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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Health Systems Division: Mental Health Services	309
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RULE CAPTION

Intensive and Emergency Psychiatric Interventions for Children and Adolescents

Not more than 15 words

RULEMAKING ACTION

ADOPT: 309-022-0192

AMEND:

309-022-0105,309-022-0110,309-022-0115,309-022-0125,309-022-0130,309-022-0140,309-022-0155,309-022-0160,309-022-0175,309-022-0180

REPEAL:

309-022-0105(T),309-022-0110(T),309-022-0115(T),309-022-0125(T),309-022-0130(T),309-022-0140(T),309-022-0155(T),309-022-0160(T),309-022-0175(T),309-022-0180(T),309-022-0192(T)

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042 & 426.415

Other Auth.:

Stats. Implemented: ORS 109.675, 161.390-161.400, 179.505, 413.520-413.522, 416.380-426.395, 426.490-426.500, 430.010, 430.205-430.210, 430.240-430.640, 430.850-430.955, 443.400-443.460, 443.991, 743A.168

RULE SUMMARY

The rules need to prescribe minimum standards for services and supports provided by addictions and mental health providers approved by the Health Systems Division (Division) of the Oregon Health Authority. These rules standardize the acceptable use of intensive and emergency services for children and adolescents, the qualification of those who authorize and implement such services, the related documentation, and other details that best ensure the safety of the children who require such services.

Authorized Signer	Printed Name	Date
[signature]	Chris Nolan	6/20/17

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OREGON HEALTH AUTHORITY,
HEALTH SYSTEMS DIVISION: BEHAVIORAL HEALTH SERVICES

DIVISION 22

INTENSIVE TREATMENT SERVICES FOR CHILDREN AND ADOLESCENTSAND CHILDRENS' EMERGENCY SAFETY INTERVENTION SPECIALIST (CESIS)

309-022-0105

Definitions

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

(2) "Health Systems Services and Supports" means all services and supports including but not limited to Outpatient Community Mental 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.

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

(4) "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.

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

(6) "Behavioral Health" means mental health, mental illness, addictive health, and addiction disorders.

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

(8) "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.

(9) "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.

(10) "Certificate" means the document or documents issued by the Division that identify and declare certification of a provider pursuant to OAR 309-008-0100 to 309-008-1600. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

(11) "Chemical Restraint" means the administration of medication for the acute management of potentially harmful behavior. Chemical restraint is prohibited in the services regulated by these rules.

(12) “Chief Officer” means the Chief Health Systems Officer of the Oregon Health Authority or designee.

(13) “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 shall be considered a child until age 21 for purposes of these rules.

(14) “Children’s Emergency Safety Intervention Specialist (CESIS)” means a Qualified Mental Health Professional (QMHP) licensed to order, monitor, and evaluate the use of seclusion and restraint in accredited and certified facilities providing intensive mental health treatment services to individuals less than 21 years of age.

(15) “Clinical Supervision” means oversight by a qualified clinical supervisor of addictions and mental health services and supports provided according to this rule, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(16) “Clinical Supervisor” means an individual qualified to oversee and evaluate addictions or mental health services and supports.

(17) “Community Mental Health Program” (CMHP) means an entity that is responsible for planning and delivery of services for individuals with substance use or mental illness diagnoses, operated in a specific geographic area of the state under an intergovernmental agreement or a direct contract with the Division.

(18) “Co-occurring Disorder” means the existence of both a substance use disorder and a mental health disorder.

(19) “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 Oregon Health 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.

(20) “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 309-014-0000.

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

(22) “Crisis” means either 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.

(23) “Cultural Competence” means the process by which people and systems respond respectfully and effectively to individuals of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, 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.

(24) “Declaration for Mental Health Treatment” means a written statement of an individual’s preferences concerning his or her 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.

(25) “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 are the medically appropriate reason for services.

(26) “Division” means the Health Systems Division.

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

(28) “Emergency Safety Intervention” means the use of seclusion or personal restraint under OAR 309-022-0175 as an immediate response to an unanticipated threat of violence or injury to an individual or others.

(29) “Emergency Safety Intervention Training” means a Division approved course that includes an identified instructor, a specific number of face-to-face instruction hours, a component to assess competency of the course materials, and an established curriculum including the following:

(a) Prevention of emergency safety situations using positive behavior support strategies identified in the individual’s behavior support plan;

(b) Strategies to safely manage emergency safety situations; and

(c) De-escalation and debriefing.

(30) “Emergency Safety Situation” means an unanticipated behavior that places the individual or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined above.

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

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

(33) “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.

(34) “Family Support” means the provision of peer delivered services to individuals 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.

