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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

BHS 9-2024
CHAPTER 309
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: BEHAVIORAL HEALTH SERVICES

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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:
309-019-0135, 309-019-0140

AMEND: 309-019-0135

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

CHANGES TO RULE:

309-019-0135
Entry and Assessment ¶

(1) The program ~~shall~~must utilize an entry procedure that at a minimum ~~shall~~must ensure the provision and documentation of the following:¶
(a) Individuals ~~shall~~must be considered for entry without regard to race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when program eligibility is restricted to children, adults, or older adults), familial status, marital status, source of income, and disability;¶
(b) The provider may not deny entry to individuals based on their decision to continue their currently prescribed or dispensed medication to treat opioid dependence while receiving outpatient behavioral health services and supports;¶
(c) Individuals ~~shall~~must receive services in the timeliest manner feasible consistent with the presenting circumstances;¶
(d) Except as permitted by law in emergencies, informed consent for services must be obtained prior to - or at the time that services begin. Written, voluntary informed consent for services ~~shall~~must be obtained from the individual or guardian, if applicable, prior to ~~the start of~~ - or at the time that services begin. If such consent is not obtained, the reason and any further attempts to obtain informed consent ~~shall~~must be documented in the service record. ¶
(e) Per CFR 440.230, the provider ~~shall~~must develop and maintain service records and other documentation that demonstrates the amount, duration and scope of each specific services and supports provided for each individual; ¶
(f) The provider ~~shall~~must 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;¶
(g) In accordance with ORS 179.505, HIPAA, and 42 CFR Part 2, an authorization for the release of information ~~shall~~must be obtained and contained in the service record for the release of any confidential information concerning the individual being considered for or receiving services;¶

(h) Prior to or at the start of treatment services, but no later than 30 days from initial service contact, the program ~~shall~~must offer to the individual and guardian, if applicable, written program ~~orientation~~ information. The written program information ~~shall~~must be in a language understood by the individual and ~~shall~~must include: ¶
(A) ~~An opportunity~~Program consent, disclosure, and orientation information.¶
(B) Information on how to complete a Declaration for Mental Health Treatment with the individual's participation and informed consent;~~.~~¶
(~~B~~C) A description of individual rights consistent with these rules;~~.~~¶
(~~C~~D) ~~Policy concerning~~Information describing how to file grievance~~s~~ and appeals consistent with these rules, including an example grievance form;~~.~~¶
(~~D~~E) Notice of privacy practices; and~~.~~¶
(~~E~~F) ~~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; and¶
(G) If written information is not provided prior or at the start of treatment services, the reason and any further attempts to provide written information must be documented in the service record. ¶
(2) Entry requirements for providers that receive the Substance Use Prevention, Treatment and Recovery (SUPTR) Block Grant:~~.~~¶
(a) Document 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) Individuals using substances intravenously ~~shall~~must 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~~must 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 education~~Educational information and resources about steps that can decrease the likelihood of Hepatitis, HIV, STD, and TB transmission; ~~caal~~¶
(~~C~~D) For pregnant individuals, ~~counseling on~~interactive social services and educational information addressing the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco, and other drug use on the fetus and referral for prenatal care; and~~.~~¶
(~~D~~E) Peer Delivered Services that address parenting and youth in transition support, as indicated.~~.~~¶
(3) At the time of entry, ~~an~~the assessment ~~shall be comple~~process must begin, be upda~~t~~ed, or ~~upda~~comple~~t~~ed and signed by a qualified program staff~~. Each assessment shall include:~~, provided individual presentation and circumstances allow ¶
(a) Each assessment document must provide clinically relevant information, or documented review of past records that contain, at minimum;¶
(~~a~~A) ~~S~~If a DSM-5 TR diagnosis cannot be identified, a Minimally sufficient information and documentation to justify the presence of a DSM-5-TR 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;~~ . ¶
(B) If a DSM-5 TR diagnosis cannot be initially identified, ICD 10 "z" , "v" or "r" codes may be utilized to document initial diagnostic impressions for up to 90 days of initial service date.. gnosis when it is determined.¶
(b) Screening for the presence of suicide risk and interventions based on the information gathered; and¶
(~~C~~A) ~~Mental health conditions; ¶~~
~~(D) Chronic medical conditions;~~A determination of the need for follow-up actions, additional services and supports, and the level of risk to the individual or to others.¶
(~~E~~B) ~~Symptoms related to psychological and physical trauma; and¶~~
~~(F) Suicide risk;¶~~
~~(c) When the screening process determ~~For updated assessments or assessments for participants returning to services in less than one calendar year, collateral information such as previous assessments can be used to inform the current assessment. Information supporting medical necessity, immediate risk screenin~~e~~gs ~~the presence of any of the above conditions or any risk to health and safety to an individual:~~ must be verified in initial assessment interviews. ¶

