Health Systems Division: Behavioral Health Services - Chapter 309

August 15, 2019

Round 2 Redline

Division 19. OUTPATIENT BEHAVIORAL HEALTH SERVICES

309-019-0100 Purpose and Scope

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

(2) In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980, ~~and~~ 943-120-01~~0~~00 through 943-120-15~~5~~05, and 410-141-3000 through 410-141-4120, these rules specify standards for behavioral health treatment services and supports provided in:

(a) Outpatient Community Mental Health Services and Supports for Children and Adults;

(b) Outpatient Substance Use Disorders Treatment Services; ~~and~~

(c) Outpatient Problem Gambling Treatment Services;

(d) Assertive Community Treatment;

(e) Supported Employment;

(f) Crisis Line Services; and

(g) Youth Wraparound Program.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 461.549 & 743A.168
History:
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0105 Definitions

In addition to the definitions listed in OAR 309-001-0100, the following definitions apply with respect to this OAR chapter 309, division 019.

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

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

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

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

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

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

(X) “ASAM Criteria" means the most current edition of the American Society of Addiction Medicine (ASAM) for the Treatment of Addictive, Substance-Related, and Co-Occurring Conditions, which is a clinical guide for developing patient-centered service plans and making objective decisions about admission, continuing care, and transfer or discharge and is incorporated by reference in these rules. The publication incorporated by reference in these rules is available from the Amererican Society of Addiction Medicine at www.asam.org.

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

(a) Low client-to-staff ratios;

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

(c) Shared caseloads among team members;

(d) Twenty-four--hour staff availability;

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

(f) Time-unlimited services.

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

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

(10) “Authority” means the Oregon Health Authority.

(11) “Behavioral Health Treatment” means treatment for mental health, substance use disorders, and problem gambling.

(1210) "Behavior Support Plan" means the individualized proactive support strategies used to support positive behavior.

(1311) “Behavior Support Strategies” means proactive supports designed to replace challenging behavior with functional, positive behavior. The strategies address environmental, social, neuro-developmental, and physical factors that affect behavior.

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

(1512) “Care Coordination” means a series of actions contributing to a patient-centered, high-value, high-quality care system. It is defined as the organized coordination of an individual’s health care services and support activities between two or more participants deemed responsible for the individual’s health outcomes and minimally includes the individual (and their family, guardian, or caregiver, as appropriate) and a single consistent individual in the role of care coordinator. Care coordination is characterized by the creation of a team and team meetings, and facilitation of transitions between levels of caremeans 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.

(1613) "Case Management" means the services provided to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, behavioral health, social, educational, government entitlement programs, and other applicable community services.

~~(17) "Certificate of Approval" means the document issued by the Authority that identifies and declares certification of a provider pursuant to OAR chapter 309, division 008.~~

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

(~~19~~14) "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.

(~~20~~15) "Clinical Supervision" means oversight by a qualified clinical supervisor of substance use, problem gambling, and mental health services and supports provided according to these rules, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(~~21~~16) "Clinical Supervisor" means an individual qualified to oversee and evaluate substance use, problem gambling, or mental health services and supports.

(~~22~~17) "Co-occurring ~~Substance Use, Problem Gambling, and Mental Health~~ Disorders (COD)" means the existence of some combination of ~~a~~ diagnose~~i~~s for a substance use disorder, problem gambling ~~disorder~~, or ~~and~~ a mental health disorder.

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

(~~24~~18) "Conditional Release" means placement by a court or the Psychiatric Security Review Board (PSRB) of an individual who has been found eligible under ORS 161.327 or 161.336 for supervision and treatment in a community setting.

~~(25) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.~~

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

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

(~~28~~19) "Crisis" means an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted, and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care or death.

(~~29~~20) "Crisis Intervention" has the meaning given that term in OAR 309-023-0110.

(~~30~~21) “Crisis Line Services” means phone-based services that establish immediate communication links and provide supportive interventions and information for individuals in an urgent or emergent situation.

(~~31~~22) “Crisis Plan” means an individualized document designed to help anticipate and prevent future crisis episodes and direct interventions in the instance of a crisis.

(23) “Crisis Respite” means urgent or emergency supports designed to provide temporary relief, to a caregiver or provider, in maintaining the current level of care. It may be used to provide services and supports outside of the home to the individual in the immediate time frame. Respite care includes supervision and behavior support consistent with the strategies specified in the person-centered service plan. It is meant to assist in maintaining current level of care and avoiding institutional placement.~~means urgent or emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. It may be used to provide relief to the individual in the immediate time frame. 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. It is meant to assist in avoiding institutional placement.~~

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

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

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

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

~~(36) “Division” means the Health Systems Division of the Oregon Health Authority, or its designee.~~

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

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

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

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

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

(~~40~~25) “Enhanced Care Services (ECS)” and “Enhanced Care Outreach Services (ECOS)” means intensive behavioral and rehabilitative mental health services to eligible individuals who reside in Aging and People with Disabilities (APD) licensed homes or facilities.

(~~41~~26) “Entry” means the act or process of acceptance and enrollment into services regulated by this rule.

(~~42~~27) “Face to Face” means a personal interaction where both words can be heard and facial expressions can be seen in person or through telehealth services where there is a live streaming audio and video, if clinically appropriate.

(~~43~~28) ~~"~~”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.

(~~44~~29) "Family Support" means the provision of peer delivered services to people defined as family to the individual. It includes support to caregivers at community meetings, assistance to families in system navigation and managing multiple appointments, supportive home visits, peer support, parent mentoring and coaching, advocacy, and furthering efforts to develop natural and informal community supports.

(~~45~~30) “Gender Identity” means an individual's self-identification of gender without regard to legal or biological identification including but not limited to individuals identifying themselves as male, female, transgender, ~~transsexual,~~ non-binary, and gender~~-~~diverse.

(~~46~~31) “Gender ~~Expression~~Presentation” means the external characteristics and behaviors that are socially defined as masculine, feminine, or non-binary, ~~androgynous~~ such as dress, mannerisms, speech patterns, and social interactions.

(~~47~~32) "Geographic Service Area" means the geographic area within the county boundaries in which the CMHP operates.

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

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

(~~50~~33) “HIPAA” means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

(~~51~~34) “Individual” means any individual being considered for or receiving services and supports regulated by these rules.

(~~52~~35) "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~~ or guardian has~~ve~~ consented to the services on, or prior to, the first date of service.

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

(~~54~~36) "Intensive Outpatient Services and Supports (IOSS)" means a defined, specialized set of integrated and comprehensive in-home and community-based supports and mental health treatment services for children, organized by care coordination, ~~that are~~ developed by the child and family team, and delivered in the ~~most integrated~~ least restrictive setting in the community.

~~(55) "Interdisciplinary Team (IDT)" means a group of professional and direct care staff that have primary responsibility for the development of a Service Plan for an individual receiving services.~~

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

(~~57~~37) "Intern" or "Student" means an individual providing paid or unpaid program services to complete a credentialed or accredited educational program recognized by the State of Oregon.

(~~58~~38) "Juvenile Psychiatric Security Review Board (JPSRB)" means the entity described in ORS 161.385.

(~~59~~39) "Lethal Means Counseling" means best practice research-based counseling strategies to help patients at risk for suicide and their families reduce access to lethal means, including but not limited to firearms.

(~~60~~40) "Level of Care" means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

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

(~~62~~41) "Licensed Medical Practitioner (LMP)" has the meaning defined in OAR 309-001-0100, except that ~~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) F~~for IOSS ~~and ITS~~ providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(~~63~~42) "Linkage agreement" means a written agreement between the program and other entities involved in supporting the individual's welfare and recovery. The agreement describes the roles and responsibilities each entity assumes in order to assure that the program's goals are achieved.~~has the meaning given that term in OAR 309-032-0860.~~

~~(64) "Local Mental Health Authority (LMHA)" means one of the following entities:~~

~~(a) The board of county commissioners of one or more counties that establishes or operates a CMHP;~~

~~(b) The tribal council in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or~~

~~(c) A regional local mental health authority composed of two or more boards of county commissioners.~~

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

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

(~~67~~43) "Medical Director" means a physician licensed to practice medicine in the State of Oregon and is designated by a ~~substance use disorders treatment~~ program to be responsible for the program's medical services, either as an employee or through a contract.

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

(~~69~~44) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis, or treatment of a physical or behavioral health condition or injuries that are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an individual or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an individual.

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

~~(71) "Mental Health Intern" means an individual who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work, or behavioral science field to meet the educational requirement of QMHP. The individual 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 practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by the provider; and~~

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

(~~72~~45) "Mobile Crisis Services" means mental health services for individuals in crisis provided by mental health practitioners who respond to behavioral health crises onsite at the location in the community where the crisis arises and who provide a face-to-face therapeutic response. The goal of mobile crisis services is to help an individual resolve a psychiatric crisis in the most integrated setting possible and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration.

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

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

(~~75~~46) "Outpatient Substance Use Disorders Treatment Program" means a program that provides assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for individuals with substance use disorders and their family members or significant others.

(~~76~~47) "Outpatient Community Mental Health Services and Supports" means all outpatient mental health services and supports provided to children, youth, and adults.

(~~77~~48) "Outpatient Problem Gambling Treatment Services" means all outpatient treatment services and supports provided to individuals with gambling related problems and their families.

(~~78~~49) "Outreach" means the delivery of behavioral health services, referral services, and case management services in non-traditional settings including but not limited to the individual's residence,

shelters, streets, jails, transitional housing sites, drop-in centers, single room occupancy hotels, child welfare settings, educational settings, or medical settings. It also means attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.

~~(79) "Peer" means any individual supporting an individual or the individual's family member who has similar life experience, either as a current or former recipient of mental health or substance use services, or as a family member of an individual who is a current or former recipient of substance use or mental health services.~~

~~(80) "Peer-Delivered Services" are community-based services and supports provided by peers and peer support specialists to individuals or family members with similar lived experience. These services are intended to support individuals and families to engage individuals in ongoing treatment and to live successfully in the community.~~

~~(81) "Peer Support Specialist" means an individual providing peer delivered services to an individual or family member with similar life experience under the supervision of a qualified clinical supervisor and a qualified peer delivered services supervisor as resources are made available. A peer support specialist shall be certified by the Authority's Office of Equity and Inclusion as required by OAR 410-180-0300 to 0380 and be:~~

~~(a) A self-identified individual currently or formerly receiving mental health or substance use services;~~

~~(b) A self-identified individual in recovery from a substance use disorder who meets the abstinence requirements for recovering staff in substance use disorders treatment and recovery programs;~~

~~(c) A self-identified individual in recovery from problem gambling; or~~

~~(d) A person who has experience parenting a child who:~~

~~(A) Is a current or former recipient of mental health or substance use treatment; or~~

~~(B) Is facing or has faced difficulties in accessing education and health and wellness services due to a mental health or behavioral health barrier.~~

~~(82) "Peer Support and Peer Wellness Specialist Supervision" means supervision by a qualified clinical supervisor and a qualified peer delivered services supervisor as resources are available. The supports provided include guidance in the unique discipline of peer delivered services and the roles of peer support specialists and peer wellness specialists.~~

~~(83) "Peer Delivered Services Supervisor" means a qualified individual, with at least one year of experience as a PSS or PWS in behavioral health treatment services, to evaluate and guide PSS and PWS program staff in the delivery of peer delivered services and supports.~~

~~(84) "Peer Wellness Specialist" means an individual who supports an individual in identifying behavioral health service and support needs through community outreach, assisting individuals with access to available services and resources, addressing barriers to services, and providing education and information about available resources and behavioral health issues in order to reduce stigma and discrimination toward consumers of behavioral health services and to provide direct services to assist~~

~~individuals in creating and maintaining recovery, health, and wellness. A peer wellness specialist shall be:~~

~~(a) A self-identified individual currently or formerly receiving mental health services;~~

~~(b) A self-identified individual in recovery from a substance use or gambling disorder who meets the abstinence requirements for recovering staff in substance use disorders or gambling treatment programs; or~~

~~(c) A family member of an individual who is a current or former recipient of mental health or substance use or problem gambling services.~~

(~~85~~50) “Problem Gambling Treatment Staff” means an individual certified or licensed by a health or allied provider agency to provide problem gambling treatment services that include assessment, development of a service plan, and group and family counseling.

(~~86~~51) "Program" means a particular type or level of service that is organizationally distinct.

(~~87~~52) "Program Administrator" or "Program Director" means an individual with appropriate professional qualifications and experience who is designated to manage the operation of a program.

(~~88~~53) "Program Staff" means an employee or individual who by contract with the program provides a service and has the applicable competencies, qualifications, or certification required to provide the service.

(~~89~~54) “Provider” means an individual, organizational provider, or Community Mental Health Program as designated under ORS 430.637(1)(b) that holds a current certificate to provide outpatient behavioral health treatment or prevention services pursuant to these and other applicable service delivery rules.

(~~90~~55) "Psychiatric Security Review Board (PSRB)" means the entity described in ORS 161.295 through 161.400.

~~(91) "Psychiatrist" means a physician licensed pursuant to ORS 677.010 to 677.228 and 677.410 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.~~

~~(92) "Psychologist" means a psychologist licensed by the Oregon Board of Psychologist Examiners.~~

(~~93~~56) “Publicly Funded” means financial support in part or in full with revenue generated by a local, state, or federal government.

~~(94) "Qualified Mental Health Associate (QMHA)” means an individual delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-019-0125.~~

~~(95) "Qualified Mental Health Professional (QMHP)" means an LMP or any other individual meeting the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-019-0125.~~

(~~96~~57) "Qualified Person" means an individual who is a QMHP or a QMHA and is identified by the PSRB and JPSRB in its Conditional Release Order. This individual is designated by the provider to deliver or arrange and monitor the provision of the reports and services required by the Conditional Release Order.

~~(97) "Quality Assessment and Performance Improvement" means the structured, internal monitoring and evaluation of services to improve processes, service delivery, and service outcomes.~~

(~~98~~58) "Recovery" means a process of healing and transformation for an individual to achieve full human potential and personhood in leading a meaningful life in communities of their choice.

(~~99~~59) "Representative" means an individual who acts on behalf of an individual at the individual's request with respect to a grievance including but not limited to a relative, friend, Division employee, attorney, or ~~legal~~ guardian.

(~~100~~60) "Resilience" means the universal capacity that an individual uses to prevent, minimize, or overcome the effects of adversity. Resilience reflects an individual's strengths as protective factors and assets for positive development.

(~~101~~61) "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. It is meant to assist in avoiding institutional placement. When respite care is provided on an urgent or emergency basis, it is referred to as "crisis respite," as described above.

(~~102~~62) "Safety Plan" means a document developed by the individual and the individual's family, as appropriate, in consultation with the individual's provider to address suicide risk, as well as other potential crises that could occur and to ensure everyone's safety. The plan shall include, as appropriate, 24-hour, 7-days-a-week response; formal, informal and natural supports, as defined in 309-019-0325; respite or back-up care; details leading to crises; successful strategies that have worked in the past; and strength-based strategies, as defined in 309-019-0325, that prevent escalation and maintain safety~~best practice research-based individual directed document developed through a collaborative process in which the provider assists the individual in listing strategies to use when suicide ideation is elevated or after a suicide attempt~~.

(~~103~~63) "Screening" means the process to determine whether the individual needs further assessment to identify circumstances requiring referrals or additional services and supports.

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

(~~105~~64) "Service Plan" means a comprehensive plan for services and supports provided to or coordinated for an individual and their family, as applicable, that is reflective of the assessment and the intended outcomes of service.

(~~106~~65) "Service Note" means the written record of services and supports provided, including documentation of progress toward intended outcomes consistent with the timelines stated in the service plan.