(35) “Family Support Specialist” means an individual who meets qualification criteria under OAR chapter 410 division 180 and provides peer delivered services to a family member who 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, health, and wellness services due to a mental health or behavioral health barrier.

(36) “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, and transsexual.

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

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

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

(40) “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).

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

(42) “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.

(43) “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.

(44) “Intensive Treatment Services (ITS)” means the range of services in the system of care comprised of Psychiatric Residential Treatment Facilities (PRTF) and Psychiatric Day Treatment Services (PDTS), or other services as determined by the Division, that provide active psychiatric treatment for children with severe emotional disorders and their families.

(45) “Interdisciplinary Team” means the group of people designated to advise in the planning and provision of services and supports to individuals receiving ITS services and may include multiple disciplines or agencies. For Psychiatric Residential Treatment Facilities (PRTF), the composition of the interdisciplinary team shall be consistent with the requirements of 42 CFR Part 441.156.

(46) “Intern” or “Student” means a person who provides a paid or unpaid program service to complete a credentialed or accredited educational program recognized by the state of Oregon.

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

(48) “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.

(49) “Licensed Health Care Professional” means a practitioner of the healing arts, acting within the scope of his or her practice under state law who is licensed by a recognized governing board in Oregon.

(50) “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.

(51) “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.

(52) “Mandatory Reporter” means any public or private official, as defined in ORS 419B.005(3), who comes in contact with or has reasonable cause to believe that an individual has suffered abuse or that any person with whom the official comes in contact with has abused the individual. Pursuant to 430.765(2), 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.

(53) “Mechanical restraint” means any device attached or adjacent to the resident’s body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. Mechanical restraint is prohibited in the services regulated by these rules.

(54) “Medicaid” means the federal grant-in-aid program to state governments to provide medical assistance to eligible persons, under Title XIX of the Social Security Act.

(55) “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.

(56) “Medically Appropriate” means services and medical supplies required for prevention, diagnosis, or treatment of a physical or behavioral health condition or injuries, and which 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.

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

(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 their practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by the provider; and

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

(58) “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 refers to attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.

(59) “Peer” means any individual supporting an individual or a 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.

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

(61) “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. A peer support specialist shall complete a Division approved training program as required in 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.

(62) "Personal Restraint" means the application of physical force without the use of any device for the purpose of restraining the free movement of an individual's body to protect the individual or others from immediate harm. Personal restraint does not include briefly holding without undue force an individual to calm or comfort him or her or holding an individual's hand to safely escort him or her from one area to another. Personal restraint may be used only in approved ITS programs as an emergency safety intervention under OAR 309-022-0175.

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

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

(65) "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 in these rules to provide the service.

(66) "Provider" means an individual , organizational provider as defined in ORS 430.637(1)(b), tribal organization, or CMHP that holds a current certificate listed in OAR 309-008-0100(2) to provide behavioral health treatment services pursuant to these and applicable service delivery rules.

(67) "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.

(68) "Psychiatric Day Treatment Services (PDTS)" means the comprehensive, interdisciplinary, non-residential, community-based program certified under these rules consisting of psychiatric treatment, family treatment, and therapeutic activities integrated with an accredited education program.

(69) "Psychiatric Residential Treatment Facility (PRTF)" means facilities that are structured residential treatment environments with daily 24-hour supervision and active psychiatric treatment including Psychiatric Residential Treatment Services (PRTS), Secure Children's Inpatient Treatment Programs (SCIP), Secure Adolescent Inpatient Treatment Programs (SAIP), and Sub-acute Psychiatric Treatment for children who require active treatment for a diagnosed mental health condition in a 24-hour residential setting.

(70) "Psychiatric Residential Treatment Services (PRTS)" means services delivered in a PRTF that include 24-hour supervision for children who have serious psychiatric, emotional, or acute mental health conditions that require intensive therapeutic counseling and activity and intensive staff supervision, support, and assistance.

(71) "Psychologist" means a psychologist licensed by the Oregon Board of Psychologist Examiners.

(72) "Publicly Funded" means financial support, in part or in full, with revenue generated by a local, state, or federal government.

(73) “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 309-022-0125.

(74) “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 309-022-0125.

(75) “Quality Assessment and Performance Improvement” means the structured, internal monitoring and evaluation of services to improve processes, service delivery, and service outcomes.

(76) “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 his or her choice.

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

(78) “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, employee of the Division, attorney, or legal guardian.

(79) “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.

(80) “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.

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

(82) “Seclusion” means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving. Seclusion may be used only in approved ITS programs as an emergency safety intervention specified in OAR 309-022-0175.

