DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STI, TB Administration

Substance Use(Abuse) Outpatient Care

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Substance Use - Outpatient

Provision of medical and/or counseling services to address substance abuse issues (including the abuse of alcohol, and/or legal and illegal drugs/substances) in an outpatient setting; these services are to be rendered by licensed professional as specified by the licensing/regulatory body in the jurisdiction in which the services are provided.

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Outpatient drug-free treatment and counseling
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually, with recertification every six months. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

   - Current lease or mortgage statement
   - Deed settlement agreement
   - Current driver's license
   - Current voter registration card
   - Current notice of decision from Medicaid
   - Fuel/utility bill (past 90 days)
   - Property tax bill or statement (past 60 days)
   - Rent receipt (past 90 days)
   - Pay stubs or bank statement with the name and address of the applicant (past 30 days)
   - Letter from another government agency addressed to applicant
   - Active (unexpired) homeowner's or renter's insurance policy
   - DC Healthcare Alliance Proof of DC Residency form
   - If homeless, a written statement from case manager, facility or a letter from landlord that customer is a resident

3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

The following are acceptable forms of proof of income:

- Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub

- A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return

- Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the applicant projecting current annual income must be included

- Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return

- SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days

- Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

INTAKE/SCREENING	
Standard	**Measure**
Intake must be performed within 3 business days of the applicant's first contact with the substance abuse agency and must be completed within 5 business days of scheduled intake. Intakes for patients who are currently hospitalized, homebound or incarcerated may take more than 3 business days to initiate and more than 5 business days to complete.	Date of initial referral or contact and date of intake correspond to time frame.
Patients referred/requesting substance abuse services are seen at the substance abuse agency to initiate substance abuse services unless they are currently hospitalized, homebound or incarcerated (Pre-release within 6 months).	If the intake is conducted outside of the substance abuse agency the reason must be noted in the progress notes in the patient's record.
All required eligibility and patient identifying information must be documented on the approved agency intake form. Copies of documents that verify eligibility should be dated and filed in the patient's record. If the applicant is eligible and chooses to receive services from the agency, staff will review and provide the patient and their legal representative, if applicable, with all four of the required standard forms, starting with a consent form. The initial intake form and the other standard forms, with the exception of the grievance procedures, must be kept in the patient's record permanently. Per eCFR Title 42 §2.22, all agencies must have written policies which regulate and control access to and use of written Substance Abuse records. In addition, all agencies must have patients sign a consent form that specifically mentions confidentiality of alcohol and substance abuse patient records. Patients must be provided a written summary of the Federal law and regulations included in eCFR Title 42 §2.22.	**Intake documentation includes at a minimum:** 1. Date of initial referral or contact/screening, including who made referral 2. Date of intake 3. Contact and identifying information (name, home address (mailing address if different), home phone, alternate contact phone numbers, birth date, Social Security number) 4. Copy of proof of residence within jurisdiction 5. Gender identity and race/ethnicity 6. Sexual orientation and gender expression 7. Language spoken and read 8. Preferred method of communication to ensure confidentiality 9. Emergency contacts 10. Copy of documents verifying Health Insurance (if applicable) and Income status/Federal Poverty Level (FPL) % 11. Presenting problem(s) 12. Date and place of initial HIV positive diagnosis 13. Written documentation of HIV diagnosis 14. Primary risk factor for HIV infection 15. Current CD4 and or Viral load 16. Current HIV medications and/or any medications 17. HIV Status, if CDC-defined AIDS diagnosis, the year of diagnosis

The grievance procedures must be shared with the patient or their legal representative annually for review, signature and date. Appropriate signed ROI forms are obtained[1]. A patient record will be initiated and maintained throughout the duration of the patient's involvement with the agency. If the applicant has a non-emergency crisis, the substance abuse counselor will provide immediate assistance through the resources of the agency or link the applicant to a more appropriate agency.	18. Names and contact information for current health care including community pharmacy and social service providers (Note, only if providers are aware of patient's HIV status) 19. Referral Source 20. Immediate health care need(s) 21. Housing status 22. Signed and dated statements that the patient or their legal representative received copies of all four required standard forms (1) consent, 2) patient bill of rights and responsibilities, 3) grievance and 4) confidentiality/Privacy Practice). The grievance form must have been signed and dated within the past 12 months. All signed and dated ROI forms expire within 12 months and specify who, what, why and where information is to be received/provided. If the patient is already enrolled in medical case management, the medical case manager must appear on the ROI. All above information and accompanying documentation can be submitted by the medical case manager to expedite enrollment in substance abuse services. A single record will be maintained on the patient (paper or electronic) and secured to protect the patient's confidentiality with access limited to appropriate personnel. Paper charts must be kept in a locked file or room. Electronic records must be password protected or on a secure server. Documentation in the progress notes in the patient's record demonstrating all the contacts and activities that happened in regards to the patient and resources provided at intake. A temporary patient record will be established for applicants in crisis until the intake process is complete.
Assessment:	
The substance abuse counselor must perform an <u>assessment</u> on every patient at the initiation of services.	
Standard	**Measure**
An assessment will occur prior to the initiation of any formal treatment to determine the need for substance abuse services and if so, the level of care based on the	The patient's chart will include an initial assessment completed within 10 business days of completing the intake. Prior assessments of patients who are being

