



Department of Human Services
Addictions and Mental Health Division

DATE: February 10, 2010

TO: Madeline M. Olson, Deputy Assistant Director
Len Ray, Adult Mental Health Services Administrator

CC: Mike Morris, Quality Improvement and Certification Manager
LuAnn Meulink, ISSR Project Manager

FROM: Rick Luthe, Rules Coordinator

RE: Hearing Report: OAR 309-032 "Integrated Services and Supports" Rule

Hearing Dates and Locations:

October 19th, 2009 800 Cardley St. **Medford, OR** 97501 Large Conference Room

October 21st, 2009 1300 Wall St. **Bend, OR** 97701 Lewis and Clark Room

October 22nd, 2009 1555 SW Southgate Place **Pendleton, OR** 97801 North Conference Room

October 28th, 2009 500 Summer St. NE **Salem, OR** 97301-1118 Room 137A (DHS Building)

Conduct of the Hearings:

The rulemaking hearings for the proposed rule adoption were convened at the locations above at 2:00 pm, except for the Salem, OR hearing, which began at 2:15 pm. People Participants were asked to sign the "Hearing Sign-up Sheet" if they wished to comment on the proposed rules, and were informed of the procedures for taking comments. They also were told that the hearing was being recorded. Before receiving comments, I briefly summarized the proposed rules were summarized.

Rule Development Process:

AMH began internal development of the ISSR in April 2008. Two committees, an internal workgroup and an internal steering committee, worked on integrating and updating service delivery requirements for providers of addictions and mental health services. The four primary goals of the project were to:

- Integrate and simplify certification requirements.
- Identify standards to promote recovery and outcome-based services and supports.
- Align certification standards with Medicaid payment standards.
- Reduce documentation requirements.

In September of 2008, AMH invited a group of external stakeholders, including 20% consumer and family representation, to review and assist in the revision of the first draft. The stakeholder group met five times for three-hour blocks of time and once for a six-hour block of time from November 2008 through April 16, 2009. Stakeholders met in groups with representation from each service area to discuss requirements and make recommendations. Approximately 30-50 people attended each meeting.

When the stakeholder process was complete, AMH met with representatives from the Association of Community Mental Health Providers (AOCMHP) to discuss specific feedback and recommendations. In addition, three sub-committee groups addressed areas requiring additional discussion including gender identity, young adults in transition and peer delivered services. AMH offered invitations to members of the external stakeholder group to participate on these committees.

Revisions continued until September 2009. On September 15, 2009, AMH filed Draft #12 of the ISSR with the Secretary of State’s Office to begin hearings. The AMH rules coordinator conducted the public hearings in October 2009 as specified above.

Summary of Revisions:

Key revisions resulting from the public hearings are as follows:

Sub-Section	Revision
Definition of “Successful DUII Completion”	Deleted “unless indigent” and added “when met the terms of the fee agreement between the provider and the individual.”
Documentation in Residential Programs	Changed requirement to update personal belongings inventory from every 90 days

	to “whenever an item of significant value is added or removed.”
Definition of Emergency Safety Interventions	Removed “time out” from the definition.
Definition of “Sexual Orientation”	Removed
Behavior Support Services	Clarification added to specify that these services are only required in ITS, ICTS and Enhanced Care Services.
Definition of “Service Conclusion”	Added “individual moves out of the service area” and “individual requires a level of care not available through the current provider” to list of circumstances resulting in service conclusion.
Clinical Supervision	Clinical supervision exceptions have been deleted.
Individual Service and Support Plan	Changed all references to “desired outcomes” to “intended outcomes.”
Individual Service and Support Plan	Added “service coordination section” for ICTS.
Variations	Removed “If required by the division” from requirement for a plan and time table for compliance with standard from which variance is sought.
Emergency Safety Interventions	Quarterly reporting has been added to the requirements.
Definition of “Reportable Incident”	The definition has been revised to narrow the list of circumstances requiring 24-hour reporting.
Definition of “Medical Director”	Changed to clarify that this term applies only to Alcohol and Other Drug Treatment Programs.
Service Delivery Policies	Requirement to include mission statement in policies has been removed.

Written Comments:

The following persons or organizations submitted the written comments transcribed below.

Association of Oregon Community Mental Health Programs (AOCMHP) comments:

AOCMHP has participated in crafting the rule with the Addictions and Mental Health Division (AMH) and a wide variety of stakeholders. There are a few remaining requested changes, some of which have been agreed to by AMH, which were not changed in draft 12.

AOCMHP Comments—Definition of 309-032-1505(129):"Successful DUI Completion" We strongly urge you to delete "unless indigent" REPLY: YES/CHANGING to "Met the terms of the fee agreement between the provider and the individual."

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Definition of 309-032-1505(106) "Qualified Mental Health Professional (QMHP)" Add "(G) INTERN" AND they propose language REPLY: NO/this definition must align with the current State Plan

309-032-1540 (2)(d)(F) & (G): We recommend changing the word ENTRY in both (F) & (G) to NOTIFICATION REPLY: NO/Changed definition of "entry" to clarify

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Scott Johnson (Deschutes County Health Services) Comments: "Are we still required to meet all guidelines in Medicaid rule?" There is some confusion if/when the Medicaid requirement is more restrictive than the ISSR. REPLY: YES/"Medicaid rule" (309-016) is also being revised to match the ISSR

309-032-1505(1)—(f) Abuse also includes the following actions by a provider, employee, program staff or volunteer:
(A) ADD > "In residential settings" AND provides rationale REPLY: [We have changed our definition to reference the Office of Investigation and Training \(OIT\) definition of "abuse of an adult with a mental illness." \(407—045-0260\)](#)

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309-032-1505(4) "Adolescent" means an individual from 12 through 17 years of age, or those individuals who are determined by the program to be developmentally appropriate for youth services.

Question: Does this include an 18-year-old still in school despite type of eligibility?
REPLY: Below

(16) "Child" means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, will be considered a child until age 21 for purposes of these rules. REPLY: Below

Question: Does this include an 18-year-old still in school despite type of eligibility?
REPLY: NO, individuals who are between the ages of 18 and 21 have all of the rights

specified for adults. The designation of “child” in this age group is only relevant to the receipt of Medicaid funds.

309-032-1505(86) “Peer” means any person supporting an individual, or a family member of an individual, who has similar life experience, either as a current or former recipient of addictions or mental health services, or as a family member of an individual who is a current or former recipient of addictions or mental health services.

Add: and who is not in a position of authority or in a professional relationship with the individual
REPLY: NO/Don't want to restrict role of "peer" in regards to "Peer Delivered Services"

309-032-1520(9) Supervision— ADD: The provider may also modify requirements for non-licensed QMHP or QMHA staff who have a minimum of 10 years related experience. This modification will be no less than 1 hour of supervision contact per month. AND provides rationale
REPLY: NO. The division will require two hours per month of supervision for all personnel providing clinical services to individuals.

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309-032-1530(d) A QMHP, who is also a licensed healthcare professional, will recommend the treatment by signing the Individual Service and Support Plan for each individual receiving mental health services within five days of the development of the ISSP.

Change to: 10 business days...AND provides rationale
REPLY: NO/ CFR440.1309(d) requires “services be recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law.” The term “recommended” does not require the signature before services are provided as the term “prescribed” would. However, the intent is that a physician or other licensed practitioner of the healing arts be involved in the decision to provide services as well the type, frequency and duration of services. A 5-day time frame would allow a brief period during which the provider must document the services were recommended by an authorized practitioner. Additionally, Oregon recently expanded the number of practitioners considered “licensed practitioners” to include Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) thus greatly increasing the availability of a licensed practitioner who can sign the plan. AMH believes the increased availability of practitioners makes compliance with the 5-day period possible for all providers.

309-032-1535(4) Documentation in Residential Programs: In addition to the requirements for Individual Service Records in subsection (2) above, residential providers will include the following documentation in the Individual Service Record:
(a) A personal belongings inventory created upon entry and updated every 90 days or on the date of service conclusion, whichever is sooner;

Change: from 90 days to ... "whenever an item of significant value is added or removed..." AND provides rationale REPLY: YES/Change made

309-032-1555(b) The Quality Improvement Committee will meet at least quarterly to:

(A) Identify indicators of quality including:

(i) Access to services;

Question: Specific Quality of Care and Prevention, Education and Outreach indicators discontinued? REPLY: NO/Covered under (ii) "Outcomes of services"

Monica J. Ford comments:

On behalf of the Oregon Association of Treatment Centers (OATC) I would like to provide comments on the proposed Integrated Services and Support Rule. Let me begin by recognizing the enormous task you and the committee have undertaken and the spirit of openness in which you conducted this effort. Many of us in the Association can appreciate the difficulty of the task from the prospective of long term mental health providers primarily from having gone through multiple changes over the years to the ways in which we conduct our mental health programs. It is from this long term experience and perspective that members of OATC wish to bring to your attention four areas of concern for your consideration.

1) Overall Comments:

In general this document is difficult to read and determine which area deals with which service element. REPLY: Not a comment

In addition it appears programs and agencies will need to rename all their documentation to language proposed in this rule? For example, Progress Note, Mental Health Assessment; Comprehensive Mental Health Assessment, Initial Treatment Plan, Treatment Plan, Plan of Care, Discharge Instructions, Discharge Summary etc.- all standard mental health terms - will need to be changed to Individual Service and Support Plan, Individual Service Note, Individual Service Record, Provisional ISSP, etc. While not a huge issue it does require time for staff to revise all documents that have been used for many years, at least since the ITS Rules were implemented. Members consider this an unfunded mandate. REPLY: NO/ The details required in documentation are much less prescriptive allowing providers to reduce and streamline documentation as appropriate on an individual basis. Even though initial changes in terminology and formats will be required, overall costs should decrease as processes improve.

In this proposed rule it seems there is an effort to ONLY specify minimum requirements in order to meet Medicaid auditing standards. As a result there are no longer any parameters for timeframes for initial assessments, treatment plan reviews, completion of

transition instructions or transition summaries, etc. **“Timelines for periodic review of progress will be determined on an individual basis, and documented in the ISSP, reflective of the type and complexity of the services and supports provided and the needs of the individual.”** OATC members consider this a problem for ITS and ICTS services and are concerned that lack of specificity will lead to watered down versions of these services in the community. OATC would like to see clear timelines for required components of service delivery. **REPLY:** NO/ Flexibility in timelines will promote individualized services, allowing providers to adjust services as appropriate for more or less complexity. ITS providers are still required to review progress every 30 days, as per CFR.

2) OATC members are also concerned with Behavior Support issues:

The definition of Behavior Support Policy has been deleted.

“Behavior Support Policy” means the written policies and procedures required in ICTS and ITS programs for children that describe the process for determining individual behavior support strategies, for providing training related to the strategies, and for measuring the effectiveness of the strategies.

Behavioral Supports has been replaced by:

A new section (9) Emergency Safety Interventions in ITS Programs:

(a) Adopt policies and procedures for Emergency safety interventions as part of a Crisis Prevention and Intervention Policy.

The approach to behavior support or management in ITS programs appears to have been replaced by an interpretation of any of the more restrictive behavioral supports as a response to crisis or safety rather than as a clinical intervention designed to improve client stabilization and emotional regulation. In (E) it states an order for personal restraint or seclusion must not be written as a standing order or on an as needed basis. Yet in (8) Behavior Support Services are to be proactive, recovery oriented, individualized and designed to facilitate positive alternatives to challenging behavior as way as to assist the individual in developing adaptive and functional living skills.

REPLY: Seclusion and restraint are not behavior support strategies or clinical interventions. They are only to be used in emergency situations to ensure the safety of individuals. The distinction between proactive behavior support strategies and emergency safety interventions is consistent with both the Division’s trauma-informed services policy and CFR.

Furthermore, requiring Time Outs to be categorized as an Emergency Safety Intervention is puzzling. Time Out is a behavioral management tool that has been widely accepted in the lay community as a method for children to employ to regain

control of their physical and emotional states. Requiring Time Out to be documented in records and analyzed in Quality Improvement Activities is frankly ridiculous. (E) *Conduct individual and aggregate review of all incidents of personal restraint, seclusion and time-out.* REPLY: YES/"Time out" has been removed from the definition of "Emergency Safety Intervention."

