Authorization Page

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TEMPORARY ADMINISTRATIVE RULES

Oregon Health Authority, Health Systems Division: Mental Health Services	309
Agency and Division	**Administrative Rules Chapter Number**
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Upon filing.	
Adopted on	
01/18/2017 thru 07/16/2017	
Effective dates	

RULE CAPTION

Temporary amendments to OAR 309-019 titled Behavioral Health Treatment Services.

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND:

309-019-0226, 309-019-0235, 309-019-0242, 309-019-0248, 309-019-0250, 309-019-0270, 309-019-0225, 309-019-0275, 309-019-0280, 309-019-0285, 309-019-0290, 309-019-0295, 309-019-0151, 309-019-0150

NR 1-17-17

NR ~~SUSPEND:~~

Stat. Auth.: ORS 413.042

Other Auth.:

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

RULE SUMMARY

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

In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980

and 943-120-0000 through 943-120-1550, these rules specify standards for behavioral health treatment services and supports provided in:

(1) Outpatient Community Mental Health Services and Supports for Children and Adults;
(2) Outpatient Substance Use Disorders Treatment Services; and
(3) Outpatient Problem Gambling Treatment Services.

STATEMENT OF NEED AND JUSTIFICATION

Temporary amendments to OAR 309-019 titled Behavioral Health Treatment Services.

In the Matter of

Other administrative rules cited within these rules can be accessed on the website of the Oregon State Archives.

Statutes cited within these rules can be accessed on the website of the Oregon State Legislature.

Documents Relied Upon, and where they are available

The rules being amended detail the staffing, services, operational standards, Fidelity requirements, and other issues related to two treatment programs which are relatively new in Oregon: Assertive Community Treatment and Supported Employment.

Need for the Temporary Rule(s)

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and to Medicaid recipients eligible for ACT and Supported Employment services. These rules need to be adopted promptly so that the Authority may detail their expectations of the providers of those services.

Justification of Temporary Rules

Karen Wheeler | Karen Wheeler | 1/17/17

Authorized Signer | Printed Name | Date

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

OREGON HEALTH AUTHORITY,
HEALTH SYSTEMS DIVISION

DIVISION 19

BEHAVIORAL HEALTH TREATMENT SERVICES

309-019-0150

Outpatient Mental Health Services to Children and Adults

(1) 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 within one hour of notification of the crisis event 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, an assessment resulting in a Service Plan that includes the crisis services necessary to assist the individual and family to stabilize and transition to the appropriate level of care.

(2) Available case management services must be provided, 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; and

(b) Referral and coordination to help individuals gain access to services and supports identified in the Service Plan;

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

(4) Peer Delivered Services must be made available.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

309-019-0151

Mobile Crisis Services

(1) The effectiveness of Mobile Crisis Services in de-escalating a crisis and diverting hospitalization or arrest is enhanced by team members competent in performing an assessment and delivering an

effective course of intervention. These services provide access to a multi-disciplinary support team, ready resources such as access to urgent appointments, brief respite services and the ability to provide brief follow-up care when indicated. Effective mobile crisis services are those that planned and delivered with local stakeholders. Mobile crisis programs shall be developed in coordination with the Local Public Safety Coordinating Council as outlined in ORS § 423.560.

(2) CMHP shall provide Mobile Crisis Services as a component of crisis services according to OAR 309-019-0150 for individuals experiencing mental health crisis within their respective geographic service area to meet the following objectives:

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

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

(3) CMHP shall provide Mobile Crisis Services including, but not limited to:

(a) 24 hours a day, 7 days a week screening to determine the need for immediate services for any individual requesting assistance or for whom assistance is requested;

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

(c) Services that are generally delivered in a natural environment by or under the supervision of a QMHP, such as QMHAs and peers, and resulting in a Service Plan. Disposition of services shall maintain as the primary goal, with diversion from hospitalization and incarceration through clinically appropriate community-based supports and services;

(d) Eliminating the need for transportation (frequently by law enforcement officers or emergency services) to a hospital emergency department or a community crisis site;

(e) Are not intended to be restricted to services delivered in hospitals or at residential programs;

(f) Mental Health crisis assessment;

(g) Brief crisis intervention;

(h) Assistance with placement in crisis respite or residential services;

(i) Initiation of commitment process if applicable;

(j) Assistance with hospital placement; and,

(k) Connecting individuals with ongoing supports and services.

(4) County shall track and report response time. County shall respond to crisis events in their respective geographic service area with the following maximum response times:

(a) Counties classified as “urban” shall respond within one (1) hour.

(b) Counties classified as “rural” shall respond within two (2) hours.

(c) Counties classified as “frontier” shall respond within three (3) hours.

(d) Counties classified as “rural” and “frontier” shall contact an individual experiencing a crisis event via telephone by a staff member who is trained in crisis management (such as a person from a crisis line or a peer) within one (1) hour of being notified of the crisis event.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

Assertive Community Treatment (ACT)

Definitions

309-019-0225

(1) In addition to the definitions identified in OAR 309-019-0105, the definitions below apply to this and subsequent rule sections.

