Service Standards

Day Treatment Services

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

Definition

Day Treatment Services are daytime programs that provide integrated, comprehensive treatment; and educational, vocational, and activity services to individuals with physical or mental disabilities, emotional disorders, behavioral disorders, and/or substance use conditions. Day treatment services also include therapeutic services for their families.

Day Treatment Services are designed to prevent movement to a more intensive level of care or as transitional or maintenance services for those who have stepped down from more intensive levels of care.

DTX providers may offer medication-assisted treatment for opioid use disorder under the Drug Addiction Treatment Act of 2000 as part of their intensive outpatient or partial hospitalization program(s). Office Based Opioid Treatment (OBOT) is different from more structured Opioid Treatment Programs (OTP), which require daily medication dosing and supervision. OBOT allows medical providers in community-based clinics or programs to administer injectable or oral forms of buprenorphine on-site or write a prescription for buprenorphine that the person can fill at a pharmacy and administer at home with ongoing monitoring provided by the prescriber at regularly scheduled visits to the program site.

Note:*Please see the DTX Reference List for the research that informed the development of these standards.*

Note:*For information about changes made in the 2020 Edition, please see the DTX Crosswalk.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Day Treatment Services

DTX 1: Person-Centered Logic Model

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.
Note: *Please see the Logic Model Template for additional guidance on this standard.?*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one outcome has been identified for all of its programs.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs.

Table of Evidence

Self Study Evidence

• Program logic model that includes a list of outcomes being measured	
• See program description completed during intake	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel

DTX 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in persons served); and
f. expected long-term impact on the organization, community, and/or system.

Examples: *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA Accreditation's PQI Guide for more information on developing and using program logic models.*

Examples: *Information that may be used to inform the development of the logic model includes, but is not limited to:*

1. *needs assessments and periodic reassessments;*
2. *risks assessments conducted for specific interventions; and*
3. *the best available evidence of service effectiveness.*

DTX 1.02

The logic model identifies outcomes in at least two of the following areas:

a. change in clinical status;
b. change in functional status;
c. health, welfare, and safety;
d. permanency of life situation;
e. quality of life;
f. achievement of individual service goals; and
g. other outcomes as appropriate to the program or service population.

Interpretation: *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

Day Treatment Services

DTX 2: Personnel

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

An interdisciplinary team of clinical and direct service personnel have the competency and support needed to provide services and meet the needs of the persons served.
Interpretation: *Competency can be demonstrated through education, training, or experience. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

Table of Evidence

Self Study Evidence

*	• Table of contents of training curricula	

* • Procedures or other documentation relevant to continuity of care and case assignment	

* • List of program personnel that includes:
1. Title
    1. Name
    2. Employee, volunteer, or independent contractor
    3. Degree or other qualifications
    4. Time in current position
• See organizational chart submitted during application	

* • Policy addressing employee health and vaccinations	

Site Visit Evidence

* • Sample job descriptions from across relevant job categories • Resume and job description of buprenorphine waivered prescriber, when applicable • Documentation tracking staff completion of required trainings and/or competencies • Training curricula • Caseload size requirements set by policy, regulation, or contract, when applicable • Documentation of current caseload size per worker

On-Site Activities

* • Interviews may include:
    1. Program director
    2. Relevant personnel
• Review personnel files

DTX 2.01

Clinical personnel include mental health or human service professionals qualified:

a. by an advanced degree, clinical training, and professional experience; and/or
b. in accordance with the requirements of their respective disciplines and any applicable legal requirements for practice.

DTX 2.02

Direct service providers have:

a. educational and experiential backgrounds that enable them to participate in the overall treatment program and to meet the emotional and developmental needs of persons served; and
b. personal characteristics and temperament suitable for working with persons with special needs.

DTX 2.03

A psychologist with appropriate credentials and experience is available to provide testing and psychological services, as necessary.

DTX 2.04

A psychiatrist or other qualified health practitioner participates in the development and implementation of the overall treatment program, including regular case reviews, and provides medication management and other services as needed.
NA: The organization provides non-psychiatric day treatment services.

DTX 2.05 (FP)

A licensed physician is available on-call during hours of operation, or the organization has formal arrangements for health services with a local primary care facility.
NA: All individuals have private physicians.

