PART He-A 304 CERTIFICATION AND OPERATIONAL REQUIREMENTS FOR OPIOID TREATMENT PROGRAMS

Statutory Authority: RSA 318-B:10, VII(b) and VIII(b)

Readopt with amendment He-A 304.07, effective 2-16-18 (Document #12476), to read as follows:

He-A 304.07 Inspections.

(a) For the purpose of determining compliance with He-A 304, the applicant or certificate holder shall admit and allow any representative from the department at any time during regular business hours to inspect the following:

(1) The facility premises;

(2) All programs and services provided by the certificate holder; and

(3) Any records required by He-A 304.

(b) The department shall conduct inspections prior to, and during:

(1) Issuance of an initial certification;

(2) Renewal of a certification;

(3) A change of ownership;

(4) A change of physical location; and

(5) An investigation of submitted complaint.

(c) In addition to (b) above, an OTP shall be subject to inspection by the department to verify the implementation of any POC accepted or issued by the department.

(d) A notice of deficiencies shall be issued when, as a result of any inspection, the department determines that the certificate holder is in violation of any of the provisions of He-A 304.

(e) If the notice identifies deficiencies to be corrected, the applicant shall submit a POC in accordance with He-A 304.09 within 21 days of the date on the letter that transmits the notice of deficiencies.

Readopt with amendment He-A 304.18, effective 2-16-18 (Document #12476), to read as follows:

He-A 304.18 Client Record System.

(a) Each OTP shall have policies and procedures to implement a comprehensive client record system that complies with this section.

(b) In addition to (a) above, the OTP shall enter client information into the client record system no later than 3 days for any of the following client interactions or changes made via in-person or telemedicine:

(1) Initial intake transaction, including and as applicable:

a. Client names(s);

b. Address;

c. Telephone number(s);

d. Sex assigned at birth;

e. Gender identity;

f. Sexual orientation, if provided by the client;

g. Date of birth;

h. Last 4 digits of the client's social security number;

i. Ethnicity, if provided by the client;

j. Race, if provided by the client;

k. Special accommodations, if any;

l. Preferred language;

m. Veteran status;

n. Family member veteran status; and

o. Name and contact information of all client's health insurance(s);

p. Name, address, and telephone number of the person to contact in the event of an emergency;

q. If either have been appointed for the client, the name, address, and telephone number of the client's guardian or representative payee;

r. Name, address, and telephone number of the client's primary care provider;

s. Name, address, and telephone number of the client's behavioral health provider;

t.. Intake facility;

u. Intake date;

v. Intake staff;

w. Method of initial contact;

x. Referral source, including contact information;

y. Case status; and

z. Initial contact date;

(2) Admission, including and as applicable;

a. Admission type;

b. Admission staff;

c. Admission date;

d. Presenting problem;

e. Codependent status;

f. Client's physical health history;

g. Client's behavioral health history;

h. Treatment history;

i. Emergency department utilization;

j. Presence of a co-occurring mental health disorder;

k. Education level;

l. Community based support group utilization;

m. Employment status;

n. Income;

o. Living situation;

p. Marital status;

q. Number of dependents;

r. History of injection drug use;

s. Substance use information;

t. Current medications;

u. Arrest history, if provided by the client;

v. Diagnostic information;

w. Planned opiate replacement therapy;

x. Information on court mandated treatment; and

y. Service domain;

(3) Treatment and continuity of care:

a. A record of all client screenings, including, and as applicable:

1. HIV testing;

2. HCV testing;

3. Pregnancy screening;

4. Primary, secondary, and tertiary substance, severity frequency and method;

5. Age of first use of substances;

6. Past 14 day administration of Naloxone;

7. Involvement with the criminal justice or child welfare protective systems;

8. The date of initial contact from the client or referring provider;

9. The date of screening; and

10. The result of the screening, including the reason for denial of services; and

b. Components of all treatment records, including but not limited to:

1. Signed receipt of notification of client rights;

2. Client's name;

3. Client's unique identification number;

4. Release of information form, which is compliant with 42 CFR, Part 2;

5. Signed informed consent to treatment, including but not limited to an explanation of the department's access to client records;

6. Documentation of all elements of the initial screening and evaluation required by He-A 304.21;

7. The individual treatment plan, as required by He-A 304.23(e)-(g), updated at designated intervals in accordance with He-A 304.23(h)-(i);

8. Documentation that is consistent with SAMHSA's "TAP 21: Addiction Counseling Competencies" (2015 edition), available as noted in Appendix A, of all client services, including, but not limited to:

(i) Record of all doses provided to the client; and

(ii). Progress notes detailing all services required in:

i. He-A 304.15(c);

ii. He-A 304.22(a)-(b);

iii. He-A 304.23(c)-(d), (j), and (r);

iv. He-A 304.24;

v. He-A 304.25(b); and

vi. He-A 304.27(a);

9. Any correspondence pertinent to the client; and

10. Any other information the OTP deems relevant;

(4) Discharge, including but not limited to:

a. Discharge date;

b. Date of last contact;

c. Discharge staff;

d. Discharge reason;

f. Post discharge living arrangements;

g. Substance use information;

h. Diagnosis information;

i. Any information on transfer facility, if client is transferring; and

j. A narrative discharge summary, as required by He-A 304.28(f); and

(5) For any client who is placed on a waitlist, as applicable:

a. All referrals to and coordination with interim services or reason that such referrals were not made;

b. All client contacts between screening and removal from the waitlist; and

c. The date the client was removed from the waitlist and the reason for removal.

(c) All client records maintained by the OTP or its contractors shall be strictly confidential.

(d) All confidential information shall be maintained in compliance with 42 CFR, Part 2.

(e) OTPs shall retain client records after the discharge or transfer of the client, as follows:

(1) For a minimum of 7 years for an adult; and

(2) For a minimum of 7 years after age of 18 for children.

(g) In the event of an OTP closure, the OTP shall arrange for the continued management of all client records in the following measures:

(1) The closing OTP shall notify the department in writing of the address where records shall be stored and specify the person managing the records;

(2) Continue to manage the records and give written assurance to the department that it shall respond to authorized requests for copies of client records within 10 working days;

(3) Transfer records of clients who have given written consent to another certified OTP; or

(4) Enter into a limited service organization agreement with a certified provider to store and manage records.

Appendix A: Incorporation by Reference Information

Rule	Title	Obtain at:
He-A 304.18(b)(3)b., 8.	TAP 21: Addiction Counseling Competencies, 2015 edition	Publisher: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment, www.samhsa.gov Available free of charge at: https://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171

APPENDIX B

Rule	RSA/Federal Citation
He-A 304	RSA 172:2-a; RSA 172:8-b, II, III, & IV; RSA 318-B:10, VII & VIII