(83) “Secure Children’s Inpatient Programs (SCIP) and Secure Adolescent Inpatient Programs (SAIP)” means ITS programs that are designed to provide inpatient psychiatric stabilization and treatment services to children up to age 14 for SCIP services and individuals under the age of 21 for SAIP services who require a secure intensive treatment setting.

(84) “Service Plan” means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family that is reflective of the assessment and the intended outcomes of service.

(85) “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.

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

(87) “Services” means those 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.

(88) “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 receiving services, the guardian of the individual receiving services, or any authorized representative of the individual receiving services.

(89) “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.

(90) “Sub-Acute Psychiatric Care” means services that are provided by nationally accredited providers to children who need 24-hour intensive mental health services and supports provided in a secure setting to assess, evaluate, stabilize, or resolve the symptoms of an acute episode that occurred as the result of a diagnosed mental health condition.

(91) “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.

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

(93) “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.

(94) “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.

(95) “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.

(96) “Variance” means an exception from a provision of these rules, granted in writing by the Division upon written application from the provider. Duration of a variance is determined on a case-by-case basis.

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

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

(99) “Wraparound” means a high fidelity process of team based intensive care coordination for children and their families based on National Wraparound Initiative values and principles.

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 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, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0110

Provider Policies

(1) All providers shall develop and implement written personnel policies and 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 shall develop and implement written policies and procedures consistent with these rules:

(a) Policies shall be available to individuals and family members upon request; and

(b) Service delivery policies and procedures shall 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) Crisis and suicide prevention and response;

(H) Incident reporting;

(I) Family involvement;

(J) Trauma-informed service delivery consistent with the AMH Trauma Informed Services Policy;

(K) Provision of culturally and linguistically appropriate services; and

(L) Peer delivered services

(3) In addition to the personnel and service delivery policies required of all providers, residential program providers shall develop and implement written policies and procedures for the following:

(a) Medical protocols and medical emergencies;

(b) Medication administration, storage and disposal;

(c) General safety, suicide risk assessment, and emergency procedures;

(d) Emergency safety interventions in ITS programs; and

(e) Behavior support policies consistent with OAR 309-022-0165.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0115

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 those 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) Have access to peer delivered services;

(d) 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;

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

(f) Confidentiality and the right to consent 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;

(g) 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 legally 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.

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

(i) Refuse participation in experimentation;

(j) Receive medication specific to the individual's diagnosed clinical needs;

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

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

(m) Have religious freedom;

(n) Be free from seclusion and restraint, except as set forth in OAR 309-021-0175;

(o) Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;

(p) 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;

(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) In addition to the rights set forth in section (1) of this rule, every individual receiving residential services has the right to:

(a) A safe, secure, and sanitary living environment;

(b) A humane service environment that affords reasonable protection from harm, reasonable privacy, and daily access to fresh air and the outdoors;

(c) Keep and use personal clothing and belongings, and have an adequate amount of private, secure storage space. Reasonable restriction of the time and place of use of certain classes of property may be implemented if necessary to prevent the individual or others from harm, provided that notice of this restriction is given to individuals and their families, if applicable, upon entry to the program, documented, and reviewed periodically;

(d) Express sexual orientation, gender identity, and gender presentation;

(e) Have access to and participate in social, religious, and community activities;

(f) Private and uncensored communications by mail, telephone, and visitation, subject to the following restrictions:

(A) This right may be restricted only if the provider documents in the individual's record that there is a court order to the contrary or that in the absence of this restriction, significant physical or clinical harm will result to the individual or others. The nature of the harm shall be specified in reasonable detail, and any restriction of the right to communicate shall be no broader than necessary to prevent this harm; and

(B) The individual and his or her guardian, if applicable, shall be given specific written notice of each restriction of the individual's right to private and uncensored communication. The provider shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible and allow for confidential communication, and that space is available for visits. Reasonable times for the use of telephones and visits may be established in writing by the provider.

(g) Communicate privately with public or private rights protection programs or rights advocates, clergy, and legal or medical professionals;

(h) Have access to and receive available and applicable educational services in the most integrated setting in the community;

(i) Participate regularly in indoor and outdoor recreation;

(j) Not be required to perform labor;

(k) Have access to adequate food and shelter; and

(L) A reasonable accommodation if due to a disability the housing and services are not sufficiently accessible.

(3) The provider shall 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 shall be in written form or upon request in an alternative format or language appropriate to the individual's need;

(b) Rights and how to exercise them shall be explained to the individual and if appropriate to her or his guardian; and

(c) Individual rights shall be posted in writing in a common area.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 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, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0125

Specific Staff Qualifications and Competencies

(1) Program administrators or program directors shall 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 shall demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, and utilization of community resources; group, family and individual therapy or counseling; and documentation and rationale for services to promote intended outcomes and implementation of all provider policies.

