Substance Use Outpatient Treatment Tool

SA Outpatient 01 (65D-30.004(1)) Does the provider maintain written operating procedures that describe outpatient services, the population served, and clinical and administrative practices?

SA Outpatient 02 ((65D-30.0046(1))) Do staff records demonstrate completion of required training within applicable timeframes and compliance with ongoing training requirements, including infection control, verbal de-escalation (if applicable), medication self-administration supervision (if applicable), overdose prevention, and Naloxone education and use?

SA Outpatient 03 (65D-30.0042(1)(a)) Does the chart contain a completed screening prior to admission, or an assessment completed at admission, documenting service needs, eligibility for placement, the rationale for the action taken, and the validated tool used for service determination?

SA Outpatient 04 (65D-30.0042(1)(d)) Does the chart include a signed consent for services completed prior to or upon placement, except in cases of involuntary placement?

SA Outpatient 05 (65D-30.004(18)) Do release of information forms contain all required consent elements, including the recipient, purpose, scope of disclosure, expiration date, revocation statement, and required signatures?

SA Outpatient 06 (65D-30.0042(1)(b)) When drug screening is conducted, does the chart include documented informed consent?

SA Outpatient 07 (65D-30.0043(3)(b)) Does the chart include documentation that orientation was completed at admission and that the individual acknowledged receipt of all required program information?

SA Outpatient 08 (65D-30.004(20)) When applicable, does the clinical record demonstrate that telehealth services were provided in accordance with provider telehealth policies and Rule 65D-30.004(20)?

SA Outpatient 09 (65D-30.0042(2)(b)) Does the chart include a psychosocial assessment completed within 30 calendar days of placement that contains the required assessment elements, a clinical summary, documentation of placement determination using a validated tool, documentation supporting the appropriateness of the level of care, and required signatures and countersignatures?

SA Outpatient 10 (65D-30.0042(2)(a)(2)(c)) Does the chart include a medical history completed within 30 calendar days prior to or upon placement, maintained in the clinical record, and updated annually when the individual remains in treatment for more than one year?

SA Outpatient 11 (65D-30.0042(2)(a)) Does the assessment include a physical health assessment?

SA Outpatient 12 (65D-30.0042(2)(b)(1)(n); 65D-30.0043(2)) Does the chart document a placement determination using a validated tool and support the appropriateness of the assigned level of care?

SA Outpatient 13 (65D-30.0042(2)(c)) Does the clinical record demonstrate that mental health and other identified needs were accommodated through services or referral, as appropriate?

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SA Outpatient 14 (65D-30.0044(1)(a)(6)) Is an individualized treatment plan completed prior to or within thirty (30) calendar days of placement?

SA Outpatient 15 (65D-30.0044(1)(a)) Does the treatment plan include measurable goals, objectives, tasks, the type and frequency of services to be provided, and expected completion dates?

SA Outpatient 16 (65D-30.0044(1)(a)) Does the treatment plan include the required signatures and dates, including a Qualified Professional countersignature and date within ten (10) calendar days when required?

SA Outpatient 17 (65D-30.0044(1)(b)) Is the initial treatment plan review completed with the individual and signed and dated by the individual within 30 calendar days of completion of the treatment plan?

SA Outpatient 18 (65D-30.0044(1)(b)) If the treatment plan review was not completed by a Qualified Professional, was it countersigned and dated by a Qualified Professional within five (5) calendar days?

SA Outpatient 19 (65D-30.0044(1)(a)(8)) When a change in level of care occurs, does the clinical record document a treatment plan review or treatment plan update?

SA Outpatient 20 (65D-30.0044(1)(c)) Does the chart include progress notes documenting the individual's progress or lack of progress toward treatment plan goals and objectives, with required signatures, dates, and credentials?

SA Outpatient 21 (65D-30.0044(1)(c)(3)) Are progress notes recorded at least weekly or, when services occur less frequently, according to the frequency of sessions?

SA Outpatient 22 (65D-30.0044(2)) Does the clinical record demonstrate that services provided are consistent with the treatment plan, including identified goals, service types, and frequencies?

SA Outpatient 23 (65D-30.0044(2)) When needed services are not provided directly, does the clinical record document referrals, linkage to services, follow-up on referrals, and whether linkage occurred or efforts were made to confirm linkage?

SA Outpatient 24 (65D-30.004(19)) When applicable, do recovery residence referrals include documentation that the recovery residence was certified and that certification was verified prior to referral?

SA Outpatient 25 (65D-30.0044(4)(a)) If the individual completes services or leaves prior to completion, does the chart include a discharge summary completed within fifteen (15) business days that includes a summary of the individual's involvement in services, the reasons for discharge, and referrals to needed aftercare and other services, and is it signed and dated by the primary counselor?

SA Outpatient 26 (65D-30.0044(4)(b)) For individuals transferred from one component to another within the same provider, is a transfer summary completed immediately, documenting the circumstances of the transfer, and signed and dated by the primary counselor within fifteen (15) days?

SA Outpatient 27 (65D-30.0044(4)(b)) For individuals transferred from one provider to another, is a transfer summary completed within five (5) calendar days, documenting the circumstances of the transfer, and signed and dated by the primary counselor within fifteen (15) days?

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SA Outpatient 28 (65D-30.004(22)) 65D-30.004(22) Does the provider maintain an overdose prevention plan and can staff demonstrate working knowledge of the plan?

SA Outpatient 29 (65D-30.004(22)(c)-(d)) Does the clinical record document that overdose prevention information was provided at admission and offered to individuals placed on a waitlist, when applicable?