(~~107~~66) “Service Record” means the collected documentation, written or electronic, ~~documentation~~ regarding an individual’s ~~and resulting from~~ entry, assessment, orientation, service~~s and supports~~ planning, service notes~~s and supports provided~~, and transfer.

(~~108~~67) "Services" means activities and treatments ~~described in the service plan~~ that are intended to assist the individual's transition to recovery from a substance use disorder, problem gambling ~~disorder~~, or mental health condition and to promote resiliency and rehabilitative and functional individual and family outcomes.

(~~109~~68) “Signature” means any written or electronic means of entering the name, date of authentication, and credentials of the individual providing a specific service, or the individual authorizing services and supports. Signature also means any written or electronic means of entering the name and date of authentication of the individual, guardian, or any authorized representative of the individual receiving services.

(~~110~~69) "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, personal relationships, drug and alcohol awareness, behavior support, symptom management, accessing community services, and daily living.

(~~111~~70) "Substance Abuse Prevention and Treatment Block Grant" or “SAPT Block Grant” means the federal block grants for prevention and treatment of substance abuse under Public Law 102-321 (31 U.S.C. 7301-7305) and the regulations published in Title 45 Part 96 of the Code of Federal Regulations.

(~~112~~71) "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol to the side effects of a medication and to a toxin exposure. The disorders include substance use disorders such as substance dependence and substance abuse and substance-induced disorders, including substance intoxication, withdrawal, delirium, and dementia, and includes but is not limited to substance induced psychotic disorder, mood disorder, as defined in DSM criteria.

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

(~~114~~72) “Substance Use Disorders Treatment Staff” means an individual certified or licensed by a health or allied provider agency to provide substance use disorders treatment services that include assessment, development of a service plan, and individual, group, and family counseling.

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

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

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

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

(~~116~~73) “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.

(~~117~~74) “Transfer” means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.

~~(118) “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, substance use, or problem gambling 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.~~

(~~119~~75) "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.

(~~120~~76) “Triage” means a classification process to determine priority needs.

~~(121) "Urinalysis Test" means an initial test and, if positive, a confirmatory test:~~

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

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

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

(~~122~~77) "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.

~~(123) "Variance" means an exception from a provision of these rules granted in writing by the Division pursuant to the process regulated by OAR 309-008-1600 upon written application from the provider. Duration of a variance is determined on a case-by-case basis.~~

(~~124~~78) "Volunteer" means an individual who provides a program service or takes part in a program service and is not a program employee and is not paid for services. The services shall be non-clinical unless the individual has the required credentials to provide a clinical service.

(~~125~~79) “Warm Handoff” means a transfer of care between two members of the health care team that involves a face-to-face meeting with the patient and family, as appropriate. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care.~~has the meaning given that term in OAR 309-032-0860.~~

(~~126~~80) “Wellness” means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.

(~~127~~81) “Wraparound” means a definable planning process that results in a unique set of community services and supports individualized for a youth and family to achieve a positive set of outcomes.~~a high fidelity model of team-based intensive care coordination for children and their families based on National Wraparound Initiative values and principles.~~

(~~128~~82) “Young Adult in Transition” means an individual who is developmentally transitioning into independence, sometime between the ages of 14 and 25.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168
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MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0110 Provider Policies

(1) Personnel policies. All providers shall develop and implement written personnel policies and ~~specific~~ procedures compliant with this OAR chapter 309, division 019. ~~These policies shall include all elements listed under OAR 309-018-0110(1); t~~These requirements are incorporated as if fully set forth in this rule. These policies shall include:~~these rules including:~~

(a) Personnel qualifications and credentialing;

(b) Mandatory abuse reporting, consistent with ~~compliant with~~ ORS 430.735 through ~~-~~ 430.768 ~~and OAR chapter 943, division 45~~;

(c) Criminal records check or background check, as required under OAR chapter 407, division 007~~Records Checks compliant with OAR 407-007-0200 to 0370;~~

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

(e) Drug and gambling free workplace ~~Free Workplace~~.

(2) Service delivery policies. All providers shall develop and implement written service delivery policies and ~~specific~~ procedures compliant with this OAR chapter 309, division 019. ~~These policies shall include all elements listed under OAR 309-018-0110(2); t~~These requirements are incorporated as if fully set forth in this rule. The policies shall ~~these rules,~~ be made available to individuals, guardians, and family members upon request, and 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) Process to notify the Authority within 48 hours of serious incidents; ;

(i) Family involvement;

(j) Trauma informed service delivery, consistent with both the Division's Trauma Informed Services Policy and any applicable Authority policies;

(k) Provision of culturally and linguistically responsive services; and

(l) Peer delivered services.

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

~~(h) Provision of culturally and linguistically appropriate services;~~

~~(i) Crisis prevention and response;~~

~~(j) Incident reporting; and~~

~~(k) Peer delivered services.~~

(3) Impermissible practices. Providers shall establish written policies that prohibit:

(a) Psychological, emotional, sexual, financial, and physical abuse of an individual;

(b) The use of seclusion, personal restraint, mechanical restraint, and chemical restraint;

(c) Withholding, for non-medical reasons, shelter, regular meals, medication, clothing, or supports for physical functioning;

(d) Allowing one individual receiving services to discipline another; and

(e) Titration of medications prescribed for the treatment of opioid dependence as a condition of receiving or continuing to receive treatment.

~~Providers shall establish written policies that prohibit the practices listed under OAR 309-018-0110(4); these requirements are incorporated as if fully set forth in this rule.~~

(4~~3~~) Providers of ECS services shall develop behavior support policies consistent with OAR 309-019-0155(3).

(5~~4~~) Community Mental Health Programs shall develop policies for linkage agreements compliant with OAR 309-032-0870.

(5) The provider's policies and procedures shall:

(a) Prohibit psychological and physical abuse of an individual;

(b) Prohibit seclusion, personal restraint, mechanical restraint, and chemical restraint;

(c) Prohibit withholding shelter, regular meals, medication, clothing, or supports for physical functioning;

(d) Prohibit discipline of one individual receiving services by another; and

(e) Prohibit titration of medications prescribed for the treatment of opioid dependence as a condition of receiving or continuing to receive treatment.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 413.520 - 413.522, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168
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MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0115 Individual Rights

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

(a) Choose from services and supports that are consistent with the assessment and service plan, culturally ~~competent~~responsive, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence;

(b) Be treated with dignity and respect;

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

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

(e) Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, ~~179.507,~~ and 192.51~~75~~;~~, 192.507,~~ 42 CFR Part 2; and 45 CFR ~~Part~~ § 205.50;

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

(A) Under age 18 and lawfully married;

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

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

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

(h) Refuse participation in experimentation;

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

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

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

(~~l~~L) Have religious freedom;

(m) Be free from seclusion and restraint;

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

(o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented;

(p) Have family and guardian involvement in service planning and delivery;

(q) ~~Have an opportunity to m~~Make a declaration for mental health treatment, ~~when~~ if legally an adult;

(r) File grievances, including appealing decisions resulting from the grievance;

(s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;

(t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; ~~and~~

(u) Exercise all rights described in this rule without any form of reprisal or punishment; and

(v) Express sexual orientation, gender identity, and gender presentation.

(2) Notification of individual rights.

(a) Consistent with OAR 309-019-0135(2), ~~T~~the provider shall give to the individual and, if ~~appropriate~~applicable, the guardian a document that describes the ~~applicable~~ individual~~'s~~ rights defined in this rule, as well as how to exercise those rights. ~~as follows:~~

~~(a) Information given to the individual shall be in written form or, u~~Upon request, this information shall be explained verbally, and shall be made available in an alternative format or language appropriate to the individual or guardian's needs;

~~(b) The rights and how to exercise them shall be explained to the individual, and if applicable the guardian; and~~

(b~~c~~) The provider shall post, ~~Individual rights shall be posted in writing~~ in a common area, a document describing the rights enumerated in this rule.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.495, 430.640 & 443.450
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380-426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460 & 743A.168
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MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0125 Specific Staff Qualifications and Competencies

Program staff shall meet the following qualifications, credentialing, or licensing standards and competencies:

(1) Program administrators ~~or~~ and 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, assessment, service planning, case management and coordination, and utilization of community resources; group, family, and individual therapy or counseling; 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) Clinical supervisors in substance use disorders treatment programs shall be certified or licensed by a health or allied provider agency as follows:

(a) For supervisors holding a certification or license in substance use counseling, qualifications for the certificate or license shall have included at least:

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

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

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

(b) For supervisors holding a health or allied provider license, the license or registration shall have been issued by one of the following state bodies, and the supervisor shall possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of substance use disorders:

(A) Oregon Medical Board;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

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

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

(B) A Bachelor's degree and four years of paid full-time experience in the social services field with a minimum of two years of direct substance use disorders counseling experience; or

(C) A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct substance use disorders counseling experience.

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

(6) Peer Delivered Services Supervisors shall be a certified Peer Support Specialist (PSS) or Peer Wellness Specialist (PWS) with at least one year of experience in behavioral health treatment services.

(7) Substance use disorders treatment staff shall:

(a) Demonstrate competence in treatment of substance- use disorders including individual assessment, to include identification of health and safety risks to self or others; individual, group, family, and other counseling techniques; program policies and procedures for service delivery and documentation, and identification; implementation and coordination of services identified to facilitate intended outcomes; and

(b) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide substance use treatment within two years of the first hire date, and shall make application for certification no later than six months following the first hire date:

(A) Clinical supervision shall document progress toward certification; and

(B) If, during the first two years of employment, the person~~individual~~ has not yet been certified or licensed, and ~~The two years is not renewable if~~ the person~~individual~~ ends employment with ~~a~~ the provider and becomes re-employed with the same provider or another provider, the person's~~individual's~~ two-year window for securing certification or licensure remains the same. The person~~individual~~ is not entitled to begin a new two-year period by virtue of having re-initiated or changed employment;

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

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

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

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

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

(A) Oregon Medical Board;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

(8) Problem Gambling treatment staff shall:

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

(b) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide problem gambling treatment within two years of the first hire date and shall make application for certification no later than six months following the first hire date.

(A) Clinical supervision shall document progress toward certification; and

(B) If, during the first two years of employment, the personindividual has not yet been certified or licensed, and The two years is not renewable if the personindividual ends employment with a the provider and becomes re-employed with the same provider or another provider, the person'sindividual's two-year window for securing certification or licensure remains the same. The personindividual is not entitled to begin a new two-year period by virtue of having re-initiated or changed employment;

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

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

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

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

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

(A) Oregon Medical Board;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

(9) 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. ~~In addition, 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 309-019-0105.~~

(10) QMHPs shall demonstrate the ability to conduct an assessment including identifying precipitating events, to include health and safety risks to self or others; gather~~ing~~ histories of mental and physical health, substance use, past mental health services, and criminal justice contacts; assess~~ing~~ family, cultural, social, and work relationships; conduct~~ing~~ a mental status examination; ~~completing~~ complete a DSM diagnosis; develop~~ing~~ a safety plan; ~~writing~~ write and supervis~~eing~~ the implementation of a service plan; and provid~~eing~~ individual, family, or group therapy within the scope of their training. ~~In addition, QMHPs shall meet the following minimum qualifications:~~

~~(a) Bachelor's degree in nursing and licensed by the State of Oregon. Nurses are accountable to abide by the Oregon Nurse Practice Act to determine if job descriptions are compliant with the competencies listed above;~~

~~(b) Bachelor's degree in occupational therapy and licensed by the State of Oregon;~~

~~(c) Graduate degree in psychology;~~

~~(d) Graduate degree in social work;~~

~~(e) Graduate degree in recreational, art, or music therapy;~~

~~(f) Graduate degree in a behavioral science field; or~~

~~(g) A qualified Mental Health Intern, as defined in 309-019-0105.~~

(~~9~~11) Peer support specialists and peer wellness specialists, including family and youth support and wellness specialists, shall meet the requirements in OAR 410-180-0300 to 0380 for certification and continuing education, and shall demonstrate:

(a) The ability to support others in their recovery or resiliency; and

(b) Personal life experience and tools of self-directed recovery and resiliency.

(10) Program staff, contractors, volunteers, and interns providing treatment services or Peer Delivered Services in substance use disorders, problem gambling, or mental health treatment programs shall be trained in and familiar with strategies for delivery of trauma informed and culturally responsive treatment services.

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

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 430.254 - 430.640, 430.850 - 430.955, 743A.168, ORS 428.205 - 428.270, 430.010 & 430.205 - 430.210
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MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
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309-019-0130 Personnel Documentation, Training, and Supervision

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

(a) When required, verification of a criminal records check or background check, consistent with OAR chapter 407, division 007~~943-007-0001 through 0501~~;

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

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

(d) Periodic performance appraisals;

(e) Staff orientation documentation; and

(f) Disciplinary documentation;

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

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

(i) For persons providing care coordination in Wraparound programs, one of the two hours of required supervision shall be provided by a qualified Wraparound Coach.

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

(a) A contract or written agreement;

(b) A signed confidentiality agreement;

(c) Orientation documentation; and

(d) For subject individuals, verification of a criminal records check or background check, consistent with OAR chapter 407, division 007~~943-007-0001 through 0501~~.

(3) Providers shall ensure that program staff receives training applicable to the specific population for whom services are planned, delivered, or supervised. The program shall document appropriate orientation for each program staff or individual providing services within 30 days of the hire date. At a minimum, training and orientation for all program staff shall include but not be limited to:

(a) A review of crisis prevention and response procedures;

(b) A review of emergency evacuation procedures;

(c) A review of program policies and procedures;

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

(e) A review of mandatory abuse reporting procedures;

(f) A review of confidentiality policies and procedures;

(g) A review of Fraud, Waste and Abuse policies and procedures;

(h) A review of care coordination policies and procedures; ~~and~~

(i) A review of cultural responsiveness;

(j) A review of trauma informed services, including any specific educational materials that may be required by the Authority; and

(k~~i~~) For Enhanced Care Services, positive behavior support training.~~.~~

(4) Program staff providing direct services shall receive clinical supervision by a qualified clinical supervisor related to the development, implementation, and outcome of services:

(a) Supervision shall be provided to assist program staff to increase their skills within their scope of practice, improve quality of services to individuals, and supervise program staff and volunteers' compliance with program policies and procedures;

(b) Documentation of two hours per month of supervision for each individual supervised. The two hours shall include one hour of individual face-to-face contact or a proportional level of supervision for part-time program staff. ~~Individual face-to-face contact may include real time, two-way audio visual conferencing~~;

(c) Documentation of two hours of quarterly supervision for program staff holding a health or allied provider license. The two hours shall include at least one hour of individual face-to-face contact for each individual supervised. ~~Individual face-to-face contact may include real time, two-way audio visual conferencing~~;

(d) Documentation of weekly supervision for program staff meeting the definition of mental health intern; or

(e) For persons providing direct p~~P~~eer ~~D~~delivered ~~S~~sservices, one of the two hours of required supervision shall be provided by a qualified p~~P~~eer ~~D~~delivered ~~S~~sservices ~~S~~supervisor ~~as resources are made available~~.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640

Statutes/Other Implemented: ORS 109.675, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168
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MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0135 Entry and Assessment

(1) The program shall utilize a written~~n~~ 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 ~~expression~~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) The provider may not solely deny entry to individuals who are prescribed medication to treat opioid dependence;

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

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

(e) The provider shall develop and maintain service records and other documentation for each individual that demonstrates the specific services and supports for which payment has been requested;

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

(g) In accordance with ORS 179.505, HIPAA, and 42 CFR Part 2, an authorization for the release of information shall be obtained for any confidential information concerning the individual being considered for or receiving services;

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

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

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

(c~~C~~) Policy concerning grievances and appeals, ~~consistent with these rules~~ including an example grievance form;

(d~~D~~) Policies concerning confidentiality~~Notice of privacy practices~~; and

(e~~E~~) An opportunity to register to vote.

