PUBLIC:
COMMUNITY ENGAGEMENT

Filing Contact:
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Filing Caption:
Mobile Crisis Intervention Services responses to a hospital campus.

STATEMENT OF NEED AND FISCAL IMPACT

Need for Rule(s) Changes:
Mobile Crisis Intervention Teams are attempting to meet the needs of their communities and further clarification around prioritization of responses, including responses to a hospital campus, is needed

Documents Relied Upon, and where they are available:
This amendment did not rely upon any documents as it is a result of conversations with the Hospital Association of Oregon, the Association of Community Mental Health Programs, the Public Health Division or OHA, the Medicaid Division of OHA, and the Behavioral Health Division of OHA.

Racial Equity Statement
The amendment to these rules is expected to clarify a Mobile Crisis Intervention Team's ability to prioritize calls and therefore improve behavioral health equity outcomes for Oregonians from minoritized communities. Minoritized communities include, but are not limited to, Black, Indigenous, American Indian/Alaska Native, Latinx, Asian, Pacific Islander D/deaf, deaf-blind, LGBTQIA2S+, or immigrant and refugee communities. Workforce shortage issues across the state have an impact on program availability and mobile crisis services can be deeply affected. By implementing this amendment, the Oregon Health Authority can help improve service capacity of Mobile Crisis Intervention Services that will help aid progress toward health equity and ensure services are accessible and available for all individuals in need.

Fiscal and Economic Impact:
There is little to no fiscal impact anticipated for Community Mental Health Programs. There is likely a fiscal impact for hospitals who will need to identify internal staff to provide crisis services to admitted individuals.

Statement of Cost of Compliance:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).

There is no known economic effect.

(2) Effect on Small Businesses:

There is no known effect on small businesses.

(a) Estimate the number and type of small businesses subject to the rule(s);

There is no known effect on small businesses.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);

There is no known effect on small businesses.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

There is no known effect on small businesses.

Describe how small businesses were involved in the development of these rule(s)?

Meetings took place with the Association of Community Mental Health Programs, the Hospital Association of Oregon, and the Behavioral Health Crisis System Advisory Committee (BHCSAC) regarding Mobile Crisis Intervention Services responses to hospital settings. These conversations informed the development of this proposed rule amendment.

Tribes Impact:

The Confederated Tribes of Warm Spring are certified to provide Mobile Crisis Intervention Services, in accordance with OAR 309-072. As a certified entity this rule amendment would potentially affect service delivery depending on the Tribe's connection or coordination with local hospital campuses.

Tribes Impact: DTLL SENT:

PENDING

Was an Administrative Rule Advisory Committee (RAC) consulted? Select Yes or No?
If not, why not?

No, a RAC will not be held OHA will focus on Community Engagement to get feedback and suggestions to the rule.

List Each Rule that you will be working on and state the action and any notes you have:

Rule Number	Action	Notes
309-072-0140	**Amend**	**Adding clarifying language**

Rule # 309-072-0140
Title - Standards for Mobile Crisis Intervention Services (MCIS)
Rule Action: Amending
Brief summary of changes you are making: Allows for a one-person response to an individual who is located on a hospital campus and has not been admitted to a hospital. This also states that MCIS may not be provided to an individual that has been admitted to a hospital.

(1) Mobile Crisis Intervention Services (MCIS) must be delivered to any individual experiencing a behavioral health crisis. MCIS must be available to the community, 24 hours a day, seven days per week, every day of the year.

(2) MCIS must be available to individuals in any community-based setting. MCIS may not be provided to an individual that has been admitted to a hospital. MCIS may be provided to an individual that is located on a hospital campus and has not been admitted to a hospital.

Commented [PL1]: This is new language that we will be discussing during the community engagement sessions. This language is currently a temporary rule.

(3) Formal interpretation services must be available to individuals and families who request services in languages not spoken by Mobile Crisis Intervention Team (MCIT) members.

(4) The initial crisis response must be provided to individuals in person by a two-person multidisciplinary MCIT between the hours of 8am and 12am that includes, at minimum:

Commented [PL2]: This is temporary language that will expire on June 29, 2025.

(a) A Qualified Mental Health Professional (QMHP) or a trained Qualified Mental Health Associate (QMHA);

(b) One other trained behavioral health provider as defined in these rules and OAR 309-019-0125;

(c) If a QMHP is not part of the two-person MCIT in person, a QMHP must be available to respond when clinically indicated, either by telehealth or in person.

(5) During the hours of 12am - 8am the initial mobile crisis response may be provided to individuals in person by one mobile crisis intervention staff who meets the following criteria:

(a) A trained Qualified Mental Health Professional (QMHP), or a

(b) Trained Qualified Mental Health Associate (QMHA)

(c) If a QMHP is not sent in person, a QMHP must be available to respond when clinically indicated, either by telehealth or in person.

