

## Integrated Services and Supports Rules

### 309-032-1500

#### Purpose and Scope

(1) Purpose: These rules prescribe minimum standards for the services and supports provided by addictions and mental health providers approved by the Addictions and Mental Health Division of the Oregon Health Authority. These rules:

(a) Promote recovery, resiliency, wellness, independence and safety for individuals receiving addictions and mental health services and supports;

(b) Specify standards for services and supports that are person-directed, youth guided, family-driven, culturally competent, trauma-informed and wellness-informed; and

(c) Promote functional and rehabilitative outcomes for individuals that are developmentally appropriate.

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 407-120-0000 through 407-120-0400, these rules specify standards for addictions and mental health services and supports provided in:

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

(b) Intensive Community-based Treatment and Support Services (ICTS) for Children;

(c) Intensive Treatment Services (ITS) for Children;

(d) Outpatient and Residential Alcohol and Other Drug Treatment Services; and

(e) Outpatient and Residential Problem Gambling Treatment Services.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

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### 309-032-1505

#### Definitions

(1) "Abuse of an adult" means the circumstances defined in OAR 407-045-0260 for abuse of an adult with mental illness.

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

(3) "Addictions and Mental Health Services and Supports" means all services and supports that are regulated by this rule, including, but not limited to, Outpatient Community Mental Health Services and Supports for Children and Adults, ICTS for Children, ITS for Children, Outpatient and Residential

Alcohol and Other Drug Treatment Services and Outpatient and Residential Problem Gambling Treatment Services.

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

(5) "Adult" means a person 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, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.

(6) "Alcohol and Other Drug Treatment and Recovery Services" means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.

(7) "Alcohol and Other Drug Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide alcohol and other drug treatment services that include assessment, development of an Individual Service and Support Plan (ISSP), and individual, group and family counseling.

(a) For treatment staff holding certification in addiction counseling, qualifications for the certificate must 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.

(b) For treatment staff holding a health or allied provider license, the license or registration must have been issued by one of the following state bodies and the person must possess documentation of at least 60 contact hours of academic or continuing professional education in alcohol and other drug treatment:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

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

(E) Board of Nursing.

(8) "Assessment" means the process of obtaining all pertinent biopsychosocial information, as identified by the individual, family and collateral sources as relevant, to determine a diagnosis and to plan individualized services and supports.

(9) "ASAM PPC-2R" means the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, Second Edition Revised, April 2001, which is a clinical guide used in matching individuals to appropriate levels of care, and incorporated by reference in these rules.

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

(11) "Behavior Support Plan" means the individualized proactive support strategies, consistent with OAR 309-032-1540(8), documented in the ISSP that are used by the provider and family when applicable, to support positive behavior.

(12) "Behavior Support Strategies" means proactive supports designed to replace challenging behavior with functional, positive behavior. The strategies address environmental, social, neurodevelopmental and physical factors that affect behavior.

(13) "Biopsychosocial Information" means the combination of physical, psychological, social, environmental and cultural factors that influence the individual's development and functioning.

(14) "Care Coordination" means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for transition-age young adults to adult services.

(15) "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, social, educational, entitlement and other applicable services.

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

(17) "Child" means a person 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, must be considered a child until age 21 for purposes of these rules.

(18) "Child and Family Team" means those persons who are responsible for creating, implementing, reviewing, and revising the service coordination section of the ISSP in ICTS programs. At a minimum, the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family.

(19) "Children's Emergency Safety Intervention Specialist (CESIS)" means a Qualified Mental Health Professional (QMHP) who is licensed to order, monitor, and evaluate the use of seclusion and restraint in accredited and certified facilities providing intensive mental health treatment services to individuals under 21 years of age.

(20) "Clinical Supervision" means oversight by a qualified Clinical Supervisor of addictions and mental health services and supports provided according to this rule, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(21) "Clinical Supervisor" means a person qualified to oversee and evaluate addictions or mental health services and supports.

(a) For supervisors in alcohol and other drug treatment programs, holding a certification or license in addiction counseling, qualifications for the certificate or license must 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, in alcohol and other drug treatment programs, holding a health or allied provider license, such license or registration must have been issued by one of the following state bodies and the supervisor must possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of alcohol and other drug-related disorders:
- (A) Board of Medical Examiners;
  - (B) Board of Psychologist Examiners;
  - (C) Board of Licensed Social Workers;
  - (D) Board of Licensed Professional Counselors and Therapists; or
  - (E) Board of Nursing.
- (22) "Co-occurring substance use and mental health disorders (COD)" means the existence of a diagnosis of both a substance use disorder and a mental health disorder.
- (23) "Community Mental Health Program (CMHP)" means an entity that is responsible for planning and delivery of services for persons with substance use disorders or a mental health diagnosis, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.
- (24) "Conditional Release" means placement by a court or the Psychiatric Security Review Board (PSRB), of a person who has been found eligible under ORS 161.327(2)(b) or 161.336, for supervision and treatment in a community setting.
- (25) "Court" means the last convicting or ruling court unless specifically noted.
- (26) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.
- (27) "Crisis" means either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care.
- (28) "Cultural Competence" means the process by which people and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.
- (29) "Culturally Specific Program" means a program that is designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture.

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

(31) "Deputy Director" means the Deputy Director of the Addictions and Mental Health Division, or that person's designee.

(32) "Developmentally Appropriate" means services and supports that match emotional, social and cognitive development rather than chronological age.

(33) "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.

(34) "Director" means the Director of the Addictions and Mental Health Division, or that person's designee.

(35) "Division" means the Addictions and Mental Health Division.

(36) "DSM" means the Diagnostic and Statistical Manual of Mental Disorders-IV-R, published by the American Psychiatric Association.

(37) "DSM Five-axis Diagnosis" means the multi-axial diagnosis, consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), resulting from the assessment.

(38) "Driving Under the Influence of Intoxicants (DUI) Alcohol and Other Drug 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 who is participating in a diversion agreement under ORS 813.200.

(39) "Emergency Safety Intervention" means the use of seclusion or personal restraint under OAR 309-032-1540(9) of these rules, as an immediate response to an unanticipated threat of violence or injury to an individual, or others.

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

(41) "Enhanced Care Services (ECS)" and "Enhanced Care Outreach Services (ECOS)" means mental health services and supports provided to individuals residing in licensed Seniors and People with Disabilities (SPD) facilities.

(42) "Entry" means the act or process of acceptance and enrollment into services regulated by this rule.

(43) "Evaluation Specialist" means a person who possesses valid certification issued by the Division to conduct DUI evaluations.

(44) "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, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

(45) "Family Support" means the provision of supportive services to persons 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.

(46) "Fully Capitated Health Plan (FCHP)" means a prepaid health plan under contract with the Division of Medical Assistance Programs to provide capitated physical or behavioral health services.

(47) "Gender Identity" means a person's self-identification of gender, without regard to legal or biological identification, including, but not limited to persons identifying themselves as male, female, transgender and transsexual.

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

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

(50) "Guardian" means a person appointed by a court of law to act as guardian of a minor or a legally incapacitated person.

(51) "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).

(52) "Incident Report" means a written description of any incident involving an individual, occurring on the premises of a program, or involving program staff or an ISSP activity, including, but not limited to, injury, major illness, accident, act of physical aggression, medication error, suspected abuse or neglect, or any other unusual incident that presents a risk to health and safety.

(53) "Individual" means any person being considered for or receiving services and supports regulated by these rules.

(54) "Individual Service and Support Plan" (ISSP) means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service.

(55) "Individual 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 ISSP.

(56) "Individual Service Record" means the documentation, written or electronic, regarding an individual and resulting from entry, assessment, orientation, service and support planning, services and supports provided, and transfer.

(57) "Informed Consent for Services" means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the

individual and guardian, if applicable, have consented to the services on, or prior to, the first date of service.

(58) "Intensive Outpatient Alcohol and Other Drug 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.

(59) "Intensive Community-based Treatment and Support Services (ICTS)" means a specialized set of comprehensive in-home and community-based supports and mental health treatment services, including care coordination as defined in these rules, for children that are developed by the child and family team and delivered in the most integrated setting in the community.

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

(61) "Interim Referral and Information Services" means services provided by an alcohol and other drug 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 alcohol and other drug use, promote the health of the individual and reduce the risk of disease transmission.

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

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

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

(65) "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.

(66) "Level of Service Intensity Determination." means the Division approved process by which children and young adults in transition are assessed for ITS and ICTS services.

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

(68) "Licensed Medical Practitioner (LMP)" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Physician licensed to practice in the State of Oregon; or

(b) Nurse practitioner licensed to practice in the State of Oregon; or

(c) Physician's Assistant licensed to practice in the State of Oregon; and

(d) Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management.

(e) For ICTS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

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

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

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

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

(70) "Mandatory Reporter" means any public or private official, as defined in ORS 419B.005(3), who comes in contact with or has reasonable cause to believe that an individual has suffered abuse, or that any person with whom the official comes in contact with, has abused the individual. Pursuant to ORS 430.765(2) psychiatrists, psychologists, clergy and attorneys are not mandatory reporters with regard to information received through communications that are privileged under ORS 40.225 to ORS 40.295.

(71) "Mechanical Restraint" means the use of any physical device to involuntarily restrain the movement of all or a portion of an individual's body as a means of controlling his or her physical activities in order to protect the individual or other persons from injury. Mechanical restraint is prohibited in the services regulated by these rules.

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

(73) "Medical Director" means a physician licensed to practice medicine in the State of Oregon and who is designated by an alcohol and other drug treatment program to be responsible for the program's medical services, either as an employee or through a contract.

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

(75) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis or treatment of a physical or mental health condition, or injuries, and which are:

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

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

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

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

(76) "Medication Administration Record" means the documentation of the administration of written or verbal orders for medication, laboratory and other medical procedures issued by a LMP employed by, or under contract with, the provider and acting within the scope of his or her license.

