, disabled, retired, or an inmate of an institution; enter 3 if “not applicable;” or enter 4 if “unknown.”

4. Housing:

Self Supported -Independent Private dwelling means that the client lives in a house or apartment and is responsible for the rent or mortgage payment; “group home” means the client lives in a group setting but is responsible for his/her housing expenses. Check the most appropriate Housing Status for this client at the time of discharge.

5. Living Conditions:

Check the most appropriate Living Conditions status for this client at the time of discharge.

6. Primary Health Care:

Enter 1 for “yes” if the client has a primary health care provider and access to health care services through a clinic or primary health care setting and does not rely on hospital emergency room services; enter 2 for “no” if the client does not have a primary care provider and access to health care services through a clinic or primary health care setting and utilizes the hospital emergency room services for primary health care, or enter 4 if “unknown.”

APPENDIX E – MODEL PROGRAM CONTENT

The *Model Program Content* provides a description of the kind of substance abuse treatment services that justifies the use of City tax funds and ensures a range of comprehensive and culturally appropriate programs that can meet the needs of City of Albuquerque low income, as defined by HUD, residents for high quality substance abuse treatment.

Service Philosophy

All substance abuse treatment agencies contracting with the City of Albuquerque and participating in the City's voucher system should abide by the following service philosophies:

1. Services are based on current research and evidence demonstrating that the treatment approach is a sound, culturally appropriate, and age appropriate method for addressing substance abuse problems.
2. Programs provide all clients with access to a full range of habilitation and rehabilitation services according to a treatment plan that considers each client's individual needs.
3. Programs provide leadership in the substance abuse field by virtue of offering high quality services; being willing to participate in program evaluation activities, and putting forth a consistent effort to meet or exceed minimum requirements.

Basic Services Required

Agencies participating in the City's Substance Abuse Services System must, at a minimum, provide the following:

1. Initial Upfront Services - With the exception of Level 0.5 clients, all new clients coming into treatment need to receive frequent and concentrated services that includes individual counseling, appropriate group counseling and family (couples/marriage) counseling or family/parent education. As clients progress in treatment, varying frequencies of these services may be changed; however, in the beginning to engage clients in treatment, to have adequate contact to fully assess clients' needs, and to develop sufficiently comprehensive treatment plans, clients need to be seen more frequently in full sessions.

2. Length in Treatment - Research continues to document that the length of time clients remain in treatment is directly proportional to their overall success in achieving treatment goals and in achieving and maintaining sobriety/recovery. All programs should develop treatment plans that will engage clients in treatment for a minimum of 90 days or three months. For some clients/families, four to six months may be needed to sufficiently resolve the substance abusing and related negative behaviors and to develop or restore a positive family environment.

3. Family Services - All programs need to be able to provide a range of family interventions to assist clients (particularly adolescents and young adult clients) in being able to live in a functional family that can support their efforts to achieve and maintain sobriety/recovery. Programs need to be able to offer one or more of the following: family counseling, couples/marriage therapy, family/parent education. In many cases, clients and their family members will benefit from a combination of counseling and education programs.

4. Group Services – There are two types of groups that are funded by the City of Albuquerque: counseling groups and education groups. All funded programs need to offer a range of group counseling, that is appropriately within the scope of practice for the licensed staff members conducting the groups.

(a) **Counseling groups** are popular and sometimes cost effective way to provide treatment services. The two variations of counseling groups the City recognizes are group counseling and group therapy. Group counseling has preventive as well as remedial aims and the groups have a specific focus which may be educational, vocational, social, or personal. Group counseling tends to be growth oriented and the counselor's role is to facilitate interaction between group members. The counselor's goal is to assist members in establishing personal goals and to help them translate personal insight into concrete plans that involve taking action outside of the group. Group counseling focuses on specific topics to help develop skills for dealing with these goals and to take action on these personal insights. Skills that may apply would include anger management, grief resolution, or interpersonal communications; dealing with stress, or assertiveness. Group therapy is done by master level licensed therapists which focuses on dealing with past blocks to growth, treatment of mental illness, and historical trauma

(b) **Education groups** impart educational information, corrects inaccuracies in existing information, and motivates clients to make informed changes in their lives. Education groups can focus on specific topics, with the intent to provide information needed to develop specific skills, **which** could include substance abuse issues, parenting techniques, vocational/educational issues, and how to seek and maintain employment.

