

Policy and Procedure

Manual

**Policy and Procedure Review\_\_\_\_**

By signing below, I certify that the policy and procedure manual has been reviewed in whole on this date:

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**Table of Contents**

**Policy Page**

Organization Description/History 6/7

Incident Reports/Critical Incidents 8/9

Staffing Patterns 10

Public Education 11

Strategic Planning 12

Medical Director 13

Nursing Supervisor 14

Evacuation Plan 15

Tracking of Medical/Professional Licenses 16

Blank 17

Rights of Patients 18/19/20

Grievance Procedure 21/22

Abuse and Neglect of Child or Elderly 23

Restricted Area Closure Policy 24

Safe Door Combination Policy 25

Restricted Area Alarm Policy 26

Fire Drills/Extinguishers 27

Panic Buttons 28

Cleanliness of Environment 29

Depositing payments 30

Mail 31

Filing 32

Petty Cash 33

Supply Orders 34

Consent for Information Requests 35

Payroll Processing 36

Clinical Director and/or Supervisor 37

Policy and Procedure Manual 38

Protection of Privacy 39

Credential/Licensure Verification 40

Legal Requirements 41/42

Blank 43

Accessing Personal Information in the Event of an Emergency 44

Content of Treatment Records 45/46/47

Content of Written Consents 48

Securing, Retention and Destruction of Records 49

Input from Patients and other Stockholders 50

Weapons 51

Internet Access 52

Illegal drugs, legal drugs and medication 53

Fiscal Policies 54

Documentation 55

Health Services/Counseling Services 56

Admission Process/Criteria 57/58

Bio-psychosocial Assessment (Admission), Updates 59/60

Patient Handbook 61

Assignment of Primary Counselor 62

Patient Consultation 63

Progress Notes 64

Treatment Plans 65/66

Needs Assessment/Behavioral Contract 67

Contact Sheets 68

Group Attendance 69

Aftercare/Continuing Care Plan/Transition Plan 70

Discharge Summary 71

Post-treatment Follow-up 72

Clinical Supervision 73

Audits/Clinical Review of Records of Patients 74/75

Crisis Intervention/Referral Services 76

Waiting List 77

Performance Improvement Plan 78

Audits 79

Meeting Minutes 80

Telephone Inquiries Regarding Program 81

Intake Scheduling 82/83

Informed Consent 84/85

Consent for Treatment w/ approved Narcotic Drug 86

Admission to Detoxification Protocol 87

Temporary Transfer 88/89

Take-home Medication 90/91/92

Vacation Take-home Medication 93

Fraudulently Obtaining a Controlled Substance 94

Request for Dose Change 95

Continued Drug Use 96

Reinstatement of Take-home Privileges 97/98

Copies of Patient Information 99

Subpoenas, Search Warrants, Investigations and other actions 100/101/102

Chart Review by the Patient 103

Take-home Medication Call Back 104

Seclusion and Restraint 105

Medically Supervised Withdrawal 106

Against Medical Advice Withdrawal 107

Criteria for Possible Discharge/Admn. Detox 108

State Registration, Dual-Enrollment 109

Initial Inventory 110

Biennial Inventory 111

DEA 222 Forms 112

Methadone Reconstitution 113/114

Emergency Supply of Methadone 115

Destruction of Methadone 116

Medical Services 117

Laboratory Testing 118

Urine Drug Screens 119/120

Blank 121

HIV Testing 122

Physical Exams 123/124

Physician Orders 125

Medical Records 126

Prescribed Medications 127

Compliance Handling Medication 128

Methadone Received via Pharmacist 129

Opening/Closing of Nurses Station 130

Medication Dispensing 131

Stored Narcotic Medication 132

Theft, Loss or Spillage 133

Manual Dosing 134

Vomiting after Medication Administration 135

Impaired Patients 136

Car Dosing 137

Required Reports 138

Prescriptions 139

Medication Use 140

Admission to Medication Replacement Treatment 141

Readmission to CTR 142/143

Transfer of Patients to CTR 144

Transfer to another Facility from CTR, Temp. or Perm. 145

Courtesy Dosing at CTR 146

Withdrawal from Methadone 147

Clinic Closing Due to Inclement Weather 148

Program Policy Variation 149

Ordering Supplies 150

Interim Maintenance Program 151

Holiday Take-home Medication 152

Non-return of Take-home Bottles 153

Delivery of Methadone to Persons Home/Residential Facility 154

Pregnancy Guidelines 155

Split Dosing 156

RIBHOLD 157

Co-Occurring Disorder 158

Theft or Loss of Take-home medication 159

Patient Unsafe Behavior Assessment 160

Benzodiazipine Policy 161/162

Performance Measurement and Management 163

Prescription Monitoring Program (PMP) 164

Peaceful Coexistence 165

Overdose Education & Administration

Of Narcan 166/167

**Health Home Program**

Program Description 168/169

Program Team Composition 170

Program Eligibility 171

Program Outcome Goals 172

Program CMS Core Measures 173

Chronic Disease Management 174

Program Coordination of Care

For Individuals with Chronic Conditions 175

Program Assessment of Quality Improvements

And Clinical Outcomes 176

Billing and Coding 177

Program Provider Standards 178-181

Program Depression Screening 182

Program Plan of Care 183-184

Program Transfers 185-187

Blank 188

Program Documentation 189

Serviced offered Education/Training 190

Team Meetings 191

**Infection Control**

Handwashing 192

Testing for TB – Patients 193

One-Way Air Valve Face Masks 194

Gloves 195

Care of Patients with AIDS/HIV 196

Precautions in Handling Blood and/or Body Fluids 197

Needlestick/Exposure to Blood/Body fluids 198

Disposal of Contaminated Sharps 199

Disposal of Needles/Syringes 200

Care of Disposable Items 201-202

Spill Kits 203

Refrigerators 204

Page 1 of 1

**Policy Number: AE - 1**

**Policy: BOD/Organization Description/History**

This policy provides the history, leadership and background information of Center for Treatment and Recovery.

1. CTR provides medication replacement therapy for opiate dependent individuals. CTR provides both outpatient maintenance and detoxification services utilizing medication replacement therapy, individual counseling and group counseling in a therapeutic environment. CTR also provides Health Home Services for all Medicaid recipients. The Latino population is a special population which historically is underserved. CTR is hoping to reach this population.
2. CTR is located at 82 Pond Street, Pawtucket, RI 02860.
3. CTR was formed by Wendy Looker in November of 2002. Madeline Rosario-Almonte joined in June of 2003. The owners/investors are committed to provide high quality treatment to opiate dependent individuals and believe that our commitment to this will help enrich the lives of those people we serve.
4. CTR is governed by the Members who are ultimately responsible for the quality of care provided to patients, licensing issues and financial management. CTR does have a Board of Directors who provide input. Please see our organizational chart for further clarification. The President of CTR or Program Director shall act as Administrator. In addition, the Board shall ensure:

a. appropriate personnel, physical resources and equipment are provided to facilitate the delivery of behavioral health treatment services.

b. that short and long term strategic plans are devised and met

c. there is an adequate quality improvement/quality insurance plan to meet the needs of the agency and patients.

d. quality service organization agreements are made with agencies who can provide needed services for patients that cannot be provided through CTR.

e. compliance with rules, regulations, standards and policies pertaining to the health and safety of patients

f. review and revision of the policy and procedure manual on a yearly basis

1. (Mission) The Mission was reviewed and revised this year as part of strategic planning which was directed by some stakeholders (employees). To provide individuals treatment for opioid addiction in a safe, structured, caring and confidential environment to transition int recovery while working on improving the quality of all aspects of their lives, reinforcing self-worth, respect and dignity.
2. CTR stakeholders also created a vision statement on how the Mission and Strategic plan will be met: CTR will provide educational opportunities for staff and outreach and advocacy for medication assisted treatment within the community. In addition, all treatment will be provided in accordance with best practice and regulatory and accreditation requirements in a safe, supportive and caring environment which will position CTR as a leader in medication assisted treatment in Rhode Island.
3. All CTR plans including risk management, technology, strategic, accessibility, community relations, diversion control, Community Relations, Cultural Diversity and Emergency plans are designed keeping our mission, values and best practice in mind to provide the best recovery environment possible so that patients are provided the best possible tools for their recovery.
4. The Leadership of the organization are involved in the day to day operation of the organization and are available either via an open-door policy or by appointment.

revised 10/29/18

Page 1 of 2

**Policy Number: AE - 2**

**Policy: Incident Reports/Critical Incidents**

CTR maintains a tracking system of all clinic incidents. Prevention of incidents is preferred and CTR policies, procedures and education are all geared toward the prevention of incidents. Because we value the safety of our staff and patients, incident reports should be written for all of the items listed below or any reason which an employee feels it is in the best interest of the agency to know: Unusual staff, visitor or patient behavior, concern over medical condition of patient, threatening or aggressive behavior by staff, visitor or patient, non-return of medication bottles by a patient, apparent intoxication of staff, visitor or patient, medication errors, injury, sentinel events, use or possession of weapons or drugs, vehicular accidents, biohazard accidents, injury or use of seclusion or restraint which is out of the ordinary for the staff member, visitor or patient, suicide or attempted suicide on the premises, communicable diseases, abuse or neglect or sexual assault.

Orientation, trainings provided by CTR, policies and procedures, various information disseminated, during the orientation period, annually, ongoing or if a pattern or incidents occur shall be considered prevention of the above noted incidents.

1. The staff member signs and dates a written incident report explaining what happened.
2. The incident report is reviewed at the next staff meeting unless more immediate assistance is required.
3. The staff reviews the incident and a member may speak to the parties involved for further clarification.
4. The incident is reviewed and documented in the staff meeting meetings with any recommendations.
5. The original incident report is placed in the Incident Report Chart with a copy to the Program Director.
6. Any corrective plan of action is carried out if needed.

Page 2 of 2

1. If this is considered a Critical incident such as:
   1. accident
   2. death
   3. Loss of record of patient

A copy of the incident report shall be mailed, return receipt requested to the State Methadone Authority. CTR shall also hold a meeting for the purpose of debriefing staff and processing the incident. All Critical incidents require a state incident report to be filled out also and forwarded to the state within 48 hours. All incident reports must be discussed with the President who will call the State if indicated. In the absence of the President, the Vice President shall decide if it is necessary to notify the state via phone in addition to the report.

1. If it is a medication error or drug reaction occurs please take the following steps:

* Notify the Nursing Director and or Program Director
* Notify the patient(s) involved of the error/reaction
* Notify the physician for further orders if any
* If patient is still in the building take VS
* Ask patient to remain in building for observation
* If needed, dial 911 and request emergency help
* If patient refuses then depending upon the circumstance ask patient if they need a ride a home.
* Maintain contact with patient throughout the day.
* Ask patient if there is a family member we can speak to if they have received too much medication to instruct to call 911 if not able to arouse patient.
* Document all interventions/steps in the individual record of the patient.

1. Debriefing, if needed, is provided as quickly as possible with the Clinical Supervisor and/or Program Director. However, every Thursday, at the staff meeting, all incidents are discussed for the purpose of informing staff and quality improvement.
2. On an annual basis, a review of the incidents and analysis are prepared with:
   1. causes
   2. trends
   3. actions for improvement
   4. results of performance improvement plans
   5. necessary education and training of personnel
   6. prevention of recurrence
   7. internal/external reporting requirements

This review and report shall become part of the annual management report and help to identify and reduce or eliminate incidents.

Revised 7/9/07

5/28/09

4/8/10

5/16/13

12/22/14

10/29/18

Page 1 of 1

**Policy Number: AE - 3**

**Policy: Staffing Patterns**

CTR will provide adequate staffing patterns to provide services to patients that comply with the generally accepted standards of professional practice and to meet the established outcomes of the patient, ensure safety of the person severed, to deal with unplanned absence of personnel and performance expectations of organization. This includes any recommendations as outlined in state and federal law.

1. CTR Program Director will monitor staffing patterns to ensure that there is an appropriate amount of staff on at all times to meet the needs of the patients. In addition, CTR will also ensure that any requirements set forth by state or federal regulations shall be followed.
2. The Director of Nursing will ensure that there is an adequate number of nursing staff scheduled daily to ensure the safety of patients in accordance with state and federal regulations. All nurses shall have a valid Rhode Island License in good standing
3. The Clinical Supervisor will ensure that there is an adequate number of counseling staff scheduled daily to ensure that the needs of the patients are met.
   1. Counselors will be responsible for no more than 50 patients at any time.
   2. 50% of the counseling staff providing direct therapeutic services with be licensed chemical dependency professions and the other 50% will be actively engaged in the process to obtain licensure.
4. The Office Manager will ensure that there is an adequate number of front office and billing staff to meet the needs of the patients.
5. The pharmacist shall be licensed by the state of Rhode Island.
6. The physician and/or medical director shall be licensed by the State of Rhode Island with a registered DEA number.

Revised 5/28/09

Page 1 of 1

**Policy Number: AE - 4**

**Policy: Public Education**

CTR encourages its staff to participate in public education. CTR will participate in the public education in schools, public agencies, colleges or any establishment that may request information regarding addiction or specifically, our agency.

CTR provides education in the following areas: our mission, our services, outcomes in conjunction with OMT program, new advances in addictions medicine and any specific requests that the establishment requesting our service may have.

The way in which CTR meets the needs of the requestor are varied. We utilize the following methods to educate the public as well as decrease the stigma associated with OMT:

1. Provide a lecture with appropriate hand-out information
2. Respond to verbal requests for information via telephone
3. Respond to requests for written information
4. Provide in-services to the requestor
5. Positive media coverage

Page 1 of 1

**Policy Number: AE - 5**

**Policy: Strategic Planning**

On an ongoing basis CTR assess the environment for the purpose of strategic planning. Strategic planning is a continuous process that considers the expectations of the patients, stakeholders, owners, competitive environment, any financial opportunities and threats, the organizations capabilities, service area needs as well as the demographics of the service area, our relationship with external stakeholders, our regulators, the legislative environment, information gathered from performance analysis and the use of technology. Our strategic plan guides where the organization would like to go and how it and how will get it there.

In 2018 a new Mission Statement, Vision Statement and Strategic Plan was completed over a period of 8-9 months which was directed by the staff and input from management taking all of the above into consideration. Please see strategic planning binder.

1. Information is gathered and reviewed via discussion, surveys, reports, meetings, or any other venue that may provide the opportunity for program improvement or growth.
2. SWOT Analysis is completed when needed.
3. Items are discussed and prioritized.
4. Items are added to Strategic planning if appropriate at that point in time.
5. Strategic planning is shared with stakeholders.
6. Strategic plan is implemented.
7. Strategic plan is monitored
8. Strategic plan is reviewed and revised as needed.

Revised 10/29/18

Page 1 of 1

**Policy Number: AE - 6**

**Policy: Medical Director/Program Physician Personnel File Requirements**

CTR will employ medical directors and program physicians who are licensed to prescribe narcotics as set forth by the state of Rhode Island to aid in the treatment of patients.

The following is needed for the confidential personnel folder for each physician, physician assistant or nurse practitioner:

1. An interview must be conducted
2. Copy of resume
3. copy of current license to practice medicine
4. copy of current controlled substance registration
5. current with the DEA
6. BCI check
7. Any other information needed to complete the personnel folder
8. The Medical Director is responsible for administration of all medical services and assume responsibility for:
   1. documented evidence of current physiological narcotic addiction
   2. completion of medical evaluation and medical history
   3. completion of lab studies
   4. signing/countersigning of medical orders
   5. review and signing of annual treatment plan
   6. review of medical policy and procedure

Page 1 of 1

**Policy Number: AE - 7**

**Policy: Nursing Supervisor**

CTR will employ an Registered Nurse who will be responsible for the supervision of all nursing and ancillary medical staff such as phlebotomist, CNA or MA. Proper supervision ensures that all patients are provided with appropriately educated staff.

1. An interview will be conducted
2. a copy of their resume
3. a copy of their current license
4. a copy of a current BCI check
5. This supervisor shall be required to participate in ongoing substance abuse education.

Page 1 of 1

**Policy Number: AE - 8**

**Policy: Evacuation Plan**

CTR will maintain and post a written evacuation plan for the building in each office or common area. This posting will outline the quickest route of egress in the event of an emergency. In addition, CTR will also conduct quarterly fire drills and document the same in accordance with state and federal regulation.

1. The written evacuation plan is posted in all rooms of the facility
2. it is expected that staff and patients will follow the posted evacuation

plans during fire drills and in the case of an emergency.

1. All employees and patients are required to meet at a specific area designated.
2. The evacuation plan will also be part of the patient handbook.

Page 1 of 1

**Policy Number: AE - 9**

**Policy: Tracking of Medical Professional Licenses/**

**Primary Source Verification.**

CTR requires that all licensed staff maintain current licenses in good standing with the proper regulatory agency. CTR shall keep copies of current licenses in personnel files and other locations deemed appropriate by management. Licensure check is performed before hire and upon renewal. At each check, a check of actions against licensure is also reviewed.

1. Updated copies of medical professional licenses are maintained in:
   1. confidential personnel file
   2. in the pharmacy
   3. in the DEA and State Audit binders
2. The Nursing Director or Designee shall review the license list on a regular basis to ensure licenses are current. The Nursing Director or designee may also go on-line and use the computer to check for active licenses and print-out a copy of the information from the appropriate web site.
3. In addition to current licensure, the Director of Nursing or Designee shall also check the status of licensure in the states in which the employee is licensed. This may be done by:
4. checking the on-line web site for each licensing body to see if any action has been taken against the individual license. A print-out may be done of the information and it can be signed and put in the appropriate locations.
5. all information is confidential
6. in addition to checking for current licenses, actions against licenses shall also be reviewed.
7. Primary source verification for LCDP’s, RCS, LMHC or any other clinical license shall be performed either on-line by the clinical supervisor. Results of this verification shall be provided to the program director and documented in the personnel file.
8. Employees shall be reminded 90, 60 and 30 days prior to expiration if needed.

Revised 7/9/07

05/7/13

5/19/15

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Page 1 of 3

**Policy Number: AE - 11**

**Policy: Rights of Patients**

**CARF: Business Practices - 1.D.1.a-c,2**

**State: 12**

Upon admission and annually thereafter, CTR will provide all patients with a copy of the rights and responsibilities of patients. In addition, CTR will also provide each patient with alternative treatment options and the advantages/restrictions of agonist therapy. Patients requesting services shall have the right to receive a clinical screening.

It is the belief of CTR that patients have undeniable rights regarding treatment. CTR maintains a comprehensive written statement of Patient Rights pursuant to Section 23-17-19.1 of the General Laws of RI as amended.

1. Each patient will be given a copy of the Rights and Responsibilities of patients upon admission
2. A staff member as well as the patient will sign a copy of the Rights and Responsibilities form.
3. The signed form will be kept in the admission part of the individual patient chart. The second form will be kept by the patient.
4. A copy of the Patient Rights will be posted in the clinic as well as Rules and Regulations.
5. Annually, with the annual physical, the patient is provided a copy of patient rights as well as given the opportunity to ask any questions which they may have regarding the same. The box on the annual physical is then checked stating they have received the copy.

Patient Rights shall include:

**Your rights include:**

1. to have treatment services provided without bias, based on race, religion, sex, sexual orientation, ethnicity, age, handicap or handicapping condition or source of financial support.
2. to be informed of your rights during the admission or orientation to the organization or whenever the facility makes changes to your rights
3. to express a concern or complaint about services, staff or the operation of the organization and informed of the grievance procedure for exercising these rights
4. to be encouraged and assisted throughout treatment to exercise your rights without fear of discrimination, restraint, interference or recrimination
5. to be informed of your rights and receive services in a language you understand
6. to receive information regarding accreditation status, discharge policies, treatment specialization, hours of operation, emergency contact procedures, grievance procedure, general services provided by the organization and your rights.
7. to receive a copy of your responsibilities, and if you are asked to leave the program for not fulfilling your responsibilities you can receive assistance in resolving the issue, assistance in accessing alternative treatment and written notification of the pending discharge and right to appeal
8. to be provided information regarding the costs of services and a copy of any charges you have been billed for and paid by you or your insurance on your behalf
9. to receive, upon request, information about credentials, training, professional experience, treatment orientation and specialization of the providers and their supervisors
10. to treatment and services that are considerate and respectful of your values and beliefs
11. to privacy, security and confidentiality of information
12. to treatment in an environment free of abuse, neglect, mistreatment, financial exploitation and any other human rights violation
13. to be protected from coercion
14. to be informed about what to expect during the treatment process
15. to be informed about and participate in, decisions regarding treatment and services and to receive, at least, the following information:
    1. current diagnosis
    2. proposed interventions, treatment, services and medications
    3. potential benefits, risks and side effects of proposed interventions, treatment, services and medications
    4. potential risks if treatment is not provided
    5. limitations on confidentiality
    6. ongoing progress/status regarding treatment goals and objectives
    7. significant alternative medications, treatments, services or interventions when appropriate
    8. the right, to the extent permitted by law, to refuse interventions, treatment, services or medications
    9. projected discharge date and plan
16. to individualized treatment services including:
    1. provision of services within the most integrated setting appropriate for the individual
    2. an individualized treatment or service plan that promotes recovery
    3. ongoing review and mutually agreed upon adjustments of the treatment or service plan
    4. competent, qualified and experienced staff to supervise and to carry out the individual’s treatment or service plan
17. to be present and actively participate in the design of your own treatment plan in all periodic reviews and to choose people to assist in the development and monitoring of the plan
18. to be offered a copy of the plan
19. to request a review of the treatment plan at any time during treatment
20. to seek an independent opinion from a mental health of substance abuse professional, of your choice, regarding treatment and services at your expense or that of your insurance coverage
21. to request a change of provider, clinician or service. If the request is denied, you shall receive a written explanation
22. to be given reason notice and reason for, any proposed change in the staff responsible for your treatment whenever possible
23. to object to any changes in treatment, services or personnel, and the right to a clear explanation if such objection cannot be accommodated
24. to refuse any treatment, procedure or medication, to the extent permitted by law and to be advised of the potential risks and impact on your treatment for refusing
25. to be referred to an alternate service, program or treatment setting if you are better served at a different level of care
26. to be present and participate in planning aftercare activities and referrals to other services you may need
27. to provide authorization, or refuse to provide authorization for the release of confidential information to family members and/or others and also for them to participate or not in your treatment
28. to access your record in compliance with applicable state and federal laws
29. If you are asked to participate in a research project you shall receive full explanations, in your language, of:
    1. the reason you are asked to participate
    2. proposed treatment
    3. elements of proposed treatment that are considered experimental or clinical trial
    4. the benefits expected
    5. the potential discomforts, risks
    6. alternative services that might benefit you
    7. the procedures to be followed, especially those that are experimental
    8. methods of addressing privacy, confidentiality and safety
    9. the right to refuse to participate without compromising your access to the organization’s services. You may refuse at any time during the research process.
30. To be offered information to participate in the Health Information Exchange/Current Care.
31. Individuals requesting services have the right to a clinical screening.

A copy of this information is located in the patient handbook which was provided to you at orientation. If you would like an additional copy, please see the front office who will provide one for you.

Revised 07/20/04

06/26/06

5/26/09

12/22/14

5/19/15

10/29/18

Page 1 of 2

**Policy Number: AE - 12**

**Policy: Grievance Procedure for Patients**

CTR believes that all patients, and former recipients of services shall have access to a procedure for submitting grievances, comments and suggestions without fear of reprisal, recrimination or discrimination by any staff member or representative of CTR . Grievances filed based on clinical decisions regarding the need for a higher level of care based on ASAM criteria for OMT treatment will be reviewed but may not impact any changes in the clinical recommendation for a higher level of care. A copy of this procedure is part of the Handbook of the Patient. Our Human Rights officer is Michelle Thomas and you may reach her by calling 401-727-1287 or ask the front office to make an appointment with her.

CTR also strongly believes that any patient who has gone through the formal grievance procedure and is not satisfied with the outcome has the right to speak to the State Methadone Authority regarding any concerns with program policy, discrimination or unfair treatment which patients feel they have unfairly been subjected to.

CTR will review all informal and formal complaints and grievances on no less than an annual basis to identify trends and areas in need of improvement. This report shall become part of the annual management report as quality improvement. A formal complaint is defined as a complaint which is documented in writing and presented to the Human Rights officer for the purpose of investigating complaint.

1. The grievance procedure shall begin with an informal presentation of the grievance to the primary counselor by the patient. If the patient so chooses, he or she may immediately contact the patient advocate of their choice then go to their counselor together if needed. If the patient feels that they are in imminent danger, they may contact the BHDDH first at 462-3291 or an advocate of your choice.
2. If the patient is unable to resolve the issue with his/her primary counselor, the patient is encouraged to present his/her grievance to the clinical supervisor.
3. If after step two the grievance is not resolved, it shall be considered a formal complaint. The patient shall be offered assistance, in writing and submitting the complaint/grievance to the HRO and in accessing an advocate if needed. The treatment team reviewing the grievance includes but is not limited to:
   1. the primary counselor
   2. the clinical supervisor
   3. the program director
   4. a member of the nursing staff
   5. a member of the office staff
   6. patient advocate, the advocate acts solely on behalf of the patient
   7. program physician, if applicable

Page 2 of 2

* 1. any other person which the patient feels may be beneficial to the grievance hearing.

1. The grievance forms are located in the waiting room and may be handed in to a member of the office staff upon completion by the patient. If the patient needs help filling out the form they may request help from any staff member.

5. Upon receipt of the grievance the HRO or designee shall log the grievance into the grievance log book.

6. The patient shall receive a written letter from the HRO that the grievance is in hand within 4 business days.

7. If possible the HRO shall make an attempt at early resolution within 5 business days or less. If resolved with the HRO, the HRO shall report, in writing, the resolution which should be forwarded to the Program Director or staff which is designated by the organization.

8. All grievance hearings will be held within 15 business days of the submission of the grievance unless doing so would cause a hardship for the patient. In which case, the hearing may be held at a later date at the discretion of CTR and the patient. However, the HRO shall make an attempt at an early resolution to the problem within 5 days of the submission of the grievance.

9. If the grievance is not resolved to the satisfaction of the patient, he or she may request, in writing, a hearing with the program director or designee.

1. If, after meeting with the program director or designee the patient is still not satisfied with the outcome, they will be directed to contact BHDDH, Linda Mahoney at 462-3291.
2. The HRO or designee will assist the patient with contacting the Department consistent with the process for forwarding complaint information to them for unresolved grievances.

Revised 4/5/05

1/25/08

06/16/10

01/23/12

1/25/17

10/29/18

Page 1 of 1

**Policy Number: AE - 13**

**Policy: Abuse and Neglect of Child or Elderly**

CTR requires that all staff have training in RI laws regarding abuse and/or neglect of children and elderly. CTR reserves the right to contact the appropriate authority to report any suspected abuse or neglect by patients or staff at any time.

1. When abuse or neglect is suspected by a staff member it should immediately be brought to the attention of the clinical supervisor and or program director.
2. Once the clinical supervisor and/or program director have been notified, the staff member who suspected the abuse must notify the appropriate authorities before the end of the working day.
3. If the patient, who is suspected of the abuse/neglect, is already involved with DCYF or Elder Services, the appropriate caseworker should also be notified of the suspicion only with the proper consent in place.
4. All contacts should be documented in the individual chart of the patient in the progress notes.

Page 1 of 1

**Policy Number: AE - 14**

**Policy: Restricted Area Closure Policy**

All employees of CTR who have access to restricted areas such as the nurse’s station and pharmacy, are to make sure that these areas are locked and alarmed when entering or exiting the area.