(77) "Mental Health Organization (MHO)" means an approved organization that manages most mental health services through a capitated payment mechanism under the Oregon Health Plan. MHOs can be fully capitated health plans, community mental health programs, private mental health organizations or combinations thereof.

(78) "Older Adult" means an individual who is 60 years of age or older.

(79) "Older Adult Services" means age-appropriate services designed for older adults and provided by professionals trained in geriatrics. The services are preventative and include primary prevention efforts including suicide prevention, early identification services, early intervention services and comprehensive local planning for older adult mental health services.

(80) "Oregon Health Authority" means the Oregon Health Authority of the State of Oregon.

(81) "Outpatient Alcohol and Other Drug Treatment Program" means a publicly or privately operated program that provides assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for individuals with alcohol or other drug use disorders and their family members, or significant others, consistent with Level I or Level II of the ASAM PPC-2R.

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

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

(84) "Outreach" means the delivery of addictions, problem gambling or mental health services, referral services and case management services in non-traditional settings, such as, but not limited to, the individual's residence, shelters, streets, jails, transitional housing sites, drop-in centers, single room occupancy hotels, child welfare settings, educational settings or medical settings. It also refers to attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.

(85) "Peer" means any person supporting an individual, or a family member of an individual, who has similar life experience, either as a current or former recipient of addictions or mental health services, or as a family member of an individual who is a current or former recipient of addictions or mental health services.

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

(87) "Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete a Division approved training program and be:

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

(b) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or

(c) A family member of an individual who is a current or former recipient of addictions or mental health services.

(88) "Performance Improvement Plan" means a plan that describes the provider's quality assessment and performance improvement strategies and measurements.

(89) "Person-directed" means the individual, and others involved in supporting the treatment and recovery of the individual, are actively involved in assessment, planning and revising services and supports and intended outcomes. Individuals are empowered through this process to regain their health, safety and independence to the greatest extent possible and in a manner that is holistic and specific to the individual, including culturally, developmentally, age and gender appropriate.

(90) "Personal Restraint" means the application of physical force without the use of any device, for the purpose of restraining the free movement of an individual's body to protect the individual, or others, from immediate harm. Personal restraint does not include briefly holding without undue force an individual to calm or comfort him or her, or holding an individual's hand to safely escort him or her from one area to another. Personal restraint can be used only in approved ITS programs as an emergency safety intervention under OAR 309-032-1540(9).

(91) "Problem Gambling Treatment Staff" means persons providing problem gambling treatment services on a quarter-time or greater basis who hold a certification in a mental health or addictions discipline and have completed, within the past two years, at least 30 hours of problem gambling specific education. Problem Gambling Treatment Staff providing services on a half time or greater basis must hold advanced certification in addictions or be a QMHP and be able to document a minimum of 1000 hours of problem gambling treatment experience and have completed 60 hours of problem gambling specific education.

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

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

(94) "Program Staff" means an employee or person who, by contract with the program, provides a service and who has the applicable competencies, qualifications or certification, required in this rule to provide the service.

(95) "Provider" means an organizational entity, or qualified person, that is operated by or contractually affiliated with, a community mental health program, or contracted directly with the Division, for the direct delivery of addictions, problem gambling or mental health services and supports.

(96) "Provisional Assessment" means an initial assessment that identifies a presenting problem, provisional diagnosis and sufficient information to support the provisional diagnosis.

(97) "Provisional ISSP" means an initial ISSP that includes short term objectives and medically appropriate services sufficient to address presenting issues as they relate to a provisional diagnosis, including any engagement strategies, crisis services and activities necessary to complete the assessment and the ISSP.

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

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

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

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

(102) "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.

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

(104) "Qualified Mental Health Associate (QMHA)" means a person delivering services under the direct supervision of a QMHP and meeting the following minimum qualifications as authorized by the LMHA or designee:

(a) Bachelor's degree in a behavioral sciences field; or

(b) A combination of at least three years relevant work, education, training or experience.

(105) "Qualified Mental Health Professional (QMHP)" means a LMP or any other person meeting one or more of the following minimum qualifications as authorized by the LMHA or designee:

(a) Bachelor's degree in nursing and licensed by the State of Oregon;

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

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

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

(f) Graduate degree in a behavioral science field.

(106) "Qualified Person" means a person who is a QMHP, or a QMHA, and is identified by the PSRB in its Conditional Release Order. This person is designated by the provider to deliver or arrange and monitor the provision of the reports and services required by the Conditional Release Order.

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

(108) "Recovery" means a process of healing and transformation for a person to achieve full human potential and personhood in leading a meaningful life in communities of his or her choice.

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

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

(111) "Residential Alcohol and Other Drug Treatment Program" means a publicly or privately operated program as defined in ORS 430.010 that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with alcohol and other drug dependence, consistent with Level III of ASAM PCC-2R.

(112) "Residential Problem Gambling Treatment Program" means a publicly or privately operated program that is licensed in accordance with OAR 309-032-1540(11), that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with gambling related problems.

(113) "Residential Transition Program" means an Alcohol and Other Drug residential program that provides a drug-free supportive living environment and provides clinical services consistent with Level III of the ASAM PPC-2R.

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

(115) "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 can be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the ISSP.

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

(117) "Seclusion" means the involuntary confinement of an individual to an area or room from which the individual is physically prevented from leaving. Seclusion can be used only in approved ITS programs as an emergency safety intervention specified in OAR 309-032-1540(9).

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

(119) "Services" means those activities and treatments described in the ISSP 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.

(120) "Signature" means any written or electronic means of entering the name, date of authentication and credentials of the person providing a specific service or the person authorizing services and supports. Signature also means any written or electronic means of entering the name and date of authentication of the individual receiving services, the guardian of the individual receiving services, or any authorized representative of the individual receiving services.

(121) "Skills Training" means providing information and training to individuals and families designed to assist with the development of skills in areas including, but not limited to, anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, symptom management, accessing community services and daily living.

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

(123) "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.

(124) "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, as well as substance induced psychotic disorder, mood disorder, etc, as defined in DSM criteria.

(125) "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; and

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

(126) "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.

(127) "Systems Integration" means the efforts by providers to work collaboratively with other service systems including, but not limited to, schools, corrections, child welfare and physical health providers, in order to coordinate and enhance services and supports and reduce barriers to service delivery.

(128) "Time out" means the restriction of a child for a period of time to a designated area from which he or she is not physically prevented from leaving, for the purpose of providing him or her an opportunity to regain self-control. When time out is documented as a behavior support strategy in the ISSP, it must be tracked for effectiveness in increasing positive behavior.

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

(130) "Trauma Informed Services" means services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health and addictions services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and are delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services.

(131) "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 ISSP.

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

(a) An initial test must 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 must be by a different analytical method from that of the initial test to ensure reliability and accuracy.

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

(133) "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.

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

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

## **309-032-1510**

### **Provider Policies**

(1) Personnel Policies: All providers must develop and implement written personnel policies and procedures, compliant with these rules, including:

(a) Personnel Qualifications and Credentialing, (b) Mandatory abuse reporting, compliant with ORS 430.735-430.768 and 407-045-0250 through 407-045-0360;

(c) Criminal Records Checks, compliant with ORS 181.533 through 181.575 and 407-007-0000 through 407-007-0370; and

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

(2) Service Delivery Policies: All providers must develop and implement written policies and procedures, consistent with these rules, describing the provider's approach to services and supports and the procedures for the delivery of services and supports.

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

(b) Service delivery policies and procedures must include, at a minimum:

(A) Entry and orientation;

(B) Fee agreements;

(C) Assessment, service planning, coordination and documentation;

(D) Person-directed services, including:

(i) Cultural competency;

(ii) Developmentally appropriate and age-appropriate service planning and delivery; and

(iii) Family involvement.

(E) Transfer and Continuity of Care;

(F) Trauma-informed Services, as defined in these rules;

(G) 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;

(H) Compliance with Title 2 of the Americans with Disabilities Act of 1990 (ADA);

(I) Grievances and Appeals;

(J) Individual Rights;

(K) Quality Assessment and Performance Improvement;

(L) Crisis Prevention and Response, and Incident Reporting;

(M) Services to Young Adults in Transition, when applicable; and

(N) Urinalysis testing to ensure validity of urine specimens collected by staff authorized to collect urine samples, when applicable.

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

(a) Medical Protocols and Medical Emergencies;

(b) Medication Administration, Storage and Disposal;

(c) Facility standards for Alcohol and Other Drug Residential Treatment Programs, including the standards under these rules;

(d) General Safety and Emergency Procedures; and

(e) Emergency Safety Interventions in ITS Programs.

(f) Alcohol and Other Drug Residential Treatment programs must establish written policies that prohibit:

(A) Physical or other forms of aversive action to discipline an individual;

(B) Seclusion, personal restraint, mechanical restraint and chemical restraint;

(C) Withholding shelter, regular meals, clothing or aids to physical functioning; and

(D) Discipline of one individual by another.

(4) Behavior Support Policies: Applicable providers, as specified below, must develop behavior support policies including:

(a) ITS and ICTS Services: policies consistent with 309-032-1540 (8) of these rules.

(b) ECS Services: policies consistent with 309-032-1540 (8) of these rules.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

### **309-032-1515**

#### **Individual Rights**

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

(a) Choose from available services and supports, those that are consistent with the ISSP and 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 ISSP, 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 to receive a copy of the written ISSP;
- (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, 192.515, 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 Individual Service Record in accordance with ORS 179.505;
- (h) Not participate in experimentation;
- (i) Receive medication specific to the individual's diagnosed clinical needs;
- (j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
- (k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
- (l) Have religious freedom;
- (m) Be free from seclusion and restraint, except as regulated in OAR 309-032-1540(9).
- (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 involvement in service planning and delivery;
- (q) Make a declaration for mental health treatment, when 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.