5. Alternative Activities - Clients with chronic substance abusing lifestyles often need to learn more productive uses of their time as well as how to live healthier lifestyles. Therefore, in addition to individual, group and family counseling, programs need to offer a variety of activities that can be experiential, educational, recreational, skill building, or offer just plain healthy fun. Programs are encouraged to be creative in offering such services as budgeting and homemaking classes, computer classes, ropes courses, exercise programs, nutrition classes, etc., that can help to structure clients' time, make treatment services more interesting, and develop needed skills. Alternative activities can be offered in both group and individual settings.

6. Case Management - All City funded treatment agencies must provide case management services for their clients, as clinically appropriate. As defined in the Albuquerque Minimum Treatment and Prevention Standards, typical case management services include such activities as helping clients to secure access to educational services, employment services, job training programs, health and welfare services and others based on the secondary needs identified in the client's initial assessment at AMCI and supplemented with other needs identified during their time in treatment. Case management services can be provided by a primary counselor, a nurse, or a position employed specifically to be a case manager.

Time spent for billing for services is NOT a case management function, nor are providing reports to the court for DWI or criminal justice clients, rescheduling appointments, or other administrative activities.

7. Drug Screening (Required effective FY08)- All City funded substance abuse treatment agencies need to conduct random drug screening monthly on clients in treatment. Programs will be required to develop policies and procedures (if not currently available) to conduct random screening.

APPENDIX F

ROLES AND RESPONSIBILITIES OF CLINICAL SUPERVISION IN SUBSTANCE ABUSE TREATMENT

As referenced throughout the Albuquerque Minimum Standards for Treatment and Prevention, Clinical Supervision is defined as “an individual, who by experience, training, and/or level of licensure is able to provide supervision to clinicians regarding the appropriate care and treatment of substance abuse clients”. Further, “supervision includes, but is not limited to: oversight of treatment plan construction; oversight of client progress notes and other written clinical records; and provision of consultation to assist treatment counselors in best working with their clients.” This includes signing the treatment plans, as well as monitoring and evaluating each of the tasks from the above definition. Clinical supervisors are key staff members that can contribute significantly to the overall quality of treatment provided. Supervision must include a balance of support, feedback, problem-solving, and instruction. The supervisor should serve as a stable source of support, encouragement, and direction in treatment planning, problem solving, and recordkeeping.²

Oversight of Treatment Planning - It is the role of a Clinical Supervisor to provide significant input into treatment plans and to help establish targets for behavior change. One of their primary functions is to keep the treatment focused on the treatment goals and how clients are going to reach those goals. This is done through regular consultation with each clinical counselor and regular review of treatment plans in client records. The purpose of having a qualified clinical supervisor is to provide oversight of the treatment process and to ensure that appropriate and adequate goals are being addressed for the client. The treatment plan guides the treatment process and having a trained objective clinical supervisor for guidance and collaboration is not only a standard operating procedure in the field, but also a New Mexico State requirement. **The supervisor will review and sign the treatment plan within two weeks of completion to ensure clinical oversight of the treatment process.**

Oversight of Client Progress Notes - Substance abuse clients often present multiple challenges to counselors, especially young counselors or those new to the field. A Clinical Supervisor who is not personally involved in administering the therapy provides objectivity and can help the counselor or therapist remain motivated, be more creative, and foster a positive attitude in working with a client population that can be difficult, resistant, and slow to progress. Through the regular review of client progress notes, Clinical Supervisors can identify and intervene with difficult clients and can ensure that the written record of client and counselor interactions is accurate and up-to-date. **The clinical supervisor will review the progress notes as clinically appropriate, and document that review to ensure clinical oversight of the treatment process via the client progress notes.**

Provision of Staff Consultation – Additionally, the role of the Clinical Supervisor is to problem-solve difficult cases with the counseling staff. This may be done in one-to-one discussions with a counselor or through staffings that conduct clinical reviews. A supervisor can help therapists sort through the complex issues that clients bring into treatment and can provide the structure, support, and encouragement to remain focused on the primary goals of treatment. **The clinical supervisor provides staff consultation and documents this consultation in a supervisor’s log, depending on the needs of the supervisee.** The preference for staff consultation is weekly, but at minimum bi-weekly, especially for new clinicians.