(2) “Collateral Contacts” are members of the individual’s family or household, or significant others (e.g. landlord, employer, etc.) who regularly interact with the individual and are directly affected by or have the capability of affecting his or her condition, and are identified in the treatment plan as having a role in the individual’s recovery. For the purpose of the Assertive Community Treatment (ACT) program, a collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g. meeting with a shelter staff who is assisting an ACT recipient in locating housing).

(3) “Community-based” means that services and supports must be provided in a participant’s home and surrounding community and not solely based in a traditional office-setting.

(a) ACT services may not be provided to individuals residing in an RTF or RTH licensed by HSD unless:

(A) The individual is not being provided rehabilitative services; or

(B) The individual has been identified for transition to a less intensive level of care. When identified for transition to a less intensive level of care, the individual may receive ACT services for up to six months prior to discharge from the RTH or RTF.

(4) “Competency” means one year of experience or training in the specialty area and demonstration of the specific skills or knowledge.

(5) “Competitive Integrated Employment” means full-time or part time work: at minimum wage or higher, at a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skill; with eligibility for the level of benefits provided to other employees; at a

location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(6) "Comprehensive Assessment" means the organized process of gathering and analyzing current and past information with each individual and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and, 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity, personal/professional roles, talents, personal traits) that can act as resources to the individual and his/her recovery planning team in pursuing goals. The results of the information gathering and analysis are used to: 1) establish immediate and longer-term service needs with each individual; 2) set goals and develop the first person directed recovery plan with each individual; and, 3) optimize benefits that can be derived from existing strengths and resources of the individual and his/her family and/or natural support network in the community.

(7) "Co-Occurring Disorders (COD) Services" include integrated assessment and treatment for individuals who have co-occurring mental health and substance use condition.

(8) "Division approved reviewer" means the Oregon Center of Excellence for Assertive Community Treatment (OCEACT). OCEACT is the Division's contracted entity that is responsible for conducting ACT fidelity reviews, training, and technical assistance to support new and existing ACT programs statewide.

(9) "Fidelity" for the purposes of the ACT program means the provider is providing services that are faithful to the evidence-based practice model and obtains a satisfactory score from the Oregon Center of Excellence for ACT as part of the their regular reviews.

(10) "Fixed point of responsibility" means the ACT team itself provides virtually all needed services, rather than sending clients to different providers. If the team cannot provide a service (e.g. dental services) the team ensures that the service is provided.

(11)"Full-Time Equivalent" (FTE) for the purpose of ACT services is a way to measure how many full-time employees are required to provide the appropriate level of services to fulfill minimum fidelity requirements.

(12) "Hospital discharge planning" for the purposes of the ACT program means a process that begins upon admission to the Oregon State Hospital and that is based on the presumption that with sufficient supports and services, all individuals can live in an integrated community setting. Discharge planning is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on principles of self-determination. Discharge planning teams at OSH include a representative of a community mental health provider from the county where the individual is likely to transition.

(13) "Individual Placement and Support (IPS) Supported Employment ~~Services "~~Services" are individualized services that assist individuals to obtain and maintain integrated, paid, competitive

employment. Supported employment services are provided in a manner that seeks to allow individuals to work the maximum number of hours consistent with their preferences, interests and abilities and are individually planned, based on person-centered planning principles and evidence-based practices.

(14) "Individual Treatment Team (ITT)" is a group or combination of three to five ACT team staff members who together have a range of clinical and rehabilitation skills and expertise. The core members are the case manager, the psychiatrist or psychiatric nurse practitioner, one clinical or rehabilitation staff person who backs up and shares case coordination tasks and substitutes for the service coordinator when he or she is not working, and a Peer Support and Wellness Specialist. The individual treatment team has continuous responsibility to: 1) be knowledgeable about the individual's life, circumstances, goals and desires; 2) collaborate with the client to develop and write the treatment plan; 3) offer options and choices in the treatment plan; 4) ensure that immediate changes are made as an individual's needs change; and 5) advocate for the client's wishes, rights, and preferences.

(15) "Initial Assessment and Individualized Treatment Plan" as it pertains to the ACT program is the initial evaluation of: 1) the individual's mental and functional status; 2) the effectiveness of past treatment; and 3) the current treatment, rehabilitation, and support service needs. The results of the information gathering and analysis are used to establish the initial treatment plan to support recovery and help the individual achieve his or her goals.

(16) "Large ACT Team" means an ACT team serving 80 ~~tp~~ to 120 individuals.

(17)"Life skills training" means training that help individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

(18) "Medication Management" is the prescribing and/or administering and reviewing of medications and their side effects, includes both pharmacological management as well as supports and training to the individual. For the purposes of Assertive Community Treatment (ACT), medication management is a collaborative effort between the individual receiving services and the prescribing psychiatrist or psychiatric nurse practitioner with the ACT treatment team.

(19) "Mid-Size Act Team" means and ACT team serving between 41 and 79 individuals.

(20) "Natural Supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships; friendships reflecting the diversity of the neighborhood and the community; association with fellow students or employees in regular classrooms and work places; and associations developed though participation in clubs, organizations, and other civic activities.

