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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

BHS 8-2024
CHAPTER 309
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: BEHAVIORAL HEALTH SERVICES

FILED
04/30/2024 1:39 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Revision to allow for rapid access and flexibility during behavioral health intake, assessment and planning.

EFFECTIVE DATE: 05/01/2024 THROUGH 10/27/2024

AGENCY APPROVED DATE: 04/30/2024

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NEED FOR THE RULE(S):

Current Rules do not allow service providers to provide person centered services at the intake, assessment and initial planning stages of service. Current Rules requirements create barriers to rapid access and can contribute to a delay in the start of services.

JUSTIFICATION OF TEMPORARY FILING:

1. Describe the specific consequences that result from the failure to immediately adopt, amend or suspend the rule(s).
Oregon's Behavioral Health Services system continues to endure long wait times to the start of services. Although contributing factors include drastically insufficient workforce capacity, the access problem is made worse by cumbersome intake and assessment processes. Provider programs are in need of immediate change in intake and assessment requirements in order to impact the bottle-neck that takes place at the start of services. Without making the proposed revisions, the current bottle-neck at the start of services will continue. When people seeking mental health and addiction services must endure long wait times, their conditions can continue to worsen, and they can also lose motivation to engage in services. Further, the impact of the bottle-neck on direct service staff results in pressure, loss of morale, and burn-out.

(2) Who would suffer these consequences:
Oregonians seeking behavioral health services and their family members, as well as front-line behavioral health staff, are negatively impacted by the above conditions.

(3) Why or how failure to immediately take rulemaking action would cause these consequences;
The current Rules have detailed requirements concerning initial intake, assessment and service planning that must be conducted before services can begin. These requirements are time consuming. Many requirements involve data collection which, although useful and needed information, are not essential to starting services. The proposed revisions will allow for most of the intake, assessment and planning tasks to occur over a period of time, rather than up-front, before the start of services. The front-loading of these requirements create barriers to efficient workflows. These

barriers slow down service access processes, disenfranchise Oregonians seeking services, and deplete behavioral health worker morale. Oregon's Behavioral Health access problems are in need of immediate relief. Oregon's Behavioral Health workforce deserve working conditions with less pressure.

(4) How the temporary action will avoid or mitigate those consequences.
A temporary/emergency to permanent Rules revision process is proposed. The proposed revisions will allow for most of the intake, assessment and planning tasks to occur over a period of time, rather than up-front, before the start of services. While the temporary, emergency Rule is in place a more thorough process involving community engagement and a Rules Advisory Committee will take place to ensure that the Permanent Rules are meet and exceed needs and requirements.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

The proposed revisions rely heavily on the Rapid Engagement Pilot – funded by Oregon Health Authority (David Corse, grant administrator) conducted by AOCMHP, as well as recommendations by the legislatively directed "Tackling Administrative Burden" Task Force.

http://www.aocmhp.org/rapid-engagement/

RULES:
309-018-0135, 309-018-0140, 309-018-0145, 309-018-0150

AMEND: 309-018-0135

RULE SUMMARY: Revision to allow for rapid access and flexibility during behavioral health intake, assessment and planning.

CHANGES TO RULE:

309-018-0135
Entry ¶

(1) The program shall utilize an entry procedure that at a minimum shall ensure the provision and documentation of the following:¶
(a) Individuals shall be considered for entry without regard to race, ethnicity, gender, gender identity, gender presentation, 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) Individuals shall receive services in the most timely manner feasible consistent with the presenting circumstances; and¶
(c) The provider may not deny entry to individuals based on the individual's decision to continue their currently prescribed medication to treat opioid dependence while receiving residential substance use disorder services.¶
(2) Except as permitted by law in emergencies, informed consent for services must be obtained prior to services. Written, voluntary informed consent for services shall be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason and any further attempts to obtain informed consent shall be documented in the service record.¶
(3) Per CRF 440.230, the provider shall develop and maintain service records and other documentation that demonstrates amount, duration and scope of each specific services and supports provided for each individual.¶
(4) The provider shall submit the identified status and service data, including Non-Medicaid Service Data where required, in the mandated state data system according to the timelines required by the Division for each individual whose services are paid for in-full or in-part by public funds and for individuals enrolled in DUII services.¶
(5) In accordance with ORS 179.505, HIPAA and 42 CFR Part 2, an authorization for the release of information shall be obtained and contained in the service record for the release of any confidential information concerning the individual being considered for or receiving services.¶
(6) Prior to or at the start of treatment services, but no later than 3 days from initial service contact, the program shall offer to the individual and guardian, if applicable, written program ~~orientation~~ information. The written