(3) Clinical supervisors in mental health programs shall meet QMHP requirements and have completed two years of post-graduate clinical experience in a mental health treatment setting.

(4) QMHAs shall demonstrate the ability to communicate effectively; understand mental health assessment, treatment, and service terminology and apply each of these concepts; implement skills development strategies; and identify, implement, and coordinate the services and supports identified in a service plan. QMHAs shall 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 309-022-0105.

(5) QMHPs shall 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; and conducting a mental status examination, completing a DSM diagnosis, writing and supervising the

implementation of a service plan; and providing individual, family, or group therapy within the scope of their training. QMHPs shall 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;

(g) A qualified mental health intern, as defined in OAR 309-022-0105.

(6) Peer support specialists shall be qualified as defined in OAR 410-0180-0312 and demonstrate knowledge of approaches to support others in recovery and resiliency and demonstrate efforts at self-directed recovery.

Stat. Auth.: ORS 161.390, 413.042, 426.490 - 426.500, 428.205 - 428.270, 430.256, 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, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0130

Documentation, Training, and Supervision

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

(a) An employment application;

(b) Verification of a criminal record check consistent with OAR 943-007-0001 through 0501;

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

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

(e) Periodic performance appraisals;

(f) Staff orientation and development activities;

(g) Program staff incident reports;

(h) Disciplinary documentation;

(i) Reference checks;

(j) Emergency contact information; and

(k) Documentation of a tuberculosis screening pursuant to OAR 333-071-0057.

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

(a) A contract or written agreement, if applicable;

(b) A signed confidentiality agreement;

(c) Service-specific orientation documentation; and

(d) Verification of a criminal records check consistent with OAR 943-007-0001 through 0501.

(3) Providers shall ensure that program staff receive training applicable to the specific population for whom services are planned or delivered to include the following minimum orientation training within 30 days of the hire date:

(a) A review of individual crisis response procedures;

(b) A review of emergency procedures;

(c) A review of program policies and procedures;

(d) A review of rights for individuals receiving services and supports;

(e) Mandatory abuse reporting procedures;

(f) Positive behavior support training consistent with OAR 309-022-0165.

(4) Individuals providing services to individuals in accordance with these rules shall receive supervision related to the development, implementation, and outcome of services by a qualified clinical supervisor:

(a) Clinical supervision shall be provided to assist program staff and volunteers to increase their skills, improve quality of services to individuals, and supervise program staff and volunteers' compliance with program policies and procedures, including:

(A) Documentation of clinical supervision for QMHP staff of no less than two hours per month. The two hours shall include one hour of face-to-face contact for each individual supervised or a proportional level of supervision for part-time QMHP staff. Face-to-face contact may include real time, two-way audio visual conferencing; or

(B) Documentation of two hours of quarterly supervision for program staff holding a health or allied provider license, including at least one hour of face-to-face contact for each individual supervised.

(b) Documentation of clinical supervision for each QMHA staff supervised of no less than two hours per month. The two hours shall include one hour of face-to-face contact for each individual

supervised related to direct care responsibilities or a proportional level of supervision for part-time QMHA staff. Face-to-face contact may include real time, two-way audio visual conferencing. Clinical supervision of a QMHA may be conducted by a lead QMHA staff;

(c) Documentation of weekly supervision for program staff meeting the definition of mental health intern. Documentation shall include:

(A) The date supervision took place;

(B) The amount of supervision time;

(C) A brief description of relevant topics discussed.

Stat. Auth.: ORS 161.390, 413.042, 426.490 - 426.500, 428.205 - 428.270, 430.256, 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, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0140

Service Planning and Coordination

(1) The provider shall deliver or coordinate for each individual appropriate services and supports to collaboratively facilitate intended service outcomes as identified by the individual and family:

(a) Qualified program staff shall facilitate a planning process, resulting in a service plan that reflects the assessment;

(b) A service plan shall be completed prior to the start of services;

(c) A licensed health care professional shall recommend the services and supports by signing the service plan;

(d) Individuals and family members shall be invited to participate in the development of the service plan;

(e) Providers shall fully inform the individual and guardian when applicable of the proposed services and supports in developmentally and culturally appropriate language, obtain informed consent for all proposed services, offer peer delivered services, and give the individual and guardian a written copy of the service plan;

(f) Providers shall collaborate with community partners to coordinate or deliver services and supports identified in the service plan;

(g) Providers shall collaborate to exchange information with any applicable physical health care providers for the individual to promote regular and adequate health care.