(21) "Psychiatry services" for the purposes of the ACT program in Oregon means the prescribing and/or administering and reviewing of medications and their side effects, includes both pharmacological management as well as supports and training to the individual. Psychiatry services must be provided by a psychiatrist or a psychiatric nurse practitioner who is licensed by the Oregon Medical Board.

(22) “Single Point of Contact” (SPOC) is a designated individual(s) in a service region that is responsible for coordinating, tracking referrals to ACT programs within their geographic service area.

(23) “Small ACT Team” means an ACT team serving between ten (10) to 40 individuals.

(24) “Symptom management” means to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment.

(25) “Tele psychiatry” as it pertains to the ACT program means the application of telemedicine to the specialty field of psychiatry. The term typically describes the delivery of psychiatric assessment and care through telecommunications technology, usually videoconferencing.

(26) “Time-unlimited services” means services are provided not on the basis of predetermined timelines but as long as they are medically appropriate.

(27) “Vocational services” for the purposes of the ACT program in Oregon means employment support services that will lead to competitive integrated employment. The Division encourages the use of fidelity IPS Supported Employment for providing vocational services within the ACT program.

(28) “Warm Handoff” means the process of transferring an individual from one provider to another, prior to discharge, which includes face-to-face meeting(s) with an individual, and which coordinates the transfer of responsibility for the individual’s ongoing care and continuing treatment and services.

A warm handoff shall either (a) include a face-to-face meeting with the community provider and the individual, and if possible, hospital staff, or (b) provide a transitional team to support the individual, serve as a bridge between the hospital and the community provider, and ensure that the individual connects with the community provider.

For warm handoffs under subparagraph (b), the transitional team shall meet face to face with the individual, and if possible, with hospital staff, prior to discharge. Face-to-face in person meetings are preferable for warm handoffs. However, a face-to-face meeting may be accomplished through technological solutions that provide two-way video-like communication on a secure line (“telehealth”), when either distance is a barrier to an in person meeting or individualized clinical criteria support the use of telehealth.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

~~OAR~~ **309-019-0226**

Assertive Community Treatment (ACT) Overview

(1) The Substance Abuse and Mental Health Services Administration (SAMHSA) characterizes ACT as an evidence-based practice for individuals with a serious and persistent mental illness. ACT is characterized by:

(a) A team approach;

(b) Community based;

(c) A small client to staff caseload, typically 10:1, to consistently provide necessary staffing diversity and coverage;

(d) Time-unlimited services;

(e) Flexible service delivery;

(f) A fixed point of responsibility; and

(g) 24/7 availability for response to psychiatric ~~crisis .~~ crisis.

(2) ACT services must include, but are not limited to:

(a) Hospital discharge planning;

(b) Case management;

(c) Symptom management;

(d) Psychiatry services;

(e) Nursing services;

(f) Co-occurring substance use and mental health disorders treatment services;

(g) Individual Placement and Support (IPS) supported employment services;

(h) Life skills training; and

(i) Peer support services.

(2) SAMHSA characterizes a high fidelity ACT Program as one that includes the following staff members:

(a) Psychiatrist or Psychiatric Nurse Practitioner;

(b) Psychiatric Nurse(s);

(c) Qualified Mental Health Professional (QMHP) ACT Team Supervisor;

(d) Qualified Mental Health Professional(s) (QMHP) Mental Health Clinician;

(e) Substance Abuse Treatment Specialist;

(f) Employment Specialist;

(g) Mental Health Case Manager(s); and

(h) Certified Peer Support Specialist(s).

(3) SAMHSA characterizes high fidelity ACT Programs as those that adhere to the ~~following~~ ~~:~~following:

(a) Provision of explicit admission criteria with an identified mission to serve a particular population utilizing quantitative and operationally defined criteria;

(b) Manage intake rates: ACT eligible individuals are admitted to the program at a low rate to maintain a stable service environment;

(c) Maintain full responsibility for treatment services which includes, at a minimum, the services required under OAR 309-019-0230(2)(a)-(i);

(d) Twenty four-hour responsibility for covering psychiatric crises;

(e) Involvement in psychiatric hospital admissions;

(f) Involvement in planning for hospital discharges; and

(g) As long as medically appropriate, ~~T~~time-unlimited services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

309-019-0235

Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0230, in order to maintain an ACT provider designation on the Division issued certificate, a provider must submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 114.

~~(2) Providers certified to provide ACT services under this rule that achieve a fidelity score of 128 or better when reviewed by the Division Approved ACT Reviewer are eligible to extend their fidelity review period to every 18 months.~~

(a) Extension of ~~Fidelity reviews~~a certification period has no bearing on the frequency or scope of fidelity reviews or re-certification reviews required under OAR 309-008.

(~~3~~2) Fidelity reviews will be conducted utilizing the Substance Abuse and Mental Health Services ACT Toolkit Fidelity Scale, which will be made available to providers electronically

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-

430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

309-019-0242

ACT Program Operational Standards

(1) Hours of operation. All ACT teams must be available seven days a week, 24 hours a day by direct phone link and regularly accessible to individuals who work or who are involved in other scheduled vocational or rehabilitative services during the daytime hours. ACT teams may utilize split staff assignment schedule to achieve coverage.