The City of Albuquerque has the following minimum requirements for clinical supervisors:

² National Institute on Drug Abuse Publications. 2003.

1. Review and sign the individualized treatment plan within two weeks of completion to ensure clinical oversight of the treatment process.
2. Read and review the progress notes and document, as appropriate.
3. Provide staff consultation biweekly at minimum for non-licensed staff.

Clinical Supervision is required for all counselors who are not independently licensed. The LADAC licensure is considered an independent substance abuse treatment licensure. It is recommended that clinical supervision through staff consultation and peer consultation occur with all counselors.

Provider agencies must ensure program policies and procedures address the need for clinical supervision, identify who will provide the supervision, and define how clinical supervision will occur.

Any person providing clinical supervision must meet, at minimum, the requirements of New Mexico Counseling and Therapy Practice, Part 19. However, the preference is in addition to the state licensure requirements, supervision received by all alcohol and/or drug abuse practitioners (such as LPC, LMHC, LMSW, etc.) must be provided by masters or higher level licensed professionals such as: a licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), licensed professional art therapist (LPAT), licensed psychiatrist, licensed clinical psychologist, or licensed independent social worker (LISW) with two years of clinically supervised experience in substance abuse plus two years of practice at their current licensure level. In addition, the City requires all clinical supervisors to participate in any City sponsored clinical supervision training.

Appendix G

Treatment Subsidy Voucher System Description

Process Description

I. Issuance and authorization of treatment vouchers

The identification of clients who are eligible for treatment subsidies is part of the standard assessment process at Albuquerque Metro Central Intake (AMCI). Clients who are determined to be financially eligible (*refer to Attachment 5*) for subsidies will have treatment vouchers created for them with an active life of one-year (365 days) by the referring AMCI counselor. ***The creation of a treatment voucher is not a guarantee of payment for services up to the full voucher value. It is only a commitment on the part of the City of Albuquerque to pay for services up to that maximum while funding is available and the client remains eligible.*** If at any point during the fiscal year funds for that year – or for the current quarter, if the fund is allocated quarterly – are exhausted, all subsidies will end for that year or quarter, *irrespective of the existence of vouchers that still retain value.* When the next fiscal period begins, whether a year or a quarter, and new money is allocated to the funding pool, vouchers that have not expired and are not fully expended will again be chargeable for services, but only for services rendered after the beginning of the new fiscal period.

Vouchers are created and information regarding use and value are forwarded to participating treatment providers in the following manner:

- 1) The Assessment Counselor at AMCI conducting the client's assessment determines eligibility and creates a computer record of the treatment voucher based on the determined level of need, including client identification, voucher type and value (*Exhibit A*), and effective and expiration dates for the voucher. All vouchers are valid for **365 days** from the date of assessment. *The voucher is not available for billing until **electronic** notification of client admission to a participating provider's program is received at AMCI.*
- 2) A release of information form, signed by the client, is faxed to the provider. The provider must have a secure fax, in accordance with 45 CFR164.530(c), to receive the release of information form.
- 3) Upon receipt of online client admission from the provider, the computerized voucher record becomes available for use *by the provider to which the client was admitted.*

II. Submission of charges for payment against treatment vouchers

Payments to providers are calculated on a service-by-service basis, using a standardized rate schedule. The services allowable are determined by the particular type of voucher that has been issued for the client and by the services offered by the submitting provider. Individual services are restricted to defined minimum and maximum time limits, and some services, such as group therapy, have other restrictions imposed on them. *Exhibit A* provides a detailed account of the voucher and service types, rate schedule and restrictions that are in effect for the voucher program.