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

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

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

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

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

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

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

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

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

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

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

(i) Participate regularly in indoor and outdoor recreation;

(j) Not be required to perform labor;

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

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

(3) Notification of Rights: The provider must give to the individual and, if appropriate, the guardian, a document that describes the applicable individual's rights as follows:

- (a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;
- (b) The rights, and how to exercise them, must be explained to the individual, and if appropriate, to her or his guardian; and
- (c) Individual rights must be posted in writing in a common area.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

### **309-032-1520**

#### **Personnel**

(1) Licensing and Credentialing: All program staff must meet applicable credentialing or licensing standards, including those outlined in these rules, for the following:

- (a) Alcohol and Other Drug Treatment Staff;
- (b) CESIS;
- (c) Clinical Supervisor;
- (d) LMP;
- (e) Medical Director;
- (f) Peer Support Specialist;
- (g) Problem Gambling Treatment Staff;
- (h) QMHA; and
- (i) QMHP.

(2) Specific Program Staff Competencies: At minimum, competencies for the following specified program staff must include:

- (a) Program Administrators or Program Directors must demonstrate competence in leadership, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, data collection, reporting, program evaluation, quality assurance, and developing and coordinating community resources;
- (b) Clinical Supervisors in addictions and mental health programs must demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, individual service and

support planning, case management and coordination, 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. In addition:

(A) Clinical Supervisors in alcohol and other drug treatment programs must be certified or licensed by a health or allied provider agency, as defined in these rules, to provide addiction treatment, and have one of the following qualifications:

(i) Five years of paid full-time experience in the field of alcohol and other drug counseling; or

(ii) 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 alcohol and other drug counseling experience; or

(iii) 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 alcohol and other drug counseling experience;

(B) Clinical Supervisors in mental health programs must meet QMHP requirements and have completed two years of post-graduate clinical experience in a mental health treatment setting; and

(C) Clinical Supervisors in problem gambling treatment programs must meet the requirements for clinical supervisors in either mental health or alcohol and other drug treatment programs, and have completed 10 hours of gambling specific training within two years of designation as a problem gambling services supervisor.

(c) Alcohol and other drug treatment staff must:

(A) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide addiction treatment within two years of the first hire date and must make application for certification no later than six months following that date. The two years is not renewable if the person ends employment with a provider and becomes re-employed with another provider.

(B) Demonstrate competence in treatment of substance-use disorders including individual assessment and 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.

(d) Problem gambling treatment staff must demonstrate competence in treatment of problem gambling including individual assessment and 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.

(e) QMHAs must 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 an ISSP.

(f) QMHPs must demonstrate the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, alcohol and other drug use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting a mental status examination, complete a five-axis DSM diagnosis, write and supervise the implementation of a ISSP and provide individual, family or group therapy within the scope of their training.

(g) Peer support specialists must demonstrate knowledge of approaches to support others in recovery and resiliency, and demonstrate efforts at self-directed recovery.

(3) Recovering Staff: Program staff, contractors, volunteers and interns recovering from a substance-use disorder, providing treatment services or peer support services in alcohol and other drug treatment programs, must be able to document continuous abstinence under independent living conditions or recovery housing for the immediate past two years.

(4) Personnel Documentation: Providers must maintain personnel records for each program staff that contains all of the following documentation:

(a) An employment application;

(b) Where required, verification of a criminal records check consistent with OAR 407-007-0200 through 407-007-0370;

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

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

(e) Periodic performance appraisals;

(f) Staff orientation and development activities;

(g) Program staff incident reports;

(h) Disciplinary documentation;

(i) Reference checks;

(j) Emergency contact information; and

(k) Information from subsection (6) of this rule, if applicable.

(5) For providers utilizing contractors, interns or volunteers, providers must maintain the following documentation, as applicable:

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

(b) A signed confidentiality agreement;

(c) Service-specific orientation documentation; and

(d) For subject individuals, verification of a criminal records check consistent with OAR 407-007-0200 through 407-007-0370.

(6) Program Specific Personnel Documentation: In addition to general program staff documentation requirements, providers must maintain additional documentation as applicable.

(a) For all program staff and volunteers providing residential services to children or adults:

(A) Results of a Tuberculosis screening as per OAR 333-071-0057.

(7) Training: Providers must ensure that program staff receives training applicable to the specific population for whom services are planned, delivered, or supervised as follows:

(a) Orientation training: The program must document appropriate orientation training for each program staff, or person providing services, within 30 days of the hire date. At minimum, orientation training for all program staff must include, but not be limited to,

(A) A review of individual crisis response procedures;

(B) A review of emergency procedures;

(C) A review of program policies and procedures;

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

(E) Mandatory abuse reporting procedures;

(F) For ICTS, ITS and Enhanced Care Services, positive behavior support training consistent with 309-032-1540(8).

(8) Supervision: Persons providing services to individuals in accordance with this rule must receive supervision by a qualified Clinical Supervisor, as defined in these rules, related to the development, implementation and outcome of services.

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

(A) Documentation of supervision for each person supervised, of no less than two hours per month. The two hours must include one hour of face-to-face contact for each person supervised, or a proportional level of supervision for part-time program staff.

(B) Documentation of quarterly supervision for program staff holding a health or allied provider license.

(b) Medical supervision must be secured, when required, through a current written agreement, job description, or similar type of binding arrangement between a LMP and the provider, which describes the LMP's responsibility in reviewing and approving the assessment and services and supports identified in the ISSP for each individual receiving mental health services for one or more continuous years.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

**309-032-1525**

## **Entry and Assessment**

(1) Entry Process: The program must utilize a written entry procedure to ensure the following:

- (a) Individuals must be considered for entry without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, except when program eligibility is restricted to children, adults or older adults, familial status, marital status, source of income, and disability.
- (b) Individuals must receive services in the most timely manner feasible consistent with the presenting circumstances.
- (c) For individuals receiving services funded by the SAPT Block Grant, entry of pregnant women to services must occur no later than 48 hours from the date of first contact, and no less than 14 days after the date of first contact for individuals using substances intravenously. If services are not available within the required timeframe, the provider must document the reason and provide interim referral and informational services as defined in these rules, within 48 hours.
- (d) Written informed consent for services must be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason must be documented and further attempts to obtain informed consent must be made as appropriate.
- (e) The provider must establish an Individual Service Record for each individual on the date of entry.
- (f) The provider must report the entry of all individuals on the mandated state data system.
- (g) In accordance with ORS 179.505 and HIPAA, an authorization for the release of information must be obtained for any confidential information concerning the individual being considered for, or receiving, services.
- (h) Orientation: At the time of entry, the program must give to the individual and guardian if applicable, written program orientation information. The written information must be in the individual's primary language and must include:
  - (A) The program's philosophical approach to providing services and supports;
  - (B) A description of individual rights consistent with these rules;
  - (C) An overview of services available including any related fees when applicable; and
  - (D) Policies concerning grievances and confidentiality.

(2) Entry Priority:

(a) Entry of adults and older adults, in community-based mental health programs, whose services are not funded by Medicaid, must be prioritized in the following order:

(A) Individuals who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of hospitalization for the treatment of mental health conditions or are in need of

continuing services to avoid hospitalization or pose a hazard to the health and safety of themselves, including the potential for suicide;

(B) Individuals who, because of the nature of their diagnosis, their geographic location or their family income, are least capable of obtaining assistance from the private sector; and

(C) Individuals who, in accordance with the assessment of professionals in the field of mental health, are experiencing mental health conditions but will not require hospitalization in the foreseeable future.

(b) Entry of children in community-based mental health services, whose services are not funded by Medicaid, must be prioritized in the following order:

(A) Children who are at immediate risk of psychiatric hospitalization or removal from home due to emotional and mental health conditions;

(B) Children who have severe mental health conditions;

(C) Children who exhibit behavior which indicates high risk of developing conditions of a severe or persistent nature; and

(D) Any other child who is experiencing mental health conditions which significantly affect the child's ability to function in everyday life but not requiring hospitalization or removal from home in the near future.

(c) Entry of individuals whose services are funded by the SAPT Block Grant, must 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 with dependent children.

(3) Assessment:

(a) When an individual is admitted for services, an assessment must be completed prior to development of the ISSP, or provisional ISSP, if applicable.

(b) When an assessment cannot be completed at entry, a provisional assessment, as defined in these rules, must document the immediate medical appropriateness of services. If services are continued, an assessment must be completed within a timeframe that reflects the level and complexity of services and supports to be provided.

(c) The assessment must be completed by qualified program staff as follows:

(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 alcohol and other drug treatment programs, and

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

(d) Each assessment must include:

(A) Sufficient biopsychosocial information and documentation to support the presence of a DSM diagnosis that is the medically appropriate reason for services.

(B) Screening for the presence of substance use, problem gambling, mental health conditions, and chronic medical conditions.

(C) Screening for the presence of symptoms related to psychological and physical trauma.

(D) Suicide potential must be assessed and individual service records must contain follow-up actions and referrals when an individual reports symptoms indicating risk of suicide.

(E) In addition, for children age zero to five, diagnosis must be informed by treatment guidelines included in the Health Services Commission prioritized list of paired conditions and treatments, and must include:

(i) Direct observation of child, parent, family and interaction;

(ii) Neurodevelopment considerations; and

(iii) Parental and family biopsychosocial functioning within the context of the home, community and culture.

(F) Subsections (3)(d)(A), (3)(d)(B), (3)(d)(C) and (3)(d)(D) of this rule, apply to alcohol and other drug assessments, which must be consistent with the dimensions described in the ASAM PPC-2R, and must document a diagnosis and level of care determination consistent with the DSM and ASAM PPC-2R.