(2) The service plan shall be a written, individualized plan 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 records and shall:

(a) Be completed prior to the start of services;

(b) Reflect the assessment and the level of care to be provided;

(c) Include the participation of the individual and family members;

(d) Be completed by a QMHP;

(e) A QMHP who is also a licensed health care professional shall recommend the services and supports by signing the Service plan within ten business days of the start of services; and

(f) An LMP shall 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.

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

(a) Individualized treatment objectives;

(b) The specific services and supports that will be used to meet the treatment objectives;

(c) Measurable and observable outcomes;

(d) A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter;

(e) The type of personnel that will be furnishing the services; and

(f) Proactive safety and crisis planning;

(g) A behavior support plan consistent with OAR 309-022-0165; and

(h) The interdisciplinary team shall conduct a review of progress and transfer criteria at least every 30 days from the date of entry and shall document the member's present, progress, and changes made. For Psychiatric Day Treatment Services, the review shall be conducted every 30 days, and the LMP shall participate in the review at least every 90 days.

(4) Providers shall document each service and support using service notes. A service note, at minimum, shall include:

(a) The specific services rendered;

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

(c) Who rendered the services;

(d) The setting in which the services were rendered;

(e) The relationship of the services to the treatment regimen described in the service plan; and

(f) Periodic updates describing the individual's progress toward the treatment objectives; and

(g) Any decisions to transfer an individual from service.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 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, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0155

General Staffing Requirements

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

(a) Availability of psychiatric services to meet the following requirements:

(A) Provision of medical oversight of the clinical aspects of care in nationally accredited sub-acute and psychiatric residential treatment facilities and provide 24-hour, seven days per week psychiatric on-call coverage, or consult on clinical care and treatment in psychiatric day treatment; and

(B) Assessment of each child's medication and treatment needs, prescribe medicine or otherwise assure that case management and consultation services are provided to obtain prescriptions, and prescribe therapeutic modalities to achieve the child's service plan goals.

(b) There shall be at least one program staff who has completed First Aid and CPR training on duty at all times.

(2) Residential ITS providers shall ensure overnight program staff will visually monitor clients at specified intervals as per agency policy during sleeping hours for signs of life. This includes monitoring for breathing and movement.

(3) ITS providers shall ensure that the following services and supports are available and accessible through direct service, contract, or by referral:

(a) Active psychiatric treatment and education services shall be functionally integrated in a therapeutic environment designed to reflect and promote achievement of the intended outcomes of each child’s service plan;

(b) Continuity of the child’s education when treatment services interrupt the child's day to day educational environment;

(c) Family therapy provided by a QMHP. The family therapist to child ratio shall be at least one family therapist for each 12 children;

(d) Psychiatric services;

(e) Individual, group, and family therapies provided by a QMHP. There shall be no less than one family therapist available for each 12 children;

(f) Medication evaluation, management, and monitoring;

(g) Pre-vocational or vocational rehabilitation;

(h) Therapies supporting speech, language, and hearing rehabilitation;

(i) Individual and group psychosocial skills development;

(j) Activity and recreational therapies;

(k) Nutrition;

(L) Physical health care services or coordination;

(m) Recreational and social activities consistent with individual strengths and interests;

(n) Educational services coordination and advocacy; and

(o) Behavior support services consistent with OAR 309-022-0165.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 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, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0160

Program Specific Requirements

In addition to the general requirements for all ITS providers listed in OAR 309-022-0150 and 0155, the following requirements for facilities and programs shall be met:

(1) Psychiatric Residential Treatment Facilities (PRTF):

(a) Children must either have or be screened for an Individual Education Plan, Personal Education Plan, or an Individual Family Service Plan;

(b) PRTFs shall maintain one or more linkages with acute care hospitals or CCOs to coordinate necessary inpatient care;

(c) Psychiatric residential clinical care and treatment shall be under the direction of a psychiatrist and delivered by an interdisciplinary team of board-certified or board-eligible child and adolescent psychiatrists, registered nurses, psychologists, other qualified mental health professionals, and other relevant program staff. A psychiatrist shall be available to the unit 24-hours per day, seven days per week; and

(d) PRTFs shall be staffed at a clinical staffing ratio of not less than one program staff for three children during the day and evening shifts at all times. At least one program staff for every three program staff members during the day and evening shifts shall be a QMHP or QMHA. For overnight program staff there shall be a staffing ratio of at least one program staff for six children at all times

for each program unit. At least one of the overnight program staff shall be a QMHA. For units that by this ratio have only one overnight program staff, there shall be additional program staff immediately available within the facility or on the premises. At least one QMHP shall be on site or on call at all times. At least one program staff with designated clinical leadership responsibilities shall be on site at all times.

