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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Health Systems Division:
Mental Health Services

309

Agency and Division

Administrative Rules Chapter Number

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RULE CAPTION

Rules Revisions Chapter 309, Division 19 Required to Comply with the Oregon
Performance Plan

Not more than 15 words

RULEMAKING ACTION

ADOPT:

309-019-0151, 309-019-0152, 309-019-0226, 309-019-0241, 309-019-0242, 309-019-0270, 309-019-0275, 309-019-0280, 309-019-0285, 309-019-0290, 309-019-0295, 309-019-0300, 309-019-0305, 309-019-0310, 309-019-0315, 309-019-0320

AMEND:

309-019-0100, 309-019-0105, 309-019-0110, 309-019-0115, 309-019-0120, 309-019-0125, 309-019-0130, 309-019-0135, 309-019-0140, 309-019-0145, 309-019-0150, 309-019-0155, 309-019-0160, 309-019-0165, 309-019-0170, 309-019-0175, 309-019-0180, 309-019-0185, 309-019-0190, 309-019-0195, 309-019-0200, 309-019-0205, 309-019-0210, 309-019-0215, 309-019-0220, 309-019-0225, 309-019-0230, 309-019-0235, 309-019-0240, 309-019-0245, 309-019-0248, 309-019-0250, 309-019-0255

REPEAL:

309-019-0105 (T), 309-019-0110 (T), 309-019-0115 (T), 309-019-0120 (T), 309-019-0125 (T), 309-019-0130 (T), 309-019-0135 (T), 309-019-0140 (T), 309-019-0145 (T), 309-019-0150 (T), 309-019-0151 (T), 309-019-0152 (T), 309-019-0155 (T), 309-019-0160 (T), 309-019-0165 (T), 309-019-0175 (T), 309-019-0180 (T), 309-019-0185 (T), 309-019-0215 (T), 309-019-0225 (T), 309-019-0226 (T), 309-019-0230 (T), 309-019-0235 (T), 309-019-0240 (T), 309-019-0241 (T), 309-019-0242 (T), 309-019-0245 (T), 309-019-0248 (T), 309-019-0250 (T), 309-019-0270 (T), 309-019-0275 (T), 309-019-0280 (T), 309-019-0285 (T), 309-019-0290 (T), 309-019-0295 (T)

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 161.390, 413.042, 426.490 - 426.500, 430.256, 430.640, 443.450, 461.549

Other Auth.:

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.630, 430.640, 430.634, 430.644 - 430.646, 430.850 - 430.955, 443.400 - 443.460, 461.549, 743A.168, 813.010 - 813.052, 813.200 - 813.270

RULE SUMMARY

The Authority needs to amend these rules in o OAR 309 Division 019 in order to comply with the Oregon Performance Plan. The majority of the changes to OAR 309-019 were made to comply with Oregon Performance Plan for Individuals with Serious and Persistent Mental Illness with the United States Department of Justice. The Oregon Health Authority (OHA) has issued a Plan to improve mental health services for adults with serious and persistent mental illness (SPMI). This Plan is referred to as the Oregon Performance Plan. The Plan is being issued after lengthy discussions with the Civil Rights Division of the United States Department of Justice (USDOJ). In the Oregon Performance Plan, the Authority commits to quality and performance improvement measures, and to data reporting. These measures cover a broad array of subjects, including Assertive Community Treatment (ACT) services, crisis services, peer-delivered services, and supported employment services. New rules are being adopted for crisis line services in order to comply with the crisis services performance outcomes of the Oregon Performance Plan.



Chris Norman

6/23/17

Authorized Signer

Printed Name

Date

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Oregon Health Authority

Health Systems Division: Behavioral Health Services

DIVISION 19

**SERVICE DELIVERY STANDARDS FOR OUTPATIENT BEHAVIORAL HEALTH
TREATMENT SERVICES**

309-019-0100

Purpose and Scope

(1) These rules prescribe minimum service delivery standards for services and supports provided by providers certified by the Health Systems Division (Division) of the Oregon Health Authority (Authority).

(2) In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for behavioral health treatment services and supports provided in:

- (a) Outpatient Community Mental Health Services and Supports for Children and Adults;
- (b) Outpatient Substance Use Disorders Treatment Services; and
- (c) Outpatient Problem Gambling Treatment Services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 461.549, 743A.168,

309-019-0105

Definitions

(1) "Abuse of an Adult" means the circumstances defined in OAR 943-045-0250 through 943-045-0370 for abuse of an adult with mental illness.

(2) "Abuse of a Child" means the circumstances defined in ORS 419B.005.

(3) "Acute Care Psychiatric Hospital" means a hospital or facility that provides 24 hours-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care, and treatment.

(4) "Addictions and Mental Health Services and Supports" means all services and supports including but not limited to Outpatient Behavioral Health Services and Supports for Children and Adults, Intensive Treatment Services for Children, Outpatient and Residential Substance Use Disorders Treatment Services, and Outpatient and Residential Problem Gambling Treatment Services.

(5) "Adolescent" means an individual from 12 through 17 years of age or those individuals determined to be developmentally appropriate for youth services.

(6) "Adult" means an individual 18 years of age or older or an emancipated minor. An individual with Medicaid eligibility who is in need of services specific to children, adolescents, or young adults in transition must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21 who are considered children for purposes of these rules must have all rights afforded to adults as specified in these rules.

(7) "Assertive Community Treatment (ACT)" means an evidence-based practice designed to provide comprehensive treatment and support services to individuals with serious and persistent mental illness. ACT is intended to serve individuals who have severe functional impairments and who have not responded to traditional psychiatric outpatient treatment. ACT services are provided by a single multi-disciplinary team that typically includes a psychiatrist, a nurse, and at least two case managers and are designed to meet the needs of each individual and to help keep the individual in the community and out of a structured service setting, such as residential and hospital care. ACT is characterized by the following:

(a) Low client to staff ratios;

(b) Providing services in the community rather than in the office;

(c) Shared caseloads among team members;

(d) Twenty-four hour staff availability;

(e) Direct provision of all services by the team (rather than referring individuals to other agencies); and

(f) Time-unlimited services.

(8) "Assessment" means the process of obtaining sufficient information through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.

(9) "ASAM Criteria" means the most current edition of the American Society of Addiction Medicine (ASAM) for the Treatment of Addictive, Substance-related, and Co-Occurring Conditions, which is a clinical guide to develop patient-centered service plans and make objective decisions about patient admission, continuing care, and transfer or discharge for individuals and is incorporated by reference in these rules.

(10) "Authority" means the Oregon Health Authority.

(11) "Behavioral Health Treatment" means treatment for mental health, substance use disorder, and problem gambling.

(12) "Behavior Support Plan" means the individualized proactive support strategies used to support positive behavior.

(13) "Behavior Support Strategies" means proactive supports designed to replace challenging behavior with functional, positive behavior. The strategies address environmental, social, neuro-developmental, and physical factors that affect behavior.

(14) "Best Practice Risk Assessment" has the meaning given that term in OAR 309-023-0110.

(15) "Care Coordination" means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.

(16) "Case Management" means the services provided to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, entitlement, and other applicable services.

(17) "Certificate" means the document issued by the Authority that identifies and declares certification of a provider pursuant to OAR 309-008-0000. A letter accompanying issuance of the certificate shall detail the scope and approved locations of the certificate.

(18) "Chief Officer" means the Chief Health Systems Officer of the Division or designee.

(19) "Child" means an individual 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 must be considered a child until age 21 for purposes of these rules.

(20) "Clinical Supervision" means oversight by a qualified clinical supervisor of addictions and mental health services and supports provided according to these rules, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(21) "Clinical Supervisor" means an individual qualified to oversee and evaluate addictions or mental health services and supports.

(22) "Co-occurring Substance Use and Mental Health Disorders (COD)" means the existence of a diagnosis of both a substance use disorder and a mental health disorder.

(23) "Community Mental Health Program (CMHP)" means the organization of various services for individuals with a mental health diagnosis or addictive disorders operated by or contractually affiliated with a local mental health authority and operated in a specific geographic area of the state under an agreement with the Division pursuant to OAR chapter 309, division 014.

(24) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.

(25) "Conditional Release" means placement by a court or the Psychiatric Security Review Board (PSRB) of an individual who has been found eligible under ORS 161.327 or 161.336 for supervision and treatment in a community setting.

(26) "Court" means the last convicting or ruling court unless specifically noted.

(27) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 943-007-0001 through 0501.

(28) "Crisis" means an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted, and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care or death.

(29) "Crisis Intervention" has the meaning given that term in OAR 309-023-0110.

(30) "Crisis Line Services" means phone-based services that establish immediate communication links and provide supportive interventions and information for individuals in an urgent or emergent situation.

(31) "Crisis Plan" means an individualized document designed to help anticipate and prevent future crisis episodes and direct interventions in the instance of a crisis.

(32) "Cultural Awareness" means the process by which individuals and systems respond respectfully and effectively to individuals of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, gender identity, gender expression, sexual orientations, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

(33) "Culturally Specific Program" means a program designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture.

(34) "Declaration for Mental Health Treatment" means a written statement of an individual's preferences concerning their mental health treatment. The declaration is made when the individual is able to understand and legally make decisions related to such treatment. It is honored, as clinically appropriate, in the event the individual becomes unable to make such decisions.

(35) "Diagnosis" means the principal mental health, substance use, or problem gambling diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the assessment and any examinations, tests, or consultations suggested by the assessment and is the medically appropriate reason for services.

(36) "Division" means the Health Systems Division.

(37) "DSM" means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(38) "Driving Under the Influence of Intoxicants (DUI) Substance Use Disorders Rehabilitation Program" means a program of treatment and therapeutically oriented education services for an individual who is either:

(a) A violator of ORS 813.010 (Driving Under the Influence of Intoxicants); or

(b) A defendant participating in a diversion agreement under ORS 813.200.

(39) "Emergent" means the onset of symptoms requiring attention within 24 hours to prevent serious deterioration in mental or physical health or threat to safety.

(40) “Enhanced Care Services (ECS)” and “Enhanced Care Outreach Services (ECOS)” means intensive behavioral and rehabilitative mental health services to eligible individuals who reside in Aging and People with Disabilities (APD) licensed homes or facilities.

(41) “Entry” means the act or process of acceptance and enrollment into services regulated by this rule.

(42) "Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers, and other primary relations to the individual whether by blood, adoption, or legal or social relationships. Family also means any natural, formal, or informal support persons identified as important by the individual.

(43) "Family Support" means the provision of peer delivered services to people defined as family to the individual. It includes support to caregivers at community meetings, assistance to families in system navigation and managing multiple appointments, supportive home visits, peer support, parent mentoring and coaching, advocacy, and furthering efforts to develop natural and informal community supports.

(44) “Family Support Specialist” means an individual who meets qualification criteria under ORS 414.665 and provides supportive services to and has experience parenting a child who is a current or former consumer of mental health or addiction treatment or is facing or has faced difficulties in accessing education and health and wellness services due to a mental health or behavioral health barrier.

(45) “Gender Identity” means an individual's self-identification of gender without regard to legal or biological identification including but not limited to individuals identifying themselves as male, female, transgender, transsexual, non-binary, and gender diverse.

(46) “Gender Expression” means the external characteristics and behaviors that are socially defined as masculine, feminine, or androgynous such as dress, mannerisms, speech patterns, and social interactions.

(47) "Geographic Service Area" means the geographic area within the county boundaries in which the CMHP operates.

(48) "Grievance" means a formal complaint submitted to a provider verbally or in writing by an individual or the individual’s representative pertaining to the denial or delivery of services and supports.

(49) "Guardian" means an individual appointed by a court of law to act as guardian of a minor or a legally incapacitated individual.

(50) “HIPAA” means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

(51) “Individual” means any individual being considered for or receiving services and supports regulated by these rules.

(52) "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 have consented to the services on or prior to the first date of service.

(53) “Intensive Outpatient Substance Use Disorders Treatment Services” means structured, nonresidential evaluation, treatment, and continued care services for individuals with substance use disorders who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services. Intensive outpatient services may include but are not limited to day treatment, correctional day treatment, evening treatment, and partial hospitalization.

(54) “Intensive Outpatient Services and Supports (IOSS)” means a specialized set of comprehensive in-home and community-based supports and mental health treatment services for children that are developed by the child and family team and delivered in the most integrated setting in the community.

(55) “Interdisciplinary Team (IDT)” means a group of professional and direct care staff that have primary responsibility for the development of a plan for the care and treatment of a patient.

(56) “Interim Referral and Information Services” means services provided by a substance use disorders treatment provider to individuals on a waiting list and whose services are funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of disease transmission.

(57) "Intern" or "Student" means an individual providing paid or unpaid program services to complete a credentialed or accredited educational program recognized by the State of Oregon.

(58) “Juvenile Psychiatric Security Review Board (JPSRB)” means the entity described in ORS 161.385.

(59) “Lethal Means Counseling” means best practice research-based counseling strategies to help patients at risk for suicide and their families reduce access to lethal means, including but not limited to firearms.

(60) "Level of Care" means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

(61) "Licensed Health Care Professional" means a practitioner of the healing arts acting within the scope of their practice under state law who is licensed by a recognized governing board in Oregon.

(62) "Licensed Medical Practitioner (LMP)” means an individual who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Physician licensed to practice in the State of Oregon; or

(b) Nurse practitioner licensed to practice in the State of Oregon; or

(c) Physician's assistant licensed to practice in the State of Oregon; and

(d) Whose training, experience, and competence demonstrate the ability to conduct a mental health assessment and provide medication management;

(e) For IOSS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(63) “Linkage agreement” has the meaning given that term in OAR 309-032-0860.

(64) “Local Mental Health Authority (LMHA)” means one of the following entities:

- (a) The board of county commissioners of one or more counties that establishes or operates a CMHP;
- (b) The tribal council in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or
- (c) A regional local mental health authority comprised of two or more boards of county commissioners.

(65) "Mandatory Reporter" means any public or private official, as defined in ORS 419B.005, who comes in contact with or has reasonable cause to believe that an individual has suffered abuse or that any individual with whom the official comes in contact with has abused the individual. Pursuant to ORS 430.765, psychiatrists, psychologists, clergy, and attorneys are not mandatory reporters with regard to information received through communications that are privileged under ORS 40.225 to 40.295.

(66) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to eligible individuals under Title XIX of the Social Security Act.

