Oregon Administrative Rules
NOTICE OF PROPOSED RULEMAKING WORKSHEET

1. All categories on this form are required by the Secretary of State and the Attorney General's Administrative Law Manual per ORS 183.335. The grey notes are advice to assist you filling out this form.

2. This form includes the Statement of Need and Fiscal Impact, and space for rule text and summaries.

3. Return completed form to the Rules Coordinator. To streamline the filing process, no other forms will be accepted

Filing Contact:

Name: David Corse

Email: david.corse@oha.oregon.gov

Filing Caption:

Revisions to streamline behavioral health treatment intake, assessment, and service planning requirements for better access.

STATEMENT OF NEED AND FISCAL IMPACT

Need for Rule(s) Changes:

Several Initiatives within Oregon Behavioral Health (Rapid Engagement, Tackling Administrative Burden, Integrated Co-Occurring Disorders, SUD 1115 Waiver Implementation) have simultaneously called for revision of these Rules in interest of lowering barriers to access, streamlining administrative process, and increasing the quality of initial engagement in behavioral health services. Oregon has been ranked as one of the poorest performing in terms of access to behavioral health services. Provider agencies have reported long wait lists, and consumers have not been able to access services in a timely manner. There are complex factors contributing to these problems, including capacity and workforce challenges. However, the Rules regarding intake, entry and assessment have been identified by providers and consumers as needing revision to be more simplified, responsive and person-centered Revision and clarification of these Rules is intended to provide much needed clarification and simplification.

Documents Relied Upon, and where they are available:

"Principles for Administrative Burden Reduction" (HB 2463) OHA Document Available Upon Request

OHA Integrated Co-Occurring Disorders Initiative

Oregon SUD 1115 Waiver

Rapid Engagement Pilot Project

New Mexico's Treatfirst Project

CMS State Medicaid Manual, Chapter 4 (s4221)

CFR 440.230

Fiscal and Economic Impact:

Financial impact may include staff time spent developing and implementing new procedures, updating policies, and updating Electronic Health Record system forms. Due to the wide variability of organizational needs, OHA can not directly estimate these costs.

OHA Behavioral Health Division may develop guidance documents and technical assistance processes, which may have an internal cost. OHA Behavioral Health Division may also contract with community entities to provide consultation and training services to providers.

Statement of Cost of Compliance:

(1) Entities that will be potentially impacted by these Rule revisions include:

OHA Behavioral Health Division Outpatient Behavioral Health and Residential SUD and Problem Gambling Provider agencies with Certificate and/or License of Approval to provide behavioral health services in Oregon. Coordinated Care Organizations (CCO's)

(2) Effect on Small Businesses:

(a) These changes will impact several hundred behavioral health provider organizations, many of which are small businesses.

(b) The impact of the proposed changes on relevant businesses will center around workflow and administrative changes. Some of these changes may have an external financial cost, such as adding or editing forms in Electronic Health Records.

(c) Financial impact may include staff time spent developing and implementing new procedures, updating policies, and updating Electronic Health Record system forms. Due to the wide variability of organizational needs, OHA can not directly estimate these costs.

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

Small businesses that provide behavioral health services are involved in structured community engagement groups. There are also members of the RAC that are small business operators.

Racial Equity Statement

Requirements for intake and assessment in behavioral health treatment settings are not intuitively person centered. Cultural diversity and care needs are not part of requirements that come from Federal level regulations. The process of revising these Rules has been one in which providing flexibility for culturally sensitive adaptations has been prioritized. Even still, the parameters required create possibility for rigid, unattuned approaches to intake, assessment and service planning. For this reason, OHA is committed to supporting culturally relevant technical support, consultation and clinical training when needed and feasible. Six community engagement groups were held. OHA BH will continue to hold provider workgroups through out the revision period. Tribal Leaders will be consulted, a RAC will be held.

Was an Administrative Rule Advisory Committee (RAC) consulted? Select Yes or No?

If not, why not?

Yes, a RAC will be convened in July of 2024 in relation to these proposed Rule changes.

Rule Text and Summary: For each of the rules below write a brief summary 2-4 sentences as to why this rule is being amended, repealed or being adopted.

Amending 10 rules

4 rules in Division 19

6 rules in division 18

Mini time line:

Rule: 309-019-0110
Rule Action: Amend
Title Provider Policies
Brief Summary of changes: Moving procedures from entry section of Rule that are not required before treatment services begin

(1) All providers shall develop and implement written service delivery policies and specific procedures compliant with these rules, to be made available to individuals and family members upon request, and shall include, at a minimum, the following:
(a) Personnel qualifications, credentialing, and training;
(b) Mandatory abuse reporting compliant with ORS 430.735 - 430.768 and OAR chapter 407 division 45;
(c) Criminal Records Checks that address program and volunteer staff, compliant with ORS 181.533 through 181.575 and OAR 943-007-0001 through 0501, where applicable;
(d) Fraud, waste, and abuse in federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510;
(e) Drug and Gambling Free Workplace;
(f) Fee agreements;

(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) Per ORS 413.046; Grievances and appeals, including an example grievance form;
(j) Individual rights;
(k) Quality assessment and performance improvement;
(l) Trauma informed service delivery consistent with the Division Trauma Informed Services Policy;
(m) Provision of culturally and linguistically appropriate services;
(n) Crisis prevention and response;
(o) Incident reporting;
(p) Peer delivered services;
(q) Prevention of communicable disease transmission;
(r) Emergency evacuation;
(s) Care coordination;
(t) Delivery of substance use disorders treatment services and supports consistent with *The ASAM Criteria* for each certified level of care;
(u) Code of conduct that includes professional boundaries and ethics;
(v) Referral, Care Coordination and Transfer of Services
(w) Medical Protocols consistent with these rules; and
(x) Urinalysis Testing.
(y) Opportunity for individuals to declare advanced directive for their mental health treatment per ORS 127.700 to 127.736
(z) Opportunity for individuals to register to vote per The National Voter Registration Act of 1993, Section 7.