(e) When the assessment process determines the presence of co-occurring substance use and mental health disorders, all providers must document referral for further assessment, planning and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(f) Providers must document updates to the assessment consistent with the timelines specified in the ISSP, and when there are changes related to the biopsychosocial information in the assessment.

(g) In addition to periodic assessment updates, any individual continuing to receive mental health services for one or more continuous years, must receive an annual assessment by a QMHP, that has documented approval by an LMP.

(h) The requirements in OAR 309-032-1525(3)(d)(A) and 309-032-1525(3)(g) are minimum requirements to meet Medicaid auditing standards and may result in financial findings when not met. The requirements in OAR 309-032-1525(3)(d)(B) through 309-032-1525(3)(f) are quality standards and may result in limitations, or revocation of, certification when not met. Failure to maintain certification may result in exclusion or limited participation in the Medicaid program.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270  
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### **309-032-1530**

#### **Individual Service and Support Planning and Coordination**

(1) Individual Services and Supports: The provider must deliver or coordinate, for each individual, appropriate services and supports to collaboratively facilitate intended service outcomes as identified by the individual, and family, when applicable.

(a) Qualified program staff must facilitate a planning process, resulting in an ISSP that reflects the assessment and the level of care to be provided.

(b) A provisional ISSP, including applicable crisis services, must be completed prior to the start of services. For mental health services, a QMHP, who is also a licensed health care professional, must recommend the services and supports by signing the provisional ISSP.

(c) If services are continued, an ISSP must be completed within a timeframe that reflects:

(A) The type and level of services and supports to be provided;

(B) A complete assessment; and

(C) Engagement and agreement of the individual, and family if applicable, in the development of the ISSP.

(d) Individuals, and family members, as applicable, must collaboratively participate in the development of the ISSP.

(e) Providers must fully inform the individual and guardian when applicable, of the proposed services and supports, in developmentally and culturally appropriate language, obtain informed consent for all proposed services, and give the individual and guardian when applicable, a written copy of the ISSP.

(f) Providers must collaborate with community partners to coordinate or deliver services and supports identified in the ISSP.

(g) Providers must request authorization to exchange information with any applicable physical health care providers or Fully Capitated Health Plans, for the individual, to collaborate in promoting regular and adequate health care.

(h) When there are barriers to services due to culture, gender, language, illiteracy, or disability, the provider must take measures to address or overcome those barriers including:

(A) Providing supports including, but not limited to, the provision of interpreters to provide translation services, at no additional cost to the individual.

(2) Individual Service and Support Plan (ISSP):

(a) The ISSP must document the specific services and supports to be provided, arranged or coordinated to assist the individual and his or her family, if applicable, to achieve intended outcomes.

(b) At minimum, each ISSP must include:

(A) Measurable or observable intended outcomes;

(B) Specific services and supports to be provided;

(C) Applicable service and support delivery details including frequency and duration of each service; and

(D) Timelines for review of progress and ISSP updates must be consistent with the level of care provided and the needs of the individual. For ITS programs, the interdisciplinary team must conduct a review of progress and transfer criteria at least every 30 days from the date of entry and must document members present, progress and changes made. For Psychiatric Day Treatment Services, the review must be conducted every 30 days and the LMP must participate in the review at least every 90 days.

(c) For ICTS programs, the ISSP must include:

(A) Identification of strengths and needs;

(B) A service coordination section that summarizes service planning in all relevant life domains by the participating team members; and

(d) For ICTS and ITS programs, the ISSP must include:

(A) Proactive safety and crisis planning; and

(B) A behavior support plan, consistent with OAR 309-032-1540(8) of these rules.

(e) A QMHP, who is also a licensed health care professional, must recommend the services and supports by signing the ISSP for each individual receiving mental health services within five days of the development of the ISSP;

(f) A LMP must approve updates to the ISSP at least annually for each individual receiving mental health services for one or more continuous years.

(g) The requirements in OAR 309-032-1530(2)(a) through 309-032-1530(2)(e) are minimum requirements to meet both Medicaid auditing and quality standards and may result in financial findings or limitations or both, or revocation of certification when not met. Failure to maintain certification may result in exclusion or limited participation in the Medicaid program.

(3) Individual Service Notes:

(a) A written individual service note must be recorded each time a service is provided.

(b) Individual Service Notes must document the:

(A) Specific service provided;

(B) Duration of the service provided;

(C) Date on which the service was provided;

(D) Location of service; and

(E) Date of authentication and name, signature, and credentials, of the person who provided the service.

(c) Individual service notes must also include:

(A) Periodic reviews of progress toward intended outcomes, consistent with timelines documented in the ISSP;

(B) Any significant events or changes in the individual's life circumstances, including mental status, treatment response and recovery status; and

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

(d) The requirements in OAR 309-032-1530(3)(a) and 309-032-1530(3)(b)(A) through 309-032-1530(3)(b)(E) are minimum requirements to meet Medicaid auditing standards and may result in financial findings when not met. The requirements in 309-032-1530(3)(c)(A) through 309-032-1530(3)(c)(C) are quality standards and may result in limitations, or revocation of, certification when not met. Failure to maintain certification may result in exclusion or limited participation in the Medicaid program.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

### **309-032-1535**

#### **Individual Service Record**

(1) Documentation Standards: Documentation must be appropriate in quality and quantity to meet professional standards applicable to the provider and any additional standards for documentation in the provider's policies and any pertinent contracts.

(2) General Requirements for Individual Service Record: All providers must develop and maintain an Individual Service Record for each individual upon entry. The record must, at a minimum, include:

(a) Identifying information, or documentation of attempts to obtain the information, including:

(A) The individual's name, address, telephone number, date of birth, gender, and for adults, marital status and military status;

(B) Name, address, and telephone number of the parent or legal guardian, primary care giver or emergency contact;

(C) Contact information for medical and dental providers;

(b) Informed Consent for Service, including medications, or documentation specifying why the provider could not obtain consent by the individual or guardian as applicable;

(c) Written refusal of any services and supports offered, including medications;

(d) A signed fee agreement, when applicable;

(e) Assessment or provisional assessment and updates to the assessment;

(f) An ISSP or provisional ISSP, including any applicable behavior support or crisis intervention planning;

(g) Individual service notes;

(h) A Transfer Summary, when required;

(i) Other plans as made available, such as, but not limited to recovery plans, wellness action plans, education plans, and advance directives for physical and mental health care; and

(j) Applicable signed consents for release of information.

(3) Medical Service Records: When medical services are provided, the following documents must be part of the Individual Service Record as applicable:

(a) Medication Administration Records as per these rules;

(b) Laboratory reports; and

(c) LMP orders for medication, protocols or procedures.

(4) Documentation in Residential Programs: In addition to the requirements for Individual Service Records in subsection 309-032-1535(2), PRTS and Alcohol and Other Drug Residential Treatment providers must include the following documentation in the Individual Service Record:

(a) A personal belongings inventory created upon entry and updated whenever an item of significant value is added or removed, or on the date of transfer;

(b) Documentation indicating that the individual and guardian, as applicable, were provided with the required orientation information upon entry;

(c) Background information including strengths and interests, all available previous mental health or substance use assessments, previous living arrangements, service history, behavior support considerations, education service plans if applicable, and family and other support resources;

(d) Medical information including a brief history of any health conditions, documentation from a LMP or other qualified health care professional of the individual's current physical health, and a written record of any prescribed or recommended medications, services, dietary specifications, and aids to physical functioning;

(e) Copies of documents relating to guardianship or any other legal considerations, as applicable;

- (f) A copy of the individual's most recent ISSP, if applicable, or in the case of an emergency or crisis-respite entry, a summary of current addictions or mental health services and any applicable behavior support plans;
- (g) Documentation of the individual's ability to evacuate the home consistent with the program's evacuation plan developed in accordance with the Oregon Structural Specialty Code and Oregon Fire Code;
- (h) Documentation of any safety risks; and
- (i) Incident reports, when required, including:
  - (A) The date of the incident, the persons involved, the details of the incident, and the quality and performance actions taken to initiate investigation of the incident and correct any identified deficiencies; and
  - (B) Any child abuse reports made by the provider to law enforcement or to the DHS Children, Adults and Families Division, documenting the date of the incident, the persons involved and, if known, the outcome of the reports.
- (5) Additional documentation in ITS Programs: In addition to OAR 309-032-1535(2), 309-032-1535(3) and 309-032-1535(4), ITS providers must include the following documentation in the Individual Service Record:
  - (a) Level of Service Intensity Determination;
  - (b) Names and contact information of the members of the interdisciplinary team;
  - (c) Documentation by the interdisciplinary team that the child's ISSP has been reviewed, the services provided are medically appropriate for the specific level of care, and changes in the plan recommended by the interdisciplinary team, as indicated by the child's service and support needs, have been implemented;
  - (d) Emergency safety intervention records, in a separate section or in a separate format, documenting each incident of personal restraint or seclusion, signed and dated by the qualified program staff directing the intervention and, if required, by the psychiatrist or clinical supervisor authorizing the intervention; and
  - (e) A copy of the written transition instructions provided to the child and family on the date of transfer.
- (6) Additional documentation in ICTS Programs: In addition to OAR 309-032-1535(2), ICTS providers must include the following documentation in the Individual Service Record:
  - (a) Level of Service Intensity Determination; and
  - (b) Names and contact information of the members of the child and family team.
- (7) PSRB and JPSRB Documentation: When the individual is under the jurisdiction of the PSRB or JPSRB, providers must include the following additional documentation in the Individual Service Record:
  - (a) Monthly reports to the PSRB or JPSRB;

(b) Interim reports, as applicable;

(c) The PSRB Initial Evaluation; and

(d) For PSRB and JPSRB services, a copy of the Conditional Order of Release.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

### **309-032-1540**

#### **Program Specific Service Standards**

In addition to individualized service and support planning and coordination, providers of each of the following program-specific service areas must ensure the following requirements listed for that service are met.