(2) Programs providing PRTS shall meet the requirements for PRTF's listed in section (1)(a).

(3) Programs providing SCIP and SAIP services shall meet the requirements for PRTFs listed in section (1). They shall also establish policies and practices to meet the following:

(a) The staffing model shall allow for the child's frequent contact with the child psychiatrist a minimum of one hour per week;

(b) Psychiatric nursing staff shall be provided in the program 24 hours per day;

(c) A psychologist, psychiatric social worker, rehabilitation therapist, and psychologist with documented training in forensic evaluations shall be available 24 hours per day as appropriate; and

(d) Program staff with specialized training in SCIP or SAIP shall be available 24 hours per day;

(e) The program shall provide all medically appropriate psychiatric services necessary to meet the child's psychiatric care needs;

(f) The program shall provide secure psychiatric treatment services in a manner that ensures public safety to youth who are under the care and custody of the Oregon Youth Authority, court ordered for the purpose of psychiatric evaluation, or admitted by the authority of the JPSRB; and

(g) The program may not rely on external entities such as law enforcement or acute hospital care to assist in the management of the SCIP or SAIP setting.

(4) In addition to the services provided as indicated by the assessment and specified in the service plan, Sub-Acute Psychiatric Care providers shall:

(a) Provide psychiatric nursing staffing at least 16 hours per day;

(b) Provide nursing supervision and monitoring and psychiatric supervision at least once per week; and

(c) Work actively with the child and family team and multi-disciplinary community partners to plan for the long-term emotional, behavioral, physical, and social needs of the child to be met in the most integrated setting in the community.

(5) Psychiatric Day Treatment Services (PDTS):

(a) PDTS shall be provided to children who remain at home with a parent, guardian, or foster parent by qualified mental health professionals and qualified mental health associates in consultation with a psychiatrist;

(b) An education program shall be provided, and children must either have or be screened for an Individual Education Plan, Personal Education Plan, or Individual Family Service Plan; and

(c) Psychiatric Day Treatment programs shall be staffed at a clinical staffing ratio of at least one QMHP or QMHA for three children.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 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, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0175

Restraint and Seclusion

(1) Providers shall meet the following general conditions of personal restraint and seclusion:

(a) Personal restraint and seclusion shall only be used in an emergency safety situation to prevent immediate injury to an individual who is in danger of physically harming himself or herself or others in situations such as the occurrence of or serious threat of violence, personal injury, or attempted suicide;

(b) Any use of personal restraint or seclusion must respect the dignity and civil rights of the individual;

(c) The use of personal restraint or seclusion shall be directly related to the immediate risk related to the behavior of the individual and may not be used as punishment, discipline, or for the convenience of staff;

(d) Personal restraint or seclusion shall only be used for the length of time necessary for the individual to resume self-control and prevent harm to the individual or others, even if the order for seclusion or personal restraint has not expired, and shall under no circumstances exceed four hours for individuals ages 18 to 21, two hours for individuals ages 9 to 17, or one hour for individuals under age 9;

(e) An order for personal restraint or seclusion may not be written as a standing order or on an as needed basis;

(f) Personal restraint and seclusion may not be used simultaneously;

(g) Providers shall notify the individual’s parent or guardian of any incident of seclusion or personal restraint as soon as possible;

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

(A) Discuss the emergency safety situation that required the intervention, including the precipitating factors that led up to the intervention and any alternative strategies that might have prevented the use of the personal restraint or seclusion;

(B) Discuss the procedures, if any, to be implemented to prevent any recurrence of the use of personal restraint or seclusion;

(C) Discuss the outcome of the intervention including any injuries that may have resulted; and

(D) Review the individual's service plan, making the necessary revisions, and document the discussion and any resulting changes to the individual's service plan in the service record.

(2) Personal Restraint:

(a) Each personal restraint shall require an immediate documented order by a physician, licensed practitioner, or a licensed CESIS;

(b) The order shall include:

(A) Name of the individual authorized to order the personal restraint;

(B) Date and time the order was obtained; and

(C) Length of time for which the intervention was authorized.