Interpretation: *The primary care facility may be a hospital.*

DTX 2.06

Clinical personnel are trained on, or demonstrate competency in, the latest information, theories, and proven practices related to the treatment of alcohol and other drug use disorders including:

a. diagnostic criteria for substance use disorders and their severity;
b. the signs and symptoms of withdrawal;
c. addiction as a disease;
d. ASAM level of care assessments and criteria to determine the need for more intensive services;
e. treatment needs of special populations including women, people experiencing homelessness, adolescents, and people with HIV/AIDS;
f. relapse prevention;
g. interventions that demonstrate respect for sociocultural values, personal goals, life style choices, and complex family interactions;
h. management of drug overdose;
i. the benefits and limitations of tests that screen for drug use, when applicable;
j. harm reduction interventions or practices; and
k. FDA-approved medications used to treat opioid use disorder, their benefits and limitations, and current federal policy regulating their use, when applicable.

NA: The organization does not provide substance use treatment services.

Interpretation: *When people are receiving office-based opioid treatment, element d should include criteria for determining when transition to a higher level of care, including a more structured opioid treatment program (OTP), may be necessary.*

DTX 2.07

Individuals who provide peer support:

a. obtain certification, as defined by their state;
b. are willing to share their personal recovery stories;
c. have a job description and clearly understand the role of a peer support worker; and
d. have adequate supports in place and appropriate supervision, including mentoring and/or coaching from more experienced peers when indicated.

NA: The organization does not utilize peer support workers.

Interpretation: *Regarding element d, supervisors of peer support staff should be trained on recognizing and responding to signs of trauma among peer support workers.*

DTX 2.08

Individuals who provide peer support receive pre- and in-service training on:

a. how to recognize the need for more intensive services and how to make an appropriate referral;
b. established ethical guidelines, including setting appropriate boundaries and protecting confidentiality and privacy;
c. wellness support methods, trauma-informed care practices, and recovery resources;
d. managing personal triggers that may occur during the course of their role as a peer support provider; and
e. skills, concepts, and philosophies related to recovery and peer support.

NA: The organization does not utilize peer support workers.

Examples: *Training on skills, concepts, and philosophies related to recovery can include, but are not limited to:*

1. *system navigation;*
2. *stages of change;*
3. *addiction as a disease; and*
4. *medication-assisted treatment.*

DTX 2.09

Personnel involved in providing office-based opioid treatment are annually screened for potential exposure to tuberculosis, and providers recommend a hepatitis B vaccination if personnel are at risk for exposure to hepatitis.

NA: The organization does not provide office-based opioid treatment.

DTX 2.10 (FP)

Personnel who prescribe or dispense opioid treatment medication in office-based settings have received a waiver under the Drug Addiction Treatment Act of 2000 and stay current with all applicable federal, state, and local laws and regulations applicable to the delivery of office-based opioid treatment.

NA: The organization does not provide office-based opioid treatment.

Interpretation: *Practitioners that may qualify for a waiver include physicians, nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse-midwives (CNMs).*

DTX 2.11

The organization minimizes the number of staff working with the person over the course of their contact with the organization by:

a. assigning a worker at intake or early in the contact; and
b. avoiding the arbitrary or indiscriminate reassignment of direct service personnel.

DTX 2.12 (FP)

There is at least one person on duty at each service delivery location any time persons served are present who has received first aid and age-appropriate CPR training in the previous two years that included an in-person, hands-on CPR skills assessment conducted by a certified CPR instructor.

DTX 2.13

The workloads of direct service personnel support the achievement of positive outcomes and are regularly reviewed.

Interpretation: *Office-based opioid treatment providers must operate within the patient number maximums set by their waiver.*

Examples: *Factors that may be considered when determining employee workloads include, but are not limited to:*

1. *the qualifications, competencies, and experience of the worker including the level of supervision needed;*
2. *the work and time required to accomplish assigned tasks and job responsibilities; and*
3. *service volume, accounting for assessed level of needs of persons served.*

Day Treatment Services

DTX 3: Intake and Assessment

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

The organization's intake and assessment practices ensure that individuals receive prompt and responsive access to appropriate services.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation by persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several case records are missing important information; or
- Participation by persons served is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Screening and intake procedures	
*	• Assessment procedures	

• Copy of assessment tool(s)	

Site Visit Evidence

- Community resource and referral list

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served
- Review case records

DTX 3.01

Individuals are screened and informed about:

a. how well their request matches the organization's services; and
b. what services will be available and when.