(3~~2~~) Entry requirements for providers that receive the Substance Abuse Prevention Treatment (SAPT) block grant:

(a) Individuals shall be prioritized in the following order:

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

(B) Women who are pregnant;

(C) Individuals who are using substances intravenously; and

(D) ~~Women~~ Individuals with dependent children.

(b) Individuals using substances intravenously shall receive interim referrals and information prior to entry to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services shall include:

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

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

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

(D) For pregnant women:

(i) ~~, c~~Counseling on the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco, and other drug use on the fetus; and

(ii) A referral for prenatal care, if the woman is not already receiving adequate prenatal care; and

(E) Peer d~~D~~elivered ~~S~~services that address parenting and youth in transition support, as indicated.

(4~~3~~) Assessment.

(a) At the time of entry, an assessment shall be completed prior to development of the service plan.~~:~~

(b~~a~~) The assessment shall be completed by q~~Q~~ualified program staff ~~shall complete the assessment .~~ as ~~follows~~appropriate for the type of program:

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

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

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

(c~~b~~) Each assessment shall include:

(A) Information and documentation to justify the presence of a DSM diagnosis that is the medically appropriate reason for services, including:

(i) Presenting problem(s);

(ii) Recent History including duration, frequency, intensity, and circumstances of symptoms;

(iii) Current level of functioning at home, work, school or child care;

(iv) Psychiatric History including previous interventions to treat psychiatric and substance use related conditions (medical and non-medical);

(v) Medical history including current primary care provider;

(vi) Family History including Mental Health and Substance Use;

(vii) Social history including family relationships, school functioning, peer relationships, substance use history, exposure to trauma and loss of key relationships;

(viii) Developmental status/history;

(ix) Developmentally appropriate mental status exam (MSE) including evaluation of risk of harm to self. This must include use of an evidence-based suicide screening tool; and

(x) Clinical formulation which identifies strengths, justifies the diagnosis, provides service recommendations, prognosis and anticipated duration of treatment. When the MSE screens positive for risk of suicide, a risk assessment, safety planning and lethal means counseling must be documented.

(B) Screening for the presence of co-occurring disorders and chronic medical conditions;

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

(d) When the assessment process determines the presence of co-occurring substance use, gambling, or and mental health disorders or any risk to health and safety:

(A) Additional assessments shall be used to determine the need for additional services and supports and the level of risk to the individual or to others; and

(B) Providers shall document and assist as needed in referral for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(e) Providers shall screen for the presence of symptoms related to physical, financial, sexual, or psychological trauma and for identification of strengths and resilience strategies.

(fe) Providers shall update assessments when there are changes in clinical circumstances; and

(gf) In addition to periodic assessment updates based on changes in the clinical circumstance, Aany individual continuing to receive mental health services for one or more continuous years shall receive an annual assessment by an QMHPLMP or designee, in accordance with OAR 309-019-0140(2)(a)(C).

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
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MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
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MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0140 Service Plan, ~~and~~ Service Notes, and Care Coordination

~~(1) In addition to any program- specific service delivery requirements, the service plan shall be a written, n individualized plan designed to improve the individual's condition to the point where the individual's continued participation in the program is no longer necessary. The service planning process and service plan is included in the individual's service record and shall meet all requirements listed under OAR 309-018-0145(1) and (2); these requirements are incorporated as if fully set forth in this rule.:~~

(1) Service planning. In addition to any program-specific service delivery requirements, 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 planning process and service plan is included in the individual's service record and shall:

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

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

(c) Reflect barriers related to discharge;

(d) Include the individual as an active participant in the creation and implementation of their service plan, unless:

(A) The individual does not wish to participate; or

(B) Seeking the individual's participation would be significantly detrimental to the individual's care or health, based on evidence documented in the service record.

(e) Include the participation of family members, as applicable and as the individual's choice indicates, which may include "caregiver or parent and child" work when a caregiver's behavioral health is impacting a child's behavioral health.

(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) Measurable, to facilitate a baseline evaluation and evaluation of progress.

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

(c) A projected schedule for service delivery, including the expected frequency and duration of each type of service or support;

(d) The credentials of the personnel furnishing each service; and

(e) Proactive safety and crisis planning;

(A) If the assessment indicates risk to the health and safety of the individual or to others, the service plan shall include a safety plan, which may be a separate document from the service plan;

(B) The safety plan shall be updated as necessary to reflect changing circumstances;

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

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

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

~~(c) 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;~~

~~(d) Include the participation of the individual and family members, as applicable;~~

(~~e~~32) Approval and review requirements.

(a) In mental health programs:

(A) The service plan shall ~~B~~be completed and signed by ~~qualified program staff as follows:~~

~~(A) 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.~~

(B~~f~~) Within 10 business days from the start of services, ~~For mental health services,~~ the service plan shall be approved and signed by 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

(C~~g~~) 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.

(b) In substance use disorder treatment programs, the service plan shall be completed and signed by qualified supervisory or treatment staff.

(c) In problem gambling treatment programs, the service plan shall be completed and signed by qualified supervisory or treatment staff.
~~(2) At minimum, each service plan shall include:~~

~~(a) Treatment objectives that are:~~

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

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

~~(b) The specific services and supports indicated by the assessment that shall be used to meet the treatment objectives;~~

~~(c) A projected schedule for service and support delivery, including the expected frequency and duration of each type of planned service or support;~~

~~(d) The credentials of the personnel providing each service and support; and~~

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

4) Service notes. 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 during which 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.

~~(3)~~ Service notes. ~~Providers shall document each service and support in a service note. to~~

~~(a) Service notes shall include all elements listed under OAR 309-018-0145(4); these requirements are incorporated as if fully set forth in this rule.:~~

(~~g~~b) For individuals identified as being at risk of suicide, whether during the assessment or during the provision of services, the service notes shall contain documented evidence that suicide risk is continually assessed, that follow-up safety plan activities are being monitored, and that lethal means counseling has been conducted.

~~(a) The specific services rendered;~~

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

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

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

~~(e) The personnel rendering the services, including their name, credentials, and signature;~~

~~(f) The setting in which the services were rendered; and~~

~~(g) Periodic updates describing the individual's progress.~~

(4) Decisions to transfer individuals shall be documented including:

(a) The date and reason for the transfer;

(b) Referrals to follow-up services and other behavioral health providers; and

(c) Outreach efforts made, as defined in these rules.

(5) Care coordination. ~~The provider shall comply with the care coordination responsibilities enumerated at OAR 309-018-0145(6) & (7); these requirements are incorporated as if fully set forth in this rule..~~

(6) Care coordination for all individuals.

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

(b) Providers shall collaborate to exchange information with any applicable physical, behavioral, or oral health care providers for the individual to promote regular and adequate health care.

(7) Care coordination for individuals who are members of coordinated care organizations (CCOs).

(a) If individual is enrolled in a coordinated care organization, is not receiving intensive care coordination services, and demonstrates potential eligibility for intensive care coordination based on the factors enumerated at OAR 410-141-3870(2), the provider shall refer the individual to the CCO for assessment and screening for intensive care coordination services.

(b) If the individual has been assigned an intensive care coordinator (ICC) through a CCO:

(A) Providers shall support the ICC in developing an intensive care coordination plan, participate in care coordination meetings, follow up and engage the individual in agreed-upon care plan responsibilities, and provide feedback on treatment status to the ICC.

(B) Providers shall facilitate and support connection between the individual and the ICC.

(C) Providers shall support the ICC's efforts to coordinate interdisciplinary team meetings, which shall be held monthly, or sooner as indicated by the individual's needs, as described in OAR 410-141-3870(7)(e).

(i) In connection with these meetings, providers shall, as necessary, provide information on the individual's progress in treatments, test results, lab reports, medications, and other care information to promote optimal outcomes and reduce risks, duplication of services, or errors.

(ii) All relevant providers shall be available for these meetings or provide individual treatment status updates for these meetings.

(D) Providers must notify the ICC of:

(i) The initiation of services;

(ii) Any referrals, change of condition, or assessments completed; and

(ii) Changes in treatment, provider, or acuity of health care needs.

(E) Providers must track the reassessment triggers enumerated in OAR 410-141-3870(3)(b) and report any identified triggers to the ICC.

(F) Providers must notify the ICC if the provider becomes aware of any changes in the individual's eligibility status for covered benefits.

~~(6)~~

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
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MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0145 Co-Occurring ~~Mental Health and Substance Use~~ Disorders (COD)

Providers approved under OAR 309-008-0100 to 309-008-1600 ~~OAR chapter 309, division 008~~ and designated to provide services and supports for individuals diagnosed with COD shall provide concurrent service and support planning and delivery for substance use disorders, gambling disorder, and mental health diagnose~~i~~s, including integrated assessment addressing co-occurring behavioral health diagnoses, service planning, and service records.

Statutory/Other Authority: ORS 413.042 & 430.640
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640 & 430.850 - 430.955
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MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0150 Community Mental Health Program~~s~~ (CMHP) Services

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

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

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

(2) Case management services shall be provided to assist individuals with the following:

(a) Gaining access to and maintaining resources such as Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing;

(b) Arrangement of transportation to help them apply for benefits;

(c) Referral and coordination to help individuals gain access to services and supports identified in the service plan; these services shall be made available to, ~~to include~~ but may not be limited to, individuals at risk of suicide;

(d) Care coordination and warm handoff processes; and

(e) Assist with a follow-up visit within seven days of discharge from an acute care psychiatric hospital.

(3) When significant health and safety concerns are identified, program staff shall ensure that necessary services or actions occur to address the identified health and safety needs for the individual, including services to individuals at ~~imminent~~ risk of suicide as determined by the assessment as described in this rule 309-019-0135 4(C)(a)(x).

(4) Peer d~~D~~elivered s~~S~~ervices shall be made available.

(5) ~~By July 1, 2018, or w~~When the CMHP is contracted to provide the service, the CMHP or their designee shall provide mobile crisis services as a component of crisis services for individuals experiencing mental health crisis within their ~~respective~~ geographic service area to meet the following objectives:

(a) Reduce acute psychiatric hospitalization of individuals experiencing mental health crisis; and

(b) Reduce the number of individuals with mental health diagnoses who are incarcerated as a result of mental health crisis events involving law enforcement.

(6) Mobile crisis services include but may not be limited to:

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

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

(c) Mental health crisis screening;

(d) Crisis intervention;

(e) Assistance with placement in respite or crisis respite, as defined in OAR 309-019-0105, peer respite, or residential care, treatment, or training, services as defined in ORS 443.400OAR 309-035-0105;

(f) Assistance to families and families of choice in managing suicide risk until the individual is engaged in outpatient services or when the individual is to receive services on an outpatient basis, including documentation that that lethal means counseling has been conducted;

(g) Initiation of involuntary services if applicable;

(h) Assistance with hospital placement; and,

(i) Connecting individuals with ongoing supports and services; and

(j) Any other services defined as part of a youth suicide communication and postvention plan, pursuant to OAR chapter 309, division 027.

(7) Each CMHP shall respond to crisis events in their respective geographic service area with the following maximum response times:

(a) In "urban" areas, a mobile crisis team member shall respond with a face-to-face interaction within one hour from the initial call to the face to face interaction within one hour;

(b) In "rural" areas, a mobile crisis team member shall respond with a face-to-face interaction within two hours from the initial call to the face to face interaction within two hours;

(c) In "frontier" areas, a mobile crisis team member shall respond with a face-to-face interaction within three hours from the initial call to the face to face interaction within three hours;

(d) In addition, in "rural" and "frontier" areas, a person who is trained in crisis management shall respond to the crisis event by phone call within one hour of being notified of the crisis event.

(8) By July 1, 2018, eEach CMHP shall develop and implement policies and procedures to monitor the mobile crisis response times to include the number of instances that mobile crisis response times exceed the maximum response times and the disposition resulting from the response outlined in these rules.

(9) The CMHP shall submit electronically a written quarterly report using forms and procedures prescribed by the Authority to the Division contract administrator no later than 45 calendar days following the end of each reporting quarter. The CMHP shall track and report the number of individuals receiving a mobile crisis services contact to include the following information:

(a) Location of mobile crisis service;

(b) Geographic area, ~~such~~ including whether the location was~~as~~ urban, rural, or frontier;

(c) Response time; and

(d) Disposition of the mobile crisis contact.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630, 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 461.549 & 743A.168
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MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0155 Enhanced Care Services (ECS) and Enhanced Care Outreach Services (ECOS)

(1) To be eligible for ECS/ECOS, an individual shall meet the following criteria:

(a) Be ~~APD service~~ eligible for services through the Aging and People with Disabilities (APD) program;

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

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

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

(e) Be currently or have been a patient at the Oregon State Hospital, or have received inpatient services in an acute psychiatric unit, for over 14 days and have been referred to non-enhanced APD facilities and denied admission due to severe mental illness with complex behaviors; and

(f) B~~b~~e currently exhibiting two or more of the following: self-endangering behavior, aggressive behavior, intrusive behavior, intractable psychiatric symptoms, complex medication needs, sexually inappropriate behavior, and elopement behavior.

(2) ECS and ~~/~~ECOS providers shall:

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

(b) Coordinate interdisciplinary team meetings (IDT meetings).

(A) The purpose of the IDT meetings is to:

(i) D~~d~~evelop the service plan;~~,~~

(ii) ~~r~~Review the behavior support plan;~~,~~ and ~~to~~

(iii) ~~c~~Coordinate care planning with the program staff for provider licensed by the Department of Human Services (Department) ~~licensed provider staff~~, APD case manager, QMHP, prescriber, and related professionals such as the Department~~-~~ licensed facility or program direct care staff, the Department licensed facility ~~RN~~registered nurse, and the facility administrator.

(B) IDT meetings shall be held:

(i) ~~in~~ In ECS programs, ~~shall be held~~ at least weekly; and

(ii) In ECOS programs, at least quarterly ~~for ECOS;~~.

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

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

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

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

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

(c) Establish a framework that ensures individualized positive behavior support practices throughout the program and articulates a rationale consistent with the philosophies supported by the Division, including the Division's ~~t~~Trauma ~~-i~~Informed ~~s~~Services policy;

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

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

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

(B) Increasing positive behavior.

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

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

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

(5) Staffing requirements include:

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

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

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

Statutory/Other Authority: ORS 161.390, 413.042, 430.640 & 443.450
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
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309-019-0160 Psychiatric Security Review Board (PSRB) and Juvenile Psychiatric Security Review Board (JPSRB)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Monthly reports to the PSRB or JPSRB;

(b) Interim reports, as applicable;

(c) The PSRB or JPSRB initial evaluation; and

(d) A copy of the Conditional Order of Release.

Statutory/Other Authority: 430.640, 443.450, 426.490 - 426.500, ORS 161.390, 413.042, 430.256 & 426.490 - 426.500
Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 426.380 - 426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 443.400 - 443.460
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MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0165 Intensive Outpatient Services and Supports (IOSS) for Children

(1) IOSS services may be delivered at a clinic, ~~facility,~~ home, school, other provider or allied agency location, or other setting as identified by the child and family team. In addition to services specified by the service plan and the standards for outpatient mental health services, IOSS services shall include:

(a) Provider participation on the child and family team ~~or wraparound team~~;

(b) A documented proactive safety and crisis plan developed by the child and family team. The proactive safety and crisis plan shall at minimum include:

(A) Strategies designed to facilitate positive alternatives to challenging behavior and to assist the individual in developing adaptive and functional living skills;

(B) Strategies to avert potential crisis without placement disruptions or placement in a higher level of care;

(C) Professional, ~~and~~ natural supports and peer delivered services to provide 24 ~~-~~ hour~~s~~, seven ~~-~~ days ~~-~~ per ~~-~~ week flexible response; and

(D) Documented informed consent from the parent or guardian.