program information shall be in a language understood by the individual and shall include: ¶
(a) Program consent, disclosure and orientation information. ¶
(b) A description of individual rights consistent with these rules;¶
(~~b~~c) ~~Policies concerning~~Information on how to file grievances and appeals consistent with these rules, including an example grievance form;¶
(~~c~~d) Notice of privacy practices; and¶
(~~d~~e) ~~An opportunity~~Information on how to register to vote, per the National Voter Registration Act of 1993, Section 7. Provider agency will supply means to register to vote upon request.¶
(7) Entry requirements for providers that receive the Substance Use, Prevention, Treatment a~~urin~~nd Recovery (SUPTR) Block Grant:¶
(a) Providers shall maintain waitlist documentation demonstrating that individuals are prioritized for entry in the following order:¶
(A) Individuals who are pregnant and using substances intravenously;¶
(B) Individuals who are pregnant;¶
(C) Individuals who are using substances intravenously; and¶
(D) Individuals or families with dependent children.¶
(b) Entry of pregnant individuals shall occur no later than 48 hours from the date of first contact and entry of individuals using substances intravenously shall occur no later than 14 days after the date of first contact. If services are not available within the required timeframes, the provider shall document the reason and provide interim referral and informational services, as defined in these rules, within 48 hours; and¶
(c) Individuals using substances intravenously shall receive interim re~~ferral~~source recommendations 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 re~~ferral~~source recommendations and informational services shall include:¶
(A) ~~Counseling and education~~An opportunity for the individual to engage in interactive social services through care coordination, peer services or other interactive supports.¶
(B) Educational material 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~~C) ~~Counseling and educ~~Educational information about steps that can decrease the likelihood of Hepatitis, HIV, STD, and TB transmission;¶
(~~C~~D) Re~~ferral for~~source recommendations for addressing Hepatitis, HIV, STD, and TB testing, vaccine, or care services if necessary; and¶
(~~D~~E) For pregnant individuals, ~~counsel~~interactive social services and educational information addressing ~~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.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168

AMEND: 309-018-0140

RULE SUMMARY: Revision to allow for rapid access and flexibility during behavioral health intake, assessment and planning.

CHANGES TO RULE:

309-018-0140
Assessment ¶

(1) At the time of entry, ~~an~~the assessment process shall be ~~comple~~gin, be upda~~te~~d~~,~~ or ~~upda~~complete~~d~~ and signed by a qualified program staff.~~¶~~
~~(2)~~ Each assessment ~~shall include:~~document shall provide record, or documented review of past record, at minimum;¶
(a) Sufficient information and documentation to justify the presence of a DSM-5-TR or ICD-10 diagnosis that is the medically necessary reason for services, including identification of each DSM-5-TR- criteria established per diagnosis, and the symptoms supporting each criteria;¶
(b) ~~Screening for the presence of:¶~~
~~(A) Substance use;¶~~
~~(B) Problem gambling; ¶~~
~~(C) Mental health conditions; ¶~~
~~(D) Chronic medical conditions;¶~~
~~(E) Presence of symptoms related to psychological and physical trauma; and ¶~~
~~(F) Suicide risk.¶~~
~~(c) When the~~When the assessment and screening process~~es~~ determine~~s~~ the presence of any of the above conditions or any risk to health and safety to the individual or others:¶
(A) Further assessment shall be completed to determine the need for follow-up actions, additional services and supports and the level of risk to the individual or to others; and¶
(B) Documentation shall contain r~~eferral~~commendations for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.¶
(~~d~~2) In addition, for substance use disorder services each assessment and update thereof shall be a multidimensional assessment, consistent with The ASAM Criteria, Third Edition, and include, at a minimum the following components, each consistent with The ASAM Criteria, Third Edition:¶
(~~A~~a) An ASAM Level of Care determination per dimension, overall, and noting any applicable discrepancies; and¶
(~~B~~)b) An initial ASAM assessment can record information derived from observation, self-report interview, collateral information or any combination of these. An initial ASAM assessment will also cover, at minimum;¶
(A) Level of Care recommendation for each ASAM dimension based on current and available information.¶
(B) Diagnostic criteria for Substance Use Disorders endorsed by individual in interest of supporting medical necessity for Substance Use Disorder diagnosis.¶
(c) A comprehensive and complete ASAM assessment will be completed as soon as possible but in no more than 10 days and include full supporting information for purposes of comprehensive service planning, which at minimum will include A Risk Assessment that is comprised of:¶
(~~i~~A) A consideration of the history of each risk as well as the present concern(s);~~-~~¶
(~~ii~~B) An identification of immediate need(s);¶
(~~iii~~C) A severity of risk for each dimension; and¶
(~~iv~~D) An overall determination of the severity of risk the individual currently is experiencing.¶
(~~e~~d) Any changes to the ASAM Level of Care placement decision shall be justified within an update to the multidimensional assessment on file; and¶
(~~f~~e) Providers shall update assessments within the scope of their practice when there are changes in clinical circumstances.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168

AMEND: 309-018-0145

RULE SUMMARY: General updates for rules alignment.