(67) "Medical Director" means a physician licensed to practice medicine in the State of Oregon and is designated by a substance use disorders treatment program to be responsible for the program's medical services, either as an employee or through a contract.

(68) "Medical Supervision" means an LMP's review and approval, at least annually, of the medical appropriateness of services and supports identified in the service plan for each individual receiving mental health services for one or more continuous years.

(69) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis, or treatment of a physical or behavioral health condition or injuries that are:

- (a) Consistent with the symptoms of a health condition or treatment of a health condition;
- (b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;
- (c) Not solely for the convenience of an individual or a provider of the service or medical supplies; and
- (d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an individual.

(70) “Medication Assisted Treatment (MAT)” means the use of medication in combination with counseling and behavioral therapies for the treatment of substance use disorders.

(71) “Mental Health Intern” means an individual who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work, or behavioral science field to meet the educational requirement of QMHP. The individual must:

- (a) Be currently enrolled in a graduate program for a master’s degree in psychology, social work, or in a behavioral science field;

(b) Have a collaborative educational agreement with the CMHP or other provider and the graduate program;

(c) Work within the scope of practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by the provider; and

(d) Receive, at a minimum, weekly supervision by a qualified clinical supervisor employed by the provider of services.

(72) "Mobile Crisis Services" means mental health services for individuals in crisis provided by mental health practitioners who respond to behavioral health crises onsite at the location in the community where the crisis arises and who provide a face-to-face therapeutic response. The goal of mobile crisis services is to help an individual resolve a psychiatric crisis in the most integrated setting possible and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration.

(73) "Mobile Crisis Response Time" means the time from the point when a professional decision is made that a face-to-face intervention is required to the time the actual face-to-face intervention takes place in the community.

(74) "Nursing Services" means services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) within the scope of practice as defined in OAR 851-045-0060.

(75) "Outpatient Substance Use Disorders Treatment Program" means a program that provides assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for individuals with alcohol or other drug use disorders and their family members or significant others.

(76) "Outpatient Community Mental Health Services and Supports" means all outpatient mental health services and supports provided to children, youth, and adults.

(77) "Outpatient Problem Gambling Treatment Services" means all outpatient treatment services and supports provided to individuals with gambling related problems and their families.

(78) "Outreach" means the delivery of behavioral health services, referral services, and case management services in non-traditional settings including but not limited to the individual's residence, shelters, streets, jails, transitional housing sites, drop-in centers, single room occupancy hotels, child welfare settings, educational settings, or medical settings. It also means attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.

(79) "Peer" means any individual supporting an individual or the individual's family member 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.

(80) "Peer Delivered Services" means an array of agency or community-based services and supports provided by peer support specialists and peer wellness specialists to individuals or family members with similar lived experience that are designed to support the needs of individuals and families as applicable.

(81) "Peer Support Specialist" means an individual providing peer delivered services to an individual or family member with similar life experience under the supervision of a qualified clinical supervisor

and a qualified peer delivered services supervisor. A peer support specialist must be certified by the Authority's Office of Equity and Inclusion as required by OAR 410-180-0300 to 0380 and be:

- (a) A self-identified individual currently or formerly receiving addictions or mental health services;
- (b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;
- (c) A self-identified individual in recovery from problem gambling; or
- (d) The family member of an individual currently or formerly receiving addictions or mental health services.

(82) "Peer Support and Peer Wellness Specialist Supervision" means supervision by a certified PSS or PWS with at least one year of experience as a PSS or PWS in behavioral health services or supervision by a qualified PSS/PWS supervisor and a qualified clinical supervisor. The supports provided include guidance in the unique discipline of peer delivered services and the roles of peer support specialists and peer wellness specialists.

(83) "Peer Delivered Services Supervisor" means an individual qualified to evaluate and guide PSSs and PWSs in the delivery of peer delivered services and supports. This individual shall be a certified PSS or PWS with at least one year experience as a PSS or PWS.

(84) "Peer Wellness Specialist" means an individual who supports an individual in identifying mental health service and support needs through community outreach, assisting individuals with access to available services and resources, addressing barriers to services, and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness. A peer wellness specialist must be certified by the Authority's Office of Equity and Inclusion as required by OAR 410-180-0300 to 0380 and be:

- (a) A self-identified individual currently or formerly receiving mental health services; or
- (b) A self-identified individual in recovery from a substance use or gambling disorder who meets the abstinence requirements for recovering staff in substance use disorders or gambling treatment programs; or
- (c) A family member of an individual who is a current or former recipient of addictions or mental health services.

(85) "Problem Gambling Treatment Staff" means an individual certified or licensed by a health or allied provider agency to provide problem gambling treatment services that include assessment, development of a service plan, and group and family counseling.

(86) "Program" means a particular type or level of service that is organizationally distinct.

(87) "Program Administrator" or "Program Director" means an individual with appropriate professional qualifications and experience who is designated to manage the operation of a program.

- (88) "Program Staff" means an employee or individual who by contract with the program provides a service and has the applicable competencies, qualifications, or certification required to provide the service.
- (89) "Provider" means an individual, organizational provider, or Community Mental Health Program as designated under ORS 430.637(1)(b) that holds a current certificate to provide outpatient behavioral health treatment or prevention services pursuant to these and other applicable service delivery rules.
- (90) "Psychiatric Security Review Board (PSRB)" means the entity described in ORS 161.295 through 161.400.
- (91) "Psychiatrist" means a physician licensed pursuant to ORS 677.010 to 677.228 and 677.410 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.
- (92) "Psychologist" means a psychologist licensed by the Oregon Board of Psychologist Examiners.
- (93) "Publicly Funded" means financial support in part or in full with revenue generated by a local, state, or federal government.
- (94) "Qualified Mental Health Associate (QMHA)" means an individual delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-019-0125.
- (95) "Qualified Mental Health Professional (QMHP)" means a LMP or any other individual meeting the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-019-0125.
- (96) "Qualified Person" means an individual who is a QMHP or a QMHA and is identified by the PSRB and JPSRB in its Conditional Release Order. This individual is designated by the provider to deliver or arrange and monitor the provision of the reports and services required by the Conditional Release Order.
- (97) "Quality Assessment and Performance Improvement" means the structured, internal monitoring and evaluation of services to improve processes, service delivery, and service outcomes.
- (98) "Recovery" means a process of healing and transformation for an individual to achieve full human potential and personhood in leading a meaningful life in communities of their choice.
- (99) "Representative" means an individual who acts on behalf of an individual at the individual's request with respect to a grievance including but not limited to a relative, friend, Division employee, attorney, or legal guardian.
- (100) "Resilience" means the universal capacity that an individual uses to prevent, minimize, or overcome the effects of adversity. Resilience reflects an individual's strengths as protective factors and assets for positive development.
- (101) "Respite Care" means planned and emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. Respite care may be provided in or

out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the service plan.

(102) "Safety Plan" means a best practice research-based patient directed document developed through a collaborative process in which the provider assists the patient in listing strategies for the patient to use when suicide ideation is elevated or after a suicide attempt.

(103) "Screening" means the process to determine whether the individual needs further assessment to identify circumstances requiring referrals or additional services and supports.

(104) "Screening Specialist" means an individual who possesses valid certification issued by the Division to conduct DUII evaluations.

(105) "Service Plan" means a comprehensive plan for services and supports provided to or coordinated for an individual and their family, as applicable, that is reflective of the assessment and the intended outcomes of service.

(106) "Service Note" means the written record of services and supports provided, including documentation of progress toward intended outcomes consistent with the timelines stated in the service plan.

(107) "Service Record" means the written or electronic documentation regarding an individual and resulting from entry, assessment, orientation, services and supports planning, services and supports provided, and transfer.

(108) "Services" means activities and treatments described in the service plan that are intended to assist the individual's transition to recovery from a substance use disorder, problem gambling disorder, or mental health condition and to promote resiliency and rehabilitative and functional individual and family outcomes.

(109) "Signature" means any written or electronic means of entering the name, date of authentication, and credentials of the individual providing a specific service or the individual authorizing services and supports. Signature also means any written or electronic means of entering the name and date of authentication of the individual, guardian, or any authorized representative of the individual receiving services.

(110) "Skills Training" means providing information and training to individuals and families designed to assist with the development of skills in areas including but not limited to anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, symptom management, accessing community services, and daily living.

(111) "Substance Abuse Prevention and Treatment Block Grant" or "SAPT Block Grant" means the federal block grants for prevention and treatment of substance abuse under Public Law 102-321 (31 U.S.C. 7301-7305) and the regulations published in Title 45 Part 96 of the Code of Federal Regulations.

(112) "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol to the side effects of a medication and to a toxin exposure. The disorders include substance use disorders such as substance dependence and substance abuse and substance-induced disorders,

including substance intoxication, withdrawal, delirium, and dementia, and includes but is not limited to substance induced psychotic disorder, mood disorder, as defined in DSM criteria.

(113) "Substance Use Disorders Treatment and Recovery Services" means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.

(114) "Substance Use Disorders Treatment Staff" means an individual certified or licensed by a health or allied provider agency to provide substance use disorders treatment services that include assessment, development of a service plan, and individual, group, and family counseling.

(115) "Successful DUII Completion" means that the DUII program has documented in its records that for the period of service deemed necessary by the program, the individual has:

(a) Met the completion criteria approved by the Division;

(b) Met the terms of the fee agreement between the provider and the individual; and

(c) Demonstrated 90 days of continuous abstinence prior to completion.

(116) "Suicide Risk Assessment" means a best practice assessment supported by research to determine an individual's risk for suicide.

(117) "Supports" means activities, referrals, and supportive relationships designed to enhance the services delivered to individuals and families for the purpose of facilitating progress toward intended outcomes.

(118) "Transfer" means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.

(119) "Trauma Informed Services" means services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health and addictions services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and are delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services.

(120) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences, and activities designed to remediate symptoms of a DSM diagnosis that are included in the service plan.

(121) "Triage" means a classification process to determine priority needs.

(122) "Urinalysis Test" means an initial test and, if positive, a confirmatory test:

(a) An initial test must include, at a minimum, a sensitive, rapid, and inexpensive immunoassay screen to eliminate "true negative" specimens from further consideration;

(b) A confirmatory test is a second analytical procedure used to identify the presence of a specific drug or metabolite in a urine specimen. The confirmatory test must be by a different analytical method from that of the initial test to ensure reliability and accuracy;

(c) All urinalysis tests must be performed by laboratories meeting the requirements of OAR 333-024-0305 through 0365.

(123) "Urgent" means the onset of symptoms requiring attention within 48 hours to prevent a serious deterioration in an individual's mental or physical health or threat to safety.

(124) "Variance" means an exception from a provision of these rules granted in writing by the Division pursuant to the process regulated by OAR 309-008-1600 upon written application from the provider. Duration of a variance is determined on a case-by-case basis.

(125) "Volunteer" means an individual who provides a program service or takes part in a program service and is not a program employee and is not paid for services. The services must be non-clinical unless the individual has the required credentials to provide a clinical service.

(126) "Warm Handoff" has the meaning given that term in OAR 309-032-0860.

(127) "Wellness" means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.

(128) "Wraparound" means a high fidelity model of team-based intensive care coordination for children and their families based on National Wraparound Initiative values and principles.

(129) "Young Adult in Transition" means an individual who is developmentally transitioning into independence, sometime between the ages of 14 and 25.

(130) "Youth Support Specialist" means an individual who meets qualification criteria under OAR 415-180.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0110

Provider Policies

(1) All providers must develop and implement written personnel policies and specific procedures compliant with these rules including:

(a) Personnel Qualifications and Credentialing;

(b) Mandatory abuse reporting compliant with ORS 430.735 - 430.768 and OAR 943-045-0250 through 943-045-0370;

(c) Criminal Records Checks compliant with ORS 181.533 through 181.575 and 943-007-0001 through 0501; and

(d) Fraud, waste, and abuse in federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510.

(2) All providers must develop and implement written service delivery policies and specific procedures compliant with these rules:

(a) Service delivery policies must be available to individuals and family members upon request; and

(b) Service delivery policies and procedures must include at a minimum:

(A) Fee agreements;

(B) Confidentiality and compliance with HIPAA, Federal Confidentiality Regulations (42 CFR, Part 2), and state confidentiality regulations as specified in ORS 179.505 and 192.518 through 192.530;

(C) Compliance with Title 2 of the Americans with Disabilities Act of 1990 (ADA);

(D) Grievances and appeals;

(E) Individual rights;

(F) Quality assessment and performance improvement;

(G) Trauma informed service delivery consistent with the Division Trauma Informed Services Policy;

(H) Provision of culturally and linguistically appropriate services;

(I) Linkage agreements compliant with OAR 309-032-0870;

(J) Crisis prevention and response, including suicide risk assessment, safety planning, and lethal means counseling;

(K) Incident reporting; and

(L) Peer delivered services.

(3) Providers of ECS services must develop behavior support policies consistent with OAR 309-019-0155(3).

(4) The provider's policies and procedures must:

(a) Prohibit titration of medications prescribed for the treatment of opioid dependence as a condition of receiving treatment;

(b) Allow continued use of medications prescribed for opioid dependence based on individual choice and physician recommendation; and

(c) Prohibit transfer of individuals who are prescribed medication for the treatment of opioid dependence based solely on the individual's initial or continued use of the medication.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 179.505, 413.520 - 413.522, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0115

Individual Rights

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

(a) Choose from available services and supports that are consistent with the service plan, culturally competent, provided in the most integrated setting in the community 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;

(b) Be treated with dignity and respect;

(c) Participate in the development of a written service plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written service plan;

(d) Have all services explained, including expected outcomes and possible risks;

(e) Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50;

(f) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:

(A) Under age 18 and lawfully married;

(B) Age 16 or older and legally emancipated by the court; or

(C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.

(g) Inspect their service record in accordance with ORS 179.505;

(h) Refuse participation in experimentation;

(i) Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;

(j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;

(k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

(L) Have religious freedom;

(m) Be free from seclusion and restraint;

- (n) Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;
- (o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented;
- (p) Be informed of suicide risk and receive best practice lethal means counseling and a safety plan, including methods for the individual, family, and guardian to mitigate risk over time;
- (q) Have family and guardian involvement in service planning and delivery;
- (r) Make a Declaration for Mental Health Treatment when legally an adult;
- (s) File grievances, including appealing decisions resulting from the grievance;
- (t) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
- (u) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
- (v) Exercise all rights described in this rule without any form of reprisal or punishment.