(c) Each personal restraint shall be conducted by program staff that have completed and use Division-approved crisis intervention training. If in the event of an emergency, a non-Division approved crisis intervention technique is used, the provider's on-call administrator shall immediately review the intervention and document the review in an incident report to be provided to the Division within 24 hours;

(d) At least one program staff trained in the use of emergency safety interventions shall be physically present, continually assessing and monitoring the physical and psychological well-being of the individual and the safe use of the personal restraint throughout the duration of the personal restraint;

(e) Within one hour of the initiation of a personal restraint, a psychiatrist, licensed practitioner, or CESIS shall conduct a face-to-face assessment of the physical and psychological well-being of the individual;

(f) A designated program staff with clinical leadership responsibilities shall review all personal restraint documentation prior to the end of the shift in which the intervention occurred; and

(g) Each incident of personal restraint shall be documented in the service record. The documentation shall specify:

(A) Behavior support strategies and less restrictive interventions attempted prior to the personal restraint;

(B) Required authorization;

(C) Events precipitating the personal restraint;

(D) Length of time the personal restraint was used;

(E) Assessment of appropriateness of the personal restraint based on threat of harm to self or others;

(F) Assessment of physical injury; and

(G) Individual’s response to the emergency safety intervention.

(3) Providers shall be certified by the Division for the use of seclusion:

(a) Authorization for seclusion shall be obtained by a psychiatrist, licensed practitioner, or CESIS prior to or immediately after the initiation of seclusion. Written orders for seclusion shall be completed for each instance of seclusion and shall include:

(A) Name of the person authorized to order seclusion;

(B) Date and time the order was obtained; and

(C) Length of time for which the intervention was authorized.

(b) Program staff trained in the use of emergency safety interventions shall be physically present continually assessing and monitoring the physical and psychological well-being of the individual throughout the duration of the seclusion;

(c) Visual monitoring of the individual in seclusion shall occur continuously and be documented at least every fifteen minutes or more often as clinically indicated;

(d) Within one hour of the initiation of seclusion, a psychiatrist or CESIS shall conduct a face-to-face assessment of the physical and psychological well-being of the individual;

(e) The individual shall have regular meals, bathing, and use of the bathroom during seclusion, and the provision of these shall be documented in the service record; and

(f) Each incident of seclusion shall be documented in the service record. The documentation shall specify:

(A) The behavior support strategies and less restrictive interventions attempted prior to the use of seclusion;

(B) The required authorization for the use of seclusion;

(C) The events precipitating the use of seclusion;

(D) The length of time seclusion was used;

(E) An assessment of the appropriateness of seclusion based on threat of harm to self or others;

(F) An assessment of physical injury to the individual, if any; and

(G) The individual's response to the emergency safety intervention.

(4) Any room specifically designated for the use of seclusion or time out shall be approved by the Division: If the use of seclusion occurs in a room with a locking door, the program shall be authorized by the Division for this purpose and shall meet the following requirements:

(a) A facility or program seeking authorization for the use of seclusion shall submit a written application to the Division;

(b) The application shall include a comprehensive plan for the need and use of seclusion of children in the program and copies of the facility's policies and procedures for the utilization and monitoring of seclusion, including a statistical analysis of the facility's actual use of seclusion, physical space, staff training, staff authorization, record keeping, and quality assessment practices;

(c) The Division shall review the application and, after a determination that the written application is complete and satisfies all applicable requirements, shall provide for a review of the facility by authorized Division staff;

(d) The Division shall have access to all records including service records, the physical plant of the facility, the employees of the facility, the professional credentials and training records for all program staff, and shall have the opportunity to fully observe the treatment and seclusion practices employed by the facility;

(e) After the review, the chief officer shall approve or disapprove the facility's application and upon approval shall certify the facility based on the determination of the facility's compliance with all applicable requirements for the seclusion of children;

(f) If disapproved, the facility shall be provided with specific recommendations and have the right of appeal to the Division; and

(g) Certification of a facility shall be effective for a maximum of three years and may be renewed thereafter upon approval of a renewal application.

(5) An ITS provider seeking certification shall have available at least one room that meets the following specifications and structural and physical requirements for seclusion:

(a) The room shall be of adequate size to permit three adults to move freely and allow for one adult to lie down. Any newly constructed room shall be no less than 64 square feet;

(b) The room may not be isolated from regular program staff of the facility and shall be equipped with adequate locking devices on all doors and windows;

(c) The door shall open outward and contain a port of shatterproof glass or plastic through which the entire room may be viewed from outside;

(d) The room shall contain no protruding, exposed, or sharp objects;

(e) The room shall contain no furniture. A fireproof mattress or mat shall be available for comfort;

(f) Any windows shall be made of unbreakable or shatterproof glass or plastic. Non-shatterproof glass shall be protected by adequate climb-proof screening;