NA: Another organization is responsible for screening, as defined in a contract.

DTX 3.02 (FP)

Prompt, responsive intake practices:

a. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
b. give priority to urgent needs and emergency situations;
c. support timely initiation of services; and
d. provide for placement on a waiting list or referral to appropriate resources when the person cannot be served or cannot be served promptly.

Examples: *Regarding element b, urgent situations can include drug overdose, impairment, or severe withdrawal; pregnancy in women with opioid use disorder; people at risk of suicide; and cases where a parent has a child in the child welfare system.*

Referral providers for crisis situations may include 24-hour mobile crisis teams, emergency crisis intervention services, crisis stabilization, or 24-hour crisis hotline.

DTX 3.03

Persons served participate in an individualized, culturally and linguistically responsive assessment that is:

a. completed within established timeframes;
b. updated as needed based on the needs of persons served; and
c. focused on information pertinent for meeting service requests and objectives.

Interpretation: *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.*

DTX 3.04

The assessment includes identification of:

a. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history;
b. physical health needs and goals including a comprehensive medical history;
c. social, emotional, educational, and vocational needs, strengths, and goals including appropriate family goals;
d. barriers to change; and
e. a diagnosis in accordance with a standardized diagnostic tool.

Interpretation: *Completion of the assessment should not delay the initiation of medication-assisted treatment for opioid use disorder. The assessment can be completed over a series of visits following the initiation of office-based opioid treatment as delaying treatment increases the risk of overdose and mortality.*

Examples: *Substance use assessments may examine a variety of factors in the person's substance use history including age at first use, routes of ingestion and history of tolerance, withdrawal, drug mixing, and overdose as well as information on current patterns of use such as which drugs the person uses, comorbid alcohol and tobacco use, and the frequency, recency, and intensity of use.*

Day Treatment Services

DTX 4: Service Planning and Monitoring

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

Each person participates in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and support.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, signatures of staff or persons served are missing and/or not dated; or
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active participation by persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- In several instances, signatures of staff or persons served are missing and/or not dated; or
- Quarterly reviews are not being done consistently; or
- Level of care for some people is clearly inappropriate; or
- Service planning is often done without full participation of the individual; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Service planning and monitoring procedures	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

- Review case records

DTX 4.01

An assessment-based service plan is developed in a timely manner with the full participation of the individual, and their guardian and/or family when appropriate, and includes:

a. agreed upon goals, desired outcomes, and timeframes for achieving them;
b. services and supports to be provided, and by whom;
c. specific referrals to be made during treatment and aftercare;
d. possibilities for maintaining and strengthening family relationships and other informal social networks;
e. procedures for expedited service-planning when crisis or urgent need is identified; and
f. the person's signature.

DTX 4.02 (FP)

The organization determines whether a crisis plan is necessary and, when indicated, engages persons served and involved family members in crisis and/or safety planning that:

a. is individualized and centered around strengths;
b. identifies individualized warning signs of a crisis;
c. identifies coping strategies and sources of support that individuals can implement during a suicidal crisis, as appropriate; and
d. specifies interventions that may or may not be implemented to help the person de-escalate and promote stabilization.

Interpretation: *For people who have been deemed to be at high risk of suicide, a safety plan includes a prioritized written list of coping strategies and sources of support that the person can use before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help people cope with suicidal feelings in order to prevent a suicide attempt or possibly death. The safety plan should be developed once it has been determined that no immediate emergency intervention is required.*

Interpretation: *"No-suicide contracts," also known as "no-harm contracts" and other similar terms, should never be used. No-suicide contracts are based on a verbal or written agreement by the person to not engage in self-harm or suicidal acts during a specific timeframe. Research does not support this practice or show that these agreements are effective at preventing suicides, nor have they been found to provide protection against malpractice lawsuits.*

Examples: *Depending on the needs of the individual, crisis plans may reference advanced mental health directives, also known as advanced psychiatric directives.*

Examples: *Components of a safety plan can also include: internal coping strategies, socialization strategies for distraction and support, family and social contacts for assistance, professional and agency contacts, and lethal means restriction.*

Examples: *Warning signs for being at high risk for suicide can include a missed appointment, or significant change in status, and personnel may conduct active outreach and service engagement strategies such as phone calls, text messages, or home visits until contact is made.*

DTX 4.03

The organization works in active partnership with the individual to:

a. assume a service coordination role, as appropriate, when the need has been identified and no other organization has assumed that responsibility;
b. ensure that they receive appropriate advocacy support;
c. assist with access to the full array of services to which they are eligible; and
d. mediate barriers to services within the service delivery system.

