# OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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## TITLE 450

# CHAPTER 24

## STANDARDS AND CRITERIA FOR COMPREHENSIVE COMMUNITY ADDICTION RECOVERY CENTERS

**Effective November 16, 2020**

**Authority:** Oklahoma Board of Mental Health and Substance Abuse Services; 43A O.S. §§ 2-101, and 3-415

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## SUBCHAPTER 1. GENERAL PROVISIONS

### 450:24-1-1. Purpose

(a) This chapter sets forth the Standards and Criteria used in the certification of Comprehensive Community Addiction Recovery Centers (CCARC) and implements 43A O.S. § 3-415. A.1., which authorizes the Board of Mental Health and Substance Abuse Services to certify private facilities and organizations which provide treatment, counseling and rehabilitation services directed toward alcohol and drug dependent persons. A CCARC is considered distinct and separate from facilities that may be certified under OAC 450:18 in that 450:24 requires the provision of all services stipulated in Subchapter 450: 24-3 et seq.
(b) The rules regarding the certification process including but not necessarily limited to application, fees and administrative sanctions are found in the Oklahoma Administrative Code, Title 450 Chapter 1, Subchapters 5 and 9.

### 450:24-1-2. Definitions

The following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

**"Ambulatory Withdrawal Management without extended on-site monitoring"** means withdrawal management within an outpatient setting, directed by a physician and has attendant medical personnel including nurses for intoxicated consumers, and consumers withdrawing from alcohol and other drugs, presenting with no apparent medical or neurological symptoms as a result of their use of substances require ambulatory withdrawal management as determined by an examining physician. This corresponds to ASAM Service Level: Level 1-WM Ambulatory withdrawal management without extended on-site monitoring.

**"ASAM criteria"** or **"ASAM"** means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

**"Case management services"** means planned referral, linkage, monitoring and support, and advocacy provided in partnership with a consumer to assist that consumer with self sufficiency and community tenure and take place in the individual's home, in the community, or in the facility, in accordance with a service plan developed with and approved by the consumer and qualified staff.

**"Clinical privileging"** means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment, and other credentials.

**"Comprehensive Community Addiction Recovery Center"** or **"CCARC"** means a facility offering a comprehensive array of community-based substance use disorder treatment services, including but not limited to, outpatient services, Intensive outpatient services, ambulatory withdrawal management services, emergency care, consultation and education; and , certain services at

the option of the center, including but not limited to, prescreening, rehabilitative services, aftercare, training programs, research and evaluation.

**"Community-based Structured Crisis Center"** or **"CBSCC"** means a program of non-hospital emergency services for mental health and substance use disorder crisis stabilization as authorized by 43A O.S. §3-317, including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance use disorder treatment services. This service is limited to CCARC's who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

**"Consumer"** means an individual, adult, adolescent, or child, who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

**"Consumer advocacy"** includes all activities on behalf of the consumer to assist with or facilitate resolution of problems in the acquisition of resources or services needed by the consumer

**"Co-occurring disorder" (COD)** means any combination of mental health symptoms and substance use disorder symptoms or diagnoses that affect a consumer and are typically determined by the current Diagnostic and Statistical Manual of Mental Disorders.

**"Co-occurring disorder capability"** means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to consumers with co-occurring disorders.

**"Co-occurring disorder enhanced"** means that the program (or subunit of the program) provides a specialized service designed for individuals with co-occurring disorders, usually with a higher level of available service capacity or intensity for the co-occurring substance use disorder than would be the case in a comparable co-occurring disorder capable program.

**"Crisis Diversion"** means an unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community.

**"Crisis Intervention"** means actions taken, and services provided to address emergency psychological, physiological, and safety aspects of alcohol, drug-related, and mental health crises.

**"Crisis stabilization"** means emergency, psychiatric, and substance use disorder treatment services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment, and, if needed, referral to an ODMHSAS certified facility having nursing and medical support available.

**"Critical incident"** means an occurrence or set of events inconsistent with the routine operation of a facility, service setting, or otherwise routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and

injuries to consumers, staff and visitors; medication errors; residential consumers that are absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

**"Cultural competency"** means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.

"**Emergency examination"** means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or drug-dependent person and a person requiring treatment, and whose condition is such that it appears that emergency detention may be warranted by a licensed mental health professional to determine if emergency detention of the person is warranted.

**"Face-To-Face"** for the purposes of the delivery of behavioral health care, means a face-to-face physical contact and in-person encounter between the health care provider and the consumer, including the initial visit. The use of telemedicine shall be considered a face-to-face encounter.

**"Gambling disorder treatment services"** means treatment activities for consumers by a gambling treatment professional that include, but are not limited to, the following:

(A) Assessment and diagnostic impression, ongoing;
(B) Treatment planning and revision, as necessary;
(C) Individual, group and family therapy;
(D) Case management;
(E) Psychosocial rehabilitation; and
(F) Discharge planning.

**"Gambling treatment professional"** means an individual holding a valid NCGC I or II certification, or has documented completion of at least thirty hours of ODMHSAS recognized core problem gambling training requirements and documented completion of ten hours of problem gambling specific continuing education every twelve months; and is either a Licensed Behavioral Health Professional or Licensure Candidate.

**"Gambling related disorders/problems"** means persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as defined by the most recent edition of the DSM.

**"Independent living skills, assistance in development of"** means all activities directed at assisting individuals in the development of skills necessary to live and function within the community, e.g., cooking, budgeting, meal planning, housecleaning, problem-solving, communication and vocational skills.

**"Intensive outpatient services"** means an organized, non-residential outpatient treatment services with scheduled sessions that provide a range of nine (9) to fifteen (15) treatment hours per week for adults or six (6) to twelve (12) treatment hours per week for children. Intensive outpatient services may offer evening outpatient services several nights per week or be incorporated into

an inpatient or residential treatment program in which the consumer participates in daytime treatment services but goes home at night. This corresponds to ASAM patient Placement Criteria Treatment Level: Level II.1 Intensive outpatient.

**"Levels of care"** means the different options for treatment as described in the current edition of the ASAM criteria that vary according to the services offered. Each treatment option is a level of care.

**"Licensed Behavioral Health Professional"** or **"LBHP"** means:

(A) allopathic or osteopathic physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;

(B) practitioners with a license to practice in the state in which services are provided by one of the following licensing boards:

(i) Psychology;

(ii) Social Work (clinical specialty only);

(iii) Professional Counselor;

(iv) Marriage and Family Therapist;

(v) Behavioral Practitioner; or

(vi) Alcohol and Drug Counselor;

(C) advanced practice nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided; or

(D) a physician assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or therapy functions.

**"Licensed mental health professional"** or **"LMHP"** as defined in Title 43A §1-103(11).

**"Licensure Candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology;

(B) Social Work (clinical specialty only);

(C) Professional Counselor;

(D) Marriage and Family Therapist;

(E) Behavioral Practitioner; or

(F) Alcohol and Drug Counselor.

**"Linkage"** refers to the communication and coordination with other service providers to assure timely appropriate referrals between the CCARC and other providers.

**"Medication error"** means an error in prescribing, dispensing or administration of medication, regardless if the error reached the consumer, e.g., omission of prescribed drugs, giving drugs not prescribed, prescribing inappropriate drugs, prescribing or administering incorrect dosages, incorrectly filling or labeling prescriptions, incorrectly transcribing medication orders.

**"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

**"Oklahoma Administrative Code"** or **"OAC"** means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A) (1) (a) and maintained in the Office of Administrative Rules.

**"On-premise meal service"** means meals that are prepared and cooked in a commercial kitchen located on the facility premises.

**"Outpatient services"** means an organized, non-residential treatment service in regularly scheduled session intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimens. This corresponds to ASAM criteria Treatment Level I, Outpatient Treatment. Services can address early intervention needs and increase in frequency and intensity up to 9 treatment hours per week.

"**Peer Recovery Support Specialist**" or "**PRSS**" means an individual who meets the qualifications and is certified as a PRSS pursuant to OAC 450:53.

**"Performance Improvement"** or **"PI"** means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous quality improvement, continuous improvement, organization-wide quality improvement and total quality management.

**"Progress notes"** mean a chronological written description of services provided to a consumer, resident, client, or patient that documents, utilizing acceptable documentation practices, the consumer's response related to the intervention plan or services provided.

**"Psychological-Social evaluations"** are in-person interviews conducted by a LBHP or Licensure Candidate trained to elicit historical and current information regarding the behavior and experiences of an individual, and are designed to provide sufficient information for problem formulation and intervention.

**"Psychotherapy"** or **"Therapy"** means a goal directed process using generally accepted clinical approaches provided face-to-face by a LBHP or Licensure Candidate with consumers in individual, group or family settings to promote positive emotional or behavioral change.

**"Rehabilitation Services"** means face-to-face individual or group services provided by qualified staff to develop skill necessary to perform activities of daily living and successful integration into community life.

**"Screening"** means the process to determine whether the person seeking assistance needs further comprehensive assessment.

**"Sentinel event"** is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide,

criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

**"Service area"** means a geographic area established by the Department of Mental Health and Substance Abuse Services for support of mental health and substance use disorder treatment services [43A O.S.§3-302(1)].

**"Service plan"** or **"Treatment plan"** means the document used during the process by which a LBHP or Licensure Candidate and the consumer together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

**"Substance withdrawal**" means a state of being in which a group of symptoms of variable clustering and degree of severity occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. The syndrome may be accompanied by signs of physiological disturbance. Onset and course of the withdrawal state are time-limited and are related to the type of substance and the dose being used immediately before abstinence.