Two methods of submitting charges for payment are available to providers, 1) electronic submission on-line from the provider's facility, (*refer to Attachment 4*) or 2) submission at AMCI. Upon request, providers will be given copies of the 'Treatment Services Form' (*Attachment 1*) that is designed to capture

the information necessary for accurate electronic entry of services. The process of submitting services follows one of two paths:

On-line submission

- 1) A member of the provider's staff who has been assigned a network User ID and password connects to AMCI's Web-based Client System via the Internet.
- 2) Using the *AMCI Web-based Client System*, the staff member logs on the voucher service entry screen. Only names of clients admitted to the users' facility and holding an authorized voucher will appear on the screen.
- 3) Working from her/his own records, the staff member enters service information for vouchered clients under the agency's care. The service entry software will only allow submission of services that meet the following criteria:
 - a) The date of service must fall between the effective and expiration dates of the voucher;
 - b) The type of service must be one of those authorized for the particular type of voucher that was issued and must be recognized as being offered by the submitting provider;
 - c) The duration of the service must fall within the limits specified for that service type;
 - d) The value of the service must be less than or equal to the remaining value of the voucher. (Gross receipts taxes will be calculated and included in the value of the service for those providers who pay such taxes)
 - e) AMCI has instituted service entry periods of two weeks in length. During those two weeks all services that can be entered for those two weeks, must be entered for those two weeks. There is a 3-business day "grace" period after the close of a 2-week period, in which providers may enter services for the preceding two week period. The provider must enter billable services during the two-week period or the 3-day grace period after the two week period, or they will not be able to enter those services at all. The two week periods follow one right after the other.

The service entry screen (*Attachment 2*) displays general information about the voucher chosen, including effective and expiration dates and remaining voucher value. The value remaining is automatically updated as new charges are entered. The voucher interface also allows the user to review services that have been submitted but not yet invoiced (*see section III*) and to edit information in those services, if needed.

- 4) The staff member exits the *AMCI Web-Based Client System* and terminates her/his dial-up connection, VPN connection or terminal services session.

Paper submission

- 1) Client services are recorded on paper by the provider using service descriptions and time limits as specified in *Exhibit A*.
- 2) On a day designated for invoice generation (*see section III*), or another day scheduled with AMCI, a representative of the provider visits AMCI with the completed service form(s) and, using one of AMCI computers and with the assistance of MIS staff, enters the services according to the process described above in 'On-line submission'. *AMCI staff will not enter services for providers.*

IMPORTANT NOTE: Any service allowed into the *Client System* **will** be subsidized. The total funds available for subsidies are decremented *as services are entered into the automated system*. It is important, therefore, that providers stay as current as possible with service entry, since the only way that significant non-payment can occur is if a provider allows a backlog of services to accumulate and then discovers when trying to enter these services that funds for that year (or quarter) are exhausted. If this occurs, *there is no recourse; these services will not be subsidized*.

III. Invoicing and payment for services

Invoices for services covered by treatment vouchers are generated every two weeks at AMCI and then submitted to the City of Albuquerque for payment. The process is:

- 1) Every other Sunday is designated as a 'start' day that initiates an invoice cycle. All valid, uninvoiced services rendered **prior to** the current start day are included on an invoice.
- 2) On the first Thursday after the start day, representatives of each provider needing an invoice come to AMCI. No appointment or notification is necessary if the visit is on the designated day, and it can be anytime between 8:00am and 4:00pm. At AMCI they – with the assistance of AMCI staff – review invoice eligible services already entered into the system, and enter new services. Once they are certain that the services entered into the data system are correct, they request that an invoice be printed.
- 3) An individual invoice for each provider is then generated and signed by the providers' representatives. *Providers cannot generate their own invoices; only AMCI staff can do so*. Services performed on or after the start day for the invoice period are not invoiced until the next invoice period. For example:
 - a) April 10, 2003 ends an invoice period. April 11th, 2003 starts the next one.
 - b) April 15th is the day on which invoices are printed.
 - c) A service rendered on April 9th or 10th and entered into the voucher system prior to the printing of the invoice on the 15th **will** show up on the invoice.
 - d) A service rendered on April 11th or 12th and entered into the voucher system prior to the printing of the invoice on the 15th **will not** show up on the invoice. It will appear on the first invoice requested after April 24th.
- 4) At the end of the day, all generated invoices are forwarded to the City of Albuquerque. The City mails checks or direct deposits the invoiced amounts directly to the providers.
- 5) The City periodically conducts a billing review. All undocumented/incorrectly documented, but paid services must be reimbursed to the City.

Once a service has been invoiced, its computerized image is fixed and cannot be modified. An invoiced service no longer appears within the context of the service entry screens, but the contents of previously printed invoices can be accessed through the screens that are used to generate invoices. A calendar of invoice days for the current fiscal year will be distributed to all participating providers.