[1] ROI forms must be specific, including identifying what information is to be released; name and address of releasing party; to whom the information is being sent; expiration date and signed by the patient/legal guardian and agency staff. ROI forms can not exceed one year.

Levels of Care. The assessment tool used must be in compliance with the jurisdiction's regulations. Tools such as the Addiction Severity Index (ASI) are increasingly being used at many treatment centers. The assessments shall be conducted by a substance abuse counselor. Patients who are assessed to need Level I or Level II, with the exception of partial hospitalization and meet all Ryan White eligibility requirements are candidates for Substance Abuse – Outpatient services. The DSM-V will be determined and documented in the patient's chart at time of admission and at time of discharge. Agencies can choose to use additional diagnostic, comprehensive and/or brief assessment tools such as the Structured Clinical Interview (SCI), Diagnostic Interview Schedule (DIS), Beck Depression Inventory (BDI), Michigan Alcoholism Screening Test (MAST), Senior Michigan Alcoholism Screening Test (S-MAST), Drug Addiction Severity Test (DAST) and/or the Cut Down, Annoyed, Guilty, Eye-Opener (CAGE), Alcohol Use Disorders ID Test (AUDIT), Client Diagnostic Questionnaire (CDQ) to better assess the patient's individual needs and situation.	readmitted or admitted from another program within 20 business days of discharge can be updated. The initial assessment must be maintained in the chart indefinitely. The assessment shall assess the following areas: 1. Substance Abuse History; 2. Physical health, including co-occurring disorders and eating behaviors, etc.; 3. Treatment history, including medications; 4. History of trauma; 5. Current Mental Health issues; 6. Psychiatric history; 7. Functional limitations; 8. Sexual behavior; 9. Legal involvement; 10. Family and social history; 11. Employment or financial support; 12. Education and 13. Strengths and barriers to care. If the patient is already enrolled in Medical Case Management, the medical case manager must appear on the ROI. All above information and accompanying documentation can be submitted by the medical case manager to expedite enrollment in Substance Abuse Services. The Substance Abuse supervisor must review, approve and sign assessments completed by non-licensed Substance Abuse staff. A completed ASI or an equivalent assessment tool accepted by DOH/HAHSTA with the date and name of the staff administering the tool must be filed in all adult patients' charts (≥ 18 years of age). A completed Substance Abuse Subtle Screening Inventory (SASSI) or an equivalent tool accepted by DOH/HAHSTA with the date and name of the Substance Abuse staff administering the tool must be filed in all adolescent (12-17 years of age) patients' charts. The disorders will be classified according to DSM-V, determined and documented in the patient's chart at time of admission and at time of discharge.

In addition, any screening tool identified by SAMHSA's Treatment Improvement Protocol manual may be used.	If the patient is seeking treatment for narcotic abuse, documentation in their chart of the following screenings must be included: 1. Drug screening test or analysis and 2. Urine screening if suspected/known cocaine use. Copies of any additional assessments completed to assess the patient must be in the patient's chart. All assessments must be signed and dated by the clinical staff administering the tool.
Treatment Plan:	
The Substance Abuse Counselor must develop a Treatment Plan with the participation of the patient.	

The treatment plan must be updated/redeveloped as required by local jurisdictional regulations. The substance abuse counselor is responsible for coordinating a face-to-face/virtual meeting with the patient and their legal representative, if applicable, to update/redevelop the treatment plan.

Level of Care Definitions:

- Level I: Outpatient treatment: An organized nonresidential treatment service or an office practice with designated addiction professionals and clinicians providing professionally directed Alcohol and other drug (AOD) treatment. This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include a weekly group counseling session, or twice weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Substance Abuse counselors serving Level I adult patients should see 30-40 patients per week, depending on the jurisdiction's requirements. For children and adolescents, the ratio may not exceed 25 patients per week.