In addition, all employees who have keys and or codes to enter the building are required to ensure that all doors are locked and alarm is turned on when exiting the building.

Failure to comply with this policy will lead to disciplinary action which may include immediate termination.

Page 1 of 1

**Policy Number: AE - 15**

**Policy: Safe Door Combination Policy**

Any personnel of CTR who have access to the controlled substance safe(s) are to make sure that the safe combination is always “scattered” by turning the dial several times randomly in both directions whenever the safe door is closed.

Also, it is against CTR policy to close the safe door with the combination on the last number away from opening capability. Those who must follow this policy are restricted to who have access to the safe: LPN’s, RN’s, Pharmacists and Program Sponsor.

Failure to follow this policy will lead to disciplinary action which may include immediate termination.

Page 1 of 1

**Policy Number: AE - 16**

**Policy: Restricted Area Alarm Policy**

CTR has electronic alarms at various points of the building that must be unalarmed at the beginning of the day and alarmed at the end of the day. Each employee has an individual code which will alarm/un-alarm the areas for which they need to have access to in order to perform their job descriptions. It is the responsibility of the individual person to ensure that these alarms are set at the end of the business day.

No employee shall “share” their alarm codes with anyone. Upon voluntary resignation or termination, all codes shall be erased immediately from the alarm system. This shall be done by calling Sonitrol. The Program Director/Program Sponsor shall have a listing of all employees and their codes (master list). These codes shall be changed from time to time in order to comply with all stated and federal regulations.

Any employee of CTR who is in violation of this policy will be subject to disciplinary action which may lead to immediate termination.

Page 1 of 1

**Policy Number: AE - 17**

**Policy: Fire Drills/Fire Extinguishers**

CTR requires that fire drills be conducted on a quarterly basis. In addition, all fire extinguishers must be maintained and tested/replaced annually by an outside agency. A copy of the facility floor plan that has been marked with the quickest plan of egress is posted in each room.

1. fire extinguishers are kept in the following locations:

* By each exit
* In the computer/communications room
* In the nurse’s station

2. On an annual basis, a comprehensive e inspection is conducted by an appropriate person.

Revised 7/26/04

Page 1 of 1

**Policy Number: AE - 18**

**Policy: Panic Buttons**

CTR maintains panic buttons in both the front office and the nurses’ station. In the event of an emergency or hold up the safety of the employees and the patients is of the utmost importance. The staff should observe the following:

* 1. If possible, comply with the request of the person. Give them what they are asking for.

1. Push the panic button once they have received what they want and are heading out the door. This will help ensure that a hostage situation is not at hand

3. Try and remember some personal information regarding the person who is committing the crime.

4. Stay as calm as possible until the authorities arrive.

Page 1 of 1

**Policy Number: AE - 19**

**Policy: Cleanliness of environment**

CTR is committed to provide a safe and sanitary environment. To achieve this, CTR cleans the building on a daily basis. In addition, CTR will perform a quarterly cleaning and safety inspection.

Added 7/26/04

Page 1 of 1

**Policy Number: AE - 20**

**Policy: Depositing of Payments**

CTR office staff will prepare a daily deposit for all monies received on any given day from patients. This money shall be deposited into the CTR business account.

1. Once the money has been collected for the day, a member of the office staff will prepare the daily deposit form specifying the following:
   1. Amount of cash collected
   2. Amount of checks collected
   3. Amount of credit card payments processed
2. The daily payment report will be printed. This much match the amount that is recorded on the report
3. Any money that is paid out shall be listed on this report so that it may be subtracted from the total. Paid out monies may be for stamps, supplies or any other reason deemed appropriate by a member of the Board or Department head.
4. The payment report and daily deposit form shall be stapled together.
5. A deposit form is filled out for the bank and put with the money and checks to be deposited.
6. A member or designee will take the deposits to the bank on a regular basis.
7. On a day when a deposit is not made the deposit shall be locked in the front office safe.
8. The deposit receipt received from the bank is stapled to the above reports and filed in chronological order in the appropriate file for reconciliation of bank statements.

Revised 10/29/18

Page 1 of 1

**Policy Number: AE - 21**

**Policy: Mail**

All mail is to be sent outgoing or distributed to appropriate staff on a daily basis. It is the responsibility of the office staff to ensure that mail is handled in accordance with the guidelines below.

1. Incoming mail is to be distributed to the staff it is addressed to without being opened in a timely manner. Mail addressed to corporate is sent via interoffice mail courier.
2. Incoming mail that is not addressed to any specific staff member may be opened by a member of the office staff and distributed accordingly.
3. Outgoing mail is kept in a bin in the front office.
4. On a daily basis the front office staff will take the outgoing mail to the mail drop off at CTR’s mail box.
5. In the event something needs to be sent via insurance, registered or otherwise in a special manner, a member of the office staff will take it to the nearest post office for processing.
6. It is the responsibility of the front office staff to ensure that CTR has a supply of stamps sufficient to process daily outgoing mail.

Page 1 of 1

**Policy Number: AE - 22**

**Policy: Filing**

The Program Director is responsible for maintaining various files which include but are not limited to: vendors, deposits, personnel files, minutes, etc. These files shall be maintained in alphabetical order by category.

Revised 5/26/09

Page 1 of 1

**Policy Number: AE - 23**

**Policy: Petty Cash**

CTR will maintain a small amount of petty cash by the front office staff for the purpose of having cash on hand to pay for various items, expenditures, etc. The front office also maintains a company credit card for the purpose of ordering.

1. Petty cash shall be taken from the daily deposit for the purpose of starting and replenishment. This amount shall be deducted from the daily deposit.
2. Petty Cash and Corporate Credit Card are kept in the safe for safe-keeping.
3. Any monies paid out of petty cash shall require a receipt.
4. A member of the office staff shall be required to ensure that the appropriate amount of petty cash is on hand as well as ensure that all receipts are received.
5. In the event that there is a discrepancy in the petty cash a member of the Members must be notified immediately.

Revised 10/29/18

Page 1 of 1

**Policy Number: AE - 24**

**Policy: Supply Orders**

To conduct business in an appropriate manner, CTR needs to have the proper supplies on hand. This includes items such as pens, paper, pads, rulers, staplers, charts, stickers, stationary, business cards, etc. It is the responsibility of the front office staff to ensure that these supplies are on hand in an appropriate quantity.

1. The front office staff shall be responsible for identifying needed supplies.
2. Staff members may make reasonable requests for supplies to conduct business appropriately. These requests shall be made to the front office who will identify the items needed in the weekly report presented to the program director.
3. Once orders are received, the office staff shall check the packing slip to ensure that the correct supplies as well as the correct number of supplies are received.
4. In the event of a discrepancy, the office staff shall contact the appropriate vendor for correction.
5. The supplies are to be distributed to the appropriate staff member by the office staff or stored in the locked supply cabinet.

Revised 5/26/09

10/29/18

Page 1 of 1

**Policy Number: AE - 25**

**Policy: Consent for Information Requests**

CTR will send out requests for information to various agencies for the purpose of the proper treatment of patients. All consents must be signed by the patient before being processed.

1. All consents to release confidential information must be filled out completely including expiration before the patient signs it.
2. Consents and cover letters are to be stamped with the 42 CFR Part 2 confidentiality stamp.
3. A copy is made and put into the appropriate counselor’s mail box who is responsible for filing it in the chart.
4. The originals are to be mailed to the appropriate agency.

Revised 10/29/18

Page 1 of 1

**Policy Number: AE - 27**

**Policy: Payroll Processing**

CTR will process payroll on a weekly basis. Each employee is responsible for maintaining their time in the ADP electronic time keeping program.

1. Electronic time cards are reviewed by the program director for accuracy.
2. Payroll is process by 11:59 pm on the Wednesday before the actual payday.
3. The paychecks are delivered by the payroll company within 24 hours of ADP receiving the payroll information.
4. The payroll checks are given are distributed by the front office upon receipt.
5. The payroll reports are filed in the Program Directors cabinet.
6. Any discrepancies in the payroll are handled in an expedient manner.

Revised 5/26/09

10/29/18

Page 1 of 1

**Policy Number: AE – 32**

**Policy: Subpoenas, Search Warrants, Investigations**

**And other actions**

A subpoena, search warrant, or arrest warrant, even when it is signed by a judge, is not sufficient, by itself, to require or even permit a program to make a disclosure. Therefore, it is important to follow the appropriate steps when dealing with those items. It is often a complex process to deal with when faced with subpoenas and warrants so the following procedure should be followed at all times to ensure the confidentiality of our patients is not compromised. Please familiarize yourself with TIP 13. See Attached.

1. If a subpoena, search warrant or arrest warrant is delivered to the program:
2. The program director is to be notified immediately. In the absence of the program director the clinical director shall be notified.
3. The program or clinical director will review the information received.
4. The program or clinical director will consult with the attorney(s) for CTR if needed.
5. Under consultation with legal counsel the program/clinical director will determine whether or not to comply with the order.
6. If a member of a law enforcement agency or any type of agency which has authority over our facility arrives as part of an investigation the program director is to be notified immediately. In the absence of the program director the clinical director shall be notified.
7. Do not give out any information until you have spoken with the program director or the clinical director.

Revised 11/18/15

**“Court Orders**

A Federal, State, or local court may authorize a program to make a disclosure of confidential patient-identifying information. A court may issue such an order, however, only after following certain procedures and making certain determinations specified in the regulations.26 A subpoena, search warrant, or arrest warrant, even when it is signed by a judge, is not sufficient, by itself, to require or even permit a program to make a disclosure.27

**Procedures and Restrictions**

Before a court can issue an order authorizing a disclosure, the program and the patient whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement in response. (However, if the information is being sought to investigate or prosecute a patient, the patient is not entitled to notice.28 Similarly, where the program is being investigated, the program is not entitled to notice.29) The application and any court order must use a fictitious name for the patient. All court order proceedings in connection with the application must be confidential unless the patient requests otherwise.30

Before it may order the disclosure of confidential patient information, a court must find that there is "good cause" for the disclosure. A court can find good cause only if it determines that the public interest and the need for disclosure outweigh any adverse effect that the disclosure may have on the patient, the doctor-patient relationship, or the effectiveness of the program's treatment services. If the information is available from another source, the court may not issue the order.31 The judge is entitled to examine the records before making a decision.32

Even where good cause for dis-closure exists, there are limits to the scope of the disclosure that the court may authorize. In fact, disclosure must be limited to the information essential to the purpose of the order, and the dissemination of the information must be restricted to those persons who need it to fulfill the purpose of the order. The court should also take steps to protect the patient's confidentiality, for example, by sealing the records of the proceeding.33

Where the information sought is a "confidential communication," it may not be disclosed unless the disclosure is necessary to protect against a threat to life or of serious bodily injury, is necessary to investigate or prosecute an extremely serious crime, or is connected with a proceeding in which the patient has already presented evidence concerning the confidential communication.34 In all other situations, not even a court can order disclosure of a confidential communication.

**Procedures in Criminal Investigations**

Where an investigative, law enforcement, or prosecutorial agency seeks an order authorizing a disclosure for the purpose of investigating or prosecuting a patient,35 it must demonstrate the following:

The crime involved is extremely serious, that is, one that causes or threatens to cause death or serious injury36

The records sought are likely to contain information of significance to the investigation or prosecution

There is no other practical way to obtain the information

The public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, or the ability of the program to provide services to other patients

The program has had an opportunity to be represented by independent counsel

(When the program is a governmental entity, it must be represented by counsel.)37

Where the order is sought to prosecute a patient, the court must follow the same procedures that apply to court-ordered disclosures generally (except that the patient need not be given notice). In addition, a court order authorizing a disclosure for the purpose of investigating or prosecuting a patient must limit the disclosure to those parts of the patient's record that are essential to the purpose of the order. Further, only those law enforcement and prosecutorial officials responsible for conducting the investigation or prosecution may have access to the information. As with other applications, the court may not order the disclosure of "confidential communications" except in narrowly defined circumstances (see "Procedures and Restrictions" above). Under no circumstances may a court authorize a program to turn over a patient's entire record to a law enforcement, investigative, or prose-cutorial agency.”

Taken from 42 CFR part II

Page 1 of 1

**Policy Number: AE - 33**

**Policy: Clinical Director and/or Supervisor**

CTR will employee a Clinical Director and/or Clinical Supervisor who will be responsible for the direction of the Clinical Department including compliance with state and federal regulation as well as accreditation requirements. The Director and/or Supervisor will be responsible for new employee orientation as well as individual and group supervision, manage a case load as needed, approving training for clinical staff, policy revision and development surrounding clinical issues, quarterly record reviews, employee reviews, employee improvement plans for clinicians and other duties that may be appropriate to the position.

The Clinical Director and/or Clinical Supervisor shall have the appropriate education, experience and credentials for this position as outlined in State regulation and job description. This shall include at a minimum:

1. Licensed independent practitioner, LCDS, LCDP with completion of a course in clinical supervision, Clinician with relevant Master’s Degree and license and at least to years full time experience providing relevant behavioral health services or Registered Nurse with ANCC certification as a psychiatric and Mental Health Nurse or at least two years full time experience providing relevant behavioral health services.

Revised 10/29/18

Page 1 of 1

**Policy Number: AE - 34**

**Policy: Policy and Procedure Manual**

This policy shall define who has access to a policy and procedure manual as well as review and revision guidelines.

1. CTR will maintain an entire copy of the policy and procedure manual in the Business office of the agency. This may be in the form of a thumb drive or actual hard copy.

2. All employees will receive information regarding the location of policy and procedure manuals. Each employee shall sign a statement that they have received such information in their individual employment record.

3. CTR will review and revise the agency policy and procedure manual on an annual basis to be consistent with BHDDH policy and our corporate compliance plan. CTR also reviews and makes revisions as needed as part of an ongoing effort to ensure best practice. Dates coinciding with the revisions are located in the lower right-hand corner of the policy and review of the policies are documented in the front of the master policy and procedure.

4. The Program Director is responsible for review and revision of the policy and procedure manual on a minimum of an annual basis, however this does not take place on a certain date but is an ongoing process.

5. Patients may request to review any policy in the policy and procedure manual with their counselor.

Revised 5/26/09

10/29/18

Page 1 of 1

**Policy Number: AE - 35**

**Policy: Protection of Privacy**

CTR has taken safeguards to provide adequate privacy of all patients. It is the responsibility of each employee of CTR to ensure at all times patients are afforded the dignity and privacy they deserve. This includes but is not limited to:

* Reception
* Dosing
* Medical
* Individual counseling
* Group counseling
* Urinalysis
* Intake interviews
* Any discussion with any staff member

Page 1 of 1

**Policy Number: AE - 36**

**Policy: Credential/Licensure Verification**

CTR provides many services for which licenses or credentialed personnel must be employed. To ensure that licensed or credentialed personnel are providing these services, CTR shall take the following steps:

1. Upon hire, a copy of any pertinent licenses are obtained by a member of their office staff to add to their individual personnel folder.
2. Written, verbal or electronic verification should be obtained by the individual who will be providing direct supervision to the employee.
   1. Medical and clinical licenses are checked on line with the appropriate agency.
   2. Upon renewal of any license, the employee is responsible to provide the office with an updated copy. This will also be verified via the web.

4. The following licenses are to be copied and/or verified upon expiration of the previous license:

a. LPN License

b. RN License

c. Pharmacist License

d. Physician License

e. LCDP

f. RCS

g. Phlebotomists

h. Nurses Aids

i. any other license pertinent to an employee fulfilling their job description.

Revised 5/7/13

**Policy Number: AE – 37**

**Policy: Legal Requirements**

CTR has numerous licenses and accreditation requirements. These include SAMHSA (federal license), BHDDH (Behavioral Health License), DEA, Board of Pharmacy (RIDOH) and CARF Accreditation. In addition, we have to comply with confidentiality requirements, reporting requirements, patient rights and patient privacy as well as employee practices.

1. SAMHSA (federal) and Confidentiality/Privacy

* Ensures all staff are provided education on 42CFR part 8.
* Updates to SMA 162 are completed as required
* Apply for Certification prior to license expiration
* Maintain Accreditation
* Complete all SMA168’s as required for take-home exceptions
* Comply with all Confidentiality Requirements 42 CFR Part 2
* Education provided for all staff upon orientation and annually on confidentiality and privacy.

1. BHDDH (Behavioral Health License)

* Leadership and Staff are educated on BHDDH regulation
* Leadership and/or staff participate in BHDDH activities
* Leadership applies for re-licensure prior to expiration of licenses
* Leadership answers recommendations noted in licensing audits
* Complete State Incident Reports as required

1. DEA

* Nurses are educated in DEA Requirements
* Nurses are educated in daily reconciliation and reporting requirements
* Narcotic reconciliation is completed on a daily basis
* Pharmacist maintains Inventory
* Only Licensed individuals are provided codes/keys/combinations to safe
* Video and Alarm Security is maintained for safe, pharmacy and nurses station.
* Policies and procedures are in place for narcotic accountability, safety, security, and incident reporting.
* Licensure is maintained on a yearly basis

1. Board of Pharmacy (RIDOH):

* Same as above

1. CARF Accreditation

* Policies and Procedures are in place as needed, reviewed at least annually
* Various Plans are prepared as required
* Performance Measurement and Performance Improvement Activities
* Initial and Ongoing Training of Employees
* Maintain at least one CARF surveyor on staff

1. Patient Rights and Privacy

* CTR maintains a comprehensive list of patient rights that are consistent with State and Accreditation regulation/standards.
* All patients are informed of their rights upon entering treatment. They are reviewed annually and are displayed in the waiting area.
* CTR has a Human Rights Officer who handles all grievances.
* CTR has a grievance procedure that meets all state and accreditation requirements.
* All patients are informed of the grievance procedure upon entering treatment and the procedure is displayed in the waiting area along with the grievance forms.
* Areas for Medicating, physician appointments and counseling appointments are private.
* All medical testing, urine testing and medicating is done in private.

1. Employment Practices

* CTR maintains a comprehensive Employee Handbook outlining personnel policies
* We follow all Department of Labor and Training regulation
* All required labor information is posted in the breakroom.
* CTR maintains comprehensive personnel files
* Workman’s compensation insurance is purchased
* All employment is considered at-will

1. Prior to employment with or contracting with any individual who is providing direct

care services to patients, a check of the Office of the Inspector General must be

provided and documented to ensure the individual or entity providing direct care

service to the any patient is not on the exclusion list. This may be done by visiting [www.oig.hhs.gov](http://www.oig.hhs.gov). The effect of an exclusion is that no payment will be made by any Federal health care program for any times or services furnished, ordered or prescribed by an excluded individual or entity. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider for which the excluded person provides services and anyone else.

1. The OIG site should be checked monthly with the results documented
2. Should an individual be found to be excluded on the site, the individual will not be hired.
3. Should the individual be found to be excluded after hire, consult CTR attorney for further action.

Revised 11/18/15

11/5/18

Page 1 of 2

**POLICY: Core Program Description**

**Procedure:**

CTR will have a program description for each program which is seeking accreditation. Health Home program description may be found in the Health Home services section of the policy and procedure. CTR provides both Methadone Maintenance and Methadone Detox. Below you will find the program description for both. Only the frequency in services differs between the programs.

**Program Description/Description of Services/Credentials of Staff**

CTR provides treatment for individuals who has a primary addiction to opioids. As part of the treatment we utilize medication, specifically methadone to alleviate withdrawal symptoms and cravings (physiological symptoms related to addiction) in combination with individual, group and family therapy, medical services including bloodwork, tb screening, std screening, urine testing, physical and medical follow-up as required. Other services provided include:

* Comprehensive bio-psychosocial assessment and referral
* HIV and Hepatitis Education
* Overdose Education and Narcan prescriptions
* Transportation from area bus-stops and other pick-up locations
* Case Management
* Individualized treatment planning, discharge planning and transition planning as appropriate
* Take-home medication when appropriate
* Linkage and referral to other community agencies

All treatment is provided by individuals consistent with State (BHDDH) regulation. Our staff are a mix of Licensed individuals and individuals working towards licensure. Each staff member is provided supervision by a qualified individual as set forth in State (BHDDH) regulation.

**CTR Philosophy**

Our philosophy is consistent with our Mission, Commitments and Vision Statement.

Page 2 of 2

**Special Populations Served**

CTR treats all individuals age 18 and older. Some special populations served include:

* Pregnant females: We have a nurse practitioner who has a specialty in pregnancy and follows pregnant females. In addition, we are able to provide referral to specialty programs for those individuals who give birth while on methadone.
* Latino: We have bi-lingual/bi-cultural staff to meet the needs of this population.
* Older Adults: We have staff who have lived experience in addiction who are also considered older adults to assist age group.
* IVDU:

**Average Frequency and Type of Contact**

MMTP: All patients enrolled in methadone maintenance shall be seen individually no less than monthly. However, at the discretion of the clinician and as identified on the treatment plan, may be seen as frequently as weekly or as infrequently as quarterly if the meet the group requirement and have been in treatment for two years.

DETOX: All patients enrolled in the detox program shall be seen weekly or bi-weekly.

**Hours and Days of Service**

Monday through Thursday: 5:30 a.m. until 2:00 p.m.

Friday: 5:30 a.m. until 1:00 p.m.

Saturday/Sunday and Holidays: 7:00 a.m. until 9:30 a.m.

Added 11/5/18

Page 1 of 2

Page 1 of 1

**Policy Number: AE - 39**

**Policy: Accessing Personal Information in the Event of an Emergency**

CTR strives to maintain the safest possible environment for both its staff and the people they server. However, in the event of an emergency, it is important that CTR is able to access personal information of both the staff and patients.

Information may be found in the following areas:

1. Personal information on patients may be found by checking the patient change screen of the METHASOFT system if the system is operational.
2. The back-up tape from the previous day may also be utilized to access personal information of patients as well as physician’s orders and dosing information.
3. Dispensing logs are run at the end of the business day. This log is kept in the safe and will provide CTR with dosing information for the next 2 days.
4. All personnel are required to fill out a questionnaire on the front of their individual personnel files which are maintained in the Program Director’s Office.

Revised 5/26/09

Page 1 of 3

**Policy Number: AE - 40**

**Policy: Content of Treatment Records**

CTR requires that records of patients contain all necessary documentation consistent with state and federal regulations.

Treatment records shall contain, but not be limited to:

**Medical Chart Order**

**Section 1 – Physician/Admission Information**

1. Physician’s Documentation of Addiction
2. Medical Physical
3. Medical Treatment Plan/Physician Orders
4. Physician Order form
5. Health History
6. Physician Progress Notes

**Section 2 – Nurses Notes**

1. Nurses notes

**Section 3 – Urine Screen Results**

1. Urine Screen Results
2. Urinalysis

**Section 4 – Lab Work**

1. Lab results
2. Attempted draws, if applicable

**Section 5 – New Patient Medication Management Form**

**Section 6 – Prescription Registration/Release**

**Section 7 – Various other Medical**

1. Tuberculosis Screening
2. Breathalyzer Documentation, if applicable
3. Prenatal Evaluation, if applicable

Page 2 of 3

**Clinical Chart Order**

1. Patient information
2. Telephone screening tool
3. State form (intake front office)
4. Consent to methadone (intake)
5. Social security License (intake front office)
6. Information exchange sheet
7. Chart review sheet

**INDIVIDUAL/GROUP**

1. Individual Sessions
2. Group sessions
3. Group notes
4. Outside meeting Contacts

**CONSENTS**

1. PHI form (intake)
2. General consent form (s) (2 general intake forms)
3. Consent for post treatment follow-up (intake)
4. Consent for emergency contact (intake)
5. Consent for disclosure to utilization review manager (intake)
6. Consent to clear patient through other state methadone agencies (intake)
7. Confidentiality of patients records (intake)
8. Receipt of patient handbook (intake)
9. 30 day probationary contract
10. Supportive referral services

**CLINICAL INFO**

1. Biopsychosocial assessment (computer generated)
2. GAF
3. ASAM DSM (3)pages
4. Master problem list
5. Initial treatment plan (intake)

Page 3 of 3

1. Treatment plan (computer generated)
2. Progress notes(computer generated)
3. Encounter forms (TO BE GENERATED FOR AUDIT)
4. Request for dose change
5. Miscellaneous clinical info from secondary sources

**TAKEHOME/URINE**

1. Authorization for take home privileges
2. Responsibility statement
3. Urine screen result

**POST TREATMENT/AFTERCARE/MISCELLANEOUS**

1. Continuing aftercare plan
2. Discharge summary
3. correspondence, miscellaneous

Page 1 of 1

**Policy Number: AE - 41**

**Policy: Content of Written Consents/Confidentiality of Records**

CTR conforms to all state and federal regulations regarding confidentiality and written consents. No information, unless otherwise unprotected, will be disclosed without the written authorization of the patient.

1. All consents must include the following information:
   1. Name and date of birth of patient
   2. Name and address of the agency or individual requesting or releasing the information; or
   3. Name and address of the agency or individual for whom the information is being requested or to whom the information is being released
   4. Specific information to be released
   5. The reason the information is being released
   6. The specific date or event or condition upon which the consent expires
   7. Date signed
   8. Signature of patient or legal guardian
   9. Signature of attorney if applicable
   10. Statement that the consent for release or transfer of information may be withdrawn by the patient by submitting the request in writing or verbally.
   11. Redisclosure statement that information disclosed, released or transferred shall not be given, sold, transferred or in any way disseminated.
2. Information may be shared without consent under the following conditions:
   1. internal program communication
   2. with a qualified service organization agreement
   3. crimes committed on the program premises or against program personnel
   4. medical emergencies
   5. mandated report of child/elderly abuse/neglect
   6. audit/evaluation by regulatory agencies
   7. by court order under certain conditions

revised 7/21/04

10/29/18

Page 1 of 1

**Policy Number: AE - 42**

**Policy: Securing, Retention and Destruction of Records**

CTR requires that all records of patients are stored consistent with state and federal regulation. All clinical charts shall be in a locked cabinet inside of the individual counselor’s office. All medical charts shall be stored in the nurse’s station which is locked and alarmed. All Health Home Charts are to be stored in a locked cabinet in the office of the Health Home nurse. All charts that are to be seen by the physician for orders, signatures, review, etc. shall be put into the medical office the evening before the doctor arrives and retrieved when the physician is through and replaced back to their storage areas. No patient identifying information shall be stored or removed from the premises at any time by any employee. No employee, without the need will have access to electronic health records. All EHR are accessed only with appropriate username/passwords which are provided by the Program Director. Employees only have access to portions of the EHR which they need in order to carry out their duties.

1. All Clinical and Medical charts shall be retained for a period of 6 years post discharge and destroyed in accordance with state and federal regulation.
2. However, all Medicaid records shall be kept for a period of 10 years in accordance with CMS.
3. All electronic records shall be maintained indefinitely but for a period of no less than 6 years after discharge.
4. No record shall be destroyed if a legal process has been initiated against the clinic.
5. All Electronic records stored on an ssl and shall be maintained as long as CTR is in operation. Should CTR cease operation, this information shall only be destroyed after the newest record is 6 years old and not destroyed if a legal process has been initiated.
6. All computer disks or CD-Roms containing forms, policy and procedure, and other various information which is not directly patient related may be destroyed at any time via the shredder with the program director’s approval.
7. Access to any patient identifying information or records is only on an as needed basis. Individuals who do not need access to patient records to complete their job duties do not have access to either electronic or hard copy records.
8. If the program ceases to operate then the all records shall be maintained in a manner consistent with state and federal guidelines.
9. All administrative records shall be under the control of the Program Director/Owner, this includes:
   1. Personnel Records
   2. Financial Statements
   3. Correspondence with regulatory, accreditation, taxation and other entitites.
   4. Checks and/or bank statements (may be kept by book-keeper)

Revised 7/9/07

1/15/15

11/25/15

10/29/18

**Policy Number: AE – 43**

**Policy: Input from Patients and**

**Other Stakeholders**

CTR obtains input in many ways on an ongoing basis. This information is gathered, reviewed and if necessary, acted upon accordingly. The Leadership of the organization believe all input is valuable for the purpose of program improvement.