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

(a) Identified ~~care coordinator and care coordination~~ provider agency and care coordinator, as well as documentation of provider participation on child and family team ~~or wraparound team~~;

(b) Documented identification of strengths, resiliency factors, and needs;

(c) A summary and review of service coordination planning by the provider or by the child and family team, ~~or wraparound team when applicable~~which shall be updated each time the child and family team meets; and

(d) A documented proactive safety and crisis plan, as defined in (1)(b) above, and in accordance with the requirements relating to suicide risk in OAR 309-019-0135 and 309-019-0140.

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
History:
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MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0170 Outpatient Problem Gambling Treatment and Recovery Services

Outpatient problem gambling treatment services include group, individual, and family treatment. These services shall be provided consistent with the following requirements:

(1) Service sessions shall address the individual's challenges ~~of the individual~~ as they relate directly or indirectly to the problem gambling behavior.

(2) Providers may provide ~~telephone~~ tele-counseling involving the individual, the family, or impacted others, ~~when face-to-face contact involves an unwise delay,~~ as follows:

(a) The individual shall be currently enrolled in the problem gambling treatment program;

(b) ~~Phone~~ Tele-counseling shall be provided by a qualified program staff within their scope of practice;

(c) Service notes for ~~phone~~ tele-counseling shall follow the same criteria as face-to-face counseling and identify the session was conducted by ~~phone~~ telehealth and the clinical rationale for the ~~phone~~ tele-counseling session;

(d) ~~Telephone~~ Tele-counseling shall meet HIPAA and ~~42 CFR~~ other applicable federal standards for privacy; and

(e) For tele-counseling involving the individual, ~~T~~there shall be an agreement of informed consent for ~~phone~~ tele-counseling that is discussed with the individual and documented in the individual's service record.

(3) Family counseling includes face-to-face or non-face-to-face service sessions between a program staff member delivering the service and a family member whose life has been negatively impacted by gambling.~~:~~

(a) Service sessions shall address the problems of the family member as they relate directly or indirectly to the problem gambling behavior; and

(b) Services to the family shall be offered even if the individual identified as a problem gambler is unwilling or unavailable to accept services.

(4) Twenty-four~~-~~hour crisis response shall be accomplished through agreement with other crisis services, on-call program staff, or other arrangement acceptable to the Division.

(5) The assessment and service plan shall expressly address the individual's financial situation.

(6) All treatment shall be provided in a trauma informed manner.~~A financial assessment shall be included in the entry process and documented in the assessment.~~

~~(6) The service plan shall include a financial component consistent with the financial assessment.~~

~~(7) A risk assessment for suicide ideation shall be included in the entry process and documented in the assessment as well as appropriate referrals made.~~

~~(8) The service plan shall address suicidal risks if determined within the assessment process or throughout services.~~

~~(9) For individuals at risk, the service notes shall contain documented evidence that suicidal risk is continually assessed and that follow-up safety plan activities are being monitored.~~

Statutory/Other Authority: ORS 161.390, 430.640 & 461.549
Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380- 426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 443.400 - 443.460
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MHS 6-2017, f. & cert. ef. 6-23-17
MHS 3-2015, f. & cert. ef. 5-28-15
MHS 1-2015(Temp), f. & cert. ef. 3-25-15 thru 9-20-15
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0175 Culturally Specific Substance Use Disorders and Problem Gambling Treatment and Recovery Services

~~Culturally specific programs are designed to meet the unique service needs of a specific culture. Programs approved and designated as culturally specific programs shall meet the following criteria.:~~ Culturally specific programs are designed to meet the unique service needs of a specific culture. Programs approved and designated as culturally specific programs shall meet the following criteria:

(1) At any given time, a majority of the individuals receiving treatment must be members of the culturally specific population;

(2) Maintain and keep current a written demographic and cultural profile of the community;

(3) Develop and implement written cultural and linguistic responsiveness policies relating to staffing, service delivery, and facilities, as outlined in this rule;

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

(5) Ensure that a majority of the treatment staff be representative of the culturally specific population being served. Implement strategies to recruit, retain, and promote staff at all levels of the organization that are representative of the population served;

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

;(7) Ensure that individuals are offered customer satisfaction surveys that address all areas of service and that the results of the surveys are used for quality improvement. Consider race, ethnicity, and language data in measuring customer satisfaction;

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

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

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

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

(c) Meet at least quarterly; and

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

(10) Maintain accessibility to culturally specific populations including:

(a) The physical location of the program shall have close proximity to at least one area in which the culturally specific population resides;

(b) The program shall have close proximity to public transportation, where available; and

(c) Hours of service, telephone contact, and other accessibility issues shall be appropriate for the population served.

(11) The physical facility where the culturally specific services are delivered shall be trauma informed for the culturally specific group.

(a) Materials displayed shall be culturally relevant; and

(b) Mass media programming (radio, television, etc.) shall be sensitive to cultural background.

(12) Consider and accommodate cultural differences whenever possible, such as the need or desire to bring family members to the facility, play areas for small children, and related accommodations; and

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

~~(1) Serve a majority of individuals representing culturally specific populations;~~

~~(2) Maintain a current demographic and cultural profile of the community;~~

~~(3) Ensure that individuals from the identified cultural group receive effective and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language;~~

~~(4) Implement strategies to recruit, retain, and promote a diverse staff at all levels of the organization that are representative of the population being served;~~

~~(5) Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery;~~

~~(6) Ensure that a majority of the substance use disorders treatment staff be representative of the specific culture being served;~~

~~(7) Ensure that individuals are offered customer satisfaction surveys that address all areas of service and that the results of the surveys are used for quality improvement;~~

~~(8) Consider race, ethnicity, and language data in measuring customer satisfaction;~~

~~(9) Develop and implement cultural awareness policies;~~

~~(10) Ensure that data on an individual's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated;~~

~~(11) Develop and maintain a governing or advisory board as follows:~~

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

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

~~(c) Meet at least quarterly; and~~

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

~~(12) Maintain accessibility to culturally specific populations including:~~

~~(a) The physical location of the program shall be within close proximity to the culturally specific populations;~~

~~(b) Where available, public transportation shall be within close proximity to the program; and~~

~~(c) Hours of service, telephone contact, and other accessibility issues shall be appropriate for the population.~~

~~(13) The physical facility where the culturally specific services are delivered shall be psychologically comfortable for the group including:~~

~~(a) Materials displayed shall be culturally relevant; and~~

~~(b) Mass media programming shall be sensitive to cultural background.~~

~~(14) Other cultural differences shall be considered and accommodated when possible, such as the need or desire to bring family members to the facility, play areas for small children, and related accommodations; and~~

~~(15) Ensure that grievance processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints.~~

Statutory/Other Authority: ORS 413.042, 430.640 & 443.450
Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 443.400 - 443.460
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MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0185 Outpatient Substance Use Disorders Treatment and Recovery Programs

(1) Programs approved to provide outpatient substance use disorders treatment services shall meet the following standards:

(a) The assessment shall contain an evaluation that identifies and assesses needs such as social isolation, self-reliance, parenting issues, domestic violence, physical health, housing, and financial considerations;

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

(c) The program shall provide or coordinate trauma informed, culturally responsive services and supports that meet the special access needs such as childcare, mental health services, and transportation, as indicated; and

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

(A) Gender-specific services and supports;

(B) Family services, including therapeutic services for children in the custody of individuals in treatment;

(C) Reintegration with family;

(D) Peer delivered services;

(E) Smoking cessation;

(F) Housing; and

(G) Transportation.

(2) Services shall include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies.

(3) The program shall coordinate services with the following, if indicated:

(a) Agencies providing services to individuals who have experienced physical abuse, sexual abuse, or other types of domestic violence; and

(b) Parenting training; and

(c) Continuing care treatment services, which shall be consistent with the ASAM PPC and include referrals to support groups, where available.

(4) Providers that receive SAPT block grant funding shall provide or coordinate the following services for pregnant women and individuals with dependent children, including individuals who are attempting to regain custody of their children:

(a) Primary medical care, including referral for prenatal care and child care;

(b) Primary pediatric care, including immunizations for their children;

(c) Gender-specific substance use treatment and other therapeutic interventions for individuals that may include but are not limited to:

(A) Relationship issues;

(B) Sexual, physical, emotional, and financial abuse;

(C) Parenting;

(D) Access to child care while the individuals are receiving these services; and

(E) Therapeutic interventions for children in the custody of individuals in treatment that may address issues including:

(i) Their developmental needs;

(ii) Any issues concerning sexual and physical abuse and neglect; and

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

(5) Providers who deliver adolescent substance use disorders treatment services or those with adolescent-designated service funding shall meet the following standards:

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

(b) Services or appropriate referrals shall include:

(A) Family counseling;

(B) Education services;

(C) Community and social skills training; and

(D) Smoking cessation service.

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

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

(B) Youth-directed self-help groups with a majority of participants being youth, where available;

(C) Linkage to emancipation services when appropriate.

(D) Linkage to sexual, physical, emotional, and financial abuse counseling and support services when appropriate; and

(E) Referral for peer delivered services by a youth support specialist.

(~~2~~6) In addition, for children ages five and under, providers shall offer dyadic treatment, meaning developmentally appropriate, evidence-supported therapeutic intervention that requires one caregiver and one child actively engaging in the therapy together to reduce symptomatology in one or both participants, and to improve the caregiver-child relationship.

(a) Examples of therapeutic treatment models designed as dyadic treatments include Parent-Child Interaction Therapy (PCIT), Child Parent Psychotherapy (CPP), and Attachment and Biobehavioral Catch-up (ABC).

(b) Additional therapeutic models that may be used as dyadic treatment under appropriate circumstances include the Parent Management Training-Oregon Model (PMTO) and Attachment, Regulation and Competency (ARC).

~~(a) The assessment shall contain an evaluation that identifies and assesses needs such as social isolation, self-reliance, parenting issues, domestic violence, physical health, housing, and financial considerations;~~

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

~~(c) The program shall provide or coordinate services and supports that meet special access needs such as childcare, mental health services, and transportation; and~~

~~(d) The program shall provide or coordinate the following services and supports:~~

~~(A) Gender-specific services and supports;~~

~~(B) Family services, including therapeutic services for children in the custody of women in treatment;~~

~~(C) Reintegration with family;~~

~~(D) Peer delivered services;~~

~~(E) Smoking cessation;~~

~~(F) Housing; and~~

~~(G) Transportation.~~

~~(2) Services shall include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies.~~

~~(3) The program shall coordinate referral services with the following:~~

~~(a) Agencies providing services to individuals who have experienced physical abuse, sexual abuse, or other types of domestic violence;~~

~~(b) Parenting training;~~

~~(c) Continuing care treatment services shall be consistent with the ASAM and shall include referrals to support groups where available.~~

~~(4) Programs that receive SAPT block grant funding shall provide or coordinate the following services for individuals:~~

~~(a) Primary medical care, including referral for prenatal care if applicable, and child care and transportation where needed;~~

~~(b) Primary pediatric care, including immunizations for their children;~~

~~(c) Gender specific substance use disorders treatment and other therapeutic interventions that may include but are not limited to:~~

~~(A) Relationship issues;~~

~~(B) Sexual and physical abuse;~~

~~(C) Parenting;~~

~~(D) Access to child care and transportation while receiving these services; and~~

~~(E) Therapeutic interventions for children in the custody of women or men in treatment that may include but are not limited to:~~

~~(i) Their developmental needs;~~

~~(ii) Any issues concerning sexual and physical abuse and neglect; and~~

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

~~(5) Providers that deliver adolescent substance use disorders treatment services or those with adolescent-designated service funding shall meet the following standards:~~

~~(a) Development of service plans and case management services shall include participation of parents, other family members, schools, children's services agencies, and juvenile corrections;~~

~~(b) Services or appropriate referrals shall include:~~

~~(A) Family counseling;~~

~~(B) Community and social skills training; and~~

~~(C) Smoking cessation service.~~

~~(6) Continuing care services shall be of appropriate duration and designed to maximize recovery opportunities. The services shall include:~~

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

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

~~(c) Referral to emancipation services when appropriate;~~

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

~~(e) Referral for peer delivered services.~~

Statutory/Other Authority: ORS 161.390, 413.042 & 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
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MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0190 Community-Based Substance Use Treatment Programs for Individuals in the Criminal Justice System

(1) ~~For individuals in the criminal justice system,~~ Duly licensed or certified providers may, subject to the requirements in this rule, offer community-based substance use treatment services and supports ~~are for~~ to individuals who are under the supervision of a probation officer or on parole or post-prison supervision or participating in a drug treatment court program or otherwise under the direct supervision of the court.

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

(a) Cognitive behavioral interventions;

(b) Motivational interventions;

(c) Relapse prevention; and

(d) Healthy relationships education.

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

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

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

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

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

Statutory/Other Authority: ORS 161.390, 413.042 & 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
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MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0195 Driving Under the Influence of Intoxicants (DUII) Services Providers

(1) Outpatient Substance Use Disorders (SUD) Treatment Programs approved by the Division as DUII Services Providers shall provide DUII Education~~,~~ and DUII Rehabilitation~~, and Recommendations for Hardship Permits~~ as outlined in this rule.

(2) The following definitions apply for purposes of this rule:

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

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

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

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

(A~~a~~) Met the completion criteria ~~approved by the Division~~specified in this rule or otherwise required by the Division; and

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

(B~~c~~) Demonstrated 90 days of continuous abstinence prior to completion, as described in section (9), below.

(3~~2~~) A DUII Services Provider may not provide Alcohol and Other Drug Screening Specialist (ADSS) services except as allowed in OAR 415-054-0545 through 415-054-0570.

(4~~3~~) DUII Services Providers shall document provision of an assessment, as outlined in OAR 309-019-0135(3), ~~all individuals seeking~~ for each individual enrolled in DUII services. Each assessment shall be consistent with the dimensions described in the ASAM Criteria and shall document a diagnosis and level of care determination consistent with the DSM-5 and the ASAM Criteria. ~~Level of care, diagnosis, frequency of contact, and duration of treatment services shall be consistent with the current DSM diagnostic and ASAM Criteria.~~

~~(4) DUII Education shall be provided for individuals who:~~

~~(a) Do not currently meet DSM diagnostic criteria for a SUD; and~~

~~(b) Meet ASAM Criteria for Level 0.5; and~~

~~(c) Have never been diagnosed with a SUD; and~~

(d) Have never been enrolled in a DUII or SUD treatment program.

(5) All individuals receiving DUII services must complete DUII Education. An individual must complete DUII Rehabilitation if the individual fails to meet any of the following criteria:

(a) The individual has had only one DUII.

(a) The individual meets ASAM Criteria for Level 0.5.

(b) The individual does not meet DSM-5 diagnostic criteria for an SUD.

(c) The individual does not have a previous SUD diagnosis.

(d) The individual demonstrates abstinence as required under section (9), below.

(65) DUII Education.

(a) DUII Services Providers shall document provision of a minimum of 12 hours of psychoeducational DUII Education services to each enrolled individual, including shall include a minimum of four sessions over a four-week period and include the provision of a minimum of 12 hours of didactic education.

(b) These minimum 12 hours does may not include the diagnostic assessment, service planning, or transfer planning.

(c) These 12 hours shall include any curricular materials required by the Division, and must include, at a minimum. DUII Education shall include but is not limited to:

(Aa) Completion of a Division--approved DUII Education Pre and Post Test;

(Bb) DUII Llaws and Cconsequences in Oregon;

(Cc) Use of alcohol and other drugs, and their effects on driving;

(Dd) Physical and psychological effects of alcohol and other drugs of abuse;

(Ee) SUD signs and symptoms;

(Ff) SUD recovery support services; and

(Gg) Alternatives to intoxicated driving.