- Level II.1: Intensive outpatient treatment – Planned and organized services in which addiction professionals and clinicians provide several AOD treatment service components to patients. Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9-20 treatment hours a week for adults and 6-20 hours weekly for adolescents. Examples include at least one weekly group counseling sessions and at least bi-weekly individual sessions. Substance Abuse counselors serving Level II.1 adult patients should see 15-20 adult patients per week, depending on the jurisdiction's requirements. For children and adolescents, the ratio may not exceed 15 patients per week.

- Mixed Levels: Substance Abuse counselors and their clinical supervisors should use their judgment based on the precise mix of their cases at the time. No substance abuse counselor should have fewer than 15 adult patients or more than 40 adult patients per week. For children and adolescents, the ratio may not be under 15 patients per week and may not exceed 25 patients per week.

Standard	Measure
A treatment plan is developed collaboratively with the patient within 10 business days of completing the initial assessment and: ● A description of the patient's current medical and psychological conditions and current services received; ● Identification of needs and barriers;	The initial treatment plan must be maintained in the patient record indefinitely and demonstrate the following: 1. Plan was based on initial assessment

● Specific measurable objectives and action steps to resolve each need or barrier; ● Defined activities/services and time frames to initiate and reach each objective. ● Documentation of who will provide the service; ● Identify resources for after hours crisis or other emergencies and ● Treatment plan is updated/redeveloped as required by local jurisdictions' regulations. A copy of the treatment plan must be offered to the patient and their legal representative or members of the patient's health care interdisciplinary team, if applicable. With permission from the patient or their legal representative, if applicable, a copy of the treatment plan will be shared with other interdisciplinary team members from outside of the substance abuse agency.	2. Formal services were not rendered until after the treatment plan was developed and 3. Verification that the initial plan was completed within 10 business days of initial assessment. 4. Approval of the treatment plan and affirmation that a copy of the treatment plan was provided to the patient or their legal representative, if applicable, by their signatures on the plan; and A current ROI must be present in patient's file for every interdisciplinary team member the patient's treatment plan is shared with. All treatment plans must include: 1. Patient's presenting issue/individualized needs; 2. Long-range and short-range treatment plan goals and objectives; 3. Strategy for implementation of treatment plan goals and objectives; 4. Infectious Disease Education; 5. Target dates for completion of treatment goals and objectives; 6. Schedules for clinical services, including individual, group, and if appropriate family counseling; 7. Criteria for successful completion of treatment; 8. Identification of and referrals to entities to provide services; 9. Signature of patient/guardian documenting their participation and approval of plan; 10. Signature and title of alcohol and substance abuse counselor who completed plan; 11. Date plan developed; 12. Projected dates the treatment plan shall be reviewed; and 13. Discharge planning which includes education on relapse prevention. The current treatment plan must be filed in the patient's chart.
Treatment:	
The substance abuse counselor must <u>treat</u> the patient based on the ASAM level of care in the patient's treatment plan.	
Standard	**Measure**

Treatment is guided by the individual's treatment plan and the jurisdiction's requirements. Each jurisdiction's regulatory body specifies the frequency for patient contact. As part of all new patients' treatment, education on infectious diseases and a risk assessment for infectious diseases are required. Other patients who engage in risky substance using behavior will need to be reassessed, as needed. All face-to-face or virtual encounters must be documented in the patient record. If the patient is being treated for narcotic abuse, screenings must be done twice per week.	Documentation the treatment plan was initiated within the timeframe required by the local jurisdiction's regulations Documentation that Infectious Disease Education was provided to all new patients within the time specified by the jurisdiction's regulatory body. The education must include the following topics: 1. Human Immunodeficiency Virus (HIV), including self-monitoring of symptoms; 2. Hepatitis; 3. Sexually Transmitted Diseases (STD); 4. Tuberculosis. Documentation that all new patients received: 1. Risk assessment for infectious diseases; 2. Risk reduction education and if appropriate; 3. Referral for counseling and testing. Documentation that all patients identified to be engaging in risky substance using behavior received: 1. Risk assessment for infectious diseases; 2. Risk reduction education and if appropriate; 3. Referral for counseling and testing. Documentation of progress notes and contacts (phone/in-person) in the patient's chart for each face-to-face/virtual encounter, based on the frequency required by the local jurisdiction's regulations. If the patient is being treated for narcotic abuse, documentation of the following screenings must be included in the patient's record: ● Drug screening test or analysis and ● If suspected/known cocaine use – urine screens, two times per week.
REFERRALS	
Standard	**Measure**
Referrals can happen at any stage of engagement (intake, assessment, treatment, and/or discharge). Referrals can include but are not limited to the following services: A. Ambulatory/Outpatient Health (Medical Care); B. Medical Case Management, and/or stand-alone Treatment Adherence; C. Mental Health; D. Other Substance Abuse Treatment programs; E. Oral Health Care;	Based on documentation of the patient's needs, copies of appropriate referrals and linkages to care are filed in the patient's chart. Referral documentation must include the: 1. Reason for referral; 2. Patient's contact information; 3. Substance Abuse counselor's contact information;