Also added to the proposed new rule is: (18) *Children's Emergency Safety Intervention Specialist (CESIS). A CESIS is a QMHP who is licensed to order, monitor, and evaluate the use of seclusion and restraint in accredited and certified facilities providing intensive mental health treatment services to individuals under 21 years of age.*

Is this rule requiring a CESIS to be a licensed QMHP or someone who is "licensed" by the Division to order the use of seclusion and restraint? **Why are we now requiring a CESIS in day treatment programs when in the past it was only required in residential programs?** OATC members do not routinely have QMHPs available at all times in day treatment programs to sign off on these emergency situations (used to be an intervention). You are probably aware that QMHPs are now asked to do their work in the client's homes. What about day treatment programs in schools? Are QMHPs always available in schools? The rule requires "an immediate documented order". Within an hour a psychiatrist, licensed practitioner, or CESIS must conduct a face to face assessment of the physical and psychological well being of the individual. This new rule will require a QMHP be available at all times and stationed by the milieu. Again, OATC members see this as an unfunded mandate to require an additional QMHP as staff in the milieu or on the premises at all times during milieu hours in order to authorize seclusions or restraints. REPLY: No/ Psychiatrist authorization for emergency safety interventions (previously "special treatment procedures") is currently required in day treatment programs. In the ISSR, this is changed to allow providers to employ a CESIS to provide this authorization as well.

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3) Continued Stay Criteria:

2) (24) page 7 of 78 Continued Stay Criteria has been dropped from the latest draft:

Continued Stay Criteria means the diagnostic, behavioral and functional indicators documented in the Individual Service and Support Plan to provide the clinical rationale for an individual to remain in an intensive mental health treatment service.

It seems to OATC members that establishing why a client should stay in services is an important component of treatment planning. REPLY: No/ "Continued Stay Criteria" has been replaced by "Service Conclusion Criteria," as this is more outcome focused.

4) Additional Documentation:

(5) Additional documentation in ITS programs requirements:

Level of Need Determination is not required to be housed in the ITS Individual Service Record. It is required to be in the ICTS individual Service Record. (In the definitions (68) Level of Need Determination means the AMH approved process by which children and young adults in transition are assessed for ITS and ICTS services.) We assume you also will want this in the ITS Individual Service Record. REPLY: YES/ “Level of Need Determination” has been changed to “Level of Service Intensity Determination” and this has been added to required documentation for ITS programs.

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On behalf of Oregon Association of Treatment Centers I again want to thank you for the opportunity to provide feedback to you and the ISSR committee. I apologize in advance if this feedback is duplicative in nature or has already been considered for revision. Please call me if I can be of further assistance.

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Joe Hromco comments: Individual Service and Support Planning and Coordination (aka Treatment Plan) comments—We would recommend a standard that is specific to integrated care that is along the lines of:

“For services provided as part of an integrated healthcare service and record, the ISSP function may be described in an Assessment Note outlining the recommended treatment protocol, including anticipated frequency and duration of services, and measurable rehabilitative objectives. These are updated through the “Plan” section of subsequent progress notes.” The practice suggested is compliant with the ISSR. This is not something we will require, however, because integrated services are still evolving and best practices emerging. As a result, we do not want to be too prescriptive at this time.

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LMP Oversight—We would recommend, therefore, keeping this requirement in the Medicaid Payment section if possible. In addition, we would recommend considering ways in which the involvement of a PCP might serve the function of an LMP in integrated settings. If a PCP documents review of integrated behavioral health services, might this be considered appropriate physician oversight? REPLY: The definition of LMP includes a PCP, so the suggested practice is compliant with the ISSR. It is our intention to continue to require annual LMP oversight in mental health programs.

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Individual Service Record—We would like to clarify that having this information in a larger healthcare record, where behavioral health is merely a subset, meets this function. In addition, it is notable that “military status” was added back in. We would recommend removing this, as this information is rarely collected in the larger behavioral health field, largely irrelevant to care, and not applicable to most age groups. NO/ISSR has the minimum necessary AND military status (or *no* status) is part of tracking for reports

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Service Conclusion—

Perhaps the most relevant section for integrated care is the service conclusion section. Integrated care is similar to primary care in that a consumer’s “case” is “always open”. In addition, integrated care involves providing brief & focused services to a large number of consumers (i.e., it is not intended as an intensive service for addressing severe and/or persistent mental illness). As a result, we would recommend exempting integrated care from this requirement. Particularly difficult is the section requiring a “service summary...within 45 calendar days following the date of the determination that the individual is not likely to return...” REPLY: The requirements of the service conclusion summary are minimal and general enough to allow for a brief summary or a more detailed summary for more complicated services. It is typical practice in both mental health and primary care settings for there to be documentation to indicate the resolution of an episode of care. The summary can be done in a concluding “Individual Service Note” and still be compliant.

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M Lauper Comments: Conclusion of an episode of care does not imply service conclusion when the provider has documented the reason that episodic service utilization is likely. REPLY: If a provider has documented that there is a valid reason to assume that episodic care is likely, it is not necessary for the provider to complete a service conclusion summary. The provider would just document the last service provided in an individual service note.

I know they are trying to use the convention “x” means “y” in the definitions section, but sexual orientation does not mean an enduring pattern...it refers to and enduring pattern..and by the way, why does this have to be defined...what is the intention for having this...versus defining heterosexuality, homosexuality, bisexuality, asexuality, etc.

(119) “Sexual Orientation” means an enduring pattern of romantic and/or sexual attractions to men, women, both or neither.

REPLY: The definition of “sexual orientation” has been removed.

Individual Rights,

1(a) Choose from available services and supports that are appropriate consistent with the ISSP and provided in a setting and under conditions that are least restrictive to the individual’s liberty, that are least intrusive to the individual and that provide for the greatest degree of independence. REPLY: "Appropriate" has been removed from the definition

Express sexuality, when legally an adult, in a socially appropriate and consensual manner. REPLY: "socially appropriate" is no longer in the rule

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- A completed assessment current within 60 days of the entry date;
- (ii) Pertinent biological, psychological and sociocultural factors influencing the individual's development and functioning;
- (iii) The acuity and severity of the individual's psychiatric symptoms as scored on measures established by the Division;
- (iv) The individual's functioning as scored on measures established by the Division; and
- (v) Attempts to provide service to the individual in a less restrictive level of care.

Will the division be defining these measures before the rules are adopted, or how soon afterward? REPLY: This subsection is no longer in the rule

p. 38 (d) Providers will document updates to the assessment consistent with the timelines specified in the ISSP and when there are changes related to the biosychosocial information in the assessment. pertinent information is available. There is a wording problem here REPLY: "Pertinent information" is no longer in the rule

p. 38 In addition to periodic assessment updates, any individual continuing to receive mental health services for one or more continuous years, will receive an annual assessment by a QMHP, that has documented approval do they mean approval, or do they mean co-signed, reviewed, authorized, or is approval the word to go with by an LMP. REPLY: Documented approval, at minimum, means a signature with credentials and date of signature, however, providers are required to specify how they will obtain "approval" in their service delivery policies.

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Morrison Child and Family Services Comments:

Behavior Support Plan and Behavior Support Services It is unclear if these concepts apply to children and adolescents receiving Outpatient mental health services or when these concepts apply or what sub-group of children and adolescents receiving routine Outpatient services might be affected by the proposed rules. At the present time Morrison Outpatient programs do not use any type of seclusion and restraint as emergency interventions or treatment interventions. Therefore, we think that the title of Section (p. 41) should be changed from Behavior Support Services to Behavior Support Services in ITS Programs and the definitions of Behavior Support Plan and Behavior Support Strategies should be amended to include that they are definitions relevant to and utilized by ITS programs only (p.12). REPLY: The behavior support section applies to ITS, ICTS and Enhanced Care Programs. Behavior support is not seclusion and restraint or any other type of emergency procedure. Seclusion and restraint are emergency safety procedures only and are addressed in the "emergency safety procedures" section. The behavior support section has been changed to clarify that it applies only to ITS, ICTS and Enhanced Care.

Definition of Case Management Expand the definition of case management (p. 12) to include service coordination and advocacy activities. The proposed definition only includes the concept of access to needed services. Current CPT Code definitions utilized by the Addictions and Mental Health Division for case management services (T1016 and T1016HN) include service coordination and advocating for the treatment needs of clients. REPLY: NO/ advocacy is not billable under “case management” and service coordination is defined separately as a different billable service.

Definition of QMHP Expand the definition of QMHP to include Master’s level graduate students enrolled in approved, accredited university programs in psychology, counseling psychology, social work, and behavioral health science receiving a minimum of 1 hour of supervision per week by a QMHP. The QMHP Supervisor must also meet any qualifications set forth by universities granting the Master’s degrees in the above named fields. REPLY: NO/The definition must align with the State Plan

Crisis Services The requirement for Child and Adolescent Outpatient Mental Health programs should be to establish effective links to the current, existing mental health crisis system in local communities. Referral and communication protocols should be in place and operate smoothly. Please remove “Crisis Services will be provided directly” (p. 37) from the section on Outpatient Mental Health Services to Children, Adults, and Older Adults. REPLY: NO/The phrase is needed as an introduction to what "crisis services" need to be available

Licensed Medical Provider Review of Individual Service and Support Plans in Children’s Outpatient Services We did not find any reference to a required annual review by a LMP in the new draft rules and assume that this requirement has been eliminated. Is this accurate? We did find references to updates of assessments, periodic updates of service plans, and review of Individual Service and Support Plans by licensed professionals. REPLY: The initial assessment and ISSP must be signed by a physician or other “licensed healthcare practitioner” as defined. The annual assessment is addressed in 309-032-1525(3)(g) and requires approval of the updates to the assessment and the ISSP annually by an LMP.

Minimum Requirements to Meet Medicaid Auditing Standards This statement appears on p. 34. Morrison Child and Family Services is requesting further assurance that all CMS (Center for Medicaid and Medicare) requirements for Medicaid billing are met when these rules become effective and are fully implemented. For example, the Medicaid Payment for Rehabilitative Mental Health Services rule contains additional documentation requirements. To date, this rule (OAR 309-016-0000 to 309-016-0450) has not been repealed. It is critical that the new draft rules and the Medicaid Payment rules do not have conflicting information and that the Medicaid Payment rules do not include more detailed, prescriptive standards than the proposed ISSR. REPLY: NO/The 309-016 "Medicaid payment" rules are being revised in conjunction with the ISSR

Lastly, it is important to note that there are multiple, new requirements put forth in the proposed rules that will have a financial impact for mental health providers and for Morrison. Costs are associated with recordkeeping changes, training requirements, licensed professional review of all service plans, board certified child psychiatrist participation in ICTS activities, and increased documentation in personnel files of employees. REPLY: NO/ The requirements for training, LMP approval of ISSPs and record keeping are not new, just somewhat different. The documentation requirements in the ISSR are aligned with CFR requirements for Medicaid reimbursement. In addition, the details required in documentation are much less prescriptive allowing providers to reduce and streamline documentation as appropriate on an individual basis.

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Chris Mason Comments:

In definition (127) "Successful DUII Completion" (b) Paid all service fees, unless indigent. The "unless indigent" appears to mean that indigent clients are not required to pay their fees. "Indigent" is defined in definition (54) as a person "without healthcare coverage, either public or private, who also meets Oregon's income standards for food stamp eligibility." I strongly urge you to delete "unless indigent" from definition (127)(b) of the ISSR. REPLY: YES/"Unless indigent" has been revised to "Met the terms of the fee agreement"

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Rick Treleaven Comments:

I have found two words that would hugely disrupt A&D DUII providers. In definition (127) "Successful DUII Completion" (b) Paid all service fees, unless indigent. The "unless indigent" appears to mean that indigent clients are not required to pay their fees. "Indigent" is defined in definition (54) as a person "without healthcare coverage, either public or private, who also meets Oregon's income standards for food stamp eligibility." I strongly urge you to delete "unless indigent" from definition (127)(b) of the ISSR. REPLY: YES/"Unless indigent" has been revised to "Met the terms of the fee agreement"

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Kristine Britton comments (Multnomah County):

309-032-1505

Definitions

- (2) "Abuse" of a child includes, but is not limited to, one or more of the following:
 - (a) Any assault, as defined in ORS chapter 163, of a child and any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury;

(b) Any mental injury to a child, which shall include only observable and substantial impairment of the child's mental or psychological ability to function caused by cruelty to the child, with due regard to the culture of the child;

Comment [b1]: Consider deleting "substantial" -any impairment to psychological functioning caused by mental injury should be considered abuse

(c) Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration, and incest, as those acts are defined in ORS chapter 163;

Comment [b2]: Consider deleting "and incest," as it is superfluous. The term "incest" speaks to the relationship between the victim and the perpetrator rather than a specific act or behavior. Any sexual act with a child is abuse with or without the added relational element defined by the term "incest."