(2) Crisis intervention. ACT teams are primarily responsible for crisis response and for after-hours calls related to individuals they serve. The ACT team must operate continuous and direct after-hours on-call system with staff experienced in the program and skilled in crisis intervention procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone. To ensure direct access to the ACT team, recipients must be given a phone list with the responsible ACT staff to contact after hours.

(3) Service Intensity

(a) The ACT team must have the capacity to provide the frequency and duration of staff-to-recipient contact required by each recipient's individualized service plan and their immediate needs;

(b) The ACT team must provide a minimum of 40% of all services in-community as demonstrated by the average in-community encounters reviewed in case record reviews;

(c) The ACT team must have the capacity to increase and decrease contacts based upon daily assessment of the individual's clinical need, with a goal of maximizing independence;

(d) The team must have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse;

(e) The ACT team must have the capacity to provide support and skills development services to individuals' natural supports and collateral contacts;

(f) Natural supports and collateral contacts may include family, friends, landlords, or employers, consistent with the service plan. Natural supports and collateral contacts are typically not supports that are paid for services;

(g) The ACT team Psychiatrist and the Psychiatric Nurse Practitioner (PNP) must have scheduling flexibility to accommodate individual needs. If the individual will not come to meet the Psychiatrist and/or the PNP at the ACT office, the Psychiatrist and/or PNP must provide services as clinically indicated for that individual in the community. Secure ~~telepsychiatry~~tele psychiatry is also acceptable when clinically indicated;

(h) The ACT team must have the capacity to provide services via group modalities as clinically appropriate; e.g. for individuals with substance abuse disorders, and for family psychoeducation and wellness self-management services.

(4) ACT Staffing Requirements. An ACT team shall have sufficient staffing to meet the varying needs of individuals. As an all-inclusive treatment program, a variety of expertise must be represented on the team. ACT team staffing is to be clearly defined and dedicated to the operation of the team.

(5) Staffing Guidelines for ACT teams:

(a) A single ACT team cannot serve more than 120 individuals unless:

(A) It is expanding for the expressed purpose of splitting into two ACT teams within a 12 month period; and

(B) Also hires the appropriate staff to meet the required 1:10 staff to individuals served ratio.

(b) ACT team individual to clinical staff ratio cannot exceed 10:1;

(c) ACT team staff must be comprised of individual staff members in which a portion or all of their job responsibilities are defined as providing ACT services;

(d) Other than for coverage when a staff member has a leave of absence, ACT teams shall not rotate staff members into the ACT team that are not specifically assigned to the team as part of their position's job responsibilities;

(6) Minimum ACT team staffing requirements: No individual ACT staff member should be assigned less than .20 FTE for their role on the team unless filling the role of Psychiatrist or PNP. The ACT team psychiatrist or PNP who should not be assigned less than .10 FTE).

(7) Maximum ACT team staffing requirements: ACT teams will not exceed the following upper staffing limits:

(a) No more than eight (8) individual staff members per small ACT team;

(b) No more than 12 individual staff member per mid-size ACT team.

(b) No more than 18 individual staff members per large ACT team.

(8) ACT team staffing is multi-disciplinary. The core minimum staffing for an ACT team includes:

(a) Team Leader: This position is to be occupied by only one person. The team leader is a QMHP level clinician qualified to provide direct supervision to all ACT staff except the psychiatric care provider and nurse. Per the table in 309-019-0242 (13), the Team Leader FTE is dictated by the number of individuals served by ~~eh~~ the ACT team. ~~as follows~~:

~~(A) Small ACT teams: .5 FTE;~~

~~(B) Mid-sized ACT teams: 1.0 FTE; and~~

~~(C) Large ACT teams: 1.0 FTE~~

(b) Per the table in 309-019-0242 (11), Psychiatric Care Provider (Psychiatrist or PNP) FTE is dictated by the number of individuals served by ~~eh~~ the ACT team ~~as follows:~~.

~~(A) Small ACT teams: Minimum Psychiatric Care Provider FTE is .10 staffing 4 hours each week for 10 ACT individuals and should reflect the equivalent of 1.0 FTE per 100 clients as the number of individuals increases, e.g. .20 FTE for 20 individuals; .35 FTE for 35 individuals; .40 FTE for 40 individuals;~~

~~(B) Mid-sized ACT teams: Minimum Psychiatric Care Provider FTE is .40 FTE staffing 16 hours each week and should reflect the equivalent of 1.0 FTE per 100 individuals as the number of individuals increases FTE; and~~

~~(C) Large ACT teams: Minimum Psychiatric Care Provider FTE is .80 FTE staffing 32 hours each week and should reflect the equivalent of 1.0 FTE per 100 individuals as the number of individuals increases~~

(c) Per the table in 309-019-0242 (11), the ~~N~~nurse FTE is dictated by the number of individuals served by ~~eh~~ the ACT team. ~~as follows:~~

~~(A) Small ACT teams: Minimum Nurse FTE is .20 FTE for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases;~~

~~(B) Mid-sized ACT teams: Minimum Nurse FTE is .80 FTE for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases; and~~

~~(C) Large ACT teams: Minimum Nurse FTE is 1.60 FTE for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases.~~

(d) The ~~P~~Program Administrative Assistant FTE is not counted in the clinical staff ratio.

