BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Substance Abuse - Outpatient
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Local Definition

Substance Abuse- Outpatient services are medical or other treatment and/or counseling services provided to clients to address substance use disorders (SUDs) (i.e. recurrent use of alcohol, opiates, stimulants, or other controlled or uncontrolled substances causing clinically significant distress or clinically significant impairment in physical, social or occupational functioning. . These services will be provided by appropriately credentialed and/or licensed treatment professionals. Substance Abuse-Outpatient Care includes individual and group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, medication-assisted treatment (MAT), trauma informed care and treatment and/or other evidence-based treatment services.

II. Key Service Components & Activities

In addition to the Substance Abuse - Outpatient Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of Substance Abuse - Outpatient services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Service Components

Outpatient Care

Outpatient Substance Abuse Care is provided to ameliorate negative symptoms from SUDs and to restore effective functioning in persons diagnosed with substance-use dependency or addiction. Outpatient Care is appropriate as an initial level of care for clients with less severe disorders; for

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

those who are in early stages of change, as a "step down" from more intensive services; or for those who are stable and for whom ongoing monitoring or disease management is appropriate. Outpatient Care is provided less than 9 hours weekly.

Intensive Outpatient Services

Intensive outpatient services for clients with SUDs provide essential addiction education and treatment components and have gradations of intensity. At a minimum, intensive outpatient services provides a support system including medical, psychologic, psychiatric, laboratory, and toxicology services within 24 hours via telehealth or within 72 hours in-person. Intensive Outpatient Services is provided from 9 – 19 hours weekly.

Day Treatment

Day treatment services differ from intensive outpatient services in the intensity of clinical services that are directly provided. Day treatment is appropriate for clients who are living with unstable medical and psychiatric conditions. Day treatment, at a minimum, meets the same treatment goals as described in *Intensive Outpatient Services*, with psychiatric and other medical consultation services available within 8 hours via telehealth or within 48 hours in- person. Day treatment services must be continuously provided at a minimum from 9:00a.m. until 10p.m. during a single 24-hour period.

Discharge

Clients will be discharged from an outpatient, intensive outpatient, or day treatment program if they meet any of the following criteria:

- Successful completion of the treatment program
- Client failure to adjust to or benefit from the treatment program, after an adequate period of transition
- Lack of continuous client cooperation or participation or evidence of disruptive hostile behavior
- Violation of a major rule or evidence of ongoing rule-breaking behavior.

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary substance abuse disorder.	1.1. 85% of clients achieve treatment plan goals by designated target date.	1.1.1. Treatment plan documented in HIV MIS.
2. Increase and/or maintain retention in primary medical care. *Retention in care reflects a primary care visit with a provider in the first 6 months and the last 6 months of a 12-month measurement period.*	2.1. 85% of clients are retained in primary medical care.	2.1.1. Client appointment record in designated HIV MIS.

IV. Assessment and Treatment Plan

Assessment

Prior to the development of a treatment plan, providers must conduct a biopsychosocial assessment of the client's mental health status, substance use concerns, functional capacity, strengths, and service needs. The biopsychosocial assessment must be reviewed and signed by a licensed practitioner.

Treatment Plan

Providers must work with each client to develop a detailed treatment plan that directly addresses the primary diagnosis(es) that is(are) consistent with the biopsychosocial assessment. The treatment plan must be an individualized, structured, and goal-oriented schedule of services with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed practitioner and the client.

Treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- Modality of treatment to be provided
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month in duration treatment plan (e.g., four units of therapeutic behavioral on-

site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed provider
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identifies the client's readiness to transition to a new level of care or out of care)

Treatment Plan Review

A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than every six months when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed practitioner and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed practitioner who participated in the review of the plan
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. Substance Abuse - Outpatient Service Delivery Standards

Standard	Measure
1. Client is asked to give express and informed consent for treatment.	1.1. Signed informed consent form in the client file.
2. Provider conducts a biopsychosocial assessment with each client prior to the development of a treatment plan within three treatment sessions.	2.1. Completed biopsychosocial assessment signed by licensed practitioner in the designated HIV MIS.
3. Provider works with each client to develop a detailed treatment plan.	3.1. Treatment plan signed and dated by licensed practitioner and client in the designated HIV MIS.
4. Provider conducts a formal treatment plan review at least every six months.	4.1. Updated treatment plan with signature and date of licensed practitioner and client in the client file.
5. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	5.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the client file.
6. All client communication is documented in client file and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	6.1. Detailed documentation with provider signature of all client communication in the client file.
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the client file.