(e) Sexual exploitation, including, but not limited to:

(D) Online sexual corruption as defined in ORS 163.431 through 163.433(g)

Maltreatment of child, which includes but is not limited to failure to provide adequate food, clothing, shelter, or medical care that is likely to endanger the child's health or welfare. Maltreatment also includes but is not limited to the willful infliction of pain or injury, hitting, kicking, scratching, pinching, choking, spanking, pushing, slapping, twisting of head, arms, or legs, tripping, exposure to domestic violence, the use of unnecessary or excessive physical force, or other physical contact with a child inconsistent with prescribed treatment or care, the use of derogatory names, phrases or profanity, ridicule, harassment, coercion, or intimidation, that is likely to endanger the child's health or welfare; REPLY: NO/ This definition is consistent with the DHS, Office of Investigations and Training (OIT) rules.

Comment [n3]: Consider adding this to the abuse definition

Comment [b4]: Consider deleting "includes but is not limited to failure to provide adequate food, clothing, shelter, or medical care that is likely to endanger the child's health or welfare. Maltreatment also," as this is redundant form the previous section (f).

(8) "Assessment" means the process of obtaining all pertinent biopsychosocial information through face-to-face interview by qualified staff, as identified by the individual, family and collateral sources, for determining a diagnosis and to plan individualized services and supports. REPLY: NO/Not all assessment activities are "face to face"

Comment [b5]: Consider adding "through a face-to-face interview by qualified staff." A face-to-face session with a qualified staff member is a crucial element in conducting an assessment. The lack of this kind of connection with the client creates significant liability issues for the agency by potentially relying on either the evaluation of less qualified staff who are merely collecting information or on the review of collateral information collected elsewhere. Under these circumstances, the potential for misdiagnosis or under diagnosis is increased.

(17) "Child and Family Team" means those persons who are responsible for creating, implementing, reviewing, and revising the service coordination section of the Individual Service and Support Plan in ICTS and ITS programs. At minimum the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family. REPLY: NO/Covered in ISSP

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Comment [b6]: The "service coordination section of the ISSP" is not defined or described in this rule. This definition should be added either here, as an independent definition, within the ISSP subsection (OAR 309-032-1530 (2, c)) or within 309-032-1540 (5). The ISSP subsection (OAR 309-032-1530 (2, c)) is recommended.

(20) "Clinical Supervisor" means a person qualified to oversee and evaluate addictions or mental health services and supports.

(a) For supervisors in alcohol and other drug treatment programs, holding a certification or license in addiction counseling, qualifications for the certificate or license must have included at least:

(A) 4000 hours of supervised experience in substance use counseling;

(B) 300 contact hours of education and training in substance use related subjects; and

(C) Successful completion of a written objective examination and portfolio review by the certifying body.

(b) For supervisors, in alcohol and other drug treatment programs, holding a health or allied provider license, such license/registration must have been issued by one of the

Comment [b7]: See deletion—this seems to belong in section 309-032-1520 (3, a, A) as that is where all the other criteria specific to an A&D "Clinical Supervisor" as well as clinical supervisory requirements for other service types are included.

following state bodies and the supervisor must possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of alcohol and other drug-related disorders:

- (A) Board of Medical Examiners;
- (B) Board of Psychologist Examiners;
- (C) Board of Clinical Social Workers;
- (D) Board of Licensed Professional Counselors and Therapists; or
- (E) Board of Nursing. REPLY: NO/This is a standard term to identify via definition

(56) "Individual Service and Support Plan" (ISSP) means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the desired outcomes of service.
REPLY: YES/Added

Comment [b8]: Add this acronym as it is widely used within the document.

(59) "Informed Consent for Services" means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the individual and guardian, if applicable, have consented to the services in writing on, or prior to, the first date of service. REPLY: NO/Generally this is done; some circumstances could prevent

Comment [b9]: Consider adding "in writing." Documented evidence of consent is needed within the chart or it will be uncertain whether or not consent has occurred. Although the rights state that a consumer has a right to consent "in writing", there is no requirement of the provider that this actually occur.

(78) "Medication Administration Record (MAR)" means the documentation of the execution of written or verbal orders for medication, laboratory and other medical procedures issued by a Licensed Medical Practitioner employed by, or under contract with, the provider and acting within the scope of his or her license. REPLY: YES/But changed to "administration of"

Comment [b10]: Consider including a Mental Status Examination definition. This is an extremely important part of an assessment process, particularly in screening for mental health issues. (See also 309-032-1525 (3, d, B) regarding the contents of the assessment))

(80) Mental Status Exam (MSE) – (include minimum elements required as definition and require that the exam is face-to-face, i.e. face-to-face interview conducted by a QMHP that documents at minimum, the individual's: mood, affect, thought process, thought content, orientation, current suicidal and homicidal ideation, judgment, and insight;) REPLY: NO/ This is not specifically required as part of the assessment but if it is needed to collect an adequate amount of biopsychosocial information, it can be used at the provider's discretion.

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Comment [b11]: Consider reformatting the section with a-g falling under (a) and h falling under (b) as the current "h" seems like *instructions* for service conclusion rather than one of the *criteria* for such

(119) "Service Conclusion" means the conclusion of services when:
(a) The individual moves out of the service area; REPLY: YES/Added

Comment [b12]: Some qualifier needs to be added here. Medicaid funded clients commonly move frequently but that should not be an acceptable reason for a provider to drop them from care in and of itself.

(h) The individual requires a level of care not available through the current provider; REPLY: YES/Added

Comment [b13]: This seems a commonly utilized reason for referral and termination

(ih) Conclusion of an episode of care does not imply service conclusion when the provider has documented the reason that episodic service utilization is likely. REPLY: YES/Deleted

Comment [b14]: This sentence is confusing. Consider rewording to something like: "If episodic service utilization is likely and documented within the clinical record, conclusion of a service episode does not necessitate Service Conclusion."

(j) The date of service conclusion is determined by... REPLY: NO/Don't want to require a specific date

Comment [b15]: This needs to be specified by the division.

309-032-1515

Individual Rights

(1) In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

(c) Participate in the development of a written ISSP, receive services consistent with that plan and undertake periodic review and reassessment of service and support needs, and to have a parent, guardian, advocate or representative assist in the development of the plan; REPLY: NO/Don't want to define periodic AND YES/Delete references to "parent, guardian, etc. assist"

Comment [b16]: Consider adding specific timelines by which consumers have a right to have their ISSP reviewed.

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(d) Have all services explained, including expected outcomes and possible risks, and to receive a copy of the written ISSP; REPLY: YES/Moved to (c)

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Comment [b17]: This should be moved to (c) above

(i) Receive medication only for specific to the individual's diagnosed clinical needs; REPLY: YES/Changed

Comment [n18]: Change to "specific to." Current language has multiple meanings.

(p) Have family involvement in service planning and delivery; REPLY: NO/Individual's have the right to have family involved as desired in both planning and service delivery.

Comment [b19]: This seems repetitive, see letter (c) of this section.

(s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules; REPLY: NO/The "non-AMH" rights might still be needed during treatment

Comment [b20]: ORS 109.610 through 109.697 and ORS 426.385 include MANY rights not applicable to mental health, chemical dependency, or problem gambling services yet providers may be in a position of having to explain these rights to consumers, consider removing this extraneous information.

(t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Department of Human Services; and REPLY: NO/If child is committed these rights would all apply

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309-032-1520

Personnel

(3) Specific Staff Competencies: At minimum, competencies for the following specified staff will include:

(b) Clinical Supervisors in addictions and mental health programs must demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, individual service and support planning, case management and coordination, utilization of community resources, group, family and individual therapy or counseling, documentation and rationale for services to promote desired outcomes and implementation of all provider policies. In addition:

(A) Clinical Supervisors in alcohol and other drug treatment programs will be certified or licensed by a health or allied provider agency, as defined in these rules, to provide addiction treatment, and have one of the following qualifications:

(i) Five years of paid full-time experience in the field of alcohol and other drug counseling; or

(ii) A Bachelor's degree and four years of paid full-time experience in the social services field, with a minimum of two years of direct alcohol and other drug counseling experience; or

(iii) A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct alcohol and other drug counseling experience;

(a) For supervisors in alcohol and other drug treatment programs, holding a certification or license in addiction counseling, qualifications for the certificate or license must have included at least:

- (A) 4000 hours of supervised experience in substance use counseling;
- (B) 300 contact hours of education and training in substance use related subjects; and
- (C) Successful completion of a written objective examination and portfolio review by the certifying body.

(b) For supervisors, in alcohol and other drug treatment programs, holding a health or allied provider license, such license/registration must have been issued by one of the following state bodies and the supervisor must possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of alcohol and other drug-related disorders:

- (A) Board of Medical Examiners;
- (B) Board of Psychologist Examiners;
- (C) Board of Clinical Social Workers;
- (D) Board of Licensed Professional Counselors and Therapists; or
- (E) Board of Nursing. REPLY: NO/This is a standard term to identify via definition

(5) Personnel Documentation: Providers must maintain personnel records for each employee that contains all of the following documentation:

(k) Written evidence of binding arrangement between the employee and Clinical Supervisor. REPLY: NO/The agreement in 1520 is between the CS & the provider

(k) Information from subsection (6) below, if applicable. REPLY: NO/ Documentation pertaining to contractors, volunteers, etc is needed to determine the person's role in providing services and to establish compliance with required qualifications.

(8) Training: Providers will ensure that staff receives training applicable to the specific population for whom services are planned, delivered, or supervised as follows:

(a) Pre-service training: The program will document appropriate orientation training for each employee, or person providing services, within 30 days of the hire date. At minimum, pre-service training for all staff will include, but not be limited to,

(H) Orientation to assessment, individual service and support planning, service delivery, and termination documentation. REPLY: NO/ Already covered in (a)

Comment [b21]: Consider moving this text from 309-032-1505 (20) and adding it here with some formatting revision.

Comment [b22]: Consider adding this requirement to the personnel documentation. This is required to be present by **309-032-1520 (9, b)**, thus should be stored in the personnel file of the staff receiving supervision

Comment [b23]: Consider deleting. This may be superfluous. If a person is an "employee" as specified within the preamble of (5), they would not meet the criteria for (6). It is unclear when this would be applicable.

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Comment [b24]: Consider adding this initial training in order to assure that the agency can enforce a certain standard regarding these documentation requirements throughout the agency.

(9) Supervision: Persons providing services to individuals in accordance with this rule will receive supervision by a qualified Clinical Supervisor, as defined in these rules, related to the development, implementation and outcome of services.

(b) Clinical Supervision will be specified through a current written agreement, job description, or similar type of binding arrangement between the Clinical Supervisor and the Provider which describes the Clinical Supervisor's oversight responsibility, including documentation of supervision no less than two hours per month. The two hours will include, at minimum, one hour of face-to-face contact for each person supervised, or a proportional level of supervision for part-time staff. REPLY: NO/"face time" is *at least* 1 hour, any more is allowable, but not required

Comment [b25]: Consider adding this qualifier so that if both hours were face-to-face, this would be permissible without question.

(c) Clinical supervision exceptions: The provider may modify the requirements specified in these rules for supervision of QMHPs and independent contractors, who are licensed under existing Oregon Revised Statutes and Oregon Administrative Rules to conduct independent practice without supervision. REPLY: NO/ This exception has been deleted. All person's providing clinical services are required to have two hours per month of clinical supervision.

Comment [n26]: Consider deleting "QMHPs and," so that independent practice **without** supervision will be allowed for Independent Contractors only and not for agency employees. Under the legal tenet of Respondeat Superior, an employer is liable for the actions of an employee. The lack of minimum requirements related to clinical supervision for an agency employee regardless of licensure status places, an agency using the rule as guidance in a position of taking on liability. The distinction of one employee who is licensed versus one who is not is contrary to the legal tenet.