(2) The provider must give to the individual and, if appropriate, the guardian a document that describes the applicable individual's rights as follows:

- (a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;
- (b) The rights and how to exercise them must be explained to the individual, and if applicable the guardian; and
- (c) Individual rights must be posted in writing in a common area.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.495, 430.640, 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380-426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 743A.168

Personnel

309-019-0120

Licensing and Credentialing

Program staff in the following positions must meet applicable credentialing or licensing standards, including those set forth in these rules:

- (1) Substance Use Disorders Treatment Staff.
- (2) Clinical Supervisors.

- (3) LMPs.
- (4) Medical Directors.
- (5) Peer Support Specialists.
- (6) Peer Wellness Specialists.
- (7) Peer Delivered Services Supervisor;
- (8) Problem Gambling Treatment Staff.
- (9) QMHAs.
- (10) QMHPs.

Stat. Auth.: ORS 430.256, 430.640

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 428.205 - 428.270, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0125

Specific Staff Qualifications and Competencies

- (1) Program administrators or program directors must demonstrate competence in leadership, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, use of data, reporting, program evaluation, quality assurance, and developing and coordinating community resources.
- (2) Clinical supervisors in all programs must demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources; group, family, and individual therapy or counseling; best practices for suicide risk assessment, lethal means counseling, and safety planning; documentation and rationale for services to promote intended outcomes; and implementation of all provider policies.
- (3) Clinical supervisors in mental health programs must meet QMHP requirements and have completed two years of post-graduate clinical experience in a mental health treatment setting.
- (4) Clinical supervisors in substance use disorders treatment programs must be certified or licensed by a health or allied provider agency as follows:
 - (a) For supervisors 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 or portfolio review by the certifying body.

(b) For supervisors holding a health or allied provider license, the license or 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 substance use disorders:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists; or

(E) Board of Nursing.

(c) Additionally, clinical supervisors in substance use disorders programs must have one of the following qualifications:

(A) Five years of paid full-time experience in the field of substance use disorders counseling; or

(B) 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 substance use disorders counseling experience; or

(C) 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 substance use disorders counseling experience.

(5) Clinical supervisors in problem gambling treatment programs must meet the requirements for clinical supervisors in either mental health or substance use disorders treatment programs and have completed ten hours of gambling specific training within two years of designation as a problem gambling services supervisor.

(6) Substance use disorders treatment staff must:

(a) Demonstrate competence in treatment of substance-use disorders including individual assessment and individual, group, family, and other counseling techniques, program policies and procedures for service delivery and documentation, suicide risk associated with problem gambling, and identification, implementation, and coordination of services identified to facilitate intended outcomes; and

(b) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide addiction treatment within two years of the first hire date and must make application for certification no later than six months following that date. The two years is not renewable if the individual ends employment with a provider and becomes re-employed with another provider;

(c) For treatment staff holding certification in addiction counseling, qualifications for the certificate must have included at least:

(A) 750 hours of supervised experience in substance use counseling;

(B) 150 contact hours of education and training in substance use related subjects; and

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

(d) For treatment staff holding a health or allied provider license, the license or registration must have been issued by one of the following state bodies, and the individual must possess documentation of at least 60 contact hours of academic or continuing professional education in substance use disorders treatment:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists; or

(E) Board of Nursing.

(7) Problem Gambling treatment staff must:

(a) Demonstrate competence in treatment of problem gambling including individual assessment and individual, group, family, and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation, and coordination of services identified to facilitate intended outcomes;

(b) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide problem gambling treatment within two years of the first hire date and must make application for certification no later than six months following that date. The two years is not renewable if the individual ends employment with a provider and becomes re-employed with another provider;

(c) For treatment staff holding certification in problem gambling counseling, qualifications for the certificate must include at least:

(A) 500 hours of supervised experience in problem gambling counseling;

(B) 60 contact hours of education and training in problem gambling related subjects; and

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

(d) For treatment staff holding a health or allied provider license, the license or registration must be issued by one of the following state bodies, and the individual must possess documentation of at least 60 contact hours of academic or continuing professional education in problem gambling treatment:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists; or

(E) Board of Nursing.

(8) QMHAs must demonstrate the ability to communicate effectively; understand mental health assessment, treatment, and service terminology as well as suicide risk assessment, lethal means counseling, and safety planning; and apply each of these concepts, implement skills development strategies, and identify, implement, and coordinate the services and supports identified in a service plan. In addition, QMHAs must also meet the following minimum qualifications:

- (a) Bachelor's degree in a behavioral science field; or
- (b) A combination of at least three years of relevant work, education, training, or experience; or
- (c) A qualified Mental Health Intern, as defined in OAR 309-019-0105.

(9) QMHPs must demonstrate the ability to conduct an assessment including identifying precipitating events; gathering histories of mental and physical health, substance use, past mental health services, and criminal justice contacts; assessing family, cultural, social, and work relationships; conducting a mental status examination; completing a DSM diagnosis; conducting best practice suicide risk assessments, lethal means counseling, and safety planning; writing and supervising the implementation of a service plan; and providing individual, family, or group therapy within the scope of their training. In addition, QMHPs must also meet the following minimum qualifications:

- (a) Bachelor's degree in nursing and licensed by the State of Oregon;
- (b) Bachelor's degree in occupational therapy and licensed by the State of Oregon;
- (c) Graduate degree in psychology;
- (d) Graduate degree in social work;
- (e) Graduate degree in recreational, art, or music therapy;
- (f) Graduate degree in a behavioral science field; or
- (g) A qualified Mental Health Intern, as defined in 309-019-0105.

(10) An individual with experience working in the peer profession as a peer support or peer wellness specialist shall:

- (a) Demonstrate knowledge of and competent implementation of the peer delivered services discipline;
- (b) Be able to support PSS and PWS in providing services and with integrity to the PDS profession.

(11) All peer support specialists and peer wellness specialists, including family and youth support and wellness specialists, shall demonstrate knowledge of the peer support discipline through certification and continuing education. They shall offer approaches to support others in their recovery or resiliency and shall also show efforts at sharing and demonstrating personal life experience and tools of self-directed recovery and resiliency.

(12) Program staff, contractors, volunteers, and interns recovering from substance use or problem gambling disorders providing treatment services or peer support services in substance use disorders treatment programs must be able to document continuous abstinence under independent living conditions or recovery housing for the immediate past two years.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0130

Personnel Documentation, Training, and Supervision

(1) Providers must maintain personnel records for each program staff that contains all of the following documentation:

(a) When required, verification of a criminal record check consistent with OAR 943-007-0001 through 0501;

(b) A current job description that includes applicable competencies;

(c) Copies of relevant licensure or certification, diploma, or certified transcripts from an accredited college, indicating that the program staff meets applicable qualifications;

(d) Periodic performance appraisals;

(e) Staff orientation documentation; and

(f) Disciplinary documentation;

(g) Documentation of trainings required by this or other applicable rules; and

(h) Documentation of clinical and non-clinical supervision. Documentation shall include the date supervision took place, the amount of supervision time, and a brief description of relevant topics discussed.

(2) Providers utilizing contractors, interns, or volunteers must maintain the following documentation, as applicable:

(a) A contract or written agreement;

(b) A signed confidentiality agreement;

(c) Orientation documentation; and

(d) For subject individuals, verification of a criminal records check consistent with OAR 943-007-0001 through 0501.

(3) Providers shall ensure that program staff receives training applicable to the specific population for whom services are planned, delivered, or supervised. The program must document appropriate

orientation for each program staff or individual providing services within 30 days of the hire date. At a minimum, training and orientation for all program staff must include but not be limited to:

- (a) A review of crisis prevention and response procedures;
- (b) A review of best practice suicide risk assessment, lethal means counseling, and safety planning;
- (c) A review of emergency evacuation procedures;
- (d) A review of program policies and procedures;
- (e) A review of rights for individuals receiving services and supports;
- (f) Mandatory abuse reporting procedures;
- (g) HIPAA and Fraud, Waste and Abuse;
- (h) For Enhanced Care Services, positive behavior support training; and
- (i) Declaration for Mental Health Treatment.

(4) Individuals providing peer delivered services must receive supervision by a qualified clinical supervisor. PSSs and PWSs must receive either one hour per month of co-supervision by a qualified clinical supervisor and qualified PDS supervisor or one hour of supervision by a qualified PDS supervisor. Whenever possible, the PDS supervision should include the specific best practice for the population being served. The supervision must be related to the development and implementation of services as relevant to the specific discipline receiving the supervision. This requirement is subject to the availability of the following resources:

- (a) Clinical supervision provided to assist program staff and volunteers to increase their skills within their discipline, improve quality of services to individuals, and supervise program staff and volunteers' compliance with program policies and procedures;
- (b) Documentation of two hours per month of clinical supervision for each individual supervised. The two hours must include one hour of individual face-to-face contact for each individual supervised or a proportional level of supervision for part-time program staff. Individual face-to-face contact may include real time, two-way audio visual conferencing;
- (c) Documentation of two hours of quarterly supervision for program staff holding a health or allied provider license, including at least one hour of individual face-to-face contact for each individual supervised; or
- (d) Documentation of weekly supervision for program staff meeting the definition of mental health intern;
- (e) Documentation of one hour a month of co-supervision by a qualified clinical supervisor and a qualified PDS supervisor for peer support and peer wellness specialists or of one hour of supervision by a qualified PDS supervisor. The one hour may be done in group, individual face-to-face, two-way audiovisual or audio conferencing. There may be a proportional level of supervision for part-time program staff.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 109.675, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

Service Delivery and Documentation Standards

309-019-0135

Entry and Assessment

(1) The program must utilize an entry procedure that at a minimum shall ensure the provision and documentation of the following:

(a) Individuals must be considered for entry without regard to race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when program eligibility is restricted to children, adults, or older adults), familial status, marital status, source of income, and disability;

(b) The provider may not allow entry to individuals who are prescribed medication to treat opioid dependence;

(c) Individuals must receive services in the most timely manner feasible consistent with the presenting circumstances;

(d) Written voluntary informed consent for services must be obtained from the individual or guardian prior to the start of services. If consent is not obtained, the reason must be documented and further attempts to obtain informed consent must be made as appropriate;

(e) The provider shall develop and maintain adequate clinical records and other documentation for each individual served that demonstrates the specific supports, care, items, or services for which payment has been requested, including documentation of a suicide risk assessment, lethal means counseling, and a safety plan, as indicated;

(f) The provider must report the entry of all individuals on the mandated state data system;

(g) In accordance with ORS 179.505 and HIPAA, an authorization for the release of information must be obtained for any confidential information concerning the individual being considered for or receiving services;

(h) At the time of entry, the program must offer to the individual and guardian, if applicable, written program orientation information. The written information must be in a language understood by the individual and must include:

(A) An opportunity to complete a Declaration for Mental Health Treatment with the individual's participation and informed consent;

(B) A description of individual rights consistent with these rules;

(C) Policy concerning grievances and appeals consistent with these rules to include an example grievance form;

(D) Notice of privacy practices; and

(E) An opportunity to register to vote.

(2) Entry of individuals whose services are funded by the SAPT Block Grant must be prioritized in the following order:

(a) Women who are pregnant and using substances intravenously;

(b) Women who are pregnant;

(c) Individuals who are using substances intravenously; and

(d) Women with dependent children.

(3) Assessment:

(a) At the time of entry, an assessment must be completed, including a best practice suicide risk assessment;

(b) The assessment must be legible and completed by qualified program staff as follows:

(A) A QMHP in mental health programs. A QMHA may assist in the gathering and compiling of information to be included in the assessment;

(B) Supervisory or treatment staff in substance use disorders treatment programs; and

(C) Supervisory or treatment staff in problem gambling treatment programs.

(c) Each assessment must include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services;

(d) For substance use disorders services, each assessment must be consistent with the dimensions described in the ASAM and must document a diagnosis and level of care determination consistent with the DSM and ASAM;

(e) When the assessment process determines the presence of co-occurring substance use and mental health disorders or any significant risk to health and safety, all providers must document referral for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider;

(f) Providers shall periodically update assessments, including suicide risk assessments, as applicable, when there are changes in clinical circumstances or risk factors for suicide; and

(g) Any individual continuing to receive mental health services for one or more continuous years must receive an annual assessment, including a suicide risk assessment by a QMHP.

(4) In addition to the requirements set forth in OAR 309-019-0135(3) and OAR 309-019-0149(1)(a), providers certified under these rules and providing services consistent with OAR 309-019-0199(2)(a) to individuals living in residential programs licensed under chapter 309, divisions 35 and 40 may

retroactively bill for medically appropriate services provided prior to the completion of the assessment and service plan if:

- (a) The assessment and service plan are completed within the first 14 days of placement at the licensed residential program;
- (b) The assessment, service plan, and any additional required documentation demonstrate medical necessity of the services consistent with OAR 410-172-0630(2); and
- (c) All requirements of OAR 410-172-0650(f) are satisfactorily met to allow for retroactive payment.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0140

Service Plan and Service Notes

(1) In addition to any program specific service delivery requirements, the service plan must be a legible, individualized plan designed to improve the individual's condition to the point where the individual's continued participation in the program is no longer necessary. The service plan is included in the individual's service record and shall:

- (a) Be completed prior to the start of services except as allowed under OAR 309-019-0135(4)(a)(A-C);
- (b) Reflect the assessment and the level of care to be provided;
- (c) Reflect the suicide risk assessment, crisis de-escalation, safety planning, and lethal means counseling, as indicated;
- (d) Include the participation of the individual and family members, as applicable;
- (e) Be completed and signed by qualified program staff as follows:
 - (A) A QMHP in mental health programs;
 - (B) Supervisory or treatment staff in substance use disorders treatment programs; and
 - (C) Supervisory or treatment staff in problem gambling treatment programs.
- (f) For mental health services, a QMHP who is also a licensed health care professional must recommend the services and supports by signing the service plan within ten business days of the start of services; and
- (g) An LMP must approve the service plan at least annually for each individual receiving mental health services for one or more continuous years. The LMP may designate annual clinical oversight by documenting the designation to a specific licensed health care professional.

(2) At minimum, each service plan shall include:

(a) Treatment objectives that are:

(A) Individualized to meet the assessed needs of the individual;

(B) Measurable for the purpose of evaluating individual progress, including a baseline evaluation.