DTX 4.04

The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of the individual, to assess:

a. service plan implementation;
b. progress toward achieving service goals and desired outcomes; and
c. the continuing appropriateness of agreed-upon service goals and chosen interventions.

Interpretation: *When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.*

Examples: *People with higher level of care needs require frequent review. For example, weekly review is recommended for individuals with suicidal ideation, recent relapse, or those with a recent mental health- or substance use-related emergency room visit or hospitalization. People with acute or complex needs (e.g., individuals receiving medications for diagnosed symptoms and conditions) or those in a higher level of care such as intensive outpatient may require that their service plan be reviewed and updated every 30 days.*

Examples: *In office-based opioid treatment, indicators that revisions to the treatment plan may be needed include:*

1. *signs or symptoms of withdrawal;*
2. *evidence of continued illicit opioid use;*
3. *the absence of opioid treatment medication in toxicology samples;*
4. *potential complications from concurrent disorders; and*
5. *inability to safely store buprenorphine in the person's living environment.*

Adjustments to the treatment plan can include increasing buprenorphine dosing, increasing the level of care (e.g. outpatient to intensive outpatient/partial hospitalization), or referring the person to an opioid treatment program when indicated and available.

DTX 4.05

The worker, individual and/or legal guardian, and his or her family when appropriate:

a. review progress toward achievement of agreed upon service goals; and
b. sign revisions to service goals and plans.

Day Treatment Services

DTX 5: Interdisciplinary Program

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

Participants regularly attend an interdisciplinary program of treatment, education, and activity that fosters active participation and incorporates available social supports to the greatest extent possible given availability of appropriate resources.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation by persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Program curriculum or sample daily program schedule	
*	• Procedures for communication/collaboration between day and residential programs	
*	• Procedures for obtaining clearance to participate in athletic activities	

Site Visit Evidence

*

- Proof of accreditation, licensure, or certification for outside providers operating adventure-based activities, if applicable

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served
- Review case records
- Observe program

DTX 5.01

The day treatment program:

a. aids in the transition from in-patient to out-patient care;
b. addresses needs not met by less intensive programming;
c. offers an alternative to more restrictive care; and
d. works with the person and other providers to ensure continuity of care.

DTX 5.02

Participants are engaged in therapeutic activities designed to:

a. develop and maintain a normalizing routine;
b. enhance personal and interpersonal skills and behaviors; and
c. address identified problem areas.

DTX 5.03

The program offers the following services and adapts the structure and content of these services based on the program model and the needs of the service population:

a. individual and group treatment;
b. family therapy;
c. educational programming;
d. psychoeducational groups;
e. medication evaluation and monitoring;
f. expressive therapies;
g. recreational activities;
h. pre-vocational training;
i. independent living skills training; and
j. other planned, structured activities.

DTX 5.04

When planning day treatment activities, the organization takes into account group characteristics and the individual's:

a. age and developmental level;
b. emotional stability;
c. readiness for change;
d. personality;
e. skills; and
f. gender.

DTX 5.05

Participants are helped to develop and expand their informal support networks including connections with friends, extended family, and community members.

DTX 5.06

Therapeutic programming provides scheduled sessions for a minimum of:

a. nine hours per week in intensive outpatient programs; or
b. sixteen to twenty hours per week in partial hospitalization programs.

Interpretation: *Outpatient day treatment programs may operate for fewer than nine hours per week when the frequency and intensity of services is appropriate to individual needs and a rationale is provided in individual service plans.*

DTX 5.07

The organization helps individuals establish and strengthen links to needed support services including:

a. basic needs, such as food and clothing;
b. supported housing;
c. supported employment;
d. medical care;
e. substance use treatment;
f. public benefits;
g. legal services;
h. financial counseling;
i. child care;
j. educational services;
k. respite care; and
l. peer support.