F. Vocational assistance; G. Legal assistance H. Self-help groups and I. Community and social supports. The agency must maintain a referral system to request services for a patient and have a tracking system to follow-up on the status of the referral. A copy of the request and any ROI must be filed in the patient's medical record. A patient's access to referral services can be dictated by their level of care. Agencies providing patients with intensive level services may need to ensure referred services are provided within a specific amount of time, based on the requirements of the local jurisdiction's regulations. Patients receiving substance abuse services should be referred for Medical Case Management services. As appropriate, patients receiving substance abuse services should be referred to *family services*, which can include an assessment of family needs, and as clinically appropriate alcohol and drug education and access or referral to *family counseling*.	4. Name and contact information of agency or staff accepting referral, including address; 5. Status of the referral and 6. Signed ROI form(s), if necessary 7. Copies of reports from accepting agency, when necessary for treatment and only with patient/guardian's consent to release.

REASSESSEMENT	
The substance abuse counselor must perform a <u>reassessment</u> of the patient as required by local jurisdiction's regulations. Information from the reassessment among other factors must be included in the periodic revision of the treatment plan as required by the local jurisdiction's regulations.	
Standard	**Measure**
Patients shall be reassessed on an ongoing basis to measure their progress on treatment plan goals, review the appropriateness of treatment interventions, update the treatment plan and determine if there is a need for relapse prevention. Monitor progress made, especially changes in drug use whether up or down or new drug introduced. Ensure that the patient is engaged in primary medical care and, if necessary, medical case management.	An update of the assessment must be completed and filed in the patient's chart as required by local jurisdictions'' regulations. A new or updated treatment plan must accompany the reassessment in the patient record. Add an updated treatment plan with interventions to address new drugs of choice. If the patient does not have an HIV Medical care doctor or a case manager, there is documentation in their chart of the referrals and follow-up for these services.

Share all information regarding the reassessment and updated/redeveloped treatment plan with members of the patient's health care interdisciplinary team. Each jurisdiction's regulatory body specifies the frequency for treatment plan updates.	

TRANSITION & DISCHARGE

The substance abuse counselor must <u>discharge</u> a patient from substance abuse services when they no longer actively receive substance abuse services and <u>close</u> their case if they no longer actively receive any other services from the agency in 12 months.

Standard	Measure
A patient maybe discharged from a substance abuse program for a variety of reasons, including: ● accomplishment of all treatment goals; ● transfer to another program; ● death of the patient; ● request for closure or ● disciplinary action, etc. All discharges regardless of the reason must follow the regulatory body's requirements in the jurisdiction in which the services are provided. A discharge summary shall be completed at the time of discharge to summarize services provided and progress made towards goals and objectives, with possible recommendations. A copy of the summary must be must filed in the patient's chart. The patient and members of the patient's health care interdisciplinary team, if applicable, should receive a copy. Patients who are involuntarily discharged must be reminded that they have the right to file a grievance if they disagree with the decision. An Unusual Incident Report must be completed and submitted to the jurisdiction's RWPA Administrative Agency on every patient that is discharged due to death of the patient.	A discharge summary must be filed in all discharged patient's charts. The discharge summary must include at a minimum the following: 1. Patient's name; 2. Reason for admission for services; 3. Reason for discharge; 4. Summary of the treatment provided, including frequency and duration; 5. Progress in meeting treatment goals; 6. Diagnosis and prognosis at time of discharge, including DSM-V; 7. Current medications, if applicable; 8. Continued service recommendations; 9. Signature of substance abuse counselor; 10. Signature of patient/guardian, if available; 11. Referrals as needed and 12. Information on how to re-enter services, if appropriate. The discharge summary for patients who are being transferred must also include contact information for the patient and both service agencies. If a patient was involuntarily discharged, there shall be documentation in their chart that the staff reviewed the agency's grievance policy with them. Patients who exercise their right to file a grievance should have copies of all the grievance documents filed in their chart.