1. Various input gathered from:

* Satisfaction surveys (patients, community, personnel)
* Comments
* Complaints
* Grievances
* Phone calls
* Community meetings
* Statewide meetings
* Chart Reviews and Audits
* Discharge Follow-up
* Performance Reviews
* State Audits
* Medicaid Audits
* DEA Audits
* CARF Surveys
* Staff meetings
* Committee Meetings
* CPA
* Legal Representation

1. This information is gathered, reviewed and utilized in the following ways:

* Policy Change
* Program Improvement
* Strategic Planning
* Community Relations Plans
* Advocacy and Education within the community
* Financial and Resource Planning

Revised 11/18/15

Page 1 of 1

**Policy Number: AE - 44**

**Policy: Weapons**

CTR does not allow any weapons of any type to be brought to the clinic by staff or employees. The exception to this is hired security with the ability to carry weapons. Any staff member who brings a weapon to work may be terminated at the discretion of the Members. Any patient who brings a weapon to CTR will be immediately discharged from the clinic without recourse. In addition, CTR reserves the right to call the police for any violation of this policy.

Page 1 of 1

**Policy Number: AE - 45**

**Policy: Internet Access**

CTR allows internet access to all employees for the purpose of fulfilling the duties of employment, assisting the patients with information on courtesy dosing, specialized services and occasional personal use as long as it does not interfere with your ability to complete your job functions. However, CTR will monitor your internet access on an occasional basis so please only visit appropriate web sites. If any improper information is downloaded or improper websites are visited, you will be terminated from employment within the agency. Improper websites include but are not limited to: pornography, sexually inappropriate web sites including children, adults and animals, web sites promoting cultural insensitivity, websites promoting illegal activity, off-shore gambling web sites, pay-for-sex websites, websites promoting cruelty to animals or people or any other information deemed inappropriate by the Program Director and/or majority of the owners. Termination for internet misuse and abuse is not a grievable termination. In addition, should this information violate any state or federal laws you will be reported to the authorities.

Added 7/9/07Page 1 of 1

**Policy Number: AE - 46**

**Policy: Illegal Drugs, Legal Drugs and Medication**

CTR prohibits both staff and patients from brining illegal drugs to the facility. In addition, illegal drug use is prohibited by employees and any employee who is found to be using illegal drugs will face disciplinary action including termination. The police will be called due to breaking of law on the premises at which point the outcome of the situation will depend on law enforcement.

Legal drugs such as medical marijuana are also prohibited from being brought into the clinic by both staff and patients alike.

Patients are discouraged from brining prescription medication to the clinic and prohibited from taking any medication in the common areas of the clinic. However, at times may be required to bring in medications for pill counts or for the purpose of registering the medication should they not have the appropriate paperwork.

Employees make take their medication as prescribed during work hours unless the medication is mind altering and interferes with their job responsibilities.

Page 1 of 1

**Policy Number: AE – 47**

**Policy: Fiscal Policies**

CTR has many policies that can be considered fiscal policies. These policies include Human Resource policies, Supply Ordering policies, Petty Cash, Payroll processing, and Billing policies. Please review those policies for specific information.

Page 1 of 1

**Policy Number: AE- 48**

**Policy: Fraternization**

CTR prohibits fraternization between staff members and persons served as outlined in the agency code of ethics. This includes current and former persons served. However, it is understood that at times persons served may have already had a relationship with a staff member before they were admitted to services. In this instance, the staff member who has a prior relationship with the person served cannot be involved in any counseling, medicating or any other type decision making process regarding this person served at any time.

Violation of this policy may lead to disciplinary action or termination.

Fraternization includes:

* Personal relationship between person served and employee
* Hiring a person served to work for a staff member outside of the agency
* Any relationship which results in financial profit of the staff member
* Professional relationship outside the agency
* Any relationship which promotes personal gain of the staff member
* Any type of sexual activity with a person served in active treatment

Revised

01/23/13

Page 1 of 1

**Policy Number: GPS - 1**

**Policy: Documentation**

CTR requires that all documentation/notes in the chart of patients be typed or written legibly. Entries to the patient record shall be made by the counselor, physician, nurse practitioner, case manager, RMA/Plebotomist, front office, health home team member or any other staff member who is responsible for documenting treatment, case management, medical services, coordination and collaboration of care, logisticare issues, courtesy rides, treatment plans, notes and group notes. If you are given a name and password into the electronic health record, you are able to make entries into the patient’s chart.

1. All entries must be made in black ink or typed and kept in the clinical chart or be able to be accessed in the counselor’s computer station protected by a password.
2. All entries must be signed and dated by the person who is writing or typing the note. Include credentials. In the event of computer generated notes, each note shall be initialed followed by complete signature on bottom of page.
3. Any errors in the chart of the patient are to be crossed out with a single line with the word error written above with the initials of the staff member who made the error.
4. It is requested that all documentation be completed at the end of the session. However, all documentation must be completed within 24 hours of contact with the patient.
5. Counselor shall document completion of portions of individual treatment plan.
6. Shall reflect significant events or changes in life of patient.
7. shall document delivery of services that support individual treatment plan.
8. White out and erasing of information is prohibited.

Updated 1/25/17

Page 1 of 1

**Policy Number: GPS 2**

**Policy: Health Services/Counseling Services**

**State:**

CTR provides counseling as required by state and federal law. In addition, CTR also takes into consideration the individual needs of the patient to schedule the appropriate number of contact hours per month. This may vary from one contact per month to one per week depending upon the needs of the patient. All patients shall have a minimum of one-hour individual counseling for the first 2 years of treatment for MMTP. All patients admitted to detox protocol shall have a minimum of 2 hours individual counseling per month. Those patients in treatment greater than 2 years may be seen on a quarterly basis if patient participates in group therapy on no less than a monthly basis.

The following services are provided but not limited to: individual, group and family counseling, HIV/AIDS, TB, Hepatitis and STD counseling, referral to outside groups such as AA, NA, CA, ANON and AL-A-TEEN.

1. Every patient is individually assessed to determine their individual treatment needs. These needs are documented in their individual treatment plan.
2. Individual counseling is performed at a minimum of one hour per month for MMTP and 2 hours per month for Detox.
3. Counseling sessions are documented in the chart of the patient on the progress note form in the DAP format.
4. Group counseling will be documented by the group leader in the appropriate group note format and placed in the treatment plan/progress note section of the chart of the patient.
5. All counseling is performed in a manner consistent with the treatment plan of the patient or professional protocol regarding crisis intervention.

Page 1 of 2

**Policy Number: GPS - 3**

**Policy: Admission Process/Criteria**

CTR will conduct admission assessments within the limits of staffing patterns. The admission process begins with a telephone screening which gathers important information as to the appropriateness of this level of treatment. In addition, this tool provides information regarding agency fees and philosophy to help the patient decide if this agency is appropriate for them.

CTR conducts the admission assessment in accordance to state and federal law and in conjunction with ASAM criteria and DSM IV.

1. Telephone screening/triage is completed and the intake coordinator will review information to insure they are appropriate for the admission assessment.
2. Appointment made for admission assessment
3. Admission assessment/paperwork completed to determine opiate dependence that qualifies or disqualifies the patient for outpatient served medication replacement therapy as defined by state and federal law and ASAM criteria.
   1. if patient information disqualifies them from this level of treatment, appropriate referrals are to be made. Exclusionary criteria includes:
4. patient who has never attempted inpatient detox may be referred to another agency
5. Prior knowledge of patient exhibiting inappropriate behavior who do not demonstrate a willingness to change
6. Patients under the age of 18 are excluded.
7. Patients with dual addiction will be evaluated for appropriateness on a case by case basis.
8. No admission to detox protocol more than 2 times in any year
   1. If patient information qualifies them for this level of treatment, admission process continues.
9. Qualifying criteria includes but is not limited to:
   1. must be 18 years of age
   2. ability to document one year of opiate addiction
   3. ability to document current physiological dependence on opiates
   4. exceptions can be made under the following circumstances:

Page 2 of 2

1. patients who have been incarcerated or in chronic care within 6 months or recently released(priority)
2. pregnant patients (priority)
3. previously treated patients at risk of relapse(priority)
4. Treatment shall not be denied to patients who are otherwise eligible based on age, race, creed, religion, color, sexual orientation, national origin or handicap. However, the Clinical Director will review all information to determine whether or not any individual is appropriate to continue with the admission the process based on previous experience, presenting problems and substances addicted to.
5. Upon intake all patients shall be informed of the costs associated with treatment.
   1. $90.00 per week for maintenance
   2. $100.00 per week for detoxification
6. Insurances currently accepted: Medicaid, NHPRI, NHPMA, UBH and Tufts Medicaid products. We also accept BCBS, NHP and United commercial insurance. In addition, CTR has a contract with the Veterans Administration to provide weekend and holiday dosing to their patients.
7. All patients shall have their identifying information entered into the Central Registry System.
8. All patients must have a urine drug screen before admission and all women of childbearing age shall be tested for pregnancy
9. patients must have photo ID and Social security card or letter that will be copied and put into their individual chart. A letter from Social Security administration may be accepted while awaiting hard copy of SS Card. Without a government ID, the patient will need a photo ID and birth cert.
10. All patients must have a physical before being admitted to treatment. The Physician has the final authority to admit or deny admission based on ASAM criteria as well as other factors.
11. All patients shall have TB screening and Blood work within the time frame allotted by state and federal regulation.
12. All patients must fill out all appropriate paperwork including signing of the consent to treat with a narcotic drug and receive informed consent for all services.
13. Intake form shall be signed and dated by person gathering information.

Revised 5/26/09

7/9/10

10/29/18

Page 1 of 2

**Policy Number: GPS - 4**

**Policy: Bio-psychosocial Assessment (Admission), Updates**

CTR requires that a comprehensive bio-psychosocial assessment and diagnostic impression is completed for each prospective patient admission by an individual authorized to do so by BHDDH regulation. The full biopsychosocial assessment shall be completed by the individual counselor and start with the first counseling session. In the event of interim maintenance, CTR will complete this during the 4-month period required.

The following are steps to be taken to accurately assess the treatment needs of the patient.

1. Once a person has been determined to be appropriate for this level of care, an initial assessment shall be completed by a licensed individual authorized to do so.
   1. counselor/intake staff will complete the bio-psychosocial assessment
   2. the assessment in conjunction with using ASAM criteria and the DSM IV TR will be used to provide the medical staff with the appropriate information for admission.
   3. This process may also exclude individuals from this level of treatment in accordance with ASAM placement criteria for which they will be referred to the appropriate agency.
2. The assessment includes the following:
   1. name
   2. address, telephone number
   3. date of birth
   4. date of assessment
   5. sex
   6. source of referral
   7. strengths, needs, abilities and preferences (SNAP)
   8. presenting problem or difficulty
   9. history of previous difficulty or treatment received
   10. medical treatment history including prescribed medications currently take and taken in the past, allergies, accidents, diseases, hospitalizations, etc. including current health status
   11. marital status
   12. education level
   13. pertinent ethnic and cultural factors
   14. occupation/employment status
   15. History of alcohol and drug use to include age of first use, patterns of use, length of time used, negative life consequences, incl. tobacco
   16. Family history of substance abuse
   17. History of childhood traumas
   18. Current stressors
   19. Sexual concerns

Page 2 of 2

* 1. Psychiatric complaints, including urgent needs and suicide risks and risk-taking behaviors
  2. Type of health insurance if any
  3. Description of living arrangements
  4. synopsis or general impressions at time of intake including patient attitude, appearance, behavior
  5. any other relevant information that may be appropriate
  6. medications and efficacy of the medications
  7. need for assistive technology

1. The assessment must be signed and dated by the person completing the intake. The physician and primary counselor shall initial it after reviewing with the patient.
2. This information will be utilized to help formulate a treatment plan and will be kept in the treatment plan/progress note section of the record of the patient.
3. Reassessments/updates should be performed with readmission and with annual treatment plan or in the event of significant change in status, major life issues, accomplishment of significant goals, incarceration or at the discretion of the counselor. The primary use of this information is to identify the expectations in treatment of the patients and be responsive to their changing needs.

Revised 5/26/09

11/15/16

10/29/18

Page 1 of 1

**Policy Number: GPS - 5**

**Policy: Patient Handbook**

CTR will provide all patients with a copy of our patient handbook. Each person who receives a copy will sign the appropriate form and it will be kept in their individual treatment record. This handbook will explain the program to patients.

1. A copy of the patient handbook is provided to the patient at intake
2. Patients sign the appropriate receipt form which is co-signed by a staff member
3. this form will be filed in the admission section of the patient’s individual treatment record
4. In addition, all patients must attend orientation group which reviews the handbook as well as other information. If patient is inappropriate for group, the counselor may provide orientation in an one-on-one basis.

Revised 7/12/04

Page 1 of 1

**Policy Number: GPS - 6**

**Policy: Assignment of Primary counselor**

Patients will be assigned a primary counselor for their treatment needs. The clinical supervisor will assign all primary counselors based on information received during the admission process as well as availability of the counselor, previous contact and patient request. Should any patient request a change in counselor, the clinical supervisor will assess all requests to determine the need for the change as well as choice of new counselor. If a new counselor cannot be provided for the patient, a referral to another agency will be made if the patient desires. The name of the person responsible for the case shall be noted in the treatment plan.

Revised 5/26/09

10/29/18

Page 1 of 1

**Policy Number: GPS - 7**

**Policy: Patient Consultation**

CTR provides a forum whereby any non-compliance or other issue by patients may be addressed and resolved. It is this forum, in conjunction with input from the patient issues may be resolved and treatment may begin or continue. This consultation includes members of each discipline of the agency or in some instances, the behavioral contract may be completed just with the counselor or physician.

1. The primary counselor meets with the clinical supervisor to discuss the concerns of the patient. During this forum the clinical supervisor may make recommendations which may include a patient consultation.
2. This information may also be discussed during group supervision at the bi-weekly staff meeting.
3. If the counselor and clinical supervisor agree that the patient should be seen in that type of forum, a letter is given to the patient which includes the date and time of the consultation.
4. Both the patient and counselor (or designee) sign the letter which verifies receipt of letter. A copy is filed in the patient chart.
5. The consultation will include but may not be limited to; the patient, the primary counselor, the clinical supervisor, group leader if applicable, program director whenever possible, a member of the nursing staff and office staff if possible.
6. The patient and staff discuss the issues and agree upon a plan of action to resolve the non-compliance. A contract is signed by all members present at the meeting.

Revised 5/26/09

10/29/18

Page 1 of 1

**Policy Number: GPS - 8**

**Policy: Progress Notes**

CTR requires that all counseling staff keep accurate and current progress notes of all individual sessions and telephone calls for the purpose of documenting treatment and the response to treatment of the patient. This shall include all progress, lack of progress and preparation towards discharge.

1. Any treatment rendered to patients shall be documented in the Progress Notes of the patient’s treatment record.
2. All progress notes shall be written in the DAP format, in a concise manner and focus on the problem areas identified in the treatment plan. The progress of the patient or lack of progress should be noted and included as well as any changes in the condition of the patient.
3. All progress notes shall include:
   1. Date
   2. Time spent with patient
   3. D: statement of issues addressed
   4. A: includes counselor observations, impressions on progress in treatment, changes in condition and response to treatment by patient.
   5. P: Plan of continued intervention
   6. Signature of the individual making the entry, credentials and the date of the entry.
4. All entries made in the progress notes are the responsibility of the clinical staff who has performed the service.
5. Progress note entries shall be made as close to completion of the service as possible but no later than 24 hours from the time of service.
6. All those in attendance shall be documented within the progress note. Family, SO contacts shall include the members present.
7. Abbreviations are not to be used unless it is an accepted abbreviation. All words are to be spelled out. See appendix for accepted abbreviations.

Revised 7/23/04

10/29/18

Page 1 of 2

**Policy Number: GPS - 9**

**Policy: Treatment Plans**

Patients at CTR shall collaborate in developing, reviewing and updating their individualized treatment plan with their primary counselor. These treatment plans shall be developed, reviewed and updated in accordance with state and federal regulations and accrediting body standards. This plan shall be communicated to the patient in a manner/language in which they can understand.

1. An initial treatment plan shall be completed upon intake with the patient. This treatment plan shall be signed by the patient and the staff member.
2. The primary counselor and the patient shall develop an individualized treatment plan within the first 30 days of beginning treatment.
3. This treatment plan shall be designed to meet the individual needs of the patient as identified by the biopsychosocial assessment and noted in the master problem checklist in conjunction with ASAM criteria and Global Assessment Functioning.
4. Treatment plans shall include and reflect but not be limited to:
   1. problem areas
   2. goals (long and short) for treatment related to the identified problem areas including strategies, indicators and/or tasks used to assess individual progress and expressed in the words of the patient.
      * the goals shall be measurable
      * the goals shall be time specific
   3. Methods for providing treatment, description of services provided and frequency including specific services provided by CTR as well as those referred to.
   4. Barriers identified which may keep patient from achieving treatment plan goals.
   5. Description of any supportive services which may be needed by the patient including referrals.
   6. Date recognized, expected achievement date and actual achievement date.
   7. Signature of patient, primary counselor and clinical supervisor. The signature of the medical director is also required on the first treatment plan and annually thereafter.
   8. Reflect informed choice
   9. Be appropriate to the patient’s culture and age

Page 2 of 2

* 1. Reflect the strengths, needs, abilities and preferences of the patient

1. This treatment plan shall address individual and family problems. When appropriate, family members, significant others may be involved in the treatment process if the patient so desire.
2. Treatment plan will be reviewed every 6 months regardless of length of time in treatment. A New treatment plan shall be developed at least once every (12) twelve months. Treatment plans include referrals for any services that are not provided by CTR.
3. The primary counselor may monitor the progress of the patient with the agency they were referred to if CTR has the written consent of the patient to do so.
4. The treatment plans major goals are the promotions of the efforts of the patient towards recovery.
5. Upon request of patient a copy of the treatment plan will be provided to the patient.

Revised 7/23/04

5/26/09

12/22/14

10/29/18

Page 1 of 1

**Policy Number: GPS - 10**

**Policy: Needs Assessment/Behavioral Contract**

To maximize the recovery experience at CTR it is important that patients comply with program/treatment procedures. If at any time a patient is not in compliance with program procedures, every attempt will be made to correct this problem via discussion between the clinical staff and patient. If that attempt is unsuccessful then CTR reserves the right to prepare a written treatment/behavior contract via a needs assessment for the purpose of resolving the issue. Behavioral contracts are to never include interventions such as corporal punishment, fear-eliciting procedures, denital of any basic need such as shelter, essential clothing and adequate nutritional diet or a person’s legal rights.

1. The counselor identifies with the patient when possible areas of difficulties or concerns and when appropriate be integrated into the treatment plan of the patient.
2. The counselor develops a behavioral contract with the input of the patient. Both parties will sign the contract.
3. Contract period will be 30, 60, or 90 days dependent upon concerns and targeted behaviors (goals and objectives).
4. The individual counselor will monitor progress with meeting the goals and objectives of the behavioral contract.
5. At the end of the contract period, contract will be reviewed by the counselor and clinical director to determine if contract has been successfully completed and may be ended, needs to be renewed to reinforce new behaviors, or objectives have not been met by the patient.
6. Any recommendations will then be brought back to the patient and a new contract will be agreed upon by both the staff and the patient.
7. In the event of refusal to sign a contract, failure to successfully complete a contract or contracts the program director is to be informed for further instruction. The program director in conjunction with physician, counselor and clinical director may provide a referral to a higher level of care, additional community services or other resolution. CTR staff will assist in the transition to another provider as a last resort.

Revised 7/8/04

12/22/14

10/29/18

Page 1 of 2

**Policy Number: GPS - 11**

**Policy: Contact Sheets**

CTR maintains documentation of all contacts between counseling staff and patients. These contacts are noted on the Contact Sheet form. There are two contact sheets in the individual chart of the patient: Individual Contact Sheet and the Group Contact Sheet.

1. The contact sheet is filed in the front of the individual chart of the patient. This sheet shall include:
   1. date of session
   2. time of session
   3. type of session (individual/family/treatment team meeting)
2. The group contact sheet is behind the contact sheet.
3. The patient signs the contact sheet upon the arrival to the scheduled session or prior to leaving the session.
4. The person providing the treatment will also sign the contact sheet in witness of the signature of the patient.
5. Group notes are to be filed in the individual chart of the patient and the group contact sheet should be filled out with:
   1. the date of the group
   2. the time of the group
   3. the name of the group
   4. and no show if the patient did not show up for the group
   5. the patient will sign for all groups attended

Page 1 of 1

**Policy Number: GPS - 12**

**Policy: Group Attendance Sheets**

CTR group leaders (or the front office) shall generate a list of patients who are scheduled to attend the group which they are leading for the purpose of documenting the attendance of the patient to ensure compliance with treatment plans and/or treatment/behavior contracts.

1. The group leader or front office shall print a copy of the group list from the METHASOFT computer system for each group session.
2. The group leader shall take attendance in accordance with this list and note all attended, cancelled and no-shows to this group as well as write in the name of any patient who is in attendance but not on the list.
3. The group leader will write a note associated with the group for all attendees.
4. For those persons who were a no show, a no show note will be entered into the computerized system.
5. The group leader will also indicate in the computer attendance and cancellations.

Revised 5/26/09

10/29/18

Page 1 of 2

**Policy Number: GPS - 13**

**Policy: Aftercare/Continuing Care Plan/Transition Plan**

CTR counselors work with patients to develop an individual and appropriate aftercare or transition plan following the ASAM criteria. This plan shall be initiated with patients at the earliest possible point in treatment whenever possible and appropriate.

Aftercare planning is an ongoing process that should be updated throughout treatment and a usable tool for the patient once treatment is completed with CTR. Aftercare planning shall be also begin at the earliest point in time

1. For patients admitted to treatment on a detoxification protocol the primary counselor is to begin the aftercare plan as soon as stabilization is achieved but no later than when beginning the detox.
   1. this plan is to be reviewed and updated with every treatment plan
   2. the plan must be fully completed prior to the end of the first thirty (30) days of treatment.
2. For patients admitted to treatment for MMTP, the aftercare/Continuing Care should be initiated at the earliest point in time (within 90 days) and must be completed prior to any of the following events:
   1. When the patient reaches 20mgs on their MSW
   2. Change in providers
3. Documentation of the aftercare/continuing care plan reviews and updates are to be:
   1. noted on the aftercare/continuing care plan form by the counselor
   2. include the date reviewed/updated
   3. noting whether or not changes were made to the plan
   4. include the initials of the counselor and patient
4. Transition plans are the forms filled out to transition into any of the following internal transitions and include such events as:
   1. Take home status
   2. MSW
   3. AMA
   4. Administrative Discharge
   5. Financial Discharge

Or external events such as:

* 1. Referrals
  2. Transfers to other levels of care such as IOP, Detox, Residential

1. Transition plans or planning may not be a formal document but rather documented in notes, case consultations or any other area of the individual chart of the patient as appropriate.

Page 2 of 2

1. A copy of this plan shall be provided to the patient.
2. Patients who successfully complete their MSW may continue their after-care at CTR.

Revised 5/26/09

5/13/13

6/29/16

10/29/18

Page 1 of 1

**Policy Number: GPS – 14**

**Policy: Discharge Summary**

CTR will complete, in its entirety, a discharge summary on every patient who has been discharged from treatment with information regarding the condition of the patient from admission through treatment termination.

It is the responsibility of the primary counselor to ensure the discharge summary is completed on each discharged patient on their caseload.

1. The discharge summary shall include the following:
   1. date of admission
   2. date of discharge
   3. drug use history/pattern
   4. initial assessment, including presenting problems
   5. initial diagnosis
   6. significant findings
   7. issues addressed, issues resolved and issues unresolved
   8. final assessment including prognosis
   9. final diagnosis
   10. recommendations as stated in the continuing care plan to include referrals and instructions provided to the patient
   11. follow-up plans
   12. attendance to group and individual counseling by patient
   13. clinic attendance/behavior while in treatment
   14. reason for discharge
   15. status of patient at discharge
2. the discharge summary shall be completed by the primary counselor within fifteen (15) days of discharge of the patient.
3. If treatment was terminated by the patient against the advice of CTR, the discharge summary shall include a statement which explains the circumstances under which the discharge took place.

Page 1 of 1

**Policy Number: GPS - 15**

**Policy: Post Treatment Follow-up**

CTR is committed to provide post treatment follow-up whenever possible and practical.

1. Upon admission to CTR, all patients will be given a consent for follow up contact form to sign. Signing of the form indicates that the patient consents to being contacted by CTR.

2. Documentation of both successful and unsuccessful follow-up contact shall be recorded in the treatment record.

3. This documentation shall include at least the following:

a. type, date and time of contact/attempted contact

b. summary of contact (summary of the recovery status of the patient)

c. reason for unsuccessful contact (if applicable)

d. signature of contact person

e. plan for future follow-up (if applicable)

1. When a person is discharged or removed from a program for aggressive/assaultive behavior, follow-up shall be made within 72 hours post discharge to ensure linkage to appropriate care.

Revised 10/29/18

Page 1 of 1

**Policy Number: GPS - 15**

**Policy: Clinical Supervision**

CTR provides a minimum of one (1) hour of individual/group clinical supervision per month for each counselor who provides treatment services and is licensed to do so. Those individuals who are working towards licensure will receive 2 hours of supervision each month. Each supervision session shall be documented accordingly.

1. Clinical supervision will be conducted by the clinical supervisor and/or designee in compliance with state requirements
2. All clinical supervision will be documented.
3. The clinical supervisor will maintain the clinical supervision logbook in their office.
4. All clinicians that are in the process of obtaining certification/licensure shall have clinical supervision documentation form completed after each clinical supervision session.
5. All supervision shall include:
   1. appropriateness of treatment or service intervention selected relative to the specific needs of each patient.
   2. Treatment/service effectiveness as reflected by the patient meeting his/her individual goals.
   3. Provision of feedback that enhances the skills of direct service personnel.
   4. Accuracy of assessment and reference skills when applicable.
6. A written professional development plan shall be completed for each employee providing direct patient care as needed. This may be part of the evaluation process.
7. Unlicensed clinicians will be required to be working towards state licensure and have a minimum of 2 hours individual supervision per month.

Revised 10/29/18

Page 1 of2

**Policy Number: GPS - 16**

**Policy: Audits/Clinical Review of Records of Patients**

CTR audits/clinically reviews all records of patients. These audits are documented to ensure adequate record keeping and clinical integrity. These audits are performed by staff which have been trained in record requirements.

1. Audits are conducted at the following points:
   1. after intake
   2. randomly (quarterly) to be performed by peer review or by the Clinical Supervisor on a representative sample of records to ensure quality of service
   3. annually (medical only)
   4. upon discharge
2. Copies of audits are provided to the primary counselor of the chart of the patient. These audits will have information regarding what if any corrections need to be made and why.
3. Any corrections of patient records required by counseling staff are to be completed within 10 business days of the receipt of the copy of the audit.
4. Discharge record reviews shall be completed by the Clinical supervisor or designee within 15 business days of the discharge date.

