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Ohio Administrative Code

Rule 5122-40-09 Non-medication services.

Effective: June 10, 2022

(A) Opioid treatment programs shall provide at a minimum, the following services:

(1) The general services, SUD case management services, and crisis intervention services pursuant to Chapter 5122-29 of the Administrative Code.

(2) Vocational rehabilitation, education and employment services for patients who either request these services or who have been determined by the program staff to be in need of these services.

(B) Opioid treatment programs will provide adequate medical, counseling, vocational, educational, employment, and other assessment and treatment services, and the program sponsor will document that these services are fully and reasonably available to all patients.

All services will be provided at the opioid treatment program with the exception of vocational services, educational services, and employment services. All other services may be provided by a community mental health services or addiction services provider certified for the residential and withdrawal management substance use disorder services as defined in rule 5122-29-09 of the Administrative Code as long as the person is receiving that service, or a state correctional facility. The program sponsor, at their discretion, will enter into formal, documented agreements with private or public agencies, organizations, practitioners, or institutions to provide these services to patients enrolled in the opioid treatment program.

(C) Services are allowed to be provided through telehealth pursuant to rule 5122-29-31 of the Administrative Code, and these services are to be documented in accordance with paragraph (G) of rule 5122-29-31 of the Administrative Code. Telehealth services including induction of any form of medication assisted treatment will only be allowed in accordance with federal and state standards.

(D) Services provided through medication units are subject to rule 5122-40-15 of the Administrative Code.

(E) Upon admission, each patient shall receive the following information both written and verbally:

(1) Signs and symptoms of overdose and when, where and how to seek emergency assistance;

(2) An explanation of the medication, including:

(a) Medication administration;

(b) Potential drug interactions;

(c) Medical issues related to detoxification from opioid treatment medications;

(d) Characteristics of the medications administered or prescribed by the program;

(e) Drug safety issues;

(f) Dispensing procedures and dosage restrictions; and,

(g) Side effects of medications administered or prescribed by the program.

(3) An explanation of alternative methods that are available for treatment of opioid addiction, whether offered by the program or not, and the potential benefits, risks and costs of each treatment;

(4) A formal agreement of informed consent to be signed by the patient and a copy retained by him or her;

(F) Every person admitted to a opioid treatment program shall receive program orientation within two weeks of admission. The orientation shall be made verbally at the earliest opportunity at which the patient is stable and capable of understanding and retaining the information presented. Orientation shall include the following:

(1) An explanation of the patient's rights and right to file a grievance and applicable appeal

procedures, in accordance with rule 5122-26-18 of the Administrative Code;

(2) An explanation of the services and activities provided by the opioid treatment program, including:

(a) Expectations and rules;

(b) Hours of operation;

(c) Access to crisis services;

(d) Confidentiality policy;

(e) Toxicological screening and random testing policies;

(f) Administrative withdrawal criteria, pursuant to rule 5122-40-14 of the Administrative Code;

(g) Interventions; and,

(h) Various discharge criteria.

(3) An explanation about obtaining reports from the prescription drug monitoring program database; how the reports are used to treat and monitor the patient and the requirement that the reports be maintained in the patient files;

(4) An explanation of any and all financial obligations of the patient; all fees charged by the opioid treatment program; and any financial arrangements for services provided by the opioid treatment program;

(5) Familiarization with the opioid treatment programs facility and premises;

(6) Provision of a naloxone kit including the nasal atomizer or other device furnished by the opioid treatment program, or a prescription for such kit.

(a) The opioid treatment program shall provide instruction on the kits use including, but not limited to, recognizing the signs and symptoms of overdose and calling 911 in overdose situations.

(b) The opioid treatment program shall provide a new naloxone kit or prescription upon expiration or use of the old kit.

(c) The opioid treatment program shall be exempt from this requirement for one year if the client refuses the naloxone kit or already has a naloxone kit.

(G) Documentation that the patient has completed the orientation training and received the written information required in paragraphs (E) and (F) of this rule, shall be completed and signed by the program and the patient and maintained in the patient's chart.

(H) Each opioid treatment program shall make available substance use disorder counseling, individual or group, to every patient as is clinically necessary.

(1) The ratio of full-time equivalent individual counselors to patients shall be no greater than one to sixty-five.

(2) Counselor to patient ratios shall be individually determined by the specific needs of the patient and allow patients access to their primary counselor if more frequent contact is merited by need or is requested by the patient.

(3) The counselor caseload shall:

(a) Allow the program to provide adequate psychosocial assessments, treatment planning and individualized counseling; and,

(b) Allow for regularly scheduled, documented individual counseling sessions.

(4) Counseling sessions shall be provided according to generally accepted best practices and shall be offered:

(a) At least weekly during the first ninety days of treatment, for at least fifty minutes in duration.

(b) Thereafter, counseling duration and frequency should be established by the counselor in collaboration with the patient and documented in the treatment plan, with consideration given to the ability of the patient to participate, recovery status, treatment engagement, and laboratory results.

(5) Exceptions to frequency of counselor to patient contact shall be clinically justified and documented in client record.