(d6) No more than four of the 12 minimum hours shall be conducted utilizing educational films or pre-recorded audio-visual presentations.

(7) DUII Rehabilitation shall be provided for individuals who:

(a) Meet DSM diagnostic criteria for a SUD; or

(b) Meet ASAM Criteria for Level 1 or higher; or

~~(c) Have been previously diagnosed with a SUD; or~~

~~(d) Have previously been enrolled in a DUII or SUD treatment program.~~

~~(8) DUII Rehabilitation shall include:~~

~~(a) DUII Education as described in section (5) of this rule; and~~

~~(b) SUD treatment services as outlined in the individual's service plan.~~

(7) DUII Rehabilitation includes:

(a) DUII Education, as defined in section (6);

(b) Completion of clinically appropriate SUD treatment services as written in the individual's service plan in compliance with OAR 309-019-0135 and 309-019-0140; and

(c) For individuals who are members of a coordinated care organization (CCO), referral to the CCO's intensive care coordination program, as described in OAR 410-141-3170.

(A) If the individual has not already been assigned an intensive care coordinator at the time of DUII services, the DUII Services Provider shall refer the individual to the CCO intensive care coordination program within the DUII Rehabilitation service period.

(B) If the individual had already been assigned an intensive care coordinator before the start of DUII services, the DUII Services Provider shall contact the individual's intensive care coordinator no less than seven days from the beginning of DUII Rehabilitation services.

(8~~9~~) DUII Service Providers shall have a written policy on testing for substances of abuse and shall a copy with the written program orientation information required in OAR 309-019-0135(2) to everyone enrolled in DUII services. The written policies and procedures shall include:

(a) Type(s) of testing used;

(b) Frequency of testing (e.g. scheduled, random, as necessary);

(c) Type(s) of observation used, if anhy;

(d) Interpretation of test results (e.g. positive vs. negative);

(e) Missed tests;

(f) Response to results that are suspected of adulteration/contamination;

(g) Process for contesting a positive test result;

(h) Chain of custody; and

(i) Compliance with the following requirements for ~~use~~ urinalysis testing: ~~for use of substances of abuse following procedures in OAR 309-019.~~

(A) Urinalysis testing. Any urinalysis test shall include an initial test and, if positive, a confirmatory test. These tests shall comply with the following requirements:

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

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

(C) All urinalysis tests shall be performed by laboratories meeting the requirements of OAR 333-024-0305 to 333-024-0365.
~~(A) Urinalysis tests shall comply with the requirements enumerated in OAR 309-018-0110(2)(m).~~

(B) Individuals enrolled in DUII services shall receive urine drug screens ~~Urinalysis tests shall be conducted~~ as deemed clinically appropriate, but no less than:

(i~~a~~) At the time of assessment; ~~and~~

(ii~~b~~) Twice per calendar month with, no more than 14 calendar days between tests; ~~and~~

(iii~~c~~) Within two weeks prior to service completion; and

(iv~~d~~) Within 72 hours of receipt of laboratory results indicating that a ~~urinalysis~~ sample was identified as out of range for Creatinine, pH, or Specific Gravity, as defined by the ~~urinalysis~~ laboratory ~~results~~urine drug screen results;

(C~~10~~) All urine drug screens ~~Urinalysis~~ shall test, at a minimum, ~~test~~ for the following substances of abuse:

(i~~a~~) Alcohol;

(ii~~b~~) Marijuana;

(iii~~c~~) Cocaine;

(iv~~d~~) Amphetamines;

(v~~e~~) Opiates; and

(vi~~f~~) Benzodiazepines.

(j~~11~~) ~~In addition to the substances of abuse outlined in section (10), a~~A requirement that an EtG/EtS test for alcohol shall be conducted, at a minimum, at the time of assessment and within two weeks prior to completion.

(k) A requirement that positive initial tests for substances of abuse shall be followed by a confirmatory test. The confirmatory test shall be by a different analytical method from that of the initial test to ensure reliability and accuracy.

(9~~12~~) Abstinence requirements.

(a) Individuals enrolled in DUII Education are expected to demonstrate abstinence from use of intoxicants as evidenced by negative negative urine drug screens~~urinalysis reports~~, except as allowed in ORS 813.200, administered pursuant to the policies described in section (8)(i). Individuals who provide a positive urine drug screen ~~alysis test~~ or who self-report use of a substance other than as allowed in ORS 813.200 shall be required to complete DUII Rehabilitation.

(b~~13~~) Individuals enrolled in DUII Rehabilitation are expected to maintain abstinence from use of intoxicants for no less than the final 90 days of the DUII Rehabilitation program, as evidenced by negative urine drug screens~~alysis tests~~, except as allowed in ORS 813.200, administered while outside of a controlled environment pursuant to the requirements in section (8)(i)~~for no less than the final 90 days of the DUII Rehabilitation program~~.

(10~~4~~) Completion and DMV Form 735-6821, the DUII Treatment Completion Certificate (DTCC).~~Division approved~~

(a~~17~~) The individual's ~~S~~service ~~R~~record must include all information necessary to document the individual's successful or unsuccessful completion of DUII Services.

(b) DUII Services Providers shall issue a ~~DUII Treatment Completion Certificate (~~DTCC~~)~~ ~~for individuals convicted of a DUII~~ using Division-approved forms and procedures for individuals convicted of a DUII, or for individuals under a Diversion agreement for DUII, after:

(~~a~~A) Receipt of referral from an ADSS; and

~~(~~B~~b~~) Successful completion, as defined in section (2) above.~~Completion of DUII Education or DUII Rehabilitation, including applicable abstinence requirements, as outlined in these rules; and~~

(c) Compliance with the terms of the fee agreement between the provider and the individual.

(c~~15~~) The Division shall issue a DTCC for individuals completing an out-of-state intoxicated driving program after:

(A~~a~~) Documentation of the individual's residency in a state other than Oregon;~~ and~~

(B~~b~~) Receipt of a copy of the individual's referral from an ADSS;~~ and~~

(C~~c~~) Documentation of completion of a~~n~~ state-licensed or -certified intoxicated driving program as allowed for the equivalent conviction in the individual's state of residence. Residents of states that do not ~~require DUII treatment~~ license or certify intoxicated driving programs shall complete a program that is substantially equivalent to Oregon's standards; and

(D) Receipt of consents for disclosure, in compliance with HIPAA and 42 CFR Part 2.

(d) DUII Services Providers may not withhold issuance of DMV Form 735-6821 or other documentation of DUII services completion based only on an individual's failure to pay for services.

(11~~6~~) ~~Division approved~~ DUII Services Providers must report, using Division-approved forms and procedures:

(a) To the Division using the mandated state data system; and

(b) To the referring ADSS, as allowed by HIPPA and 42 CFR Part 2:

(A) No later than 30 calendar days from the date of referral;

(B) Every 30 calendar days while the individual is enrolled in DUII Rehabilitation;

(C) No later than 14 calendar days from the date of discharge;

(D) No later than seven calendar days from the written request of the ADSS.

~~(17) The individual's Service Record must include all information necessary to document the individual's successful or unsuccessful completion of DUII Services.~~

~~(18) Division approved DUII Services Providers are designated by the Authority to determine whether an individual has a problem condition involving alcohol, inhalants, or controlled substances as defined in ORS 813.040 and to provide recommendations for issuance of a hardship permit as allowed in ORS 813.500. Issuance of a hardship permit is at the sole discretion of DMV.~~

~~(19) When a DUII Services Provider determines that an individual does not have a problem condition involving alcohol, inhalants, or controlled substances as described in ORS 813.040, a recommendation for a hardship permit may be provided using the forms and procedures required by DMV if:~~

~~(a) The recommendation does not create a health or safety risk to the individual or the public; and~~

~~(b) The individual:~~

~~(A) Is enrolled in or has completed a Division approved DUII Education Program; and~~

~~(B) Maintains abstinence as defined in this rule; and~~

~~(C) Agrees to ongoing contact and abstinence monitoring after successful completion of the DUII Education Program as often as deemed clinically appropriate, but no less than once per calendar month while the individual is issued a hardship permit.~~

~~(20) The ongoing contact and abstinence monitoring shall be documented in the service plan and included in the individual's service record~~

~~(21) When a DUII Services Provider determines that an individual has a problem condition involving alcohol, inhalants, or controlled substances as described in ORS 813.040, a recommendation for a hardship permit may be provided using the forms and procedures required by DMV if:~~

~~(a) The recommendation does not create a health or safety risk to the individual or the public; and~~

~~(b) The recommendation is deemed clinically appropriate; and~~

~~(c) The individual is:~~

~~(A) Enrolled in or has completed a Division approved DUII Rehabilitation Program; and~~

~~(B) Maintaining abstinence as defined in this rule;~~

~~(C) Agrees to ongoing contact and abstinence monitoring after successful completion of the DUII Rehabilitation Program as often as deemed clinically appropriate, but no less than once per calendar month while the individual is issued a hardship permit.~~

~~(22) The ongoing contact and abstinence monitoring shall be documented in the service plan and included in the individual's service record.~~

~~(23) The recommendation for issuance of a hardship permit shall be completed using forms and procedures required by DMV and shall state specifically the times, places, routes, and days of the week minimally necessary for the individual to:~~

~~(a) Seek or retain employment;~~

~~(b) Attend any alcohol or drug treatment or rehabilitation program;~~

~~(c) Obtain necessary medical treatment for the individual or a member of the individual's immediate family; or~~

~~(d) Get to and from a gambling addiction treatment program.~~

~~(24) The recommendation for issuance of a hardship permit shall be withdrawn if:~~

~~(a) A health or safety risk to the individual or public exists; or~~

~~(b) The individual:~~

~~(A) Tests positive, except as allowed in ORS 813.200; or~~

~~(B) Discontinues contact with the DUII Services Provider; or~~

~~(C) Does not successfully complete a Division approved DUII Education or Rehabilitation Program.~~

~~(25) The Individual Record must include all information necessary to document the DUII Services Provider's decision to issue, not issue, or withdraw a recommendation for hardship permit to DMV.~~

~~(26) Division approved DUII Services Providers shall establish a procedure for individuals to appeal in the event that a recommendation for issuance of a hardship permit is denied or withdrawn. The appeal process shall include but not be limited to:~~

~~(a) Information on how to file a complaint with the Division directly; and~~

~~(b) Recourse to the staff supervisor, program director, and CMHP Director. Complaints that are unresolved at the provider level may be referred to the Division for review.~~

Statutory/Other Authority: ORS 413.042, ORS 430.640, ORS 430.254, ORS 430.256 & ORS 430.357
Statutes/Other Implemented: ORS 430.010, ORS 743A.168, ORS 430.030 & ORS 430.254-430.640
History:
BHS 8-2018, amend filed 03/22/2018, effective 04/01/2018
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0200 Medical Protocols in Outpatient Substance Use Disorders Treatment and Recovery Programs

Medical protocols shall be approved by a medical director under contract with a program or written reciprocal agreement with a medical practitioner under coordinated care. The protocols shall: ~~comply with the requirements enumerated at OAR 309-018-0185; these requirements are incorporated as if fully set forth in this rule.:~~

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

(a) Providers may not use an individual's lack of medical history records as a reason to delay or deny an assessment or entry to a program. Self-report of medical history is sufficient for an individual to enter services.

(b) Providers shall offer support to an individual in gaining medical records.

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

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

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

(5) Require that the program provide, within 30 days of entry, information and risk assessment regarding HIV and AIDS, ~~T~~tuberculosis~~B~~, sexually transmitted disease, Hepatitis and other infectious diseases relevant for the individual's community ~~information and risk assessment, including any needed referral, within 30 days of entry~~.

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

Statutory/Other Authority: ORS 430.640 & 443.450
Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 443.400 - 443.460
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18

MHS 6-2017, f. & cert. ef. 6-23-17
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0205 Building Requirements in Behavioral Health Programs

All behavioral health treatment programs governed under chapter 309, division 019 must:

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

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

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

(4) Provide rest-rooms for individuals, visitors, and staff that are accessible to individuals with disabilities pursuant to:

(a) Title II of the Americans with Disabilities Act, if the program receives any public funds; or

(b) Title III of the Act, if no public funds are received.

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

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

Statutory/Other Authority: ORS 413.042, 430.640 & 443.450
Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.524 - 430.640, 430.850 - 430.955 & 443.400 - 443.460
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
Suspended by MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0210 Quality Assessment and Performance Improvement

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

(a) A quality improvement committee; and

(b) A performance improvement process documented in a performance improvement plan.

(2) The quality improvement committee shall include representatives of individuals served and their families, and shall meet at least quarterly to:

(a) Identify and assess the following indicators of quality:

(A) Access to services;

(B) Outcomes of services;

(C) Systems integration and coordination of services; and

(D) Utilization of services.

(b) Review incident reports, grievances, and other documentation as applicable;

(c) Identify measurable and time-specific performance objectives and strategies to meet the objectives and measure progress;

(d) Recommend policy and operational changes necessary to achieve performance objectives; and

(e) Reassess and, if necessary, revise objectives and methods to measure performance on an ongoing basis and ensure sustainability of improvements.

(3) The quality assessment and performance improvement process shall be documented in a performance improvement plan, which shall include the performance objectives, strategies, and progress metrics identified by the quality improvement committee.

~~. The provider's quality assessment activities shall comply with the requirements enumerated in OAR 309-018-0205; these requirements are incorporated as if fully set forth in this rule.~~

Statutory/Other Authority: ORS 430.640
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640 & 430.850 - 430.955
History:
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0215 Grievances and Appeals

(1) Any individual ~~or parent or guardian~~ receiving services, or their parent or guardian, may file a grievance with the provider, the individual's Medicaid managed ~~coordinated~~ care plan, or the Division. For purposes of this rule, a "grievance" means a formal complaint submitted to a provider, whether verbally or in writing, by an individual or the individual's chosen representative, pertaining to the denial or delivery of services and supports.

(2) Individuals whose services are funded by Medicaid shall file grievances and appeals in accordance with the procedures set forth in OAR 410-141-3230 through 410-141-3255.

(3) The provider's grievance process shall:

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

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

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

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

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

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

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

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

(4) The provider shall post a Grievance Process Notice in a common area stating the telephone numbers of:

(a) The Division;

(b) Disability Rights Oregon;

(c) The community mental health program;
~~Any applicable coordinated care organization~~
(d) All coordinated care organizations with service areas that include the provider; and

~~; and~~

(d) The Governor's Advocacy Office.

(5) In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures are completed, the individual or guardian of the individual may request an expedited review.

(a) The program administrator shall review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response shall include information about the appeal process. This response may be that the grievance does not merit expedited review, in which case the grievance shall be adjudicated pursuant to the standard timeline.

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

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

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

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

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

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

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

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: 430.254 - 430.640, 430.850 - 430.955, 743A.168, ORS 161.390 - 161.400, 179.505, 428.205 - 428.270, 430.010 & 430.205 - 430.210
History:
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MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0220 Variances

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

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

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

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16
MHS 4-2014, f. & cert. ef. 2-3-14
MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0225 Assertive Community Treatment (ACT) Definitions

(1) In addition to the definitions listed in OAR 309-019-0105, the following definitions ~~below~~ apply with respect to OAR 309-019-0225 through 309-019-0255~~this and subsequent rule sections~~.

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

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

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

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

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

(5) "Competitive Integrated Employment" has the meaning defined in OAR 309-019-0270. ~~means full-time or part time work:~~

~~(a) At minimum wage or higher;~~

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

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

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

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

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

(a) Mental and functional status;

(b) Effectiveness of past treatment;

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

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

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

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

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

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

~~(8) "Division" means the Health Systems Division of the Oregon Health Authority, or its designee.~~

(8~~9~~) "Division-Approved Reviewer" means the Division's contracted entity that is responsible for conducting ACT fidelity reviews, training, and technical assistance to support new and existing ACT programs statewide.