5. The clinical supervisor or designee shall ensure:

a. post treatment follow-up has been completed

b. discharge summary was accurately completed

c. treatment plan closure was completed

d. progress note written stating the reason the patient left treatment with the discharge date.

1. The quarterly review (random), performed by the clinical director, will address:
   1. quality of service delivery as evidenced by the record of the patient.
   2. Appropriateness of services
   3. Patterns of service utilization
   4. Patients were provided handbook and orientation
   5. Patient was actively informed in treatment decisions
   6. Assessments of patients were thorough, complete and done in a timely manner
   7. Goals of service/treatment were based on the results of the assessments and input from patient
   8. Services were related to the goals/objectives of the treatment plan.

Revised 5/26/09

10/29/18

Page 1 of 1

**Policy Number: GPS - 17**

**Policy: Crisis Intervention/Referral Services**

CTR provides crisis intervention as needed. Staff members who have training or are most experienced to handle this will provide the intervention. CTR has medical, clinical and ancillary services that may be able assist with various interventions. CTR will provide referral services for any crisis which cannot be dealt with by the CTR staff. Referrals shall be made only after the consent of the patient has been received.

1. Crisis related to child abuse and neglect are handled by Victoria DaPonte or Wendy Looker
2. Crisis related to mental health issues are handled by Victoria DaPonte
3. Crisis which involved Latino population handled by Madeline Rosario-Almonte
4. Crisis related to medical issues are handled by Melissa Souza, RN
5. Crisis involving violence are handled by Billy Greene and Madeline Rosario-Almonte

Added 5/9/04

Revised 4/12/10

5/13/13

10/29/18

Page 1 of 1

**Policy Number: GPS -18**

**Policy: Waiting List**

CTR will ensure adequate staffing at all times to decrease the need for, or eliminate, a waiting list. CTR believes that any patient seeking treatment should receive a prompt intake assessment as well as medical exam. Should CTR not be able to provide a reasonable time frame (2 weeks) for intake assessment and medical exam, we will refer all patients to one of the other OMT clinics in the state of Rhode Island or the appropriate medical or crisis intervention facility.

1. A waiting list is maintained by the front office of potential admissions should the patient choose to wait and not accept a referral.
2. Initial information shall be obtained from the screening sheet. Priority shall be given to admissions in the following order:
   1. pregnant women
   2. HIV/Hep C positive
   3. Recent release from a penal institution
   4. Patients completing MSW shall have priority readmission within 30 days of leaving treatment

A log book shall be maintained under each heading listed above that includes the name, phone number and date of the initial contact.

1. The potential patient shall be asked to call on a weekly basis for an update or, if preferred, the intake coordinator may call them when there is an opening.
2. Each contact shall be logged in the log book by the intake coordinator of the potential patient or calls the potential patient.

Revised 5/26/09

Page 1 of 1

**Policy Number: GPS - 19**

**Policy: Performance Improvement Plan**

All CTR employees are part of performance improvement for ensuring quality treatment to patients.

All members of the agency will play an active role in continuous performance assurance and performance improvement. Board Members shall receive a copy of the annual management summary which outlines quality measures and improvement plans. Input, if any, is recorded in the minutes of the meetings.

**Goal:**

To establish a Performance Improvement/Performance Control Plan that is user friendly and ensures that opportunities for improvement are identified via patient grievance, patient advocacy or staff are not only recognized but also acted on to improve the quality of care provided to patients. This process shall be kept simple as we are a small agency.

**Objectives:**

* To provide a systematic method related to
  + Identification of opportunity for improvement/data gathering
  + Making appropriate changes to meet the opportunity
  + Implementing changes
  + Review of changes
  + Implement additional changes if needed to plan or continue as is

**Auditing/Reporting Format:**

* Patient or staff member or any other stakeholder may identify an opportunity for improvement in any area of patient care, policy and/or procedure implementation or safety.
* This item will be brought to the attention of the Program Director or Designee
* The information is discussed at staff meetings, or any other agency meetings and documented as part of the minutes.
* Information may also be found in policy change, newsletters, or by talking to staff and patients

Revised 6/21/04

5/26/09

11/09/12

12/22/14

Page 1 of 1

**Policy Number: GPS - 20**

**Policy: Audits**

All charts, medical and clinical charts, are to be audited within the first 14 days of treatment in accordance with the initial audit checklist. CTR will also complete Random Audits, yearly audits and discharge audits of all files. This information will be used for both quality improvement and quality assurance to identify areas in which CTR can improve patient services and comply with all state and federal regulations.

**Initial Audits (Quantitative)**:

1. The person responsible for all auditing will retrieve all new admission charts within the first 24 hours of treatment. (front office does the initial quantitative clinical chart audit and once completed, the Clinical staff will resume with numbers 4-7)
2. Each item on the initial audit checklist is checked and the checklist is filled out that the item is either complete or incomplete.
   1. Any incomplete items are flagged for completion
3. Once completed the checklist is copied. The original checklist is taped to the front of the chart and the chart is given back to the counselor or medical staff. The copy is kept in a file for follow-up and statistical reasons.
4. Once the counselor or medical staff has corrected the deficiency, they are to note it on the audit checklist with the date it was corrected and hand those checklists back to the auditor.
5. The auditor or designee will match up the corrected audit checklist with the copy in her file and staple together. These checklists will be transferred to a completed file that is kept for statistics.
6. The information will be used to provide training to staff as needed.
7. All other audits (**random, yearly and discharge**) are to be completed in the same manner outlined above utilizing the correct audit checklist.

Added 1/12/04

Revised 10/29/18

Page 1 of 1

**Policy Number: GPS - 21**

**Policy: Meeting Minutes**

CTR requires that minutes be taken at all clinical and administrative meetings held by the agency. These minutes shall be kept in their respective binder in the front office for easy access and reference.

1. A member of the office staff or designee is to take the minutes at each staff meeting (HH or Staff meeting). These minutes shall be in the following format:
   1. Meeting Name
   2. Meeting Date
   3. Members present
   4. Discussions at meetings
   5. Signature of person taking the meeting minutes
2. The clinical supervisor or designee with take the minutes at the Clinical Group Supervision meeting in the same format.
3. A member of the office staff or appointed designee with be responsible for taking meeting minutes at any meeting deemed appropriate by the Members.
4. All meeting minutes are to be kept in a binder for review.

Revised 10/29/18

Page 1 of 1

**Policy Number: GPS - 22**

**Policy: Telephone Inquiries regarding Program**

**CARF: 3.B.3**

CTR will answer any inquiries regarding our program and treatment services. If the person answering the telephone is not qualified to answer such questions or complete telephone screening tool, then the appropriate staff member is to be located to do so while the inquiring person is on hold.

1. The staff member is to answer any questions that the inquiring person may have regarding program structure.
2. If the inquiry is coming from the Media, State, Federal Agency or Accreditation these must all be directed to Wendy Looker.
3. In the event the inquiring person is interested in completing an intake assessment to our program, the telephone screening sheet is to be completed by an individual who is trained to administer the screening tool.
4. Once the sheet is completed, the staff member should ensure that the inquiring person knows the costs associated with treatment, alternative treatment options, the length of time it takes to complete the intake process, which personal information, identification they need to bring with them and which medical tests are required such as lab work, tb test and urinalysis.
5. If the inquiring person still wishes to move forward with the intake process then an appointment is scheduled at the convenience of the inquiring person within CTR’s business hours, please see appropriate policy GPS-23.

Revised 10/29/18

**Policy Number: GPS - 23**

**Policy: Intake Scheduling**

The Front office is responsible for scheduling intake appointments for patients for the purpose of completing the appropriate paperwork to complete the bio-psychosocial assessment and determine appropriate for treatment with medication replacement therapy.

1. Once the telephone screening sheet is completed and appropriate topics explained to the inquiring person, an appointment is made.
2. Write down the name of the inquiring person in the intake appointment book/computer at the time which is most convenient, and available, for the person.
3. When the inquiring person arrives at the clinic the office staff is to notify the intake coordinator who will be completing the assessment and begin the paperwork.
4. The Office Staff is to make three copies of their picture identification, social security card or letter of application and any insurance card they currently have. One copy is for the medical chart, one for the clinical chart and one to enter the information into the state MIS/billing system.
5. The Office Staff or designee gives each prospective patient the following information and reviews this information with them:
   * Rules and Regulations for CTR
   * Rights of Patients
   * Receipt of CTR Handbook sheet
   * Insurance Authorization
   * Consent forms
   * Health History
   * Patient Responsibility Statement
   * Consent to contact other Treatment Program Methasoft
   * Verification not enrolled in another treatment program
   * Any other information/consents/forms deemed appropriate
6. The office staff will enter the information into the computer and fill out the state MIS form.

Page 2 of 2

7. The office staff will answer any questions that the patient may have and review all forms which need to be signed by the patient including:

* Consent to Treat with a Narcotic Drug
* Consent for Release of Information
* Initial Treatment Plan
* Consent for post-treatment follow-up

1. The office staff will give them an appointment to see the Physician, attend orientation group and overdose prevention group before they leave.

Revised 5/26/09

10/29/18Page 1 of 2

**Policy Number: GPS - 24**

**Policy: Informed Consent**

CTR believes all patients are entitled to have all clinical, medical and procedural processes explained to them throughout their treatment. CTR believes the individual patient is an integral part of the treatment team and requires them to be actively involved in and informed about their treatment.

1. This process begins with a telephone screening when a call is received by CTR by a person seeking treatment. The following is explained to the patient:
   1. costs associated with treatment
   2. available appointment times
   3. what to expect of the admission process
   4. time involved in admission process
   5. identification required to begin treatment
2. The process continues with the actual admission assessment where the person seeking treatment is explained:
   1. diagnosis relevant to treatment
   2. recommendations for treatment/including referral if indicated
   3. providing patient with copy of patient handbook
   4. rights and responsibilities of patients
   5. rules and regulations for patients
   6. clinic polices regarding no shows for counseling appointments
   7. consent to treat with a narcotic drug
   8. confidentiality of records of patients
   9. take home medication responsibilities
   10. clinic dosing hours
   11. clinic hours of operation’
   12. counseling expectations
   13. date and time of admission physical appointment including date treatment begins.
3. During the admission physical the physician and nursing staff informs the patient:
   1. their prescribed dosage level
   2. blood work needed for admission
   3. information regarding TB testing
4. An induction group (orientation)is scheduled which will cover the following:
   1. review of patient’s rights and responsibilities
   2. review of patient’s rules and regulations
   3. individual and group counseling expectations
   4. nursing policy and procedures
   5. overdose prevention

Page 2 of 2

1. The nursing staff shall continue this process daily with:
   1. monitoring for withdrawal/intoxication symptoms related to medical replacement therapy
   2. assess for illicit/licit drug use
   3. ensuring appropriate lab work and tests are performed and explained to the patient
2. Counseling staff continues this process with:
   1. overall diagnostic impression based upon the intake note as well as physician orders and nursing notes
   2. counseling expectations and scheduling
   3. group counseling expectations and scheduling
   4. clinical issues concerned with initial stabilization
   5. composing the individualized first treatment plan with patient
3. The process of informed consent continues throughout treatment and may change relevant to the following:
   1. titration requests
   2. take home requests
   3. medically supervised withdrawal requests
   4. treatment plan updates
   5. group selections
   6. patient consultation
   7. patient referral
   8. change in fees
   9. change in clinic policy
   10. change in state or federal regulations
   11. individualized treatment contracts
   12. other contingencies

revised 10/29/18

Page 1 of 1

**Policy Number: GPS - 25**

**Policy: Consent for Treatment with an Approved Narcotic Drug**

**CARF:**

CTR requires that all patients are required to read and sign the consent to treat with a narcotic drug upon initiating the intake process. This consent explains the advantages and risks associated with this type of intervention. If the patient cannot read this consent or it is not in their native language, CTR requires that it be read to the person in a language which they understand.

1. The patient is given the consent for treatment with an approved narcotic drug to review and sign upon beginning the admission process.
   1. the patient reviews this form prior to seeing a counselor
   2. the counselor asks the patient if they have any questions regarding this form
   3. the form is signed and dated by the patient and staff
2. If the patient has any questions, the admission process will be halted at this point so that any questions may be addressed.
3. Once the questions have been answered and the patient elects to continue, the admission process will continue.
4. If the patient chooses not to continue with the intake process for any reason, the counselor with their supervisor or Program Director shall speak to the patient regarding other forms of treatment and ensure that all appropriate treatment referrals have been made to assist the patient with obtaining the most effective form of treatment for them.

Page 1 of 1

**Policy Number: GPS - 26**

**Policy: Admission to Detoxification Protocol**

CTR offers detoxification protocol for patients that do not meet the criteria for maintenance therapy. All Admission requirements must be met and the admission procedure will be the same except for the detox schedule is to be determined between the physician and patient but under no circumstances is more than 180 days.

1. When the patient expresses that they would like to enter a detoxification protocol, the staff member completing the admission is to:
   1. review the consent for admission to detoxification treatment with the patient
   2. answer any questions that the patient may have regarding the consent
   3. patient and staff member completing the admission are to sign and date the protocol
2. Once the paperwork has been completed for detoxification, the intake will proceed the same as outlined in the admission policy.

3. A program shall not admit patients for more than 2 detox attempts during one year. With 2 or more unsuccessful detox attempts, patient shall be readmitted to MMTP.

Revised 6/25/04

11/25/16

Page 1 of 2

**Policy Number: GPS - 27**

**Policy: Temporary Transfer/Courtesy Dosing**

CTR believes that medication replacement therapy should not interfere with the everyday life of the patient. However, CTR also understands that not every patient is eligible for take home medication. Because of this, CTR will provide the option of temporarily transferring the patient to another clinic for the purpose of work or vacation travel. Temporary transfer is not available to those patients who are on an administrative detox or AMA detox without the approval of the program director and physician.

1. At least 30 days attendance at the clinic should be observed before temporary transfer of the patient.
2. Arrangements for courtesy dosing should be made in advance whenever possible. At least two weeks advance time should be allowed. In the case of an emergency, CTR will do our best to ensure there is no interruption in medication replacement therapy.
3. Temporary transfers for patient who were admitted to a detox protocol are not permitted as many clinics will not allow the detox to continue.
4. Take home medication may be provided in conjunction with the temporary transfer for patients who meet the take home medication criteria. All take home medication is by physician order only.

Counselor/Nursing:

* Written consent must be obtained to contact the treatment agency the patient is looking to temporarily transfer to.
* Phone contact is made to determine the information and format needed by the agency transferring to.
* CTR temporary transfer form is completed by the primary counselor, clinical supervisor or nurse.
* The Medical Director/Program Physician approves the temporary transfer after reviewing and signs the transfer form if needed.
* Necessary information is transmitted by letter, fax and/or phone to the agency to which the patient is transferring.
* The patient will be given a sealed copy of the information faxed and/or mailed to the agency to which the patient is transferred.
* The signed temporary transfer form is then filed in the physician section of the patient chart.
* A copy of the signed form should be given to the front office and nursing staff.
* Patient’s financial account should be credited for days away from the clinic.
* Last dose letter given last day in home clinic and requested for last day in transferring clinic.

Revised 6/21/04

5/26/09

10/28/19

Page 1 of 3

**Policy Number: GPS - 28**

**Policy: Take Home Medication**

All take home medication is dispensed in accordance with state and federal regulation. No medication shall be provided to patients that do not meet the criteria set forth in those regulations, clinic policy or without a physician order. In addition, all medication must be dispensed in child-proof containers in a locked box.

As a general rule, all patients must observe a period of two (2) months adhering to program policies, including negative urine screens before take home doses may be granted:

- 2 months, up to one take home, 6 clinic visits/wk. after add’l.

- 3 months, up to two take homes, 5 clinic visits/wk, after add’l.

- 6 months, up to four take homes, 3 clinic visits per week, with a maximum of 2 take-homes given consecutively

- 1 year, up to five take-homes, 2 clinic visits per week with a maximum of

three take homes given consecutively

- 2 years, up to six take-homes, one clinic visit per week

- 3 years, up to a 13 day supply of take-homes

- 4 years, up to a 28 day supply of take homes – at this time, CTR does not provide for 28 day supply of take-home medication

Changes to these schedules are at the discretion of the medical director within the state and federal guidelines. Length of time must be without a break in service but may include treatment at more than one agency.

Take home medication is not allowed on AMA, Financial or Medical Detox.

1. The patient must reside in a stable home environment
   1. No known untreated/illicitpositive individuals residing in the home
      * Signed releases should be obtained by both parties who reside in the home and are being treated at CTR
2. Patient must not have any untreated alcohol or drug problems – must be illicit drug free.
3. All take-home containers must have child-proof caps and be shrink wrapped by the nursing department
4. all take-home containers must be returned to a member of the nursing staff on the next day the patient is due in the clinic
5. Take-home medication is not allowed for any person who is on a detox of 180 days or less, unless it is approved by the appropriate agency(s)

Page 2 of 3

1. Take-home medication containers must be labeled with the following information:
   1. patient name
   2. name and amount of drug
   3. directions for use
   4. date issued and date to be taken
   5. program/physician name and address
   6. program telephone number
2. Revocation of take-home status must be documented by the physician when the patient is no longer adhering to program rules, this includes behavioral issues or deemed inappropriate by the program physician. All take-home medication will be earned on an individual basis set forth by Medical Director in conjunction with state and federal regulation.
3. Any patients who feels that revocation of their take-home is not consistent with policy and procedures of CTR may file a grievance as outlined in grievance procedure.
4. Procedures for Counselors to follow to obtain take-home medication for patient:
   1. primary counselor is to complete the take-home request form with patient who also signs the form, attach appropriate documentation, and review the request with the clinical supervisor.
   2. The primary counselor is to inform the patient they need to sign up for the take-home group that is convenient to their schedule.
   3. The clinical supervisor will review the take-home form for completeness including take-home group attendance.
   4. Once approved by the Clincial Supervsior, the form will be forwarded to program director.
   5. Program Director will review and access PMP which will be attached to the request for the physician.
   6. The request will then be forwarded to the physician for final approval.
5. Special/Emergency take homes may be granted in the case of a documentable hardship such as acute illness, family crisis, job related travel or death of a family member at the sole discretion of the medical director.
6. Vacation, holiday and travel doses may be granted within the limits allowed by state and federal regulation.
7. The counselor must review the Take Home Responsibility form patients. This form shall be reviewed with the patient upon intake, prior to initiation of take home privileges and upon receipt of additional take home privileges which outlines safe storage and handling.
8. Patient must verbalize understanding of these responsibilities and sign and date form as well as the counselor who reviews the form with them.



1. At any time a staff member may request a call-back of medication. This call back shall be made by their individual counselor requesting that the person

served return to the clinic and bring with them all of their take-home medication bottles, empty and full.

* 1. the nurse shall account for all bottles both empty and full
  2. the nurse will request an observed urine screen
  3. if any bottles are not accounted for then a suspension of take home medication will instituted and the patient will be required to meet with the Medical Director or Program Physician before reinstatement.

1. Take-homes may be suspended during periods which patients have a short term prescription for opiate pain medication. Any exceptions to this are at the discretion of the Medical Director only. Take-homes are also suspended for individuals who have a payment balance.
2. Take-homes will be limited to no more than 6Xwk for those patients who are receive ongoing medications such as opiates or benzodiazipines. Any exception to this are at the discretion of the Medical Director.
   1. CTR may at their discretion reserve the right to increase it’s monitoring of both prescription medications and take-home privileges for those individuals who are on chronic pain, anxiety or psychotropic medications.
3. Those individuals who are transitioning to 13 day take-home status are expected to have a primary care physician and routine health care. If the patient does not have a primary care physician, a referral may be made with consent in advance of receiving 13 day take-home status.
4. Medical Marijuana is only allowed in two forms: Marinol and Cesamet which can be obtained through a pharmacy. Marijuana in other forms or obtained from a compassion center or dispensary are considered illicit for the purpose of take-home privileges as they are not legal under federal regulation.

Revised 5/13/04

Revised 8/15/04

Revised 3/12/07

Revised 4/4/07

5/26/09

10/03/11

04/25/17

09/22/17

10/29/18

Page 1 of 1

**Policy Number: GPS - 29**

**Policy: Vacation Take-home Medication**

Patients who meet state and federal guidelines as well as clinic policy for take home medication are also entitled to receive vacation take-home medication as approved by the Medical Director/Program Physician.

Vacation take homes are for the purpose of taking time off of work for the purpose of taking recreational time with family, friends and significant others. However, the total number of requested take-homes may or may not be approved by the staff of CTR.

1. Eligibility requirements include, but may not be limited to:
   1. clinic attendance for 90 days or longer
   2. currently has take-home medication status
   3. current clinic fees
   4. three week notice of need for vacation take-homes
2. The same procedure is required for approval as filing out any take-home request.
3. If needed, an electronic submission for state and federal approval will be completed by the medical department.

Revised 5/26/09

Page 1 of 1

**Policy Number: GPS - 30**

**Policy: Fraudulently Obtaining a Controlled Substance**

If any person attempts to obtain a controlled substance by fraud, deceit, misrepresentation, subterfuge, the concealment of a material fact or otherwise make false representation to obtain a controlled substance in accordance with the provisions of Chapter 21-28-4.05 of the Generals Laws of RI, as amended shall be reported to the Department of Health, Division of Drug Control.

1. A written incident report will be completed by appropriate agency staff.
2. A copy of the incident report will remain in the agency incident report file.
3. the original shall be mailed, return, receipt requested, to the Department of Health, Division of Drug Control.

Page 1 of 1

**Policy Number: GPS - 31**

**Policy:**  **Request for Dose Change**

CTR understands that patients may require medication dosage adjustments for various reasons. There are times when patients may need an increase or decrease in their prescribed dose of medication. All changes of medication dosage require a physician order and are at the discretion of the physician based on objective and subjective data.

1. Once the patient discusses any request for dosage change with their counselor, the counselor must complete the dosage adjustment assessment in the EHR.
2. The request will then go to the Nursing Director or appropriate designee to review.
3. The RN/designee will then either get a telephone order and enter it appropriately or print the sheet for review by the physician during the next visit.
4. The physician either approves or denies this request based on objective and subjective data presented.
5. the physician will write the order and sign and date the form. The
6. form is placed in the proper section of the patient medical chart and
7. a member of the nursing staff will enter the new order into the computer.
   1. All staff shall take into consideration when request for dose changes are initiated:
   2. current medical conditions
   3. current medications of patient
   4. illicit drug use and symptoms of withdrawal
   5. any relevant lab work such as peak and trough required for dosages above 150 mg or at the request of medical staff.
   6. whether or not a release is filled out for the prescribing physician.

Revised 7/22/04

5/26/09

10/28/19

Page 1 of 1

**Policy Number: GPS - 32**

**Policy: Continued Drug Use**

Patients treated at CTR are all treated on an individual basis as prescribed in their individualized treatment plan. If all treatment options have been exhausted at CTR, we may require the patient seek alternative treatment options that are both reasonable and appropriate. All justification for seeking alternative treatment options will be based upon the diagnostic protocols outlined in the ASAM criteria. CTR will assist the patient in this transition by way of referral to the appropriate agency.

For patients who continue with toxicology screens that are positive for illicit drugs for a period of more than 180 days and who do not appear to be making adequate progress towards being illicit drug free, such as being noncompliant with their treatment goals and objectives, the following should be considered:

1. When appropriate, based on the illicit drug being used, titration is discussed with patient as an option for addressing continued substance use.
2. Frequency of scheduled individual counseling sessions may be increased to no less than 2 times per month. The combined time for these sessions should be no less than 90 minutes.
3. Toxicology screens may be increased to 2 times per month random, and may be supervised.
4. A safety plan is to be implemented, especially with illicit benzo, alcohol or fentanyl use.
5. If no improvement is noted after a reasonable amount of time, discussion between counselor and clinical director should direct next steps to be discussed with patient.

Revised 7/23/04

10/29/18

Page 1 of 2

**Policy Number: GPS - 33**

**Policy: Reinstatement of Take-home Privileges**

Patients at CTR are all treated on an individual basis as prescribed in their individualized treatment plan. Individuals may have their take-home privileges revoked or suspended for various reasons which include, but may not be limited to, positive urine screens, absences from clinic after a take-home without notifying clinic, loss of take homes or bottles, non-compliance with agency policies, behavioral issues or financial non-compliance.

Reinstatement of these take-homes may follow the schedule as listed below. However, the Medical Director, in conjunction with the clinical and nursing staff may provide a varied schedule to meet the individual needs of the patient. Although time frames have been provided, CTR medical and clinical staff reserve the right to lengthen or shorten those time frames on an individual basis due to the seriousness of non-compliance or because of multiple losses of take-homes.

All other regular requirements of take-homes must be met in addition to the following:

1. Loss of take homes due to positive urine screen
   1. at least 30 day period from the date of positive screen must be observed with daily visits to the clinic
   2. 1 clean urine screen (may be requested as observed) in the next month
   3. 1 hour of individual counseling

i. up to three (3) take-homes, will earn them back one each 30 days

ii. four (4) take-homes, will earn one (1) back after 30 days, the second after 30 days and after the next 30 days will earn back both three (3) and four (4)

iii. five (5) take-homes, will earn one back after the first 30 days, then two back after the next 30 and the last two back after the next 30 days.

iv. six (6) or thirteen (13) take-homes, will earn two back after each 30 days.

1. Loss of take-homes due to absence from the clinic after takehome without notifying the clinic prior to the absence “unexcused”
   1. 30 day probationary period with daily visits to the clinic
   2. No exception take-homes are allowed
2. Loss of take-homes due to continued missed counseling appointments
   1. a minimum of 30-60 days with daily visits at the discretion of the staff.
3. Loss of take home for non-return of take-home bottles
   1. a minimum of 30 days with daily visits to the clinic

Page 2 of 2

1. Loss of take-homes for non-compliance with medical exams and tests
   1. until compliance with required medical exams and tests
2. Loss of take homes due to behavioral issues
   1. dependent upon the behavioral contract and at the discretion of the Medical Director in conjunction with clinical and medical staff.
3. Loss of take-homes due to non-compliance with financial obligations
   1. loss of take-homes until finances are current
   2. if put on a financial detox, loss of take-homes until 14 days after stabilization is met
4. Recent Incarceration/inpatient psychiatric hospitalization/hospitalization
   1. individualized based on Medical Director, clinician and nursing assessment of current situation.
5. Loss of take-homes non-compliance with call back
   1. individualized based on Medical Director, clinician and nursing input.
   2. Repeat offenses may be permanent loss of take-home
6. Loss of take-home due to non-compliance with medications and medical issues (medical instability)
   1. Individualized based on medical stability.
7. Loss of take-home due to unstable living arrangements
   1. May resume take-home when living situation is stable

Revised 1/20/05

5/26/09

10/30/18

Page 1 of 1

**Policy Number: GPS - 34**

**Policy: Copies of Patient Information**

CTR will provide copies of patient records in accordance with all state and federal regulations including 42 CFR part 2 and HIPAA and with valid patient consent. All copies shall be sent to providers free of charge. However, any copies that are for personal use or legal use, which is not requested by a court of law or prohibited by state or federal law shall have flat fee of $15 imposed for retrieval of the record(s). In addition, a charge of $.25 per page for the first 100 pages copied. All pages after that shall be a charge of $.10 per page. If a copy of one page is requested, the retrieval fee shall be prorated at so that a single page copy is equal to $1.00. All Electronic record copies shall be billed in the same manner. Medicaid patients are not charged for copies. CTR reserves the right to withhold copies of any information which may be detrimental to the patient. In addition, CTR will not disclosed copies for a third part.