309-032-1525 Entry and Assessment

(1) Entry Process: The program will utilize a written entry procedure to ensure the following:

(d) Written informed consent for services will be obtained from the individual or guardian, if applicable, prior to the start of services. If such written consent is not obtained, the reason for such, along with evidence that consent for services has been explained to the individual and the date that this occurred will be documented and further attempts to obtain written informed consent will be made as appropriate.

Comment [b27]: Consider adding a minimum requirement for supervision related to compliance with program policies and procedures as required by (a).

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REPLY: NO/Documentation is already required, & consent should have already been explained

Comment [b28]: This provides some protection for the agency in relationship to liability regarding consent and assurance that the individual's rights to consent have been protected.

(3) Assessment:

(b) When an assessment is not completed at entry, a provisional assessment, as defined in these rules, will document the immediate medical appropriateness of services. If services are continued, an assessment will be completed within a timeframe that reflects the level and complexity of services and supports to be provided. REPLY: YES/Changed to "cannot be" completed at entry...

Comment [n29]: This sentence would indicate that the provisional assessment, when utilized in place of an assessment, must be completed "at entry". It is unclear what "at entry" means. Consider adding a timeline for when the provisional assessment must be completed and placed in the clinical record.

(d) Each assessment will include:

(A) Sufficient biopsychosocial information and documentation to support the presence of a DSM 5-Axis diagnosis that is the medically appropriate reason for services.

REPLY: NO/More specific than necessary

Comment [n30]: Specify "5-axis diagnosis" as the rule distinguishes between "DSM Diagnosis" and "DSM 5-Axis diagnosis." This is the optimal way that a biopsychosocial evaluation and screening for substance use, problem gambling, mental health conditions, physical health conditions and trauma will be reflected and documented within a diagnosis.

(B) Mental Health Assessments should also include an adequate Mental Status Exam that addresses at minimum: mood, affect, thought process, thought content, orientation,

current suicidal and homicidal ideation, judgment, and insight; and that concludes with a clinical formulation. REPLY: NO/More than necessary

Comment [n31]: The MSE and clinical formulation are bare essential elements of an adequate mental health assessment. The MSE completed by a QMHP also assures that a face-to-face session between the client and the QMHP will occur. (See also 309-032-1505 would become (80)).

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(E) For problem gambling, suicide potential must be assessed and clinical records must contain follow-up actions and referrals when an individual reports symptoms indicating risk of suicide. REPLY: This requirement has been moved to the general requirements subsection and is to be completed by all providers during assessment.

Comment [b32]: Consider making assessment for suicide potential required for all types of assessment, not just problem gambling.

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(f) Providers will document updates to the assessment consistent with the timelines specified in the ISSP, and when there are changes related to the biopsychosocial information in the assessment. REPLY:NO/Needed

Comment [b33]: This could drive frequent assessment updates that might put an undue burden on the provider. Consider more specific language related to the changes that would require an assessment update.

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309-032-1530

Individual Service and Support Planning and Coordination

(1) Individual Services and Supports: The provider will deliver or coordinate, for each individual, appropriate services and supports to collaboratively facilitate desired service outcomes as identified by the individual, and family, when applicable. REPLY: YES/Changed "desired outcomes" to "intended outcomes."

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(a) Qualified program staff will facilitate a planning process, resulting in an Individual Service and Support Plan (ISSP) that reflects the assessment and the level of care to be provided.

Comment [b34]: If the plan is to document the "appropriate services and supports to collaboratively facilitate the desired service outcome" the desired service outcome should be identified within the plan. See addition suggested within 309-032-1530 (2, C)

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(b) A provisional ISSP, including applicable crisis services, will be completed following the assessment process and prior to the start of services. For mental health services, a QMHP will recommend the services by signing the provisional ISSP. REPLY: NO/Covered in definition

Comment [b35]: This wording as it is written is confusing. Assessment is considered a treatment service and according to the definition of "Provisional ISSP" found within 309-032-1505 (98), the provisional ISSP must "address presenting issues as they relate to a provisional diagnosis." Consider adding language so that this reads "completed following the assessment process and prior to the start of services."

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(c) If services are continued, an ISSP will be completed within a timeframe that reflects: REPLY: NO/Don't want specific timeframe

(A) The type and level of services and supports to be provided;

(B) A complete assessment; and REPLY: NO/Not a comment

(2) Individual Service and Support Plan (ISSP):

(b) At minimum, each ISSP will include:

(A) Measurable or observable rehabilitative and functional objectives;

(B) Specific services and supports to be provided;

(C) Applicable service and support delivery details including frequency and duration of each service;

Comment [n36]: Consider adding a timeline to reflect the maximum time that will be allowed to lapse prior to a completed ISSP. "If services are continued..." also lacks specificity. Compliance with ... [1]

Comment [b37]: Remove extra space

(C) Desired service outcomes as identified by the individual, and family, when applicable and consistent with the assessment; and REPLY: NO/"Desired" removed

Comment [n38]: If the plan is to document the "appropriate services and supports to collaboratively facilitate..." [2]

(D) Timelines for review of progress and ISSP updates, consistent with the level of care provided and the needs of the individual. REPLY: NO/Don't want hard timeline

Comment [n39]: Consider adding a hard timeline after which the ISSP must be updated, perhaps at the annual review.

(c) For ICTS and ITS programs, the ISSP will include:

Comment [n40]: This is identified/referenced within 309-032-0154 ((5, c) and within 309-032-1505 (17) thu... [3]

(F) A service coordination section REPLY: NO/Comment already addressed

(3) Individual Service Notes:

(b) Individual Service Notes will document:

(F) The time the service occurred **REPLY: NO/Requirement is service *duration***

(G) For ICTS services, Individual Service Notes should also include who was present during service delivery. **REPLY: NO/Cost & not needed**

(c) Individual service notes will also include:

(D) **Notes** documenting the delivery of medication management services, **will contain documented assessment of potential side effects and adverse reaction, a Procedure, Alternatives, Risks and Questions (PARQ) conference for any new medications prescribed, and a list of current medications and dosage.** **REPLY: NO/Covered in medical administration**

(d) Timelines for periodic review of progress will be determined on an individual basis, and documented in the ISSP, **reflective of the type and complexity of the services and supports provided and the needs of the individual.** **REPLY: NO/ Flexibility in timelines will promote individualized services, allowing providers to adjust services as appropriate for more or less complexity. ITS providers are still required to review progress every 30 days, as per CFR.**

(e) The requirements in OAR 309-032-1530(3)(a) and OAR 309-032-1530(3)(b)(A) through OAR 309-032-1530(3)(b)(E) are minimum requirements to meet Medicaid auditing standards and may result in financial findings when not met. The requirements in OAR 309-032-1530**(3)(c)(A)** through OAR 309-032-1530(3)(c)(C) are quality standards and may result in limitations, or revocation of, certification when not met. Failure to maintain certification may result in exclusion or limited participation in the Medicaid program. **REPLY: All numbering references have been checked and adjusted as needed.**

Comment [b41]: Consider adding this requirement as it assists in helping internal and external reviewers determine potential double billing and adds to context to the overall picture of the service delivery within the clinical documentation of such.

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Comment [b42]: This service type often involves multiple family members and/or providers. Documentation of who was present adds important context to the individual service note.

Comment [n43]: The basic requirements within the community standard for medication management service documentation.

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Comment [b44]: This expectation for the provider is repeated throughout the rule. Our concern is that, as it is difficult to quantify, it will be difficult for the agency to utilize within the clinical documents with any level of consistency across clinicians or across providers within the community at large. As a result, consumers with a set level of complexity will receive the benefit of review of progress at potentially vastly different levels across agencies depending on how this is interpreted by a specific agency or even a specific clinician.

Comment [b45]: Update the references if the suggested additions are accepted

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309-032-1535

Individual Service Record

(2) General Requirements for Individual Service Record: All providers will develop and maintain an Individual Service Record for each individual upon entry. The record will, at minimum, include:

(b) Identifying information, or documentation of attempts to obtain the information, including:

(A) The individual's name, address, telephone number, date of birth, gender, marital status and military status;

(B) Name, address, and telephone number of **parent, or legal guardian, primary care giver, if applicable, next of kin, and or emergency contact;** **REPLY: YES/Added**

Comment [b46]: (B) Documentation should require documentation of BOTH the parent AND the legal guardian.

Comment [b47]: (B) Both next of kin AND emergency contact are important.

(e) Provisional Assessment, and full Assessment and/or updated Assessment, as applicable Assessment or provisional assessment and updates to the assessment; **REPLY: NO/Can't use and/or**

Comment [b48]: Consider rewording this language (e), "Assessment or provisional assessment and updates to the assessment" to, "Provisional assessment and full assessment and/or updated assessments as applicable." Also consider rewording (f) as shown

(f) An Individual Service and Support Plan or Pprovisional ISSP, and full ISSP including any applicable behavior support or crisis intervention planning, as applicable; REPLY: NO/ Focus is on a completed ISSP.

(j) Applicable signed consents for release of information and/or authorization to disclose information. REPLY: NO/”Signed release of information” is the same as “authorization to disclose information.”

Comment [n49]: Consider adding this language as found within HIPAA regulations related to mental health services.

(6) Additional documentation in ICTS Programs: In addition to subsection (2) above, ICTS providers will include the following documentation in the Individual Service Record:

(c) Documentation that child and family team meetings have occurred quarterly REPLY: NO/ Requirement is for child and family team meetings to occur at a frequency established in the ISSP. This will allow for more frequent meetings when needed.

Comment [b50]: Consider adding this documentation requirement and guideline regarding the minimum frequency of child and family team meetings.

(7) PSRB and JPSRB Documentation: When the individual is under the jurisdiction of the PSRB or JPSRB, providers will include the following additional documentation in the Individual Service Record:

(d) For PSRB and JPSRB services, a copy of the Conditional Order of Release.

(e) A copy of the Agreement to Conditional Release REPLY: YES/Fixed

Comment [b51]: See deletion, this language is redundant as the whole subsection is PSRB/JPSRB specific

Comment [b52]: This documentation requirement should be added as 309-032-1540 (4) requires that services are consistent with this document

309-032-1540

Program Specific Service Standards

In addition to individualized service and support planning and coordination, providers of each of the following program-specific service areas will ensure the following requirements listed for that service are met.

(1) Co-Occurring Mental Health and Substance Use Disorders (COD):

(a) Providers **approved and designated** to provide services and supports for individuals with co-occurring substance use and mental health disorders will: REPLY: NO/Designated during licensing & service approvals

Comment [b53]: This process is not explained in any way. How will these providers be determined? Who will provide oversight for these providers?

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Comment [b54]: These are separate issues. Contracted practitioners often still see consumers “on-site” at an agency. The current language leaves LMPs who are employees out and seems to be addressing only contracted LMPs. Consider changing the language, “either on-site or contracted;” to “ who is either an employee of the agency or a contracted practitioner” or something more accurate.

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(2) Outpatient Mental Health Services to Children, Adults and Older Adults: The following services will be made available to individuals as needed: REPLY: NO/Not needed

(b) Assessment, service plan development, Individual, family and group therapy provided by a QMHP; REPLY: NO/Covered elsewhere

(c) Psychiatric services including medication management as applicable, provided by a LMP, either **on-site or contracted**; and REPLY: YES/Changed

(d) **Available** case management services either provided by the agency or through a referral process including the following: REPLY: NO/Already changed

Comment [b55]: What is the purpose of this qualifier? Consider clarifying. Are providers REQUIRED to offer case management services or do case management requirements only apply if agencies choose to offer this service type

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(B) Assistance with completion of a declaration for mental health service treatment with the individual's participation and informed consent; REPLY: YES/Changed

Comment [b56]: Change “service” to “treatment”, as “Declaration For Mental Health Treatment” is the accurate name of the term as defined within this rule.

(4) Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board: Services and supports will include all appropriate services determined necessary to assist the individual in maintaining community placement and which are consistent with Conditional Release Orders and the Agreement to Conditional Release.