(9) Other clinical staff to achieve minimum staffing per ACT team model. ACT team minimum staffing must include clinical staff with the following FTE and specialized competencies:

(a) Per the table in 309-019-0242 (11), the Substance Abuse Specialist FTE is dictated by the number of individuals served by the ACT team as follows:

~~(A) Small ACT teams: Minimum Substance Abuse Specialist FTE is 20 FTE SAS time for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases;~~

~~(B) Mid-sized ACT teams: Minimum Substance Abuse Specialist FTE is .80 FTE SAS time for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases; and~~

~~(C) Large ACT teams: Minimum Substance Abuse Specialist FTE is 1.60 FTE SAS time for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases;~~

(D) Substance Abuse Specialist specialized competencies must include:

(i) Substance abuse assessment and substance abuse diagnosis

(ii) Principles and practices of harm reduction

(iii) Knowledge and application of motivational interviewing strategies

(b) Per the table in 309-019-0242 (11), the Employment Specialist FTE is dictated by the number of individuals served by the ACT team. ~~as follows:~~

~~(A) Small ACT teams: Minimum Employment Specialist FTE is 20 FTE SAS time for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases;~~

~~(B) Mid-sized ACT teams: Minimum Employment Specialist FTE is .80 FTE SAS time for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases; and~~

~~(C) Large ACT teams: Minimum Employment Specialist FTE is 1.60 FTE for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases;~~

(~~D~~A) Employment Specialist specialized competencies must include:

(i) Competent in the IPS Supported Employment fidelity model;

(ii) Vocational assessment;

(iii) Job exploration and matching to recipient's interest and strengths;

(iv) Skills development related to choosing, securing, and maintaining employment;

(c) Per the table in 309-019-0242 (11), the Peer Support and Wellness Specialist FTE is dictated by the number of individuals served by the ACT ~~team as follows~~team.:

~~(A) Small ACT teams: Minimum Peer Support and Wellness Specialist FTE is 20 FTE for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases;~~

~~(B) Mid-sized ACT teams: Minimum Peer Support and Wellness Specialist FTE is .80 FTE for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases; and~~

~~(C) Large ACT teams: Minimum Peer Support and Wellness Specialist FTE is 1.60 FTE for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 individuals as the number of individuals increases;~~

(~~D~~A) Employment Specialist specialized competencies must include:

(i) Trained by an OHA Approved Peer Support Specialist or Peer Wellness Specialist Training Program as described in OAR 410-180-0300 - 410-180-0380. A directory of Approved Peer Support Specialist

or Peer Wellness Specialist Training Programs can be found at Division's Peer Delivered Services website; and

(ii) Be an OHA Office of Equity and Inclusion (OEI) Certified Peer Support Specialist or Peer Wellness Specialist before providing ACT services.

(10) ACT Team Staffing Core Competencies.

(a) At hire, all clinical staff on an ACT team must have experience in providing direct services related to the treatment and recovery of individuals with a serious and persistent mental illness. Staff should be selected consistent with the ACT core operating principles and values. Clinical staff should have demonstrated competencies in clinical documentation and motivational interviewing;

(b) All staff will demonstrate basic core competencies in designated areas of practice, including the Assertive Community Treatment core principles, integrated mental health and substance abuse treatment, supported employment, psycho-education and wellness self-management;

(c) All staff must complete ACT receive ACT 101 training from the Division approved reviewer prior to receiving HSD provisional certification; and

(d) All professional ACT team staff must have obtained the appropriate licensure to provide services in Oregon for their respective area of specialization.

(11) ACT Team Size Staff (FTE) to Individual Ratio Table:

	Small or Micro Team (10 to 40 individuals)	Mid-size team (between 41 and 79 individuals)	Large Team (80-120 individuals)
Staff to individual ratio: includes all team members except the psychiatric care provider and program assistants	1 team member per 10 individuals	1 team member per 10 individuals	1 team member per 10 individuals
Team Leader: This position is to be occupied by only one person. The team leader is a QMHP level clinician qualified by OARs to provide direct supervision to all ACT staff (except psychiatric care provider and nurse)	One team leader (.50 FTE to 1.0 FTE)	One full-time team leader (1.0 FTE)	One full-time team leader (1.0 FTE)
Psychiatric Care Provider: (Psychiatrist or Psychiatric Nurse Practitioner) Prorating of FTE allowed given number of individuals served. No more than two psychiatric care providers per ACT team	Minimum FTE is .10 (4 hours each week) for 10 ACT participants and should reflect the equivalent of 1.0 FTE per 100 clients as the number of individuals increases (.20 FTE for 20 individuals; .35 FTE for 35 individuals; .40 FTE for 40 individuals)	Minimum FTE is .40 FTE (16 hours each week) and should reflect the equivalent of 1.0 FTE per 100 clients as the number of individuals increases	Minimum FTE is .80 FTE (32 hours each week) and should reflect the equivalent of 1.0 FTE per 100 clients as the number of individuals increases
Nurses: Registered Nurses (RN) or Advanced Practice Registered	Minimum of .20 FTE RN time for 10 individuals,	Minimum of .80 FTE RN time for 40 individuals,	Minimum of 1.60 FTE RN time for 80 individuals, and