(aa) Submission of the identified status and service data, including Non-Medicaid Service Data where required, in the mandated state data system according to the timelines required by the Division for each individual whose services are paid for in-full or in-part by public funds and for individuals enrolled in DUII services. Policy must require data to be entered as soon as possible but not longer than 90 days from start of services.

(bb) Entry and pre-entry requirements for providers that receive the Substance Use Prevention, Treatment and Recovery (SUPTR) Block Grant:

(A) Document that individuals are prioritized for entry in the following order:

(i) Individuals who are pregnant and using substances intravenously;

(ii) Individuals who are pregnant;

(iii) Individuals who are using substances intravenously; and

(iv) Individuals or families with dependent children.

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

(i) 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;

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

(iii) For pregnant individuals, 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; and

(iv) Peer Delivered Services that address parenting and youth in transition support, as indicated.

(2) All written service delivery policies and specific procedures shall prohibit the following:
(a) Psychological and physical abuse of an individual;
(b) Seclusion, personal restraint, mechanical restraint, and chemical restraint;
(c) Withholding shelter, regular meals, medication, clothing, or supports for physical functioning;
(d) Discipline of one individual receiving services by another; and
(e) Titration of medications prescribed for the treatment of opioid dependence as a condition of receiving or continuing to receive treatment.
(3) Providers of Enhanced Care Services (ECS) services shall develop behavior support policies consistent with OAR 309-019-0155(3).
(4) Community Mental Health Programs shall develop policies for linkage agreements compliant with OAR 309-032-0870.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 413.520 - 413.522, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168

Rule: 309-019-0125
Rule Action: Amend
Title Staff Qualifications
Brief Summary of changes: Correcting error designating requirements for problem gambling treatment staff.

Provider must ensure that staff in the following positions meet applicable qualifications, credentialing, or licensing standards and competencies, including those set forth in these rules:

(1) Program staff providing treatment services or Peer-Delivered Services in substance use disorders, problem gambling, or mental health treatment programs shall be trained in and familiar with strategies for the delivery of trauma informed and culturally responsive treatment services. All treatment services shall be provided in a trauma informed and culturally responsive manner.

(2) Program administrators and program directors shall demonstrate competence in leadership, cultural responsiveness, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, use of data, reporting, program evaluation, quality assurance, and developing and coordinating community resources.

(3) Medical Directors shall be licensed under ORS 677 or 685 and may perform health maintenance and restoration measures consistent with generally recognized and accepted principles of medicine, including but not limited to:

(a) Administering, dispensing, or writing prescriptions for medications;

(b) Recommending the use of specific and appropriate over-the-counter pharmaceuticals;

(c) Ordering diagnostic tests; and

(d) Perform tasks required by OAR 309-019-0200.

(4) Clinical supervisors in all programs shall demonstrate competence in leadership, cultural responsiveness, oversight and evaluation of services, staff development, assessment, person-centered treatment 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.

(5) Clinical supervisors in mental health programs shall meet Qualified Mental Health Professional (QMHP) requirements and have completed two years equivalent of post-graduate clinical experience in a mental health treatment setting.

(6) Clinical supervisors in substance use disorders treatment programs shall be certified by a Division recognized credentialing body as follows:

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

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

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

(C) Successful completion of a professional psychometric examination by a Division recognized credentialing body. A substantively equivalent portfolio evaluation by a Division recognized credentialing body may be accepted in lieu of a professional psychometric examination using procedures approved by the Division.

(b) Clinical supervisors not holding a certification in substance use disorder counseling shall have health or allied provider license. The license shall have been issued by one of the following state bodies and the supervisor shall possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of substance use disorders.

(A) Oregon Medical Board;

(B) Oregon Board of Psychologist Examiners;

(C) Oregon Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

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

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

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

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

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

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

(9) Substance use disorders treatment staff shall:

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

(b) Receive clinical supervision that documents progress towards certification and recertification; or

(c) At the date of first hire to provide substance use disorder treatment, if the program staff is not certified to provide substance use disorder treatment, they shall register with the Division recognized credentialing body within 30 days of hire and obtain professional substance use disorder treatment certification within two years from the date of first hire unless they obtain a variance from the Division before that time has elapsed;

(d) For program staff holding certification in substance use disorder counseling, qualifications for certification shall have included at least:

(A) 1000 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 professional psychometric examination by a Division recognized credentialing body. A substantively equivalent portfolio evaluation by Division recognized credentialing body may be accepted in lieu of a professional psychometric examination using procedures approved by the Division.