(a) Providers of PSRB and JPSRB services acting through the designated Qualified Person, will submit reports to the PSRB or JPSRB as follows:

(A) Orders for Evaluation: For individuals under the jurisdiction of the PSRB or the JPSRB, providers will take the following action upon receipt of an Order for Evaluation:

(i) Within 15 days of receipt of the Order, **schedule an interview with the individual** for the purpose of initiating or conducting the evaluation; REPLY: YES/Changing

(C) Interim reports, including immediate reports by phone, if necessary, to ensure the public or individual's safety including:

(ii) Upon noting major symptoms requiring psychiatric stabilization or hospitalization or
(iii) any other major change in the individual's ISSP; REPLY: YES/Changed

(5) Intensive Community-Based Treatment and Support Services (ICTS) for Children:

ICTS services may be delivered at a clinic, facility, home, school, other provider or allied agency location or other setting as identified by the child and family team. In addition to services specified by the ISSP and the standards for outpatient mental health services, ICTS services will include:

(a) Care coordination provided by a QMHP or a QMHA supervised by a QMHP; with the following minimum qualifications:

(i) Demonstrated competencies in child and adolescent mental health treatment and experience providing intensive services to families;

(ii) Extensive knowledge about services and resources available to children and families in the community;

(iii) Experience facilitating service coordination meetings and collaborating with system partners; and

(iv) Experience facilitating crisis prevention and intervention services. REPLY: YES/Already changed—current "(a)" deleted

(b) A child and family team, as defined in these rules;

(c) **Service coordination** as specified in the **service coordination section of the ISSP**, to be developed by the child and family team; REPLY: YES/Changed

(d) Review of progress at child and family team meetings to occur at a frequency documented in the ISSP. REPLY: This language is intended to facilitate a more individualized approach.

(6) Intensive Treatment Services (ITS) for Children:

Comment [b57]: This badly needs clarification. Is the act of scheduling the interview to occur within 15 days with the actual interview session happening with no deadline OR is the interview to be scheduled so that it is actually conducted within 15 days of the order?

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Comment [b58]: This should be a separate bullet, (i-ii) would already generate updates to the ISSP and anything else requiring a major change should also require communication with the PSRB.

Comment [b59]: If a QMHA will be allowed to function as the care coordinator, minimum skills and experience should be in place. If the rule is changed to allow a QMHP only to function as the care coordinator, the minimum qualifications can be left out. The high visibility of clients and the diversity of system partners involved at this level of service creates added liability for the agency when underqualified staff are responsible for providing coordination.

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Comment [b60]: (c) How is "service coordination" distinct from "care coordination"? Care Coordination is defined while service coordination is not. If the terms are used interchangeably, consider using only "care coordination".

Comment [b61]: The "service coordination section of the ISSP" (or "care coordination section of the ISSP" if applicable) is not defined or required by these rules. This will need to be... [4]

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Comment [b62]: Consider defining minimum required frequency for child and family team meetings to occur.

(b) General staffing requirements: ITS providers will have the clinical leadership and sufficient QMHP, QMHA and other staff to meet the 24-hour, seven days per week treatment needs of children and will establish policies, procedures and contracts to assure:

(E) Individual, and group will be and family therapies provided by a QMHP. There will be no less than one family therapist available for each 12 children; REPLY: NO/ This is consistent with current requirements.

Comment [b63]: See deleted text, (E) and (C) contain redundant language.

(7) Program Specific Requirements for ITS Providers: In addition to the general requirements for all ITS providers listed in OAR 309-032-1540(6), the following program-specific requirements will be met:

(b) Secure Inpatient Programs for Children up to age 14 (SCIP) and young adults under the age of 21 (SAIP): In addition to the requirements for Psychiatric Residential Treatment Facilities listed in (a) above, programs providing SCIP and SAIP Services will establish policies and practices to meet the following:

(A) The staffing model will allow for the child's frequent contact with the child psychiatrist a minimum of one hour per week and psychiatric nursing staff 24 hours per day;

(B) A psychologist, psychiatric social worker, rehabilitation therapist and staff with specialized training in SCIP or SAIP will be available 24 hours per day; REPLY: NO/Not a comment

Comment [n64]: Remove extra space

Comment [b65]: See deletion, wording is awkward and may not be applicable to every case as worded. Consider changing to "and related behavioral challenges"

Comment [b66]: Current wording is awkward. Consider revision of language as noted within (c).

Comment [b67]: (e) "and articulates a rationale consistent with the philosophies supported by the Division, including the Division's Trauma-informed Services Policy;" These elements seem changeable and may be difficult for an agency to represent comprehensively. Consider removing this language.

Comment [n68]: Consider adding he descriptor "legal" to avoid potential confusion between the legal guardian and the custodian.

(8) Behavior Support Services: Behavior support services will be proactive, recovery-oriented, individualized, and designed to facilitate positive alternatives to challenging behavior, as well as to assist the individual in developing adaptive and functional living skills. When behavior support services are required in the ISSP, providers will:

(a) Take into consideration the neurodevelopmental challenges of the individual and related behavioral challenges; and not address negative behavior as volitional in nature; REPLY: YES/Changed

(c) Document the behavior support strategies and measures for tracking progress as a within the behavior support plan in section of the ISSP; NO/Want current

(e) Establish a framework which assures individualized positive behavior support practices throughout the program; and articulates a rationale consistent with the philosophies supported by the Division, including the Division's Trauma-informed Services Policy; REPLY: NO/Want "trauma" language

(f) Obtain informed consent from the parent or legal guardian, when as applicable, in the use of behavior support strategies and communicate both verbally and in writing the information to the individual and guardian in the individual's primary language and in a developmentally appropriate manner; REPLY: NO/Keep current

Comment [b69]: (f) Consider replacing "when" with "as" in relationship to who would sign the consent (parent or legal guardian). The preamble following (8) states that these requirements apply, "When behavior support services are required in the ISSP." When behavior support services are required, a consent for these services would also be required. "When applicable," implies that consent *may* not be required. (Alternatively, consider removing "parent or" and "when applicable" as the consent can only be signed by the legal guardian whether this person is a parent or another person.)

(g) For ITS services: Establish outcome-based tracking methods reflecting behavior support strategies that reduce the use of seclusion, restraint or time-out and increase desired behaviors; REPLY: NO/Covered in definition
(i) Require staff to receive training specific to the individual support strategies to be implemented; REPLY: YES/Grammar

Comment [b70]: (g) "seclusion, restraint or time-out services" are not allowed in ICTS level services thus a qualifier "For ITS services" should be included at the start of (g). Another option would be to replace, "the use of seclusion, restraint or time-out services" with "maladaptive behaviors" if the division desires that ICTS providers also develop outcome-based tracking methods.

(9) Emergency Safety Interventions in ITS Programs: Providers of ITS services will:
(f) Providers will meet the following general conditions of personal restraint and seclusion:

(G) If incidents of personal restraint or seclusion used with an individual cumulatively exceed five interventions over a period of five days, or a single episode of one hour within 24 hours, the psychiatrist, or designee, will convene by phone or in person individuals in the program with designated clinical leadership responsibilities to:

(iiiiv) Discuss the outcome of the intervention including any injuries that may have resulted and REPLY: NO/See section title

Comment [b71]: Formatting problem

(iv) Review the child's ISSP, making the necessary revisions, and document the discussion and any resulting changes to the child's ISSP in the Individual Service Record.

(h) Seclusion: Providers must be approved by the Divison for the use of seclusion.
(F) Each incident of seclusion will be documented in the child's individual service record. The documentation will include:

(i) *Any room specifically designated for the use of seclusion or timeout will be approved by the Division. If the use of seclusion occurs in a room with a locking door, the program will be authorized by the Division for this purpose and will meet the following requirements: REPLY: NO/Not a comment*

Comment [b72]: Formatting problem, indent removed

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Comment [b73]: This culturally specific/target population sections seem very valuable. Consider including these requirements in relationship to mental health services.

(12) Alcohol and Other Drug Treatment and Recovery Services:

(b) Culturally Specific Services: Programs approved and designated as culturally specific programs will meet the following criteria: REPLY: NO/Not at this time

Comment [b74]: How is the date of service conclusion established? Is this based on the date that the agency decides the chart is closed or the date of last service contact? Once the decision is made to close the chart, the provider should only need 30 days to complete the service conclusion summary regardless of the reason for discharge. The original 15 day additional time period for unplanned discharges was allowed in order to give providers time to re-engage the client. If we are now starting the clock once "the determination documenting that the individual is not likely to return in the event of unplanned service conclusion" has been made, no extra time to complete paperwork should be needed. Consider the language, "(c) Complete a Service Conclusion Summary within 30 calendar days following the documented date of the determination to conclude services."

309-032-1550

Service Conclusion, Transfer, and Continuity of Care

(2) Service Conclusion Process: Prior to service conclusion, providers will:

(c) Complete a Service Conclusion Summary within 30 calendar days following the documented date of the determination to conclude services Complete a Service Conclusion Summary within 30 calendar days following a planned service conclusion and within 45 calendar days following the date of the determination documenting that the individual is not likely to return in the event of unplanned service conclusion; REPLY: NO/Section already changed

(d) When services are concluded due to the absence of the individual, the provider will document outreach efforts made to locate or contact and re-engage the individual, or document the reason why such efforts were not made; REPLY: YES/Changed

Comment [b75]: Consider adding this expectation. Providers should be expected to make efforts to re-engage the client in care, not just to contact them. Only requiring contact will allow providers to merely let the consumer know that they will be disenrolled from care without actually attempting to re-engage the client in treatment.

(3) **Service Conclusion Summary:** The service conclusion summary will contain information sufficient to promote continuity of care including:

(b) A summary statement that describes the effectiveness of services in assisting the individual and his or her family to achieve desired outcomes identified in the ISSP; REPLY: YES/ Changed “desired” to “intended.”

Comment [b76]: Once again, these desired outcomes need to be a required documentation element as part of the ISSP or (b) will not be able to occur.

(e) DSM 5-axis diagnosis at discharge REPLY: NO/Not required for A&D; MH should already have updated

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(f) Recommendations for further treatment or community supports REPLY: NO/ Original language is consistent with focus on recovery.

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Comment [b77]: Consider adding (e) and (f). Discharge summaries are often forwarded to subsequent providers and this information is essential in avoiding starting from scratch with the client. This information is also useful if the client returns to care as the Service Conclusion Summary is the most current document at the time of discharge.

309-032-1565

Variances

(2) Application for a Variance:

(d) Variance requests will contain the following:

(F) If required by the division, a plan and timetable for compliance with the section of the rule for which the variance applies. REPLY: YES/ “If required by the division” has been removed.

Comment [n78]: This is a required part of the variance request. How will an applicant know when this portion of the application is required?

Charles Lame Crow Comments:

One of the most commonly asked questions during GOBHI's Encounter Data Trainings relates to the issue of "annual assessment updates". I have tended to argue that the rules are quite clear that:

1. Each assessment and assessment update should be a stand-alone document that meets all established requirements for assessments;
2. All assessments should be updated as new information relevant to understanding the client's treatment needs is presented or uncovered or as the client's diagnoses change;
3. The requirement that the assessment be updated at least yearly implies that no assessment or assessment update authored more than 12 months in the past is valid (i.e., that the clock for the required annual update is reset, not by the date of the client's enrollment, but by the date of the last assessment or assessment update; and
4. After one or more continuous year of treatment, assessment updates must be reviewed and approved by an LMP. I have also argued that there is no requirement that the client receive an assessment once a year, only that the assessment be updated to reflect the client's current condition and to include important information gleaned during previous treatment sessions. In other words, since, in most cases, the clinician has already billed for the time required to gather the information (previous treatment sessions), the assessment update is a non-billable paperwork task and does not

necessarily involve scheduling the client for a new (and perhaps wastefully expensive) assessment procedure. The Integrated Services and Supports Rule, however, appears to imply that the client must actually receive a formal reassessment annually, regardless of the date of the last assessment update. In addition to periodic assessment updates, any individual continuing to receive mental health services for one or more continuous years, will receive an annual assessment by a QMHP, that has documented approval by an LMP. [309-032-1525(3)(g)].

Two questions:

1. Have I been providing an incorrect interpretation of OAR requirements related to timelines for updating assessments? NOTE: *FORMER* 309-016-0080(3) begins with: "Conduct a complete Comprehensive Mental Health Assessment for all clients receiving continual rehabilitative mental health services for more than one year from date of enrollment

2. Is it the intent of the new rule that a new assessment must be conducted annually on or around the anniversary of the client's enrollment in treatment? NOTE: 309-032-1525(3) states : "(g) In addition to periodic assessment updates, any individual continuing to receive mental health services for one or more continuous years, will receive an annual assessment by a QMHP, that has documented approval by an LMP.

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Erica Fuller Comments (summarized): Ms. Fuller submitted a document outlining the Rimrock Trails policy and procedure regarding MRSA (*methicillin-resistant Staphylococcus aureus*); they also included information for their employees. REPLY: Not appropriate for the rule; should be included in general medical policies.