Nurse (APRN) may fill this position. Prorating of FTE allowed given number of individuals actually served.	and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.	and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.	should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.
Substance Abuse Specialist (SAS): QMHP or QMHA with a minimum of one year experience providing substance abuse treatment services (CADC 1 or above preferred to meet this credential)	Minimum of .20 FTE SAS time for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.	Minimum of .80 FTE SAS time for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.	Minimum of 1.60 FTE SAS time for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.
Peer Specialist: An Oregon certified peer support specialist who has a mental health diagnosis themselves for which they have received treatment and is willing to self-disclose their lived experience	Minimum FTE is .10. FTE is flexible based on peer preference and staffing needs of the ACT team.	Minimum FTE is .40. FTE is flexible based on peer preference and staffing needs of the ACT team. More than one peer may perform this role.	Minimum FTE is .80. FTE is flexible based on peer preference and staffing needs of the ACT team. More than one peer may perform this role.
Vocational Specialist: QMHP or QMHA with one year experience providing employment services that focus on competitive employment outcomes..	Minimum of .20 FTE SA time for 10 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.	Minimum of .80 FTE SA time for 40 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.	Minimum of 1.60 FTE SA time for 80 individuals, and should reflect the equivalent of 2.0 FTE per 100 clients as the number of individuals increases.
Program Administrative Assistant A program office manager or administrative assistant is highly recommended to be dedicated to the ACT team	.50 FTE ACT dedicated office manager/administrative assistant is highly recommended	.50 - 1.0 FTE ACT dedicated office manager/administrative assistant is highly recommended	1.0 FTE ACT dedicated office manager/administrative assistant is highly recommended
Additional Staff (QMHP and or QMHA level mental health clinicians, housing specialists, case managers) to meet the ACT fidelity ratio of 1 staff for 10 individuals served	0-2.5 additional FTE may be required to meet the 1:10 staff to individual ratio and provide comprehensive services ACT recipients need	0-4.0 additional FTE may be required to meet the 1:10 staff to individual ratio and provide comprehensive services ACT recipients need	1-6.0 additional FTE may be required to meet the 1:10 staff to individual ratio and provide comprehensive services ACT recipients need

(~~11~~12) ACT Team meetings. The ACT team shall conduct daily organizational staff meetings at least four (4) days per week and regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:

(a) The ACT team shall maintain in writing:

(A) A roster of the individuals served in the program; and

(B) For each individual, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the individual's status that day;

(b) The daily organizational staff meeting includes a review of the treatment contacts which occurred the day before and provides a systematic means for the team to assess the day-to-day progress and status of all clients.

(c) During the daily organizational staff meeting, the ACT team shall also revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.

(~~12~~13) Treatment planning meetings. The ACT team shall conduct treatment planning meetings under the supervision of the team leader and the Psychiatrist or PNP. These treatment planning meetings shall:

(a) Convene at regularly scheduled times per a written schedule set by the team leader;

(b) Occur and be scheduled when the majority of the team members can attend, including the psychiatrist or psychiatric nurse practitioner, team leader, and all members of the treatment team;

(c) Require individual staff members to present and systematically review and integrate an individual's information into a holistic analysis and prioritize problems; and

(d) Occur with sufficient frequency and duration to make it possible for all staff to:

(A) Be familiar with each individual and their goals and aspirations;

(B) Participate in the ongoing assessment and reformulation of problems;

(C) Problem-solve treatment strategies and rehabilitation options;

(D) Participate with the individual and the treatment team in the development and the revision of the treatment plan; and

(E) Fully understand the treatment plan rationale in order to carry out each individual's plan.

(1~~3~~4) ACT Assessment and Individualized Treatment Planning.

(a) An initial assessment and treatment plan is completed upon each individual's admission to the ACT program; and

(b) Individualized treatment plans for ACT team served individuals must be updated at least every six (6) months.

(1~~4~~5) Service Note Content.

(a) More than one intervention, activity, or goal may be reported in one service note, if applicable.

(b) ACT team staff must complete a service note for each contact or intervention provided to an individual. Each service note must include all of the following:

(A) Individual's name;

(B) Medicaid identification number or client identification number;

(C) Date of service provision;

(D) Name of service provided;

(E) Type of contact;

(F) Place of service;

(G) Purpose of the contact as it relates to the goal(s) on the individual's Treatment Plan;

(H) Description of the intervention provided. Documentation of the intervention must accurately reflect substance abuse related treatment for the duration of time indicated;

(I) Duration of service: Amount of time spent performing the intervention;

(J) Assessment of the effectiveness of the intervention and the Individual's progress towards the individual's goal;

(K) Signature and credentials or job title of the staff member who provided the service; and

(L) Each service note page must be identified with the beneficiary's name and client identification number.