**"Supportive services"** refers to assistance with the development of problem-solving and decision-making skills to maintain or achieve optimal functioning within the community and can include consumer education.

**"Tobacco"** means any nicotine delivery product or device that is not approved by the U.S. Food and Drug Administration (FDA) for the purpose of nicotine dependence treatment, including, but not limited to cigarettes, cigars, snuff, chewing tobacco, electronic cigarettes and vaping devices.

**"Trauma informed capability"** means the capacity for a facility and all its programs to recognize and respond accordingly to the presence of the effects of past and current traumatic experiences in the lives of its consumers.

**"Urgent Recovery Clinic"** means a program of non-hospital emergency services for mental health and substance use crisis response including, but not limited to, observation, evaluation, emergency treatment, and referral, when necessary to a higher level of care. This service is time limited and cannot exceed 23 hours and 59 minutes. This service is limited to CMHCs and Comprehensive Community Addiction Recovery Centers (CCARCs) certified by ODMHSAS or facilities operated by ODMHSAS.

**"Vocational assessment services"** means a process utilized to determine the individual's functional work-related abilities and vocational preferences for the purpose of the identification of the skills and environmental supports needed by the individual in order to function more independently in an employment setting, and to determine the nature and intensity of services which may be necessary to obtain and retain employment.

**"Vocational placement services"** means a process of developing or creating an appropriate employment situation matched to the functional abilities and choices of the individual for the purpose of vocational placement. Services may include, but are not limited to, the identification of employment positions, conducting job analysis, matching individuals to specific jobs, and the provision

of advocacy with potential employers based on the choice of the individual served.

**"Vocational preparation services"** means services that focus on development of general work behavior for the purpose of vocational preparation such as the utilization of individual or group work-related activities to assist individuals in understanding the meaning, value and demands of work; to modify or develop positive work attitudes, personal characteristics and work behaviors; to develop functional capacities; and to obtain optimum levels of vocational development.

**"Volunteer"** means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

**"Walk through"** means an exercise in which staff members of a facility walk through the program's treatment processes as a consumer. The goal is to view the agency processes from the consumer's perspective for the purpose of removing barriers and enhancing treatment.

**"Wellness"** means the condition of good physical, mental and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle

### 450:24-1-3. Meaning of verbs in rules

The attention of the facility is drawn to the distinction between the use of the words "shall," "should," and "may" in this chapter:

(1) "Shall" is the term used to indicate a mandatory statement, the only acceptable method under the present standards.

(2) "Should" is the term used to reflect the most preferable procedure, yet allowing for the use of effective alternatives.

(3) "May" is the term used to reflect an acceptable method that is recognized but not necessarily preferred.

### 450:24-1-4. Services

All facilities providing services shall have a group of services herein designated as required core services in accordance with 450:24-3 et seq. CCARC's may have specific additional services some of which are designated as optional services in accordance with 450:24-5 et seq.

### 450:24-1-5. Applicability

The standards and criteria for services as subsequently set forth in this chapter are applicable to CCARC’s as stated in each subchapter.

## SUBCHAPTER 3. REQUIRED SERVICES

## PART 1. CCARC REQUIRED CORE SERVICES

### 450:24-3-1. Required core services

The services in this subchapter are core services, are required of each CCARC, and are required to be provided in a co-occurring capable manner.

**450:24-3-2. Core community addiction recovery services**

(a) All services required pursuant to the rule in OAC 450:24 shall provide in accordance with criteria established by the most current edition of the ASAM criteria as applicable to that specific service.

(b) Each CCARC shall provide the following services:

(1) Screening and referral services;
(2) Emergency services;
(3) Outpatient services based on ASAM criteria;
(4) Intensive Outpatient services based on the ASAM criteria
(5) Case management services;
(6) Rehabilitation services;
(7) Medication clinic services;
(8) Facilitation to medical withdrawal management services based on the ASAM criteria;
(9) Facilitation to residential substance use disorder treatment based on the ASAM criteria;
(10) Service to homeless individuals;
(11) Peer Recovery Support Services, and
(12) Wellness Activities and Support.
(13) Ambulatory withdrawal management (Adults only) based on ASAM criteria.

(c) Compliance with 450:24-3-2 shall be determined by a review of the following:

(1) On-site observation;
(2) Staff interviews;
(3) Written materials;
(4) Program policies;
(5) Program Evaluations;
(6) Data reporting; and
(7) Clinical records.

**450:24-3-3. Availability of services**

(a) The core services shall be available to individuals regardless of their work or school schedule.

(1) All services provided on an outpatient basis shall be routinely available at least forty (40) hours per week, and will include evenings or weekends.
(2) CCARC policy shall provide for hours in addition to 8:00 AM - 5:00 PM. This applies to the main CCARC location and full time satellite offices with two (2) or more full time employed clinical staff.
(3) For CCARC's not providing 24 hour on-site services, hours of operation shall be conspicuously posted.

(b) Compliance with 450:24-3-3 shall be determined by a review of the following: schedules; posting of hours; policy and procedures; and consumer needs assessment.

## PART 3. SCREENING, ASSESSMENT AND REFERRAL

**450:24-3-21. Integrated screening and assessment services**

(a) CCARC policy and procedure shall require that a screening of each consumer's service needs is completed in a timely manner. An integrated screening should be welcoming, trauma-informed, and culturally appropriate, include screening of whether the consumer is a risk to self or others, including suicide risk factors, as well as maximize recognition of the prevalence of co-occurring disorders among those who present for services at a Community Comprehensive Addiction Recovery Center.

(b) Upon determination of appropriate admission, a biospychsocial assessment must be completed using the Addiction Severity Index (ASI) which gathers sufficient information to assist the consumer in developing an individualized service plan. The assessment must also list the client's past and current psychiatric medications. The assessment must be completed by a Licensed Behavioral Health Professional or Licensure Candidate.

(c) The consumer and family as appropriate shall be an active participant(s) in the screening and assessment process.

(d) The CCARC shall have policy and procedures specific to each program service which dictate timeframes by when assessments must be completed and documented. In the event the consumer is not admitted and as a result the assessment is not included in the clinical record, the policy shall specify how screening and assessment information is maintained and stored.

(e) Compliance with 450:24-3-21 shall be determined by a review of clinical records, and policy and procedures.

**450:24-3-22. Screening and assessment services, access or referral to needed services**

(a) Written policy and procedures governing the screening and assessment services shall specify the following:

(1) The information to be obtained on all applicants or referrals for admission;

(2) The procedures for accepting referrals from outside agencies or organizations;

(3) The procedure to be followed when an applicant or referral is found to be ineligible for admission;

(4) Methods of collection of information from family members, significant others or other social service agencies;

(5) Methods for obtaining a physical examination or continued medical care where indicated;

(6) Referral to other resources when the consumer has treatment or other service needs the facility cannot meet;

(7) Emphasis on welcoming all consumers and conveying a recovery oriented hopeful message; and

(8) No barriers to entry based solely on the presence of historic, current or recent mental health symptoms.

(b) Compliance with 450:24-3-22 shall be determined by a review of the facility's written policy and procedures.

## PART 5. EMERGENCY SERVICES

### 450:24-3-41. Emergency services

(a) CCARCs shall provide, on a twenty-four (24) hour basis, accessible co-occurring disorder capable services for substance use disorder related emergencies.

(b) This service shall include the following:

(1) 24-hour assessment and evaluation, including crisis intervention, characterized by welcoming engagement of all individuals and families;

(2) Availability of referral to 24-hour medical withdrawal management, residential treatment, and half-way house services;

(3) Availability of assessment and evaluation in external settings unless immediate safety is a concern. This shall include but not be limited to schools, jails, and hospitals;

(4) Referral services, which shall include actively working with local sheriffs and courts regarding the appropriate referral process and appropriate court orders (43A O.S. §§ 5-201 through 5-407);

(5) CCARC's serving multiple counties shall provide or arrange for on-site assessment of persons taken into protective custody [43A O.S. § 5-206 et seq.] for substance use disorder related emergencies in each county;

(6) The CCARC's emergency telephone response time shall be less than fifteen (15) minutes from initial contact, unless there are extenuating circumstances;

(7) Face-to-face strength based assessment, unless there are extenuating circumstances, addressing substance use disorder and/or co-occurring issues which include a description of the client's strengths in managing substance use disorder issues and disorders during a recent period of stability prior to the crisis;

(8) Intervention and resolution; and

(9) No arbitrary barriers to access an evaluation based on active mental health symptoms or designated substance levels.

(c) Compliance with 450:24-3-41 shall be determined by a review of policy and procedures, and clinical records.

### 450:24-3-42. Emergency Crisis Intervention

(a) The CCARC shall provide or otherwise ensure the capacity for performing emergency assessment of substance use disorder related crisis. This capacity must be available 24 hours per day, seven days a week.

(b) Compliance with 450:24-3-42 shall be determined by a review of the following: policy and procedures; emergency contact records; clinical records; PI documentation; and staff on-call schedules.

(c) Failure to comply with 450:24-3-42 will result in the initiation of procedures to deny, suspend and/or revoke certification.

**450:24-3-43. Crisis Intervention, staffing**

(a) Staff providing crisis intervention shall be an LBHP or Licensure Candidate which shall include core competency in emergency evaluation of co-occurring disorders and meet the CCARC's privileging requirements for the provision of emergency services, with the availability of an LMHP as defined in 43A O.S. § 1-103 for emergency examinations when warranted.

(b) Compliance with 450:24-3-43 shall be determined by a review of clinical privileging records and personnel records.