Interpretation: *Regarding element d, people with both chronic pain and substance use disorder should receive integrated treatment from appropriate medical specialists.*

DTX 5.08

A program that serves a mix of individuals who live in residential care and in the community ensures that:

a. residents and non-residents receive a comprehensive program that is tailored to individual needs;
b. mechanisms for communication between day and residential programs are in place; and
c. responsibilities of residential and day programs are clearly delineated.

NA: The organization does not serve a mixed population of residents and non-residents.

DTX 5.09 (FP)

The organization evaluates the person's ability to participate in athletic activities and obtains:

a. written, signed permission slips from their legal guardians;
b. a medical records release;
c. a signed document from a qualified medical professional stating that the service recipient is physically capable of participating; and/or
d. an adult waiver and release of liability.

NA: The organization does not offer athletic activities to persons served.

DTX 5.10 (FP)

Organizations that purchase services from providers that operate adventure-based activities with a significant degree of risk request proof of accreditation, licensure, or certification with a nationally recognized authority for the activity being conducted, when available.

NA: The organization does not purchase services from providers that operate adventure-based activities.

Examples: *Adventure-based activities with a significant degree of risk can include white water rafting, climbing walls, or ropes courses.*

Day Treatment Services

DTX 6: Services for Families

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

The person, family, and organization work together to achieve an optimal level of family participation.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation by persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for involving the family of the primary person served	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

- Review case records

DTX 6.01

The organization engages the family and encourages active participation in the treatment process, including participation in family counseling, unless such involvement is contraindicated.
Examples: *Examples of ways to engage family members may include demonstrating:*

1. *sensitivity to the willingness of the family to be engaged;*
2. *a non-threatening manner;*
3. *respect for the person's autonomy and confidentiality;*
4. *flexibility; and*
5. *persistence.*

DTX 6.02

When involvement of family members or significant others is desired by the person but proves difficult to achieve, the organization:

a. attempts to reestablish contacts and positive interactions between family members through activity and educational programs;
b. provides individual and group counseling to family members or significant others who accept services; and
c. aids the person in identifying ways to build and enhance a social support system.

DTX 6.03

The families or significant others of participants are offered services including:

a. family psycho-education;
b. emotional support and therapy;
c. community and support services;
d. care coordination, as needed; and
e. self-help referrals.

Day Treatment Services

DTX 7: Education Services

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

The organization provides or arranges for individuals to receive education services and supports to help them achieve their educational and/or vocational goals.

Interpretation: *Organizations that do not provide educational services on-site should coordinate with schools or community-based providers to meet the educational needs of all people. When organizations do not directly provide or arrange education services, case records should indicate that education plans are integrated into treatment plans and document advocacy for areas of unmet educational need. Education services will vary depending on the population served.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for developing and/or integrating education plans	
*	• Procedures for coordinating education services with community-based providers, if applicable	

Site Visit Evidence

*

- Proof of certification, accreditation, or registration, as applicable

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

- Review case records

DTX 7.01

A comprehensive, coordinated education plan is developed and integrated into the service plan for any person who has educational goals, or vocational goals that include an educational component.

Interpretation: *If the organization does not participate in the development of the education plan, it must still integrate each person's education plan into their service plan.*

DTX 7.02

People pursuing educational goals are enrolled in an appropriate education program on-site or in the community that is approved, certified, accredited, registered, or operated by or in conjunction with the local school district.

DTX 7.03

The education program incorporates effective instructional practices, quality curriculum design, and educational tools and supports for diverse learning needs of children and youth.

NA:

- The organization does not provide day treatment services to school-age children or youth.
- The organization does not directly provide the education program or develop education plans for children or youth.

Examples: *Diverse learning needs can include children who require support due to a learning disability, are learning English as an additional language, or are intellectually gifted.*

DTX 7.04

The organization provides or arranges, as needed:

a. tutoring;
b. preparation for a high school equivalency diploma;
c. college preparation;
d. parent/teacher meetings;
e. vocational or continuing education opportunities; and/or
f. advocacy and support.

Day Treatment Services

DTX 8: Substance Use Services

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

The organization provides coordinated substance use prevention, treatment, and recovery services based on the person's assessed needs and goals.