All requests shall be in writing on a properly executed release of information that is 42 CFR compliant. Once the release is received, the requested records shall be copied and provided within 30 days.

Once a statement has been made to CTR that copies of the patient’s chart are being sought for the purpose of litigation they shall only be released in accordance with 42 CFR part II with valid court order. A subpoena, search warrant, or arrest warrant, even when it is signed by a judge, is not sufficient, by itself, to require or even permit a program to make a disclosure.

Added 3/14/05

11/25/15

10/30/18

Page 1 of 1

**Policy Number: GPS – 36**

**Policy: Chart Review by Patient**

Patients may access their personal health information. Access to records must be requested by the patient in writing.

1. The patient makes the request to review their chart in writing.
2. The request is given to the front office.
3. The front office will make an appointment for the patient with their counselor.
4. At this appointment the patient may review their clinical and or/medical charts.
5. If the patient disagrees with any aspect of the chart they may fill out a Patient Statement of Disagreement outlining what items in their chart they do not agree with.
6. The Statement of Disagreement is filed within the patient’s chart, either clinical or medical, depending upon what it is they disagree with.

Added 3/14/05

Page 1 of 1

**Policy Number: GPS – 37**

**Policy: Take-Home Medication Call Back**

From time to time CTR may perform random call backs of medication from those individuals who have take-home status. Random call backs of medication help to insure the integrity of patient and clinic in following all state and federal guidelines as well as best practice. CTR does not take back medication that may have been tampered with. However, the patient will be required to return to the clinic daily with the medication in the box and take the medication in front of the nurse. When the take-homes are finished, the patient will not receive any more take-homes until they are re-earned.

1. The counselor, program director or nursing staff will make a list of patients which they would like to see have a random call back of medication.
2. The nursing department will call the patient the morning they would like the patient to return to the clinic with the medication.
3. The patient will be required to return to the clinic on that day but under no circumstances later than 24 hours from the phone call.
4. The patient will also be given an observed urine screen on the day that they have their call back.
5. Any patient who refused to return to the clinic with their medication will have their take-home medication suspended for an indefinite period of time for program non-compliance.
6. Any pt. who does not respond to a message left will also have their take-home medication suspended.

Added 4/1/05

Revised 1/06

5/26/09

Page 1 of 1

**Policy Number: GPS – 38**

**Policy: Seclusion and Restraint**

**Non – Violent Practices**

CTR does not utilize seclusion or restraint of any kind. Employees of CTR shall try to diffuse the situation as outlined in our Fire and Safety/Emergency training packet. Whenever possible key staff will be provided education in non-violent crisis prevention and how to deal with difficult people. If efforts to diffuse the situation are not successful, either the panic button shall be pushed which goes immediately to the Police Department or 911 shall be called by a staff member.

Page 1 of 2

**Policy Number: GPS - 39**

**Policy: Medically Supervised Withdrawal Agreement**

CTR provides and encourages patients the opportunity to complete a medically supervised withdrawal from medication replacement therapy. It is recommended if an individual have a co-occuring disorder that their primary physician or mental health counselor concur that an MSW is appropriate and nursing shall send out the appropriate form with patient consent.

1. The process is initiated when the patient discusses with their primary counselor the he/she would like to begin a medically supervised withdrawal.

2. The primary counselor:

a. discusses with the patient how the MSW will clinically affect them

b. 6 months of illicit drug free status is required to begin an MSW

c. outside support systems, counseling, group counseling, or other appropriate support system is required of the patient.

3. Once the above criteria are met the counselor and patient develop their aftercare/continuing care plan

1. Once the agreement is reviewed with the patient by the counselor, and the patient understands and agrees to it, both the patient and counselor sign the MSW transition plan request form.
2. The counselor brings the request, with supporting documentation to the Clinical Director for review.
3. If the MSW is approved by the Clinical Director or Program Director, the physician is given the information the next day they are at the clinic to review and approve.
4. Once the physician has written and signed the order, the nurse will transcribe the order into the computerized dispensing system for the MSW to begin. If the patient is a woman of childbearing age, a pregnancy test is to be completed before beginning or resuming an MSW.
5. If it is decided that the patient does not meet the criteria for the MSW, the counselor is to assist the patient by identifying treatment options and establishing a plan of action to address the requirements not met.
6. If the patient has a urine drug screen positive for illicit substances, the MSW will be stopped for a minimum of 30 – 60 days to address the issue with their counselor as well as stabilize. Once they have met with their counselor and has at least one negative urine screen, the MSW may be resume. If the patient has a second positive urine screen while on an MSW, no less than 90 days but up to 180 days may be required to resume as well as meeting with their counselor to discuss use. A new MSW Transition Plan will need to be completed to resume the MSW regardless of whether it is the first or subsequent relapse.
7. Patients who successfully complete the MSW are eligible to continue aftercare with CTR.
   1. The EHR shall be updated to reflect drug free status
   2. RIBHOLD shall be updated to reflect the change in status
8. Any patient who completes an MSW shall be given priority status for readmission.

Revised 7/14/04

5/26/09

02/16/10

09/04/18

10/30/18

Page 1 of 1

**Policy Number: GPS - 40**

**Policy: Against Medical Advice (AMA) Withdrawal**

CTR will make available to patients an AMA withdrawal if they do not meet the criteria for an MSW but are adamant that they want to withdraw. Although CTR believes that this may not be the best treatment option for the patient, CTR respects the rights of the patient and offers this option as an alternative for those not appropriate for an MSW. Regardless of any co-occurring disorder, the patient has the right to enter into an AMA at their request.

1. This process is initiated when the patient makes the request to their primary counselor.
2. the primary counselor and patient discuss the reasons the patient feels they need to complete the AMA withdrawal
3. the primary counselor explains to the patient:
   1. no take-home medication is allowed on an AMA withdrawal
   2. the clinical impact of the AMA withdrawal on treatment Documentation in the record of the patient shall include:
   3. efforts taken by program staff to avoid AMA discharge
   4. reasons the patient is seeking AMA discharge
4. The counselor, with the patient, completes the appropriate form, Against Medical Advice Transition form.
5. the AMA request is attached to the individual chart of the patient and provided to the physician on the next day the physician is due in the clinic.
6. the patient schedules an appointment with the physician, through the office staff, to review the AMA withdrawal request with the physician.
7. the physician and patient discuss the AMA withdrawal request.
   1. if the patient still chooses to begin an AMA withdrawal, the physician will sign the form and write the order for the AMA withdrawal in the individual chart of the patient.
   2. A member of the nursing staff will transcribe the order into the computerized METHASOFT dosing system.
   3. The nursing department will ensure a pregnancy test is completed of all childbearing age women before initiation of the AMA.

revised 6/28/04

5/26/09

2/16/10

10/30/18

Page 1 of 1

**Policy Number: GPS - 41**

**Policy: Criteria for Possible Discharge/Administrative Discharge**

CTR reserves the right to discharge any patient from treatment for items outlined below. CTR will not discharge any patient without sufficient cause. In most cases, patients will be entitled to a grievance hearing unless doing so would put the staff or other patients in an unsafe environment. Also, CTR will do its best to aid the patient who is being discharged to an alternative treatment setting including inpatient or another OTP provider.

1. Possible reasons for discharge include, but are not limited to:
   1. five days of unexcused absences from the clinic
   2. violent or threatening behavior towards agency staff or patients
   3. harassment directed towards agency staff or patients
   4. possession of fire arms or other dangerous weapons
   5. possession of alcohol, unauthorized controlled substances and or illicit drugs
   6. violation of behavior/treatment contract
   7. inability to meet financial obligations
   8. transfer to another narcotic treatment provider
   9. incarceration
   10. patient no longer meets eligibility criteria for outpatient level of care in conjunction with ASAM criteria
   11. any other reason deemed as interference with treatment at CTR
   12. inappropriate behavior towards any neighbor of the facility.
2. Patients who are discharged for possession of firearms or violence/threats of violence, will be deemed ineligible for re-admission to CTR for future treatment and will be provided an appropriate referral.
3. Documentation in the individual chart of the patient shall include:
   1. efforts to transfer
   2. that due process was provided
   3. any co-occurring disorders
   4. any specific health needs
4. All administrative detoxes are at a rate to be determined by the Program Physician/Medical Director.
   1. Before an administrative discharge on a woman of child-bearing age, the results of a pregnancy test shall be documented.
      1. Detoxes shall not start on a Saturday or a Sunday
      2. Results of pregnancy test shall e documented in individual chart before physician is notified.

Revised 2/16/10

8/23/11

10/30/18

Page 1 of 1

**Policy Number: GPS - 42**

**Policy: State Registration, Dual – Enrollment**

CTR requires compliance with all state and federal regulations. This requires CTR to register and clear each patient with the state MIS system to ensure that the patient is not enrolled in more than one treatment program at a time. If it is felt that the patient could benefit from being treated at more than one facility at a time, but not two medication replacement therapy programs, the appropriate paperwork must be completed.

1. Once the counselor and patient that have identified that the patient could benefit from dual enrollment, the counselor must discuss this with the clinical supervisor.
2. Once it is determined by the counselor and clinical supervisor, it should be discussed with the patient as to their options, agree on which agencies to contact and phone these agencies.
3. Once an agency is willing to accept the patient, a Request for Patient Dual Enrollment form must be completed and sent to the appropriate state agency.

Page 1 of 1

**Policy Number: GPS - 43**

**Policy: Initial Inventory**

CTR will conduct an initial inventory for its first day of business. This form shall be labeled Initial Inventory, have the name and address of CTR, the DEA#, the date and the signature of the person taking the inventory. For the purposes of CTR, the initial inventory amount shall be zero (0) unless we had methadone on hand.

Page 1 of 1

**Policy Number: GPS - 44**

**Policy: Biennial Inventory**

Two years from the opening date and initial inventory, the pharmacist, with verification of a nurse, will conduct a written, biennial inventory and document the results. This record shall be maintained for a period of two years. For all intents and purposes, the biennial inventory may be taken on any date which is within two years of the previous biennial inventory date.

The controlled substance act as well as state and federal regulation, require this biennial inventory as a means of accountability.

1. The inventory shall document:
   1. name and address of CTR
   2. DEA License Number
   3. date of inventory
   4. whether it is the opening or close of the business day
   5. quantity of methadone on hand listed as powder or liquid (buprenorphine, if any)
   6. signature of pharmacist and nurse who performs the inventory
   7. the unit of measure shall be milligrams
2. Any variation of the date of the biennial inventory must be approved by the DEA.

Page 1 of 1

**Policy Number: GPS - 45**

**Policy: DEA 222 Forms**

The program sponsor has the ability to order the 222 forms. The program sponsor shall also fill out a power of attorney so that the pharmacist can obtain an adequate supply of forms and order the methadone powder or buprenorphine.

1. Using the DEA 222a form, the pharmacist or program sponsor shall request the maximum number of six (6) order form books from the DEA in Boston.
2. When the DEA 222 form books arrive, the pharmacist or program sponsor shall open them and place all books in consecutive order by number.
3. When only one DEA 222 form book remains, the pharmacist or program sponsor shall order additional books. CTR should never have less than one full book on hand at all times.
4. These DEA 222 form books shall be stored in the small safe which houses the methadone powder in a properly labeled folder “unexecuted 222 forms”.
5. Any missing unexecuted 222 forms must be reported to the DEA immediately as it is noticed.

Page 1 of 2

**Policy Number: GPS - 46**

**Policy: Methadone Reconstitution**

The pharmacist is responsible for compounding the methadone into a solution of 10mg/ml for the purpose of the nursing staff to administer to patients in treatment at CTR.

The following is a guideline for the pharmacist to follow when preparing the powder form to the liquid form for administration:

1. Remove safety seal on 100 gram Methadone Hcl powder container.
2. Weigh the bottle with the cover and record weight in grams on the container
3. Tare the weight of the beaker on the scale
4. With a spatula remove 40 grams of methadone powder from the container and place into the empty beaker
5. Re-weigh the container with the cover on and subtract this amount from the original weight written on the label to ensure that 40 grams of powder was taken.
6. Add 400 ml of distilled water to the beaker containing the 40 grams of methadone powder, stir well.
7. Using a funnel, add the methadone/distilled water solution to an empty 4 litre bottle that has already been weighed, labeled and measured to the 4000 ml line.
8. Add another 400 ml of distilled water into the beaker and stir to dissolve all methadone powder residue. Add to the 4ltr container and repeat again.
9. Put cap on 4 litre container and shake well to ensure that methadone powder is well mixed into a solution.
10. Weigh the 4000 ml bottle with the cap off on the scale, add enough distilled water until the weight is reached. Replace cap and shake well.
11. Record all deductions from the methadone powder perpetual Inventory.
12. Record the amount of milligrams being added to the Nursing perpetual inventory.

Page 2 of 2

1. Record date, amount in milligrams, lot number of bottles, and bottle number, pharmacist signature and nursing signature to the Transfer to Nursing Log.
2. All prepared methadone must be labeled with lot number, bottle number, amount of methadone and expiration date.
3. Record date, lot number, bottle number and amount to the Pharmacy Transfer to Nursing Log.

Page 1 of 1

**Policy Number: GPS - 47**

**Policy: Emergency Supply of Methadone**

In the event of an emergency, CTR shall maintain a enough methadone to ensure there is at least 2 months of medication on hand at all times.

Revised 11/5/18

Page 1 of 1

**Policy Number: GPS - 48**

**Policy: Destruction of Methadone**

In most cases CTR will use a reverse distributor for destruction. The pharmacist shall obtain the 222 form from the distributor and fill out all paperwork accordingly. A copy of this paperwork shall be kept in the folder in the safe.

If CTR does not use a reverse distributor, as in the case of a single dosage of methadone to be destroyed. All destruction shall be completed with two nurses using kitty litter to absorb all medication. It can then be disposed of. An incident report is required.

Revised 10/30/18Page 1 of 1

**Policy Number: GPS - 49**

**Policy: Medical Services**

CTR provides certain medical services in conjunction with the recommendations of state and federal agencies. Any services not offered by CTR that would benefit patients will be done via referral to an outside agency only with consent of the patient.

1. Admission Physical and Annual Physical
2. TB screening upon admission and annually thereafter
   1. Once screening is completed the physician may order a TB test if indicated.
3. Blood work for RPR (and may include if requested by the physician CBCD, LFT’s, Hep B antigen/antibody) upon admission and annually if requested by the physician thereafter.
4. Urinalysis drug screen upon admission and at least monthly thereafter.
5. Blood sugar testing and vital sign monitoring.
6. Urinalysis for pregnancy as ordered
7. Various other blood work if deemed necessary by the medical director/program physician.
8. Any reportable illness which we diagnose is reportable to the DOH within an allotted amount of time. Please go to the RIDOH website for the appropriate form.

Revised 10/30/18

Page 1 of 1

**Policy Number: GPS - 50**

**Policy: Laboratory Testing**

Laboratory work is done upon intake and at a minimum of annually thereafter (when indicated). Lab work may include but is not limited to:

* Blood glucose level
* BUN
* RPR
* Liver function
* CBC with DIFF
* Hep B. surface antigen
* Any other lab work that may be ordered by the medical director/program physician.

The information gathered by these tests not only provides baseline medical data but the ongoing medical needs of the patients of this facility.

All testing is performed by a phlebotomist or nurse who has been trained in venipuncture.

Once the results are received:

1. The nurse will enter the results into the computerized dosing system and enter the date the results were received into the blood work log.
2. They will review the blood work and make note of any results not in the normal range or positive results for RPR or Hep B.
3. They will provide the Medical Director/Program Physician with the results for review and recommendation.
4. The nurse will then provide the patient with a copy of the blood work. If any results require follow-up the nurse is to make an appointment to review this with them at the convenience of the patient. The nurse as well as the patient will sign the blood-work verifying that the blood work results were discussed with them.
5. The blood work will be filed in the individual medical chart of the patient.
6. The date the physician reviewed the blood work as well as the date the patient was given a copy of the blood work will be noted in the patient Blood Work Log.

Page 1 of 2

**Policy Number: GPS - 51**

**Policy: Urine Drug Screens**

CTR is required by state and federal regulation to monitor patients by a drug screen on a regular basis, at least 8 times per year. At certain times during treatment, the medical director/program physician may require that drug screens be performed more frequently than on a monthly basis. Therefore, it is an individual treatment decision regarding the frequency of the drug screens. Patients requiring more frequent drug screens then monthly may be required to pay for the cost of the screens at $20.00 per screen.

All drug screens are collected in a manner in which minimizes falsification. These screens are monitored via directly by the patient services staff. If any person is suspected of falsification of the urine screen, a member of the staff of the same sex may be required to observe the urine collection.

Below is a guideline, however, in an attempt to provide individualized treatment to the patients, the medical director/program physician may request a variation. CTR does not provide swabs for the purpose of drug screens unless there is a serious health or mental health issue which inhibits the patient from urinating.

Lastly, CTR may ask for urine screens for a “dip” which is an in-house test for certain drugs such as opiates, cocaine or benzos. The cost of this test is $10.00

1. Urine drug screens are performed at the following intervals:
   1. upon intake – a positive result for opiates are not necessary if other requirements for admission have been met.
   2. Randomly – a minimum of 8x per year
   3. Possibly after a missed day of dosing without contacting the clinic
   4. By request of staff for possible falsification, tampering, suspected use
   5. All urines are monitored
   6. May be observed
2. All females of childbearing age will be tested for pregnancy upon intake and before beginning a detox, MSW, AMA, Administrative, Medical or Financial taper.
3. Any drug testing that comes back positive for illicit drugs (including marijuana products other than Marinol and Cesamet) may be retested at the request and expense of the patient.
   1. possible loss of take-home status may result from positive drug screens
   2. possible cessation of MSW may result from positive drug screens
   3. negative methadone urine test may lead to loss of take-home status (these will be retested at a lower level) The medical staff understands

Page 2 of 2

that patients who may be quick to metabolize or those on a low

lose of methadone may have very low levels of in their urine results.

1. All testing is performed by a state licensed laboratory.

5. All samples are randomly selected by the computer and the collection set-up is provided to the patient by the check-in window.

a. The label is printed by the computer by the office staff.

b. The office staff will label the collection container and the paperwork

c. The office staff will provide the collection container to the patient who will then go to the patient bathroom and provide the sample.

* 1. The patient will bring the specimen to the security person or Intake coordinator/patient advocate who will feel the collection container for warmth and look at it to check for color/appearance.
  2. They will put the specimen in the appropriate collection box for the daily pick-up.
  3. The nurse will then medicate the patient.

1. All urines results provide information to assist the treatment team to provide the most appropriate services to the patient. Urine screens in and of themselves are not the sole reason for privileges or suspension of privileges.
2. The patient may, at his/her own expense, have the sample retested (confirmation).
3. The patient may, at his/her own expense, have a positive urine result confirmed by GCMS.
4. All urine results shall be documented in the record of the patient and aid in making decisions but not be the sole determination of service.
5. Any patient who falsifies a urine screen may be administratively discharged or put on a treatment contract. However, the patient may review options their counselor.
6. If the patient reports using illicit drugs that CTR does not normally test for, that drug will be included as part of the regular toxicology panel indefinitely.

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5/26/09

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Page 1 of 1

**Policy Number: GPS - 53**

**Policy: HIV Testing**

CTR requires that all patients attend the HIV informational group upon admission as required by law. This group is for the purpose of offering information regarding how to reduce the risk of HIV transmission.

1. All patients are offered the HIV serology test. They are asked to sign a form stating they have been pre-test counseled and offered the test. The person may decline to have testing done.

2. If the patient would like to have the HIV serology test performed after the have attended the HIV pre-counseling group, the following steps will be taken:

a. The patient will sign a consent for HIV testing

b. The patient will pay $10.00 for the HIV test

c. The person will be given a day and time to have the blood test performed by the phlebotomist or nurse

d. The patient will have their blood drawn

e. The results of the test will be given to the medical director/program physician who will review the results

f. The patient will meet with the post-test counselor who will review the results with them.

g. The post-test counseling form is completed by the post-test counselor.

h. The results of the test will be put into a separate locked file in the nurses station, not the individual chart of the patient.

3. If the results are negative emphasis on risk reduction should be provided to the patient.

4. If the test results are positive, the patient is given an appointment to speak to the medical director/program physician at the convenience of the patient.

5. A positive HIV report form must be completed and forwarded to:

Department of Infectious Disease

Rhode Island Department of Health

3 Capitol Hill

Providence, RI 02908-5097

6. Any patient who tests positive for HIV will receive a referral for medical follow-up. Consents must be signed by patients prior to any referral.

Page 1 of 2

**Policy Number: GPS - 54**

**Policy: Physical Exams**

Physical exams will be performed by the Medical Director, Program Physician, Physician Assistant or Nurse Practitioner. These exams shall include all systems, ie, pulmonary, cardiac and hepatic. Each patient shall have an initial exam and annually thereafter. In addition, each patient who is hospitalized, visits the ER or urgent care or any significant change in medical condition shall see the physician at the earliest point in time possible.

Patients must be medically stable to participate in medication replacement therapy. Any patients requiring medical follow-up will be provided a referral to their primary physician or specialist. A consent form must be obtained prior to a referral by CTR. All patients shall have a physical within 14 days of admission into a outpatient treatment.

1. A physical performed by appropriate medical personnel within the last 12 months may fulfill this requirement.
2. All appointments are scheduled via the front office.
3. All medical charts must be put into medical office for the physician on the day the patient is due to see the physician.
4. The physician will perform an interview and medical exam noting his findings on the proper forms.
5. The nurse assisting the physician will take and record the vital signs including weight and height as required.
6. Between each patient the paper is to be changed on the exam table, and instruments used are to be cleaned with alcohol wipes (ie. Otoscope, stethoscope, etc) and hands are to be washed.
7. At the end of the exams, the nurse is to restock the medical office as required.
8. The physician must ensure that the following information is filled out:
   1. physical exam/medical history
   2. physician order form
   3. physician documentation of addiction
   4. review and sign health history form that was completed by the patient
9. A nurse’s note shall be written by the nurse who is assisting the physician for each admission or annual physical.

Page 2 of 2

1. All orders are checked and transcribed by the nurse assisting the physician and entered into the computerized dosing system.

Revised 7/26/04

Page 1 of 1

**Policy Number: GPS - 55**

**Policy: Physician Orders**

The records of patients shall include: physician orders for medication/treatment; change of orders and/or special treatments or evaluations and any other medical orders as deemed appropriate by the medical director or program physician.

All medication is to be dispensed in accordance with physician orders only. No medication will be changed or dispensed without one.

All initial doses of methadone shall not exceed 30 milligrams of methadone for the initial dosage amount unless they are transferring from another agency and we have received documentation of the amount of methadone they have been receiving on a daily basis.

1. All physician orders are transcribed and co-signed by the nurse who is assisting the physician or received the verbal order from the physician.
   1. the nursing staff must ensure that all verbal orders are signed by the medical director/program physician
2. The nurse may receive a verbal order from the medical director or program physician for the following, but may not be limited to:
   1. emergency/medical take-home medication
   2. verbal readmission
   3. any reason not covered by standing orders
3. All telephone orders are written on a physician’s order form with:
   1. date order received
   2. order exactly as stated by the physician
   3. repeat the order to the physician to verify it is correct
   4. letters TORB written followed by physician’s name with a / and the signature of the nurse who took the order (TORB stands for telephone order read back)
4. All telephone orders are to be signed by the physician the next time due in clinic.
5. After the orders have been signed the chart is returned to the medical chart records area in the nurse’s station.
6. Standing orders are located in the nurse’s station and are signed and dated yearly by the medical director.
7. The physician may use his signature stamp which is kept in a locked box to which only he has access.
8. All physician orders shall be renewed with the annual physical of the patient.

Revised 7/26/04

Page 1 of 1

**Policy Number: GPS - 56**

**Policy: Medical Records**

CTR requires that the individual medical records chart of the patient contain information required by state and federal regulation as well as information needed by the medical director/program physician to make accurate treatment decisions for each patient. All medical records shall be stored in the nurse’s station behind locked doors.

1. Nurses notes shall be maintained and include at a minimum an admission note, annual physical notes, any medical condition brought to the attention of the nurse by the patient, communication with outside agencies.
2. Justification for the continuation of medication replacement therapy on an annual basis or justification for discontinuance.
3. Urine results
4. Take-home medication responsibility forms
5. Take-home request forms
6. Documentation of addiction completed by the medical director/program physician upon admission and annually thereafter.
7. Physician orders
8. Physician progress notes
9. Results of physical exams
10. Blood-work results
11. Medical information received from outside providers/referral
12. Any other tests or medical information received or obtained.
13. Any information related to HIV status shall not be part of the patient chart and maintained in a separate area in a filing cabinet in the nurses station if the patient has not openly disclosed their status to clinic staff.

Page 1 of 1

**Policy Number: GPS - 57**

**Policy: Prescribed Medications**

CTR prescribes only the methadone. CTR never prescribes any medication other than methadone except per State regulation we will provide a prescription for Naloxone upon patient request. Please see policy on Medication Use and Overdose/Narcan Administration.

1. Methadone:
   1. will be dispensed in the form of a liquid
   2. by physician order only
   3. by a licensed nurse authorized to do so after patient is identified and assessed to be medically and clinically appropriate.
2. Physician order/treatment record will include:
   1. name of drug prescribed
   2. dosage (strength of methadone 10mg/ml)
   3. dates medication administered or given as take-home medication
   4. discontinuance of medication
   5. changes in orders

revised 1/21/04

5/26/09

5/7/10

7/7/16

Page 1 of 1

**Policy Number: GPS - 58**

**Policy: Compliance of handling medication pertaining to state and federal regulations**

CTR will comply with all state and federal regulations pertaining to the handling of medication

Page 1 of 1

**Policy Number: GPS - 59**

**Policy: Methadone Received via Pharmacist**

The pharmacist is responsible for preparing methadone that is used by the nursing staff for daily dispensing.

CTR requires the tracking of the methadone to ensure that the amount of methadone prepared by the pharmacist is the same amount received by nursing for the purpose of narcotic accountability.

1. The pharmacist will provide the nurse with a lot number, bottle number, actual amount of methadone in the bottle and the date.
   1. This log is signed by the pharmacist and the nurse who receives it.
   2. The nurse will cross the bottles off of the list as they are used
2. All bottles will have the weight of the bottle and the weight of the solution written on it.
3. Transfer from pharmacy to nursing form will be documented and signed by both.
4. Nursing shall keep a copy of transfer form with original back to pharmacy.

Revised 7/26/04

Page 1 of 1

**Policy Number: GPS - 60**

**Policy: Opening/Closing of Nurses Station**

CTR requires that the nurses’ station be opened and closed on a daily basis for the purpose of dispensing medication. All medication is dispensed via the computerized dispensing system in accordance with their procedures. All necessary reports are completed and prepared by the computerized dispensing system also. Please see the attached procedures for these as outlined by the METHASOFT system.

To Open:

1. Each nurse shall have a security code for the nurses’ station and the pharmacy as well as the key and/or safe combination.

a. computers, pumps, label machines, lights, etc. shall be turned on

b. the pharmacy shall be opened with the appropriate alarm code

c. the safe will be opened by using the appropriate combination.

d. the correct numbered bottles shall be located and weighed prior to being brought to dispensing station. The weight is recorded on the appropriate forms.

e. the bottle is brought to the appropriate dispensing station.