(e) Program staff not holding certification from a Division recognized credentialing body in substance use disorder counseling shall have a license or registration from a Division recognized credentialing body and at least 60 contact hours of academic or continuing professional education in the treatment of substance use disorders. The license or registration shall have been issued by one of the following state bodies:

(A) Oregon Medical Board;

(B) Oregon Board of Psychologist Examiners;

(C) Oregon Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

(10) Problem Gambling treatment staff shall:

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

(b) Complete a minimum of two hours every two years or three hours every three years of training in suicide risk screening, suicide risk assessment, treatment and management;

(c) Receive clinical supervision that documents progress towards certification and recertification;

(d) At the date of first hire to provide problem gambling~~substance use disorder~~ treatment, if the program staff is not certified to provide problem gambling~~substance use disorder~~ treatment, they shall register with the Division recognized credentialing body within 30 days of hire and obtain professional problem gambling~~substance use disorder~~ treatment certification within two years from the date of first hire unless they obtain a variance from the Division before that time has elapsed;

(e) For program staff holding certification in gambling addiction counseling, qualifications for certification shall include at least:

(A) 500 hours of supervised experience in gambling addiction counselor domains;

(B) 30 contact hours of education and training in problem gambling;

(C) 24 hours of face-to-face, telephone, email or other electronic communication, of certification consultation from a problem gambling approved certification consultant; and

(D) Successful completion of a professional psychometric examination by a Division recognized credentialing body or a substantively equivalent portfolio evaluation by a Division recognized credentialing body may be accepted in lieu of a professional psychometric examination using procedures approved by the Division.

(f) Program staff not holding certification in gambling addiction counseling by a Division recognized credentialing body shall have at least 30 contact hours of academic or continuing professional education in the treatment of gambling addiction. The license or registration shall have be issued by one of the following state bodies:

(A) Oregon Medical Board;

(B) Oregon Board of Psychologist Examiners;

(C) Oregon Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

(11) Rehabilitative Behavioral Health Service Providers, including medical treatment staff, shall demonstrate cultural responsiveness and meet the requirements and qualifications in OAR 410-172-0660.

(12) Behavioral health clinicians shall meet one of the following qualifications and maintain the corresponding credential in the State of Oregon:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

(c) A licensed nurse practitioner with a specialty in psychiatric mental health;

(d) A licensed clinical social worker;

(e) A licensed professional counselor or licensed marriage and family therapist;

(f) A certified clinical social work associate;

(g) A Mental Health Intern or resident who is working under a board-approved supervisory contract in a clinical mental health field;

(h) A Qualified Mental Health Practitioner (QMHP); or

(i) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(13) Qualified Mental Health Associates (QMHA) program staff shall:

(a) Demonstrate the following minimum competencies: cultural responsiveness, effective communication, care coordination, inter- and intra-agency collaboration, working alliances with individuals, assist in the gathering and compiling of information to be included in the assessment, screen for suicide and other risks, and implement timely interventions, teach skill development strategies, case management, and transition planning;

(b) Render services and supports within their scope to individuals engaged in a Division approved behavioral health services provider; and

(c) Shall meet the following minimum qualifications:

(A) Bachelor's degree in psychology, social work, or behavioral science field and documentation of a minimum of two hours every two years or three hours every three years of suicide risk screening, Intervention, and management training;

(B) An equivalent degree as evidenced by providing transcripts indicating applicable coursework meeting the required competencies and approved by a Division certified behavioral health provider and documentation of a minimum of two hours every two years or three hours every three years of suicide risk screening, Intervention and management training; or

(C) A combination of at least three years of relevant work, education, training, or experience and documentation of a minimum of two hours every two years or three hours every three years of suicide risk screening, Intervention and management training.

(d) Receive clinical supervision that documents progress towards certification and recertification.

(14) Qualified Mental Health Professional QMHP program staff shall:

(a) Demonstrate the following minimum competencies: cultural responsiveness, effective communication, care coordination, inter- and intra-agency collaboration, working alliances with individuals, suicide and other risk assessments and interventions, creating and monitoring safety plans, completion of bio-psycho-social assessments and additional assessments, updating assessments when clinical circumstances change, generating a differential DSM-5-TR diagnosis, prioritizing health, wellness and recovery needs, writing measurable service objectives, creating, monitoring and revising service plans, delivery of mental health and recovery treatment services in individual, group and family formats within their scope, gathering and recording data that measures progress toward the service objectives and documenting services, supports and other information supportive of the service plan.

(b) Render services and supports within their scope to individuals engaged in a Division approved behavioral health services program;

(c) Document a minimum of two hours every two years or three hours every three years of suicide risk screening, suicide risk assessment, treatment and management training;

(d) Meet the following minimum qualifications:

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

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

(C) Graduate degree in psychology, social work, recreational art or music therapy, or behavioral science field;

(D) An equivalent degree as evidenced by providing transcripts indicating applicable coursework meeting the required competencies and approved by a Division certified behavioral health provider; or

(E) Qualify as a Mental Health Intern, as described in these rules.

(e) Receive clinical supervision that documents progress towards certification and recertification.

(15) Mental Health Intern (MHI) program staff shall:

(a) Be currently enrolled in a graduate program for a master's degree in psychology, social work, or related field of behavioral science;

(b) Have a collaborative educational agreement between the Division certified provider and the graduate program for the student;

(c) Demonstrate cultural responsiveness, effective communication and competence in care coordination, development of working alliances with individuals, inter- and intra-agency collaboration, and the rendering of services and supports within their scope and in accordance with the service plan, including transition planning; and

(d) Work within the scope of practice and competencies identified by collaborative educational agreement and the policies and procedures for the credentialing of clinical staff as established by the provider and the graduate program;

(e) Document of a minimum of two hours every two years or three hours every three years of suicide risk screening, suicide risk assessment, treatment and management training.