~~(10) "Face to Face" is defined as a personal interaction where both words can be heard and facial expressions can be seen in person or through telehealth services where there is a live streaming audio and video.~~

(~~11~~9) "Fidelity" ~~for the purposes of the ACT program~~ means the provider is providing services that are faithful to the evidence-based practice model and obtains a satisfactory score from the Oregon Center of Excellence for ACT as part of ~~the~~ their regular reviews.

~~(12) "Fixed Point of Responsibility" means the ACT team provides virtually all needed services, rather than sending clients to different providers. If the team cannot provide a service, the team ensures that the service is provided.~~

(~~13~~10) "Full-Time Equivalent" (FTE) means a way to measure how many full-time employees are required to provide the appropriate level of services to fulfill minimum fidelity requirements.

(~~14~~11) "Hospital Discharge Planning" means a process that begins upon admission to the Oregon State Hospital (OSH) or an acute care psychiatric hospital and that is based on the presumption that with sufficient supports and services, all individuals can live in an integrated community setting. Discharge planning is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on principles of self-determination. For OSH, discharge

planning teams include a representative of a community mental health provider from the county where the individual is likely to transition.

(12) "Individual Placement and Support (IPS) Supported Employment Services" has the meaning defined in OAR 309-019-0270.

~~(15) "Individual Placement and Support (IPS) Supported Employment Services" means individualized services that assist individuals to obtain and maintain integrated, paid, competitive employment. Supported employment services are provided in a manner that allows individuals to work the maximum number of hours consistent with their preferences, interests, and abilities and are individually planned, based on person-centered planning principles and evidence-based practices.~~

(~~16~~13) "Individual Treatment Team ~~(ITT)~~" means a group or combination of three to five ACT team staff members who together have a range of clinical and rehabilitation skills and expertise. The core members are the case manager, the psychiatrist or psychiatric nurse practitioner, one clinical or rehabilitation staff individual who backs up and shares case coordination tasks and substitutes for the service coordinator when they are not working, and a peer support and wellness specialist.

(~~17~~14) "Initial Assessment and Individualized Treatment Plan" means the initial evaluation of:

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

(b) The effectiveness of past treatment; and

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

~~(18) "Large ACT Team" means an ACT team serving 80 to 120 individuals.~~

~~(19) "Life Skills Training" means training that helps individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.~~

~~(20) "Medication Management" means the prescribing and administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. For the purposes of ACT, medication management is a collaborative effort between the individual receiving services and the prescribing psychiatrist or psychiatric nurse practitioner with the ACT treatment team.~~

~~(21) "Mid-Size Act Team" means an ACT team serving between 41 and 79 individuals.~~

(~~22~~15) "Natural Supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for individuals, including but not limited to family relationships, friendships reflecting the diversity of the neighborhood and the community, association with fellow students or employees in regular classrooms and work places, and associations developed though participation in clubs, organizations, and other civic activities.

~~(23) "Psychiatry Services" means the prescribing and administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. Psychiatry services shall be provided by a psychiatrist or a psychiatric nurse practitioner licensed by the Oregon Medical Board.~~

~~(24) "Serious and Persistent Mental Illness (SPMI)" means the current DSM diagnostic criteria for at least one of the following conditions, as a primary diagnosis for an adult 18 years of age or older:~~

~~(a) Schizophrenia and other psychotic disorders;~~

~~(b) Major depressive disorder;~~

~~(c) Bipolar disorder;~~

~~(d) Anxiety disorders limited to Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD);~~

~~(e) Schizotypal personality disorder; or~~

~~(f) Borderline personality disorder.~~

~~(25) "Single Point of Contact (SPOC)" means the entity designated by OHA that coordinates and tracks referrals, and coordinates the provision of services and supports in collaboration with the provider, the CCO, and the CMHP~~.

~~(26) "Small ACT Team" means an ACT team serving between ten to 40 individuals.~~

~~(27) "Symptom Management" means to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment.~~

~~(28) "Telepsychiatry" means the application of telemedicine to the specialty field of psychiatry. The term describes the delivery of psychiatric assessment and care through telecommunications technology, usually videoconferencing.~~

(~~29~~16) "Time-~~u~~Unlimited Services" means services with a duration that is established based on medical appropriateness, ~~that are provided~~ not on the basis of predetermined timelines ~~but if they are medically appropriate~~.

(~~30~~17) "Vocational Services" means employment support services that leads to competitive integrated employment. The Division ~~encourages~~ requires the use of fidelity IPS Supported Employment for providing vocational services within the ACT program.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18

MHS 6-2017, f. & cert. ef. 6-23-17
MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0226 ~~Assertive Community Treatment (~~ACT~~:) Overview~~ General Standards

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

(a) A team approach;

(b) Being ~~C~~community-based;

(c) A small client-to-staff caseload, typically 10:1, to consistently provide necessary staffing diversity and coverage;

(d) Time-unlimited services;

(e) Flexible service delivery;

(f) A fixed point of responsibility, meaning that the ACT team provides virtually all needed services, rather than sending clients to different providers. If the team cannot provide a service, the team ensures that the service is provided; and

(g) 24/7 availability for response to psychiatric crisis.

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

(a) Hospital discharge planning, including OSH and acute care psychiatric hospitals;

(b) Case management;

(c) Symptom management, with the goal of preventing or treating as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment;

(d) Psychiatry services, meaning the prescribing and administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. Psychiatry services shall be provided by a licensed psychiatrist or psychiatric nurse practitioner;

(e) Nursing services, meaning services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) within the scope of practice as defined in OAR 851-045-0060;

(f) Co-occurring substance use and mental health disorders treatment services;

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

(h) Life skills training, meaning training that helps individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.; and

(i) Peer delivered services.

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

(a) Psychiatrist or Psychiatric Nurse Practitioner;

(b) Psychiatric Nurse;

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

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

(e) Substance Abuse Treatment Specialist;

(f) Employment Specialist;

(g) Mental Health Case Manager; and

(h) Certified Peer Support Specialist.

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

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

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

(c) Maintaining full responsibility for treatment services that includes, at a minimum, the services required in these rules;

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

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

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

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

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
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309-019-0230 ACT: Provider StandardsQualifications

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

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

(b) The provider shall hold and maintain a certificate issued by the Division under OAR 309-019-0225 through 309-019-0255 for the purpose of providing ACT; and

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

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

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

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

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168
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MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0235 ACT: Continued Fidelity Requirements

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

(2) Providers certified to provide ACT services that achieve a fidelity score of 114 or better when reviewed by the Division-approved reviewer are certified for 12 months.

(~~2~~3) Fidelity reviews shall be conducted utilizing the Substance Abuse and Mental Health Services ACT Toolkit Fidelity Scale, which the Division shall make available to providers electronically.

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

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: 430.254 - 430.640, 430.850 - 430.955, 743A.168, ORS 161.390 - 161.400, 428.205 - 428.270, 430.010 & 430.205 - 430.210
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MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0240 ACT: Failure to Meet Fidelity Standards

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

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

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

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

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

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

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

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

Statutory/Other Authority: ORS 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168
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MHS 6-2017, f. & cert. ef. 6-23-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0241 ACT: Waiver of Minimum Fidelity Requirements

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

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

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

(2) Waivers granted to ACT minimum fidelity requirements shall result in an extension to the ACT program's certification period. An ACT program that has a Division-approved waiver is eligible to receive Medicaid and State General Fund reimbursement for ACT services if the ACT program meets the following criteria:

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

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

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

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

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

Statutory/Other Authority: ORS 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168
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MHS 6-2017, f. & cert. ef. 6-23-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0242 ACT: Program Operational Standards

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

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

(3) Service Intensity:

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

(b) The ACT team shall provide a minimum of 40 percent of all services in-person and in-community as demonstrated by the average in-community encounters reviewed in case record reviews. When in-person services are not feasible, such as while the individual is admitted to hospitals or residential treatment facilities, the ACT team may use telehealth for the delivery of any ACT service;

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

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

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

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

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

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

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

(5) Staffing ~~Guidelines~~ rules for ACT teams:

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

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

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

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

(c) ACT team staff shall be composed of individual staff members ~~in which~~ for whom a portion or all of their job responsibilities are defined as providing ACT services;

(A) No individual ACT staff member shall be assigned less than 0.20 FTE for their role on the team unless filling the role of psychiatrist or PNP.

(B) The ACT team psychiatrist or PNP may not be assigned less than 0.10 FTE.

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

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

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

(A~~a~~) No more than eight individual staff members per small ACT team (a team that serves up to 40 individuals);

(B~~b~~) No more than 12 individual staff members per mid-size ACT team (a team that serves 41 to 79 individuals);

(C~~c~~) No more than 18 individual staff members per large ACT team (a team that serves 80 to 120 individuals).

(6~~8~~) ACT team staffing is multi-disciplinary. The core minimum staffing for an ACT team includes:

(a) A team leader position that shall be occupied by only one individual. The team leader ~~is~~ shall be a QMHP ~~level clinician~~ qualified to provide direct supervision to all ACT staff except the psychiatric care

provider and nurse. ~~Pursuant to the table in OAR 309-019-0242(13), t~~The Team Leader FTE is dictated by the number of individuals served by the ACT team, pursuant to section (5) of this rule;

(b) ~~Pursuant to the table in OAR 309-019-0242(11), The~~ Psychiatric Care Provider (Psychiatrist or PNP) FTE is dictated by the number of individuals served by the ACT team, pursuant to section (5) of this rule;

(c) ~~Pursuant to the table in OAR 309-019-0242(11), t~~The Nurse FTE is dictated by the number of individuals served by the ACT team, pursuant to section (5) of this rule;

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

(~~7~~9) ACT team minimum staffing shall include clinical staff with the following FTE and specialized competencies:

(a) ~~Pursuant to the table in OAR 309-019-0242(11), t~~The Substance Abuse Specialist FTE is dictated by the number of individuals served by the ACT team, pursuant to section (5) of this rule. A Substance Abuse Specialist specialized competencies shall include:

(A) Substance abuse assessment and substance abuse diagnosis;

(B) Principles and practices of harm reduction; and

(C) Knowledge and application of motivational interviewing strategies.

(b) ~~Pursuant to the table in OAR 309-019-0242(11), t~~The Employment Specialist FTE is dictated by the number of individuals served by the ACT team, pursuant to section (5) of this rule. An Employment Specialist specialized competencies shall include:

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

(B) Vocational assessment;

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

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

(c) ~~Pursuant to the table in OAR 309-019-0242(11), t~~The Peer Support and Wellness Specialist FTE is dictated by the number of individuals served by the ACT team, pursuant to section (5) of this rule.~~;~~

~~(d) See a Certified Peer Support Specialist or Peer Wellness Specialist as described in OAR 410-180-0300 to 0380 and defined in OAR 309-019-0105(81) and 309-019-0105(84).~~ A registry of certified Peer Support Specialist Specialists and Peer Wellness Specialists may be found at the Office of Equity and Inclusion's Traditional Health Worker's website.

(~~10~~8) ACT Team Staffing Core Competencies:

(a) Upon hiring, all clinical staff on an ACT team shall have experience in providing direct services related to the treatment and recovery of individuals with a serious and persistent mental illness. Staff shall be

selected consistent with the ACT core operating principles and values. Clinical staff shall have demonstrated competencies in clinical documentation and motivational interviewing;

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

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

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

~~(11) ACT Team Size Staff (FTE) to Individual Ratio Table.~~

(9~~12~~) The ACT team shall conduct ~~daily~~ organizational staff meetings at least four days per week ~~and~~ at regularly scheduled times per a schedule established by the team leader. These meetings shall be conducted in accordance with the following procedures.~~:~~

(a) The ACT team shall maintain in writing:

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

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

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

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

(10~~3~~) The ACT team shall conduct treatment planning meetings under the supervision of the team leader and the Psychiatrist or PNP. These treatment planning meetings shall:

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

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

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

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

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

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

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

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

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

(114) ACT Assessment and Individualized Treatment Planning:

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

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

(125) Service Note Content:

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

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

(A) Individual's name;

(B) Medicaid identification number or client identification number;

(C) Date of service provision;

(D) Name of service provided;

(E) Type of contact;

(F) Place of service;

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

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

(I) Amount of time spent performing the intervention;

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

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

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

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

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

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

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

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

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

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
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309-019-0245 ACT: Admission Criteria

(1) ACT services must be medically appropriate, as defined in OAR 309-019-0105, for each ~~P~~participant~~s shall meet the medically appropriate standard as designated in OAR 309-019-0105~~. ACT services may be found medically appropriate only for individuals ~~Participants who are medically appropriate shall have~~ with the following characteristics:

(a) ~~Participants~~ A primary diagnosis~~ed with~~ of a serious and persistent mental illness, as defined in ~~this rule~~OAR 309-001-0100.~~;~~

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

~~(c) Participants~~ Individuals with other psychiatric illnesses leading to psychosis are eligible dependent on the level of the long-term disability.~~;~~

(b~~d~~) ~~Participants with s~~Significant functional impairments, as demonstrated by persistent or recurrent difficulty with any ~~at least one~~ of the following ~~conditions~~:

(A) ~~Significant difficulty c~~Consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene);

(B) ~~or persistent or recurrent difficulty p~~Performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives;

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

(D~~C~~) ~~Significant difficulty m~~Maintaining a safe living situation (e.g., repeated evictions or loss of housing).

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

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

(B) ~~Intractable (e.g., p~~Persistent and ~~or very~~ recurrent~~) severe major symptoms,~~ affective, psychotic, or suicidal symptoms~~)~~;

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

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

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

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

(G) Repeated failed attempts ~~Difficulty effectively~~ utilizing traditional office-based outpatient services.

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

(3) ACT services may ~~not~~ be provided to individuals residing in residential treatment for expediting stabilization, and for providing a transition to more independent living settings.

(a) When ACT and residential treatment are co-provided, ACT will be viewed as the primary, ongoing service and residential treatment will be viewed as the secondary, temporary service focused on stabilization and community living preparation.

(b) To avoid duplication of services, the individualized service plan shall clearly describe the services provided through the ACT program and the services provided through residential treatment.

~~an RTF or RTH licensed by the Division unless:~~

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

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

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
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MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0248 ACT: Admission Process

(1) ~~A comprehensive assessment as defined in OAR 309-019-0105(8) that demonstrates medical appropriateness shall be completed prior to the provision of this service.~~ Admission may be based on a recently completed assessment that satisfies the requirements of ~~If a substantially equivalent assessment is available that reflects current level of functioning and contains standards consistent with~~ OAR 309-019-0135 and ~~to~~ includes sufficient information and documentation to justify admission for ACT services under these rules.~~the presence of a diagnosis that is the medically appropriate reason for services, the equivalent assessment may be used to determine admission eligibility for the program.~~

(2) A referral for ACT is managed and coordinated by a designated single point of contact (SPOC), meaning the Authority-designated entity that coordinates and tracks referrals, and coordinates the provision of services and supports in collaboration with the provider, the CCO, and the CMHP.~~as defined in these rules:~~

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

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

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

(3) The SPOC shall report the provider's admission decision to the Division within five business days of receiving the determination.