(b) The specific services and supports indicated by the assessment, including peer delivered services and addressing suicide risk, as indicated, that shall be used to meet the treatment objectives;

(c) A projected schedule for service and support delivery, including the expected frequency and duration of each type of planned therapeutic encounter and peer support services;

(d) The credentials of the personnel that will be providing each service and support; and

(e) A projected schedule for re-evaluating the service plan.

(3) Service Notes:

(a) Providers must document each service and support;

(b) A service note at a minimum must include:

(A) The specific services rendered;

(B) The specific service plan objectives being addressed by the services provided;

(C) The date, time of service, and the actual amount of time the services were rendered;

(D) The relationship of the services provided to the treatment objective described in the service plan;

(E) Documentation of the suicide risk assessment, lethal means counseling, and safety plan, as indicated;

(F) The personnel rendering the services, including their signature and credential;

(G) The setting in which the services were rendered.

(4) Decisions to transfer individuals must be documented, including the reason for the transfer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

Program Specific Minimum Service Standards

309-019-0145

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

Providers approved under OAR 309-008-0000 and designated to provide services and supports for individuals diagnosed with COD must provide concurrent service and support planning and delivery

for substance use disorders, gambling disorder, and mental health diagnosis, including integrated assessment addressing co-occurring behavioral health diagnoses, service plan, and service record.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955

309-019-0150

Outpatient Mental Health Services to Children and Adults

(1) Crisis services must be provided directly or through linkage to a local crisis services provider and must include the following:

(a) Twenty-four hours, seven days per week telephone or face-to-face screening within one hour of notification of the crisis event to determine an individual's need for immediate community mental health services; and

(b) Twenty-four hours, seven days per week capability to conduct, by or under the supervision of a QMHP, an assessment, including suicide risk assessment, resulting in a service plan that includes the crisis services necessary to assist the individual and family to stabilize and transition to the appropriate level of care.

(2) Available case management services must be provided including the following:

(a) Program staff must assist individuals in gaining access to and maintaining resources such as Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing. When needed, program staff must arrange transportation or accompany individuals to help them apply for benefits; and

(b) Referral and coordination to help individuals gain access to services and supports identified in the service plan; and

(c) Assistance with a warm handoff process, as indicated, compliant with OAR 309-032-0870;

(d) Referral and coordination to help individuals at risk of suicide and their families.

(3) When significant health and safety concerns are identified, program staff must ensure that necessary services or actions occur to address the identified health and safety needs for the individual, including services to individuals at imminent risk of suicide as determined by the suicide risk assessment.

(4) Peer Delivered Services shall be made available.

Stat. Auth.: ORS 413.042

Stats Implemented: ORS 430.630

309-019-0151

Mobile Crisis Services

(1) By July 1, 2018, or when the CMHP is contracted to provide the service, CMHP or their designee shall provide mobile crisis services as a component of crisis services according to OAR 309-019-0150 for individuals experiencing mental health crisis within their respective geographic service area to meet the following objectives:

- (a) Reduce acute psychiatric hospitalization of individuals experiencing mental health crisis; and
- (b) Reduce the number of individuals with mental health diagnoses who are incarcerated as a result of mental health crisis events involving law enforcement.

(2) CMHP shall provide mobile crisis services including at a minimum but not limited to:

(a) Twenty-four hours a day, seven days a week screening to determine the need for immediate services for any individual requesting assistance or for whom assistance is requested;

(b) Within appropriate safety considerations, a face-to-face therapeutic response delivered in a public setting at locations in the community where the crisis arises including but not limited to an individual's home, schools, residential programs, nursing homes, group home settings, and hospitals to enhance community integration;

(c) Services that are generally delivered in a natural environment by or under the supervision of a QMHP, such as QMHAs and certified peer support specialists, and resulting in linkages to service and supports and a support service plan if required. Disposition of services shall maintain as the primary goal with diversion from hospitalization and incarceration through clinically appropriate community-based supports and services;

(d) Minimizing the need for transportation (frequently by law enforcement officers or emergency services) to a hospital emergency department or a community crisis site;

(e) Are not intended to be restricted to services delivered in hospitals or at residential programs;

(f) Mental health crisis assessment;

(g) Crisis intervention;

(h) Assistance with placement in crisis respite, peer respite, or residential services as defined in OAR 309-035-0100;

(i) Assistance to families and families of choice in managing suicide risk until the individual is engaged in outpatient services or when the individual is to receive services on an outpatient basis;

(j) Initiation of involuntary services if applicable;

(k) Assistance with hospital placement; and,

(L) Connecting individuals with ongoing supports and services.

(3) Counties shall track and report response time. Counties shall respond to crisis events in their respective geographic service area with the following maximum response times:

(a) Counties classified as "urban" shall respond within one hour;

- (b) Counties classified as “rural” shall respond within two hours;
 - (c) Counties classified as “frontier” shall respond within three hours;
 - (d) Counties classified as “rural” and “frontier” shall contact an individual experiencing a crisis event via telephone by a staff member who is trained in crisis management (such as an individual from a crisis line or a certified peer specialist) within one hour of being notified of the crisis event.
- (4) By July 1, 2018, each CMHP shall establish internal policies to monitor the number of instances that mobile crisis response times exceed the maximum response times established in OAR 309-019-0151. At the time of the site certification review, a sample of mobile crisis events shall be reviewed to evaluate adherence to the maximum response times established in OAR 309-019-0151.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.254 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052, 813.200 - 813.270

309-019-0152

Mobile Crisis Response Reporting Requirements

- (1) The CMHP shall submit electronically a written quarterly report using forms and procedures prescribed by the Authority to the Division contract administrator no later than 45 calendar days following the end of each reporting quarter:
- (2) The CMHP shall track and report the number of individuals receiving a mobile crisis services contact to include the following information:
 - (a) Location of mobile crisis service;
 - (b) Disposition of the mobile crisis contact;
 - (c) Whether the crisis contact resulted in admission to acute care; or
 - (d) If the mobile crisis contact resulted in referral in mental health treatment and stabilization in a community setting.
- (3) Counties shall track and report response time:
 - (a) Counties classified as “urban” shall respond within one hour;
 - (b) Counties classified as “rural” shall respond within two hours;
 - (c) Counties classified as “frontier” shall respond within three hours.

Stat. Auth.: ORS 413.042

Stats Implemented: 430.630 and 430.634

309-019-0155

Enhanced Care Services (ECS) and Enhanced Care Outreach Services (ECOS)

(1) To be eligible for ECS/ECOS, an individual must:

(a) Be APD service eligible;

(b) Meet the diagnostic criteria of severe mental illness with complex behaviors or be approved by the enhanced care services team;

(c) Require intensive community mental health services to transition to a lower level of care;

(d) Have a history of multiple APD placements due to complex behaviors; and

(e) Be currently or have been a patient at the Oregon State Hospital or have received in-patient services in an acute psychiatric unit for over 14 days and have been referred to non-enhanced APD facilities and denied admission due to severe mental illness with complex behaviors and be currently exhibiting two or more of the following: self-endangering behavior, aggressive behavior, intrusive behavior, intractable psychiatric symptoms, complex medication needs, sexually inappropriate behavior, and elopement behavior.

(2) ECS/ECOS providers must:

(a) For ECS, provide a minimum of four hours per day or additional hours as required to support the needs of the enhanced care facility, seven days per week of mental health staffing provided or arranged for by the contracted mental health provider;

(b) Coordinate interdisciplinary team meetings (IDT) to develop the service plan, review the behavior support plan, and to coordinate care planning with the Department of Human Services (Department) licensed provider staff, APD case manager, QMHP, prescriber and related professionals such as the Department licensed facility or program direct care staff, the Department licensed facility RN, and facility administrator. IDTs in ECS programs must be held weekly and at least quarterly for ECOS;

(c) Coordinate quarterly behavioral health trainings for Department-licensed providers and related program staff providing services to ECS and ECOS recipients; and

(d) Ensure the availability of consultation and crisis services staffed by a QMHP or the local CMHP available to the ECS and ECOS provider and the Department licensed facility direct care staff 24-hours per day.

(3) Behavior support services must be designed to facilitate positive alternatives to challenging behavior and to assist the individual in developing adaptive and functional living skills. Providers must:

(a) Develop and implement individual behavior support strategies based on a functional or other clinically appropriate assessment of challenging behavior;

(b) Document the behavior support strategies and measures for tracking progress as a behavior support plan in the service plan;

(c) Establish a framework that ensures 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;

(d) Obtain informed consent from the individual or guardian, if one is appointed, in the use of behavior support strategies and communicate both verbally and in writing the information to the individual or guardian, if one is appointed, in a language understood;

(e) Establish outcome-based tracking methods to measure the effectiveness of behavior support strategies in:

(A) The use of least restrictive interventions possible; and

(B) Increasing positive behavior.

(f) Require all program staff to receive quarterly mental health in-service training in evidence-based practices to promote positive behavior support and related to needs of each individual; and

(g) Review and update behavior support policies, procedures, and practices annually.

(4) Providers must develop a transition plan for each individual as part of the initial assessment process. Each individual's mental health service plan shall reflect their transition goal and the supports necessary to achieve transition.

(5) Staffing requirements include:

(a) Each ECS and ECOS program must have a minimum of one FTE QMHP for programs serving five or more individuals who is responsible for coordinating entries, transitions, and required IDT's; assuring the completion of individual assessments, mental health service, and behavior support plans; providing supervision of QMHP's and QMHA's; and coordinating services and trainings with facility staff;

(b) Each ECS and ECOS program must have psychiatric consultation available. For ECS programs serving more than ten individuals, the psychiatrist must participate.

(6) In ECS programs, the CMHP and the Department licensed provider must develop a written collaborative agreement that addresses at a minimum: risk management, census management, staff levels, training, treatment and activity programs, entry and transition procedures, a process for reporting and evaluating critical incidents, record keeping, policy and procedure manuals, dispute resolution, and service coordination.

Stat. Auth.: ORS 161.390, 413.042, 430.640, 443.450

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0160

Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board

(1) Services and supports must include all appropriate services, including peer delivered services, determined necessary to assist the individual in maintaining community placement and that are consistent with Conditional Release Orders and the Agreement to Conditional Release.

(2) Providers of PSRB and JPSRB services acting through the designated qualified individual must submit reports to the PSRB or JPSRB as follows:

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

(A) Within 15 days of receipt of the Order, schedule an interview with the individual for the purpose of initiating or conducting the evaluation;

(B) Appoint a QMHP to conduct the evaluation and to provide an evaluation report to the PSRB or JPSRB;

(C) Within 30 days of the evaluation interview, submit the evaluation report to the PSRB or JPSRB responding to the questions asked in the Order for Evaluation; and

(D) If supervision by the provider is recommended, notify the PSRB or JPSRB of the name of the individual designated to serve as the individual's qualified person who shall be primarily responsible for delivering or arranging for the delivery of services and the submission of reports under these rules.

(b) Monthly reports consistent with PSRB or JPSRB reporting requirements as specified in the Conditional Release Order that summarize the individual's adherence to Conditional Release requirements and general progress; and

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

(A) At the time of any significant change in the individual's health, legal, employment, or other status that may affect compliance with Conditional Release orders;

(B) Upon noting major symptoms requiring psychiatric stabilization or hospitalization;

(C) Upon noting any other major change in the individual's service plan;

(D) Upon learning of any violations of the Conditional Release Order; and

(E) At any other time when, in the opinion of the qualified person, such an interim report is needed to assist the individual.

(3) PSRB and JPSRB providers must submit copies of all monthly reports and interim reports to both the PSRB or JPSRB and the Division.

(4) When the individual is under the jurisdiction of the PSRB or JPSRB, providers must include the following additional documentation in the service record:

(a) Monthly reports to the PSRB or JPSRB;

- (b) Interim reports, as applicable;
- (c) The PSRB or JPSRB initial evaluation; and
- (d) A copy of the Conditional Order of Release.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 430.640, 443.450

Stats. Implemented: ORS 161.390 - 161.400, 179.505, 426.380 - 426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460

309-019-0165

Intensive Outpatient Services and Supports (IOSS) for Children

(1) IOSS 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 service plan and the standards for outpatient mental health services, IOS services must include:

- (a) Provider participation on the child and family team or wraparound team;
- (b) A documented proactive safety and crisis plan developed by the child and family team, if applicable, or the provider. The proactive safety and crisis plan must at minimum include:
 - (A) Strategies designed to facilitate positive alternatives to challenging behavior and to assist the individual in developing adaptive and functional living skills;
 - (B) Strategies to avert potential crisis without placement disruptions;
 - (C) Professional and natural supports to provide 24 hours, seven days per week flexible response; and
 - (D) Documented informed consent from the parent or guardian.

(2) IOSS providers must include the following additional documentation in the service record:

- (a) Identified care coordinator and care coordination provider as well as documentation of provider participation on child and family team or wraparound team;
- (b) Documented identification of strengths and needs;
- (c) A summary and review of service coordination planning by the provider or by the child and family team or wraparound team when applicable; and
- (d) A documented proactive safety and crisis plan including a suicide prevention plan.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254- 430.640, 430.850 - 430.955

309-019-0170

Outpatient Problem Gambling Treatment Services

Outpatient problem gambling treatment services include group, individual, and family treatment consistent with the following requirements:

- (1) The first offered service appointment must be five business days or less from the date of request for services.
- (2) Service sessions must address the challenges of the individual as they relate, directly or indirectly, to the problem gambling behavior.
- (3) Providers may provide telephone counseling when face-to-face contact would involve an unwise delay, as follows:
 - (a) The individual must be currently enrolled in the problem gambling treatment program;
 - (b) Phone counseling must be provided by a qualified program staff within their scope of practice;
 - (c) Service notes for phone counseling must follow the same criteria as face-to-face counseling and identify the session was conducted by phone and the clinical rationale for the phone session;
 - (d) Telephone counseling must meet HIPAA and 42 CFR standards for privacy; and
 - (e) There must be an agreement of informed consent for phone counseling that is discussed with the individual and documented in the individual's service record.
- (4) Family counseling includes face-to-face or non-face-to-face service sessions between a program staff member delivering the service and a family member whose life has been negatively impacted by gambling:
 - (a) Service sessions must address the problems of the family member as they relate directly or indirectly to the problem gambling behavior; and
 - (b) Services to the family must be offered even if the individual identified as a problem gambler is unwilling or unavailable to accept services.
- (5) Twenty-four hour crisis response must be accomplished through agreement with other crisis services, on-call program staff, or other arrangement acceptable to the Division.
- (6) A financial assessment must be included in the entry process and documented in the assessment.
- (7) The service plan must include a financial component consistent with the financial assessment.
- (8) A risk assessment for suicide ideation must be included in the entry process and documented in the assessment as well as appropriate referrals made.
- (9) The service plan must address suicidal risks if determined within the assessment process.