(1) Co-Occurring Mental Health and Substance Use Disorders (COD):

(a) Providers approved and designated to provide services and supports for individuals diagnosed with COD must:

(A) Provide concurrent service and support planning and delivery for substance use and mental health diagnosis, including integrated assessment, ISSP and individual service record

(2) Outpatient Mental Health Services to Children, Adults and Older Adults:

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

(A) 24 hours, seven days per week telephone or face-to-face screening to determine an individual's need for immediate community mental health services; and

(B) 24 hour, seven days per week capability to conduct, by or under the supervision of a QMHP, a provisional assessment resulting in a provisional ISSP that includes the crisis services necessary to assist the individual and family to stabilize and transition to the appropriate level of care.

(b) Individual, family and group therapy provided by a QMHP;

(c) Psychiatric services including medication management as applicable, provided by a LMP who is either an employee of the provider or is a contracted provider; and

(d) Available case management services including the following:

(A) Assistance in applying for benefits to which the individual may be entitled. Program staff must assist individuals in gaining access to, and maintaining, resources such as Social Security benefits, general

assistance, food stamps, vocational rehabilitation, and housing. When needed, program staff must arrange transportation or accompany individuals to help them apply for benefits;

(B) Assistance with completion of a declaration for mental health treatment with the individual's participation and informed consent;

(C) Referral and coordination to help individuals gain access to services and supports identified in the ISSP;

(D) When an individual receives residential services, program staff must collaborate with the residential program and family to coordinate services;

(E) When an individual resides in an Adult Foster Home, program staff must assist in the development of a Personal Care Plan. Program staff must also evaluate the appropriateness of services in relation to the individual's assessed need and review the Personal Care Plan every 180 days;

(F) When an individual is admitted to a hospital or non-hospital facility, program staff must make contact in person or by telephone with the individual within one working day of entry and P must be actively involved with transition planning from the hospital or non-hospital facility;

(G) If an individual is receiving treatment in a state funded long-term care psychiatric facility, program staff must, from the point of entry, be actively involved with transitioning the individual from long term care;

(H) When significant health and safety concerns are identified, program staff must assure that necessary services or actions occur to address the identified health and safety needs for the individual; and

(I) For children and youth, program staff must create linkages to and ongoing communication with other involved child-serving providers and agencies such as child welfare, education, primary care and juvenile justice, and make referrals for additional services and supports as indicated.

(e) Skills training as indicated;

(f) Peer delivered supports, as indicated; and

(g) Older adult services, including preventative mental health services, when applicable.

(3) Enhanced Care Services:

(a) Enhanced care services must be provided in DHS' SPD licensed facilities that have a multipurpose room, an area providing an environment with low stimulation, an accessible outdoor space with a covered area, a refrigerator, a microwave conveniently located for program activities, space for interdisciplinary meetings, space for mental health treatment and space for storage of records. A minimum of one private room is required in facilities opened after January 1, 1994.

(b) Services must include:

(A) 12 hours per week of mental health services available during evening and weekend shifts provided or arranged for by the contracted mental health provider;

(B) Weekly interdisciplinary team meetings to develop the ISSP, review the behavior support plan and to coordinate care planning with the SPD licensed provider staff and related professionals, including a QMHP, prescriber, SPD direct care staff, SPD case manager, SPD facility RN and SPD facility administrator; and

(C) A crisis service staffed by a QMHP or the local CMHP available to the provider and facility direct care staff 24-hours per day.

(c) ECOS services must be delivered according to the individual's needs and do not require the services listed under OAR 309-032-1540(3)(b)(A) and 309-032-1540(3)(b)(B) of this rule.

(d) Behavior support services must be consistent with OAR 309-032-1540(8) of these rules.

(4) Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board: Services and supports must include all appropriate services determined necessary to assist the individual in maintaining community placement and which are consistent with Conditional Release Orders and the Agreement to Conditional Release.

(a) Providers of PSRB and JPSRB services acting through the designated Qualified Person, must submit reports to the PSRB or JPSRB as follows:

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

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

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

(iii) 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

(iv) If supervision by the provider is recommended, notify the PSRB or JPSRB of the name of the person designated to serve as the individual's Qualified Person, who must 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:

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

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

(iii) Upon noting any other major change in the individual's ISSP;

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

(v) At any other time when, in the opinion of the Qualified Person, such an interim report is needed to assist the individual.

(b) JPSRB providers must submit copies of all monthly reports and interim reports to both the JPSRB and the Division.

(5) Intensive Community-Based Treatment and Support Services (ICTS) for Children: ICTS 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 ISSP and the standards for outpatient mental health services, ICTS services must include:

(a) Care coordination provided by a QMHP or a QMHA supervised by a QMHP;

(b) A child and family team, as defined in these rules;

(c) Service coordination as specified in the ISSP, to be developed by the child and family team;

(d) Review of progress at child and family team meetings to occur at a frequency documented in the ISSP;

(e) Family support and respite care, as indicated;

(f) Proactive safety and crisis planning that utilizes professional and natural supports to provide 24 hours, seven days per week flexible response and is reflective of strategies to avert potential crisis without placement disruptions; and

(g) Behavior support planning, consistent with OAR 309-032-1540(8) of these rules.

(6) Intensive Treatment Services (ITS) for Children:

(a) ITS Providers must meet the following general requirements:

(A) Maintain the organizational capacity and interdisciplinary treatment capability to deliver clinically and developmentally appropriate services in the medically appropriate amount, intensity and duration for each child specific to the child's diagnosis, level of functioning and the acuity and severity of the child's psychiatric symptoms;

(B) Maintain 24 hour, seven days per week treatment responsibility for children in the program;

(C) Non-residential programs must maintain on-call capability at all times to respond directly or by referral to the treatment needs of children, including crises, 24 hours per day and seven days per week;

(D) Inform the Division and the legal guardian within twenty-four hours of reportable incidents;

(E) Maintain linkages with primary care physicians, CMHPs and MHOs and the child's parent or guardian to coordinate necessary continuing care resources for the child; and

(F) Maintain linkages with the applicable education service district or school district to coordinate and provide the necessary educational services for the children and integrate education services in all phases of assessment, service and support planning, active treatment and transition planning.

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

(A) Availability of psychiatric services to meet the following requirements;

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

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

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

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

(A) Active psychiatric treatment and education services must be functionally integrated in a therapeutic environment designed to reflect and promote achievement of the intended outcomes of each child's ISSP;

(B) When treatment services interrupt the child's day to day educational environment, the program must provide or make arrangements for the continuity of the child's education;

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

(D) Psychiatric services;

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

(F) Medication evaluation, management and monitoring;

(G) Pre-vocational or vocational rehabilitation;

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

(I) Individual and group psychosocial skills development;

(J) Activity and recreational therapies;

(K) Nutrition;

(L) Physical health care services or coordination;

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

(N) Educational services coordination and advocacy; and

(O) Behavior support services, consistent with OAR 309-032-1540(8) of these rules.

(7) Program Specific Requirements for ITS Providers: In addition to the general requirements for all ITS providers listed in OAR 309-032-1540(6), the following program-specific requirements must be met:

(a) Psychiatric Residential Treatment Facilities (PRTF):

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

(B) Psychiatric Residential Treatment Facilities must maintain one or more linkages with acute care hospitals or MHOs to coordinate necessary inpatient care;

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

(D) Psychiatric Residential Treatment Facilities must be staffed at a clinical staffing ratio of not less than one program staff for three children during the day and evening shifts. At least one program staff for every three program staff members during the day and evening shifts must be a QMHP or QMHA. For overnight program staff there must be a staffing ratio of at least one program staff for six children; at least one of the overnight program staff must be a QMHA. For units that by this ratio have only one overnight program staff, there must be additional program staff immediately available within the facility or on the premises. At least one QMHP must be on site or on call at all times. At least one program staff with designated clinical leadership responsibilities must be on site at all times.

(b) SCIP and SAIP: Programs providing SCIP and SAIP Services must meet the requirements for PRTFs listed in 7(a) of this subsection. They must also establish policies and practices to meet the following:

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

(B) Psychiatric nursing staff must be provided in the program 24 hours per day;

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

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

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

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

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

(c) Sub-Acute Psychiatric Care: In addition to the services provided as indicated by the assessment and specified in the ISSP, Sub-Acute Psychiatric Care providers must:

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

(B) Provide nursing supervision and monitoring and psychiatric supervision at least one to three times per week; and

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

(d) Psychiatric Day Treatment Services (PDTs):

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

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

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

(8) Behavior Support Services: Behavior support services must be proactive, recovery-oriented, individualized, and designed to facilitate positive alternatives to challenging behavior, as well as to assist the individual in developing adaptive and functional living skills. Behavior support services are required in ITS, ICTS and ECS Services. Providers of these services must:

(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 ISSP;

(c) Establish a framework which assures individualized positive behavior support practices throughout the program and articulates a rationale consistent with the philosophies supported by the Division, including the Division's Trauma-informed Services Policy;

(d) Obtain informed consent from the parent or guardian, when applicable, in the use of behavior support strategies and communicate both verbally and in writing the information to the individual and guardian in the individual's primary language and in a developmentally appropriate manner;

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

(A) Reducing or eliminating the use of emergency safety interventions ; and

(B) Increasing positive behavior.

(f) Require all program staff to receive annual training in Collaborative Problem Solving, Positive Behavior Support or other Evidence-based Practice to promote positive behavior support; and

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

(9) Emergency Safety Interventions in ITS Programs: Providers of ITS services must:

(a) Adopt policies and procedures for Emergency safety interventions as part of a Crisis Prevention and Intervention Policy. The policy must be consistent with the provider's trauma-informed services policies and procedures.

(b) Inform the individual and his or her parent or guardian of the provider's policy regarding the use of personal restraint and seclusion during an emergency safety situation by both furnishing a written copy of the policy and providing an explanation in the individual's primary language that is developmentally appropriate.