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

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

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

(b) ~~ACT capacity in a geographic regional service area is not a sufficient reason for not providing ACT services to an ACT eligible individual.~~ If an individual who is ACT-~~-~~eligible cannot be served due to inadequate ACT capacity, the SPOC shall notify the CCO and place ~~provide~~ the individual ~~with the option~~

~~of being added to~~ on a wait~~ing~~ list for ACT services.~~until such time as the ACT eligible individual may be admitted to a certified ACT program:~~

(A) While on the waitlist, the SPOC will offer ~~The ACT eligible individual who is not accepted into an ACT program or placed on the waitlist due to capacity shall be offered alternative~~ evidence-based alternatives for ~~community-based rehabilitative~~ services until ACT services become available~~as described in the Oregon Medicaid State Plan that includes evidence-based practices to the extent possible~~;

(B) These ~~A~~alternative evidence-based services shall be made available to the individual ~~:~~

~~(i) U~~until the individual is admitted into an ACT program, unless:~~;~~

(~~i~~i) The ~~A~~alternative evidence-based services are medically appropriate and meet the individual's treatment goals, in which case no ACT referral may be necessary; or

(~~i~~ii) The individual refuses alternative medically appropriate evidence-based services, in which case the individual may remain on the ACT waitlist without receiving alternative services.

(C) The Authority shall monitor each regional wait~~ing~~ list until sufficient ACT program capacity is developed to meet the needs of the ACT eligible population.

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

(a) A tentative admission is indicated;

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

(A) The reasons for not admitting;

(B) The disposition of the case; and

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

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

(7~~8~~) ~~In addition, i~~If an individual is denied ACT and believes that denial is in error based on ~~services and has met~~ the admission criteria set forth in OAR 309-019-0245, the SPOC shall ensure that the CCO provides a Notice of Action to the individual, who ~~who is denied services or their guardian~~ may appeal the decision to the CCO. If not resolved satisfactorily, the SPOC shall ensure the individual receives support to file ~~by filing~~ a grievance with the Division in the manner set forth in OAR 309-008-1500.

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

History:
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MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0250 ACT: Transition to Less Intensive Services and Discharge

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

(2) This transition shall occur when individual~~s~~ receiving ACT:

(a) Has~~ve~~ successfully reached individually established goals for transition;

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

(c) Requests discharge, or declines or refuses services; or

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

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
History:
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MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16
MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0255 ACT: Reporting Requirements

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

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

(a) The names of all ~~i~~individuals served, along with identification and tallies of individuals who:

(A) ~~Individuals who a~~Are homeless at any point during a quarter;

(B) ~~Individuals with~~ Have had safe, stable housing for the last six months;

(C) ~~Individuals using~~ Used emergency departments during ~~each~~ the quarter for a mental health reason;

(D) ~~Individuals~~ Were hospitalized in OSH or in an acute psychiatric facility during ~~each~~ the quarter;

~~(E) Individuals hospitalized in an acute care psychiatric facility during each quarter;~~

(E~~F~~) ~~Individuals~~ Were in jail at any point during ~~each~~ the quarter;

(~~G~~F) ~~Individuals receiving~~ Received supported employment services during ~~each~~ the quarter;

(G~~H~~) ~~Individuals who a~~Are employed in competitive integrated employment, as defined ~~above~~in OAR 309-019-0225;

(I) ~~Individuals receiving~~ Received ACT services ~~that~~ and are not enrolled in Medicaid.

(b) Referrals and Outcomes:

(A) Number of referrals received during each quarter;

(B) Number of individuals accepted during each quarter;

(C) Number of individuals admitted during each quarter; and

(D) Number of individuals denied during each quarter and the reason for each denial.

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
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0270 Supported Employment: Definitions

In addition to the definitions listed in OAR 309-019-0105, the following definitions apply with respect to OAR 309-019-0270 through 309-019-0295.

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

(a) At minimum wage or higher;

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

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

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

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

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

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

(4~~5~~) "Individual Placement and Support (IPS) Supported Employment Services" means individualized services that assist individuals to obtain and maintain integrated, paid, competitive employment. Supported employment services are provided in a manner that allows individuals to work the maximum number of hours consistent with their preferences, interests, and abilities and are individually planned, based on person-centered planning principles and evidence-based practices.

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

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History:
MHS 6-2017, f. & cert. ef. 6-23-17

MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0275 Supported Employment: General Standards for Individual Placement and Support (IPS) Supported Employment ~~Overview~~

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

(2) Supported employment is characterized by:

(a) Emphasis on competitive employment;

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

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

(d) Individuals have access to personalized benefits planning;

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

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

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

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

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

(a) Job development;

(b) Supervision and job training;

(c) On-the-job visitation;

(d) Consultation with the employer;

(e) Job coaching;

(f) Counseling;

(g) Skills training; and

(h) Transportation.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History:
MHS 6-2017, f. & cert. ef. 6-23-17

MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0280 Supported Employment: Provider~~s~~ Standards

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

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

(b) The provider shall hold and maintain a certificate issued by the Division under OAR 309-019-0270 through 309-019-0295 for the purpose of providing supported employment; and

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

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

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

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

(2~~3~~) A provider holding a certificate of approval under OAR chapter 309, division 008 may request ~~the addition of~~ that IPS supported employment services be added to their certificate of approval ~~via~~ using the procedure outlined in OAR 309-008-0400 and 309-008-1000(1). ~~:~~

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

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

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0285 Supported Employment: Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0275 and 309-019-0280 to maintain an IPS supported employment provider designation on the ~~Division issued~~ certificate, a provider shall submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 100 out of 125.

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

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

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

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0290 Supported Employment: Failure to Meet Fidelity Standards

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

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

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

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

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

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

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

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History:
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0295 Supported Employment: Reporting Requirements

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

(2) Each quarterly report shall provide the ~~following information~~names and tallies of all individuals who:

(a) ~~All individuals who r~~Received supported employment in the ~~reporting~~ quarter;

(b) ~~Individuals who r~~Received supported employment services who are, at the time of reporting, employed in competitive integrated employment; and

(c) ~~Individuals who d~~Discontinued receiving supported employment services and are, at the time of reporting, employed in competitive integrated employment; and

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

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History:
MHS 6-2017, f. & cert. ef. 6-23-17
MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17
MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0300 Crisis Line: Service Requirements

(1) Crisis line services shall be provided 24/7 by all providers certified under this OAR chapter 309, division 019, whether directly or through linkages to a crisis line services provider ~~24/7~~.

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

(a) 24/7 accessibility to a QMHP;

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

(c) 24/7 telephone screening to determine the need for immediate intervention;

(d) 24/7 linkage to emergency service providers, including first responders and mobile crisis services;

(e) Best practice risk assessment, as defined in OAR 309-023-0110, including suicide risk assessment;

(f) Suicide intervention and prevention;

(g) Lethal means counseling and safety planning for individuals at risk for suicide;

(h) Crisis intervention;

(i) Crisis plan development;

(j) Triage;

(k) Providing information regarding services and resources in the community; and

(L) Procedures for de-escalation for calls from suicidal individuals.

Statutory/Other Authority: ORS 413.042 & 430.640
Statutes/Other Implemented: ORS 430.630, 430.640 & 430.644 - 430.646
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0305 Crisis Line: Provider ~~Standards~~ Policies

(1) Crisis line services providers shall develop and implement written policies and procedures to address provider standards.

(2) Provider standards shall include but ~~is~~ are not limited to:

(a) Training curriculum and ongoing education programs to meet training requirements;

(b) Coordination with other treatment providers, including mobile crisis services and other crisis line services providers to support seamless transitions of care;

(c) Linkages to emergency services providers including first responders to address imminent risks and to support seamless transitions of care;

(d) De-escalation procedures;

(e) Follow-up procedures when indicated and appropriate;

(f) Documentation;

(g) Code of ethics; and

(h) Security of information protocols.

Statutory/Other Authority: ORS 413.042 & 430.640
Statutes/Other Implemented: ORS 430.630, 430.640 & 430.644 - 430.646
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0310 Crisis Line: Minimum Staffing Requirements

(1) At least one QMHP shall be available 24/7 by phone or face-to-face ~~24/7~~ for consultation.

(2) At least one QMHP shall provide regular clinical supervision to staff.

Statutory/Other Authority: ORS 413.042 & 430.640
Statutes/Other Implemented: ORS 430.630, 430.640 & 430.644 - 430.646
History:
MHS 4-2018, amend filed 02/27/2018, effective 03/01/2018
MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18
MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0315 Crisis Line: Training Requirements

(1) Staff training curriculum shall include but is not limited to:

(a) Triage protocol;

(b) Referral resources;

(c) Crisis plan development; and

(d) Screening for a Declaration for Mental Health Treatment.

(2) Staff training curriculum shall include best practices for the following:

(a) Risk assessment, including suicide risk assessment;

(b) Suicide intervention and prevention;

(c) Safety planning;

(d) Lethal means counseling;

(e) De-escalation methods;

(f) Crisis intervention;

(g) Recovery support, including peer delivered services;

(h) Trauma informed care; and

(i) Cultural ~~awareness~~responsiveness.

Statutory/Other Authority: ORS 413.042 & 430.640
Statutes/Other Implemented: ORS 430.630, 430.640 & 430.644 - 430.646
History:
MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0320 Crisis Line: Documentation Requirements

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

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

(b) A risk assessment for suicidal~~e~~ ideation as well as any referrals made~~If a suicide risk assessment was completed~~;

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

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

Statutory/Other Authority: ORS 413.042 & 430.640
Statutes/Other Implemented: ORS 430.630, 430.640 & 430.644 - 430.646
History:
MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0325 Youth Wraparound Definitions

In addition to the definitions listed in OAR 309-019-0105, the following definitions apply with respect to OAR 309-019-0326.

(1) "Child and Adolescent Needs and Strengths Assessment" means a multi-purpose tool developed to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to monitor outcomes of services and supports. It utilizes a communication perspective to facilitate the linkage between the assessment process and the design of individualized Wraparound plans of care, including the application of evidence-based practices.

(2) "Child-Serving Systems" means agencies that serve children, youth and families. Agencies may be DHS Child Welfare, Intellectual/Developmental Disabilities, Education, Juvenile Justice, Oregon Youth Authority, Mental Health programs, tribal entities, agencies serving homeless youth, and Primary Care.

(3) "Crisis and Safety Plan" means a document developed by the youth and family and the Wraparound team to address potential crises that could occur for the youth and their family, and to ensure everyone's safety. It shall include 24-hour, 7-days-a-week response; formal, informal and natural supports; respite or back-up care; details leading to crises; successful strategies that have worked in the past; and strength-based strategies that prevent escalation and maintain safety.

(4) "Family Partner" means an individual certified and listed on the registry as a Family Support Specialist in accordance with ORS 410-180-0305, and who has completed specialized training approved by the Authority, in the Wraparound process. A Family Partner is a formal member of the Wraparound team whose role is to support the family.

(5) "Family Organization" means a family run and led, non-profit community organization providing education, connection, and empowerment to families and their communities to assure improved outcomes for youth experiencing significant behavioral health challenges. Family Organizations fulfill a significant role in facilitating family voice in local, state and national policy making.

(6) "Fidelity" means the degree to which the principles, phases, core elements and activities of Wraparound, and supports at the organizational and system level, are implemented as recommended through training, consultation and best practices dissemination.

(7) "Formal Supports" means services and supports provided by professionals or individuals who are financially compensated for their time.

(8) "Informal Supports" means supports provided by individuals or organizations through citizenship and work on a volunteer basis under a structure of certain qualifications, training and oversight.

(9) "Linguistic Responsiveness" means that individuals are informed of the availability of language assistance services in their preferred language, both verbally and in writing. Individuals are provided with easy to understand print and multi-media materials and signage appears in the languages commonly used by the populations in the service area.

(10) "Natural Supports" means individuals or organizations in the youth and family's own community, social, cultural or spiritual networks, such as friends, extended family members, neighbors, and other

individuals as identified by the youth and family, providing supports, who are not financially compensated for their time.

(11) "Peer Partner Supervisor or Coach" means an individual with Youth Partner or Family Partner expertise, certified and listed on the registry in accordance with OAR 410-180-0300, who has a specific intentional focus in supporting Youth Partners or Family Partners to ensure the meaningful engagement of youth and family voices in the Wraparound plan, to develop their practice skills in Wraparound principles and participation in the Wraparound process and who works in connection with other Peer Support Specialists or peer delivered services.

(12) "Phases of Wraparound" means the four distinct phases of Wraparound: engagement, initial plan development, implementation, and transition. The activities within each phase of Wraparound are part of fidelity practice.

(13) "Strength-based" means based on functional assets, skills, capacities, and talents of a person, family or group.

(14) "Strengths and Needs Summary" means a comprehensive "strengths and needs" assessment and summary process that begins immediately when a youth and their family are referred into Wraparound. This process is complemented by other Division-approved assessment tools, such as the Child and Adolescent Needs and Strengths Assessment (CANS).

(15) "Ten Wraparound Principles" means these principles associated with Wraparound ~~services and~~ supports: family- driven and youth-guided, collaboration, persistence, culturally and linguistically responsive, community based, team based, natural supports, individualized, strength-based, and outcome-based.

(16) "Wraparound" means a voluntary and definable care planning process that results in a unique set of community services and supports individualized for a youth and family to achieve a positive set of outcomes.

(17) "Wraparound Care Coordinator (WCC)" means a QMHA or QMHP, as defined in OAR 309-019-0125, who is completing or has completed a Division-approved Wraparound foundational training program. The WCC is a member of the Wraparound team specifically trained to coordinate and facilitate the components of a Wraparound team meeting to fidelity, in each phase of the Wraparound process, for an individual family. The person in this role may change over time, and may include a parent, caregiver, youth or other team member who takes over facilitating Wraparound team meetings.

(18) "Wraparound Coach" means an individual with Wraparound expertise in relation to Wraparound principles and in strategies to facilitate a Wraparound meeting to fidelity. Wraparound Coaches provide clear and constructive feedback regarding fidelity components and facilitation skills to Wraparound Care Coordinators.

(19) "Wraparound Flexible Funding" means a financial resource for purchasing one-time or occasional needed goods or services for youth and/or their families, when the goods and services cannot be provided by another funding source, and the services or goods are directly tied to meeting needs and outcomes in the Wraparound plan of care.

(20) “Wraparound Plan of Care” means a dynamic document which describes the youth, the family, the team, and the goals and action plan to be undertaken to meet the youth and family’s needs, achieve the team mission and work toward the family’s long-term vision.

(21) “Wraparound Review Committee” means a local community group of people representing Child Welfare, Juvenile Justice, Intellectual Developmental Disabilities, Education, Mental Health, Federally Recognized Tribes or tribal entities, Youth and Family members and/or youth and family advocates who convene with the goal of reviewing and determining Wraparound eligibility.

(22) “Wraparound Supervisor” means an individual responsible for supervising a Wraparound Care Coordinator, Wraparound Coach, Family Partner, or Youth Partner through their respective agency.

(23) “Wraparound Team” means a group of people chosen by the youth and family and connected to them through natural, community, and formal supports. The Wraparound team develops and implements the youth and family’s plan, addresses unmet needs, and works toward the family’s vision and team mission together with the youth and family.

(24) “Wraparound Team Meeting” means a meeting where members of the Wraparound team convene to address the family and youth’s mission, vision, strengths and needs identified by the team.

(25) “Youth” means a person who participates in Wraparound ~~before the age of eighteen~~. Youth is the accepted term in statewide Wraparound to describe children, adolescents, teenagers and young adults. Youth who participate in Wraparound may remain in Wraparound as young adults if they entered prior to age 18. ~~Youth is the accepted term in statewide Wraparound to describe children, adolescents, teenagers and young adults.~~

(26) “Youth Partner” means an individual certified and on the registry as a Youth Support Specialist in accordance with OAR 410-180-0305. A Youth Partner is a formal member of the Wraparound team whose role is to support the youth.

(27) “Youth Organization” means a youth-led non-profit organization dedicated to improving the services and systems that foster and promote positive growth of youth and young adults. Youth Organizations ensure that youth voices are represented at all levels of policy and practice by utilizing peer support and uniting the voices of individuals who have experienced obstacles in child-serving systems.