(c) Failure to comply with 450:24-3-43 will result in the initiation of procedures to deny, suspend and/or revoke certification.

## PART 7. AMBULATORY WITHDRAWAL MANAGEMENT SERVICES

**450:24-3-61. Ambulatory withdrawal management services without extended on-site monitoring services**

Ambulatory withdrawal management shall be provided outside a medical facility in an outpatient setting, but under the direction of a licensed physician for consumers who are withdrawing or are intoxicated from alcohol or other drugs.

(1) Presenting consumers shall be assessed as currently experiencing no apparent medical or neurological symptoms as a result of their substance use that would require a higher level of care using the ASAM criteria.

(2)Treatment services: Services shall occur daily (seven [7] days a week during hours of operation). Substance use disorder ambulatory withdrawal management treatment services shall be provided which shall include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time per visit or more often as indicated by the consumer's condition.

**450:24-3-62. Ambulatory withdrawal management services without extended on-site monitoring staffing**

(a) A licensed physician providing supervision of withdrawal management shall be on site or on call during hours of operation;

(b) Staff members shall be knowledgeable about the physical signs of withdrawal, the taking of vital signs, the implication of those vital signs, and emergency procedures.

(c) Oklahoma licensed nurses (RN's and LPN's as appropriate) shall provide on-site monitoring, and statutorily approved personnel shall administer medications in accordance with physician's orders;

(d) Staff shall be knowledgeable regarding facility-required education, evidenced based practices, training and policies; and

(e) The facility shall document in personnel records all education, training and experience stated in (b), (c) and (d) above prior to staff providing direct care services.

**450:24-3-63. Ambulatory withdrawal management services without extended on-site monitoring assessment/placement**

(a) A medical assessment for appropriateness of placement shall be completed and documented by a licensed physician during the admission process to the program.

(b) An individualized case management plan shall be developed for each consumer prior to discharge;

(c) Compliance with 450:24-6-0 may be determined by a review of the following:

(1) Licenses;

(2) Policy and procedures;

(3) Treatment protocols;

(4) Personnel records, documentation of professional licensure, certification or licensure as an alcohol and drug counselor, documentation of professional work experience, ongoing in-service training(s);

(5) Treatment records;

(6) Interviews with staff; and

(7) Other supporting facility documentation.

**450:24-3-64. Ambulatory withdrawal management without extended on-site monitoring environment**

(a) The facility shall provide for monitoring/documenting vital signs, food, and liquids.

(b)The facility shall provide a safe, welcoming, trauma-informed, and culturally/age appropriate environment.

(c) The facility shall maintain a written plan for emergency medical procedures, which shall be approved by a licensed physician; and

(d) The facility shall have supplies, as designated in the written emergency procedures, which shall be accessible to the staff.

(e) The facility shall maintain written programmatic descriptions and operational methods for (a), (c) and (d).

(f) Compliance with 450:24-6-0 may be determined by a review of the following:

(1) Policy and procedures;

(2) Treatment protocols;

(3) Treatment records;

(4) Interviews with staff; and

(5) Other supporting facility documentation.

**450:24-3-65. Ambulatory withdrawal management without extended on-site monitoring, substance use disorder, co-occurring**

(a) Facilities shall provide co-occurring disorder capable intensive ambulatory withdrawal management without extended on-site monitoring treatment services.

(b) These services shall include the provision of or referral for Human Immunodeficiency Virus (HIV), Sexually Transmitted Diseases (STD), and Acquired Immunodeficiency Syndrome (AIDS) education, training, and counseling services for drug dependent persons (43A O.S. §3-425.1), and every facility shall:

(1) Provide or refer for educational sessions regarding HIV/STD/AIDS to consumers and the significant other(s) of the consumer; and

(2) Provide or refer all drug dependent persons, and their identified significant other (s), for HIV/STD/AIDS testing and counseling;

(3) Provide documentation of services described in (1) and (2) above, including refusal of these services; and

(4) Maintain all test results in the confidential manner prescribed by applicable state or federal statutes or regulations.

(c) Compliance with 450:24-6-0 shall be determined by a review of the following: written policy and procedures; consumer records; and other supporting facility records and documentation.

## PART 9. OUTPATIENT TREATMENT SERVICES

### 450:24-3-81. Outpatient treatment services

(a) Outpatient services shall be determined as necessary using the ASAM criteria and shall include a range of services to consumers based on their needs regarding emotional, social and behavioral problems. These outpatient services shall be provided or arranged for, and shall include, but not be limited to the following:

(1) Individual therapy;

(2) Group therapy;

(3) Family therapy;

(4) Rehabilitation services;

(5) Case management services;

(6) Peer recovery support services; and

(7) Wellness services and related activities.

(b) Compliance with 450:24-3-81 shall be determined by a review of written policy and procedures; clinical records; and data reported by facilities.

### 450:24-3-82. Outpatient treatment services, substance use disorder, co-occurring

(a) Facilities shall provide co-occurring disorder capable outpatient substance use disorder treatment services.

(b) These services shall include the provision of or referral for Human Immunodeficiency Virus (HIV), Sexually Transmitted Diseases (STD), and Acquired Immunodeficiency Syndrome (AIDS) education, training, and counseling services for drug dependent persons (43A O.S. §3-425.1), and every facility shall:

(1) Provide or refer for educational sessions regarding HIV/STD/AIDS to consumers and the significant other(s) of the consumer; and

(2) Provide or refer all drug dependent persons, and their identified significant other(s), for HIV/STD/AIDS testing and counseling;

(3) Provide documentation of services described in (1) and (2) above, including refusal of these services; and

(4) Maintain all test results in the confidential manner prescribed by applicable state or federal statutes or regulations.

(c) Compliance with 450:24-3-82 shall be determined by a review of the following: written policy and procedures; consumer records; and other supporting facility records and documentation.

## PART 11. INTENSIVE OUTPATIENT SERVICES

### 450:24-3-101. Intensive outpatient treatment services

(a) Intensive outpatient services shall be determined as necessary using the ASAM criteria and shall include a range of nine (9) to fifteen (15) treatment services per week for adults or six (6) to twelve (12) treatment hours per week for children based on their needs regarding emotional, social and behavioral problems. These intensive outpatient services shall be provided or arranged for, and should include, but not be limited to the following:

(1) Individual therapy;
(2) Group therapy;
(3) Family therapy;
(4) Rehabilitation services;
(5) Case management services;
(6) Peer recovery support services; and
(7) Wellness services and related activities.

(b) Compliance with 450:24-3-101 shall be determined by a review of written policy and procedures; clinical records; and data reported by facilities.

### 450:24-3-102. Intensive outpatient treatment services, substance use disorder, co-occurring

(a) Facilities shall provide co-occurring disorder capable intensive outpatient substance use disorder treatment services.

(b) These services shall include the provision of or referral for Human Immunodeficiency Virus (HIV), Sexually Transmitted Diseases (STD), and Acquired Immunodeficiency Syndrome (AIDS) education, training, and counseling services for drug dependent persons (43A O.S. §3-425.1), and every facility shall:

(1) Provide or refer for educational sessions regarding HIV/STD/AIDS to consumers and the significant other(s) of the consumer; and
(2) Provide or refer all drug dependent persons, and their identified significant other (s), for HIV/STD/AIDS testing and counseling;
(3) Provide documentation of services described in (1) and (2) above, including refusal of these services; and
(4) Maintain all test results in the confidential manner prescribed by applicable state or federal statutes or regulations.

(c) Compliance with 450:24-3-62 shall be determined by a review of the following: written policy and procedures; consumer records; and other supporting facility records and documentation.

## PART 13. MEDICATION CLINIC SERVICES

### 450:24-3-121. Medication clinic services

(a) CCARCs shall offer comprehensive medication clinic services to consumers in need of this service,
(b) Medication clinic services shall include an assessment of each individual's condition and needs; and an assessment of the effectiveness of those services.
(c) Medication clinic services shall be co-occurring capable and shall utilize accepted practice guidelines for psychopharmacologic management of co-occurring and/or substance use disorders.
(d) Medication clinical services shall include but not be limited to:

(1) Prescribing or administering medication, including evaluation and assessment of the medication services provided.
(2) Medication orders and administration:

(A) Only licensed staff physicians, medical residents or consultant physicians shall write medication orders and prescriptions.
(B) A list of those physicians authorized to prescribe medications shall be maintained and regularly updated.
(C) A list of licensed staff members authorized to administer medications shall be maintained and regularly updated.

(3) Physician's assistants and nurse practitioners may write medication orders, or prescriptions consistent with state and federal law.

(e) Compliance with 450:24-3-121shall be determined by on-site observation and a review of the following: clinical records, written policy and procedures, and roster of licensed, credentialed staff.

**450:24-3-122. Medication clinic, medication monitoring**

(a) Medication administration, storage and control, and consumer reactions shall be regularly monitored.
(b) Facilities shall assure proper storage and control of medications, immediate response if incorrect or overdoses occur, and have appropriate emergency supplies available if needed.

(1) Written procedures for medication administration shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications.
(2) All medications shall be kept in locked, non-consumer accessible areas. Conditions which shall be considered in medication storage are light, moisture, sanitation, temperature, ventilation, and the segregation and safe storage of poisons, external medications, and internal medications.
(3) Telephone numbers of the state poison centers shall be immediately available in all locations where medications are prescribed, or administered, or stored.
(4) A qualified physician shall supervise the preparation and stock of an emergency kit which is readily available, but accessible only to physician, nursing and pharmacy staff.