(16) Student Intern program staff shall:

(a) Be currently enrolled in an educational program for an undergraduate degree in a behavioral health field; or

(b) Demonstrate cultural responsiveness, effective communication and competence in care coordination, development of working alliances with individuals, inter- and intra-agency collaboration, and the rendering of services and supports within their scope and in accordance with the service plan, including transition planning;

(c) Have a collaborative education agreement between the Division certified provider and the educational institute for the student;

(d) Work within the scope of practice and competencies identified by the collaborative educational agreement and the policies and procedures for the credentialing of clinical staff as established by the provider; and

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

(17) Intern program staff shall:

(a) Render services and supports under the direct supervision of a qualified supervisor employed by the provider of services, within the scope of practice and competencies identified by the collaborative educational agreement, and within the policies and procedures for the credentialing of program staff as established by the provider;

(b) Be working towards obtaining a behavioral health credential;

(c) Receive, at a minimum, weekly individual supervision by a qualified clinical supervisor employed by the provider of services; and

(d) Demonstrate cultural responsiveness, effective communication and competence in care coordination, development of working alliances with individuals, inter-and intra-agency collaboration, and the rendering of services and supports within their scope and in accordance with the service plan, including transition planning.

(e) Community Health Workers working in substance use disorders treatment and recovery programs shall be certified as described in OAR 410-180-0310 and who:

(A) Has expertise or experience in behavioral health;

(B) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(C) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the members of the community where the worker serves;

(D) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(E) Provides health education and information that is culturally appropriate to the individuals being served.

(f) Assists community members in receiving the care they need;

(g) CHW staff may:

(A) Give peer assistance and guidance on health including behavioral health behaviors; and

(B) Provide skills restoration services.

(18) Peer Support Specialists and Peer Wellness Specialists, including family and youth support and wellness specialists, shall meet the requirements in OAR 410-180-0300 to 0380 for certification and continuing education, and:

(a) A Peer Support Specialist and Peer Wellness Specialist shall be:

(A) Someone self-identified as currently or formerly receiving mental health, problem gambling or substance use services;

(B) Someone self-identified as in recovery from a substance use disorder;

(C) Someone self-identified as in recovery from problem gambling; or

(D) Someone who has experience parenting a child who:

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

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

(b) A Peer Support Specialist and Peer Wellness Specialist shall demonstrate:

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

(B) Personal life experience and tools of self-directed recovery and resiliency; and

(C) Demonstrate cultural responsiveness and effective communication.

(19) “Youth support specialist” means a person who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(a) Is not older than 30 years of age; and

(b) Is a current or former consumer of mental health or addiction treatment; or

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

(d) A “youth support specialist” may be a peer wellness specialist or a peer support specialist.

(20) Program staff include, but are not limited to:

(a) Licensed Medical Professional (LMP);

(b) Licensed Practical Nurse (LNP);

(c) Registered Nurse (RN);

(d) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(e) Psychologist licensed by the Oregon Board of Psychology;

(f) Professional Counselor (LPC) or Marriage and Family Therapist (LMFT) licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(g) Clinical Social Worker (CSW) licensed by the Oregon Board of Licensed Social Workers;

(h) Licensed Master Social Worker (LCSW) licensed by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;

(i) Licensed Psychologist Associate granted independent status as described in OAR 858-010-0039;

(j) Licensed Occupational Therapist licensed by the Oregon Occupational Therapy Licensing Board;

(k) Board registered interns, including:

(A) Psychologist Associate Residents as described in OAR 858-010-0037;

(B) Licensed Psychologist Associate under continued supervision as described in OAR 858-010-0038;

(C) Licensed Professional Counselor Associate or Marriage and Family Therapist Associate registered with the Oregon Board of Licensed Professional Counselors and Therapists as described in OAR 833-050-0011;

(D) Certificate of Clinical Social Work Associate issued by the Oregon Board of Licensed Social Workers as described in OAR 877-020-0009;

(E) Registered Bachelor of Social Work issued by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105.

(l) QMHP as defined in OAR 309-019-0105;

(m) QMHA as defined in OAR 309-019-0105;

(n) Mental health intern as defined in OAR 309-019-0105;

(o) Problem Gambling treatment staff registered with the Mental Health and Addiction Certification Board of Oregon (MHACBO), which includes:

(A) Certified Gambling Addiction Counselor-Registered (CGAC-R);

(B) Certified Gambling Addiction Counselor-I (CGAC-I); or

(C) Certified Gambling Addiction Counselor-II (CADC-II).

(p) SUD Treatment Staff registered with the Mental Health and Addiction Certification Board of Oregon (MHACBO), which includes:

(A) Certified Alcohol and Drug Counselor-Registered (CADC-R);

(B) Certified Alcohol and Drug Counselor-I (CADC-I);

(C) Certified Alcohol and Drug Counselor-II (CADC-II); and

(D) Certified Alcohol and Drug Counselor-III (CADC-III).

(q) Peer-Support Specialist (PSS) as defined in OAR 309-019-0105;

(r) Peer Delivered Services Supervisor as defined in OAR 309-019-0105;

(s) Peer Wellness Specialist (PWS) as defined in OAR 309-019-0105; and

(t) Youth Support Specialist.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 428.205-428.270, 430.010, 430.254-430.640, 430.850-430.955 & 743A.168

309-019-0135
Rule Action: Amend
Title **Entry and Assessment**

Brief Summary of changes: Streamlining and clarifying requirements regarding entry and assessment processes.