NA: The organization does not provide substance use services.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for communication/collaboration among team members	
*	• Criteria for determining the level of care	

Site Visit Evidence

*

- Documentation tracking staff completion of required training and/or competencies related to opioid overdose, when applicable

On-Site Activities

*

- Interviews may include:
  - Clinical/Medical director
  - Relevant personnel
  - Persons served
- Review case records
- Observe facility

DTX 8.01 (FP)

A qualified team of health professionals, with experience, training, and competence in engaging, diagnosing, and treating persons with substance use disorders, provide services including:

a. administering or reviewing diagnostic, toxicological, and other health related examinations;
b. determining the optimal level and intensity of care including clinical and community support services;
c. evaluation for psychotropic medications and medication-assisted treatment;
d. prescribing and managing medication including appropriate management of pharmacotherapy for people with co-occurring conditions or those receiving office-based opioid treatment, when applicable;
e. review of complicated cases where co-occurring substance use, health, and mental health conditions intersect; and
f. coordinating care with other service providers, including primary care and mental health providers, when appropriate and with the consent of the service recipient.

DTX 8.02

The organization directly provides a comprehensive range of prevention and treatment services including:

a. illness management and psychoeducation interventions;
b. clinical monitoring and drug screening;
c. coping skills training;
d. relapse prevention;
e. acute care; and
f. support groups and self-help referrals.

Examples: *Other services may include intensive outpatient care, medical care, psychiatric rehabilitation, and targeted case management services.*

DTX 8.03

Therapeutic services help individuals develop the knowledge, skills, and supports necessary to:

a. manage mental health and/or substance use disorders;
b. develop and practice prosocial behaviors;
c. cultivate and sustain positive, meaningful relationships with peers, family members, and the community;
d. develop self-efficacy; and
e. promote recovery, resilience, and whole-person wellness.

Examples: *Recovery is a holistic process of change where people learn to overcome or manage their diagnosed symptoms and conditions in order to improve overall well-being and achieve optimal health.*

DTX 8.04

Individuals, and their families when possible, are actively connected with peer support services, either directly or by referral, appropriate to their request or need for service.

Interpretation: *Connections to outside self-help/mutual aid groups should not be limited to providing the time and location for a meeting. Organizations can support the person's acclimation to a new group by, for example, discussing meeting protocols and what to expect prior to attending, accompanying them to their first meeting, and encouraging them to make connections with peers while at the meeting.*

Examples: *Peer support refers to services provided by individuals who have shared, lived experience. Services promote resiliency and recovery and can include peer recovery groups, peer-to-peer counseling, peer mentoring or coaching, family and youth peer support, or other consumer-run services. Peer recovery groups may be specialized for particular groups of individuals or families, such as individuals affected by HIV/AIDS.*

DTX 8.05

The organization maintains a supply of naloxone on-site and appropriately trained staff are available to administer this medication in the event of an overdose.

Day Treatment Services

DTX 9: Office-Based Opioid Treatment

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

The organization provides buprenorphine-assisted treatment for opioid use disorder that is responsive to individual strengths, needs, and goals.

NA: The organization does not provide office-based opioid treatment.

Rating Indicators:

1

All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Access procedures, including operating hours and 24/7 emergency coverage	

* • Office-based opioid treatment screening and assessment procedures	
* • Procedures for administration of opioid treatment medication	
* • Procedures for referring individuals for services	
* • Policies related to toxicology testing	
* • Procedures for toxicology testing	
* • Diversion control plan	
* • Procedures for withdrawal from medication assisted treatment	
* • PDMP procedures	

Site Visit Evidence

* • Waivered provider coverage schedule for previous month • Educational materials or other documentation of information provided to persons served and their families • Evidence of collaboration with obstetricians

On-Site Activities

* Interviews may include: 1. Clinical/Medical director 2. Relevant personnel 3. Persons served • Observe facility • Review case records

DTX 9.01

The organization provides a welcoming environment for patients to receive office-based opioid treatment that is conducive to rehabilitation, and services are available:

a. during hours that are based on the needs of the service population; and
b. 24 hours a day, seven days a week for emergencies including the availability of alternate waived prescribers when the primary provider is out of the office.

DTX 9.02

The provider and the person work together to explore available treatment options and determine the appropriateness of office-based opioid treatment taking into account:

a. the person's preference;
b. results of the comprehensive assessment including confirmation of opioid use disorder (OUD), OUD severity, and potential contraindications to opioid treatment medications;
c. co-occurring disorders;
d. risk of diversion;
e. ASAM placement criteria; and
f. legal requirements and/or national guidelines for accessing treatment.