Oral comments:

The following persons or organizations provided the oral comments transcribed below.

Medford Hearing:

The first commenter was Maureen Graham (Jackson County Mental Health): Maureen Graham (Jackson County Mental Health) Comments—A new "Qualified Mental Health Professional *Intern*" staff designation should be considered; the Oregon Association of Community Mental Health Programs has suggested rule language for this. REPLY: NO/this definition must align with the current State Plan

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She also commented that under the ISSR # 309-032-1540(2)(d)(F) that the rule should require contact with the individual within one day of *notification* that the individual has

been admitted, rather than one day of *entry*. REPLY: NO/ Outpatient program staff providing case management services to individuals admitted to residential care or hospitalization should be notified prior to the date of entry.

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The second commenter was Bob Lieberman (Executive Director of Southern Oregon Adolescent Study and Tx Center): I also am involved in the Children’s system through the Oregon Alliance of Children’s Programs and Children’s MH system in general. In that regard, I am reflecting some of the concerns that have been thus far informally discussed and I don’t have the exact citation for all of my comments but I can point to parts of the rule or take a moment to look them up I thought I would have more time.

The primary main category of comments have to do with Emergency Safety Interventions and focusing on time out so in a couple of definitions number **39 and 130** I do have those citations, **Time Out is defined as an emergency safety intervention in those two places** and there is a few problems there. One is that later on in the rule the internal coherence problem when restraint and seclusion which are currently defined as emergency safety interventions are described with no reference to time out so the rule is inconsistent in that but I am not really asking that the rule be made consistent. **I am asking that time out not be considered in Emergency Safety Intervention.** Emergency Safety Intervention by federal law, Medicaid regulations, as well as existing state rule are reserved for those moments when it is truly an emergency, where there is an immediate, palpable harm to self or others that is very likely to occur in the estimation not only of the immediate staff but also of someone who is authorizing the intervention which in Oregon is a licensed Child Emergency Safety Intervention Specialist. Or a physician. **So the definition of immediate means someone will get hurt right now if this restraint or seclusion does not occur to stop this event.** If a baseball bat is coming to someone's head, we need to stop that baseball bat from landing on someone's head, something is being thrown at somebody, it's defined as a very imminent situation. **Time out doesn't really meet that threshold as commonly used in residential treatment facilities, PRTE, and day treatment milieus or in people's homes.** So time out is something that occur for example there is a child lying in the middle of the floor in the living room in the middle of the group and the child is 11 years old, flailing his legs and arms furiously and he’s swearing with a stream of expletives and vulgarities with names of body parts many of us have never heard before but we know what body parts he’s talking about expressed with the F word, the S word, the B word, the A word, you name the words and it’s a string of vulgarities, now there is not an immediate danger to self or others from these vulgarities and **so the rest of the youth are getting very anxious and upset about the vulgarities and now they are also starting to use vulgarities and the whole place is in danger of something happening because we well know when this happens it could occur that some youth will completely fall apart and a chair will coming towards someone’s head or**

through a window. This is a very unsafe moment. We don't want that to happen. That's the kind of moment when we want to be able to use time-out and not have it be considered at the same threshold of Emergency Safety Intervention. So we have a threshold of an Emergency Safety Intervention that is imminent risk to self or others which no argument about that threshold. It was established in the state about 10 years ago last time we did this rule. Now we are saying that the earlier interventions such as time out and obviously we would like to use time-out before the scenario I just described. An earlier intervention such as time out now reaches the same threshold which means if Gary at the end of the table begins to start swearing at me and we are sitting having dinner and thinking that we don't want to see plates fly across the room or people mad at Gary for swearing and **we ask Gary to take a time-out, in order to do that according to the rules we would have to go get someone to authorize that time-out which is an Emergency Safety Intervention.** And then there will be 77 items of documentation that we have to complete every time we use a time-out. Which is a proactive preventative kind of intervention, so for those reasons **I have been told that time out finding its way in as ESI is an error in these rules.** It was one those pieces that go in as all of the various pieces were being integrated into one integrated rule and I am hoping that is the case. I've also been advised two ways by division staff, one is to write something and get all the providers to sign off on it, and the other is to not go through all that time and effort and raise that kind of stuff because this is anomaly and it's a mistake because putting time out at that threshold would basically be an administrative burden of unbelievable proportions to fill out all that paperwork and it would be a clinical burden because we are basically saying to the staff you have no intervention that you can use in a group setting without it being considered as an ESI and then the definition of ESI is no longer imminent threat to others it is something that's disturbing us and we don't want ESI to be defined as something that just is disturbing us because Gary down here at the end of the table is upset and he decides to swear at Kim and Rita and now we have a whole thing going. We don't want to define that as imminent danger, we want to define that as something to intervene with the best we can. All of those events, every time out if this goes through every time out in every ITS program would be reported to the state. So we are talking about a volume of paperwork that is staggering, that would have to be filled out at the line level and from my point of view it does not hit the fiscal impact trading off some reduction nothing in the kids world actually does, in the adult world, I think it does. Because the kids world kept all the paperwork but it doesn't hit the fiscal impact because the fiscal impact of having to report all that would be staggering. The fiscal impact to the state of having to review every time-out would be staggering. **REPLY: YES/"Time out" has been removed from the definition.**

Closely related to that-just a comment-documenting timeouts of more than 15 minutes I wouldn't argue with some kind of documentation of more than 15 because that tends to become an isolation. **So the requirement now, the existing requirement before this**

rule moving on is that reportable incidents get reported to the state within 24 hours and there is a very specific definition with a very detailed clarification that Justin Hopkins put out a couple years ago, the new requirement of this rule is that emergency safety interventions also be reported within 24 hours. I am aware that other states have this requirement. I am not aware of the research on this particular nuance but I am not aware that the states that have the requirement are saying they are experiencing a great reduction of seclusion and restraint because of the requirement. I am not sure the requirement itself leads to reduction of seclusion and restraint. **I think it might because it's basically a disincentive to use seclusion and restraint. Everyone has to be reported.** It's a disincentive. Sometimes seclusion and restraints needed and staff is afraid to use it especially restraint. But obviously I would agree that we need to be reducing it as much as humanly possible. **There is awful lot of cost and paperwork both at the organization level, the provider level, and at the state level for reporting every single ESI. So I would request that that be looked at carefully.** **Does the state have the wherewithal to review every ESI.** I am aware of a reportable that we sent in 3 weeks ago. It had not reached the top of the pile of the state person reviewing it because he said he had a big stack, he had to rifle through the pile to find a legitimate reportable according to the current rules where there was ...this one had to with a hospital visit after a bike accident. **So I think the request here is that the state look carefully at what's the trade off between getting staff organizations to report every single restraint or seclusion to the state and the state having to review all that as opposed to the current system where we report an aggregate and the state reviews it aggregate quarterly.** I am not sure of the cost benefits there. It's a cost benefit issue because we are under funded system. We could system by the cost study that was approved by AMH by Dale Jarvis as funded .60 cents on the dollar across the whole system including out-patients, so whether or not that's value added its worth a careful look. **REPLY: Quarterly reporting has been added into the emergency safety procedures section. The definition of "reportable incident" has been changed to specify the severity of the incidents that require 24-hour reporting to the Division (see below for new definition).**

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309-032-1190

Special Treatment Procedures

(1) Providers shall have policies and procedures and a quality management system to:

(c) Report the number of seclusions, the number of restraints, and the total number of patient days to the Division within 30 days of the end of each calendar quarter.

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The definition of reportable and **I will refer to this definition number 113**-It's the last one **I have a citation for-Definition of reportable incident basically says including but not limited to a list of things: Injury, illness, act of physical aggression, risk to health and safety. These are kind of vague.** So what level of physical aggression again working with children there is often pushes and shoves that happen on the basketball

court, the baseball field or in the living room that we might treat as an act of physical aggression. Does that require a lengthy incident report and a review by the state. **The request here is that be probably clarified in rule rather than have it come out and have us wait for the next clarification coming from the staff. That those are vague terms and physical aggression some people call a push or shove as an assault when I consider it a shove. So I think that is an area that would need to be clarified.**

REPLY: YES/ The definition of “reportable incident” has been changed as follows:

“Reportable incident” means a serious incident involving an individual in an ITS program, that must be reported in writing to the Division within 24 hours of the incident, including, but not limited to, serious injury or illness, act of physical aggression that results in injury, suspected abuse or neglect, involvement of law enforcement or emergency services, or any other serious incident that presents a risk to health and safety.

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There is many requirements regarding transfer of youth or clients-Do all of these requirements apply when the transfer is between levels of care with the same provider? There are some very specific requirements about transfer from one organization to another. It would appear in the writing of the rule. **Do they also apply when they transfer within the same provider agency and I would ask that when looking at that that there be consideration given to the fact that within the same provider agency it can be the same doctor, same clinical director, same therapist, depending on how the agency is organized. Some of the requirements of transfer may be duplicative functions.** REPLY: NO/This is a data-system issue

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The training requirement requires all the required training activities happen within 30 days. I have no conceptual argument with that, neither does my staff, **in the real world that is very hard to accomplish.** Basically if we are prohibited from putting people on line until these are completed and completed within 30 days, **there is a very significant cost** especially in the kids world where workers are paid typically \$10 per hour to work on line, they turn over rapidly **so some flexibility in the requirements that perhaps an organization have a training plan that guarantees that some start-up of new staff with-in a certain amount of time.** Currently we do ours within a 10 week time frame. And we have it structured so we can rotate existing staff back through initial training if they need a touch up. Not that that would be the rule, but 30 days is going to be a costly requirement in a system that is under funded right now to get that all done. Look at carefully. Is that the best use of the limited resource? REPLY: NO/This is considered to be "core" training necessary to provide services

Comment-about the individualized services and support plan-the ISSP-As I read through that, again I apologize for not having the citation, **the service coordination portion of that-How are services being coordinated.** I thought it had the required

elements on the treatment planning but the service coordination, how we coordinating multiple entities, that wasn't clear. **So the request here is to look at that again and see especially, I don't know the adult world well enough to say this but in the children's world children are often as everybody knows in multiple systems. And the importance of coordinating those multiple systems surrounding the children is really critical. So the service coordination plan I think is a main piece that came in with the ICTS level of care and it didn't jump out of the ISSP requirements.** That section would need to be looked at. REPLY: YES/Definition and requirement in the ISSP section have both been changed to reflect this

Next item is **the requirement that there be a medical director.** SOASTC was my organization for which I worked. We had a medical director for years and years. We were first conserving organization to use that title. But we moved away from the title. I think conceptually it is not a bad idea, however, **what that really connotes in terms of the requirement to have a medical director on staff.** I think it connotes more cost for the psychiatrist who would be the medical director. Having the title may put them in the position that they have to be paid more to have that responsibility. **Medical Director is a term that is used in clinical organizations and hospitals when there are a number of doctors working in the hospital and the medical directors function is to help coordinate the overall medical care.** Many provider organizations are small and are lucky to have one doctor, especially in the children's world and so medical director functionally it is hard to know what that really means. **Making it a requirement that we have a medical director is running a risk of driving up costs and creating some arenas of confusion.** Most positions would think about medical director in the terms of a hospital, whereas most of our organizations are not in fact hospitals or operate as hospitals. **The request would be that that requirement be eliminated. In its place have requirements be the active physician directives support if not eliminated, then looked at real carefully.** What does this mean, how does it play out in the really small rural organizations in the state or when the organization is not large enough to have more than one physician on staff. REPLY: There is not a specific requirement for a "medical director" in ITS programs. The definition has been changed to clarify that this is only for Alcohol and Other Drug Treatment Programs.

I am going back to the emergency safety interventions. There is a lack of clarity in the language of the rule about how many staff have to be physically present during one of these interventions. We have gotten clarification from the regulators on the kid's side, Justin and others. **It reads as if maybe it requires 3 staff to be present, physically present during an intervention.** I would love to be able to do that but there is no way on earth that the funding supports that. **The funding really doesn't adequately support having 2 staff during an intervention** which is what we require even though that is not technically physically required in the rule. **So some clarification there, what does that really mean? How many staff have to be physically present**

during an intervention? Then *the other request would be in the current resource environment to leave it at 2* with all the other authorizations and permissions and approvals and debriefs and analysis of the event in place as a safety net for right now, In a better resource environment then I think 3 would be great to have available. But we can't support it right now. REPLY: NO/The rule requires that there be 2 people present during an emergency safety intervention.