(1) The provider~~ogram~~ must utilize and document an entry procedure that at a minimum will~~must~~ ensure the ~~provision and documentation of~~ the following:

(a) Individuals must be considered for entry without regard to race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when program eligibility is restricted to children, adults, or older adults), familial status, marital status, source of income, and disability;

(b) The provider will~~may~~ not deny entry to individuals based on their decision to continue ~~their~~ currently prescribed or dispensed medications for ~~to treat~~ opioid use disorder (MOUD)~~dependence~~ while receiving outpatient behavioral health services and supports;

(c) Individuals must receive services in ~~the timeliest manner feasible~~ a manner consistent with the presenting circumstances;

(~~d~~)

(d~~e~~) Per CFR 440.230, the provider must develop and maintain service records and other documentation that demonstrates the amount, duration and scope of each specific services and supports provided for each individual.~~;~~

(e~~f~~) ~~The provider must submit the identified status and service data, including Non-Medicaid Service Data where required, in the mandated state data system according to the timelines required by the Division for each individual whose services are paid for in-full or in-part by public funds and for individuals enrolled in DUII services;~~

(f~~g~~) In accordance with ORS 179.505, HIPAA, and 42 CFR Part 2, the provider must obtain an authorization for the release of information ~~must be obtained and contained in the service record~~ for the release of any confidential information concerning the individual being considered for or receiving services;

g(f~~h~~) In accordance with HIPAA Rules and CFR 164.520, e~~E~~xcept as permitted by law in emergencies, the provider must obtain written, voluntary informed consent for services from the individual, or guardian if applicable~~must be obtained~~ prior to – or at the start of~~time that~~ services ~~begin~~. ~~Written, voluntary informed consent for services must be obtained from the individual or guardian, if applicable, prior to – or at the time that - services begin .~~ ~~If such consent is not obtained, the reason and any further attempts to obtain informed consent must be documented in the service record.~~

(h) Prior to or at the start of treatment services, ~~but no later than 30 days from initial service contact,~~ the program must offer to the individual and guardian, if applicable, written program information. The written program information must be in a language understood by the individual and must include disclosures and description of services to be provided, as well as other information regarding the program. The written program information shall include:~~:~~

~~(A) Program consent, disclosure, and orientation information.~~

~~(B) Information on how to complete a Declaration for Mental Health Treatment with the individual's participation and informed consent;~~

(A~~C~~) A description of individual rights consistent with these rules, and;

~~(D) Information describing how to file grievance and appeals consistent with these rules, including an example grievance form;~~

(B~~E~~) Notice of privacy practices; ~~and~~

~~(F) Information on how to register to vote, per the National Voter Registration Act of 1993, Section 7. Provider agency will supply means to register to vote upon request; and~~

(C~~G~~) If written program information, disclosures, notice of privacy practices, consents and individual rights documents are~~is~~ not provided prior or at the start of treatment services, the reason, ~~-~~and any further attempts to provide written information and consent, must be documented in the service record.

~~(2) Entry requirements for providers that receive the Substance Use Prevention, Treatment and Recovery (SUPTR) Block Grant:~~

~~(a) Document that individuals are prioritized for entry in the following order:~~

~~(A) Individuals who are pregnant and using substances intravenously;~~

~~(B) Individuals who are pregnant;~~

~~(C) Individuals who are using substances intravenously; and~~

~~(D) Individuals or families with dependent children.~~

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

~~(A) An opportunity for the individual to engage in interactive social services through care coordination, peer services or other interactive supports.~~

~~(B) Educational material about blood borne pathogens including Hepatitis, HIV, STDs, and Tuberculosis (TB); the risks of needle and paraphernalia sharing; and the likelihood of transmission to sexual partners and infants;~~

~~(C) Educational information and resources about steps that can decrease the likelihood of Hepatitis, HIV, STD, and TB transmission;~~

~~(D) For pregnant individuals, interactive social services and educational information addressing the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco, and other drug use on the fetus and referral for prenatal care; and~~

~~(E) Peer Delivered Services that address parenting and youth in transition support, as indicated .~~

(2~~3~~) Per CMS State Medicaid Manual Section 4221, a~~A~~t the time of entry, an initial assessment documenting a medically necessary reason for services, appropriateness for treatment by the program, and current risks - must be completed and signed by qualified staff. ~~the assessment process must begin, be updated, or completed.~~ ~~and signed by a qualified program staff, provided individual presentation and circumstances allow~~. Providers must complete a full assessment that includes comprehensive biological,

psychological, social and historical information for comprehensive service planning within a timeline that prioritizes immediate individual needs, but no later than 90 days following the first date of service.

(a) Each assessment ~~document~~ must include~~provide~~ clinically relevant information, or documented review of past records that contain~~;, at minimum~~;

(A) ~~Minimally sufficient information and documentation to~~ Documentation of~~justify~~ the presence of a DSM-5-TR diagnosis that is the medically necessary reason for services, including identification of each DSM-5-TR criteria established per diagnosis, and the symptoms supporting each criteria;~~.~~

~~(B) If a DSM-5 TR diagnosis cannot be initially identified, ICD 10 "z" , "v" or "r" codes may be utilized to document initial diagnostic impressions for up to 90 days of initial service date.~~

(i~~b~~) Screening for the presence of suicide risk and documented interventions, as indicated ~~based on the information gathered~~; ~~and~~

(ii~~A~~) A determination of immediate~~the~~ need for follow-up actions, additional services and supports;~~,~~ and

(iii) the level of psychological and physical trauma and risk to the individual or to others~~.~~

(B) An assessment can record diagnostic information derived from clinical observation, self-report interview, collateral information (such as assessments from other programs or previous treatment episodes) or any combination of these.