(c) Obtain a written acknowledgment from the parent or guardian that he or she has been informed of the provider's policies and procedures regarding the use of personal restraint and seclusion.

(d) Prohibit the use of mechanical restraint and chemical restraint as defined in these rules.

(e) Establish an Emergency Safety Interventions Committee or designate this function to an already established Quality Assessment and Performance Improvement Committee. Committee membership must minimally include a program staff with designated clinical leadership responsibilities, the person responsible for staff training in crisis intervention procedures and other clinical personnel not directly responsible for authorizing the use of emergency safety interventions. The committee must:

(A) Monitor the use of emergency safety interventions to assure that individuals are safeguarded and their rights are always protected;

(B) Meet at least monthly and must report in writing to the provider's Quality Assessment and Performance Improvement Committee at least quarterly regarding the committee's activities, findings and recommendations;

(C) Analyze emergency safety interventions to determine opportunities to prevent their use, increase the use of alternatives, improve the quality of care and safety of individuals receiving services and recommend whether follow up action is needed;

(D) Review and update emergency safety interventions policies and procedures annually;

(E) Conduct individual and aggregate review of all incidents of personal restraint and seclusion; and

(F) Report the aggregate number of personal restraints and incidents of seclusion to the Division within 30 days of the end of each calendar quarter.

(f) Providers must meet the following general conditions of personal restraint and seclusion:

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

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

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

(D) Personal restraint or seclusion must only be used for the length of time necessary for the individual to resume self-control and prevent harm to the individual or others, even if the order for seclusion or personal restraint has not expired, and must under no circumstances, exceed 4 hours for individuals ages 18 to 21, 2 hours for individuals ages 9 to 17, or 1 hour for individuals under age 9;

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

(F) Personal restraint and seclusion must not be used simultaneously;

(G) Providers must notify the individual's parent or guardian of any incident of seclusion or personal restraint as soon as possible;

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

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

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

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

(iv) Review the individual's ISSP, making the necessary revisions, and document the discussion and any resulting changes to the individual's ISSP in the Individual Service Record.

(g) Personal Restraint:

(A) Each personal restraint must require an immediate documented order by a physician, licensed practitioner, or, in accordance with OAR 309-034-0400 through 309-034-0490, a licensed CESIS;

(B) The order must include:

(i) Name of the person authorized to order the personal restraint;

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

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

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

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

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

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

(G) Each incident of personal restraint must be documented in the individual service record. The documentation must specify:

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

(ii) Required authorization;

(iii) Events precipitating the personal restraint;

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

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

(vi) Assessment of physical injury; and

(vii) Individuals response to the emergency safety intervention.

(h) Seclusion: Providers must be approved by the Division for the use of seclusion.

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

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

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

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

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

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

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

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

(F) Each incident of seclusion must be documented in the individual service record. The documentation must specify:

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

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

(iii) The events precipitating the use of seclusion;

(iv) The length of time seclusion was used;

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

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

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

(i) Any room specifically designated for the use of seclusion or time out must be approved by the Division.

(j) If the use of seclusion occurs in a room with a locking door, the program must be authorized by the Division for this purpose and must meet the following requirements:

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

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

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

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

(E) After the review, the Deputy Director of the Division or their designee must approve or disapprove the facility's application and upon approval must certify the facility based on the determination of the facility's compliance with all applicable requirements for the seclusion of children;

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

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

(k) Structural and physical requirements for seclusion: An ITS provider seeking this certification under these rules must have available at least one room that meets the following specifications and requirements:

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

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

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

(D) The room must contain no protruding, exposed, or sharp objects;

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

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

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

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

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

(J) The room must be designed and equipped in a manner that would not allow a child to climb off the ground;

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

(L) Adequate and safe bathrooms must be available.

(10) Outpatient Problem Gambling Treatment Services: These services include group, individual and family treatment consistent with the following requirements:

(a) The first offered service appointment must be five business days or less from the date of request for services;

(b) Service sessions must address the challenges of the individual as they relate, directly or indirectly, to the problem gambling behavior;

(c) Telephone counseling: Providers may provide telephone counseling when person-to-person contact would involve an unwise delay, as follows:

(A) Individual must be currently enrolled in the problem gambling treatment program;

(B) Phone counseling must be provided by a qualified provider within their scope of practice;

(C) Individual service notes must follow the same criteria as face-to-face counseling and identify the session was conducted by phone and the clinical rationale for the phone session;

(D) Telephone counseling must meet HIPAA and 42 CFR standards for privacy; and

(E) There must be an agreement of informed consent for phone counseling that is discussed with the individual and documented in the individual's service record.

(d) Family Counseling: 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 must address the problems of the family member as they relate directly or indirectly to the problem gambling behavior; and

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

(e) 24-hour crisis response accomplished through agreement with other crisis services, on-call program staff or other arrangement acceptable to the Division.

(11) Residential Problem Gambling Treatment Services: Providers of this service must comply with OAR 309-032-1545 of these rules.

(a) When problem gambling treatment services are provided in a psychiatric health facility, providers must have Division approved written policies and procedures for operating this service, and must be licensed in accordance with OAR 309-035-0100 through OAR 309-035-0460.

(b) When problem gambling treatment services are provided in an alcohol and other drug residential treatment facility providers of this service must have Division approved written policies and procedures for operating this service and have a current license issued by the Division in accordance with OAR 415-012-0000 through 415-012-0090.

(c) Providers must coordinate services and make appropriate referrals to other formal and informal service systems to insure continuity of care, including, but not limited to, mental health, self-help support groups, financial consultants, legal advice, medical, crisis management, cultural issues, housing and vocational. All referral and follow-up actions must be documented in the individual service record.

(12) Alcohol and Other Drug Treatment and Recovery Services:

(a) Interim Referral and Information Services: Pregnant women or other individuals using substances intravenously, whose services are funded by the SAPT Block Grant, must receive interim referrals and information prior to entry, to reduce the adverse health effects of alcohol and other drug use, promote

the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services must 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; and

(D) For pregnant women, 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 referral for prenatal care.

(b) Culturally Specific Services: Programs approved and designated as culturally specific programs must meet the following criteria:

(A) Serve a majority of individuals representing the culturally specific population; and

(B) Governing Board: Develop and maintain a governing or advisory board that must:

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

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

(iii) Include at least 20% representation of individuals, as defined in these rules, or family members of individuals; and

(iv) Meet at least quarterly.

(C) Maintain accessibility to culturally specific populations including:

(i) The physical location of the program must be within close proximity to the culturally specific populations;

(ii) Where available, public transportation must be within close proximity to the program; and

(iii) Hours of service, telephone contact, and other accessibility issues must be appropriate for the population; and

(D) The physical facility within which the culturally specific services are delivered must be psychologically comfortable for the group including:

(i) Materials displayed must be culturally relevant;

(ii) Mass media programming (radio, television, etc.) must be sensitive to cultural background; and

(iii) Other cultural differences must 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.

(c) Adolescent Treatment Services: Programs approved to provide adolescent alcohol and other drug treatment services or those with adolescent-designated service funding must meet the following standards:

(A) Residential programs providing services to individuals defined as children for purposes of this rule must, in addition to the applicable requirements of this rule, be licensed by DHS' Children, Adults and Families Division in cooperation with the Division.

(B) Development of ISSPs and case management services must include participation of parents, other family members, schools, children's services agencies, and juvenile corrections, as appropriate;

(C) Services, or appropriate referrals, must include:

(i) Family service;

(ii) Recreation and leisure time consistent with the individual's interests;

(iii) Community and social skills training;

(iv) Academic education services or referral; and

(v) Smoking cessation service.

(D) Continuing care services must be of appropriate duration, consistent with ASAM PPC-2R criteria, and designed to maximize recovery opportunities. The services must include:

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

(ii) Youth dominated self-help groups where available;

(iii) Linkage to emancipation services when appropriate; and

(iv) Linkage to physical or sexual abuse counseling and support services when appropriate.

(E) There must be a sufficient number of qualified program staff to ensure a ratio of at least one treatment staff per eight adolescents at all times.

(F) Program staff coverage must be provided 24 hours per day, seven days per week.

(d) Women's Treatment Services: Programs approved and designated to provide alcohol and other drug treatment services primarily to women must meet the following standards:

(A) The Assessment must contain an evaluation that identifies and assesses needs specific to women's issues in service such as social isolation, self-reliance, parenting issues, domestic violence, women's physical health, housing and financial considerations;

(B) The Individual Service and Support Plan must address all areas identified in (12)(d)(A) of this subsection as well as alcohol and other drug use and any other applicable service coordination details;

(C) The program must provide or coordinate services and supports that meet the special access needs of women such as childcare, mental health services, and transportation, as indicated;

(D) The program must provide, or coordinate, the following services and supports unless clinically contraindicated:

- (i) Gender-specific services and supports;
- (ii) Family services, including therapeutic services for children in the custody of women in treatment;
- (iii) Reintegration with family;
- (iv) Peer delivered supports;
- (v) Smoking cessation;
- (vi) Housing; and
- (vii) Transportation.

(E) Individual Service and Support Planning and treatment must include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies;

(F) Referral Services: The program must coordinate services with the following, if indicated:

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

(ii) Parenting training; and

(G) Continuing care treatment services must be consistent with the ASAM PPC-2R and must include referrals to female dominated support groups where available; and

(H) Programs that receive SAPT Block Grant funding must provide or coordinate the following services for pregnant women and women with dependent children, including women who are attempting to regain custody of their children:

(i) Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;

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

(iii) Gender specific substance abuse treatment and other therapeutic interventions for women which may include, but are not limited to:

(I) Relationship issues;

(II) Sexual and physical abuse;

(III) Parenting; and

(IV) Access to child care while the women are receiving these services; and

(iv) Therapeutic interventions for children in the custody of women in treatment which may include, but are not limited to:

(I) Their developmental needs; and

(II) Any issues concerning sexual and physical abuse, and neglect; and

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

(e) Specialized Alcohol and Other Drug Community-based Programs for Individuals in the Criminal Justice System: These services and supports are for 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.