(c) Compliance with 450:24-3-122 shall be determined by on-site observation and a review of the following: written policy and procedures, clinical records, and PI records.

**450:24-3-123. Medication clinic, error rates**
(a) The facility's performance improvement program shall specifically, objectively, and systematically monitor medications administration or dispensing or medication orders and prescriptions to evaluate and improve the quality of consumer care.
(b) Compliance with 450:24-3-123 shall be determined by a review of the following: facility policies; PI logs; data; and reports.

## PART 15. CASE MANAGEMENT

**450:24-3-141. Case management services**
(a) Case management efforts shall empower consumers to access and use needed services and meet self-determined goals. These services include resource skills development and consumer advocacy provided in various settings based on consumer need.
(b) Case management services shall be offered to all adults who are receiving services and, to each child (or their parent/guardian).
(c) Case management shall be co-occurring disorder capable.
(d) Case management services shall be planned referral, linkage, monitoring and support, and advocacy assistance provided in partnership with a client to support that client in self sufficiency and community tenure. Activities include:

(1) Completion of strengths based assessment for the purpose of individual plan of care development, which shall include evidence that the following were evaluated:

(A) Consumer’s level of functioning within the community;
(B) Consumer’s job skills and potential; and/or educational needs;
(C) Consumer strengths and resources;
(D) Consumer's financial needs;
(E) Consumer's legal needs;
(F) Consumer’s present living situation and support system;
(G) Consumer’s use of substances and orientation to changes related to substance use;
(H) Consumer’s medical and health status;
(I) Consumer’s needs or problems which interfere with the ability to successfully function in the community; and
(J) Consumer’s goals.

(2) Development of case management care plan;
(3) Referral, linkage and advocacy to assist with gaining access to appropriate community resources;
(4) Contacts with other individuals and organizations that influence the recipient's relationship with the community, i.e., family members, law enforcement personnel, landlords, etc;
(5) Monitoring and support related to the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress;
(6) Follow-up contact with the consumer if they miss any scheduled appointments (including physician/medication, therapy, rehabilitation, or

other supportive service appointments as delineated on the service plan); and

(7) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist consumer(s) from progression to a higher level of care.

(e) Compliance with 450:24-3-141 shall be determined by on-site observation and a review of the following: clinical records, and written policy and procedures.

**450:24-3-142. Case management services, locale and frequency**

(a) Case management services shall be provided within community settings; the residence of the consumer; or any other appropriate settings, based on the individual needs of the consumer. Contact with consumers shall be made on at least a monthly basis unless otherwise specified in the service plan.

(b) Compliance with 450:24-3-142 shall be determined by a review of the following: Case managers shall contact each consumer at least once a month, unless otherwise specified in the service plan to monitor progress or provide case management services. Inability to make face to face contact shall be documented. Contact was made with consumers as specified in the service plan.

**450:24-3-143. Case management services for consumers admitted to higher levels of care**

(a) Case managers shall maintain contact with existing CCARC consumers, and establish contact with newly referred persons who are receiving services in residential treatment settings, Community Based Structured Crisis Centers (CBSCC), or 24-hour settings providing substance use disorder withdrawal management treatment.

(b) Each CCARC shall assign at least one (1) staff member who is responsible for linkage between CBSCCs, withdrawal management center and/or the residential substance use disorder treatment facility and the CCARC. Linkage shall include, but not limited to, the following activities, pursuant to appropriately signed releases and adherence to applicable privacy provisions:

(1) Regular visits or communication with the CBSCC, withdrawal management setting, and/or residential substance use disorder treatment facility to monitor progress of those consumers in a CBSCC, withdrawal management setting and/or in facility-based substance use disorder treatment from the CCARC's service area.

(2) Provide knowledge and communication to other CCARC staff regarding CBCSC, withdrawal management setting, and/or residential substance use disorder treatment facility and discharge procedures.

(c) Case managers from the CCARC to which the consumer will be discharged shall assist the consumer and unit, CBSCC, and/or substance use disorder treatment facility with discharge planning for consumers returning to the community.

(d) Individuals discharging from an inpatient setting, CBSCC, and/or substance use disorder treatment facility, who have not already been engaged, shall be offered case management and other supportive services. This shall occur as soon as possible, but shall be offered no later than one (1) week post-discharge.
(e) Compliance with 450:24-3-143 shall be determined by a review of the following: clinical records; staff interviews; information from ODMHSAS operated psychiatric inpatient unit; CBSCC facilities, substance use disorder treatment facilities; meetings minutes (CCARC or state-operated psychiatric inpatient unit); and a review of a minimum of ten (10) clinical records of consumers who received services at an inpatient unit, CBSS, and/or 450-hour setting providing substance use disorder treatment within the past twelve (12) months.

**450:24-3-144. Case management services, staff credentials**
(a) Individuals providing case management services shall be an LBHP, Licensure Candidate, CADC, or certified as a behavioral health case manager pursuant to Oklahoma Administrative Code, Title 450, Chapter 50.
(b) Facility supervisors must be a certified behavioral health case manager pursuant
to Oklahoma Administrative Code, Title 450, Chapter 50 if they directly supervise the equivalent of two (2) or more FTE certified behavioral health case managers who provide case management services as part of their regular duties.
(c) Compliance with 450:24-3-144 shall be determined by a review of the facility personnel records and credentialing files.

## PART 17. BEHAVIORAL HEALTH REHABILITATION SERVICES

**450:24-3-161. Rehabilitation services**
(a) This section governs individual and group rehabilitation services for both adults and children.
(b) Policy and procedures shall reflect that all rehabilitation programs and services incorporate the following core principles:

(1) Recovery is the ultimate goal of rehabilitation. Interventions must facilitate the process of recovery and wellness.
(2) Addiction rehabilitation practices help people re-establish normal roles in the community and their integration into community life.
(3) Rehabilitation practices facilitate the development of personal support networks.
(4) Rehabilitation practices facilitate an enhanced quality of life for each person receiving services.
(5) People have the capacity to learn and grow.
(6) People receiving services have the right to direct their own affairs, including those that are related to their behavioral health.
(7) People are to be treated with respect and dignity.
(8) Rehabilitation practitioners make conscious and consistent efforts to eliminate labeling and discrimination, particularly discrimination based upon a disabling condition.

(9) Culture and ethnicity play an important role in recovery. They are sources of strength and enrichment for the person and the services.
(10) Rehabilitation interventions build on the strength of each person.
(11) Rehabilitation services are to be coordinated, accessible, and available as long as needed.
(12) Services are to be designed to address the unique needs of each individual, consistent with the individual's cultural values and norms.
(13) Rehabilitation practices actively encourage and support the involvement of persons in normal community activities, such as school and work, throughout the rehabilitation process.
(14) The involvement and partnership of persons receiving services and family members is an essential ingredient of the process of rehabilitation and recovery.
(15) Rehabilitation practitioners should constantly strive to improve the services they provide.

(c) CCARC policy and procedures shall reflect that rehabilitation services shall be co-occurring disorder capable and facilitate processes for dual recovery for these individuals.

(d) Compliance with 450:24-3-161 shall be determined by on-site observation; interviews with participants; interviews with staff; a review of policy and procedures; and a review of clinical records.

**450:24-3-162. Individual and Group Rehabilitation Services**

(a) CCARC policy and procedures shall reflect that individual and group rehabilitation services are available to both adults and children.

(b) Facility policy and procedures shall outline the way these services are provided, including but not limited to the populations served, staff qualifications for providing the service, and general design(s) by which these services are provided.

(c) Compliance with 450:24-3-146 shall be determined by a review of CCARC policy and procedures and personnel files.

## PART 19. SERVICES TO HOMELESS INDIVIDUALS

**450:24-3-181. Services to homeless individuals**

(a) CCARCs shall provide the following services to individuals within their service area who are homeless, including those individuals experiencing chronic homelessness and who have a serious addictive disorder, including co-occurring disorders:

(1) Linkage and contacts with local emergency services, shelters, state-operated psychiatric inpatient unit, Community Based Structured Crisis Centers, Urgent Recovery Clinics and any other organizations which may be in contact with homeless persons;
(2) Linkage and contacts with local housing authorities;
(3) Contact, and work with those who are homeless and who have a serious addiction disorders, to assist with accessing CCARC services,

income benefit programs, and housing programs, among other services; and

(4) These services shall be addressed in CCARC policy and procedures.

(b) Compliance with 450:24-3-181 shall be determined by a review of the following: documentation of linkage activities and agreements; clinical records; reporting data; and, CCARC policy and procedures.

## PART 21. PEER RECOVERY SUPPORT SERVICES

### 450:24-3-201. Peer recovery support services

(a) Peer recovery support services are provided as a program integrated within the overall structure of Comprehensive Community Addiction Center services and must be offered to children ages 16 and 17, and adults age 18 and older with addiction disorders, including co-occurring disorders.

(b) Peer recovery support services may be offered to other consumers of the CCARC and their families.

(c) These services shall

(1) Be based on an individualized, recovery-focused service philosophy that allows individuals the opportunity to learn to manage their own recovery and advocacy process;

(2) Recognize the unique value of services being provided by persons with lived experience who are able to demonstrate their own hopefulness and recovery;

(3) Enhance the development of natural supports, coping skills, and other skills necessary to function as independently as possible in the community, including, but not limited to assisting re-entry into the community after residential treatment or other institutional settings;

(4) Have written policies specific to these services; and,

(5) Be provided by certified Peer Recovery Support Specialist(s) as defined by 450:24-3-202.

(d) Each CCARC shall have in place provisions for direct supervision and other supports for staff providing this service.