(C) Medically Necessary Reason for services must be documented in the assessment record and signed by a credentialed staff member with appropriate scope of practice.

(D~~B~~) For updated assessments or assessments for participants returning to services ~~in less than one calendar year~~, collateral information such as previous assessments can be used to inform the current assessment. Information supporting a medically necessary reason for services~~medical necessity~~, immediate risk and trauma screenings, must be verified in initial assessment interviews.

(E) If a DSM-5 TR diagnosis cannot be initially identified, relevant ICD 10 codes currently on the Oregon prioritized list may be utilized to document initial diagnostic impressions for up to 30 days of initial service date.

(b~~c~~) If the provider cannot document a medically necessary reason for services at entry, the provider must at minimum, document a screening for suicide risk, immediate needs, safety risk and trauma impact. The provider can render the following services for up to 30 days without a documented medically necessary reason for services,~~Should medical necessity not be possible to document at entry, the following services may be rendered prior to an assessment being completed for up to 30 days,~~ or at any appropriate time during a treatment episode:

(A) Care coordination (such as certain types of case management activities);

(B) Peer mentoring;

(C) Screening; and

(D) Crisis intervention.

(cd) Assessments and updated assessments are considered comprehensively complete when the following information has also been added to assessment documentation within 90 days of the initial service date;

~~Assessments conducted in less than 90 days are considered comprehensively complete when the following information has also been documented as part of an assessment within 90 days of the initial service date~~;

(A) Symptoms related to psychological and physical trauma;

(B) Current suicide risk;

(C) Current Substance use;

(D) Current Problem Gambling Behavior;

(E) Current Mental Health conditions, including currently prescribed psychiatric medications;

(F) Current Medical conditions, including currently prescribed treatments and medications ;

(G) Additional and sufficient Historical, Biological, Psychological and Social information relevant to planning services; and

(H) When indicated, documentation must contain recommendations for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(de) In addition to completion of (a) –(c) above, for substance use disorder services each assessment and update thereof must be a multidimensional assessment, consistent with *The ASAM Criteria, Third Edition*, and include, at a minimum the following components, each consistent with *The ASAM Criteria, Third Edition*:

(A) ASAM Level of Care determination per dimension, overall, and noting any applicable discrepancies; and

(B) An initial ASAM assessment must ~~can~~ include ~~record~~ information obtained~~derived~~ from observation, self-report interview, collateral information or any combination of these.

(C) An initial ASAM assessment must include~~will also cover~~, at minimum;

(i) Level of Care recommendation for each ASAM dimension based on current and available information.

(ii) The DSM-5-TR Diagnostic criteria for Substance Use Disorders present for the~~endorsed by~~ individual if not included in other assessment documentation of the current episode of treatment. ~~in interest of supporting medical necessity for Substance Use Disorder diagnosis.~~

(iv) A consideration of the history of each substance use related risk as well as the present substance use related risk concern(s);

~~(v) An identification of immediate need(s) and risks;~~

(v~~i~~) A severity of risk for each dimension; and

(vi~~i~~) An overall determination of the severity of risk the individual currently is experiencing.

(C) A comprehensive ~~and complete~~ ASAM assessment will be completed as soon as possible but in no more than 90 days and include full supporting information for purposes of comprehensive service planning. A comprehensive ASAM assessment may~~will~~ reflect consideration of~~include~~ information from initial assessments without duplication as well as;

(i) Additional and sufficient Historical, Biological, Psychological and Social information relevant to planning services; and

(ii) When indicated, documentation must contain recommendations for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(e~~f~~) Any changes to the ASAM Level of Care placement decision must be justified within an update to the multidimensional assessment on file;

(f~~g~~) Providers must update assessments within the scope of their practice when there are changes in clinical circumstances; and

(g~~h~~) Any individual continuing to receive mental health services for one or more continuous years must receive an annual assessment by a QMHP.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168

309-019-0140

Rule Action: Amend
Title **Service Plan and Service Notes**

Brief Summary of changes: Streamlining and clarifying requirements regarding service plan and service notes.

(1) ~~T~~The service plan must be a written, individualized plan designed to improve the individual's condition to the point where the individual's continued participation in the program or level of care is no longer necessary. Per Oregon State Plan, brief services may be provided prior to completion of a Service Plan. Per CMS State Medicaid Manual, section 4221, services not documented in a Service Plan may be provided with documented explanation. Service plans shall; ~~The service plan is included in the individual's service record and must~~:

(a) B~~B~~e completed~~started~~ before~~prior to~~ rendering of treatment services~~,~~ and provider must document reason for any delay in the service record ~~with a comprehensive service plan completed no later than 90 days from date of initial service contact~~;

(b) Reflect the initial or comprehensive assessment in its' most updated form;

(c) Address areas of concern identified in the current assessment that the individual agrees to address;

(d) Include a safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the service plan;

(e) Include the participation, and reflect agreement, of the individual and family members, as applicable;

(f) Be completed and signed by qualified program staff as follows:

(A) A QMHP in mental health programs;

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

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

(g) For mental health services, a QMHP who meets the qualifications of a Clinical Supervisor shall approve the services and supports by signing the service plan within ten business days of the start of services; and

(h) A QMHP who meets the qualifications of a Clinical Supervisor shall approve the service plan at least annually for each individual receiving mental health services for one or more continuous years.