Stat. Auth.: ORS 161.390430.640, 461.549

Stats. Implemented: ORS 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380- 426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460,

309-019-0175

Outpatient Substance Use Disorders Treatment and Recovery Services

(1) Pregnant women or other individuals using substances intravenously whose services are funded by the SAPT Block Grant must receive interim referrals and information prior to entry to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services must include:

(a) Counseling and education about blood borne pathogens including Hepatitis, HIV, STDs, and Tuberculosis (TB); the risks of needle and paraphernalia sharing; and the likelihood of transmission to sexual partners and infants;

(b) Counseling and education about steps that can decrease the likelihood of Hepatitis, HIV, STD, and TB transmission;

(c) Referral for Hepatitis, HIV, STD, and TB testing and vaccine or care services if necessary;

(d) For pregnant women, counseling on the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco, and other drug use on the fetus, and referral for prenatal care; and

(2) Programs approved and designated as culturally specific programs must meet the following criteria:

(a) Serve a majority of individuals representing culturally specific populations;

(b) Maintain a current demographic and cultural profile of the community;

(c) Ensure that individuals from the identified cultural group receive effective and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language;

(d) Implement strategies to recruit, retain, and promote a diverse staff at all levels of the organization that are representative of the population being served;

(e) Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery;

(f) Ensure that a majority of the substance use disorders treatment staff be representative of the specific culture being served;

(g) Ensure that individuals are offered customer satisfaction surveys that address all areas of service and that the results of the surveys are used for quality improvement;

(h) Consider race, ethnicity, and language data in measuring customer satisfaction;

(i) Develop and implement cultural awareness policies;

(j) Ensure that data on an individual's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated;

(k) Develop and maintain a governing or advisory board as follows:

(A) Have a majority representation of the culturally specific group being served;

(B) Receive training concerning the significance of culturally relevant services and supports;

(C) Meet at least quarterly; and

(D) Monitor agency quality improvement mechanisms and evaluate the ongoing effectiveness and implementation of culturally relevant services (CLAS) and supports within the organization.

(L) Maintain accessibility to culturally specific populations including:

(A) The physical location of the program must be within close proximity to the culturally specific populations;

(B) Where available, public transportation must be within close proximity to the program; and

(C) Hours of service, telephone contact, and other accessibility issues must be appropriate for the population.

(m) The physical facility where the culturally specific services are delivered must be psychologically comfortable for the group including:

(A) Materials displayed must be culturally relevant; and

(B) Mass media programming must be sensitive to cultural background.

(n) Other cultural differences must be considered and accommodated when possible, such as the need or desire to bring family members to the facility, play areas for small children, and related accommodations; and

(o) Ensure that grievance processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints.

Stat. Auth.: ORS 413.042, 430.640, 443.450

Stats. Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460

309-019-0180

Outpatient Adolescent Substance Use Disorders Treatment and Recovery Services

Programs approved to provide adolescent substance use disorders treatment services or those with adolescent-designated service funding must meet the following standards:

(1) Development of service plans and case management services must include participation of parents, other family members, schools, children's services agencies, and juvenile corrections, as appropriate.

(2) Services or appropriate referrals must include:

(a) Family counseling;

(b) Community and social skills training; and

(c) Smoking cessation service.

(3) Continuing care services must be of appropriate duration and designed to maximize recovery opportunities. The services must include:

(a) Reintegration services and coordination with family and schools;

(b) Youth dominated self-help groups where available;

(c) Linkage to emancipation services when appropriate;

(d) Linkage to physical or sexual abuse counseling and support services when appropriate; and

(e) Access to peer delivered services.

Stat. Auth.: ORS 161.390, 413.042, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 430.010, 428.205 - 428.270, 430.205 - 430.210, 430.254- 430.640, 430.850 - 430.955, 743A.168

309-019-0185

Outpatient Women's Substance Use Disorders Treatment and Recovery Programs

(1) Programs approved to provide women's substance use disorders treatment services or those with women-specific designated service funding must meet the following standards:

(a) The assessment must contain an evaluation that identifies and assesses needs specific to women's issues in service such as social isolation, self-reliance, parenting issues, domestic violence, women's physical health, housing, and financial considerations;

(b) The service plan must address all areas identified in the assessment and applicable service coordination details to address the identified needs;

(c) The program must provide or coordinate services and supports that meet the special access needs of women such as childcare, mental health services, and transportation as indicated; and

(d) The program must provide or coordinate the following services and supports unless clinically contraindicated:

(A) Gender-specific services and supports;

- (B) Family services, including therapeutic services for children in the custody of women in treatment;
 - (C) Reintegration with family;
 - (D) Peer delivered services;
 - (E) Smoking cessation;
 - (F) Housing; and
 - (G) Transportation.
- (2) Services must include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies.
- (3) The program must coordinate referral services with the following, if indicated:
- (a) Agencies providing services to women who have experienced physical abuse, sexual abuse, or other types of domestic violence;
 - (b) Parenting training;
 - (c) Continuing care treatment services must be consistent with the ASAM and must include referrals to female dominated support groups where available.
- (4) Programs that receive SAPT Block Grant funding must provide or coordinate the following services for pregnant women and women with dependent children, including women who are attempting to regain custody of their children:
- (a) Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;
 - (b) Primary pediatric care, including immunizations for their children;
 - (c) Gender specific substance abuse treatment and other therapeutic interventions for women that may include but are not limited to:
 - (A) Relationship issues;
 - (B) Sexual and physical abuse;
 - (C) Parenting;
 - (D) Access to child care while the women are receiving these services; and
 - (E) Therapeutic interventions for children in the custody of women in treatment that may include but are not limited to:
 - (i) Their developmental needs;
 - (ii) Any issues concerning sexual and physical abuse and neglect; and

(iii) Sufficient case management and transportation to ensure that women and their children have access to services.

Stat. Auth.: ORS 161.390, 413.042, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254- 430.640, 430.850 - 430.955, 743A.168

309-019-0190

Community-Based Substance Use Treatment Programs for Individuals in the Criminal Justice System

(1) For individuals in the criminal justice system, community-based substance use treatment services and supports are for individuals who are under the supervision of a probation officer or on parole or post-prison supervision or participating in a drug treatment court program or otherwise under the direct supervision of the court.

(2) Services and supports must incorporate interventions and strategies that target criminogenic risk factors and include:

(a) Cognitive behavioral interventions;

(b) Motivational interventions;

(c) Relapse prevention; and

(d) Healthy relationships education.

(3) Providers must demonstrate coordination of services with criminal justice partners through written protocols, program staff activities, and individual record documentation.

(4) Program directors or clinical supervisors must have experience in community-based offender treatment programs and have specific training and experience applying effective, evidence-based clinical strategies and services for individuals receiving community-based substance use disorders treatment services to individuals in the criminal justice system.

(5) Within the first six months of hire, program staff must:

(a) Receive training on effective principles of evidenced-based practices for individuals with criminogenic risk factors; and

(b) Have documented knowledge, skills, and abilities demonstrating treatment strategies for individuals with criminogenic risk factors.

Stat. Auth.: ORS 161.390, 413.042, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0195

DUII Rehabilitation Programs

(1) In addition to the general standards for substance use disorders treatment programs, those programs approved to provide DUII rehabilitation services must meet the following standards:

(a) DUII rehabilitation programs must assess individuals referred for treatment by the screening specialist;

(b) Placement, continued stay, and transfer of individuals must be based on the criteria described in the ASAM PPC, subject to the following:

(A) Individuals must demonstrate continuous abstinence for a minimum of 90 days prior to completion as documented by urinalysis tests and other evidence;

(B) Only DUII rehabilitation programs may certify treatment completion;

(C) Using the criteria from the ASAM, the DUII program's assessment may indicate that the individual requires treatment in a residential program. When the individual is in residential treatment, it is the responsibility of the DUII program to:

(i) Monitor the case carefully while the individual is in residential treatment;

(ii) Provide or monitor outpatient and follow-up services when the individual is transferred from the residential program; and

(iii) Verify completion of residential treatment and follow-up outpatient treatment.

(2) A minimum of one urinalysis sample per month must be collected during the period of service, the total number deemed necessary to be determined by an individual's DUII rehabilitation program:

(a) Using the process outlined in these rules, the samples must be tested for at least five controlled drugs, including alcohol;

(b) At least one of the samples must be collected and tested in the first two weeks of the program, and at least one must be collected and tested in the last two weeks of the program;

(c) If the first sample is positive, two or more samples must be collected and tested, including one sample within the last two weeks before completion; and

(d) Programs may use methods of testing for the presence of alcohol and other drugs in the individual's body other than urinalysis tests if they have obtained the prior review and approval of such methods by the Division.

(3) The program must report:

(a) To the Division on Division prescribed forms;

(b) To the screening specialist within 30 days from the date of the referral by the screening specialist. Subsequent reports must be provided within 30 days of completion or within ten days of the time that the individual enters noncompliant status; and

(c) To the appropriate screening specialist, case manager, court, or other agency as required when requested concerning individual cooperation, attendance, treatment progress, utilized modalities, and fee payment.

(4) The program must send a numbered Certificate of Completion to the Department of Motor Vehicles to verify the completion of convicted individuals. Payment for treatment may be considered in determining completion. A certificate of completion may not be issued until the individual:

(a) Meets the completion criteria approved by the Division;

(b) Meets the terms of the fee agreement between the provider and the individual; and

(c) Demonstrates 90 days of continuous abstinence prior to completion.

(5) The DUII rehabilitation program must maintain in the permanent service record urinalysis results and all information necessary to determine whether the program is being or has been successfully completed.

(6) Without the approval of the chief officer, no agency or individual may provide DUII rehabilitation to an individual who has also been referred by a judge to the same agency or individual for a DUII screening. Failure to comply with this rule shall be considered a violation of ORS chapter 813. If the chief officer finds such a violation, the chief officer may deny, suspend, revoke, or refuse to renew a letter of approval.

Stat. Auth.: ORS 161.390, 413.042, 430.640, 443.450

Stats. Implemented: ORS 161.390 - 161.400, 430.010, 428.205 - 428.270, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 743A.168

309-019-0200

Medical Protocols in Outpatient Substance Use Disorders Treatment and Recovery Programs

Medical protocols must be approved by a medical director under contract with a program or written reciprocal agreement with a medical practitioner under coordinated care. The protocols must:

(1) Require a medical history be included in the assessment.

(2) Designate those medical symptoms that, when found, require further investigation, physical examinations, service, or laboratory testing.

(3) Require that individuals admitted to the program who are currently injecting or intravenously using a drug or have injected or intravenously used a drug within the past 30 days or who are at risk of withdrawal from a drug or who may be pregnant must be referred for a physical examination and appropriate lab testing within 30 days of entry to the program. This requirement may be waived by the medical director if these services have been received within the past 90 days and documentation is provided.

(4) Require pregnant women be referred for prenatal care within two weeks of entry to the program.

(5) Require that the program provide HIV and AIDS, TB, sexually transmitted disease, Hepatitis and other infectious disease information and risk assessment, including any needed referral, within 30 days of entry.

(6) Specify the steps for follow up and coordination with physical health care providers in the event the individual is found to have an infectious disease or other major medical problem.

Stat. Auth.: ORS 430.640, 443.450

Stats. Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460

Building Requirements, Quality Assessment, Grievances, and Variances

309-019-0205

Building Requirements in Outpatient Substance Use Disorders Treatment Programs

All substance use disorders treatment programs must:

(1) Comply with all applicable state and local building, electrical, plumbing, fire, safety, and zoning codes.

(2) Maintain up-to-date documentation verifying that they meet applicable local business license, zoning, and building codes and federal, state, and local fire and safety regulations. It is the responsibility of the program to check with local government to make sure all applicable local codes have been met.

(3) Provide space for services including but not limited to intake, assessment, counseling, and telephone conversations that assure the privacy and confidentiality of individuals and is furnished in an adequate and comfortable fashion including plumbing, sanitation, heating, and cooling.

(4) Provide rest rooms for individuals, visitors, and staff that are accessible to individuals with disabilities pursuant to Title II of the Americans with Disabilities Act if the program receives any public funds or Title III of the Act if no public funds are received.

(5) Adopt and implement emergency policies and procedures, including an evacuation plan and emergency plan in case of fire, explosion, accident, death, or other emergency. The policies and procedures and emergency plans must be current and posted in a conspicuous area.

(6) Outpatient programs may not allow tobacco use in program facilities and on program grounds.

Stat. Auth.: ORS 413.042, 430.640, 443.450

Stats. Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.524 - 430.640, 430.850 - 430.955, 443.400 - 443.460

309-019-0210

Quality Assessment and Performance Improvement

Providers shall develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families.

Stat. Auth.: ORS 430.640

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955

309-019-0215

Grievances and Appeals

(1) Any individual or parent or guardian receiving services may file a grievance with the provider, the individual's coordinated care plan, or the Division.

(2) For individuals whose services are funded by Medicaid, grievance and appeal procedures are set forth in OAR 410-141-0260 through 410-141-0266.

(3) For individuals whose services are not funded by Medicaid, providers must:

(a) Notify each individual or guardian of the grievance procedures by reviewing a written copy of the policy upon entry;

(b) Assist individuals and parents or guardians to understand and complete the grievance process and notify them of the results and basis for the decision;

(c) Encourage and facilitate resolution of the grievance at the lowest possible level;

(d) Complete an investigation of any grievance within 30 calendar days;

(e) Implement a procedure for accepting, processing, and responding to grievances including specific timelines for each;

(f) Designate a program staff individual to receive and process the grievance;

(g) Document any action taken on a substantiated grievance within a timely manner; and

(h) Document receipt, investigation, and action taken in response to the grievance.

(4) The provider must have a Grievance Process Notice that must be posted in a conspicuous place stating the telephone number of:

(a) The Division;

(b) Disability Rights Oregon; and

(c) The applicable Coordinated Care Organization.

(5) In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures are completed, the individual or guardian of the individual may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.