Similarly related to resources, currently this is another item, **Hep B is a nice to have, not required having. In these new rules it is required to have which means if we have to require staff to do it we have to pay for it and those costs aren't contemplated in our rates.** This consideration and I feel funny saying something about Hep B, in my organization it is a lot different than it would be in Rita's organization for example. I feel funny about it but again I think in the children's world the fiscal analysis of this rule I think in broad terms is accurate but in the children's world, **the rule really doesn't reduce paperwork, it doesn't really reduce some of those requirement and it does, unless some of these provisions are changed, increase cost.** So if you take the kids piece separately, I don't think the fiscal analysis is a wash because all the reporting and paperwork requirements are there or even heightened in the rule as written. **So I had to raise the Hep B thing because it is an additional cost and were woefully underfunded right now.** REPLY: No/ Hepatitis B screening for staff is required of all providers in residential settings. This is also an OSHA requirement.

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The third commenter was Ann Ford: Back on 309-032-1555 which is the quality assessment and performance improvement plan. **I would like to see added some indication that the critical incident reports go through the MHO for quality improvement process first, prior to going to the state.** It would be wording in there AMH the local MHO is involved in those incidents. REPLY: NO/This is between the MHO & the provider

The next part I wanted to talk about was 309-032-1525-looking at the assessment piece. **Number 3b.** If an assessment is not completed at entry provisional assessment as defined in these rules, will document if the services are continued, the assessment completed within time frame that reflects a level of complexity and services to be provided. **My concern with that is dropping the time frames from those requirements, for assessments, treatment plans, leaves it up to the various MHO's In that there could be room for misinterpretation or different interpretations from one MHO to the next.** So you could have two MHO's doing totally different things across the state which does lead to questions to quality. How can we as a state we have quality care if were doing different things across the state? My hope would be that we move toward an integrated system state wide. That is a large hope, I understand that but **if we drop all the time frames were dropping that further.** REPLY: NO/ Flexibility in timelines will promote individualized services, allowing providers to adjust services

as appropriate for more or less complexity. ITS providers are still required to review progress every 30 days, as per CFR.

Also **the Reportable critical incidents, the definitions I agree are vague.** They leave a lot of room for interpretation so **I would ask that those be defined further as to what a report is and what a critical incident is.** And I said before who those get reported to and the time frames. REPLY: Reportable incident has been redefined.

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The fourth commenter was Kim Miller: *Just the indigent piece.* There was a concern that it might lock people out. The concern is that folks who are defined as indigent without healthcare that need food stamps have a substantial portion of these clients meet income standards **but don't have public funding and the services are paid through source element 66 which is very ? The concern was that could block folks from accessing treatment.** Section is definition 127 REPLY: YES/"Fee agreement" added

Bend Hearing:

The first (only) commenter was Jeff Emrick: "...required for Medicaid recipients because of a lot the providers when its sided into rules when you provide the OAR references I don't think providers are going to pay much attention to that and so they are going to fall short on the process. So my thought would be its going to be a little painful at first but **lets just go ahead and have all the pain up front and have the standard be a little more stringent around that so that everybody is on the same page.** And I think that was my only concern because then you don't have AMH is coming out and their doing a recredentialing audit of the provider based on a minimal standard that they have but the bulk of the providers business is Medicaid stuff and so they are not looking at that. Then when I come out and say well, **what was good for AMH is not good enough for Medicaid,** I get the glare over from providers, AMH said it was fine well, its not really. This is a pretty big deal in my world. REPLY: NO/ These rules & the revised "Medicaid Payment" 309-016 rules, when considered together meet the need described in the comment.

Pendleton Hearing:

The first (only) commenter was Matt Bergstrom: Matt Bergstrom (Facility Administrator for Community Counseling Solutions-Morrow County) Comments—A

few things that the AOCMHP wanted me to bring to your attention the definition of 127 successful DUI completion. We strongly encourage you to delete the? **Indigent from the definition based upon just holding people accountable. If you do not require these people to pay their fees for completing the DUI programs, its enabling them.** Also its another way to help fund under funded programs requiring these individuals to participate in these programs and pay the fee if they are able to. It would help fund these programs. REPLY: YES/"Fee agreement" added

Also, we would like to **look at the definition of the QMHP. We would like to address interns in small communities. We have interns that practice.** Our agency has 2-3 a year in an office. At Heppner we have 1 individual clinician. When you have an intern that doubles besides that we can manage. **We would like to see a section labeled G added: an intern in an accredited graduate program, in a behavioral science program operating under a formal agreement between a graduate program and the certified providers and under the provisions of the QMHP, and who has worked two or more years in a post graduate experience. Competencies and qualifications of an intern will be documented and subject for review and work under the approval of the local program.** REPLY: NO/The definition must align with the state plan

Salem Hearing:

The first commenter was Don Langenberg: Don Langenberg: Director of Pacific Ridge Residential Alcohol and Drug Treatment Center and Pacific Recovery Outpatient Treatment Center) Comments—I am the one mentioned that was not on the list-so I want it to be on public record. I was on the list for a number of years. I have been a provider for as long as anyone. And made it just about every hearing even though I sometimes question because the reason I do this because not a lot happens, too my testimony so I am going to bring up some of the old things that have been brought up in the past and maybe some new things. The difficulty I have besides lack of knowing that these rules were being changed until late last week was that when I did get the rules I haven't read every word so I am going to be quite scattered around this. **It is hard for me to understand and read all the new acronyms.** And I recall the state sending out memos to us saying **we need to use a minimum of 14 point font for clients** and now that I have gotten older you see me with glasses. I had troubles reading, and trying to understand the acronyms was quite puzzling. It was talking about integrated the rule **to make this look like a combined rule than an integrated rule.** The one you just passed today is shorter than the one I got **but 55 pages seems absolutely overwhelming.** –I was one two people that voted against it when they voted to **DUII's need a minimum of 90 days of treatment. And I want it noted again that I am still against that** we use ? Asam criteria for all clients for placement continued stay and discharge except for DUII's. **And the comments that were made in the room about making the**

amendment 90 days was all based on financial needs of providers and had nothing to do with quality of care and since I thought this is what the rules are to be about. I don't see it as being fair. While were on ? Asam criteria for alcohol and drug, we have been using that for a number of years here in Oregon. **We know some of the best practices that are being noted by the state, instead of being client driven like the Asam criteria, their program driven, and they say that they are getting better results than the treatment was useful which would be the Asam driven criteria, and I think those sections need to be looked at. It's OK to not always make everything client driven if there is best practices out there that's program driven that would be giving good quality of care and better outcomes.** REPLY: NO/Not a comment

Another thing I have some difficulties with and has been brought up multiple times in the past **is putting in contract issues like with the Feds and such with their money that don't necessarily impact everyone or the state may want that issue with their contract fees and so instead of putting it in contracts they put it in OAR's**. And the reasoning I was given in the past is the DOJ says it's the easiest way to hold people in compliance. But I have never seen that as the purpose of the rules and I know I am not the only provider who sees it that way and there have been some interesting discussions in this building regarding that but nothing is ever done differently. **The rules keep getting bigger, like I said 55 pages when we really don't need that.** Last time we were dealing with Administrative Rules, **it was discussed and realized that some of the things like having periodic reviews of staff to be something that agencies can handle by themselves. They don't need a rule about it and have site reviews to see if they reviewed people x number of days.** Particularly, when we have so many other agencies taking a look at each facility. For Pacific Ridge, **we have the health department, because we have a well, we have another agency coming in, we have the bureau of labor. We have so many different agencies, and these rules seem to so frequently start covering areas that are already covered by other agencies such as, like I said, do we really need to be adding all this extra to it like I need to make a work plan for my staff and do it on a regular basis. I don't think so. I think it's a little too descriptive and not necessary.** REPLY: NO/Not a comment

I saw something else in the language about a mission statement, and **I think mission statements are frequently used by non-profits, but most certainly not a requirement of a for-profit agency.** I'll admit right now, we don't have a mission statement. **If these rules are passed as written we will have to have a mission statement. I think that should be completely taken out.** REPLY: YES/Reference to "mission statement" removed

We see in here some talk about the Americans with Disabilities Act regarding compliance with the different types of agencies based on their funding. Once again,

to me that is a contractual thing. It doesn't really need to be in there and then when we have people coming in to review us, I was wondering where do they get their training. Do they have specialists on ADA? Especially since every reviewer has a different idea of what it is. REPLY: AMH requires policies pertaining to compliance with the ADA for both CFR compliance and to address any complaints related to requirements in the ADA.

I saw on **definition 132 about trauma informed services.** I read that about 5 or 6 times and **I can't make sense of it.** If it is going to be in the rule which is something new, I would like to be able to make sense out of it so I can make the correct policies and procedures. There is an idea I have had for years and **were supposed to be providing consent to treatment and these rules are writing more information about consent to treatment with the risks and benefits as such to treatment** and I became even more aware of it because I recently did a peer review of another program and I saw their consent to treatment and it hit me with an idea that **I would really like to see the State of Oregon give us their written definitions of the risk and benefits for each level of care and types of treatment.** REPLY: NO/Not in rules

I know I have went on the internet and searched for consent to treatment and risk and benefits and ended up being confused and not very helpful and if were going to be having those definitions in these documents, **I think it would be great to have a consistent statement from our licensing agency since we have more than one thing.** There was a thing about **a written agreement to do supervision for clinical supervision** and that kind of puzzled me. **I wasn't quite sure what that meant because yes we do supervision but we need to get written permission for our staff to do clinical supervision?** NO/No requirement to get permission from staff. The requirement is to have either a job description, a contract, or other form of binding agreement between the provider and the person providing clinical supervision that specifies the responsibilities of the clinical supervisor.

I saw where **we had to do personal inventory of all the belongings of our residents who come in and when they leave.** I can see that for maybe a child program, but these are adults. And most of our residential treatment centers I think are adults and **most of the people should be able to take responsibility for self.** REPLY: YES/Change made

There are some observations I have made over the past few years and one is that **the rule in here about no nicotine use in out-patient alcohol and drug treatment programs and any residential and for out-patient none on their property.** I live in Corvallis, so I drive through Salem, through Albany, to home. And almost every day I will see groups of patients outside smoking. **And I don't know how to clear it but I as providers, we are here to not only treat but have a safe protective place for our patients and when they are right outside the door with the name of the program on**

the sign. Everyone who is driving by identify these as being their patients, there is something wrong. **And that maybe that is something to be looked**. REPLY: NO/Not the role of these rules

Another thing that has really bothered me over the years has to do with **funding**. In the past I used to talk about **public programs supporting private insurers because insurance was run out and people go to the public programs for continued treatment. To me this becomes even worse**. Many of the private providers are paying less than the public reimbursement rates like OHP, Medicaid etc. for services. I even thought that was, I may be wrong, that **you can't charge the federal government more money than you charge other people like private insurers**. It is going on constantly through the state. **This made it difficult for the private provider like me who only gets client fees and private insurance to stay in business and it once again shows the public providers are supporting the private insurance**. REPLY: This is not an issue that is addressed in the ISSR.

Another thing I have seen, I have always thought **these administrative rules are here to protect the health, safety, and welfare of our clients and to provide quality care. It says in these rules that we won't be working our clients but then again there is bartering I am seeing all the time which I always wonder about ethics**. There is clients been put on fee day newspaper ads, whatever, to raise money. And then there are fundraisers like these car washes sponsored by so and so program to raise money. And **there is something really wrong with that system. Just like there is something wrong with clients having to give up their food stamps to pay for their treatment**. REPLY: Prevention of unethical treatment of individuals is addressed both in the "Individual Rights" section and in the definition of "abuse."