Commented [PL3]: This is temporary language that will expire on June 29, 2025. Once this expires there will be a renumbering.

(6) Regardless of the time of day, if the individual is located on a hospital campus and has not been admitted to a hospital, the initial crisis response may be provided to individuals in person by one mobile crisis intervention staff who meets the following criteria:

(a) A trained Qualified Mental Health Professional (QMHP), or a
(b) Trained Qualified Mental Health Associate (QMHA)
(c) If a QMHP is not sent in person, a QMHP must be available to respond when clinically indicated, either by telehealth or in person.

(7) MCIT must carry naloxone and have at least one team member in person who is trained in its administration to reverse opioid overdoses.

(8) Providers must ensure equitable access to services, particularly for individuals and families who may have faced historical and contemporary discrimination and inequities in health care based on race or ethnicity, physical or cognitive ability, gender, gender identity or presentation, sexual orientation, socioeconomic status, insurance status, citizenship status, or religion.

(9) MCIT must be dispatched when requested by 988 call centers in collaboration with the MCIT. Prior to arrival on scene, there must be ongoing determination of the MCIT's safety.

(10) MCIT must maintain and implement written policies and protocols, Letters of Agreement, or MOU in place with 988 call centers, and other crisis call centers detailing how individuals in crisis will be monitored until a MCIT reaches the location of an individual or family in crisis.

(11) Providers must have program staff available to respond to crisis events in their respective geographic service area with the following maximum response times:

(a) In "urban" areas, MCIT must respond in person within one hour from the request for dispatch;

(b) In "rural" areas, MCIT must respond in person within two hours from the request for dispatch;

(c) In "frontier" areas, MCIT must respond in person within three hours from the request for dispatch;

(d) In "rural" and "frontier" areas, a provider who is trained in trauma-informed crisis response, de-escalation strategies, and harm reduction strategies must respond to the crisis event by phone call within one hour of being notified of the crisis event.

(12) Providers must maintain and implement written policies and protocols to request law enforcement presence or co-response at the location of response when appropriate.

(13) Non-CMHP providers certified by the Division of the Authority to provide MCIS must maintain written policies and protocols, Letters of Agreement, or MOU with all CMHPs within their service area to include at minimum:

(a) Policies and procedures for coordination of services; and

(b) Policies and procedures to comply with OAR 309-033-0230 (2)(b).

(14) MCIT must attempt and document the attempt to collect the following information during transit to the location of crisis, or when appropriate, either directly from the individual in crisis or from a 988 call center or any other crisis line that requested mobile response for the individual or family in crisis:

(a) Name of individual in crisis and individual who called;

(b) Relationship to caller if it is a third-party call;

(c) Date of birth of the individual in crisis;

Commented [PL4]: This is new language that we will be discussing during the community engagement sessions. This language is currently a temporary rule.

(d) Insurance provider;

(e) Current presentation, symptoms, circumstances of person of concern that prompted the call;

(f) Caller phone number;

(g) Specific requested developmental, cultural, or linguistic needs, if any;

(h) The desired response and outcome the caller is seeking;

(i) Whether other individuals are physically near the individual in crisis and their relationship to the individual in crisis;

(j) Presence of an animal including a service animal, if any;

(k) Presence of weapon, if any;

(l) Knowledge of current and/or historical aggression;

(m) Presence of any physical barrier to reach individual or family at the location of crisis;

(n) Any available information about immediate unmet needs such as housing, employment, food insecurity etcetera;

(o) Current services or supports in place such as primary care, family peer support, peer wellness support, faith-based support.

(15) Providers must have written agreements in place with any 911 center in their service area. These agreements must outline the information needed from the 911 center when transferring a caller to the MCIT. If known, the 911 center will provide the following information regarding the call:

(a) Name of the caller;

(b) Name of the person in need of MCIS, if different from the caller;

(c) Date of birth of individual in crisis;

(d) Current location of the person in need;

(e) Caller phone number;

(f) Reason for the call;

(g) Presence of any known weapons;

(h) Any specific threats of harm to self or others by the individual in crisis.

(16) Providers must 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:

(a) CMHPs must report to the Authority data listed in the County Financial Assistance Agreement based on the frequency of collection and reporting required by the Authority;

(b) Providers must report the data using a tool or platform for data collection and reporting approved by the Authority;

(c) Non-CMHP providers approved by the Division of the Authority to provide MCIS must comply with all reporting requirements set by the Authority.

Statutory/Other Authority: ORS 179.040, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.021, 430.256, 430.357, 430.560, 430.626-430.630, 430.640, 430.870 & 743A.168
Statutes/Other Implemented: ORS 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.626-430.630 & 430.637