1. The nurse will follow the proper METHASOFT procedure for dispensing.

To Close:

1. After the last patient is medicated, the pumps are to be shut down in accordance with METHASOFT procedure.
2. Methadone containers are to be brought into the back and weighed, without caps and placed in safe.
3. weights are recorded on the appropriate forms.
4. daily reports are run in accordance with METHASOFT procedure.
5. The safe is locked as well as the pharmacy door.
6. The pharmacy alarm is activated.
7. The door to the nurses station is locked as well as alarm activated.

Page 1 of 1

**Policy Number: GPS - 61**

**Policy: Medication Dispensing**

All medication is dispensed in single doses in the form of a liquid according to product labeling. Nurses are to ensure proper patient identification. No medication is distributed without proper ID. All medication is dispensed by licensed personnel who meet all state and federal guidelines to dispense narcotics.

1. All doses shall be dispensed by licensed personnel after the patient has been properly identified.
   1. the patient must have a valid picture ID, however, the picture in the computer dosing system may fulfill this requirement.
   2. the patients picture will be in the computerized dosing system for comparison when medicating.
   3. Each patient must be evaluated for any alcohol or drug use prior to be medicated.
2. CTR dispenses all medication as prescribed by physician order only
   1. current dosage is verified with dose ordered by computerized METHASOFT dispensing system.
   2. The dispensing nurse shall repeat the name of the patient and dosage before providing them with the medication.
   3. If two patients have the same name, in addition to the above, the patient will have to verify the last 4 digits of their social security number.
3. No drinks are to be taken to the dispensing window.
4. No children or pets are allowed at the dispensing window.
5. One patient at a time at each window to ensure confidentiality.
6. no sunglasses at the window. The nurse needs to observe eyes for signs of illicit drug use.
7. Patient must sign the sign in sheet before ingestion of medication.
8. Patient must ingest medication at the window and speak to the nurse before leaving the window.
9. If at any time the nurse feels that the patient is not safe to be medicated it is his/her professional and ethical responsibility to withhold the medication and evaluate the situation. The patient is to be informed as to the reason why and it shall be documented in a note.

Page 1 of 1

**Policy Number: GPS – 62**

**Policy: Stored Narcotic Medication**

CTR requires that all medication be stored in accordance with state and federal regulation in a manner which conforms to DEA requirements. This includes keeping it in covered containers, in a properly alarmed pharmacy and safe.

These steps will help decrease the incidence of possible external or internal diversion of narcotics to the best of the ability of CTR.

1. Each employee with access and authorization to narcotic medication will have their own individual alarm code.
2. These codes will be erased upon termination of an employee.
3. All stored narcotic medication shall contain the following information:
   1. name of substance
   2. strength of substance
   3. date of reconstitution
   4. lot number
   5. reconstituted expiration date or manufacturer expiration date, whichever is shorter

4. All nursing and pharmacy personnel are responsible to ensure that all areas are properly locked and alarmed on a daily basis in accordance with Safety and Security policies.

Page 1 of 1

**Policy Number: GPS - 63**

**Policy: Theft, Loss or Spillage**

Any theft, suspected theft, spillage (only large amounts, not one individual medication dosage) or loss of methadone shall be reported to the State Department of Controlled Substances and the State Methadone Authority.

In addition, unless a large amount of methadone is involved, the DEA 106 form may be held in the nurse’s station for accountability for DEA inspections.

These figures may be used for tracking and Quality Improvement.

1. RI Report of Unusual Incident form will be completed.
2. A DEA 106 form will be completed.
3. Copies of both reports will be sent to the state Methadone Authority.
4. The original DEA 106 is held in a folder. If unsure whether or not to forward to the DEA, consult with the pharmacist.
5. A copy of the forms will be forwarded to the Program Director.
6. Please send all forms via return receipt requested.

Revised 10/30/18

Page 1 of 1

**Policy Number: GPS - 64**

**Policy: Manual Dosing**

CTR will use manual dosing in the event of an emergency such as computer malfunction, loss of electricity or any other problem which may interfere with computerized dosing. In the event of one of the aforementioned, patients may be medicated by utilizing the scale or syringe. Manual dosing will ensure that all patients are medicated in such emergency.

1. A member of nursing is to retrieve the daily dosing log from the safe to ensure the accuracy of the dose of the patient.
2. Utilizing the open bottles of methadone, individuals will be medicated utilizing either the scale (weight) if electricity is still on or by syringe if there is no electricity.
3. Utilizing the scale:

a. as each patient approaches the window, identify them and verify the amount of their dose and number of take-homes with the daily dosing log after they have provided picture ID.

b. cross their name off of the log

c. Patients will need to sign full name, initials, dosage amount on the manual sign-in sheet.

d. a cup will be placed on the scale and the scale will be zeroed out.

e. methadone will be placed in the cup using another cup or syringe until the exact number of milligrams is displayed on the scale.

f. give medication to patient.

g. take-home medication will not be provided during a power outage.

1. Utilizing a syringe:
   1. CTR has both larger and smaller syringes for the purpose of medicating individuals

b. as each patient approaches the window, identify them and verify the amount of their dose and number of take-homes with the daily dosing log after they have provided picture ID.

c. cross their name off of the log

d. Patients will need to sign full name, initials, dosage amount on the manual sign-in sheet.

e. a cup will be placed on the scale and the scale will be zeroed out.

f. methadone will be placed in the cup using another cup or syringe until the exact number of milligrams is displayed on the scale.

g. give medication to patient.

h. take-home medication will not be provided during a power outage.

5. Using a calculator with adding tape, run an individual tape for each page of the methadone administration form as well as a separate tape to total all pages.

6. Weight remaining methadone and record amounts on the appropriate forms.

1. Fill out the patients dosed from back-up log
2. Generate a hand written or manually typed daily dose dispensed report.
3. If able before the end of day, enter all of the dosages of medication into the dispensing system to generate reports.

Revised 10/30/18

Page 1 of 1

**Policy Number: GPS - 65**

**Policy: Vomiting and Vomiting after medication administration**

CTR will reissue medication if a patient vomits within 10 minutes of ingesting their methadone. Vomitus must be seen by a member of the staff for verification. All medication is reissued at ½ of their daily dosage amount. If patient is actively vomiting upon entering the clinic, complains of severe abdominal pain, vomiting blood, diarrhea with blood or has any other condition which warrants medical attention, the patient will be asked to seek medical attention before being medicated. CTR may call rescue if patient is unable to drive.

Because methadone is very irritating to the stomach lining it is not advisable to medicate patient until the patient is medically cleared or has been at least 6-12 hours without vomiting.

**Standing Order:**

Any patient who vomits within 10 minutes of receiving their methadone, if verified by a member of staff, the nurse may reissue medication at an amount that is ½ their daily medication dosage.

Page 1 of 1

**Policy Number: GPS - 66**

**Policy: Impaired Patients**

If, at any time, in the professional and ethical judgment of the nurse**,** any patient appears to be under the influence of alcohol or any drug, making it medically unsafe to provide their medication, the nurse may withhold the medication.

1. Upon presentation to the dosing window, the nurse is to evaluate the status of each patient including speech, pupil size, coordination, gait and odor (smell of alcohol).
2. If further evaluation is required, the person is asked to take a seat and a staff member will be with them as soon as possible.
3. If necessary, the patient is taken to the medical exam room and pulse, respiration and blood pressure are taken in addition to their eyes being checked for pupil reactiveness and or litmus test.
4. Upon completion of the exam the nurse may either dose the patient or withhold the medication if the nurse feels that the safety of the patient may be jeopardized by being medicated.
5. The nurse will write a detailed nurse’s note and fill out the appropriate form with their findings and inform the patient that the reason they are not being medicated.

**Standing Order:** If at any time a patient presents to the clinic and appears to be under the influence as noted in subjective and objective findings, the nurse, after an evaluation, may choose to withhold their medication if it appears that they are medically unsafe to do so.

If at any time these signs and symptoms are not definitive, the medical director or program physician for further instruction.

Page 1 of 1

**Policy Number: GPS - 67**

**Policy: Car Dosing**

CTR understands that due to health reasons a person may need to be car dosed in order to be medicated on a daily basis. Car dosing may be done for any physical reason which makes it impossible for patients to enter the clinic. This may be due to flue, chicken pox, mumps, measles, broken bones, recent surgery, etc.

For the safety of the staff and patients, car dosing must be done in accordance with the following procedure:

1. The patient shall make arrangements for car dosing prior to the arrival at the clinic.
   1. prior arrangements may need to include:
      * date of surgery
      * potential length of stay at hospital
      * consent signed by patient to speak with physician
      * agreement on time for arrival to clinic
      * arrangements must be made with financial office for payment
      * any other information needed to facilitate a smooth transition
2. The nurse who is to administer the medication via car dosing will follow these guidelines:
   1. label the take-home bottle with the patient’s name and medication dosage
   2. dispense medication into the bottle
   3. notify the security guard, a counselor or the director of nursing to escort the nurse to the vehicle
   4. the nurse is to take a sign-in sheet with her for the patient to sign manually for their medication dosage.
   5. Once they have arrived at the vehicle the nurse is to verify the ID with the patient
   6. The medication is given to the patient for ingestion
   7. The patient must sign the sign in sheet and speak to the nurse
   8. The nurse returns inside with the empty bottle and the clip board
3. The nurse will write a nurse’s note regarding the car dosing and justification for it in the nurses note section of the individual medical chart of the patient.
4. A copy of the note should be given to the counselor and director of nursing.
5. The nursing director is responsible for follow-up on the progress of the patient and the need for continuation of car dosing with the physician.

Page 1 of 1

**Policy Number: GPS - 68**

**Policy: Required Reports**

CTR is required to keep various reports for the state and federal authorities regarding narcotic accountability, methadone administration, nurse’s notes and physician orders. These reports are run on a consistent basis. Below please find the appropriate schedule:

Daily Reports: all daily reports are automatically run at the end of the day by going to reports, choosing Dispensing Daily then click on Print.

Revised 10/30/18

Page 1 of 1

**Policy Number: GPS - 69**

**Policy: Prescriptions**

In an effort to provide comprehensive health care to those we serve, CTR requires that any prescriptions received from outside providers by patient be brought to CTR so that we may review them for possible interactions with medication replacement therapy. As needed prescriptions are valid for a period of no longer than 30 days unless otherwise specified. In addition, some prescriptions may increase or decrease serum levels of methadone whereby making it difficult for the patient to reach a stabilization period.

1. Patients are required to bring all prescriptions into CTR before beginning if possible so that we may record the information in their individual medical chart.
2. The patient is asked to sign a consent form so that a member of the medical staff may contact the prescribing physician if necessary. Failure to sign the appropriate release will result in program non-compliance and may lead to discharge.
3. Prescriptions should be brought into the clinic whenever they are filled/refilled. .
4. If the patient is given medication prior to or after surgery, or at an emergency room visit, the patient should bring the discharge paperwork to the nursing staff which states which medication(s) the patient was given as well as what prescriptions they were discharged with.
5. It is the responsibility of each patient to inform nursing of all medications prior to testing positive for any substance during random urinalysis.
6. When patients are on short-term opiate prescriptions, take-home medication may be suspended until all medication has been taken and a urine negative of opiates is completed. Any exceptions to this are at the discretion of the Medical Director and in circumstances where the patient may be bedridden or have had a serious operation. Exceptions are not provided for those individuals who receive scripts from numerous physicians, for undocumented reasons, or in circumstances which do not interfere with the activities of daily living.

Revised 1/10/07

5/26/09

05/20/13

Page 1 of 1

**Policy Number: GPS - 70**

**Policy: Medication Monitoring and USE**

CTR understands that under certain circumstances patients may need to monitored taking medication on a daily basis other than methadone. This may be due to a positive PPD, Antabuse or any reason which the primary care physician of the patient and the program physician agree that there is a need for such monitoring. If any patients are required to take any medications in front of the staff as part of their treatment, CTR will NEVER take possession of medication. We will just observe them taking medication in their possession. CTR medical staff does not prescribe any medication other than Methadone and when appropriate Narcan.

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Revised 1/10/06

10/30/18

Page 1 of 1

**Policy Number: GPS - 71**

**Policy: Admission to Medication Replacement Treatment**

CTR is required by state and federal law that certain requirements are met by patients prior to being admitted into a medication replacement treatment program. Each patient must meet the criteria set forth in policy number. Once the criteria are met, the following must also be completed prior to beginning methadone treatment.

1. After all paperwork is completed with the front office and the prospective patient has met with a counselor, an appointment is made for them to see the program physician.
2. The physician must read and initial the bio-psychosocial which is completed upon intake with the diagnostic impression of the counselor who completed the admission.
3. The physician completes the physical with the patient.
4. The physician writes an order to admit the patient to either a maintenance or detox program.
5. The patient may then proceed to the dispensing window to see the nurse for their first dosage of medication if they have been cleared through the state clearing system.
6. If the program physician feels that the prospective patient is not appropriate for treatment with methadone, the appropriate referral will be made by the staff of CTR to ensure they are referred for treatment.

Page 1 of 2

**Policy Number: GPS - 72**

**Policy: Readmission to CTR**

CTR will consider all patients for readmission to our program unless there have been extreme circumstances in which a patient was discharged such as violent behavior towards staff or other patients, theft or drug dealing. In most cases a person will be allowed to meet with the program director, clinical director and nursing director to assess whether or not they should be considered for readmission. All readmissions are processed in accordance with all state and federal regulations.

1. Exclusionary Criteria – please see policy number GPS - 3

2. Readmission – Medical:

a. All paperwork must be completed with the front office and intake counselor.

b. The patient is given an appointment to see the program physician.

* There must be 7 days between detoxification attempts. Only three days required between detox and maintenance.
* A copy of the admission paperwork of the patient is located and put into the individual chart of the patient if readmission occurs within one year; physical form, physician orders, urinalysis results, blood work results, tb results, bio-psychosocial.
  1. the nurse should notify the physician if the patient needs an updated physical.
  2. The physician will perform the physical and write the orders.
  3. The patient may go to the nurses station for their first dose of medication provided they have been cleared through the state clearing system.
  4. If patient is readmitted within 3 months of discharge, you may use the physical from the last 12 months.

Revised 10/30/18Page 1 of 1

**Policy Number: GPS - 73**

**Policy: Transfer of Patients to CTR**

CTR respects the rights of the patients to transfer from one medication replacement treatment center to another without an interruption in medication or scheduled take-home medication.

1. Once verification of dosage amount and take-home privileges as well as other information requested from the clinic the patient is transferring from, the program physician or designee will review this information.
2. The exchange of information may only be obtained with a proper signed consent from the patients in compliance with 42CFR part II and HIPAA regulations.
3. The same admission procedure will have been followed including physical.
4. Dose verification and last dose received will be obtained from the medical professional at the clinic the patient is transferring from to the medical professional at CTR. The telephone call will be made during the physical if the written information is not yet received.
5. At the discretion of the medical director for the safety of the patient, the program physician may, if found to be in the best interest of the patient, change the previous prescribed amount of medication or number of take-homes received in accordance with state and federal regulation as well as best practice guidelines.
6. Before the first dose of methadone may be provided to the patient from CTR, the patient must be cleared via the state clearing registry.

Revised 7/26/04

Page 1of 1

**Policy Number: GPS - 74**

**Policy: Transfer to another Facility from CTR, Temp or Perm.**

CTR will assist all persons serve in their efforts to transfer to another facility for the purpose of a temporary transfer or permanent transfer in a manner which is consistent with best practice. This will ensure that no interruption of medication or take-home privileges happen which is in the best interest of the patient and their recovery. Courtesy dosing is not allowed on AMA detoxes or Administrative detoxes. All patients requesting a courtesy dose shall be in good-standing at CTR and on a stable dosage of medication.

1. Courtesy Dosing:

It is required by CTR that patients notify their primary counselor at least 2 weeks in advance of their need for courtesy dosing. The patient should have been on CTR for a period of at least 30 days. Once the counselor has made the arrangements, the medical department is responsible for:

* 1. verification of information on the temporary transfer form
  2. ensuring that the physician reviews and signs the form, if required
  3. verification of the dosage amount and last dose received with the clinic the patient is transferring to
  4. next date the patient is due in clinic must be changed to coincide with the date they are to return to the clinic from their transfer
  5. resume daily dosing when patient returns in accordance with the physician order

1. Permanent Transfers:

It is the responsibility of the patient to notify their counselor as soon as possible when transferring to another treatment facility. In most cases however, this may be handled without prior notice. Once the individual counselor or medical staff knows that the patient will be leaving they shall:

* 1. in a timely fashion provide the clinic that the patient is transferring to the information they need to facilitate the transfer once a signed consent is received this includes pertinent medical records.
  2. Once verification is received that the patient will be dosed at the transferring clinic, CTR will discharge them from our facility in the METHASOFT system and with the state.

Page 1 of 2

**Policy Number: GPS – 75**

**Policy: Courtesy Dosing at CTR**

CTR will accept requests for courtesy dosing from other treatment facilities provided they have been on the clinic they are transferring from for a period of at least 30 days and they are not on a detox protocol. It is our desire that patients be able to go on with their daily routine including business trips and vacations without interruption of medication.

1. The member of the medical or clinical staff that speaks with the clinic member from which the patient is transferring from shall inform them:
   1. there is a $15.00 fee
   2. a valid picture ID is required
   3. a letter from the clinic they are transferring from, signed by the physician with the following information must be received:
      * Name
      * DOB
      * Hair color, eye color, height and weight
      * Social security number
      * Name, address and phone number of facility patient is transferring from
      * Dates to be courtesy dosed
2. Upon arrival at CTR, the patient being courtesy dosed will need to provide the above information.
3. Information will need to be put into the computer system by the office staff in conjunction with the procedure outlined in the METHASOFT training manual.
4. Once all information is entered, the $15.00 fee is paid and the physician order entered in accordance with the home clinic documentation, the patient will be medicated by the nursing staff.
5. Take-home medication is allowed only with written documentation from the clinic they are transferring from.
6. Courtesy dosing may be up to 30 days. Permanent transfer is required for any period longer than 30 days.
7. CTR will not accept the following courtesy dosing patients:
   1. Those with the inability to pay
   2. Individuals without an ID
   3. Individuals who are not in good standing at the current clinic
8. CTR refuses the right to courtesy dose any patient that appears under the influence, not medically stable, has a positive breathalyzer test or does not pay for medication.

Page 2 of 2

1. CTR will, if payment is made, provide urine tox screens for the home clinic. The cost of the urine tox screen is $20.00

Revised 3/05

7/26/13

10/31/18

Page 1 of 1

**Policy Number: GPS - 76**

**Policy: Withdrawal from Methadone**

CTR supports and encourages patients to be active in their own treatment. Once appropriate for withdrawal, CTR will do whatever is necessary to maximize the chance for a successful withdrawal from methadone for patients.

Once the appropriate meetings are held, forms filled out and physician is consulted with regarding an order to withdraw from Methadone, the physician will write the order for the withdrawal in accordance with best practice and in a way which minimizes any discomfort on the part of the patient. The purpose of contacting the primary physician is for input related to the persons’ served health needs or co-occurring disorders that may influence the success of the medically supervised withdrawal. The nurse will then transcribe the order into the computerized dosing system and it will begin on the next day the patient is due in clinic.

Page 1 of 1

**Policy Number: GPS - 77**

**Policy: Clinic Closing due to inclement weather**

In an effort to ensure the safety of the staff and patients, CTR may chose to close the clinic or alter dispensing hours. All efforts are made to contact each patient to inform them of the need to return to the clinic for take home medication. This shall be done via broadcasts over the radio or television as well as phone calls to the homes of patients. An assessment of appropriateness for emergency take-home medication shall be put into the chart of the patients.

In most cases, the Department of BHDDH, State methadone authority should be called for approval to provide take-home medication for clinic closing. In the event this is not possible, the Medical Director shall be called and an order received to give all patients a take-home for the emergency. The State methadone authority shall be notified as soon as possible.

In the event all patients cannot be reached, every effort will be made to ensure a nurse can get to the dispensary as soon as possible unless doing so puts the safety of the staff and/or patients at risk.

Page 1 of 1

**Policy Number: GPS - 78**

**Policy: Program Policy Variation**

Variations to program policy may be made at the discretion of the Medical Director and program management if in his/her best judgment the variation would benefit the safety and health of the patients and/or staff or provide an individualized approach to treatment. Changes in program policy that do not involve the need for a physician order may be done by the management of CTR in an effort to provide individualized treatment for the patient. However, it should be noted that these variations should be in accordance with state and federal regulation and in the form of a written order co-signed by a member of management.

Page 1 of 2

**Policy Number: GPS - 79**

**Policy: Ordering Supplies**

CTR does not require a purchase order to order supplies by all departments. The nursing director or designee is responsible for ordering supplies for the medical department. At all times adequate supplies must be stocked to ensure that the medical staff has the appropriate resources to medicate patients, perform venipuncture, urinalysis, physicals and basic first aid.

1. The nursing director or designee compiles a list of needed items.
2. The items are ordered
3. When the supplies are received, the purchase order is removed from the file in the nurse’s station and the items are verified in accordance with the purchase order and packing slip. The packing slip is signed and refilled.
4. Any discrepancies must be called in to the vendor as soon as possible.
5. any times that need to be returned should be returned as soon as possible for credit to the facility account.

Page 1 of 1

**Policy Number: GPS - 80**

**Policy: Interim Maintenance Program**

In the event that a individual seeking treatment cannot be entered into a methadone maintenance program within the state within 14 days, CTR will admit such patients into an interim maintenance program in accordance with 42CFR part8.12(j)(1). The following outlines the procedures to be followed:

1. All treatment shall be in accordance with state and federal law.
2. The state methadone authority shall be notified when any person begins interim maintenance treatment, leaves interim maintenance treatment or transfers to a comprehensive methadone treatment. Such notification shall be documented.
3. Urine screens shall be no less than upon admittance to interim maintenance and two other screens during this 120-day period. CTR reserves the right to test upon admission and monthly thereafter.
4. Individuals entering interim treatment shall be transferred to either CTR’s maintenance program when appropriate or, if in the best interest of the patient, to another facility providing methadone maintenance within 120 days. Priority transfers will be provided to those patients who are pregnant, HIV, Hep C positive or recently released from a penal institution.
5. Medication must be administered daily to all individuals.
6. Take home medication is not allowed during interim treatment.
7. Treatment planning, primary counselor and counseling services are not required during interim maintenance. However, CTR will provide counseling and medical services when needed or appropriate to interim maintenance patients.
8. Interim maintenance cannot be provided for longer than 120 days in any 12- month period for any patient.
9. CTR will hire the appropriate number of qualified staff in the event of a large influx of patients to transition all interim maintenance patients to methadone maintenance.
10. CTR will be flexible in daily hours to accommodate patients in the event of a large influx of patients into interim maintenance treatment and adjust their hours of operation accordingly.

Added 11/03

Page 1 of 1

**Policy Number: GPS - 81**

**Policy: Holiday Take-home Medication**

Center for Treatment and Recovery will be open for all holidays. However, CTR reserves the right to give take-home medication for the purpose of holiday observation to those patients who have achieved take-home status.

1. Patients who have achieved take-home status will be given one extra take-home for the holiday.

Added 12/31/03

Revised 12/7/04

5/26/09

Page 1 of 1

**Policy Number: GPS - 82**

**Policy: Non-return of take-home bottles**

CTR requires that all take-home medication bottles are returned intact, without tampering of labels on the next day due in clinic by the patient. Non-return or tampering of take-home bottles will result in the following agency intervention:

1. If a take-home bottle is not returned because it has been stolen, a police report must be obtained by the person-served it was stolen from and presented to the clinic as documentation.
2. If the take home bottle was lost the following is to be taken into consideration.
   1. Length of time on the clinic
   2. Is this a repeated occurrence
   3. Is there appropriate reason for damage to the container or inability to produce the container
3. For the first offense: (with regular take-home status)
   1. An incident report shall be written and loss of take-home privileges for a period of 30 days.
4. For the second offense: (with regular take-home status)
   1. An incident report shall be written and a loss of take-home privileges for a period of 60 days.
5. For the third offense: (with regular take-home status)
   1. An incident report shall be written and a loss of take-home privileges for a period of 90 days.
6. Any offense after that shall result in an indefinite period of time for loss of take-homes but shall be no less than a period of 6 months and possible discharge/transfer for program non-compliance. (with regular take-home status)
7. Any loss/tampering/stolen holiday take-home for those patients who have not achieved regular take-home status will result in no further holiday take-home medication and a 90-day waiting period until which take-homes may be achieved from the holiday date.
8. CTR will not withhold medication for non-return of take-home bottles.

Added 1/2/04

Page 1 of2

**Policy Number: GPS - 83**

**Policy: Delivery of Methadone to Person’s Home/Residential Facility**

CTR understands that there are times due to extreme illness that a patient is not able to attend the clinic on a daily basis for medication administration. CTR will, with a physician’s order, deliver the medication to the appropriate patient at their discretion on a temporary basis. Also, for those persons who are dually enrolled in residential treatment or supportive living community, medication may be delivered on a weekly basis. However, many facilities have a previous agreement with CODAC. If the facility a CTR patient is transferring to has the agreement with CODAC, CODAC will become their home clinic for a period of time

1. Written proof of medical need/was seen by a physician for a medical issue that would prevent the person from attending the clinic daily.
2. The Medical Director/Physician is to be called for an order allowing CTR to deliver medication directly to the home.
3. The dose will be dispensed into a take-home container by the dispensing nurse and labeled accordingly.
4. The nurse delivering the medication will sign the patient sign in sheet.
5. The medication is to be put into a locked box for delivery.
6. A licensed or registered nurse, along with another member of the staff will deliver the medication together.
7. The nurse will take the take-home container with her back to the clinic for destruction.
8. If patient is receiving weekly deliveries at their residential/supportive living facility, an exception form must be completed with appropriate approvals as well as delivery forms/chain of custody.

Added 1/5/04

10/30/18

Page 1 of 1

**Policy Number: GPS - 84**

**Policy: Pregnancy Guidelines**

To ensure pregnant patients get the best possible care to achieve the best pregnancy outcome for Mom and baby, CTR shall, once pregnancy is verified provide information via pregnancy packet as well as referral to MOMs program at Kent or Project Link or Sstar when needed as needed.

1. Pt will be asked to follow up with an ob-gyn. If patient does not have one, releases may be signed and referrals made. If the patient refuses care of an ob-gyn, this shall be documented in the individual record of the patient.
2. A detox for Pregnant women shall not be initiated by either the patient or the clinic, even for non-compliance or non-payment. A transfer shall be initiated to another treatment provider for detox services if that is what the patient wants.
3. Pregnant women shall be followed for dose related withdrawal and medications shall be adjusted accordingly. Medications shall also be adjusted accordingly after the birth.
4. Pregnant women shall be offered parenting classes or provided parenting education either in-house or by referral. If they refuse to access these services it shall be documented in the individual record of the patient.
5. Pregnant women shall have weekly observed urine screens unless otherwise ordered by the Medical Director.
6. Pregnant women shall see the Medical Director, Program Physician or Nurse Practitioner a minimum of:
   1. Once during the first trimester
   2. Once during the second trimester
   3. Monthly during the last trimester

(this may be waived with documentation of regular ob-gyn visits)

The results shall be documented in the individual chart.

* 1. The Physician or Nurse Practitioner may require meeting as often as twice monthly if pregnancy is high risk.

1. The patient shall meet with the Medical Director/Program Physician/NP/PA approximately 4-8 weeks after the delivery and the results of the appointment shall be documented in the chart of the patient.