(e) Compliance with 450:24-3-201 shall be determined by a review of the following: documentation of linkage activities and agreements; clinical records; reporting data; and, CCARC policy and procedures.

### 450:24-3-202. Peer Recovery Support Specialists staff requirements

(a) Peer Recovery Support Services shall be provided only by Peer Recovery Support Specialists meeting the requirements and certified pursuant to OAC 450:53.

(b) Each CCARC shall document and maintain records to verify compliance with training and testing requirements of each provider of this service.

(c) Compliance for 450:24-3-202 shall be determined by a review of the facility personnel records and ODMHSAS files.

### 450:24-3-203. Peer Recovery Support services: Locale and frequency

(a) Peer Recovery Support services can be provided in any location. The majority of contacts should be face-to-face; however, services may be provided over the telephone as necessary to help the consumer achieve his/her goals.
(b) Compliance for 450:24-3-203 shall be determined by a review of the agency policy and procedures, data reporting system, consumer records, consumer interviews, and observation.

## PART 23. WELLNESS SERVICES AND RELATED ACTIVITIES

### 450:24-3-221. Wellness Services and Related Activities

(a) Wellness Services and Related Activities are consumer-driven services and supports that promote healthy lifestyles and behaviors which may include and not be limited to smoking cessation activities, exercise, stress management, spirituality, and education on nutrition and healthy eating.
(b) These services shall:

(1) Be based on an individualized, recovery-focused service philosophy that allows individuals the opportunity to learn to manage their own wellness; and~~,~~

(2) Be provided by staff credentialed by ODMHSAS as Wellness Coaches; and

(3) Have written policies specific to this services.

(c) Compliance for 450:24-3-221 shall be determined by a review of the following: documentation of activities and agreements; clinical records; reporting data; and, CCARC policy and procedures.

# SUBCHAPTER 5. OPTIONAL SERVICES

## PART 1. APPLICABILITY

### 450:24-5-1. Applicability

The services in this subchapter are optional services. However, if the services in this subchapter are provided, either on the initiative of the CCARC, or as an ODMHSAS contractual requirement of the CCARC, all rules and requirements of this subchapter shall apply, as applicable, to the affected CCARC's certification.

## PART 2. MEDICALLY-SUPERVISED AND NON-MEDICAL WITHDRAWAL MANAGEMENT

### 450:24-5-11. Medically-supervised withdrawal management

If provided, Medically-supervised withdrawal management shall be provided pursuant to OAC 450:18-13-61 through 18-13-63.

### 450:24-5-13. Non-medical withdrawal management

If provided, non-medical withdrawal management shall be provided pursuant to OAC 450:18-13-81 through 18-13-83.

## PART 3. RESIDENTIAL TREATMENT

### 450:24-5-21. Residential treatment for adults

Facilities providing substance use disorder treatment services for adults in the residential setting must meet the requirements found in Sections 450:18-13-101 through 18-13-103.

## PART 5. RESIDENTIAL TREATMENT FOR PERSONS WITH DEPENDENT CHILDREN

### 450:24-5-41. Residential treatment for persons with dependent children

Facilities providing substance use disorder treatment services for persons with dependent children in the residential setting must meet the requirements found in Sections 450:18-13-121 through 18-13-124.

## PART 7. RESIDENTIAL TREATMENT FOR ADULTS WITH CO-OCCURRING DISORDERS

### 450:24-5-61. Adult residential treatment for consumers with co-occurring disorders

Facilities providing treatment services for adults with co-occurring disorders in the residential setting must meet the requirements found in Sections 450:18-13-141 through 18-13-143.

## PART 9. RESIDENTIAL TREATMENT FOR ADOLESCENTS

### 450:24-5-81. Residential treatment for adolescents

Facilities providing substance use disorder treatment services for adolescents in the residential setting must meet the requirements found in Sections 450:18-13-161 through 18-13-163.

## PART 11. HALFWAY HOUSE SERVICES

### 450:24-5-101. Halfway house services

Facilities providing halfway house services must meet the requirements found in Sections 450:18-13-181 through 18-13-183.

## PART 13. ADOLESCENT HALFWAY HOUSE SERVICES

### 450:24-5-121. Adolescent halfway house services

Facilities providing adolescent halfway house services must meet the requirements found in Sections 450:18-13-190 through 18-13-192.

## PART 15. HALFWAY HOUSE SERVICES FOR PERSONS WITH DEPENDENT CHILDREN

### 450:24-5-141. Halfway house services for persons with dependent children

Facilities providing halfway house services for persons with dependent children must meet the requirements found in Sections 450:18-13-201 through 18-13-203.

## PART 17. VOCATIONAL EMPLOYMENT SERVICES

### 450:24-5-161. Vocational employment services

(a) The vocational employment services program is an identified program within the CCARC that assists in the rehabilitation and support of persons with addiction disorders, which may include but is not limited to the following:

(1) Vocational assessment services;
(2) Vocational preparation services;
(3) Vocational placement services; and
(4) Other on and off-site employment support services.

(b) If offered by a CCARC, vocational employment services should be co-occurring disorder capable and be available to individuals with co-occurring disorders who are interested in work as a goal, even if they are not yet abstinent.

(c) Compliance with 450:24-5-161 shall be determined by on-site observation and a review of the following: organization chart; interagency agreements; written policy and procedures; and contractual agreements.

## PART 19. GAMBLING DISORDER TREATMENT SERVICES [REVOKED]

### 450:24-5-162. Gambling Disorder Treatment Services [REVOKED]

### 450:24-5-163. Level of Care [REVOKED]

### 450:24-5-164. Admission criteria [REVOKED]

### 450:24-5-165. Discharge criteria [REVOKED]

### 450:24-5-166. Treatment services [REVOKED]

## SUBCHAPTER 7. FACILITY CLINICAL RECORDS

### 450:24-7-1. Clinical record keeping system

Each CCARC shall maintain an organized clinical record system for the collection and documentation of information appropriate to the treatment processes; and which insures organized, easily retrievable, usable clinical records stored under confidential conditions and with planned retention and disposition.

### 450:24-7-2. Applicability

The requirements of this subchapter are applicable to a CCARC's clinical services, core and optional.

### 450:24-7-3. Basic requirements

(a) The CCARC's policies and procedures shall:

(1) Define the content of the consumer record in accordance with 450:24-7-4 through 24-7-9.

(2) Define storage, retention and destruction requirements for consumer records. ODMHSAS operated CCARCs shall comply with the Department's Records Disposition Schedule as approved by the Oklahoma Archives and Records Commission.

(3) Require consumer records be maintained in locked equipment which is kept within a locked room, vehicle, or premise.

(4) Require legible entries in consumer records, signed with first name or initial, last name, and dated by the person making the entry.

(5) Require the consumer's name be typed or written on each page in the consumer record.

(6) Require a signed consent for treatment before a consumer is admitted on a voluntary basis.

(7) Require a signed consent for follow-up before any contact after discharge is made.

(b) Compliance with 450:24-7-3 shall be determined by a review of the following: facility policy, procedures or operational methods; clinical records; other facility provided documentation; and PI information and reports. A CCARC may propose administrative and clinical efficiencies through a streamlining of the requirements noted in this subchapter if client outcomes are maintained or improved and face-to-face clinical time is able to be increased by proposed reduction in recordkeeping requirements. Such proposal shall be submitted for consideration and approval by the Department.

**450:24-7-4. Record access for clinical staff**

(a) The CCARC shall assure consumer records are readily accessible to the program staff directly caring for the consumer. Such access shall be limited to the minimum necessary to carry out the staff member's job functions or the purpose for the use of the records.

(b) Compliance with 450:24-7-4 shall be determined by on-site observation and staff interviews.

**450:24-7-5. Clinical record content, screening and assessment**

(a) All facilities shall complete a face-to face screening with each individual to determine appropriateness of admission.

(b) The CCARC shall document the face-to-face screening between the potential consumer and the CCARC including how the consumer was welcomed and engaged, how the consumer was assisted to identify goals and experience hope, how the consumer received integrated screening to identify both immediate and ongoing needs and how the consumer was assisted to determine appropriateness of admission, and/or to access other appropriate services.

(c) All facilities shall assess each consumer for appropriateness of admission to the treatment program. Each presenting consumer for substance use disorder treatment shall be assessed, according to ASAM criteria, which includes a list of

symptoms for all six dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care. The Oklahoma Determination of ASAM Service Level (ODASL) must be completed when determining clinically appropriate residential treatment placement. For facilities offering gambling disorder treatment services, each presenting consumer for gambling disorder treatment shall be assessed using the Southern Oaks Gambling Screen (SOGS). Facilities must ensure that a consumer's refusal of a particular service does not preclude the consumer from accessing other needed mental health or substance-related or addictive disorder treatment services. Should the service provider determine the consumer's needs cannot be met within the facility, clinical assessments and referrals for the consumer shall be documented.

(d) Any consumer seeking admission to inpatient or residential services, including medically-supervised withdrawal management and non-medical withdrawal management while under the influence or undergoing withdrawal of alcohol or drugs, shall be assessed prior to admission for medical needs. The written criteria to be used for medical needs assessment of persons under the influence or undergoing withdrawal of alcohol or drugs, shall be approved by the facility's consulting physician.

(e) Upon determination of appropriate admission, consumer assessment demographic information shall contain, but not be limited to, the following:

(1) Date of initial contact requesting services;
(2) Date of the screening and/or assessment;
(3) Consumer's name;
(4) Gender;
(5) Birthdate;
(6) Home address;
(7) Telephone number;
(8) Referral source;
(9) Reason for referral;
(10) Significant other to be notified in case of emergency; and
(11) PICIS data core content, if the facility reports on PICIS.