309-019-0326 Youth Wraparound Program Rules

(1) Wraparound providers shall:

(a) Make eligibility criteria and referral processes available to the public. At a minimum, the following categories of youth shall be eligible:

(A) Youth served in two or more child-serving systems and experiencing complex needs; and

(B) Youth who have been approved by a Wraparound Review Committee convened by the CCO;

(b) For youth being served under Medicaid, obtain a mental health assessment within 60 days of Wraparound referral;

(c) Provide capacity to implement peer delivered services in accordance with OAR chapter 410, division 180 for youth and families participating in Wraparound;

(d) Screen for any complex needs and any other factors identified by ~~-t~~The Wraparound Review Committee in the local community ~~determines the complex needs considered in screening~~;

(e) Ensure that youth have access to Wraparound if they are Medicaid-eligible and enrolled in any of the following: Secure Children's Inpatient Program, Secure Adolescent Inpatient Program, Psychiatric Residential Treatment Services, or the Commercial Sexually Exploited Children's residential program funded by the Division; and

(f) Ensure that program staff, contractors, volunteers, and interns providing Wraparound programs are trained in and familiar with strategies for delivery of trauma informed and culturally responsive treatment services. At a minimum, completion of an online foundational course for trauma informed care approved by the Division shall be required of program staff, contractors, volunteers and interns.

(g) Ensure that Youth Partner and Family Partner services have been offered to the youth and family, and that any selected partners attend Wraparound team meetings;

(2) Wraparound providers may not:

(a) Require Medicaid-eligible youth to receive services or supports prior to applying for Wraparound;

(b) Exclude a youth who is not a CCO member from receiving Wraparound if funding is available from other payors;

(c) Place a youth on a waitlist to receive Wraparound.

(3) The Wraparound team shall be approved by the youth and family and at a minimum shall include:

(a) The youth;

(b) Parents or guardians of the youth and any additional family members requested by the youth;

(c) Youth Partners or Family Partners, if chosen by the youth or family.

(d) Wraparound Care Coordinator;

(e) System Partners or formal supports; and

(f) Natural and informal supports as requested by the youth and family.

(4) Wraparound team meetings.

(a) Meetings shall be facilitated face-to-face or by two-way audio-visual conference or by telephone.

(b) Meetings shall be conducted in the preferred language of the youth and family. Professional interpretation services must be used, if requested by the youth and family.

(c) Meetings are scheduled and decisions shall be made with the youth and family's direct involvement and approval.

(d) The Wraparound team shall maintain the following meeting schedule.

(A) The team shall convene a meeting a minimum of one time per month, and as necessary to meet the needs of the youth and family, as determined by the youth, family, and Wraparound team.

(B) During Phase Two, the team shall meet a minimum two times each month.

(5) The Wraparound team shall include a Wraparound Care Coordinator (WCC). The WCC shall:

(a) Facilitate the Wraparound process to fidelity standards, in accordance with any procedures and standards established by the Authority;

(b) Implement the Wraparound process in collaboration with Youth Partners, Family Partners, and other Wraparound team members;

(c) Facilitate the Wraparound process for no more than 15 families at any time when in a full-time position;

(d) Provide other service or support roles for youth on the Wraparound team they facilitate only when a variance has been approved~~requested~~;

(e) Complete a Division-approved Wraparound foundational training within 90 days of the hire date;

(f) Receive clinical supervision in accordance with OAR chapter 309, division 019; and

(g) Receive orientation and shadowing opportunities, be observed, have documents reviewed, and be coached by a Wraparound Coach as defined in these rules and in accordance with any procedures and standards established by the Authority.

(6) Family Partners shall meet the requirements for Family Support Specialists outlined in OAR 410-180-0305. They may receive support or technical assistance from a family organization and shall, at a minimum:

(a) Complete a Division-approved Wraparound foundational training within 90 days of the hire date;

(b) Receive peer supervision in accordance with OAR 309-019-0130;

(c) Provide peer delivered services and supports to no more than 15 families at any time when in a full-time position;

(d) Support family members and guardians to:

(A) Navigate the child-, youth-, and family-serving systems;

(B) Communicate effectively with family members, their support system, and agency representatives; and

(C) Make informed decisions to direct the Wraparound process;

(e) Provide individual and group support to enable and facilitate meaningful engagement with Wraparound team and service providers; and

(f) Assist in connecting the family to resources within the community, support the family through barriers, help family members to acquire tools and strategies for success and advocate for the family's needs, interests, voice, and vision to be heard and thoughtfully considered.

(7) Youth Partners shall meet the requirements outlined for Youth Support Specialists in OAR 410-180-0305. They may receive support or technical assistance from a youth organization, and shall, at a minimum:

(a) Complete a Division-approved Wraparound foundational training within 90 days of the hire date;

(b) Receive peer supervision in accordance with OAR 309-019-0130;

(c) Provide peer delivered services and supports to no more than 15 youth at any time when in a full-time position;

(d) Have at least one year of relevant lived experience, knowledge of the child- and youth-serving systems, and the ability to navigate the system;

(e) Assist the youth to engage in the Wraparound process and support them in expressing themselves to members of their Wraparound team;

(f) Assist the youth in identifying community resources, navigating barriers, acquiring tools and strategies for success and bridging the gap between the youth and the adults on the Wraparound team; and

(g) Advocate for the youth's needs, interests, voice and vision to be heard.

(8) The Wraparound provider shall, during the first phase of Wraparound ~~,~~ gather and compile a strengths and needs summary that is complemented by the Division-approved assessment tools ~~-~~for ages 0-5 and 6-20, as described below. Strengths and needs information to gather and compile shall include:

(a) Documentation of face-to-face meetings with the youth and family, which shall be conducted at a reasonable time and location chosen by the youth and family;

(b) Documentation of interviews with current formal and natural supports;

(c) A review of referral documentation; and

(d) Consideration of each one of the following domains: family and relationships, home and a place to live, psychological and emotional, health and medical, crisis and safety, financial, educational and vocational, legal, cultural and spiritual, daily living, substance abuse and addictions, social and recreational.

(9) The Wraparound provider shall conduct a strengths and needs assessment tool for each youth enrolled in Wraparound services and supports. The assessment tool shall:

(a) Be completed within 30 days of documented participation in Wraparound, and updated at least every 90 days thereafter and upon a change in clinical circumstances or other significant event;

(b) Be a Division-approved strengths and needs assessment tool for ages 0-5 and 6-20;

(c) Be completed by a Wraparound Care Coordinator, Family Partner, or Youth Partner certified in the Division-approved strengths and needs assessment tool;

(d) Include strengths and needs of the youth;

(e) Incorporate input from the youth, family, and all team members; and

(f) Be used to assist in developing a Wraparound plan of care.

(10) Wraparound Crisis and Safety Plans shall at a minimum:

(a) Be developed and approved by the youth and family in consultation with the Wraparound team;

(b) Document the youth and family's definition of crisis;

(c) Be completed during the engagement phase of Wraparound; the initial crisis and safety plan shall include at least one strategy to prevent a crisis situation and at least one strategy to use during a crisis situation;

(d) Include a list of triggers, warning signs, and recommended de-escalation strategies and supports identified by the youth and family in consultation with the Wraparound Team;

(e) Document strategies for risk prevention for existing or anticipated safety concerns; this shall include strategies developed through lethal means counseling to help individuals at risk for suicide and their families to reduce access to lethal means, including but not limited to firearms;

(f) Include strength-based strategies for addressing the youth and family's needs when in crisis;

(g) Document natural and formal supports approved by the youth and family for crisis response;

(h) Be updated at the request of the youth or family, or when clinical circumstances change, including following any placement change, psychiatric crisis, overdose, suicide attempt, police involvement, or other situations identified by the youth or family;

(i) Document safety requirements from other child-serving or legal systems;

(j) Be culturally and linguistically responsive;

(k) Include contact information for resources that the youth and family may use before or during a crisis event;

(l) Be provided to the youth and family in a format chosen by the youth and family; and

(m) Be available to Wraparound team members.

(11) A Wraparound Plan of Care shall:

(a) Include a family vision statement developed by the youth and family during the engagement phase;

(b) Include a team mission statement developed by the Wraparound team;

(c) Include a list of strengths and needs derived from the youth, family, ~~and~~ the Child and Adolescent S~~s~~trengths and N~~n~~eeds ~~summary~~Assessment, and the strengths and needs summary;

(d) Include goals for each prioritized need;

(e) Include strategies to achieve the desired outcomes, including identified strategies implemented by Youth or Family Partners;

(f) Include action steps that team members will undertake to meet the needs identified by the youth and family, including identified action steps implemented by Youth or Family Partners;

(g) Be reviewed and updated at each team meeting;

(h) Be culturally and linguistically responsive;

(i) Be approved by the youth and family;

(j) Be made available to the youth and family within five business days of the Wraparound team meeting in the format and language chosen by the youth and family;

(k) If appropriate and desired by the youth or family, include a blend of formal and informal supports; ~~or~~

~~(B) Include the use of flexible funding to meet needs.~~

(l) Include a list of team members and contact information; and

(m) Be present and discussed at each team meeting.

(12) Peer Partner Coaches shall:

(a) Be a certified Family Support Specialist or a certified Youth Support Specialist who has, at a minimum, two years of experience as a Traditional Health Worker as defined in OAR 410-180-0305;

(b) Demonstrate understanding of the ten Wraparound principles, the four phases of Wraparound, and the facilitation components associated with each phase of Wraparound;

(c) Provide peer supervision in accordance with OAR 309-019-0130, including face to face individual and group coaching to Youth or Family Partners a minimum of one time per month;

(d) Uphold Wraparound principles as evidenced by coaching notes;

(e) Be rater certified in use of the Division-approved assessment tools for ages 0-5 and 6-20;

(f) Ensure that Youth and Family Partners are delivering Wraparound to youth and families in a culturally and linguistically responsive manner;

(g) Create documentation which demonstrates that coaching is responsive to diverse cultural beliefs, practices, languages, learning styles, and communication as evidenced by written feedback from Youth and Family Partners and Peer Delivered Service Supervisors;

(i) Peer Coaches must be available to provide coaching in the language spoken by the family, when possible, to bilingual Youth and Family Partners and be able to observe meetings and perform document review in the family's primary language without impact on the youth, family or WCC; and

(j) Peer Coach must seek out additional resources when the coach does not have lived experience to provide culturally specific coaching to the Youth or Family Partner.

(13) Wraparound Coaches shall:

(a) Have at a minimum two years of experience as a Wraparound Care Coordinator;

(b) Demonstrate understanding of the ten Wraparound principles, the four phases of Wraparound, and the activities and facilitation components associated with each phase of Wraparound;

(c) Complete a Division-approved Wraparound Coaches and Supervisors training within 90 days of the hire date;

(d) Meet with the Wraparound Supervisor at least monthly;

(e) Provide the following coaching to Wraparound Care Coordinators:

(A) For WCCs with less than one year of Wraparound experience:

(i) 20 hours of individual coaching, 10 hours of group coaching, and five hours of document review within one year of the WCC's hire date, using the coaching model approved by the Division;

(ii) At ~~At least 5 of the 20 hours of individual coaching shall occur within the 90-day period before the WCC receives the Division approved foundational training~~least 5 of the 20 hours of individual coaching shall occur within the 90-day period before the WCC receives the Division approved foundational training; if the Division approved foundational training is not available or if the WCC is unable to attend during the first 90 days of employment, the WCC must receive biweekly individual coaching until the foundational training takes place~~.~~;

(iii) Within the first twelve months of the WCC beginning to work with youth and families, observe four Wraparound team meetings for each WCC, including one meeting representing each phase of the Wraparound process;

(B) For WCCs with at least one year of Wraparound experience, provide 10 hours of individual coaching, 10 hours of group coaching and two to four Wraparound team meeting observations within one calendar year;

(f) Utilize the coaching plan created with the Wraparound coach and document to include the names of the Coach and the WCC, the date, and the content of the coaching session;

(g) Create documentation which demonstrates that coaching is responsive to diverse cultural beliefs, practices, languages, learning styles, and communication as evidenced by written feedback from WCC and Wraparound Supervisor;

(h) Be available to provide coaching to bilingual WCCs in the language spoken by the family, when possible, and be able to observe meetings and perform document review in the family's primary language without impact on the youth, family, or WCC;

(i) Seek out additional resources when the Coach does not have lived experience to provide culturally specific coaching to a WCC; and

(j) Be rater-certified in the use of the Division-approved assessment tools for ages 0-5 and 6-20.

(14**)** Wraparound Supervisors shall:

(a) Demonstrate through experience the ability to understand and articulate the ten Wraparound principles, the four Wraparound phases, and facilitation components associated with each phase of Wraparound;

(b) Be informed of and implement their agency's Wraparound policies and procedures;

(c) Complete a Division-approved Wraparound foundational training and Wraparound Coaches and Supervisors training within 90 days of the hire date;

(d) Conduct or provide for clinical supervision, in accordance with OAR 309-019-0130, of Wraparound Care Coordinators, Wraparound Coaches, Family Partners, and Youth Partners, and uphold Wraparound principles as evidenced by notes in a supervision log that includes: name, date, and content of supervision;

(e) Coordinate coaching provided by the Wraparound Coach and Peer Support Coach;

(f) Ensure a coaching plan is written for each WCC, Family Partner, and Youth Partner per the Division-approved Coaches and Supervisor training;

(g) Ensure that the provision of Wraparound is culturally and linguistically responsive to the needs of Wraparound Care Coordinators, Youth Partners, Family Partners, youth and families;

(h) Adapt caseload size to provide adequate time to complete tasks if a WCC is working with a youth or family that requires an interpreter, bilingual services, and/or if there are other accessibility needs;

(i) Ensure Wraparound Coaches implement coaching plans that are culturally and linguistically responsive; and

(j) Be rater-certified in use of the Division-approved assessment tools for ages 0-5 and 6-20.

(15) A Fidelity Monitoring Tool (FMT) approved by the Division shall be used to assess fidelity to Wraparound.

(a) The FMT shall be implemented no sooner than six months after a youth has been enrolled in Wraparound;

(b) Any youth over the age of eleven may complete the FMT;

(c) A parent, guardian, or legal caregiver who knows the youth best and has also participated in Wraparound may complete the FMT;

(d) The youth and parent, guardian or legal caregiver shall complete the FMT without the team's Wraparound Care Coordinator present;

(e) The FMT shall be offered to wraparound team members when approved of by the youth or family;

(f) The FMT shall be administered electronically or in written form, as chosen by the youth and family; and

(g) Other approved fidelity tools in addition to the FMT may be administered by the Division.

(16) Transitions from Wraparound.

(a) Upon completing the Wraparound team's mission statement, during the fourth phase of Wraparound, the team shall create a transition plan outlining the tasks required for Wraparound to be completed and shall implement the plan.

(b) The Wraparound transition plan shall:

(A) Outline the mix of formal and natural supports that the youth and family have chosen;

(B) Include a post-transition crisis management plan;

(C) Include referrals and coordination of formal services; and

(D) If the youth and family have chosen to no longer participate in Wraparound, they shall be informed that Intensive Care Coordination is a potential option.

(c) Youth, family members, or a chosen community member may conduct the Wraparound meetings.

(d) The WCC supports the team in creating a transition document that summarizes and highlights the youth and family's functional strengths, lessons learned and successfully used strategies.

(e) The team conducts a meaningful and culturally appropriate activity that acknowledges the end of formal Wraparound.

(f) A young adult shall not be made to transition out of Wraparound solely due to attaining the age of 18. Young adults who reach the age of 18 while enrolled in Wraparound shall be offered the option to remain in Wraparound until their mission statement is achieved.

(17) Flexible funding is a funding stream meant to supplement available resources for carrying out the Wraparound Plan of Care , and shall be documented as related to a need, on the Wraparound plan of care.

~~[PLACEHOLDER provision on flexible funding.]~~

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