(2) Per CMS State Medicaid Manual, section 4221, a~~A~~t minimum, each service plan, in addition to requirements in 309-019-0135 (1) -above- must include:

(a) Treatment objectives that are individualized;

(b) Treatment objectives that meet the assessed needs of the individual.

(c) Measurable for the purpose of evaluating individual progress, including a baseline.

(3) In addition, c~~C~~omprehensive service plans ~~that~~ must be completed~~written~~ as soon as a comprehensive assessment is completed, but within no more than 90 days of initial service contact, and reflect the Comprehensive assessment~~.~~ Comprehensive service plans will be measurable for the purpose of evaluating individual progress, as well as;

(a) The specific therapeutic, psychiatric and support ~~and social~~ services ~~and supports~~ that must be used to meet the treatment objectives;

(b) Expected frequency, quantity and duration of each type of planned service or support; ~~and~~

(c) A schedule for re-evaluating the service plan; and~~.~~

(d) the type of personnel that will be furnishing each of the services.

(4) Per CMS State Medicaid Manual, section 4221, p~~P~~roviders must document the following ~~each service and support~~ in a service note for each service and support ~~to include~~:

(a) The specific service or supports rendered;

(b) The relationship of the services to the treatment regimen described in the service plan;

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

(c) The date, time of service or support, and the actual amount of time the services or support was~~were~~ provid~~render~~ed;

(d) The personnel provid~~render~~ing the services, including their name, credentials, and signature;

(e) The setting in which the service or supports was~~ere~~ provid~~render~~ed; and

(f) Periodic updates describing the individual's progress, stasis, or deterioration ~~.~~

(5) Decisions to transfer individuals must be documented including:

(a) The date of the transfer;

(b) The reason for the transfer;

(c) For substance use disorder and co-occurring services, ASAM level of care recommendation and overall determination of the severity of risk the individual is experiencing at the time of transfer;

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

(e) Outreach efforts made as applicable and as defined in these rules.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256 & 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955 & 743A.168

309-018-0110

Rule Action: Amend
Title **Provider Policies**

Brief Summary of changes: moving requirements from entry section of Rule that are not required to be completed prior to the start of clinical services.

(1) All providers shall develop and implement written policies and procedures compliant with these rules.

(2) Policies shall be available to individuals, guardians, and family members upon request.

(3) Providers shall develop and implement written policies and procedures including but not limited to:

(a) Personnel qualifications, credentialing and training;

(b) Criminal Records Checks that address program and milieu staff, compliant with ORS 181.533 through 181.575 and OAR 943-007-0001 through 0501, where applicable;

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

(d) Drug free workplace;

(e) Fee agreements;

(f) 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;

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

(h) Per ORS 413.046; Grievances and appeals, including an example grievance form; ~~Grievances and appeals;~~

(i) Individual rights;

(j) Quality assessment and performance improvement;

(k) Crisis prevention and response;

(l) Incident and critical incident reporting;

(m) Family involvement;

(n) Trauma-informed service delivery, consistent with the Division's Trauma Informed Services Policy;

(o) Provision of culturally and linguistically appropriate services;

(p) Medical protocols;

(q) Medication administration, storage, and disposal;

(r) Facility standards;

(s) General safety and emergency procedures to include an evacuation plan and emergency plan in case of fire, explosion, accident, death, or other emergencies. The evacuation and emergency procedures and plans shall be current and posted in a common area;

(t) Delivery of services and supports consistent with *The ASAM Criteria, Third Edition* for each licensed level of care;

(u) Code of conduct that includes professional boundaries and ethics; and

(v) Referral, Care Coordination and Transfer of Services.

(4) Additionally, providers shall establish written policies that:

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

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

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

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

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

(f) Opportunity for individuals to declare advanced directive for their mental health treatment per ORS 127.700 to 127.736
(g) Opportunity for individuals to register to vote per The National Voter Registration Act of 1993, Section 7.

(h) Submission of the identified status and service data, including Non-Medicaid Service Data where required, in the mandated state data system according to the timelines required by the Division for each individual whose services are paid for in-full or in-part by public funds and for individuals enrolled in DUII services. Policy must require data to be entered as soon as possible but not longer than 90 days from start of services.

(i) Entry and pre-entry requirements for providers that receive the Substance Use Prevention, Treatment and Recovery (SUPTR) Block Grant:

(A) Document that individuals are prioritized for entry in the following order:

(i) Individuals who are pregnant and using substances intravenously;

(ii) Individuals who are pregnant;

(iii) Individuals who are using substances intravenously; and

(iv) Individuals or families with dependent children.

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

(i) 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;

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

(iii) For pregnant individuals, 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; and

(iv) Peer Delivered Services that address parenting and youth in transition support, as indicated.

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640 & 443.450
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549 & 743A.168

309-018-0125

Rule Action: Amend
Title **Staff Qualifications and competencies**

Brief Summary of changes: correcting error in education hours required for professionally certified problem gambling counselors 309-0108-0125 (9)(e)

Provider must assure that staff in the following positions meet applicable qualifications, credentialing or licensing standards and competencies, including those set forth in these rules:

(1) Program staff providing treatment services or Peer-Delivered Services in substance use disorders or problem gambling treatment programs shall be trained in and familiar with strategies for the delivery of trauma informed and culturally responsive treatment services. All treatment services shall be provided in a trauma informed and culturally responsive manner. (2) Medical Directors shall be licensed under ORS 677 or 685 and may perform health maintenance and restoration measures consistent with generally recognized and accepted principles of medicine, including but not limited to:

(a) Administering, dispensing, or writing prescriptions for medications;

(b) Recommending the use of specific and appropriate over-the-counter pharmaceuticals;

(c) Ordering diagnostic tests; and

(d) Perform tasks required by OAR 309-019-0200.