Agencies can choose to use additional diagnostic, comprehensive and/or brief assessment tools such as the Structured Clinical Interview (SCI), Diagnostic Interview Schedule (DIS), Beck Depression Inventory (BDI), Michigan Alcoholism Screening Test (MAST), Senior Michigan Alcoholism Screening Test (S-MAST), Drug Addiction Severity Test (DAST) and/or the Cut Down, Annoyed, Guilty, Eye-Opener (CAGE), Alcohol Use Disorders ID Test (AUDIT), Client Diagnostic Questionnaire (CDQ) to better assess the patient's progress in treatment. In addition, any screening identified by SAMHSA's Treatment Improvement Protocol manual may be used.	A copy of the Unusual Incident Report must be placed in the patient's chart. The charts of all discharged patients must be maintained in a secure room, locked file cabinet, safe or other similar container at the agency designated for "inactive" charts for a time specified by HRSA or local jurisdictions' regulatory bodies. **Per eCFR Title 42 §2.22, all agencies must have written policies which regulate and control access to and use of written Substance Abuse records. **The Substance Abuse staff must adhere to CFR Title 42 Chapter 1A Part 2 *Confidentiality of Alcohol and Substance Abuse Patient Records* and the agency must adhere to the *Health Information Portability Accountability Act of 1996* (HIPAA).
CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals ● Decides to transfer to another agency ● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer ● Can no longer be located ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan ● Exhibits pattern of abuse as defined by agency's policy	Documentation of case closure in customer's record with clear rationale for closure

● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program ● Is deceased	

IV. PERSONNEL QUALIFICATIONS

- Each jurisdiction within the EMA must adhere to their regulatory body's requirements. Substance Abuse Counselors must be able to work effectively with their patients with regard to their substance abuse issues in addition to facilitating access to other needed services. The ability to accomplish these objectives requires specific skills that can best be acquired through education and previous work experience. The preferred qualifications are as follows:
    - Substance Abuse Counselors
        - BA or Master's level degree (depending on local jurisdictional requirements) and certification by the local jurisdiction's regulatory body.
    - Substance Abuse Services Clinical Supervisors
        - Master's level degree and, if applicable in the jurisdiction, certification to supervise substance abuse counselors by the local jurisdiction's regulatory body.

- Substance Abuse Services supervisors must conduct quarterly record reviews of each substance abuse counselor's patients' records to ensure a substantial number of the records adhere to standards of care.

- Substance Abuse counselors must be evaluated on core performance areas, core competencies and process documentations annually.

- Clinical supervision must occur at a minimum of one hour every month.

Substance abuse counselors or others who provide infectious disease education to patients in substance abuse counseling sessions must have completed one of the following curricula:

- HIV Facts and Fundamentals
- Jurisdiction-approved curricula
- CDC-approved curricula
- HRSA HAB-approved curricula

Each jurisdiction's regulatory body specifies the frequency for staff training.

IX. CLINICAL QUALITY MANAGEMENT

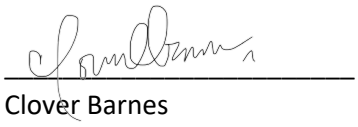
A continuous Clinical Quality Management Program for HIV patient care. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

SERVICE STANDARDS FOR SUBSTANCE USE SERVICES, HAHSTA/DC HEALTH

Every agency that provides Ryan White supported Substance Abuse services must develop and implement a Quality Management (QM) Plan. The QM Plan should be actively supported and guided by the formal agency leadership and senior administration, and appropriate resources should be committed to support continuous quality improvement activities. Agencies with multiple funded service categories must integrate the Substance Abuse QM Plan into their broader QM Plan and specifically address HIV-related services. The QM Plan must be in writing. At least once a year, the QM Plan must be reviewed and updated routinely by the QM committee. Staff from all levels of the agency, as well as patients should serve on the QM committee. Each member of the committee should be aware of the QM infrastructure. However, all agency staff regardless of their participation on the committee must understand their role in the agency's/program's quality improvement activities.

V. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on July 28, 2021. The next annual review is July 28,2022.



Clover Barnes
Division Chief
Care and Treatment Division
DC Health/HAHSTA

Sarcia Adkins
Community Co-Chair
Washington DC Regional Planning Commission
on Health and HIV (COHAH)