Added 6/04

Revised 11/06

5/26/09

2/9/11

9/28/16

10/30/18

Page 1 of 1

**Policy Number: GPS - 85**

**Policy: Split Dosing**

It is the desire of CTR to ensure all patients are provided an adequate medication dosage. At times, patients require split dosing versus one time per day dosing. Split dosing is provided through Physician order only. Criteria for possible split dosing includes: inability to normalize on once daily dosing despite multiple titrations, counseling and nursing intervention, and results of a peak and trough which when reviewed by the physician clearly shows that split dosing would be of benefit to the patient.

Education regarding take-home policy and storage and securing of medication shall be documented in the individual record of the patient.

If the patient does not have take-home status, the nursing department will seek an exception for split dosing from the CSAT and our SMA.

Revised 10/30/18

Page 1 of 1

**Policy Number: GPS - 86**

**Policy: RIBHOLD**

CTR complies with all state and federal regulations and will register all patients with the state tracking system. The purpose of registration is to eliminate potential patients from being enrolled in more than one medication replacement clinic in Rhode Island. In addition, updates shall be done on a quarterly basis to RIBHOLD if any changes of status occur with the patient such as employment, marital, housing, financial, etc. has changed.

1. The front office staff is to use the blank copy of the state registry form to answer the appropriate questions to enter the patients into the Central Registry system.
2. The front office staff is to ask the questions as they appear on the form and enter it. Use the appropriate codes if necessary.
3. When completed file in the clinical chart.
4. The day that the patient presents for his physical exam, the patient must be “cleared” with the state before being medicated.
5. Enter the information into the state system.
6. On a quarterly basis the clinical or nursing staff will provide information to the person responsible for entering the RIBHOLD data that needs to be updated.

Revised 1/21/04

12/22/15

Page 1 of 1

**Policy Number: GPS - 87**

**Policy: Co-Occurring Disorder Policy**

CTR understands a number of patients may have a co-existing mental health issues. When patients receive treatment/prescriptions for mental health issues from a community physician it is required the patient sign a release for the treating/prescribing physician so that coordination of care between them and CTR can occur. If the patient does not have a mental health physician, the individual counselor may assist in obtaining one. If the patient is a Health Home patient a case manager which is assigned to them can assist them in obtaining a mental health professional. If the patient refuses mental health treatment and has been assessed by the clinical supervisor who is an LMHC to need such services, the patient may be discharged from treatment due to program/medical non-compliance.

1. The patient is asked to sign a completed release of confidential information for the prescribing physician. If the patient refuses, the patient must be informed that they will be unable to be treated at CTR and will be transferred to another facility.
2. Once the consent is signed it is either mailed or faxed to the prescribing physician.
3. If the physician does not reply within 30 days a second request is sent out.
4. If the physician does not reply within 30 days of that request a call will be made by the medical department to the physician asking them to fill out the consent form.
5. This form is valid for one year and a new consent shall be completed, signed and forwarded to the prescribing physician annually.
6. If there is any cause for concern regarding the patient’s mental health status, the counselor or the medical staff may contact the physician with their concerns if the consent is still in place.

Revised 10/30/18

Page 1 of 1

**Policy Number: GPS-88**

**Policy: Theft or loss of Take-home Medication**

It is a serious incident when any medication that has been dispensed in the form of take-home medication is either reported stolen or lost by the patient. When this occurs the following procedure should be followed.

* + 1. The Nursing/Program Director is informed immediately.
    2. The Medical Director is called for further orders: loss of take-home status, dosing in the clinic daily and any other order the physician may feel is appropriate.
    3. An incident report is completed by the staff member who took the information regarding the theft/loss.
    4. An immediate loss of take-home privileges is entered into the computer.
    5. A copy of the police report, if provided to the patient, shall be put into the patient’s file.
    6. Patient’s will earn take-home privileges back on an individual basis but due to the seriousness of the incident, a prolonged waiting period will be observed before any take-home medication is reinstated.
    7. For multiple incidents, the patient may not be eligible for any take-home medication during treatment due to the inability to keep the medication safely stored.

**Policy Number: GPS - 89**

**Policy: Patient Unsafe Behavior Assessment**

Suicide is a serious and immediate emergency. Whenever a patient discusses with a staff member they are considering suicide, have recently attempted suicide or show marks on their body consistent with attempts of suicide the following steps must be taken. In addition, 42CFR Part 2 identifies suicide threat and overdose as a medical emergency and “even without consent, patient identifying information may be disclosed to certain persons in a medical emergency.” Other unsafe behavior that may need immediate Assessment include: Unsafe substance use, urgent medical Conditions or any other issue that the Staff perceives as an immediate danger/threat.

1. The staff member who has been informed of the threat must
   1. Notify the clinical supervisor, program director or owner immediately even if by phone.
   2. Notify the nursing department so that a full assessment may be completed which includes BP, P and R and also checking any marks which the patient may have inflicted upon themselves.
   3. The clinical supervisor, program director or owner will speak with the patient to assess their mental status and whether or the patient is currently suicidal, medically unstable or under the influence. If the supervisory staff are not yet in the building, the most senior counselor will speak with the patient. If appropriate a safety contract shall be made between the patient and CTR.
   4. The supervisory staff member or designee will contact the police and explain there is a medical emergency and that we have a suicidal individual in the building or 911 may be called for medical emergency.
   5. A staff member shall stay with the patient until the emergency personnel have arrived.
   6. If the patient refuses intervention and leaves before emergency personnel arrive, patient identifying data may be released including name, address, phone number and date of birth so that this patient may be located.
   7. Documentation shall be entered in the patient chart of all discussions, assessments, interventions and disposition.
   8. The program director shall write up the incident as a medical emergency and evaluate for effectiveness or needed improvement.

Added 9/28/10

Revised 6/19/13

10/30/18

Page 1 of 2

**Policy Number: GPS-91**

**Policy: Benzodiazipine Policy**

Benzodiazipines and methadone can be a serious risk to the patient. Therefore, CTR will follow what we consider best practice for those individuals who are taking benzodiazipines with a valid prescription as well as those who are taking them illicitly. The purpose of this policy is not to exclude or discriminate but rather to ensure, to the best of our ability, the safety of the patients of CTR. Any patient who refuses to sign releases for their prescribers will be referred to another treatment provider. PMP’s are check at admission, with each increase in take-homes and also with the annual physical at a minimum.

1. Benzodiazipines upon admission:
   * 1. If by prescription (upon admission or thereafter):
     2. Patient to sign release with prescribing physician
     3. Patient to bring in actual prescription and on a monthly basis thereafter
     4. Patient to obtain pharmacy print-out, if needed
     5. Titration to methadone maintenance dose may be slower
     6. Earning of take-home privileges may be slowed or restricted.
     7. Patient required to bring in prescriptions monthly
     8. Patient is subject to random call-ins to bring bottle of medication to be

Counted.

* + 1. Patient to sign release with prescribing physician annually
    2. Benzodiazipine levels are required on drug screen results
    3. Monitor patient for untoward effects such as drowsiness, lethargy, slurring of words.
    4. If necessary, and on an individualized basis, the dosage of methadone may be lowered or not increased above a certain dosage amount.

If illicit

* + - * 1. Develop with physician a plan for abstinence within first 30-45 days.
        2. At two weeks post admission UA for benzodiazipines including clonazepam.

1. Benzodiazipines while in treatment:

A. If illicit

1. If three out of any 6 month period:

a. Patient will receive a letter with interaction information

b. Patient will meet with Medical Director for

plan/consultation

c. Twice per month urine screens will be scheduled

d. Monitor patient for 60 days including untoward effects such

drowsiness, lethargy, slurring of words, etc.

Page 2 of 2

e. If necessary, and in an individual basis dosage of methadone may be lowered.

f. Safety plan plan to be established and completed with individual counselor.

g. Mandatory attendance to group which addresses ongoing use

h. weekly Urine screen

i. if continued positive meet again with to review and revise safety plan with Medical Director which may include in patient detox, IOP or other treatment based on needs of patient.

j. Possible discharge for program non compliance with 30 day detox may be appropriate.

If at any time the patient has an adverse event involving benzos. Patient will meet with Medical director to formulate a new plan which may include discharge.

Updated 5/10/16

6/24/16

10/21/16

10/30/18

**Policy Number: GPS – 91**

**Policy: Performance Measurement and Management**

CTR has a systematic plan for measuring and managing certain areas of performance. Performance improvement is an important part of ensuring that CTR provides quality, effective and appropriate treatment in a manner that is respectful and efficient. The Board of Directors will be provided with a copy of the Annual Management Summary and QI/QA information to review at meetings and for input.

**Goal:**

To establish a Performance Measurement and Management plan that is appropriate to CTR’s mission and core values for both MMTP and Detox programs within CTR. The Program Director has the main responsibility for Performance Measurement and Management.

**Objectives:**

To obtain and measure data for the purpose of:

* Fiscal stability
* Accessibility for patients, staff and other stakeholders
* Allocation of resources
* Risk management activities
* Human resource/staff satisfaction
* Technological compliance
* The health and safety of the patients, staff and other stakeholders
* Service delivery
* Treatment appropriateness

**Auditing/Reporting Format:**

Information may come from many different avenues. These include but are not limited to surveys, chart audits, suggestion boxes, patient or staff grievances, reports from Methasoft, financial statements, etc. Once the information is received the program director will be made aware (or is aware) of any potential areas that may be improved or what areas are consistently on target. If the item needs improvement, it will be discussed at staff meetings, between management or with the patient or employee for possibility of adding it to performance improvement. Because we are a small agency and both owners work daily Performance Measurement and Management as well as Performance improvement is more of an informal process and may be found in revision of policies, newsletter, staff meeting minutes or by talking with staff and patients. The above noted objectives are addressed yearly in the annual management summary.

**Policy Number: GPS – 92**

**Policy: Prescription Monitoring Program (PMP)**

CTR is required to check the PMP upon admission and with increase in take-home status per State licensing regulation. In addition, CTR will check this PMP periodically including admission and with take-home increases as well as with the annual physical. Checking the PMP provides valuable information to make well-informed decisions for the treatment of patients in accordance with best practice.

1. CTR Medical Director/Program Physician or designee will check the PMP upon admission, with increase in number of take-homes, periodically and with the annual physical.
2. If information is found that the patient did not disclose they will be asked to sign a release with the prescribing physician, if applicable, all take-home medication will be suspended for an undetermined amount of time.
3. Patient may be asked to bring print out from Pharmacy.
4. If the patient refuses then they may not be admitted or will be considered non compliant with program policy and can lose any privileges they have or be discharged for program non-compliance.
5. If the patient signs the consent, the release is faxed to the treating physician’s office and coordination of care begins.
6. Any patient on long-term opiates or benzodiazipines may not be appropriate for take-home privileges and will be decided on an individual basis by CTR Staff and Medical Director.

Added 2/1/13

**GPS: GPS - 93**

**Policy: Peaceful Coexistence**

CTR does all that it can to ensure that we are a good neighbor within our neighborhood and community including maintaining a community relations plan.

1. Community Education
   1. An open house was held before we moved into our new location with residents in the area and ongoing
   2. Ongoing participation in community such as prevention, neighborhood meetings, etc.
2. Visiting neighbors
   1. Both Wendy and Madeline speak with abutting neighbors on a regular basis to ensure there are no issues which we are unaware of.
   2. Immediately addressing any concerns which are brought to our attention by any neighbor.
3. Strict rules
   1. No loitering policy
   2. No smoking policy
   3. Patient Service Staff
4. Open door policy
   1. Neighbors are informed they can come over or call at any time to discuss any issues or concerns they may have.

Added 5/11/16

Revised 10/30/18

Page 1 of 2

**Policy Number: GPS - 94**

**Policy: Overdose Education and Administration of Narcan**

Narcan is used for completely or partially reversing the effects of narcotics. It is a narcotic antagonist. It works by blocking the opiate receptor sites, which reverses or prevents toxic effects of narcotic (opioid) analgesics.

CTR has Narcan on hand at all times for the purpose of treating an opioid overdose. In addition, all employees and patients are required to attend overdose prevention education. If requested, CTR will provide prescription for Narcan and written information. However, in the state of Rhode Island any individual may go to a pharmacy and receive Narcan without a prescription.

1. All employees are provided education on Naloxone, overdose, how to respond to an overdose, administering Naloxone and information regarding side effects of Naloxone.
   1. This is documented in the Personnel file of the employee
2. All patients are provided education on Naloxone, overdose, how to respond to an overdose, administering Naloxone and information regarding side effects of Naloxone and after-hours contact information.
   1. This is documented in the individual file of the patient.
   2. Training and printed information is available in Spanish for patients whose primary language is Spanish.
3. Providing Narcan Prescription to patients:
   1. The prescription is provided upon request by any patient.
   2. In addition to the prescription, printed information is provided from drugs.com on Narcan. This information is available in English and Spanish. Information is located in the Physician Office
   3. The name of the patient who receives the prescription and information is to be entered into the log book located in the physician’s office.
   4. A note shall be entered into the patient’s electronic chart indicating that they have been provided a prescription, printed information and have had the opportunity to ask any questions.
4. Responding to a suspected overdose – employees:
   1. Review patient/individual for signs of overdose which include:
      1. Blue or pale skin color, small pupils, low blood pressure, slow heartbeat, slow or shallow breathing, snoring sound, gasping for breath.
      2. Try rousing the patient/individual by calling their name and rubbing your knuckles on their chest. If they are still unresponsive, they may be experiencing an overdose, especially if they exhibit any of the signs noted above.
      3. Call 911
      4. Give rescue breaths if indicated.
      5. Give naloxone
         1. Open the cap of the naloxone vial. Remove the cap of the needle and insert into the vial. With the vial upside down, pull back the plunger and draw up 1ml (1cc) of naloxone which is 2mg. Using a needle at least one inch long inject into the muscle of the upper arm or thigh.
         2. Begin rescue breathing if indicated. If no response, may repeat in 2-3 minutes
         3. Administer another 2mg of naloxone (1ml/1cc).
         4. Continue rescue breathing if indicated. If no response, may repeat in 2-3 minutes
         5. Administer another 2mg of naloxone (1ml/1cc)
         6. Continue rescue breathing if indicated.
      6. If no response after 6mg, the condition may not be due to an overdose. Continue rescue breathing if indicated until help arrives.
      7. If you must leave the patient, then make sure they are in the rescue position which is on their side with their top leg and arm crossed over their body. This makes it difficult for them to roll over and lessen the chance of choking on vomit.
5. Once the ambulance arrives, allow them to take over put provide support if needed. Answer all questions and provide them with a copy of the Emergency Information Form on the patient.
6. An incident report must be filled out and a team meeting should be held to discuss/debrief. During this meeting, effectiveness of policy should be documented and changes to policy or education needed should be noted to be documented under health and safety for a medical emergency.

Added 6/13/15

Revised 10/30/18

Page 1 of 2

**Policy Number: GPS - 95**

**Policy: EKG Machine and Testing**

CTR maintains an EKG machine for the purpose of providing EKG’s for patients when indicated. Studies have shown over 200 medications that are prescribed may lead to an elongated QT Interval leading to Pointes Torsades. While methadone is one on the list of medications, studies have shown that the instance of this is low. However, it is thought that with high dosages (professionals do not agree on the definition of a “high dose”) or when combined with other medications that can lead to an elongated QT Interval the chances increase. CTR has defines below how we will use the EKG report as part of treatment and medical monitoring.

1. CTR has defined a “high dose” as any dosage of methadone that is 150mgs or higher.
   1. All patients will be given an EKG when their dosage reaches 150mgs.
   2. All patients who are on other medications which may also cause an elongated QT Interval will be provided and EKG
   3. Any patient who has a history of cardiac conduction/electrical issues will be provided an EKG upon intake and annually.
2. The identified patients are given the instructions to follow on the day of the EKG as well as set up with an appointment for it to be completed.
3. On the day of the appointment please make sure the patient followed the instructions, all cell phones are out of the patient’s pockets, etc.
4. Perform the EKG per the EKG machine instructions.
5. All EKG results are to be given to the physician to review on the next day a physician is in the clinic.
6. Once the physician reviews the EKG he will sign the EKG report that it was reviewed and write a note.
7. If there are any concerns about the EKG a member of the nursing department or health home team will assist the patient with a referral for follow-up.
8. Patient will be required to follow up with PCP, Cardiologist or walk-in within 14 days. Proof of follow-up is required.

Page 2 of 2

1. When indicated, patients will be required to repeat EKG annually or with the addition of any other medications which may contribute to a QT elongation.

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Page 1 of 2

**Policy Number: GPS - 96**

**Policy: Implementing Violence Prevention Measures**

CTR maintains a safe and welcoming environment. In an effort to prevention violence in the work place we have initial and annual training in workplace violence as well as personnel policies regarding workplace violence. In addition, to protect from external violence we employ numerous efforts to decrease the possibility of being affected by external violence.

1. Internal Violence Prevention Measures:
   1. Education and training among hire and annually
   2. Personnel Policies and Procedures on workplace violence
   3. Zero tolerance of workplace violence
   4. Security Cameras
   5. BCI Checks
   6. No weapons policy
2. External Violence Prevention Measures:
   1. Education and training among hire and annually
   2. Dedicated Patient Service Staff
   3. Non-violence policy
   4. No weapons policy
   5. Incident reporting education, implementation and debriefing
   6. Security system with panic buttons
   7. External trainings as necessary on de-escalation
   8. Staff meetings to discuss patients who need to be monitored and considered volatile
   9. Zero tolerance with violence or violent situations with immediate discharge and referral if necessary.
   10. Active shooter education

**Policy Number: HH-1**

**Policy: Health Home Program Description**

CTR provides Health Home services consistent with the CMS SPA. Health homes are defined as a fixed point of responsibility to coordinate and ensure the delivery of **person centered care;** provide timely post discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive integrated services. Emphasis is placed on the monitoring of chronic conditions and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits.

All OTP’s will be required to apply for Health Home Accreditation in their next scheduled Accreditation cycle.

All OTP’s will be required to sign a Health Homes Certification Agreement with BHDDH.

1. Populations served: All Medicaid and Medicaid expansion patients are automatically enrolled in an OTP Health Home unless they are patients in a Health Home elsewhere.
   1. Patients may opt-out of health home services at their request
   2. Patients may be opted out of health home services by staff if there is 90 days of inactivity.
2. Care coordination is provided by case managers and nurses and include the following:
   1. Physicians/Specialists/Hospitals
   2. Community Case managers
   3. DCYF
   4. Probation/Parole
   5. Outside community agencies for social services such as housing, food, furniture
3. Disease Management Services include:
   1. Coordination/Collaboration with outside medical providers
   2. Monthly review of prescriptions by pharmacist for possible interactions
   3. Individual sessions with education on disease processes
   4. Monthly group participation on disease topics
   5. Data collection as outlined in the Health Home Manual
4. Population Health Management is defined as the management, integration and outcome measurement of any program affecting the health and productivity of your organization. Population Health Management for our health home program has been measured in satisfaction surveys, focus groups and by reviewing patterns of utilization of services and community medical services.
5. Provision of, access to and coordination of care:
   1. Primary care is not provided by CTR. However, Case managers assist patients who do not have primary care to find PCP either private, through Health and Wellness centers or within FQHC’s that are located throughout the state. CTR will assist with referrals for such services. CTR requires all patients to sign a release of information with PCP’s and other treating physicians for the purpose of coordination/collaboration of care.
   2. Behavioral Healthcare is not provided by CTR. Behavioral Health care is provided for our patients at either CMHC’s or private practice. CTR case managers work with patients to find providers when needed. CTR will assist with referral to such specialists. Once a patient has a Behavioral Health Care specialist we require all patients to sign a release of information with the provider for the purpose of coordination and collaboration of care.
   3. Community and social support services are done through referral, providing information or even going to the agency with patient as needed. A comprehensive Community Resource Manual has been developed and maintained by the Health Home Staff. When necessary, releases of information are obtained.
6. As with all patients at CTR we have the ability to:
   1. Respond to after-hour phone calls via our after-hour number at 401-413-1131
   2. The capacity for a patient to see a staff member either same day or next day
   3. Flexible scheduling with appointments Monday through Friday, 5:30 a.m. – 2:00 p.m.
   4. Services are provided at CTR, however, at times they may be provided in the community via patient request or due to mobility issues.

**Policy Number: HH-2**

**Policy: Health Home Program Team Composition**

The OTP Health Home team staff composition required to provide services based on a population of 125 patients per team. Any deviation from that staffing pattern will require a written proposal to the Department for approval that includes clinical and financial justification. However, using the patient acuity model allows from some flexibility of the team based on the needs of the patients. Each FTE is based on a 35 hour work week. Positions may be shared.

**Qualifications Health Home FTE**

Master’s Level Team Coordinator 1.0

Physician 0.25

Registered Nurse 1.0

Case Manager

Hospital/Health Care Liason 1.0

Case Manager 1.0

Pharmacist 0.1

Total Personnel 4.35

**Policy Number: HH-3**

**Policy: Health Home Program Eligibility**

Patient eligibility for participation in a Health Home Program includes receiving opioid treatment with a diagnosis of opioid dependence and must be at risk of another chronic condition. In addition, the eligibility also includes having RI Medicaid as a primary payer of services.

1. All patients with Medicaid as a primary payer are provided and appointment with a member of the health home staff.
   1. The health home team member will explain health home services
   2. The health home team member will complete the Health Home Eligibility Assessment as well as the Social History.
   3. On an annual basis the health home team member will complete with the patient the Annual Health Home Eligibility Assessment.
2. If the patient meets the criteria for participation in the health home program and wants to participate in the health home program they complete the appropriate paperwork (OTP Health Homes Consent to receive/resume Services)with the health home team member and they are provided with a letter regarding health home services as well as a pamphlet.
3. If the patient does not want to participate in the program they need to sign an opt-out form with the health home team member and no further services are provided.
4. Re-enrollment is possible for initial or subsequent patients who initially decline health home services. If an OTP believes it is clinically warranted and in the best interest of the patient, the patient can be re-enrolled into the health home program. Steps 1 and 2 listed above must be completed.
5. Disenrollment may occur for patients who initially accept health home services but who do not consistently participate in any given 90 day period despite the efforts of the health home team to get them to engage.
   1. This shall be documented in the record of the patient.
   2. A letter shall be provided to the patient that he/she is being disenrolled.

**Policy Number: HH-4**

**Policy: Health Home Program Outcomes/Goals**

The goals of the health home program is to reduce hospital admissions and readmissions. It is the responsibility of BHDDH to obtain this information from the Medicaid Data Warehouse. To reduce preventable emergency room visits. It is the responsibility of BHDDH to obtain this information. And to reduce skilled nursing facilities. Again, it is the responsibility of BHDDH to obtain this information.

**Policy Number: HH-5**

**Policy: Health Home Program CMS core measures**

As part of the Health Home program, Center for Treatment and Recovery is responsible for collecting the information below and report it via our OTP spreadsheet to BHDDH on a quarterly basis for all patients who are enrolled in any given quarter.

1. BMI
2. Ambulatory Care – sensitive admission
3. Care Transition – transition recovery transmitted to health care professional
4. Follow-up after hospital for mental illness
5. Plan – All cause readmissions
6. Screening for Clinical Depression and follow-up plan
7. Controlling High Blood Pressure
8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Additional OTP Health Home Specific Goals:

1. The number of OTP HH clients reporting housing stability
2. Improved Employment/wages eared
3. Reduce rates of arrest and incarceration
4. Reduction of illicit drug use
5. Reduction of smoking rates

**Policy Number: HH-6**

**Policy: Health Home Chronic Disease Management**

For new individuals of OTP Health Home Services, the state will track hospital referrals and/or hospital liaison encounters as well as track face-to-face follow-up by a health team member within 2 days after hospitalization discharge. The State will also monitor the number of referrals/post discharge follow-up contacts that resulted in development of the care plan. DOH will monitor and report on the number of referrals made to the Chronic Conditions Self-Management Education Programs and the follow-through rates on those referrals. Claims data will provide the state with information on the utilization of specialty care providers for chronic disease, frequency of appropriate screening and potential medication adherence. This information will be gathered by the Administrative Level Coordinator and submitted to BHDDH on a quarterly basis.

**Policy Number: HH-7**

**Policy: Health Home Program Coordination of Care for**

**Individuals with Chronic Conditions**

Each Health Home enrollee will have an established health home and access to the DOH’s Chronic Conditions Self-Management Education Program and access to all of the Health Home team staff, all of which will be documented in the Plan of Care to ensure coordination and follow-up among team members and with the patient. Rhode Island OTPs already have established relationships and extensive experience coordinating with a wide range of community supports and services. Rhode Island will use claims, encounters, and clinical registry data to collect information on patients’ coordination of care, including post-inpatient discharge continuation of care. The State will monitor updates to RI\_BHOLD to trach changes in primary diagnoses, Axis IV diagnosis and track individual’s self-reported co-occurring physical health conditions.

**Policy Number: HH-8**

**Policy: Health Home Program Assessment of Quality Improvements and**

**Clinical Outcomes.**

The State will utilize the previously described quality process and outcome measures to assess quality improvements and clinical outcomes. As the OTP Health Homes program progresses, Rhode Island anticipates implementing additional quality improvement and clinical outcome measures, including but not limited to: reduction in rates of arrest/incarceration, increasing rates of employment/wages earned, increasing housing stability, reducing rates of positive urine drug screens, engaging patients in documenting self-management goals and written self- management plans, reducing smoking rates, reducing use of high cost/high use categories such as pharmacy, lab and residential treatment.

1. Once a full year of information has been collected and measured, CTR will review and establish benchmarks based on historical data to address performance in the areas of medical, health, behavioral health and other items noted above.
2. At least annually thereafter CTR will review this information to address:
   1. Trends
   2. Actions for improvement
   3. Results of performance improvement plans
   4. Necessary education and training of:
      1. Patients
      2. Families and support systems
      3. Personnel
      4. Other stake-holders in the community.

**Policy Number: HH-9**

**Policy: Health Home Billing and Coding**

As with all of our billable services, CTR will only bill for actual services rendered.

1. The standard methadone maintenance treatment code shall be used for all patients who chose to opt out of health homes – H0020
2. For all Health home, regular Medicaid recipients (not ritecare), the methadone treatment code used should be –H0020 with a U1 modifier.
3. For all Rite care patients, treatment should be billed to the insurer as usual but the health home service will be billed through HP using the following code and modifiers – H0046 U1 U8
4. For all Health Home patients, the Health Home code should be – H0046 with a U1 modifier
5. Health Home events should be recorded in 15 minute units. The first unit must last a full 15 minutes. Additional units during the same encounter should be rounded up/down as appropriate.
6. Health Home telephone contacts may be recorded in five minute units. The first unit must last a full 5 minutes and additional units during the same encounter should be rounded up/down as appropriate.