(c) Documentation of discharge or transition to lower levels of care must include all of the following:

(A) The reasons for discharge or transition as stated by both the individual and the ACT team;

(B) The Individual's biopsychosocial status at discharge or transition;

(C) A written final evaluation summary of the Individual's progress toward the goals set forth in the Person Centered Treatment Plan;

(D) A plan for follow-up treatment, developed in conjunction with the Individual; and

(E) The signatures of the individual, the team leader, and the Psychiatrist or PNP.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

309-019-0248

Admission Process

(1) A comprehensive assessment as described in OAR 309-019-0105(6) that demonstrates medical appropriateness must be completed prior to the provision of this service. If a substantially equivalent assessment is available, that reflects current level of functioning, and contains standards consistent with OAR 309-019-0135, to include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services, the equivalent assessment may be used to determine admission eligibility for the program.

(2) Admission to ACT is managed through a referral process that is coordinated by a designated single point of contact (SPOC) that represents the Coordinated Care Organization's (CCO) and/or Community Mental Health Program's (CMHP) geographical service area.

(a) The designated single point of contact shall accept referrals and verify the required documentation supports the referral for services when an approximate, reasonable date of admission to the ACT program is anticipated~~.~~.

(b) OHA will work with the CCOs and the CMHPs to identify regional SPOCs.

(c) OHA will work with the CCOs and the CMHPs to identify a process where referrals can be received and tracked.

(3) An admission decision by the designated SPOC must be completed and reported to the Division within seven (7) business days of receiving the referral. To accomplish this, the SPOC must be fully informed as to the current capacity of ACT programs within the SPOC's geographic service area at all times.

(4) All referrals for ACT services must be submitted through the designated regional SPOC, regardless of the origin of the referral when an approximate, reasonable date of admission to the ACT program is anticipated. The designated regional SPOC shall accept and evaluate referrals from mental health outpatient programs, residential treatment facilities or homes, families and/or individuals, and other referring sources.

(5) Given the severity of mental illness and functional impairment of individuals who qualify for ACT-level services, the final decision to admit a referral rests with the provider. Any referral to a provider should therefore present a full picture of the individual by means of the supporting medical documentation attached to the OHA Universal ACT Referral and Tracking Form and include an approximate date the referred individual will be able to enroll in an ACT program. An admission decision by the ACT services provider must be completed within five (5) business days of receiving the referral.

(a) The individual's decision not to take psychiatric medication is not a sufficient reason for denying admission to an ACT program.

(b) ACT capacity in a geographic regional service area is not a sufficient reason for not providing ACT services to an ACT eligible individual. If an individual who is ACT eligible cannot be served due to capacity, the SPOC must provide individual with the option of being added to a waiting list until such time the ACT eligible individual can be admitted to a ~~qualified~~ certified ACT program.

(A) The ACT eligible individual who is not accepted into an ACT program due to capacity will be offered alternative community-based rehabilitative services as described in the Oregon Medicaid State Plan which includes evidence-based practices to the extent possible.

(B) Alternative rehabilitative services will be made available to the individual:

(i) Until the individual is admitted into an ACT program;

(ii) Alternative rehabilitative services are medically appropriate and meet the individual's treatment goals; or

(iii) The individual refuses alternative medically appropriate rehabilitative services.

(6) Upon the decision to admit an individual to the ACT program, the OHA Universal ACT Referral and Tracking Form shall be updated, to include:

(a) An admission is indicated.

(b) When an admission is not indicated, notation shall be made of the following:

(A) The reason(s) for not admitting;

(B) The disposition of the case; and

(C) Any referrals or recommendations made to the referring agency, as appropriate.

(7) Individuals who meet admission criteria and are not admitted to an ACT program due to program capacity, may elect to be placed on a waiting list. The waiting list will be maintained by the appropriate regional SPOC. OHA will monitor each regional waiting list until sufficient ACT program capacity is developed to meet the needs of the ACT eligible population.

(8) In addition if an individual is denied ACT services and has met the admission criteria set forth in OAR 309-019-045, the individual who is denied services or their guardian may appeal the decision by filing a grievance in the manner set forth in OAR 309-008-1500.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

309-019-0250

Transition to Less Intensive Services and Discharge

(1) Transition to less intensive services shall occur when the individual no longer requires ACT level of care and is no longer medically appropriate for ACT services. This shall occur when individuals receiving ACT:

(a) Have successfully reached individually established goals for transition.

(b) Have successfully demonstrated an ability to function in all major role areas (i.e. work, social, ~~self~~and self-care) without ongoing assistance from the ACT provider;

(c) When the individual requests discharge, declines, or refuses services; and

(d) When the individual moves outside of the geographic area of the ACT program's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT provider or another provider wherever the individual is moving. The ACT team shall maintain contact with the individual until this service is implemented.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Individual Placement and Support (IPS) Supported Employment Services

309-019-0270

Definitions

(1) "Competitive Integrated Employment" means full-time or part time work: at minimum wage or higher, at a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skill; with eligibility for the level of benefits provided to other employees; at a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(2) "Division Approved Reviewer" means the Oregon Supported Employment Center for Excellence (OSECE). OSECE is the Division's contracted entity that is responsible for conducting IPS Supported ~~Employment fidelity~~Employment fidelity reviews, training, and technical assistance to support new and existing IPS Supported Employment programs statewide.

(3) "Fidelity" for the purposes of the IPS Supported Employment program means the provider is providing services that are faithful to the evidence-based practice model and obtains a satisfactory score from the Oregon Supported Employment Center for Excellence for IPS Supported Employment as part of the their regular reviews.