(A) Services and supports must incorporate interventions and strategies that target criminogenic risk factors and include:

(i) Cognitive behavioral interventions;

(ii) Motivational interventions;

(iii) Relapse prevention; and

(iv) Healthy relationships education;

(B) Providers must demonstrate coordination of services with criminal justice partners through written protocols, program staff activities, and individual record documentation;

(C) Program Directors or clinical supervisors must 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 alcohol and other drug treatment services to individuals in the criminal justice system;

(D) Within the first six months of hire, program staff must receive training on effective principles of evidenced-based practices for individuals with criminogenic risk factors; and

(E) Within six months of hire, program staff must have documented knowledge, skills, and abilities demonstrating treatment strategies for individuals with criminogenic risk factors.

(f) DUII Alcohol and Other Drug Rehabilitation Programs: In addition to the general standards for alcohol and other drug treatment programs, those programs approved to provide DUII rehabilitation services must meet the following standards:

(A) DUII rehabilitation programs must assess individuals referred for treatment by the evaluation specialist. Placement, continued stay and transfer of individuals must be based on the criteria described in the ASAM PPC-2R, subject to the following additional terms and conditions:

(i) Abstinence: Individuals must demonstrate continuous abstinence for a minimum of 90 days prior to completion as documented by urinalysis tests and other evidence;

(ii) Treatment Completion: Only DUII rehabilitation programs may certify treatment completion;

(iii) Residential Treatment: Using the ASAM PPC-2R, the DUII program's assessment may indicate that the individual requires treatment in a residential program. It is the responsibility of the DUII program to:

- (I) Monitor the case carefully while the individual is in residential treatment;
  - (II) Provide or monitor outpatient and follow-up services when the individual is transferred from the residential program; and
  - (III) Verify completion of residential treatment and follow-up outpatient treatment.
- (iv) Urinalysis Testing: A minimum of one urinalysis sample per month must be collected during the period of service deemed necessary by an individual's DUII rehabilitation program:
- (I) Using the process defined in these rules, the samples must be tested for at least five controlled drugs;
  - (II) At least one of the samples is to be collected and tested in the first two weeks of the program and at least one is to be collected and tested in the last two weeks of the program;
  - (III) If the first sample is positive, two or more samples must be collected and tested, including one sample within the last two weeks before completion; and
  - (IV) Programs may use methods of testing for the presence of alcohol and other drugs in the individual's body other than urinalysis tests if they have obtained the prior review and approval of such methods by the Division.
- (v) Reporting: The program must report:
- (I) To the Division on forms prescribed by the Division;
  - (II) To the evaluation specialist within 30 days from the date of the referral by the specialist. Subsequent reports must be provided within 30 days of completion or within 10 days of the time that the individual enters noncompliant status; and
  - (III) To the appropriate evaluation specialist, case manager, court, or other agency as required when requested concerning individual cooperation, attendance, treatment progress, utilized modalities, and fee payment.
- (vi) Certifying Completion: The program must send a numbered Certificate of Completion to the Department of Motor Vehicles to verify the completion of convicted individuals. Payment for treatment may be considered in determining completion. A certificate of completion must not be issued until the individual has satisfied the abstinence requirements of 309-032-1540(f)(A)(i).
- (vii) Records: The DUII rehabilitation program must maintain in the permanent Individual Service Record, urinalysis results and all information necessary to determine whether the program is being, or has been, successfully completed.
- (viii) Separation of Evaluation and Rehabilitation Functions: Without the approval of the Director , no agency or person may provide DUII rehabilitation to an individual who has also been referred by a Judge to the same agency or person for a DUII evaluation. Failure to comply with this rule will be considered a violation of ORS chapter 813. If the Director finds such a violation, the Director may deny, suspend, revoke, or refuse to renew a letter of approval.

(13) Medical Protocols in Alcohol and Other Drug Treatment Programs: Medical protocols must be approved by a medical director under contract with a program or written reciprocal agreement with a medical practitioner under managed care. The protocols must:

(a) Require, but not be limited to a medical history, as described in the Assessment;

(b) Designate those medical symptoms that, when found, require further investigation, physical examinations, service, or laboratory testing;

(c) 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, must 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;

(d) Require pregnant women be referred for prenatal care within two weeks of entry to the program;

(e) Require that the program provide HIV and AIDS, TB, sexually transmitted disease, Hepatitis and other infectious disease information and risk assessment, including any needed referral, within 30 days of entry; and

(f) 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.

(14) Administration of Medications: The following guidelines must be followed in policies on administration of medications in all programs:

(a) Medications prescribed for one individual must not be administered to or self-administered by another individual or program staff;

(b) When an individual self-administers medication in a residential program, self-administration must be approved in writing by a physician and closely monitored by the residential program staff;

(c) No unused, outdated, or recalled drugs must be kept in a program. On a monthly basis any unused, outdated, or recalled drugs must be disposed of in a manner that assures they cannot be retrieved;

(d) Disposal of prescription drugs in a residential program: A written record of all disposals of drugs must be maintained in the program and must include:

(A) A description of the drug, including the amount;

(B) The individual for whom the medication was prescribed;

(C) The reason for disposal; and

(D) The method of disposal.

(e) Storage of Prescription Drugs in residential programs: All prescription drugs stored in the residential program must be kept in a locked stationary container. Medications requiring refrigeration must be stored in a refrigerator using a locked container; and

(f) Written documentation of medications prescribed for the individual by a LMP must be maintained in the Individual Service Record. Documentation for each medication prescribed must include the following:

(A) A copy or detailed written description of the signed prescription order;

(B) The name of the medication prescribed;

(C) The prescribed dosage and method of administration;

(D) The date medications were prescribed, reviewed, or renewed;

(E) The date, the signature and credentials of program staff administering or prescribing medications; and

(F) Medication records which contain:

(i) Observed side effects including laboratory findings; and

(ii) Medication allergies and adverse reaction.

(15) Building Requirements for Alcohol and Other Drug Programs: Each alcohol and other drug treatment program must provide facilities that:

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

(b) Maintain up-to-date documentation verifying that they meet applicable local business license, zoning and building codes and 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;

(c) Provide space for services including but not limited to intake, assessment, counseling and telephone conversations that assures the privacy and confidentiality of individuals and is furnished in an adequate and comfortable fashion including plumbing, sanitation, heating, and cooling;

(d) Provide rest rooms for individuals, visitors, and staff that are accessible to persons with disabilities pursuant to Title II of the Americans with Disabilities Act if the program receives any public funds or Title III of the Act if no public funds are received;

(e) 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; and

(f) Tobacco Use: Outpatient programs must not allow tobacco use in program facilities and on program grounds. Effective July 1, 2012, residential programs must not allow tobacco use in program facilities and on program grounds.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955,

443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270  
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

### **309-032-1545**

#### **Facility Standards for Alcohol and Other Drug Residential Treatment Programs**

(1) Building Requirements: In addition to the building requirements for outpatient Alcohol and Other Drug treatment programs, residential programs must meet the following standards:

(a) Prior to construction of a new building or major alteration of or addition to an existing building:

(A) One set of plans and specifications must be submitted to the State Fire Marshal for approval;

(B) Plans must be in accordance with the State of Oregon Structural Specialty Code and Fire and Life Safety Regulations;

(C) Plans for construction containing 4,000 square feet or more must be prepared and bear the stamp of an Oregon licensed architect or engineer; and

(D) The water supply, sewage, and garbage disposal system must be approved by the agency having jurisdiction.

(2) Interiors: All rooms used by individuals must have floors, walls, and ceilings that meet the interior finish requirements of the State of Oregon Structural Specialty Code and Fire and Life Safety Regulations:

(a) A separate dining room or area must be provided for exclusive use of individuals, program staff, and invited guests, and must:

(A) Seat at least one-half of the individuals at a time with a minimum of 15 square feet per occupant; and

(B) Be provided with adequate ventilation.

(b) A separate living room or lounge area must be provided for the exclusive use of individuals, program staff, and invited guests and must:

(A) Provide a minimum of 15 square feet per occupant; and

(B) Be provided with adequate ventilation.

(c) Bedrooms must be provided for all individuals and must:

(A) Be separate from the dining, living, multi-purpose, laundry, kitchen, and storage areas;

(B) Be an outside room with a window that can be opened, and is at least the minimum required by the State Fire Marshal;

(C) Have a ceiling height of at least seven feet, six inches;

(D) Provide a minimum of 60 square feet per individual, with at least three feet between beds;

- (E) Provide permanently wired light fixtures located and maintained to give light to all parts of the room; and
  - (F) Provide a curtain or window shade at each window to assure privacy.
- (d) Bathrooms must be provided and conveniently located in each building containing a bedroom and must:
- (A) Provide a minimum of one toilet and one hand-washing sink for each eight individuals, and one bathtub or shower for each ten individuals;
  - (B) Provide one hand-washing sink convenient to every room containing a toilet;
  - (C) Provide permanently wired light fixtures located and maintained to give adequate light to all parts of the room;
  - (D) Provide arrangements for personal privacy for individuals;
  - (E) Provide a privacy screen at each window;
  - (F) Provide a mirror; and
  - (G) Be provided with adequate ventilation.
- (e) A supply of hot and cold water installed and maintained in compliance with rules of, the Authority , Health Services, Office of Public Health Systems, must be distributed to taps conveniently located throughout the residential program;
- (f) All plumbing must comply with applicable codes;
- (g) Laundry facilities, when provided, must be separate from:
- (A) Resident living areas, including bedrooms;
  - (B) Kitchen and dining areas; and
  - (C) Areas used for the storage of unrefrigerated perishable foods.
- (h) Storage areas must be provided appropriate to the size of the residential program. Separate storage areas must be provided for:
- (A) Food, kitchen supplies, and utensils;
  - (B) Clean linens;
  - (C) Soiled linens and clothing;
  - (D) Cleaning compounds and equipment; and
  - (E) Poisons, chemicals, insecticides, and other toxic materials, which must be properly labeled, stored in the original container, and kept in a locked storage area.