(6) A grievant, witness, or staff member of a provider may not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include but is not limited to dismissal or harassment, reduction in services, wages, or benefits, or basing service or a performance review on the action.

(7) The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

(8) Individuals and their legal guardians may appeal entry, transfer, and grievance decisions as follows:

(a) If the individual or guardian is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services. The appeal must be submitted to the Division;

(b) If requested, program staff must be available to assist the individual;

(c) The Division must provide a written response within ten working days of the receipt of the appeal; and

(d) If the individual or guardian is not satisfied with the appeal decision, they may file a second appeal in writing within ten working days of the date of the written response to the chief officer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 179.505, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168,

309-019-0220

Variances

(1) Requirements and standards for requesting and granting variances or exceptions are found in OAR 309-008-1600.

(2) The Division's chief officer or designee must approve or deny the request for a variance to these rules. The request must be made in writing using the Division approved variance request form and following the variance request procedure pursuant to OAR 309-008-1600.

(3) Granting a variance for one request does not set a precedent that must be followed by the Division when evaluating subsequent requests for variance.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

Assertive Community Treatment (ACT)

309-019-0225

Definitions

(1) In addition to the definitions in OAR 309-019-0105, the definitions below apply to this and subsequent rule sections.

(2) “Collateral Contacts” means members of the individual’s family or household or significant others (e.g., landlord, employer) who regularly interact with the individual and are directly affected by or have the capability of affecting their condition and are identified in the treatment plan as having a role in the individual’s recovery. For the purpose of the Assertive Community Treatment (ACT) program, a collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g., meeting with a shelter staff who is assisting an ACT recipient in locating housing).

(3) “Community-Based” means services and supports that must be provided in a participant’s home and surrounding community and not solely based in a traditional office-setting. ACT services may not be provided to individuals residing in an RTF or RTH licensed by the Division unless:

(a) The individual is not being provided rehabilitative services; or

(b) The individual has been identified for transition to a less intensive level of care. When identified for transition to a less intensive level of care, the individual may receive ACT services for up to six months prior to discharge from the RTH or RTF.

(4) “Competency” means one year of experience or training in the specialty area and demonstration of the specific skills or knowledge.

(5) “Competitive Integrated Employment” means full-time or part time work:

(a) At minimum wage or higher;

(b) At a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skill;

(c) With eligibility for the level of benefits provided to other employees;

(d) At a location where the employee interacts with other individuals who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other individuals; and

(e) That present opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(6) “Comprehensive Assessment” means the organized process of gathering and analyzing current and past information with each individual and the family and support system and other significant individuals to evaluate:

(a) Mental and functional status;

(b) Effectiveness of past treatment;

(c) Current treatment, rehabilitation, and support needs to achieve individual goals and support recovery; and,

(d) The range of individual strengths (e.g., knowledge gained from dealing with adversity, personal or professional roles, talents, personal traits) that may act as resources to the individual and the recovery planning team in pursuing goals. The results of the information gathering and analysis are used to:

(A) Establish immediate and longer-term service needs with each individual;

(B) Set goals and develop the first person directed recovery plan with each individual; and,

(C) Optimize benefits that can be derived from existing strengths and resources of the individual and family and natural support network in the community.

(7) “Co-Occurring Disorders (COD) Services” means integrated assessment and treatment for individuals who have co-occurring mental health and substance use condition.

(8) “Division Approved Reviewer” means the Division’s contracted entity that is responsible for conducting ACT fidelity reviews, training, and technical assistance to support new and existing ACT programs statewide.

(9) “Fidelity” for the purposes of the ACT program means the provider is providing services that are faithful to the evidence-based practice model and obtains a satisfactory score from the Oregon Center of Excellence for ACT as part of their regular reviews.

(10) “Fixed Point of Responsibility” means the ACT team provides virtually all needed services, rather than sending clients to different providers. If the team cannot provide a service, the team ensures that the service is provided.

(11) “Full-Time Equivalent” (FTE) means a way to measure how many full-time employees are required to provide the appropriate level of services to fulfill minimum fidelity requirements.

(12) “Hospital Discharge Planning” means a process that begins upon admission to the Oregon State Hospital (OSH) or an acute care psychiatric hospital and that is based on the presumption that with sufficient supports and services, all individuals can live in an integrated community setting. Discharge planning is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on principles of self-determination. For OSH, discharge planning teams include a representative of a community mental health provider from the county where the individual is likely to transition.

(13) “Individual Placement and Support (IPS) Supported Employment Services” means individualized services that assist individuals to obtain and maintain integrated, paid, competitive employment. Supported employment services are provided in a manner that seeks to allow individuals to work the maximum number of hours consistent with their preferences, interests, and abilities and are individually planned, based on person-centered planning principles and evidence-based practices.

(14) “Individual Treatment Team (ITT)” means a group or combination of three to five ACT team staff members who together have a range of clinical and rehabilitation skills and expertise. The core members are the case manager, the psychiatrist or psychiatric nurse practitioner, one clinical or rehabilitation staff individual who backs up and shares case coordination tasks and substitutes for the service coordinator when they are not working, and a peer support and wellness specialist.

(15) “Initial Assessment and Individualized Treatment Plan” means the initial evaluation of:

(a) The individual’s mental and functional status;

(b) The effectiveness of past treatment; and

(c) The current treatment, rehabilitation, and support service needs. The results of the information gathering and analysis are used to establish the initial treatment plan to support recovery and help the individual achieve their goals.

(16) “Large ACT Team” means an ACT team serving 80 to 120 individuals.

(17) “Life Skills Training” means training that helps individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

(18) “Medication Management” means the prescribing and administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. For the purposes of ACT, medication management is a collaborative effort between the individual receiving services and the prescribing psychiatrist or psychiatric nurse practitioner with the ACT treatment team.

(19) “Mid-Size Act Team” means an ACT team serving between 41 and 79 individuals.

(20) “Natural Supports” means personal associations and relationships typically developed in the community that enhance the quality and security of life for individuals, including but not limited to family relationships, friendships reflecting the diversity of the neighborhood and the community, association with fellow students or employees in regular classrooms and work places, and associations developed through participation in clubs, organizations, and other civic activities.

(21) “Psychiatry Services” means the prescribing and administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. Psychiatry services must be provided by a psychiatrist or a psychiatric nurse practitioner licensed by the Oregon Medical Board.

(22) “Single Point of Contact” (SPOC) means a designated individual in a service region that is responsible for coordinating and tracking referrals to ACT programs within their geographic service area.

(23) “Small ACT Team” means an ACT team serving between ten to 40 individuals.

(24) “Symptom Management” means to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment.

(25) “Telepsychiatry” means the application of telemedicine to the specialty field of psychiatry. The term describes the delivery of psychiatric assessment and care through telecommunications technology, usually videoconferencing.

(26) “Time-unlimited Services” means services that are provided not on the basis of predetermined timelines but if they are medically appropriate.

(27) “Vocational Services” means employment support services that will lead to competitive integrated employment. The Division encourages the use of fidelity IPS Supported Employment for providing vocational services within the ACT program.

Stat. Auth.: ORS 413.042

Stats Implemented: ORS 430.630

309-019-0226

Assertive Community Treatment (ACT) Overview

(1) The Substance Abuse and Mental Health Services Administration (SAMHSA) characterizes ACT as an evidence-based practice for individuals with a serious and persistent mental illness. ACT is characterized by:

- (a) A team approach;
- (b) Community based;
- (c) A small client to staff caseload, typically 10:1, to consistently provide necessary staffing diversity and coverage;
- (d) Time-unlimited services;
- (e) Flexible service delivery;
- (f) A fixed point of responsibility; and
- (g) 24/7 availability for response to psychiatric crisis.

(2) ACT services must include but are not limited to:

- (a) Hospital discharge planning, including OSH and acute care psychiatric hospitals;
- (b) Case management;
- (c) Symptom management;
- (d) Psychiatry services;
- (e) Nursing services;
- (f) Co-occurring substance use and mental health disorders treatment services;

(g) Individual Placement and Support (IPS) supported employment services;

(h) Life skills training; and

(i) Peer delivered services.

(3) SAMHSA characterizes a high fidelity ACT program as one that includes the following staff members:

(a) Psychiatrist or Psychiatric Nurse Practitioner;

(b) Psychiatric Nurse;

(c) Qualified Mental Health Professional (QMHP) ACT Team Supervisor;

(d) Qualified Mental Health Professional (QMHP) Mental Health Clinician;

(e) Substance Abuse Treatment Specialist;

(f) Employment Specialist;

(g) Mental Health Case Manager; and

(h) Certified Peer Support Specialist.

(4) SAMHSA characterizes high fidelity ACT programs as those that adhere to the following:

(a) Providing explicit admission criteria with an identified mission to serve a particular population using quantitative and operationally defined criteria;

(b) Managing intake rates. ACT eligible individuals are admitted to the program at a low rate to maintain a stable service environment;

(c) Maintaining full responsibility for treatment services that includes, at a minimum, the services required under OAR 309-019-0230(2)(a) – (i);

(d) Twenty-four hour responsibility for covering psychiatric crises;

(e) Involvement in hospital admissions, including OSH and acute care psychiatric hospitals;

(f) Involvement in planning for hospital discharges, including OSH and acute care psychiatric hospitals; and

(g) As long as medically appropriate, time-unlimited services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0230

ACT Provider Qualifications

(1) In order to be eligible for Medicaid or State General Fund reimbursement, ACT services shall be provided only by those providers meeting the following minimum qualifications:

(a) The provider must hold and maintain a certificate issued under the authority established in OAR chapter 309, division 008 issued by the Division for the purpose of providing outpatient behavioral health treatment services; and

(b) The provider must hold and maintain a certificate issued by the Division under OAR 309-019-0225 through 025 for the purpose of providing ACT; and

(c) A provider certified to provide ACT services must be reviewed annually for fidelity adherence by the Division approved reviewer and achieve a minimum score of 114 on the fidelity scale. Providers may not bill Medicaid or use General Funds for the provision of ACT services unless they complete an annual fidelity review by the Division approved reviewer:

(A) The Division approved reviewer shall forward a copy of the annual fidelity review report to the Division and provide a copy of the review to the provider;

(B) The provider shall forward a copy of the annual fidelity review report to the appropriate CCO.

(2) A provider already holding a certificate of approval under OAR chapter 309, division 008 may request the addition of ACT services be added to their certificate of approval using the procedure outlined in OAR 309-008-0400 and 309-008-1000(1), in addition to application materials required in OAR chapter 309, division 008 and this rule. The provider must also submit to the Division a letter of support that indicates receipt of technical assistance and training from the Division approved ACT reviewer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0235

Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0230 to maintain an ACT provider designation on the Division issued certificate, a provider must submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 114. Extension of a certification period has no bearing on the frequency or scope of fidelity reviews or re-certification reviews required under OAR chapter 309, division 008.

(2) Fidelity reviews shall be conducted utilizing the Substance Abuse and Mental Health Services ACT Toolkit Fidelity Scale, which the Division shall make available to providers electronically.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0240

Failure to Meet Fidelity Standards

(1) In addition to any plan of correction requirements issued by the Division under OAR 309-008-0800(4)(c), if a certified ACT provider does not receive a minimum score of 114 on any fidelity review, the following shall occur:

(a) Technical assistance shall be made available by the Division approved reviewer to address problem areas identified in the fidelity review;

(b) Technical assistance shall be available for a period of 90 days from the date of the fidelity review where the provider scored below the minimum established in section one of this rule;

(c) At the end of the 90 day period, a follow-up review shall be conducted by the Division approved reviewer;

(d) The provider shall forward a copy of the amended fidelity review report to the provider's CCO; and

(e) The Division approved reviewer shall forward a copy of the fidelity review report to the Division.

(2) In addition to the standards set for suspension and revocation of a certificate in OAR 309-008-1100(1) and (2), a provider of ACT services may also have their certificate of approval suspended or revoked if the 90 day re-review results in a fidelity score of less than 114.

(3) A provider who is issued a notice of intent to apply a condition, revoke, suspend, or refusal to renew its certificate under these rules shall be entitled to request a hearing in accordance with ORS Chapter 183 and OAR 309-008-1300.

Stat. Auth.: ORS 413.042, 430.256, 430.640

Stats. Implemented: ORS 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0241

Waiver of Minimum Fidelity Requirements

(1) The Division may grant a waiver of minimum ACT fidelity requirements and extend an ACT program's certification period if the waiver to the requirement would not diminish the effectiveness of the ACT model, violate the purposes of the program, or adversely affect the program participants' health and welfare:

(a) Waivers may not be granted that are inconsistent with the individual participant's rights or federal, state, or local laws and regulations;

(b) The Division shall review waivers to minimum fidelity requirements on a case-by-case basis.

(2) Waivers granted to ACT minimum fidelity requirements shall result in an extension to the ACT program's certification period. An ACT program that is a Division approved waiver period is eligible

to receive Medicaid and State General Fund reimbursement for ACT services if the ACT program meets the following criteria:

(a) The ACT program must receive technical assistance from the Division approved reviewer and develop a plan to meet the minimum fidelity requirements; and

(b) The ACT program shall notify the appropriate CCO that the program is operating under the Division approved waiver of minimum fidelity requirements.

(3) The Division shall grant waivers of minimum fidelity requirements for a period that may not exceed 180 days.

(4) A waiver of minimum fidelity requirements may only be granted to ACT programs that have received a fidelity review within 12 months prior to the request.

(5) Requests for a waiver of minimum fidelity requirements shall be submitted to the Division's ACT program coordinator for approval.

Stat. Auth.: ORS 413.042, 430.256, 430.640

Stats. Implemented: ORS 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0242

ACT Program Operational Standards

(1) All ACT teams must be available seven days a week, 24 hours a day by direct phone link and regularly accessible to individuals who work or are involved in other scheduled vocational or rehabilitative services during the daytime hours. ACT teams may utilize split staff assignment schedules to achieve coverage.

(2) ACT teams are primarily responsible for crisis response and for after-hour calls related to individuals they serve. The ACT team must operate continuous and direct after-hours on-call system with staff experienced in the program and skilled in crisis intervention procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone. To ensure direct access to the ACT team, individuals must be given a phone list with the responsible ACT staff to contact after hours.