(4) "Vocational services" for the purposes of the ACT program in Oregon means employment support services that will lead to competitive integrated employment. The Division encourages the use of fidelity IPS Supported Employment for providing vocational services within the ACT program.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

309-019-0275

Individual Placement and Support (IPS) Supported Employment Overview

(1) Supported Employment is an evidence-based practice for individuals with serious mental illness.

(2) Supported Employment is characterized by:

(a) Emphasis on competitive employment;

(b) Every person who is interested in work is eligible for services regardless of symptoms, substance use disorders, treatment decisions, or any other issue;

(c) Employment services are integrated with mental health treatment;

(d) Individuals have access to personalized benefits planning;

(e) Job search begins soon after a person expresses interest in working; and

(f) Client preferences for jobs, and preferences for service delivery, are honored.

(3) Supported Employment services include, but are not limited to:

(a) Job development;

(b) Supervision and job training;

(c) On-the-job visitation;

(d) Consultation with the employer;

(e) Job coaching;

(f) Counseling;

(g) Skills training; and/or

(h) Transportation.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

309-019-0280

Supported Employment Providers

(1) In order to be eligible for Medicaid or State General Fund reimbursement, Supported Employment services shall be provided only by those providers meeting the following minimum qualifications:

(a) The provider must hold and maintain a current certificate under OAR 309-008, issued by the Division, for the purpose of providing behavioral health treatment services; and

(b) The provider must hold and maintain a current certificate, issued by the Division, under OAR 309-019-0225 through 309-019-026055 OAR 309-019-for the purpose of providing Assertive Community Treatment; and

(c) A provider certified to provide Supported Employment services under this rule must be reviewed annually for fidelity adherence by the Division approved reviewer and achieve a minimum score of 100 on the fidelity scale. Providers shall not bill Medicaid or use General Funds unless they are subject to an annual fidelity review by the Division approved reviewer.

(A) The Division approved reviewer shall forward a copy of the annual fidelity review report to the Division approved reviewer and provide a copy of the review to the provider.

(B) The provider shall forward a copy of the annual fidelity review report to the appropriate CCO. (1) To be eligible for Medicaid reimbursement, Supported Employment services must be provided by a Certified Supported Employment Provider.

(2) A Provider already holding a certificate of approval under OAR 309-008 may request the addition of ACT services be added to their certificate of approval via the procedure outlined in OAR 309-008-0400 and 309-008-1000(1).

(a) In addition to application materials required in OAR 309-008 and this rule, the provider must also submit to the Division a letter of support which indicates receipt of technical assistance and training from the Division approved Supported Employment reviewer.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

309-019-0285

Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0275, in order to maintain a Supported Employment provider designation on the Division issued certificate, a provider must submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 100.

(2) Providers certified to provide Supported Employment services under this rule that achieve a fidelity score of 100 or better when reviewed by the Division Approved Supported Employment Reviewer are certified for 12 months.

(a) Extension of Fidelity reviews has no bearing on the frequency of re-certification reviews required under OAR 309-008.

(3) Fidelity reviews will be conducted utilizing the Substance Abuse and Mental Health Services Supported Employment Fidelity Scale, which will be made available to providers electronically.

(4) Provider shall cooperate with the Division Approved Supported Employment Reviewer for the purpose of improving Supported Employment Services.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

309-019-0290

Failure to Meet Fidelity Standards

(1) In addition to any plan of correction requirements issued by the Division under 309-008-0800(4)(c); If a Provider certified under these rules to provide Supported Employment services does not receive a minimum score of 100 on a fidelity review, the following shall occur:

(a) Technical assistance shall be made available by the Division approved reviewer for a period of 90 days to address problem areas identified in the fidelity review;

(b) At the end of the 90 day period, a follow-up review will be conducted by the Division approved reviewer; and

(c) The provider shall forward a copy of the amended fidelity review report to the provider's appropriate CCO.

(d) The Division approved reviewer shall forward a copy of the fidelity review report to the Division.

(A) In addition to the standards set for suspension and revocation of a certificate in OAR 309-008-1100(1) & (2) a provider of Supported Employment services may also have their certificate of approval suspended or revoked if the 90 day re-review results in a fidelity score of less than 100.

(B) A provider issued a notice of intent to apply a condition, revoke, suspend, or refusal to renew its certificate under these rules shall be entitled to request a hearing in accordance with ORS Chapter 183 and OAR 309-008-1300.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634

309-019-0295

Reporting Requirements

Providers certified by the Division to provide Supported Employment services shall submit quarterly outcomes reports, using forms and procedures prescribed by the Division, within 45 days following the end of each subject quarter to the Division or the Division approved reviewer. Each quarterly report shall provide the following information:

(1) All individuals who received Supported Employment in the reporting quarter:

(a) Individuals who receive Supported Employment services who are employed in competitive integrated employment; and

(b) Individuals who discontinued receiving Supported Employment services and are employed in competitive integrated employment; and

(c) Individuals who received Supported Employment services as a part of the Assertive Community Treatment Program.

Stat. Auth.: ORS 413.042
Stats Implemented: 430.630 and 430.634