(g) There may be no exposed pipes or electrical wiring in the room. Electrical outlets shall be permanently capped or covered with a metal shield secured by tamper-proof screws. Ceiling and wall lights shall be recessed and covered with safety glass or unbreakable plastic. Any cover, cap, or shield shall be secured by tamper-proof screws;

(h) The room shall meet State Fire Marshal fire, safety, and health standards. If sprinklers are installed, they shall be recessed and covered with fine mesh screening. If pop-down type, sprinklers shall have breakaway strength of under 80 pounds. In lieu of sprinklers, combined smoke and heat detectors shall be used with similar protective design or installation;

(i) The room shall be ventilated, kept at a temperature no less than 64°F and no more than 85°F. Heating and cooling vents shall be secure and out of reach;

(j) The room shall be designed and equipped in a manner that would not allow a child to climb off the floor;

(k) Walls, floor, and ceiling shall be solidly and smoothly constructed to be cleaned easily and have no rough or jagged portions; and

(L) Adequate and safe bathrooms shall be available.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 28.270, 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, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0180

Transfer and Continuity of Care

(1) Providers shall meet the following requirements for planned transfer:

(a) Decisions to transfer individuals shall be documented in a transfer summary. The documentation shall include the reason for the transfer;

(b) Planned transfers shall be consistent with the transfer criteria established by the interdisciplinary team and documented in the service plan.

(c) Providers may not transfer services unless the interdisciplinary team in consultation with the child's parent or guardian and the next provider agree that the child requires a more or less restrictive level of care; and

(d) If the determination is made to admit the child to acute care, the provider may not transfer services during the acute care stay unless the interdisciplinary team in consultation with the child's parent or guardian and the next provider agree that the child requires a more or less restrictive level of care following the acute care stay.

(2) Prior to transfer, providers shall:

(a) Coordinate and provide appropriate referrals for medical care and medication management. The transferring provider shall assist the individual to identify the medical provider who will provide continuing care and arrange an initial appointment with that provider;

(b) Coordinate recovery and ongoing support services for individuals and their families including identifying resources and facilitating linkage to other service systems necessary to sustain recovery including peer delivered services;

(c) Complete a transfer summary;

(d) When services are transferred due to the absence of the individual, the provider shall document outreach efforts made to re-engage the individual or document the reason why such efforts were not made;

(e) If the individual is under the jurisdiction of the PSRB or JPSRB, the provider shall notify the PSRB or JPSRB immediately and provide a copy of the transfer summary within 30 days;

(f) The provider shall report all instances of transfer on the mandated state data system; and

(g) At a minimum, the provider's interdisciplinary team shall:

(A) Integrate transfer planning into ongoing treatment planning and documentation from the time of entry and specify the transfer criteria that shall indicate resolution of the symptoms and behaviors that justified the entry;

(B) Review and, if needed, modify the transfer criteria in the service plan every 30 days;

(C) Notify the child's parent or guardian and the provider to which the child shall be transitioned of the anticipated transfer dates at the time of entry and when the service plan is changed;

(D) Include the parent or guardian peer support when requested by the parent or guardian and provider to which the child shall be transitioned in transfer planning and reflect their needs and desires to the extent clinically indicated;

(E) Finalize the transition plan prior to transfer and identify in the plan the continuum of services and the type and frequency of follow-up contacts recommended by the provider to assist in the child's successful transition to the next appropriate level of care;

(F) Assure that appropriate medical care and medication management shall be provided to individuals who leave through a planned transfer. The last service provider’s interdisciplinary team shall identify the medical personnel who will provide continuing care and shall arrange an initial appointment with that provider;

(G) Coordinate appropriate education services with applicable school district personnel; and

(H) Give a written transition plan to the child's parent or guardian and the next provider if applicable on the date of transfer.

(3) A Transfer summary shall include the following:

(a) The date and reason for the transfer;

(b) A summary statement that describes the effectiveness of services in assisting the individual and his or her family to achieve intended outcomes identified in the service plan;

(c) Where appropriate, a plan for personal wellness and resilience, including relapse prevention safety and suicide prevention planning; and

(d) Identification of resources to assist the individual and family including peer delivered services, if applicable, in accessing recovery and resiliency services and supports;

(e) If the transfer is to services with another provider, all documentation contained in the service record requested by the receiving provider shall be furnished, compliant with applicable confidentiality policies and procedures within 14 days of receipt of a written request for the documentation;

(f) A complete transfer summary shall be sent to the receiving provider within 30 days of the transfer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.45
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

309-022-0192

Variances

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

(2) The chief officer of the Division shall approve or deny the request for a variance. The variance shall be made in writing using the Division approved variance request form and following the variance request procedure set forth in 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, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168