(3) Service Intensity:

(a) The ACT team must have the capacity to provide the frequency and duration of staff-to-individual contact required by each individual's service plan and their immediate needs;

(b) The ACT team must provide a minimum of 40 percent of all services in-community as demonstrated by the average in-community encounters reviewed in case record reviews;

(c) The ACT team must have the capacity to increase and decrease contacts based upon daily assessment of the individual's clinical need with a goal of maximizing independence;

(d) The team must have the capacity to provide multiple contacts to individuals in high need and a rapid response to early signs of relapse;

(e) The team must have the capacity to provide support and skills development services to individuals' natural supports and collateral contacts;

(f) Natural supports and collateral contacts may include family, friends, landlords, or employers, consistent with the service plan. Natural supports and collateral contacts are typically not supports that are paid for services;

(g) The ACT team Psychiatrist and the Psychiatric Nurse Practitioner (PNP) must have scheduling flexibility to accommodate individual needs. If the individual will not come to meet the Psychiatrist or the PNP at the ACT office, the Psychiatrist or PNP must provide services as clinically indicated for that individual in the community. Secure telepsychiatry may be used when clinically indicated;

(h) The ACT team must have the capacity to provide services via group modalities as clinically appropriate, including but not limited to individuals with substance abuse disorders and for family psychoeducation and wellness self-management services.

(4) An ACT team shall have sufficient staffing to meet the varying needs of individuals. As an all-inclusive treatment program, a variety of expertise must be represented on the team. Staffing must be clearly defined and dedicated to the operation of the team.

(5) Staffing Guidelines for ACT teams:

(a) A single ACT team may not serve more than 120 individuals unless:

(A) It is expanding for the expressed purpose of splitting into two ACT teams within a 12-month period; and

(B) It hires the appropriate staff to meet the required 1:10 staff ratio to individuals served.

(b) ACT team individual to clinical staff ratio may not exceed 10:1;

(c) ACT team staff must be comprised of individual staff members in which a portion or all of their job responsibilities are defined as providing ACT services;

(d) Other than for coverage when a staff member has a leave of absence, ACT teams may not rotate staff members into the ACT team that are not specifically assigned to the team as part of their position's job responsibilities.

(6) No individual ACT staff member shall be assigned less than .20 FTE for their role on the team unless filling the role of psychiatrist or PNP. The ACT team psychiatrist or PNP may not be assigned less than .10 FTE.

(7) Maximum ACT team staffing requirements: ACT teams may not exceed the following upper staffing limits:

(a) No more than eight individual staff members per small ACT team;

(b) No more than 12 individual staff members per mid-size ACT team;

(c) No more than 18 individual staff members per large ACT team.

(8) ACT team staffing is multi-disciplinary. The core minimum staffing for an ACT team includes:

(a) A team leader position that shall be occupied by only one individual. The team leader is a QMHP level clinician qualified to provide direct supervision to all ACT staff except the psychiatric care provider and nurse. Pursuant to the table in OAR 309-019-0242 (13), the Team Leader FTE is dictated by the number of individuals served by the ACT team;

(b) Pursuant to the table in OAR 309-019-0242 (11), Psychiatric Care Provider (Psychiatrist or PNP) FTE is dictated by the number of individuals served by the ACT team;

(c) Pursuant to the table in OAR 309-019-0242 (11), the Nurse FTE is dictated by the number of individuals served by the ACT team;

(d) The Program Administrative Assistant FTE is not counted in the clinical staff ratio.

(9) ACT team minimum staffing must include clinical staff with the following FTE and specialized competencies:

(a) Pursuant to the table in OAR 309-019-0242 (11), the Substance Abuse Specialist FTE is dictated by the number of individuals served by the ACT team. A Substance Abuse Specialist specialized competencies must include:

(A) Substance abuse assessment and substance abuse diagnosis;

(B) Principles and practices of harm reduction;

(C) Knowledge and application of motivational interviewing strategies.

(b) Pursuant to the table in OAR 309-019-0242 (11), the Employment Specialist FTE is dictated by the number of individuals served by the ACT team. An Employment Specialist specialized competencies must include:

(A) Competence in the IPS Supported Employment fidelity model;

(B) Vocational assessment;

(C) Job exploration and matching to individual's interest and strengths;

(D) Skills development related to choosing, securing, and maintaining employment.

(c) Pursuant to the table in OAR 309-019-0242 (11), the Peer Support and Wellness Specialist FTE is dictated by the number of individuals served by the ACT team.

(d) See a Certified Peer Support Specialist or Peer Wellness Specialist as described in OAR 410-180-0300 and 410-180-0380. A registry of certified Peer Support Specialist Specialists and Peer Wellness Specialists may be found at the Office of Equity and Inclusion's Traditional Health Worker's website.

(10) ACT Team Staffing Core Competencies:

(a) Upon hiring, all clinical staff on an ACT team must have experience in providing direct services related to the treatment and recovery of individuals with a serious and persistent mental illness. Staff shall be selected consistent with the ACT core operating principles and values. Clinical staff shall have demonstrated competencies in clinical documentation and motivational interviewing;

(b) All staff shall demonstrate basic core competencies in designated areas of practice, including the Assertive Community Treatment core principles, integrated mental health and substance abuse treatment, supported employment, psycho-education, and wellness self-management;

(c) All staff must receive ACT 101 training from the Division approved reviewer prior to receiving the Division provisional certification; and

(d) All professional ACT team staff must obtain the appropriate licensure to provide services in Oregon for their respective area of specialization.

(11) ACT Team Size Staff (FTE) to Individual Ratio Table:	Small or Micro Team (10 to 40 individuals)	Mid-size team (between 41 and 79 individuals)	Large Team (80-120 individuals)
Staff to individual ratio: includes all team members except the psychiatric care provider and program assistants	1 team member per 10 individuals	1 team member per 10 individuals	1 team member per 10 individuals
Team Leader: This position is to be occupied by only one individual. The team leader is a QMHP level clinician qualified by OARs to provide direct supervision to all ACT staff (except psychiatric care provider and nurse)	One team leader (.50 FTE to 1.0 FTE)	One full-time team leader (1.0 FTE)	One full-time team leader (1.0 FTE)
Psychiatric Care Provider: (Psychiatrist or Psychiatric Nurse Practitioner) Prorating of FTE allowed given number of individuals served. No more than two psychiatric care providers per ACT team	Minimum FTE is .10 (4 hours each week) for 10 ACT participants and should reflect the equivalent of 1.0 FTE per 100 clients as the number of individuals increases (.20 FTE for 20 individuals; .35 FTE for 35 individuals; .40 FTE for 40 individuals)	Minimum FTE is .40 FTE (16 hours each week) and should reflect the equivalent of 1.0 FTE per 100 clients as the number of individuals increases	Minimum FTE is .80 FTE (32 hours each week) and should reflect the equivalent of 1.0 FTE per 100 clients as the number of individuals increases

<p>Nurses: Registered Nurses (RN) or Advanced Practice Registered Nurse (APRN) may fill this position. Prorating of FTE allowed given number of individuals actually served.</p>	<p>Minimum of .20 FTE RN time for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>	<p>Minimum of .80 FTE RN time for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>	<p>Minimum of 1.60 FTE RN time for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>
<p>Substance Abuse Specialist (SAS): QMHP or QMHA with a minimum of one year experience providing substance abuse treatment services (CADC 1 or above preferred to meet this credential)</p>	<p>Minimum of .20 FTE SAS time for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>	<p>Minimum of .80 FTE SAS time for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>	<p>Minimum of 1.60 FTE SAS time for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>
<p>Peer Specialist: An Oregon certified peer support specialist who has a mental health diagnosis themselves for which they have received treatment and is willing to self-disclose their lived experience</p>	<p>Minimum FTE is .10.FTE is flexible based on peer preference and staffing needs of the ACT team.</p>	<p>Minimum FTE is .40.FTE is flexible based on peer preference and staffing needs of the ACT team. More than one peer may perform this role.</p>	<p>Minimum FTE is .80.FTE is flexible based on peer preference and staffing needs of the ACT team. More than one peer may perform this role.</p>
<p>Vocational Specialist: QMHP or QMHA with one year experience providing employment services that focus on competitive employment outcomes.</p>	<p>Minimum of .20 FTE SA time for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>	<p>Minimum of .80 FTE SA time for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>	<p>Minimum of 1.60 FTE SA time for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.</p>
<p>Program Administrative Assistant A program office manager or administrative assistant is highly recommended to be dedicated to the ACT team</p>	<p>.50 FTE ACT dedicated office manager/administrative assistant is highly recommended</p>	<p>.50 - 1.0 FTEACT dedicated office manager/administrative assistant is highly recommended</p>	<p>1.0 FTE ACT dedicated office manager/administrative assistant is highly recommended</p>
<p>Additional Staff (QMHP and or QMHA level mental health clinicians, housing</p>	<p>0-2.5additional FTE may be required to meet the 1:10 staff to</p>	<p>0-4.0 additional FTE may be required to meet the 1:10 staff to</p>	<p>1-6.0 additional FTE may be required to meet the 1:10 staff to</p>

specialists, case managers) to meet the ACT fidelity ratio of 1 staff for 10 individuals served	individual ratio and provide comprehensive services ACT recipients need	individual ratio and provide comprehensive services ACT recipients need	individual ratio and provide comprehensive services ACT recipients need
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(12) The ACT team shall conduct daily organizational staff meetings at least four days per week and regularly scheduled times per a schedule established by the team leader. These meetings shall be conducted in accordance with the following procedures:

(a) The ACT team shall maintain in writing:

(A) A roster of the individuals served in the program; and

(B) For each individual, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the individual's status that day.

(b) The daily organizational staff meeting includes a review of the treatment contacts that occurred the day before and provides a systematic means for the team to assess the day-to-day progress and status of all clients;

(c) During the daily organizational staff meeting, the ACT team shall also revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.

(13) The ACT team shall conduct treatment planning meetings under the supervision of the team leader and the Psychiatrist or PNP. These treatment planning meetings shall:

(a) Convene at regularly scheduled times per a written schedule set by the team leader;

(b) Occur and be scheduled when the majority of the team members can attend, including the psychiatrist or psychiatric nurse practitioner, team leader, and all members of the treatment team;

(c) Require individual staff members to present and systematically review and integrate an individual's information into a holistic analysis and prioritize problems; and

(d) Occur with sufficient frequency and duration to make it possible for all staff to:

(A) Be familiar with each individual and their goals and aspirations;

(B) Participate in the ongoing assessment and reformulation of problems;

(C) Problem-solve treatment strategies and rehabilitation options;

(D) Participate with the individual and the treatment team in the development and the revision of the treatment plan; and

(E) Fully understand the treatment plan rationale in order to carry out each individual's plan.

(14) ACT Assessment and Individualized Treatment Planning:

(a) An initial assessment and treatment plan is completed upon each individual's admission to the ACT program; and

(b) Individualized treatment plans for ACT team-served individuals must be updated at least every six months.

(15) Service Note Content:

(a) More than one intervention, activity, or goal may be reported in one service note, if applicable;

(b) ACT team staff must complete a service note for each contact or intervention provided to an individual. Each service note must include all of the following:

(A) Individual's name;

(B) Medicaid identification number or client identification number;

(C) Date of service provision;

(D) Name of service provided;

(E) Type of contact;

(F) Place of service;

(G) Purpose of the contact as it relates to the goals on the individual's treatment plan;

(H) Description of the intervention provided. Documentation of the intervention must accurately reflect substance abuse related treatment for the duration of time indicated;

(I) Amount of time spent performing the intervention;

(J) Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goal;

(K) Signature and credentials or job title of the staff member who provided the service; and

(L) Each service note page must be identified with the beneficiary's name and client identification number.

(c) Documentation of discharge or transition to lower levels of care must include all of the following:

(A) The reasons for discharge or transition as stated by both the individual and the ACT team;

(B) The individual's biopsychosocial status at discharge or transition;

(C) A written final evaluation summary of the individual's progress toward the goals set forth in the person-centered treatment plan;

(D) A plan for follow-up treatment, developed in conjunction with the individual; and

(E) The signatures of the individual, the team leader, and the psychiatrist or PNP.

Stat. Auth.: ORS 413.042

Stats Implemented: 430.630

309-019-0245

Admission Criteria

(1) Participants must meet the medically appropriate standard as designated in OAR 309-019-0105. Participants who are medically appropriate must have the following characteristics:

(a) Participants diagnosed with severe and persistent mental illness as listed in the Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability;

(b) Individuals with a primary diagnosis of a substance use disorder or intellectual developmental disabilities or borderline personality disorder or traumatic brain injury or an autism spectrum disorder are not the intended recipients of ACT and may not be referred to ACT if they do not have a co-occurring, qualifying psychiatric disorder;

(c) Participants with other psychiatric illnesses are eligible dependent on the level of the long-term disability;

(d) Participants with significant functional impairments as demonstrated by at least one of the following conditions:

(A) Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives;

(B) Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities);

(C) Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

(e) Participants with one or more of the following problems, which are indicators of continuous high service needs (e.g., greater than eight hours per month):

(A) High use of acute care psychiatric hospitals or emergency departments for psychiatric reasons, including psychiatric emergency services as defined in OAR 309-023-0110(e.g., two or more readmissions in a six month period);

(B) Intractable (e.g., persistent or very recurrent) severe major symptoms, affective, psychotic, suicidal);

(C) Coexisting substance abuse disorder of significant duration (e.g., greater than six months);

(D) High risk or recent history of criminal justice involvement (e.g., arrest, incarceration);

(E) Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless;

(F) Residing in an inpatient or supervised community residence in the community where ACT services are available, but clinically assessed to be able to live in a more independent living situation if intensive services are provided or requiring a residential or institutional placement if more intensive services are not available;

(G) Difficulty effectively utilizing traditional office-based outpatient services.

(2) The ACT program provides community-based, long-term or time-unlimited services and is not intended to be in and of itself a transitional program.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0248

Admission Process

(1) A comprehensive assessment as described in OAR 309-019-0105(6) that demonstrates medical appropriateness must be completed prior to the provision of this service. If a substantially equivalent assessment is available that reflects current level of functioning and contains standards consistent with OAR 309-019-0135 to include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services, the equivalent assessment may be used to determine admission eligibility for the program.

(2) Admission to ACT is managed through a referral process that is coordinated by a designated single point of contact (SPOC) that represents the Coordinated Care Organization's (CCO) or the Community Mental Health Program's (CMHP) geographical service area:

(a) The designated single point of contact shall accept referrals and verify the required documentation supports and the referral for services when an approximate, reasonable date of admission to the ACT program is anticipated;

(b) The Authority shall work with the CCOs and the CMHPs to identify regional SPOCs;

(c) The Authority shall work with the CCOs and the CMHPs to identify a process where referrals can be received and tracked.