Examples: *Information that can assist people in choosing their preferred treatment option can include: the indications, risks, and benefits of medication-assisted treatment and its alternatives; the types of settings that offer medication-assisted treatment; geographic location of treatment providers and the availability of public transportation; cost of treatment; and requirements for participating in various treatment options (e.g. frequency of visits.)*

DTX 9.03

The organization queries the state prescription drug monitoring program (PDMP):

a. prior to initiating medication-assisted treatment; and
b. once per quarter or more frequently when required by state law.

NA: There is no PDMP available in the state.

DTX 9.04 (FP)

Office-based opioid treatment is administered as follows:

a. an approved prescriber makes all dosage decisions within the medically accepted dosage range for effective treatment and in accordance with approved product labeling;
b. medication-assisted treatment is used in conjunction with individualized psychosocial treatment; and
c. opioid antagonist medications are recommended and made available to all individuals either through standing state orders or prescription.

Examples: *Guidelines published by the American Society of Addiction Medicine include dosage recommendations.*

DTX 9.05

Early in treatment, each person receives a physical exam and laboratory testing in accordance with national practice guidelines that includes, but is not limited to:

a. screening for commonly co-occurring medical conditions, pregnancy and methods of contraception, acute trauma, and history of narcotic dependence and IV drug use;
b. evidence of current physical dependence; and
c. laboratory testing to identify existing medical conditions and current substance use.

Interpretation: *Completion of the physical exam and/or lab work should never delay the initiation of medication-assisted treatment. This standard requires that all people receiving office-based opioid treatment have an up-to-date physical exam that meets the requirements of the standard. If a current physical exam that satisfies these requirements is not present in the person's record, the prescriber should conduct the exam as part of the comprehensive assessment process or facilitate completion of the exam in partnership with the person and applicable providers.*

Examples: *Guidelines published by the American Society of Addiction Medicine and by the Substance Abuse and Mental Health Services Administration include practice recommendations for conducting physical exams and laboratory testing.*

DTX 9.06 (FP)

Persons served, and the adults with whom they live, are educated about the dangers of continued alcohol, tobacco, or drug use including:

a. cross-tolerance and other risks of continued use during medication-assisted treatment;

b. signs and symptoms of overdose, administering opioid antagonist medications, and when to seek emergency assistance; and
c. clinical support and other treatment options including recommended FDA-approved medications for cessation when available.

DTX 9.07

Persons served, and adults with whom they live, are educated about:

a. the nature of addictive disorders;
b. dependency substitution and self-medication;
c. therapeutic effects of opioid treatment medication;
d. common myths about opioid treatment medication;
e. the benefits of treatment and the recovery process; and
f. toxicology testing expectations and procedures.

DTX 9.08

Persons served receive:

a. infectious disease prevention and risk reduction information and education;
b. counseling on HIV infection and other infectious diseases and referral for testing;
c. counseling on the importance of treatment adherence and honest communication with the provider; and
d. noncompliance procedures.

DTX 9.09

Ongoing, random drug testing is conducted using CLIA waived tests at a frequency that supports achievement of the person's treatment goals, and testing procedures include:

a. maintaining a therapeutic atmosphere that respects privacy during testing;
b. minimizing falsification during drug testing sample collection;
c. discussing positive results with the person and investigating the possibility of false positive results when the person denies drug use;
d. reviewing false-positive and false-negative results;
e. conducting confirmation testing when indicated; and
f. documenting results in the case record along with the person's response.

Interpretation: *Evidence of ongoing drug use on its own should not be considered grounds for discharge.*

DTX 9.10

Following the receipt of drug test results, the organization:

a. immediately investigates possible diversion of opioid medication when test results indicate lack of buprenorphine and related metabolites;
b. reviews dosage when positive results for drugs are received; and
c. uses the results to determine the need for additional interventions or changes to the treatment plan.

DTX 9.11

The organization implements a plan to reduce the risk of diversion of controlled substances from legitimate treatment use that includes a process for corrective action when systemic problems are identified.