(c) Should medical necessity not be possible to document at entry, the following services may be rendered prior to an assessment being completed, or at any appropriate time during a treatment episode:¶
(A) Care coordination;¶
(B) Peer mentoring;¶
(C) Screening; and¶
(AD) ~~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 other~~Crisis intervention.¶
(d) Assessments conducted in less than 90 days are considered complete when the following information has also been documented as part of an assessment within 90 days of the initial service date;¶
(A) Symptoms related to psychological and physical trauma; ¶
(B) Current suicide risk;¶
(C) Current Substance use;¶
(D) Current Problem Gambling Behavior;¶
(E) Current Mental Health conditions;¶
(F) Current Medical conditions; ¶
(G) Additional and sufficient Historical, Biological, Psychological and Social information relevant to planning services; and ¶
(BH) ~~D~~When indicated, documentation ~~shall~~must contain re~~ferral~~commendations for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider. ¶
(~~d~~e) In addition, for substance use disorder services each assessment and update thereof ~~shall~~must 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) ASAM Level of Care determination per dimension, overall, and noting any applicable discrepancies; and¶
(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;¶
(i) Level of Care recommendation for each ASAM dimension based on current and available information.¶
(ii) 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 90 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 consideration of the history of each risk as well as the present concern(s); ¶
(ii) An identification of immediate need(s);¶
(iii) A severity of risk for each dimension; and¶
(iv) An overall determination of the severity of risk the individual currently is experiencing.¶
(~~e~~f) Any changes to the ASAM Level of Care placement decision ~~shall~~must be justified within an update to the multidimensional assessment on file; ¶
(~~f~~g) Providers ~~shall~~must update assessments within the scope of their practice when there are changes in clinical circumstances; and ¶
(~~g~~h) Any individual continuing to receive mental health services for one or more continuous years ~~shall~~must receive an annual assessment by a QMHP.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

AMEND: 309-019-0140

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

CHANGES TO RULE:

309-019-0140
Service Plan and Service Notes ¶

(1) The service plan ~~shall~~must be a written, individualized plan designed 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:~~ must:¶
(a) Be started prior to rendering of ~~services;~~ treatment services, with a comprehensive service plan completed no later than 90 days from date of initial service contact;¶
(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;¶
(~~f~~e) Include the participation of the individual and family members, as applicable;¶
(~~g~~f) Be completed and signed by qualified program staff as follows:¶
(A) A QMHP in mental health programs;¶
(B) Supervisory or treatment staff in substance use disorders treatment programs; and¶
(C) Supervisory or treatment staff in problem gambling treatment programs.¶
(~~h~~g) For mental health services, a ~~QMHP who meets the qualifications of a Clinical S~~n appropriately licensed practitioner - program supervisor or Licensed practitioner designated by the program supervisor ~~shall~~must recommend the services and supports by signing the service plan within ten business days of the start of services~~; and ¶~~
~~(i) A QMHP who meets the qualifications of a Clinical Supervisor shall~~, when service plan objectives are changed or updated. An appropriately Licensed practitioner must approve the service plan at least annually for each individual receiving mental health services for one or more continuous years.¶
(2) At minimum, each service plan ~~shall~~must include:¶
(a) Treatment objectives that are~~: ¶~~
~~(A) I~~ individualized~~t~~;¶
(b) To meet the assessed needs of the individual~~;~~.¶
(~~B~~3) ~~M~~4Comprehensive service plans must be written within 90 days of initial service contact. Comprehensive service plans will be measurable for the purpose of evaluating individual progress, ~~including a baseline evaluation.~~ as well as;¶
(~~b~~a) The specific therapeutic and social services and supports that ~~shall~~must be used to meet the treatment objectives;¶
(~~c~~b) Expected frequency of each type of planned service or support; and¶
(~~d~~c) A schedule for re-evaluating the service plan.¶
(~~3~~d) the type of personnel that will be furnishing the services.¶
(4) Providers ~~shall~~must 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 their name, credentials, and signature;¶
(e) The setting in which the services were rendered; and¶
(f) Periodic updates describing the individual's progress.¶
(5) Decisions to transfer individuals ~~shall~~must be documented including:¶
(a) The date of the transfer;¶
(b) The reason for the transfer;¶
(c) For substance use disorder and co-occurring services, ASAM level of care recommendation and overall determination of the severity of risk the individual is experiencing at the time of transfer;¶
(d) Referrals to follow up services and other behavioral health providers; and¶
(e) Outreach efforts made as applicable and as defined in these rules.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640

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