(f) Compliance with 450:18-7-21 may be determined by a review of the following:

(1) Policies and procedures;
(2) Intake protocols;
(3) assessment instruments;
(4) Treatment records;
(5) Interviews with staff and consumers; and
(6) Other facility documentation.

**450:24-7-6. Clinical record content, on-going assessment**

(a) The CCARC shall have procedures and policies which delineate the process, protocols, and timeframes by which on-going clinical assessments occur.

(b) Compliance with 450: 24-7-6 shall be determined by a review of the clinical records and agency policies and procedures.

**450:24-7-7. Behavioral Health Service Plan**

(a) The service plan is performed by a LBHP or Licensure Candidate with the active participation of the consumer and a support person or advocate if requested by the consumer. In the case of children under the age of 18, it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate. The service plan shall provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon consumer's progress or preference or the identification of new needs, challenges and problems.

(b) The service plan is developed after and based on information obtained in the mental health assessment and includes the evaluation of the assessment information by the clinician and the consumer.

(c) For adults, the service plan must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(d) Comprehensive service plans must be completed within six (6) treatment sessions and adhere to the format and content requirements described in the facility policy and procedures.

(e) Service plan updates should occur at a minimum of every 6 months during which services are provided and adhere to the format and content requirements described in the facility policy and procedures.

(f) Service plans, both comprehensive and update, must include dated signatures for the consumer customer (if over age 14), the parent/guardian (if under age18 or otherwise applicable), and the primary service practitioner. Signatures must be obtained after the service plan is completed.

(g) Compliance with 450:24-7-7 shall be determined by a review of the clinical records, policies and procedures, and interviews with staff and consumers, and other agency documentation.

**450:24-7-8. Medication record**

(a) A medication record shall be maintained on all consumers who receive medications or prescriptions through facility services and shall be a concise and accurate record of the medications the consumer is receiving or prescribed.

(b) The consumer record shall contain a medication record with the following information on all medications ordered or prescribed by licensed medical staff:

(1) Name of medication,

(2) Dosage,

(3) Frequency of administration or prescribed change, and

(4) Staff member who administered or dispensed each dose, and prescribing physician; and

(c) A record of pertinent information regarding adverse reactions to drugs, drug allergies, or sensitivities during the admission process, updated when required by virtue of new information, and kept in a highly visible location in or on the record.

(d) Compliance with 450:24-7-8 shall be determined by a review of medication records and clinical records.

**450:24-7-9. Progress Notes**

(a) Progress notes shall chronologically describe the services provided, the consumer's response to the services provided and the consumer's progress in treatment.

(b) Progress notes shall address the following:

(1) date;
(2) consumer's name;
(3) Start and stop time for each timed treatment session or service;
(4) type of service provided; and
(5) signature of the service provider with their credential(s).

(c) Outpatient staff must document each visit or transaction, except for assessment completion or service plan development, including missed appointments.

(d) Compliance with 450:24-7-9 shall be determined by a review of clinical records and policies and procedures.

**450:24-7-10. Other records content**

(a) The consumer record shall contain copies of all consultation reports concerning the consumer.

(b) When psychometric or psychological testing is done, the consumer record shall contain a copy of a written report describing the test results and implications or recommendations for treatment.

(c) The consumer record shall contain any additional information relating to the consumer, which has been secured from sources outside the program.

(d) Compliance with 450:24-7-10 shall be determined by a review of clinical records.

**450:24-7-11. Discharge assessment**

(a) All facilities shall assess each consumer for appropriateness of discharge from a substance use disorder treatment program. Each consumer shall be assessed using ASAM criteria that includes a list of symptoms for all six dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination for appropriate placement to a specific level of care based on the consumer's severity of symptoms and current situations.

(b) Compliance with 450:24-7-11 may be determined by a review of the following:

(1) Policies and procedures;
(2) Continuing care plans;
(3) Discharge assessments;
(4) Discharge summaries;
(5) Progress notes;
(6) Consumer records;
(7) Interviews with staff and consumers; and

(8) Other facility documentation.

**450:24-7-12. Continuing care plan**

(a) The facility shall assist the consumer to obtain services that are needed, but not available within the facility, and/or in transitioning from one level of care to another, and/or discharging from a facility. A written plan of recommendations and specific referrals for implementation of continuing care services, including medications, shall be prepared for each consumer who meets the ASAM PPC dimensional continued service criteria, in each level of care. Continuing care plans shall be developed with the knowledge and cooperation of the consumer. The continuing care plan may be included in the discharge summary. The consumer's response to the continuing care plan shall be noted in the plan or a note shall be made that the consumer was not available and why. In the event of the death of a consumer, a summary statement including this information shall be documented in the record.

(b) Compliance with 450:24-7-12 may be determined by a review of closed clinical records.

**450:24-7-13. Discharge Summary**

(a) The discharge summary shall document the consumer's progress made in treatment and response to services rendered.

(b) A completed discharge summary shall be entered in each consumer's record within fifteen (15) days of the consumer completing, transferring, or discontinuing services. Consumers who have received no services for one hundred eighty (180) days shall be discharged if it is determined that services are no longer needed or desired.

(c) In the event of death of a consumer: A summary statement including this information shall be documented in the record; and

(d) Compliance with 450:247-13 may be determined by a review of closed consumer records.

## SUBCHAPTER 9. CONSUMER RECORDS AND CONFIDENTIALITY

**450:24-9-1 Confidentiality of mental health and drug or alcohol abuse treatment information**

Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-3-20.1, OAC 450: 15-3-20.2 and OAC 450:15-30-60.

## SUBCHAPTER 11. CONSUMER RIGHTS

**450:24-11-1. Consumer rights, inpatient and residential**

The CCARC shall comply with applicable rules in Title 450, Chapter 15. Consumer Rights.

## SUBCHAPTER 13. ORGANIZATIONAL AND FACILITY MANAGEMENT

### 450:24-13-1. Organizational and facility description

(a) The CCARC shall have a written organizational description which is reviewed annually and minimally includes:

(1) The overall target population to be served;

2) The overall mission statement; and

(3) The annual facility goals and objectives, including the goal of continued progress for the agency in providing recovery oriented, culturally competent, trauma informed and co-occurring capable services.

(b) The CCARC's governing authority shall review and approve the mission statement and annual goals and objectives and document their approval.

(c) The CCARC shall make the organizational description, mission statement and annual goals available to staff.

(d) The CCARC shall make the organizational description, mission statement and annual goals available to the general public upon request.

(e) Each CCARC shall have in writing, by program component or service, the following:

(1) Philosophy and description of services, including the philosophy of recovery oriented and welcoming service delivery;

(2) Identity of the professional staff that provides these services;

(3) Admission and exclusionary criteria that identify the type of consumers for whom the services is primarily intended, with no exclusion criteria based on active substance use disorders;

(4) Goals and objectives, including making progress toward co-occurring capable, trauma informed, and culturally competent service delivery; and

(5) Delineation of processes to assure welcoming accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.

(f) The CCARC shall have written statement of the quality improvement processes, procedures and plans for attaining the organization's goals and objectives. These procedures and plans shall define specific tasks, including actions regarding the organization's co-occurring capability set target dates and designate staff responsible for carrying out the procedures and plans.

(g) Compliance with OAC 450:24-13-1 shall be determined by a review of the facility's target population definition; facility policy and procedures; mission statement; written plan for professional services; other stated required documentation; and any other supporting documentation.

### 450:24-13-2. Information analysis and planning

(a) The CCARC shall have a defined and written plan for conducting an organizational needs assessment which specifies the methods and data to be collected, to include, but not limited to information from:

(1) Consumers;

(2) Governing Authority;

(3) Staff;
(4) Stakeholders;
(5) Outcomes management processes;
(6) Quality record review and
(7) Self-assessment tools to determine progress toward co-occurring, recovery oriented, trauma informed and consumer driven capability.

(b) The CCARC shall have a defined ongoing system to collect data and information on a quarterly basis to manage the organization.

(c) Information collected shall be analyzed to improve consumer services and organizational performance.

(d) The CCARC shall prepare an end of year management report, which shall include but not be limited to:

(1) an analysis of the needs assessment process, and
(2) performance improvement program findings, and
(3) claims and accomplishments by facilities, including but not limited to consumer count and success rates, which may be verified by the ODMHSAS Board.

(e) The management report shall be communicated and made available to, among others:

(1) the governing authority,
(2) facility staff, and
(3) ODMHSAS if and when requested.

(f) Compliance with OAC 450:17-13-2 shall be determined by a review of the written program evaluation plan(s); written annual program evaluation(s), special or interim program evaluations; program goals and objectives; and other supporting documentation provided.

## SUBCHAPTER 15. PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT

### 450:24-15-1. Performance improvement program

(a) The CCARC shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care.

(b) The Performance improvement program shall also address the fiscal management of the organization.