**Policy Number: HH-10**

**Policy: Health Home Program Provider Standards**

CTR will maintain the following requirements necessary for certification as a health Home provider:

**Admission/Discharge Criteria:**

1. Admission criteria includes patients with opioid dependence that meet state and federal criteria for Methadone Maintenance Treatment and are currently receiving financial support through the entitlement program of Medicaid.
2. Discharge Criteria: is consistent to the rules and regulations for the licensing of Behavioral Health Organizations in Section 28.0

**Provider Standards:**

1. Provide quality drive, cost effective, culturally appropriate and person and family centered Health Home services;
2. The HH team shall maintain staff compliant with competencies, professional qualifications and experience as described throughout the RI Rules and Regulations for the Licensing of Behavioral Health Organizations.
3. Have a physician(s) assigned for the purpose of Health Home team participation to each individual receiving OTP Health Home services.
4. Conduct wellness interventions as indicated based on individuals’ level of risk and willingness to participate.
5. Agree to participate in any statewide learning collaborative that may be implemented for Health Home providers.
6. Within three months of Health Home service implementation, have executed a contract or MOU with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants as well as maintain a mutual awareness and collaboration to identify individuals seeking Emergency Department services that might benefit from a connection with an OTP Health Home provider.
7. Agree to establish a contract(s) or MOU(s) with Federal Qualified Healthcare Centers and/or primary care centers in the OTP area.
8. Establish a process for receiving and accepting relevant information to coordinate care for Health Home participants among the OTP and primary and specialty care Providers, including mental health treatment providers.
9. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and providing feedback to practices, as feasible and appropriate.
10. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease-management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
11. Develop treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions.
12. Monitor individual and population health status and service use to determine adherence to or variance from treatment guidelines.
13. Develop and disseminate reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
14. Agree to convene regular, ongoing and documented internal health home team meetings with all relevant providers to plan and implement goals and objectives of practice transformation.
15. Agree to participate in CMS and state-required evaluation activities.
16. Agree to develop required reports describing OTP Health Home activities, efforts and progress in implementing Health Home services.
17. Ensure capacity to provide multiple contacts as needed for a team of 125 patients. Contacts can include phone contact, such as coordination of care with other providers and support systems as well as direct contact with the individual.
18. Agree to participate in annual chart reviews by the Department to assure compliance with standards, measures, outcomes and quality care from each team.
19. Any compliance concerns regarding program standards, team composition, measures, outcomes or reporting will be reviewed by the Department for certification status.

**Health Home Care Coordination Team:**

1. Develop and maintain a Health Home team which, at a minimum, is comprised of the following: a case manager who will serve as the central coordinator for Health Home services, a case manager/hospital liaison, a physician, a registered nurse, a master’s level team leader, and a pharmacist.
2. Agree to work with centralized members of Health Home Implementation team including Health Information Technology Coordinator, Administrative Level Coordinator and Health Home Training Coordinator.
3. Other Health Home Team members may include, but are not limited to: primary care physicians, peer wellness specialists, metnal health specialist, employment specialists and community integration specialists.
4. Team members shall meet all of the qualification s in the BHDDH “rules and regulations for the licensing of behavioral healthcare organizations.
5. The Health Home Team Staff Composition required to provide services based on a 125 person team as outlined in policy .
6. Monthly census of team composition will be submitted to the Department for review and compliance with the standard.
7. Programs will share the positions of Administrative level coordinator, HIT coordinator, and Training coordinator.

**Care Coordination Responsibilities:**

1. Coordinate and provide access to high-quality health care services informed by evidence based clinical practice guidelines.
2. Coordinate and provide access to preventative and health promotion services, including prevention of metnal illness and other substance use disorders.
3. Coordinate and provide access to mental health and other substance abuse services.
4. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings.
5. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families and referrals through the Department of Health’s Chronic Disease Self Management Programs.
6. Coordinate and provide access to individual and family supports, including referral to community, social support and recovery services.
7. Coordinate and provide access to long-term care supports and services
8. Develop and implement a person-centered care plan tat is flexible and integrates all clinical and non-clinical healthcare related needs and services. Plan is compliant with sections 25 and 26 of the Rules and Regulations for the Licensing of Behavioral Healthcare Organizations.
9. Ensure that all services, including mental health treatment are coordinated across provider settings.
10. Behavioral Health Care Organizations, in review of their Policies and Procedures are to update all relevant Policies and Procedures to reflect health homes.
11. Changes in any aspect of an individual’s health must be noted, shared with the team and used to change the care plan as necessary. All relevant information is to be obtained and reviewed by the team.
12. Facilitate timely and effective transitions from inpatient and long-term care settings to the community, as appropriate.
13. Health Home providers will identify hospital liaisons to assist in the discharge planning of individuals, existing OTP clients and new referrals from inpatient settings to OTPs and mental health treatment if indicated.
14. Care coordination may also occur when transitioning an individual from a jail/prison setting into the community.
15. A member of the team of health professionals provides care coordination services between hospitals and community services.
16. Team members collaborate with physicians, nurses, social workers, discharge planners and pharmacists as needed to ensure that a person-centered care plan has been developed and work with family members and community providers to ensure that the plan is communicated, adhered to and modified as appropriate.
17. Provide assistance to individuals to identify and develop social support networks
18. Provide assistance with medication and treatment management and adherence to include referrals for mental health vocational and counseling services.
19. Connection to peer advocacy groups, wellness centers, NAMI, RICARES, Family Psychoeducational programs, etc.
20. Provide individual and family support services to assist individuals to access services that will reduce barriers to treatment and improve health outcomes. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills.
21. Referral to primary and or specialty care as requested by physician.

**Policy Number: HH-11**

**Policy: Health Home Program Depression Screening**

All Health Home patients shall have a depression screening 30 days after admit. CTR utilizes the PHQ-9 as a screening tool and can be found in our EHR/Computerized dispensing software system. For those patients 65 years of age and older the Geriatric Depression Scale shall be used. Please see the Health Home Team Coordinator for a copy of this tool.

1. The screening tool shall be completed in the Methasoft software system.
2. If the scoring indicates a referral should be made please discuss with the patient where they would like to obtain treatment. Document in the patient chart.
3. If the patient refuses the referral this shall also be documented in the patient chart.
4. A statement should be made in the patient’s plan of care such as “the patient will be monitored for signs and symptoms of depression during medication stabilization. At 30 days following admission a PHQ-9 will be administered to screen depression.

**Policy Number: HH-12**

**Policy: Health Home Program Plan of Care**

CTR will complete a plan of care for all health home patients based upon the mutually agreed upon item the patient prefers to work on.

1. Within 30 days of admission, the OTP HH Team’s identified list of issues is discussed with the patient to determine their level of understanding and to assess how well the patient is managing in these key areas.
2. Based on the discussion and the information gathered during the completion of the bio-psychosocial and medical assessments, the OTP Health Home Team member and patient negotiate and agree on which of these issues they will work on together. In collaboration with the patient, determine the status of each of the issues/problems identified – active, deferred, resolved.

**Mutually Agreed upon Identified Issues/Problems**

1. In accordance to patient’s priorities, the agreed upon issues/problems are documented in the section entitled, Mutually Agreed upon Identified Issues/Problems. Please note there may be items that the provider feels are important to address but patient is not willing to commit to right now. If this is the case, ask the patient’s permission to list them on the plan of care to be dealt with at a future time when the patient is ready.
2. This section is to be completed during the initial development of the plan of care and reviewed and updated annually or as needed.

**Patient Centered Action Plan**

1. Each mutually agreed upon identified issue/problem will require that a separate patient-centered action plan be developed. Please note: It is expected that only one patient-centered action plan be developed at a time.
2. Each issue should be fully explored in terms of what has been the most unsatisfying aspect or difficult part regarding their issue.
3. Goals must be clearly defined and be written as stated by the patient. Each goal is to address tangible elements in their situation that must change in order for them to feel better.
4. Identify the steps the patient is willing and wanting to take toward achieving their goal. A strength based approach is to be employed in the identification of the action steps.
5. Complete the remaining sections of the action plan as stated by the patient.
6. Agree on follw-up plan, which might include e-mail, etxt or phone call to check in to see how the plan is working.
7. The OTP HH Team member and patient sign and date the treatment plan.
8. Following signature, print a copy of the action plan to give to the patient. Theoriginal action plan becomes part of the patient’s file.

**Follow-up Progress Notes**

1. Follow-up/progress note(s) should be completed monthly unless otherwise indicated.
2. The OTP HH Team member should meet with the patient to review their progress toward achieving their goal.
3. Progress is to be documented in the follow-up and progress note. Changes in the patient’s change process are to be noted when appropriate.

**Policy Number: HH-13**

**Policy: Health Home Program Transfers**

CTR recognizes that Health Home Transfers may be appropriate for some patients to a CMHO or from a CMHO. All transfer requests are effective the first day of the month following the month in which the transfer was approved. Transfers from one health home to another may be initiated by a physician, OTP or physician CMHO.

1. All phone contact forms, completed transfer request forms, and transfer confirmation letters will be emailed to the Health Home Team Coordinator. The Health Home Team Coordinator may designate additional staff, including the clerical support person to also receive these types of emails.
2. When the provider receives a phone contact form, a completed transfer request form, or a transfer confirmation letter from the Health Home Team Coordinator, an email acknowledging receipt of the form or letter must always be sent to the attention of the Health Home Team Coordinator.
3. All Transfer request forms emailed to the Health Home Team Coordinator must be sent in an encrypted email or the form attached to the email must be password protected to comply with HIPAA requirements. The words “HH TRANSFER” should be included in the subject line of the email.
4. Providers must meet with the patient to confirm they received the transfer confirmation letter or to explain their current status.

**Transfers initiated by an OTP Health Home to CMHO Health Home**

1. A physician of an OTP Health Home may initiate the transfer of an enrolled patient to another Health Home in the service area if they believe the patient would benefit from the transfer.
2. Patient must be consulted to discuss and approve the transfer request. The transfer request form is completed by the current OTP Health Home Team Coordinator or designated staff member.
3. The OTP Health Home Team Coordinator contacts the Director/Team Coordinator of the CMHO Health Home and they consult with each other regarding the transfer request.
4. If the transfer request is agreed to by the CMHO Health Home:
5. The OTP Health Home provider completes the HH transfer request form and emails it to the attention of the CMHO Health Home Team Coordinator to complete the transfer.
6. The CMHO Health Home Team Coordinator completes the transfer request form and emails it to the Health Home Directors of both Health Homes. The CMHO Health Home Team Coordinator emails a transfer approval notification letter to the OTP Health Home Coordinator and to the patient.
7. The OTP Health Home Team Coordinator emails the CMHO Health Home Team Coordinator an acknowledgement of receipt of the completed transfer request form and the transfer approval notification letter.
8. The CMHO Health Home Team Coordinator must meet with the patient for an introduction to the new agency and to review details of the transfer and assure continuity of care.
9. If the transfer request is not agreed to by the CMHO Health Home, the CMHO Health Home Team Coordinator completes the HH transfer request form and emails it to the OTP Health Home Coordinator and the OTP Health Home Coordinator refers the request to the physician for further review.

**Transfers initiated by CMHO Health Home to OTP Health Home**

1. A physician of a CMHO Health Home may initiate the transfer of an enrolled patient to an OTP Health Home in the service area if they believe the patient would benefit from the transfer.
2. The patient must be consulted to discuss and approve the transfer request. The transfer request form is completed by the current CMHO Health Home Team Coordinator or designated staff member.

* The CMHO Health Home Team Coordinator contacts the Director/Team Coordinator of the OTP Health Home and they consult with each other regarding the transfer request.
* If the transfer request is agreed upon to by the OTP Health Home:

1. The CMHO Health Home provider completes the HH transfer request form and emails it to the attention of the OTP Health Home Team Coordinator to complete the transfer.
2. The OTP Health Home Team Coordinator completes the transfer request form and emails it to the Health Home Directors of both Health Homes. The OTP Health Home Team Coordinator emails a transfer approval notification letter to the CMHO Health Home Coordinator and the patient.
3. The CMHO Health Home Team Coordinator emails the OTP Health Home Team Coordinator an acknowledgement of receipt of the completed transfer request form and the transfer approval notification letter.
4. The OTP Health Home Team coordinator must meet with the patient for an introduction to the new agency, and to review details of the transfer and assure continuity of care.
5. If the transfer request is not agreed to by the OTP Health Home:

* The OTP Health Home Team Coordinator completes the HH transfer request form and emails it to the CMHO Health Home Team Coordinator.
* The CMHO Health Home Team Coordinator refers the request to the physician for further review.

**Transfers initiated by OTP Health Home to another OTP Health Home**

1. A physician of an OTP Health Home may initiate the transfer of an enrolled patient to another OTP Health Home if they believe the patient would benefit from the transfer or if the patient is moving from one service area to another.
2. Patient must be consulted to discuss and approve the transfer request. The transfer request form is completed by the current OTP Health Home Team Coordinator or designated staff member.

* The primary OTP Health Home Team Coordinator contacts the Director/Team Coordinator of the secondary OTP Health Home and they consult with each other regarding the transfer request.
* If the transfer is agreed to by the secondary OTP Health Home:

1. The primary OTP Health Home provider completes the HH transfer request form and emails it to the attention of the secondary OTP Health Home Team Coordinator to complete the transfer.
2. The primary OTP Health Home Team Coordinator completes the transfer request form and emails it to the OTP Health Home Directors of both Health Homes. The secondary OTP Health Home Team Coordinator emails a transfer approval notification letter to the primary OTP Health Home Coordinator and to the patient.
3. The primary OTP Health Home Team Coordinator emails the secondary OTP Health Home Team Coordinator an acknowledgement of receipt of the completed transfer request form and the transfer approval notification letter.
4. The secondary OTP Health Home Team Coordinator must meet with the patient for an introduction to the new agency, and to review details of the transfer and assure continuity of care.
5. If the transfer request is not agreed to by the secondary OTP Health Home:

* The secondary OTP Health Home Team Coordinator completes the HH transfer request form and emails it to the primary OTP Health Home Team Coordinator.
* The primary OTP Health Home Team Coordinator refers the request to the physician for further review.

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**Policy Number: HH-14**

**Policy: Health Home Program Documentation**

CTR will maintain appropriate documentation in the Health Home care of the patient. However, there may be additional supportive documentation in the medical or clinical chart and also in the EHR.

1. Documentation includes:
2. Health Home Eligibility Assessment
3. Social Assessment
4. PHQ-9 or Geriatric Depression Scale
5. Consents
6. Referrals
7. Plan of Care
8. Health Home Notes
9. Group Health Home Notes
10. Information received from coordination/collaboration of care with outside agencies
11. Correspondence both internal and external
12. Any other information deemed appropriate to health home services

**Policy Number: HH-15**

**Policy: Health Home Services Offered**

**Education and Training**

CTR offers various education and training for patients. When applicable and allowed by patients, families are encouraged to participate in case management session and educational activities.

1. Education and training include but is not limited to:
2. Active involvement in care planning
3. Impact of health conditions of the patients on family/support system
4. Interaction between behavioral health and physical health
5. Medication management
6. Prevention/intervention, including but not limited to:
   1. Chronic disease management
   2. Mental health
   3. Nutrition
   4. Physical Activity
   5. Tobacco Use
   6. Substance Use
7. Resilience and recovery
8. Self-management of:
   1. Physical health
   2. Behavioral health
   3. Other life issues identified by the patient
9. Wellness

**Policy Number: HH-16**

**Policy: Health Home Team Meetings**

While Health Home team members often confer on a daily basis regarding patients, a full team meeting is held bi-weekly. All members, except for the pharmacist is required to attend. Patients are discussed with the team for follow-up and minutes are kept regarding the discussion. A note is entered into the computer on each patient who was discussed.

Page 1 of 1

**Policy Number: Infection Control - 1**

**Policy: Hand-washing**

It is the policy of CTR that all employees, especially those with direct, hands on care, utilizes good hand-washing throughout their work day. It has been shown that proper hand washing decreases the risk of infection.

1. Anti-bacterial soap is available at all sinks. It is expected it will be used at all times. Some of the more general times include:

a. before and after work

b. As soon as possible after contact with any bodily fluid

c. before and after eating

d. when hands become soiled

e. after removal of latex gloves

f. in between caring for each Patient while assisting Medical Director

with physicals.

2. Antimicrobial soap is designed primarily for hand washing and will be used:

a. before contact with any compromised patient

b. before and after contact with any patient who has an infectious disease

3. Waterless hand washing gel, antimicrobial and/or antibacterial will be provided in the event that the employee is not able to get to a sink.

4. Steps to proper hand washing include:

a. Use warm water

b. moisten hands thoroughly

c. place a small amount of soap on your hands and wash vigorously

including all parts, palms, in-between fingers, back of hands and wrists.

d. rinse well under running water

e. pat dry with paper towels

f. turn off faucets with paper towels then discard.

5. Paper towels will be provided at each hand washing site.

6. Safety:

a. always consider the sink contaminated. Stand away from it and minimize splashing and/or spraying.

b. report empty or faulty operating soap dispensers.

Page 1 of 2

**Policy Number: Infection Control - 3**

**Policy: Testing for Tuberculosis**

It is the policy of CTR to screen all Patients for Tuberculosis upon admission to the program and annually thereafter. The results of the screening is kept in the computerized database of the patients individual information.

The purpose of this policy is to ensure that all Patients are free from active tuberculosis, are treated for active TB or prophylactic.

1. The screening sheet is filled out by the patient then reviewed by the physician to determine if a TB test or referral should be administered.

2. A nurse who is trained in administering the intradermal skin test for TB will gather the appropriate materials:

a. A tuberculin syringe

b. a purified Tuberculin derivative solution in a vial

c. Alcohol preps

d. gloves

3. After washing her hands the nurse will then:

a. open a alcohol prep

b. swab the top of the tuberculin vial

c open the tuberculin syringe package and fill syringe with .10 cc of

air

e inject air into vial

f pull back syringe while still in vile and fill syringe to .10cc with

tuberculin testing derivative. If needed you may recap.

g. choose site on forearm to administer test

h. swab that site with alcohol prep

i. put on gloves

j. with bevel side up of needle, pierce the skin at a 15 degree angle,

entering about 1/8th of an inch

k. press plunger on the syringe to expel contents into the intradermal

space. A bleb should appear.

l. immediately discard needle in a sharps’ container. DO NOT RECAP

m. discard gloves

n. wash hands

1. Forty-eight (48) hours after administration of the TB test, the nurse will then look at the testing site to see if there has been any type of reaction to the TB derivative.
2. Any indurated reaction greater than 10mm in size will need to be referred to their primary physician for a follow-up chest x-ray.

Page 2 of 2

1. Documentation of the follow-up appointment must be provided to CTR as well as the chest x-ray findings and any prophylactic medication or treatment that is being ordered.

Revised 10/30/18

Page 1 of 1

**Policy Number: Infection Control - 4**

**Policy: One-Way Air Valve Face-Masks**

CTR shall have on hand at least one (1) one-way air valve face masks for the purpose of performing CPR in the event of an emergency within the clinic. The one-way air valve face mask decreases the risk of transmission of infectious disease.

1. Before you can use the mask you must push out the center. This will make it form a dome shape.

2. For adults, hold the facemask with the triangle part over the victim’s mouth and nose.

3. Perform CPR as usual except for blowing into the valve instead of blowing into the patient’s mouth. The valve prevents any expired air from the victim as well as any body fluid from the victim’s mouth coming into contact with the person performing CPR.

4. Upon completion of CPR the mask can be cleaned with the standard bleach solution but the valve should be discarded and a new one put in it’s place.

1. Store the mask in its proper place.

Page 1 of 1

**Policy Number: Infection Control - 5**

**Policy: Gloves**

CTR requires gloves to be worn by medical staff, nursing staff, and/or housekeeping staff when they come into direct contact with any material that may be contaminated or infections such as waste paper baskets, cleaning of restrooms and handling of body fluid specimens. Using gloves decrease the possible transmission of infectious diseases.

1. Gloves are to be worn for a single use and then discarded in the appropriate

trash receptacle before leaving the area. (If gloves are tainted with body fluids

such as blood, urine or vomitus, they must be discarded in a red bagged receptacle. All others may be discarded in the regular trash.

2. Never leave a room wearing contaminated gloves.

3. After removal of the gloves the employee must wash their hands in accordance with the hand-washing procedure.

4. Gloves must be changed between patients and before any handling of items that will be used by others such as pens, telephones, etc.

5. Should an employee be allergic to latex or the powder inside of the gloves, CTR will purchase gloves made from another material or powder free for their use.

Page 1 of 1

**Policy Number: Infection Control - 6**

**Policy: Care of Patient with AIDS/HIV**

CTR shall not discriminate in the care of individuals who hare HIV positive or actively infected with the AIDS virus. CTR shall use the same standard precautions when caring for all persons regardless of their health care status.

1. Use normal standard precautions with all patients regardless of their health status

2. Pocket masks or Ambu bags are to be used in the event of emergency

resuscitation for all Patients.

3. An HIV prevention/education in orientation class is mandatory for all Patients.

4. Sero-positive HIV/AIDS is not a sufficient reason for any health care worker to decline providing care to any patient.

5. Medical follow-up is required and offered by our physician if the Patient so chooses. The patient may decline such follow-up or choose to have their own physician provide routine care. A nurse’s note will be placed into their individual confidential chart located in the nurse’s station stating that they decline to have our physician follow their medical status on a quarterly basis.

Page 1 of 1

**Policy Number: Infection Control - 7**

**Policy: Precautions in Handling Blood and/or Body Fluids**

It is the policy of CTR to follow OSHA guidelines when handling any Blood and/or Body Fluids.

1. Gloves are required for the handling of all Blood and/or Body Fluids:

a. ALL lab/urine specimens and containers which are not contained in the plastic biohazard bag

b. contact with any liners soiled with blood/body fluid

c. contact with any material soiled with blood/body fluid

d. any direct or indirect contact with a patients blood/body fluid

e. When splashing of blood is anticipated, protective gowns and eyewear must be worn. These items will be supplied by CTR.

Page 1 of 1

**Policy Number: Infection Control – 8**

**Policy: Needlestick and/or Puncture Wounds, Bites or Other**

**Exposure to Blood by Employees Including Mucous Membrane and Open Wound Exposure**

CTR strives to decrease or prevent the above from happening. But, in the case of such exposure prompt medical attention and tracking is required. These exposures are subject to all reporting guidelines as set forth by the State of Rhode Island Department Of Health.

1. The employee will immediately cleanse the area either with soap and water or by flushing the area with normal saline.

1. In the event of a bleeding wound, the employee is to continue to make the area bleed by applying a stripping kind of pressure to the site then wash with soap and water.

2. The employee will report the injury to the Nursing Director and Program Director who will:

a. Make sure the area was immediately cleaned and dressed properly.

b. Refer employee immediately to their health care provider for all the appropriate testing and prophylactic treatment.

1. Ask patient, if known, who was involved in the incident if they would consent to testing for HIV and Hepatitis.

d. Fill out the Supervisor’s Report of Accident/Injury and Incident Report which will then be filled.

e. After medical care has been received the follow-up section on the Incident Report should be filled out.

Page 1 of 1

**Policy Number: Infection Control – 9**

**Policy: Disposal of Contaminated Sharps**

CTR will be compliance with all of the requirements for the disposal of sharps in accordance with all of the regulations set forth in the Federal Register. This includes needles or any object that was used deliberately or by accident that caused blood to be drawn, all injection equipment, and any other sharps with potential blood contact. This aids in preventing injury and/or infection from biohazard sharps containers to those employed and treated at CTR.

1. All equipment used to draw blood, injection and any and all instruments that were used for any cutting injury by patient or staff will be disposed of in the red sharps containers that are located in the Physician’s office and nurses station. These items are not to be thrown into regular trash receptacles.

2. Ensure that containers are not overfilled and empty containers are always in stock.

3. The nursing staff is responsible for monitoring of all sharps containers and biohazard material containers on a continual basis.

4. Biohazard containers are not to be emptied. They are to be secured and stored in the biohazard waste box inside of the Physician’s Office in the appropriate container left for this purpose by the Medical Waste Company.

5. The nursing staff is responsible for appropriately securing the biohazard box and filling out required paperwork for pick up by the medical waste company on a quarterly basis.

Page 1 of 1

**Policy Number: Infection Control – 10**

**Policy: Disposal of Needles/Syringes**

CTR will safely dispose of needles and syringes in accordance with the guidelines set for by OSHA regulation to decrease the incidence of needle-stick exposure and decrease the risk of spreading infectious disease.

1. To aid in the prevention of accidental needle sticks, **NEEDLES ARE NEVER TO BE RECAPPED BY ANY MEMBER OF THE HEALTH CARE TEAM.**

2. Immediately after needles/syringes are used, they should be deposited in the red biohazard containers located in the nurses’ station and physician office.

3. Our contracted waste management company will collect all biohazard material on a quarterly basis as needed.

4. New needle/syringe containers (sharps) are to be ordered by the nursing staff and kept on hand at all times for replacement of full biohazard containers.

5. CTR shall obtain a generators license from the State of Rhode Island and renew it on an annual basis.

Page 1 of 1

**Policy Number: Infection Control – 11**

**Policy: Care of Disposable Items**

CTR uses disposable items whenever possible for the purpose of care and treatment of the patient for the prevention of infections disease and ensuring sterility.

1. All products which are not able to be sterilized or are not capable of withstanding rigorous cleaning in order to be considered safe to be used a second time are to be considered disposable.

2. Disposable items are never to be reused.

3. Prior to use of disposable and sterile items, all packages are to be checked for expiration date and integrity of package by a member of the nursing staff. If the integrity of the package has been compromised during shipping or storage, this item may not be used and will either be returned for credit or be destroyed.

4. All supplies will be stored in the nurses’ station and/or physician’s office.

5. All disposable items are to be discarded in the trash except for needles, syringes and contaminated/isolation material which are to be discarded in accordance with their individual policy and procedure.

Page 2 of 2

**Disposable vs. Non Disposable Items**

**Disposable**

Needles

Syringes

Take-home containers

Alcohol preps

Band-aids

Gauze

vacutainer’s

Cups

**Non Disposable**

Blood pressure cuff

Stethoscope

vacutainer sleeves

Tourniquets

Page 1 of 1

**Policy Number: Infection Control – 12**

**Policy: Spill Kits**

CTR will use professionally manufactured spill kits for the purpose of cleaning of any spill of a body fluid, including blood, urine, vomit, diarrhea, etc. to ensure that all contaminated spills are cleaned/decontaminated for the purpose of decreasing exposure to infectious disease.

1. Open spill kit (located in Nurses Station and/or Physician’s Office) and follow directions utilizing the enclosed materials.

1. In the absence of a spill kit:

a. Use bleach 1part to water 10 parts to clean spill after using an absorbent medium such as saw dust or kitty litter to absorb spill.

b. Wear gloves

c. Wear personal protective equipment if needed, gown, eyewear, etc.

d. Dispose of all wastes in the red biohazard receptacles.

Page 1 of 1

**Policy Number: Infection Control – 13**

**Policy: Refrigerator**

CTR will maintain a refrigerator for the sole purpose of storing medical supplies as needed to decrease the risk of cross contamination between food items and medical supplies.

1. Food and drinks must never be kept in the refrigerator, freezer, shelves, or cabinets where blood or other potentially infectious materials are present, or where medical items are stored.

a. In the event that two separate refrigerators are not feasible, any medical item and or blood or other potentially infectious material must be kept in a separate, leak proof, airtight, puncture proof container inside of the refrigerator. This container must be clearly labeled biohazard or medical.

Page 1 of 1

**Policy Number: Infection Control – 14**

**Policy: Hazardous Materials**

CTR maintains cleaning supplies and disinfectants, some of which may be considered hazardous. Common hazardous substances in the workplace include: acids, caustic substances, disinfectants, glue, paint, pesticides and solvents. For the purpose of our organization and facility, we aim to keep these at a minimum.

1. All cleaning supplies and disinfectants shall be kept and stored in original containers.

1. All cleaning supplies shall be stored in either the locked lockers on the first floor, the locked cabinets in the front office, the locked cabinet in the basement or any other locked space.