We got notification from the state office about **only using labs that are for urinalysis testing that are certified based on some OAR rule I can't remember what**. I think it's in here. **I think needs to be clarified because it said the way I read it I couldn't be using saliva testing**, I couldn't be using urine testing for example in my own program unless I got licensed as a lab. But it is a consistent thing that is happening in programs even though I think that note went out that programs are doing their own lab testing and the program directors are thinking they are in compliance because that means only when you want to nail someone, it doesn't mean the screening. **The screening is fine to use those store bought kits, then it should say so, if it isn't, it should say so**. I just would like to see that clarified in the rule. REPLY: NO/Urinalysis is the current standard, & other rules apply

NOTE: At the end of the Salem public hearing Mr. Langenberg asked to submit this comment, as well: I want to state one more thing- under the rules, **medical directors need to be licensed physicians and if you look at least in alcohol and drug**

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outpatient, I know that it would be a relief and a benefit to many programs if nurse practitioners could be the medical director. It's not like they are doing surgery in alcohol and drug and so it falls in the scope of what the rules want for a nurse practitioner to do the tasks that are required. REPLY: NO/Good idea, but AMH doesn't want to get ahead of progress on this

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The second commenter was Drew McWilliams (Morrison Child and Family Services- primarily in Multnomah County but also in Washington County and throughout the state): NOTE: These are comments repeated from Morrison's written comments, & are addressed on pages 6 & 7 of this report

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The third commenter was Kristine Britton: NOTE: She referred me to her written comments

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The fourth commenter was Joan Rice (Multnomah County Mental Health and Addictions): You already got a listing of the specific elements of the OAR's that Christine just read from our county's perspective on recommendations for changes. **But I wanted to make sure that I was able to give some testimony on two other really important areas. One is that I would like to request that this rule is not approved and implemented without actually having repeal of rules-the record contradict this rule such as ? there are sections of the 309-016 series that could alone for payment services. I would ask that all other portions of the rule that pertain to that we said are covered under the documentation here, are repealed.** REPLY: NO/309-016 also being revised

Rick stated the 016 rules are being revised.

So, am I hearing you correctly, in that **the temp rule will be filed in a time frame that wouldn't have us following a less restricted rule than the 016 rule? The temp would be filed at the same time?** REPLY: NO/309-016 also being revised

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Rick said yes.

Rules that govern what the counties responsibilities are for recommending certification into programs. Reviewed and clarified with the counties so that once these rules are filed, that the county MH authorities including MH programs will have a clear direction on how to actually conduct and certify people whose certificates of approval will be expiring at that time. Currently the 309-014 series don't explain how we actually conduct an audit under the current rule. I think that needs to be clarified. It appears it would be fairly simple that a county whether you are

going to a psych visit-look at the ? REPLY: NO/The 309-014 rules will be revised separately

The final section-We have well over 400 treatment beds in Multnomah County and I think **we are concerned on some of the language differences in the Residential Treatment Rules in the 035 series and this series and would like to make sure when this rule is implemented there are some areas that can be misleading for programs that are doing residential treatment services.** REPLY: NO/ Adult Mental Health Residential Services are not addressed in the ISSR.

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If the 14 series governing how the counties are doing their responsibilities and certifying programs, I think that they don't really have anything. The 14 series rules, maybe do some sort of memo to all the counties at the same time with clarification how we would conduct business when the week after the rule comes out were scheduled to do some auditing. What are the expectations for the timing of when a county moves to a new rule and are we looking at the old rule compliance on all performance. That is the type of clarity that we need. REPLY: NO/The 309-014 rules will be revised separately.

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I wanted to make sure I brought up an issue that was brought up by representatives that have come to the input hearings from Multnomah County Health Department. I brought forth a request and I know that Joe Romco from one of our Mental Health Providers has brought up the request, and from Lifeworks Northwest to make sure that the rule is covered under some exception in an area of the rule or to add a specific element just as we have identified-Intensive treatment services, children's services, adult problem gambling. **You need to add another area for integrated healthcare services. These rules currently prohibit the billing of Medicaid services for mental health under the CPT codes because the documentation requirements go beyond the requirements of a primary care providers office.** The state has put forth legislative policy. **We have demonstration pilot projects to look at integrated mental health, alcohol and drug, and primary care services and these rules do not allowthey are set up so that the rules governing the documentation in a primary care office will notif they follow their standard documentation will not be able to bill for Medicaid services under this rule and there needs to be some sort of exception written.** REPLY: There is nothing in the CPT codes that precludes the delivery of mental health services in physical health care settings. The code to bill for a mental health service is the same whether the service is provided in a behavioral health care setting or a physical health care setting. The new documentation requirements in the ISSR are aligned with the Division of Medical Assistance Program (DMAP) general rules and the Medicaid payment rule is being revised to align with the ISSR, so providers should be able to bill for mental health services without having an additional documentation burden.

Rick- This sounds like this was all in the email that was written and sent in.

Yes, I am just making sure its here too.

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The fifth commenter was Mary Meacham: I am not affiliated with any organization here but I have had experience with regulations in my professional career so I am not affiliated at this point. My comments are in one area. Since I haven't lived and breathed with these rules, but I have lived and breathed similar rules. **The major area I am going to raise today is the one about synchronizing these rules and the emphasis in these rules with the materials in the Oregon Medicaid State Plan.** My understanding, and I may be wrong about this, is that **there is a document which I have pages from here, that outline what Oregon's Medicaid services need to have in them in order to meet the minimum federal requirements, so there are standard rules that the federal government has but what there is in a state like Oregon which has a waiver on a lot of those rules, there is then a document that outlines of plan of what the federal government has authorized or one of the minimum standards, so it says Oregon, this is a document that is shared between the federal government and Oregon that then lays out what Oregon must have minimally in its service regulation for plan in order to comply with CMS rules.** And there are a number of areas that I would like to point to but **I want to focus on is what the gentleman from the children's service talked about on page 34 is that the rules, although they are minimal in this state plan document, because they outline definitions of professionals, and they also talk about what an evaluation must contain, what a comprehensive treatment plan is and how often evaluations have to take place. While a lot of the language in here is contained in these proposed regulations, I think sometimes in the way these regulations are written it would be possible for a provider to miss the emphasis within the requirement, lets say of a ISSP that these rules may there are 10 things you have to have but the federal requirement emphasizes one or two of them. I think most providers would need to know which of the 10 things that a provider has to attend to in their policies and their practices...which of the ones the federal government is looking at.** My understanding is that, I am relatively new to Oregon so I may not understand everything, when the federal government does an audit of a state it looks for these requirements to be met and **if the state is what they call "silent" on a particular requirement that the federal government has, the federal government rule applies, if the state doesn't get a pass on it or if the state hasn't addressed it.** The one thing I would be most concerned about is if I could start going down the list of items. **I have 4 or 5 items that I think need more emphasis, more clarity, or just need to be flagged as requirements By the federal government and actually all I am saying is I would hope before these rules are finalized that somebody has a copy of these and says check check check, to make sure its there cause sometimes it's a matter of language**

and emphasis. So, I'm looking at a document that I printed out that says Oregon Medicaid State Plan, and it's on the DHS/health plan/tools/policies/state plan, if anybody wants this.

This state plan part 1, part 2, and part 3, actually there are 4 parts. **Part 3 says attachments regarding scope of services, quality assurance, and payment methodologies and so on. And if you go into those sections, there are sections that are headed medical social and psychological evaluations and then there is a whole thing about rehabilitative services, addiction services, addictions, mental health services so there are all flagged, and my understanding is that in Oregon the rules that are applied, what I am referencing are the rehabilitation rules.** Let me go through and show you what I have flagged. When you go into **part 3 it scrolls down to all the different services, all kinds of health services and so on and this is what you have to do.** Let me go through a bunch of the ones that I have noticed, a number of which are already in these rules. REPLY: NO/The ISSR is compliant with the Medicaid State Plan

Clinical supervision talks about.....it's really short. **These are 50 pages and the federal rules are like 3 so its quite a bit less and as I said I think the issue becomes more a matter of emphasis because it almost seems random that the federal government says you can do anything you want but you have to be sure and do this and this and this. Clinical supervision defined below-clinical supervisors provide documented clinical oversight at least every 3 months of the effectiveness of mental health treatment services delivered by qualified mental health associates and by qualified mental health professionals. I think that's pretty much here because in fact on page 30 it calls for supervision every 2 hours every month. So in fact these rules call for supervision more often but I am not entirely sure, it talks about including documentation of supervision.** A lot of places use logs and so on. That should be enough. **These regulations call for something more intensive than what is in here.** The other one is Licensed Medical Practitioner defined below-provide ongoing medical oversight, **LMP's document the medical necessity and appropriateness of services by approving comprehensive mental health assessments and individualized treatment plans at least annually. And I know that is kind of covered here but there is a question about whether that means after a person has been in service for a year or at the beginning of that time.** If you need that kind of sign off I think that there is a matter of emphasis that that's required. **There needs to be a sign off somewhere to make sure that that language is clear.** And some of this may need to be clarified with whoever wrote these rules cause this is something that Oregon took part in since 1985. **So if the federal government were coming in.....CMS were coming in to audit, how would they define this and would they be looking for sign offs by licensed medical practitioners at the beginning of service or is it only after they have been in service for a year. And do most providers understand that if a**

person has been in service for a year, is a sign off from the medical practitioner, not just the QMHP. Because in some cases it's an overlap _____? But after a year you need an LMP to do it. That's just a question, again I am not clear because I'm not intimately familiar with these rules. REPLY: NO/Assessment after one year continues

The next one has to do with Utilization Review. It says "MH rehab. Services include coordinated assessment therapy, daily structure, and medication management and so on. The mental health and developmental service division may provide these services in various settings. Each contract or sub contract provider or rehab services establish a quality assurance system and a utilization review process. Each contract or sub contract provider in conjunction with representative quality assurance committee writes a quality assurance plan to implement a continuous cycle of measurement, assessment, and improvement of clinical outcomes based upon input from service providers plans, families, and client representatives." So, in there it talks about utilization review and quality assurance systems which are on page 55. But I noticed the way this is written here that it just lists these, they are all there, it's not like stuff is missing here but on page 55. OK so it says "quality improvement committee has to meet quarterly to identify indicators of quality improving." Then it says "Utilization of services" I just think that there might be a little bit more integration with what it says here you need to have with again the wording in the federal requirements. I don't think this is clear enough that you need to have a utilization review system and need to be able to have that defined cause I think utilization review has to do with –does this person still need to be on the roles? And I think it's a matter of emphasis and maybe clarity. And whether or not anybody would be looking for an annual written report or do there only need to be a set of policies that providers adhere to. I think its unclear if you are reviewing an agency, do they just need to say this is stuff were doing or does there needs to be a report for the federal government. I doubt if they would want that.
REPLY: NO/Not a comment

Page 33-the ISSP that was on the plan. In these rules, a comprehensive treatment plan it talks about a periodic revision and treatment plan under the direction of a physician or licensed practitioner of the healing arts within the scope of which specifies the type and duration of treatment needed to remedy the defined physical or mental disorders." Again, I am not sure that summary is clear enough here. I think it's covered, but I'm not sure that if you started...if you were the federal government you starting with this, would you be sure and see this and mostly if I'm a provider and I want to make sure I am following these federal rules, does this give me enough guidance to know which parts of this are the ones I really should emphasize and can't budge on. Again, I think its just a matter of going through these, the plan, and making sure that these rules provide sufficient guidance to

providers so if they follow them they will at the same time also meet federal rules so if the state or providers are audited there would be a match between what they are expected to do and what the federal government is going to do. **The last thing I would say is that I would agree with the comments you made about the integrated projects of behavioral health, primary care and behavioral health** because I know from my own experience that **the primary care service sights follow very much a medical model and the health department rules and its like an entirely different animal than what goes on in behavioral health and to force a behavioral health organization to meet all the medical rules in order to provide behavioral health services** – integration, or maybe its simply a variance that says as these develop cause health care reform is very much talking about having a medical homes for seriously mental ill or having community mental health centers be able to provide the home base for its clients and get those services. I know **this has been a problem when same individual agencies try and provide integrated addictions and mental health services its usually a nightmare**. So **only compounded once you go in to the primary care, so I think probably rather than trying to predict exactly how the rules on health care reform will come around since you probably are not going to want to revise these rules soon**, again, that **having as you say a variance that says notwithstanding all these rules, there would be a consideration given to temporary or other rules necessary as a part of ? Or integrated primary care and behavioral health care services for behavioral health organizations acting as health care homes**.REPLY:
Not a comment. This is considered to be an observation, not a comment.

Conclusion of the public hearings:

The hearings all adjourned at 2:30 pm, except for the Salem hearing, which adjourned at 4:00 pm. The public comment period closed at 5:00 P.M. on October 30th, 2009.

Agency Response to Public Comments Received:

Responses to comments are at the end of each suggestion, using "track changes."

Please let me know if I can supply further information.