(i) Furniture must be provided for each individual and must include:

(A) A bed with a frame and a clean mattress and pillow;

(B) A private dresser or similar storage area for personal belongings which is readily accessible to the individual; and

(C) Access to a closet or similar storage area for clothing and

(j) Linens must be provided for each individual and must include:

(A) Sheets and pillowcases;

(B) Blankets, appropriate in number and type for the season and the individual's comfort; and

(C) Towel and washcloth.

(3) Food Service and Storage: The residential program must meet the requirements of the State of Oregon Sanitary Code for Eating and Drinking Establishments relating to the preparation, storage, and serving of food. At minimum:

(a) Menus must be prepared in advance to provide a sufficient variety of foods served in adequate amounts for each resident at each meal;

(b) Records of menus as served must be filed and maintained in the residential program records for at least 30 days;

(c) All modified or special diets must be ordered by a physician;

(d) At least three meals must be provided daily;

(e) Supplies of staple foods for a minimum of one week and of perishable foods for a minimum of a two-day period must be maintained on the premises;

(f) Food must be stored and served at proper temperature;

(g) All utensils, including dishes, glassware, and silverware used in the serving or preparation of drink or food for individuals must be effectively washed, rinsed, sanitized, and stored after each individual use to prevent contamination in accordance with Health Division standards; and

(h) Raw milk and home-canned vegetables, meats, and fish must not be served or stored in a residential program.

(4) Safety: The residential program must meet the following safety requirements:

(a) At no time must the number of individuals served exceed the approved capacity;

(b) A written emergency plan must be developed and posted next to the telephone used by program staff and must include:

(A) Instructions for the program staff or designated resident in the event of fire, explosion, accident, death, or other emergency and the telephone numbers of the local fire department, law enforcement

agencies, hospital emergency rooms, and the residential program's designated physician and on-call back-up program staff;

(B) The telephone number of the administrator or clinical supervisor and other persons to be contacted in case of emergency; and

(C) Instructions for the evacuation of individuals and program staff in the event of fire, explosion, or other emergency.

(c) The residential program must provide fire safety equipment appropriate to the number of individuals served, and meeting the requirements of the State of Oregon Structural Specialty Code and Fire and Life Safety Regulations:

(A) Fire detection and protection equipment must be inspected as required by the State Fire Marshal;

(B) All flammable and combustible materials must be properly labeled and stored in the original container in accordance with the rules of the State Fire Marshal; and

(C) The residential program must conduct unannounced fire evacuation drills at least monthly. At least once every three months the monthly drill must occur between 10 p.m. and 6 a.m. Written documentation of the dates and times of the drills, time elapsed to evacuate, and program staff conducting the drills must be maintained.

(d) At least one program staff who is trained in First Aid and CPR must be onsite at all times; and

(e) In Residential Transition programs, at least one individual, designated by the administrator as being capable of managing emergencies and other situations that require immediate attention, must be onsite at all times when there is no onsite program staff coverage.

(5) Sanitation: The residential program must meet the following sanitation requirements:

(a) All floors, walls, ceilings, window, furniture, and equipment must be kept in good repair, clean, neat, orderly, and free from odors;

(b) Each bathtub, shower, hand-washing sink, and toilet must be kept clean and free from odors;

(c) The water supply in the residential program must meet the requirements of the rules of the Health Division governing domestic water supplies;

(d) Soiled linens and clothing must be stored in an area separate from kitchens, dining areas, clean linens and clothing and unrefrigerated food;

(e) All measures necessary to prevent the entry into the program of mosquitoes and other insects must be taken;

(f) All measures necessary to control rodents must be taken;

(g) The grounds of the program must be kept orderly and free of litter, unused articles, and refuse;

(h) Garbage and refuse receptacles must be clean, durable, water-tight, insect- and rodent proof and kept covered with a tight-fitting lid;

(i) All garbage solid waste must be disposed of at least weekly and in compliance with the rules of the Department of Environmental Quality; and

(j) Sewage and liquid waste must be collected, treated and disposed of in compliance with the rules of the Department of Environmental Quality.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

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### **309-032-1550**

#### **Transfer and Continuity of Care**

(1) Planned Transfer: Providers must meet the following requirements for planned transfer:

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

(b) For alcohol and other drug treatment services, planned transfer must be consistent with ASAM criteria established in the assessment;

(c) For ITS programs, planned transfer must be consistent with the transfer criteria established by the interdisciplinary team and documented in the ISSP. In addition:

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

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

(d) For DUII Alcohol and Other Drug Rehabilitation Programs, the balance, if any, of fees charged not paid by the individual.

(2) Transfer Process and Continuity of Care: Prior to transfer, providers must:

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

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

(c) Complete a Transfer Summary;

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

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

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

(g) Transfer in ITS programs: At a minimum, the provider's interdisciplinary team must:

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

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

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

(D) Include the parent, guardian and provider to which the child must be transitioned in transfer planning and reflect their needs and desires to the extent clinically indicated;

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

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

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

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

(3) Transfer Summary:

(a) A Transfer Summary must include:

(A) The date and reason for the transfer;

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

(C) Where appropriate, a plan for personal wellness and resilience, including relapse prevention; and

(D) Identification of resources to assist the individual and family, if applicable, in accessing recovery and resiliency services and supports.

(b) If the transfer is to services with another provider, all documentation contained in the Individual Service Record requested by the receiving provider must be furnished, compliant with applicable confidentiality policies and procedures, within 14 days of receipt of a written request for the documentation.

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

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.45

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

### **309-032-1555**

#### **Quality Assessment and Performance Improvement**

(1) Quality Assessment and Performance Improvement Process: 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.

(2) Quality Improvement Committee: The Quality Improvement Committee must oversee and advise the Quality Assessment and Performance Improvement process:

(a) The Quality Improvement Committee must include representatives of individuals served and their families; and

(b) The Quality Improvement Committee must meet at least quarterly to:

(A) Identify indicators of quality including:

(i) Access to services;

(ii) Outcomes of services;

(iii) Systems integration and coordination of services; and

(iv) Utilization of services.

(B) Review incident reports, emergency safety intervention documentation, 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 to ensure sustainability of improvements.

(3) Performance Improvement Plan: The quality assessment and performance improvement process must be documented in a Performance Improvement Plan including:

- (a) Performance objectives aimed at improving services; and
- (b) Strategies designed to meet the performance objectives and measure progress.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

### **309-032-1560**

#### **Grievances and Appeals**

(1) Any individual receiving services, or the parent or guardian of the individual receiving services, may file a grievance with the provider, the individual's managed care plan or the Division.

(2) For individuals whose services are funded by Medicaid, grievance and appeal procedures outlined in OAR 410-141-0260 through 410-141-0266, must be followed.

(3) For individuals whose services are not funded by Medicaid, providers must:

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

(b) Assist individuals and parents or guardians, as applicable, 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 person 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) Grievance Process Notice. The provider must have a Grievance Process Notice, which must be posted in a conspicuous place stating the telephone number of:

(a) The Division;

(b) The CMHP;

(c) Disability Rights Oregon; and

(d) The applicable managed care organization.

(5) Expedited Grievances: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these rules are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.

(6) Retaliation: A grievant, witness or staff member of a provider must 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) Immunity: 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) Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:

(a) If the individual or guardian, if applicable, 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 as applicable. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable;

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

(c) The CMHP Director or Division, must provide a written response within ten working days of the receipt of the appeal; and

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

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10

### **309-032-1565**

#### **Variations**

(1) Criteria for a Variance: Variations may be granted to a LMHA, CMHP or provider holding a certificate directly with the Division, by the Division:

(a) If there is a lack of resources to implement the standards required in these rules; or

(b) If implementation of the proposed alternative services, methods, concepts or procedures would result in improved outcomes for the individual.

(2) Application for a Variance:

(a) CMHPs and other providers may submit their variance request directly to the Division;

(b) Providers who hold Certificates of Approval jointly with CMHP's and the Division must submit their variance requests to the CMHP. The CMHP must then submit the variance request, along with the CMHP's written recommendation;

(c) The LMHA, CMHP or provider requesting a variance must submit a written application to the Deputy Director; and

(d) Variance requests must contain the following:

(A) The section of the rule from which the variance is sought;

(B) The reason for the proposed variance;

(C) The alternative practice, service, method, concept or procedure proposed;

(D) When the variance directly affects services provided, a description of the individual's opinion and participation in requesting the variance;

(E) A proposal for the duration of the variance; and

(F) A plan and timetable for compliance with the section of the rule for which the variance applies.

(3) Division Review and Notification: The Deputy Director of the Division must approve or deny the request for a variance and must notify the LMHA, CMHP or provider in writing of the decision to approve or deny the requested variance, within 30 days of receipt of the variance. The written notification must include the specific alternative practice, service, method, concept or procedure that is approved and the duration of the approval.

(4) Appeal Application: Appeal of the denial of a variance request must be made in writing to the Director of the Division, whose decision will be final and must be provided in writing within 30 days of receipt of the appeal.

(5) Written Approval: The LMHA, CMHP or provider may implement a variance only after written approval from the Division.

(6) Duration of Variance: It is the responsibility of the LMHA, CMHP or the provider to submit a request to extend a variance in writing prior to a variance expiring. Extension must be approved in writing by the Division.

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

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10