(3) An admission decision by the designated SPOC must be completed and reported to the Division within seven business days of receiving the referral. To accomplish this, the SPOC must be fully informed as to the current capacity of ACT programs within the SPOC's geographic service area at all times.

(4) All referrals for ACT services must be submitted through the designated regional SPOC, regardless of the origin of the referral when an approximate, reasonable date of admission to the ACT program is anticipated. The designated regional SPOC shall accept and evaluate referrals from mental health outpatient programs, residential treatment facilities or homes, families or individuals, and other referring sources.

(5) Given the severity of mental illness and functional impairment of individuals who qualify for ACT-level services, the final decision to admit a referral rests with the provider. Any referral to a provider shall therefore present a full picture of the individual by means of the supporting medical documentation attached to the Universal ACT Referral and Tracking Form and include an approximate date the referred individual will be able to enroll in an ACT program. A tentative admission decision and an agreement to screen by the ACT services provider must be completed within five business days of receiving the referral:

(a) The individual's decision not to take psychiatric medication is not a sufficient reason for denying admission to an ACT program;

(b) ACT capacity in a geographic regional service area is not a sufficient reason for not providing ACT services to an ACT eligible individual. If an individual who is ACT eligible cannot be served due to capacity, the SPOC must provide the individual with the option of being added to a waiting list until such time as the ACT eligible individual may be admitted to a certified ACT program:

(A) The ACT eligible individual who is not accepted into an ACT program due to capacity shall be offered alternative community-based rehabilitative services as described in the Oregon Medicaid State Plan that includes evidence-based practices to the extent possible;

(B) Alternative rehabilitative services shall be made available to the individual:

(i) Until the individual is admitted into an ACT program;

(ii) Alternative rehabilitative services are medically appropriate and meet the individual's treatment goals; or

(iii) The individual refuses alternative medically appropriate rehabilitative services.

(6) Upon the decision to admit an individual to the ACT program, the Authority's Universal ACT Referral and Tracking Form shall be updated to include:

(a) A tentative admission is indicated;

(b) When an admission is not indicated, notation shall be made of the following:

(A) The reasons for not admitting;

(B) The disposition of the case; and

(C) Any referrals or recommendations made to the referring agency, as appropriate.

(7) Individuals who meet admission criteria and are not admitted to an ACT program due to program capacity may elect to be placed on a waiting list. The waiting list will be maintained by the appropriate regional SPOC. The Authority shall monitor each regional waiting list until sufficient ACT program capacity is developed to meet the needs of the ACT eligible population.

(8) In addition, if an individual is denied ACT services and has met the admission criteria set forth in OAR 309-019-0245, the individual who is denied services or their guardian may appeal the decision by filing a grievance in the manner set forth in OAR 309-008-1500.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0250

Transition to Less Intensive Services and Discharge

(1) Transition to less intensive services shall occur when the individual no longer requires ACT level of care and is no longer medically appropriate for ACT services.

(2) This transition shall occur when individuals receiving ACT:

(a) Have successfully reached individually established goals for transition;

(b) Have successfully demonstrated an ability to function in all major role areas including but not limited to work, social, and self-care without ongoing assistance from the ACT provider;

(c) Requests discharge or declines or refuses services;

(d) Moves outside of the geographic area of the ACT program's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT provider or another provider wherever the individual is moving. The ACT team shall maintain contact with the individual until this service is implemented.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

309-019-0255

Reporting Requirements

(1) Providers certified by the Division to provide ACT shall submit quarterly outcome reports using forms and procedures prescribed by the Division.

(2) Providers shall submit quarterly outcome reports within 45 days following the end of each subject quarter to the Division or the Division reviewer. Each quarterly report shall provide the following information:

(a) Individuals served:

- (A) Individuals who are homeless at any point during a quarter;
- (B) Individuals with safe stable housing for six months;
- (C) Individuals using emergency departments during each quarter for a mental health reason;
- (D) Individuals hospitalized in OSH or in an acute psychiatric facility during each quarter;
- (E) Individuals hospitalized in an acute care psychiatric facility during each quarter;
- (F) Individuals in jail at any point during each quarter;
- (G) Individuals receiving supported employment services during each quarter;
- (H) Individuals who are employed in competitive integrated employment, as defined above;
- (I) Individuals receiving ACT services that are not enrolled in Medicaid.

(b) Referrals and Outcomes:

- (A) Number of referrals received during each quarter;
- (B) Number of individuals accepted during each quarter;
- (C) Number of individuals admitted during each quarter; and
- (D) Number of individuals denied during each quarter and the reason for each denial.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 430.640

Stats. Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

Individual Placement and Support (IPS) Supported Employment Services

309-019-0270

Definitions

(1) Competitive Integrated Employment” means full-time or part time work:

- (a) At minimum wage or higher rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skill with eligibility for the level of benefits provided to other employees;

(b) At a location where the employee interacts with other individuals who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other individuals;

(c) As appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(2) “Division Approved Reviewer” means the Oregon Supported Employment Center for Excellence (OSECE). OSECE is the Division’s contracted entity responsible for conducting IPS Supported Employment fidelity reviews, training, and technical assistance to support new and existing IPS Supported Employment programs statewide.

(3) “Fidelity” for the purposes of the IPS Supported Employment program means the provider is providing services that are faithful to the evidence-based practice model and obtains a satisfactory score from the Oregon Supported Employment Center for Excellence for IPS Supported Employment as part of the their regular reviews.

(4) “Vocational Services” for the purposes of the ACT program in Oregon means employment support services that will lead to competitive integrated employment. The Division specifies the use of fidelity IPS Supported Employment for providing vocational services within the ACT program, as described in OAR 309-019-0225 – 309-019-0255.

Stat. Auth.: ORS 413.042

Stats Implemented: 430.630

309-019-0275

Individual Placement and Support (IPS) Supported Employment Overview

(1) Supported employment is an evidence-based practice for individuals with serious mental illness.

(2) Supported employment is characterized by:

(a) Emphasis on competitive employment;

(b) Every individual interested in work is eligible for services regardless of symptoms, substance use disorders, treatment decisions, or any other issue;

(c) Employment services are integrated with mental health treatment;

(d) Individuals have access to personalized benefits planning;

(e) Job search begins soon after an individual expresses interest in working; and

(f) Client preferences for jobs and preferences for service delivery are honored;

(g) Employment specialists systematically visit employers who are selected based on job seeker preferences to learn about their business needs and hiring preferences;

(h) Job supports are individualized and continue for as long as each worker wants and needs the support.

(3) Supported employment services include but are not limited to:

(a) Job development;

(b) Supervision and job training;

(c) On-the-job visitation;

(d) Consultation with the employer;

(e) Job coaching;

(f) Counseling;

(g) Skills training; and

(h) Transportation.

Stat. Auth.: ORS 413.042

Stats Implemented: 430.630

309-019-0280

Supported Employment Providers

(1) To be eligible for Medicaid or State General Fund reimbursement, supported employment services shall be provided only by those providers meeting the following minimum qualifications:

(a) The provider must hold and maintain a current certificate under OAR chapter 309, division 008 issued by the Division for the purpose of providing behavioral health treatment services; and

(b) A provider certified to provide supported employment services must be reviewed annually for fidelity adherence by the Division approved reviewer and achieve a minimum score of 100 on the fidelity scale. Providers may not bill Medicaid or use general funds unless they are subject to an annual fidelity review by the Division approved reviewer:

(A) The Division approved reviewer shall forward a copy of the annual fidelity review report to the Division and provide a copy of the review to the provider;

(B) The provider shall forward a copy of the annual fidelity review report to the appropriate CCO.

(2) To be eligible for Medicaid reimbursement, supported employment services must be provided by a certified supported employment provider.

(3) A provider holding a certificate of approval under OAR chapter 309, division 008 may request the addition of IPS supported employment services to their certificate of approval via the procedure outlined in OAR 309-008-0400 and 309-008-1000(1):

(a) In addition to application materials required in OAR chapter 309, division 008, and this rule, the provider must also submit to the Division a letter of support that indicates receipt of technical assistance and training from the Division approved supported employment reviewer;

(b) New providers of IPS supported employment services must submit a letter to the Division that indicates the intention to implement a high-fidelity IPS supported employment program.

Stat. Auth.: ORS 413.042

Stats Implemented: 430.630

309-019-0285

Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0275 to maintain an IPS supported employment provider designation on the Division issued certificate, a provider must submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 100 of 125.

(2) Providers certified to provide IPS supported employment services that achieve a fidelity score of 100 or better when reviewed by the Division approved supported employment reviewer are certified for 12 months.

(3) Fidelity reviews shall be conducted utilizing the Substance Abuse and Mental Health Services Supported Employment Fidelity Scale, which shall be made available to providers electronically.

(4) Providers shall cooperate with the Division approved supported employment reviewer for the purpose of improving supported employment services.

Stat. Auth.: ORS 413.042

Stats Implemented: 430.630

309-019-0290

Failure to Meet Fidelity Standards

(1) In addition to any plan of correction requirements issued by the Division under 309-008-0800(4)(c), if a provider certified under these rules to provide supported employment services does not receive a minimum score of 100 on a fidelity review, the following shall occur:

(a) Technical assistance shall be made available by the Division approved reviewer for a period of 90 days to address problem areas identified in the fidelity review;

(b) At the end of the 90-day period, a follow-up review shall be conducted by the Division approved reviewer; and

(c) The provider shall forward a copy of the amended fidelity review report to the provider's CCO;

(d) The Division approved reviewer shall forward a copy of the fidelity review report to the Division.

(2) In addition to the standards set for suspension and revocation of a certificate in OAR 309-008-1100(1) and (2), a provider of supported employment services may also have their certificate of approval suspended or revoked if the 90-day re-review results in a fidelity score of less than 100.

(3) A provider who is issued a notice of intent to apply a condition, revoke, suspend, or refusal to renew its certificate may request a hearing in accordance with ORS Chapter 183 and OAR 309-008-1300.

Stat. Auth.: ORS 413.042

Stats Implemented: 430.630

309-019-0295

Reporting Requirements

(1) Providers of supported employment services shall submit quarterly outcome reports using forms and procedures prescribed by the Division within 45 days following the end of each subject quarter to the Division or the Division approved reviewer.

(2) Each quarterly report shall provide the following information:

(a) All individuals who received supported employment in the reporting quarter;

(b) Individuals who received supported employment services who are employed in competitive integrated employment; and

(c) Individuals who discontinued receiving supported employment services and are employed in competitive integrated employment; and

(d) Individuals who received supported employment services as a part of the Assertive Community Treatment program.

Stat. Auth.: ORS 413.042

Stats Implemented: 430.630

Crisis Line Services

309-019-0300

Service Requirements

(1) Crisis line services must be provided directly or through linkages to a crisis line services provider 24/7.

(2) Crisis line services shall include but is not limited to:

(a) 24/7 accessibility to a QMHP;

(b) 24/7 bi-lingual or interpreter availability;

- (c) 24/7 telephone screening to determine the need for immediate intervention;
- (d) 24/7 linkage to emergency service providers, including first responders and mobile crisis services;
- (e) Best practice risk assessment, including suicide risk assessment;
- (f) Suicide intervention and prevention;
- (g) Lethal means counseling and safety planning for individuals at risk for suicide;
- (h) Crisis intervention;
- (i) Crisis plan development;
- (j) Triage;
- (k) Providing information regarding services and resources in the community; and
- (L) Procedures for de-escalation for calls from suicidal individuals.

Stat. Auth.: ORS 413.042 and 430.640

Stats Implemented: ORS 430.630, 430.640, 430.644 - 430.646

309-019-0305

Provider Standards

- (1) Crisis line services providers must develop and implement written policies and procedures to address provider standards.
- (2) Provider standards shall include but is not limited to:
 - (a) Training curriculum and ongoing education programs to meet training requirements;
 - (b) Coordination with other treatment providers including mobile crisis services and other crisis line services providers to support seamless transitions of care;
 - (c) Linkages to emergency services providers including first responders to address imminent risks and to support seamless transitions of care;
 - (d) De-escalation procedures;
 - (e) Follow-up procedures when indicated and appropriate;
 - (f) Documentation;
 - (g) Code of ethics; and
 - (h) Security of information protocols.

Stat. Auth.: ORS 413.042 and 430.640

Stats Implemented: ORS 430.630, 430.640, 430.644 - 430.646

309-019-0310

Minimum Staffing Requirements

- (1) At least one QMHP must be available by phone or face-to-face 24/7 for consultation.
- (2) At least one QMHP shall provide regular clinical supervision to staff.

Stat. Auth.: ORS 413.042 and 430.640

Stats Implemented: ORS 430.630, 430.640, 430.644 - 430.646

309-019-0315

Training Requirements

- (1) Staff training curriculum shall include but is not limited to:
 - (a) Triage protocol;
 - (b) Referral resources;
 - (c) Crisis plan development;
 - (d) Screening for a Declaration for Mental Health Treatment.
- (2) Staff training curriculum shall include best practices for the following:
 - (a) Risk assessment, including suicide risk assessment;
 - (b) Suicide intervention and prevention;
 - (c) Safety planning;
 - (d) Lethal means counseling;
 - (e) De-escalation methods;
 - (f) Crisis intervention;
 - (g) Recovery support, including peer delivered services;
 - (h) Trauma informed care; and
 - (i) Cultural awareness.

Stat. Auth.: ORS 413.042 and 430.640

Stats Implemented: ORS 430.630, 430.640, 430.644 - 430.646

309-019-0320

Documentation requirements

(1) Documentation of calls shall include but is not limited to:

(a) Summary of presenting concern, assessment of risk factors, interventions, evaluation of interventions, the plan for the management and resolution of the crisis or emergency situation reported, referrals to other services, and collaboration that occurred with emergency services providers or other treatment providers, when appropriate;

(b) If a suicide risk assessment was completed;

(c) Summary of safety planning and lethal means counseling, as appropriate.

(2) A log or report of all contacts with the provider, including the name of each caller, when available, the crisis line worker, and the time and duration of the call shall be maintained for quality assurance review and ongoing staff supervision.

Stat. Auth.: ORS 413.042 and 430.640

Stats Implemented: ORS 430.630, 430.640, 430.644 - 430.646