(c) The facility shall have an annual written plan for performance improvement activities. The plan shall include but not be limited to:

(1) Outcomes management specific to each program component which minimally measures:
(A) efficiency;
(B) effectiveness; and
(C) consumer satisfaction.
(2) A quarterly quality consumer record review to evaluate and ensure, among others:
(A) the quality of services delivered;

(B) the appropriateness of services;
(C) patterns of service utilization;
(D) consumers are provided an orientation to services, and actively involved in making informed choices regarding the services they receive;
(E) assessments are thorough, timely and complete;
(F) treatment goals and objectives are based on, at a minimum,
(i) assessment findings, and
(ii) consumer input;
(G) services provided are related to the treatment plan goals and objectives;
(H) services are documented as prescribed by policy; and
(I) the service plan is reviewed and updated as prescribed by policy.
(3) Clinical privileging;
(4) Review of critical and unusual incidents and consumer grievances and complaints; and
(5) Improvement in the following:
(A) co-occurring capability, including the utilization of self-assessment tools as determined or recommended by ODMHSAS;
(B) provision of trauma informed services;
(C) provision of culturally competent services; and
(D) provision of consumer driven services; and
(6) Activities to improve access and retention within the treatment program, including an annual “walk through” of the intake and admission process.
(d) The CCARC will identify a performance improvement officer.
(e) The CCARC shall monitor the implementation of the performance improvement plan on an ongoing basis and makes adjustments as needed.
(f) Performance improvement findings shall be communicated and made available to, among others:
(1) the governing authority;
(2) facility staff;
(3) consumers;
(4) stakeholders; and
(5) ODMHSAS, as requested.
(g) Compliance with 450:24-15-1 shall be determined by a review of the written program evaluation plan; written program evaluations (annual and or special or interim; program goals and objectives; and other supporting documentation provided).

**450:24-15-2. Critical incident reporting**
(a) The facility shall have written policies and procedures requiring documentation and reporting of critical incidents and analysis of the contributors to the incident, with attention to issues that may reflect opportunities for system level or program level improvement.
(b) The documentation for critical incidents shall minimally include:

(1) the facility, name and signature of the person(s) reporting the incident;
(2) the name(s) of the consumer(s), staff member(s) or property involved;
(3) the time, date and physical location of the critical incident;
(4) the time and date the incident was reported and name of the staff person within the facility to whom it was reported;
(5) a description of the incident;
(6) resolution or action taken, date action taken, and signature of appropriate staff; and
(7) severity of each injury, if applicable. Severity shall be indicated as follows:
(A) No off-site medical care required or first aid care administered on-site;
(B) Medical care by a physician or nurse or follow-up attention required; or
(C) Hospitalization or immediate off-site medical attention was required;

(c) Critical incidents shall be reported to ODMHSAS with specific timeframes, as follows:
(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to ODMHSAS Provider Certification within twenty-four (24) hours of the incident being documented.
(2) Critical incidents involving allegations constituting a sentinel event or consumer abuse shall be reported to ODMHSAS immediately via telephone or fax, but not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.

(d) Compliance with 450:24-15-2 shall be determined by a review of facility policy and procedures; critical incident reports at the facility and those submitted to ODMHSAS, performance improvement program documents and reports, and staff interviews.

## SUBCHAPTER 17. HUMAN RESOURCES

### 450:24-17-1. Personnel policies and procedures

(a) The facility shall have written personnel policies and procedures approved by the governing authority.
(b) All employees shall have access to personnel policies and procedures, as well as other Rules and Regulations governing the conditions of their employment.
(c) The facility shall develop, adopt, and maintain policies and procedures at each provider location to promote the objectives of the center and provide for qualified personnel during all hours of operation to support the functions of the facility and the provision of quality care.
(d) Compliance with 450:24-17-1 shall be determined by a review of written personnel policies and procedures, and other supporting documentation provided.

### 450:24-17-2. Job descriptions

(a) There shall be job descriptions for all positions setting forth minimum qualifications and duties of each position.
(b) All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.
(c) Compliance with 450:24-17-2 shall be determined by a review of written job descriptions for all facility positions, and other supporting documentation provided.

### 450:24-17-3. Utilization of volunteers

(a) In facilities where volunteers are utilized, specific policies and procedures shall be in place to define the purpose, scope, and training, supervision and operations related to the use of volunteers.
(b) A qualified staff member shall be assigned the role of, or responsibility as, the volunteer coordinator.
(c) Volunteer policies and procedures shall be reviewed by the governing authority upon revision.
(d) There shall be documentation to verify orientation of each volunteer which shall enable him or her to have knowledge of program goals and familiarity with routine procedures.
(e) Volunteers are required to receive in-service training pursuant to 450:24-19-3.
(f) Compliance with 450:24-17-3 shall be determined by a review of volunteer policies and procedures; designation of a volunteer coordinator; written orientation plan; orientation program; written goals and objectives; volunteer personnel files; and volunteer records.

## SUBCHAPTER 19. STAFF DEVELOPMENT

### 450:24-19-1. Staff qualifications

(a) All staff who provide clinical services shall have documented qualifications or training specific to the clinical services they provide within the CCARC.
(b) Staff qualifications for contracted entities shall be in compliance with 450:1-1-1.1 and 450:1-3-5.
(c) Compliance with 450:24-19-1 shall be determined by a review of staff personnel files and other supporting documentation provided.

### 450:24-19-2. Staff development

(a) The CCARC shall have a written plan for the professional growth and development of all administrative, professional and support staff.
(b) This plan shall include, but not be limited to:

(1) orientation procedures;
(2) in-service training and education programs;
(3) availability of professional reference materials; and
(4) mechanisms for insuring outside continuing educational opportunities for staff members.

(c) The results of performance improvement activities, accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes.
(d) Staff competency development shall be aligned with the organization's goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.
(e) Staff education and in-service training programs shall be evaluated by the CCARC at least annually.
(f) Compliance with 450:24-19-2 shall be determined by a review of the staff development plan; clinical privileging processes; documentation of in-service training programs; and other supporting documentation provided.

**450:24-19-3. Annually required in-service training for all employees and volunteers**

(a) In-service presentations shall be conducted each calendar year and are required for all employees and volunteers upon hire and annually thereafter on the following topics:

(1) Fire and safety;
(2) AIDS and HIV precautions and infection control;
(3) Consumer's rights and the constraints of the Mental Health and Drug or Alcohol Abuse Services Consumer Bill of Rights;
(4) Confidentiality;
(5) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115; and
(6) Facility policy and procedures;
(7) Cultural Competence;
(8) Co-occurring disorder competency and treatment principles;
(9) Trauma informed; and
(10) Age and developmentally appropriate trainings, where applicable.

(b) All clinical staff shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within three (3) months of being hired with annual updates thereafter.
(c) The local facility Executive Director shall designate which positions and employees, including temporary employees and volunteers, will be required to successfully complete physical intervention training. An employee or volunteer, so designated by the Executive Director, shall not provide direct care services to consumers until completing this training.
(d) The training curriculum for 450:24-19-3 (b) and (c) must be approved by the ODMHSAS commissioner or designee in writing prior to conducting of any training pursuant to this provision.
(e) Compliance with 450:24-19-3 shall be determined by a review of in-service training records; personnel records; and other supporting written information provided.

### 450:24-19-4. First Aid and CPR training

(a) The CCARC shall have staff during all hours of operation at each program site who maintains current certification in basic first aid and Cardiopulmonary Resuscitation (CPR).
(b) Compliance with 450:24-19-4 shall be determined by a review of staff training records and other supporting written information, including, but not limited to staff schedules to assure all program sites are continuously staff with staff trained in item (a) above.

## SUBCHAPTER 21. FACILITY ENVIRONMENT

### 450:24-21-1. Facility environment

(a) The CCARC shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.
(b) CCARC staff shall know the exact location, contents and use of first aid supply kits and firefighting equipment. First aid supplies and firefighting equipment shall be maintained in appropriately designated areas within the facility.
(c) There shall be posted written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather.
(d) Facility grounds shall be maintained in a manner to provide a safe environment for consumers, personnel, and visitors.
(e) The director of the CCARC or designee shall appointment of a safety officer.
(f) The facility shall have an emergency preparedness program designed to provide for the effective utilization of available resources so that consumer care can be continued during a disaster. The emergency preparedness program is evaluated annually and is updated as needed.
(g) Policies for the use and control of personal electrical equipment shall be developed and implemented.
(h) There shall be an emergency power system to provide lighting throughout the facility.
(i) The CCARC director shall ensure there is a written plan to cope with internal and external disasters. External disasters include, but are not limited to, tornados, explosions, and chemical spills.
(j) Compliance with 450:24-21-1 shall be determined by visual observation; posted evacuation plans; a review of the CCARC's annual fire and safety inspection report; and a review of policy, procedures and other supporting documentation provided.

### 450:24-21-1.1. Tobacco-free campus

(a) The facility shall provide a tobacco-free campus for its employees, consumers and visitors. Possession and use of any tobacco product is prohibited on the grounds of the facility by employees, consumers, volunteers and visitors.
(b) Facility will visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.

(c) Facility employees shall not share tobacco or tobacco replacement products with consumers.
(d) The facility shall offer assistance to employees who are tobacco users while he or she is employed by the facility. The assistance shall include, but is not limited to, the provision of information on the health impact of continued tobacco use; the integrated assessment of consumer's tobacco use into standard practice; referrals to tobacco cessation programs such as the Oklahoma Tobacco Helpline; the provision of or access to FDA-approved prescription and/or non-prescription medications for the treatment of nicotine dependence when available; the delivery of evidence-based behavioral interventions for tobacco use cessation by counselors and other clinicians; and provision of appropriate follow-up to facilitate cessation intervention and prevent relapse.
(e) The facility shall always inquire of the consumers' tobacco use status and be prepared to offer treatment upon request of the consumer.
(f) Compliance with this Section shall be determined by visual observation; posted signs; consumer and staff interviews; and a review of the facility's policy, procedures and other supporting documentation provided.