IV. Voucher closure/expiration and subsidy shortfalls

Vouchers are in effect for 365 days from the date of assessment, when client eligibility is determined. If at the end of this period all subsidy funds have not been expended and the client is still in treatment, a client may – on a case-by-case basis – receive a time extension on the voucher's expiration date. No

request for additional funding will be accepted or approved during the course of the client's treatment. If the client presents to AMCI for another assessment *subsequent to* the expiration of a previous voucher, voucher eligibility may be reconsidered, but this will also be on a case-by-case basis.

The one way in which a client can be made eligible for more money than was originally granted is for the client's voucher to be upgraded to a type that includes a greater variety of services and a higher total value. Thus a client who initially received an *Outpatient (I)* voucher, valued at \$2,600, might subsequently be deemed in need of more intensive services, and the voucher upgraded to *Outpatient with Intensive Services (II.1)*, worth \$3,200. This latter value – \$3,200 – is the maximum value for which an individual client can be vouchered within any treatment episode, and it is available **only** with a voucher that includes intensive services. The upgrade process requires a clinical review of the client's circumstances by either AMCI staff or a designated Utilization Review person/board, and documentation in the client's chart as to the rationale for the upgrade and the outcome of the process.

The only circumstances that would necessitate the closure of a voucher prior to its 365-day life are:

- 1) A change in the client's residence, moving her/him outside metropolitan Albuquerque.
- 2) The death of the client.

Providers are responsible for notifying AMCI when either of the above occurs. In addition, providers are required by their contracts with the City to communicate discharge/separation information to AMCI via the *Web Client System*. Failure to provide this information constitutes non-compliance with the contract and could be grounds for contract termination. Clients cannot receive subsidies for the same type of treatment from more than one provider at a time, so separation information is necessary if a client is being re-referred and the new provider is expecting the client to be subsidized. Separation information is also essential if AMCI and the provider network are to accomplish the goal of capturing accurate descriptive data – length of stay, treatment completion rates, circumstances at discharge, etc. – regarding the substance abuse treatment setting in Albuquerque.

Discharge information will be collected via the *Web Client System* on the final Outcomes Reporting Form (see Attachment 3, Section 3.A.: Outcome Status at Discharge and Section 3.B.).

Because the voucher program operates with limited money while the need for subsidized treatment is great, it is unlikely that each year's subsidy fund will cover all services provided to all qualified clients. In order to reduce the impact of funding shortfalls on providers, subsidy funds will be allocated on a quarterly basis during the fiscal year (July 1 to June 30), one-fourth being made available July 1st, one-fourth added in on October 1st, and so on. If the quarterly allotment is exhausted prior to the end of the quarter *service subsidies will stop* until the new quarter begins and a new allotment is added. At that point services rendered *after the beginning of the new quarter* can be entered and subsidized. Services that the *Client System* does not allow at the end of any quarter will not be subsidized. This approach to fund allocation may produce a brief period of non-payment at the end of each quarter, but it will guarantee that funding is available in all four quarters, and that there is no long, disruptive interruption of subsidies in the last months of the fiscal year.

Appendix H

Computerized Voucher System Technical Information

The voucher system is designed as a web based application, using Microsoft SQL Server (running on a server at AMCI), Microsoft IIS Server, and ASP.Net. The ASI system is designed as a client/server database application, using both Microsoft Access (on the user's PC) and SQL Server as the main database. The forms (screens) and programs that provide access to the client data are written in Visual Basic .Net for the voucher system and Visual Basic 6 for the ASI system.

Providers may access the ASI by using the AMCI Web Client System. In order to do this, the provider must log in to the system at <https://amci.unm.edu/clientsystem>. Once logged into the system, the user must select a client. After a client has been selected, the ASI Reports link will become active. This link is located on the left side of the screen under the section titled reports.

The Web Client System also allows providers to enter services over the Internet. Providers must be running Internet Explorer version 5.5 or higher and have an Internet connection to access this system. They have a password and user name given to them by AMCI that allows providers to access this information.

The client information that is created as part of the voucher system will at first reside exclusively on the servers at AMCI, in a SQL Server database. The data in the ASI also originates at AMCI and resides there. Providers have access to confidential information about only their own clients, or clients that have been referred to them. AMCI technical staff are also happy to act in a consultative role regarding questions about the use of client data, ASI or about computer-related issues in general.