Examples: *Diversion control strategies may include, but are not limited to:*

1. *frequent office visits, including weekly visits at the beginning of treatment;*
2. *observed urine drug testing;*
3. *validity testing of urine samples;*
4. *use of combination buprenorphine products;*

5. *use of injectable buprenorphine when clinically indicated;*
6. *recall visits for pill counts; and*
7. *providing individuals with guidance on how to safely secure their medication at home.*

DTX 9.12

Treatment of pregnant woman with opioid use disorder:

a. is in accordance with national treatment guidelines for treatment during pregnancy; and
b. is coordinated with an obstetrician.

DTX 9.13 (FP)

Individuals are maintained on opioid treatment medication as long as they desire and derive benefit from treatment, but when withdrawal from opioid treatment medication is needed or desired, the organization:

a. documents the reason for discontinuation;
b. educates the person about the process including risk of relapse, overdose, and mortality;
c. assesses for pregnancy, when applicable;
d. conducts dose reduction at a rate well tolerated by the person and in accordance with accepted medical practices;
e. conducts periodic assessments of mental status;
f. discontinues withdrawal and resumes treatment in the event of impending relapse;
g. offers the person relapse prevention services including counseling, support, and education;
h. encourages the person to participate in continued monitoring and support beyond the point of discontinuation;
i. invites the person to re-enter treatment at any time if they fear or have experienced a return to opioid use;
j. provides the person with information about and referral or transfer to a suitable, alternative treatment program, whenever possible; and
k. provides the person with a naloxone kit or prescription.

Day Treatment Services

DTX 10: Care and Supervision

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

The organization provides sufficient care and supervision to ensure participant safety and service quality.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Coverage schedules for the most recent month indicating staff-to-participant ratios	

Site Visit Evidence

*	• Coverage schedules for the previous six months indicating staff-to-participant ratios

On-Site Activities

*	• Interviews may include:

1. Program director
2. Relevant personnel
3. Persons served

- Observe program

DTX 10.01

Personnel-to-participant ratios are appropriate to the developmental and clinical needs of participants and:

a. increase during emergencies, with after-hours and holiday coverage available for crisis situations; and
b. increase to meet the special needs of individuals during busier or more stressful periods.

DTX 10.02 (FP)

In organizations providing educational services to school-age children or youth, special education teachers and teaching or therapeutic aides provide a classroom ratio of one adult for every four participants.

NA:

- The organization does not serve children or youth.
- The organization does not directly provide education services to school-age children or youth.

Day Treatment Services

DTX 11: Case Closing and Aftercare

Purpose

Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms.

The organization works with persons served, and family members when appropriate, to plan for case closing and, when possible, to develop aftercare plans.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, the organization terminated services inappropriately; or
- Active participation of persons served occurs to a considerable extent; or
- A formal case closing evaluation is not consistently provided to the public authority per the requirements of the standard.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Services are frequently terminated inappropriately; or
- Aftercare planning is not initiated early enough to ensure orderly transitions; or
- A formal case closing summary and assessment is seldom provided to the public authority per the requirements of the standard; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Case closing procedures	
*	• Aftercare planning and follow-up procedures	

Site Visit Evidence

*
- Relevant portions of contract with public authority, as applicable

On-Site Activities

*
- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

- Review case records

DTX 11.01

Planning for case closing:

a. is clearly defined and includes assignment of staff responsibility;
b. begins at intake; and
c. involves the worker, persons served, and others as appropriate to the needs and wishes of the participant.

DTX 11.02

Upon case closing, the organization notifies any collaborating service providers, including the courts, as appropriate.

DTX 11.03

If a person has to leave the program unexpectedly, the organization makes every effort to identify other service options and link the person with appropriate services.

Interpretation: *The organization must determine on a case-by-case basis its responsibility to continue providing services to persons whose third-party benefits are denied or have ended and who are in critical situations.*

Interpretation: *See DTX 9.13 for more information on withdrawal from office-based opioid treatment.*

DTX 11.04

When appropriate, the organization works with the person and their family to:

a. develop an aftercare plan, sufficiently in advance of case closing, that identifies short- and long-term needs and goals and facilitates the initiation or continuation of needed supports and services; or
b. conduct a formal case closing evaluation, including an assessment of unmet need, when the organization has a contract with a public authority that does not include aftercare planning or follow-up.

DTX 11.05

The organization follows up on the aftercare plan as appropriate, when possible, and with the permission of the service recipient.
NA: The organization has a contract with a public authority that prohibits or does not include aftercare planning or follow-up.