**450:24-21-1.2. Hygiene and sanitation**

(a) Residential facilities shall provide the following services and applicable supporting documentation:

(1) Lavatories in a minimum ratio of one per each eight resident beds.

(2) Toilet facilities in a minimum ratio of one per eight resident beds. Each toilet room shall include a lavatory in the same room or immediately adjacent thereto.

(3) Bathing facilities in a minimum ratio of one tub or shower per each eight resident beds.

(4) Sewage discharge into a municipal sewerage system or collected, treated, and disposed of in an independent sewerage system.

(5) The facility shall have proof of regular inspections and treatment by a licensed pest control operator.

(6) Solid waste disposal through public systems or in a manner approved by the local agency having jurisdiction and the OSDH or Department of Environmental Quality (DEQ), as necessary.

(7) Water obtained from an approved public water supply or tested at least quarterly and treated as necessary, thereby maintaining a determination as an approved water supply by the authority having jurisdiction and the OSDH or DEQ, as necessary.

(8) Linen in quantities adequate to provide at least two changes of bedding each week.

(9) Housekeeping services so that a hygienic environment is maintained in the facility.

(b) Outpatient treatment facilities shall provide:

(1) Lavatories and toilet facilities in a minimum ratio of one (1) per twenty (20) persons.

(2) Water and sewerage in the same manner as prescribed for residential facilities.

(3) Housekeeping services so that a hygienic environment is maintained in the facility.

**450:24-21-1.3. Standards for food service**

**The following shall be applicable to all residential facilities and to any** outpatient facilities which provide an on-premise meal service or food services provided by an outside vendor.

(1) Storage, preparation, transportation, and serving of food shall be in compliance with the requirements of the OSDH regulations governing public feeding establishments.

(2) Dishwashing may be accomplished by either mechanical dishwashers or by approved manual methods. If mechanical dishwashers are used, the final rinse shall be in clear water of 180 degrees Fahrenheit, or in compliance with the OSDH regulations. Manual procedures, if used, shall follow a written procedure which outlines the steps followed, temperature of cleaning and rinsing solutions, detergents and chemicals used, etc., and shall be specifically approved by the local or OSDH.

(3) Equipment used in the preparation and handling of food shall bear the seal of or document compliance with the National Sanitation Foundation (NSF) or equivalent, or with OSDH standards or other appropriate regulatory body.

(4) Ice used in contact with food or drink shall come from a source approved by the OSDH. Transportation, storage, handling, and dispensing shall be in a sanitary manner approved by the OSDH.

**450:24-21-1.4. Dietetic services**

(a) Any facility which provides twenty-four (24) hour per day care shall have a written plan describing the organization and delivery of dietetic services (either directly or through contract) to meet the dietary needs of consumers.

(b) Menus for meals provided by the facility shall be reviewed annually and as needed for consumer's with special dietary needs (diabetes, pregnancy, religious requirements, etc.). This review shall be made by an Oklahoma Registered Dietician. Approval of the review shall be documented by the dietician's signature, American Dietetic Association (AA) Registration Number (RD#), Oklahoma License Number (DL#), and date of the review.

(c) Dietetic services, including health policy and procedures for food service staff, other staff, and consumers performing food service duties as a part of their treatment plan, shall be in compliance with all applicable federal, state, and local statutes and regulations, and shall be so noted in facility policy and procedure. All programs preparing meals provided to consumers shall document, on an annual basis, compliance with OSDH rules and regulations pertaining to kitchen facilities.

(d) Food shall be served in an appetizing and attractive manner, at realistically planned mealtimes, and in a congenial and relaxed atmosphere.

(e) Information pertinent to special dietetic needs of consumers shall be entered into the consumers' treatment records, and when medically indicated, forwarded to parties having permission to receive information regarding consumers' treatment.
(f) Compliance with 450:18-5-4 may be determined by a review of the following:
(1) Facility policy and procedures;
(2) Written plan for dietetic services;
(3) Menus;
(4) Menu approvals;
(5) OSHD reports; and
(6) Any other supporting facility documentation.

**450:24-21-2. Technology**
(a) The facility shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:
(1) Hardware and software.
(2) Security.
(3) Confidentiality.
(4) Backup policies.
(5) Assistive technology.
(6) Disaster recovery preparedness.
(7) Virus protection.
(b) Compliance with 450:24-21-2 shall be determined by a review of the facility policies, performance improvement plans and technology and system plan.

## SUBCHAPTER 23. GOVERNING AUTHORITY

**450:24-23-1. Documents of authority**
(a) There shall be a duly constituted authority and governance structure for assuring legal responsibility and for requiring accountability for performance and operation of the facility (including all components and satellites).
(b) The governing authority shall have written documents of its source of authority, which shall be available to the public upon request.
(c) In accordance with governing body bylaws, rules and regulations, the chief executive officer is responsible to the governing body for the overall day-to-day operation of the facility, including the control, utilization, and conservation of its physical and financial assets and the recruitment and direction of the staff.
(1) The source of authority document shall state:
(A) The eligibility criteria for governing body membership;
(B) The number and types of membership;
(C) The method of selecting members;
(D) The number of members necessary for a quorum;
(E) Attendance requirements for governing body membership;

(F) The duration of appointment or election for governing body members and officers; and

(G) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.

(2) There shall be an organizational chart setting forth the operational components of the facility and their relationship to one another.

(d) Compliance with 450:24-23-1 shall be determined by a review of the following: bylaws, articles of incorporation, written document of source of authority, minutes of governing board meetings, job description of the CEO, and the written organizational chart.

**450:24-23-2. Board composition**

(a) Members of the Board of Directors shall reside, or be employed, or otherwise have a demonstrated interest in the area served.

(b) The composition of the Board shall reflect an equitable representation of the population distribution in the service area. Each county in a multi-county service area of five or fewer counties must be represented on the Board by at least one resident of the county. CCARC's serving six or more counties may rotate such membership or otherwise ensure representation.

(c) Composition of the Board shall also reflect a broad representation of the community, including minorities, at least one consumer of addiction recovery services and one family member of an adolescent who has received addiction recovery services.

(d) No more than forty percent of the Board's members shall be providers of mental health and/or addiction recovery services.

(e) The Board shall have no less than seven members.

(f) System shall be devised to provide for a staggering of terms so that the terms of the Directors do not all expire at the same time.

(g) The Board shall have a provision for the removal of individuals from the Board for non-attendance of Board meetings.

(h) The governing body shall meet at least quarterly.

(i) Employees of an agency shall be prohibited from participation as Board members of their governing authority, except in an ex-official, nonvoting capacity.

(j) The meetings of the Board of Directors shall comply with the Oklahoma open meeting laws.

(k) Compliance with 450:24-23-2 shall be determined by a review of facility policy and procedures regarding governing authority; governing body bylaws, rules and regulations; governing body minutes; membership rolls; and other documentation as needed.

## SUBCHAPTER 25. SPECIAL POPULATIONS

**450:24-25-1. Americans with Disabilities Act of 1990**

(a) Under Titles 11 and 111 of the ADA, the CCARC's shall comply with the "Accessibility Guidelines for Buildings and Facilities (ADAAG) for alterations and

new construction." United States government facilities are exempt for the ADA as they shall comply with the "Uniform Federal Accessibility Standards (UFAS)", effective August 7, 1984. Also available for use in assuring quality design and accessibility is the American National Standards Institute (ANSI) A117.1 "American National Standard for Accessible and Usable Buildings and Facilities."
(b) State and local standards for accessibility and usability may be more stringent than ADA, UFAs, or ANSI A 117.1. The CCARC shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.
(c) The CCARC shall have written policy and procedures providing or arranging for services for persons who fall under the protection of the Americans With Disabilities Act of 1990 and provide documentation of compliance with applicable Federal, state, and local requirements. A recommended reference is the "Americans With Disabilities Handbook" published the in U.S. Equal Employment Opportunities Commission and the U.S. Department of Justice.
(d) Compliance with 450:24-25-1 shall be determined through a review of facility written policy and procedure; and any other supporting documentation.

**450:24-25-2. Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS)**
(a) The facility shall have a policy of non-discrimination against persons with HIV infection or AIDS.
(b) All facilities shall observe the Universal Precautions For Transmission of Infectious Diseases as set forth in, "Occupational Exposure to Bloodborne Pathogens" published by the (U.S.) Occupations Safety Health Administration [OSHA]; and
(1) There shall be written documentation the aforestated Universal Precautions are the policy of the facility;
(2) In-service training regarding the Universal Precautions shall be a part of employee orientation and, at least once per year, is included in employee in-service training.
(c) Compliance with 450:24-25-2 is determined by reviews of facility policy and procedure and in-service training records, schedules, or other documentation.

## SUBCHAPTER 27. CERTIFICATE OF NEED

**450:24-27-1. Purpose**
The purpose of this Subchapter is to set forth rules regulating Certificate of Need requirements for applicable facilities.

**450:24-27-2. Applicability**
The rules set forth in this Subchapter are applicable only to facilities that seek to obtain initial certification under this Chapter for residential substance use disorder services, medically supervised withdrawal management services, or halfway house services and that intend to enroll with the Oklahoma Health Care

Authority as a Medicaid provider. Such facilities will be required to provide a Certificate of Need from the Department to the Oklahoma Health Care Authority upon enrollment as a Medicaid provider, in accordance with OAC 317:30.

**450:24-27-3. Certificate of Need requirements**

(a) Applicable providers must provide required documentation and meet criteria as specified in 450:18-17-3 to obtain a Certificate of Need.

(b) Failure of a facility to obtain a Certificate of Need shall not prohibit the facility from obtaining certification from the Department.