CHANGES TO RULE:

309-018-0145
Service Plan and Service Notes ¶

(1) 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 or level of care is no longer necessary. The Service Plan is included in the individual's service record and shall:¶
(a) Be started prior to the rendering of treatment services;¶
(b) Reflect the assessment in its' most updated form;¶
(c) Address areas of concern identified in the assessment that the individual agrees to address;¶
(d) When applicable, document the ASAM Level of Care placement. When there is a discrepancy, document the individual's preferred ASAM Level of Care placement; ¶
(e) Include a safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the Service Plan;¶
(fe) Include the participation of the individual and family members as applicable; and¶
(gf) Be completed and signed by qualified program staff as follows:¶
(A) Supervisory or treatment staff in substance use disorders treatment and recovery programs; and¶
(B) Supervisory or treatment staff in problem gambling treatment and recovery programs.¶
(2) At minimum, each service plan shall include:¶
(a) Treatment objectives that are:¶
(A) Individualized to meet the assessed needs of the individual; and¶
(B) M.¶
(B) Comprehensive service plans must be written within ten business days from entry. Comprehensive service plans will be measurable for the purpose of evaluating individual progress, including a baseline evaluation.as well as:¶
(b) The specific services and supports that shall be used to meet the treatment objectives;¶
(c) The expected frequency of each type of planned service or support; and¶
(d) A schedule for re-evaluating the service plan.¶
(3) Providers shall document each service and support in a service note to 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 personnel rendering the services, including the name, credentials and signature;¶
(e) The setting in which the services were rendered; and¶
(f) Periodic updates describing the individual's progress.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168

AMEND: 309-018-0150

RULE SUMMARY: Rule updating to align with rest of the changes in this rule.

CHANGES TO RULE:

309-018-0150
Service Record ¶

(1) Documentation shall be appropriate in quality and quantity to meet professional standards applicable to the provider and any additional standards for documentation in the provider's policies and any pertinent contracts.¶
(2) All providers shall develop and maintain a Service Record for each individual. The record shall, at a minimum, include:¶
(a) Identifying information or documentation of attempts to obtain the information, including:¶
(A) The individual's name, address, telephone number, date of birth, gender, and for adults, marital status, and military status;¶
(B) Name, address, and telephone number of the parent or legal guardian, primary care giver or emergency contact; and¶
(C) Contact information for medical and dental providers.¶
(b) Informed Consent for Service including medications or documentation specifying why the provider could not obtain consent by the individual or guardian as applicable;¶
(c) Written refusal of any services and supports offered, including medications;¶
(d) A signed fee agreement, when applicable;¶
(e) A personal belongings inventory created upon entry and updated whenever an item of significant value is added or removed or on the date of transfer;¶
(f) Background information including strengths and interests, all available previous mental health or substance use assessments, previous living arrangements, service history, behavior support considerations, education service plans if applicable, and family and other support resources;¶
(g) Medical information including a brief history of any health conditions, documentation from a LMP or other qualified health care professional of the individual's current physical health, and a written record of any prescribed or recommended medications, services, dietary specifications, and aids to physical functioning;¶
(h) Copies of documents relating to guardianship or any other legal considerations, as applicable;¶
(i) Documentation of the individual's ability to evacuate the home consistent with the program's evacuation plan developed in accordance with the Oregon Structural Specialty Code and Oregon Fire Code;¶
(j) Documentation of any safety risks;¶
(k) Documentation of follow-up actions and referrals when an individual reports symptoms indicating risk of suicide; and¶
(l) Critical Incidents shall be reported to the Division through submission of an incident report and as applicable, to the Office of Training Investigation and Safety (OTIS), and other authorities:¶
(A) In at least the following examples of circumstances:¶
(i) Death, including by suicide or overdose;¶
(ii) Severe injury, ~~including injury leading to hospitalization, injury resulting in medical attention needed or no medical attention needed,~~ overdose resulting in hospitalization or needing medical attention, and emergency services needed;¶
(iii) Ongoing risk to health (for example: environmental risks such as black mold);¶
(iv) Police involvement;¶
(v) Extensive damage to the facility or other substantial change in living conditions; and¶
(vi) Where abuse or neglect is suspected, including unethical client and staff relationships; and¶
(vii) Relationships between individuals that result in harm to at least one individual or that are sexual in nature.¶
(B) Within 24 hours of the event;¶
(C) On the original, unredacted incident report;¶
(D) All incident reports shall be maintained in the corresponding service record and in a common file for quality improvement purposes and review by the Division; and¶
(E) In accordance with privacy rules and regulations, incident reports filed in service records shall not contain protected health information belonging to any other individual.¶
(3) Incident reports shall contain, at a minimum, the following information:¶
(a) The time and date of the event;¶
(b) The time and date of when the incident report form was completed;¶
(c) Name and title of staff who filled out the report;¶
(d) Identification of all staff involved in the incident and the response to the incident, and their titles;¶

(e) Identification of each individual involved;¶
(f) Description of event;¶
(g) Description of program response;¶
(h) Description of which policies and procedures were followed and when appliable, any that were not followed;¶
(i) Identification of staff who were notified, and their titles;-¶
(j) Identification of which authorities the event was reported to; and¶
(k) Description of administrative response and follow-up.¶
(4) When medical services are provided by the program or a community provider, the following documents shall be part of the Service Record as applicable:¶
(a) Medication administration records as per these rules;¶
(b) Laboratory reports;-¶
(c) LMP orders for medication, protocols or procedures; and¶
(d) Documentation of medical screenings, assessments, consultations, interventions, and procedures.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168