(3) Clinical supervisors in all programs shall demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service 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.

(4) Clinical supervisors in substance use disorders treatment and recovery programs shall be certified or licensed by a health or allied provider agency as follows:

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

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

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

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

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

(A) Oregon Medical Board;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

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

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

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

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

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

(6) Clinical supervisors of mental health services shall meet Qualified Mental Health Professional (QMHP) requirements and have completed two years equivalent of post-graduate clinical experience in a mental health treatment setting.

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

(8) Substance use disorders treatment staff shall:

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

(b) Receive clinical supervision that documents progress towards certification and recertification; or

(c) At the date of first hire to provide substance use disorder treatment, if the program staff is not certified to provide substance use disorder treatment, they shall register with the Division recognized credentialing body within 30 days of hire and obtain professional substance use disorder treatment certification within two years from the date of first hire unless they obtain a variance from the Division before that time has elapsed;

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

(A) 1000 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 professional psychometric examination by a Division recognized credentialing body. A substantively equivalent portfolio evaluation by Division recognized credentialing body may be accepted in lieu of a professional psychometric examination using procedures approved by the Division.

(e) Substance use disorder treatment staff not holding certification from a Division recognized credentialing body in substance use disorder counseling shall have a license or registration from a Division recognized credentialing body and at least 60 contact hours of academic or continuing professional education in the treatment of substance use disorders. The license or registration shall have been issued by one of the following state bodies:

(A) Oregon Medical Board;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

(9) Problem gambling treatment staff shall:

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

(b) Receive clinical supervision that documents progress towards certification and recertification;

(c) At the date of first hire to provide problem gambling ~~substance use disorder~~ treatment, if the program staff is not certified to provide problem gambling ~~substance use disorder~~ treatment, they shall register with the Division recognized credentialing body within 30 days of hire and obtain professional problem gambling ~~substance use disorder~~ treatment certification within two years from the date of first hire unless they obtain a variance from the Division before that time has elapsed;

(d) For program staff holding certification in problem gambling counseling, qualifications for the certificate shall have included at least:

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

(B) 3~~6~~0 contact hours of education and training in problem gambling related subjects; and

(C) 24 hours of face-to-face, telephone, email or other electronic communication, of certification consultation from a problem gambling approved certification consultant; and

(D) Successful completion of a professional psychometric examination by a Division recognized credentialing body or a substantively equivalent portfolio evaluation by a Division recognized credentialing body may be accepted in lieu of a professional psychometric examination using procedures approved by the Division.

(e) Program staff not holding certification in gambling addiction counseling by a Division recognized credentialing body shall have at least 3~~6~~0 contact hours of academic or continuing professional education in the treatment of gambling addiction. The license or registration shall have been issued by one of the following state bodies:

(A) Oregon Medical Board;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

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

(E) Oregon State Board of Nursing.

(10) Rehabilitative Behavioral Health Service Providers, including medical treatment staff, shall demonstrate cultural responsiveness and meet the requirements and qualifications in OAR 410-172-0660.

(11) Behavioral health clinicians shall meet one of the following qualifications and maintain the corresponding credential in the State of Oregon:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

(c) A licensed nurse practitioner with a specialty in psychiatric mental health;

(d) A licensed clinical social worker;

(e) A licensed professional counselor or licensed marriage and family therapist;

(f) A certified clinical social work associate;

(g) A Mental Health Intern or resident who is working under a board-approved supervisory contract in a clinical mental health field;

(h) A Qualified Mental Health Practitioner (QMHP); or

(i) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(12) Qualified Mental Health Associates (QMHA) program staff shall:

(a) Demonstrate the following minimum competencies: cultural responsiveness, effective communication, care coordination, inter- and intra-agency collaboration, working alliances with individuals, assist in the gathering and compiling of information to be included in the assessment, screen for suicide and other risks, and implement timely interventions, teach skill development strategies, case management, and transition planning;

(b) Render services and supports within their scope to individuals engaged in a Division approved behavioral health services provider; and

(c) Shall meet the following minimum qualifications:

(A) Bachelor's degree in psychology, social work, or behavioral science field;

(B) An equivalent degree as evidenced by providing transcripts indicating applicable coursework meeting the required competencies and approved by a Division certified behavioral health provider; or

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

(d) Receive clinical supervision that documents progress towards certification and recertification.

(13) Qualified Mental Health Professional (QMHP) program staff shall:

(a) Demonstrate the following minimum competencies: cultural responsiveness, effective communication, care coordination, inter- and intra-agency collaboration, working alliances with individuals, suicide and other risk assessments and interventions, creating and monitoring safety plans, completion of bio-psycho-social assessments and additional assessments, updating assessments when clinical circumstances change, generating a differential DSM-5-TR diagnosis, prioritizing health, wellness and recovery needs, writing measurable service objectives, creating, monitoring and revising service plans, delivery of mental health and recovery treatment services in individual, group and family formats within their scope, gathering and recording data that measures progress toward the service objectives and documenting services, supports and other information supportive of the service plan.

(b) Render services and supports within their scope to individuals engaged in a Division approved behavioral health services program;

(c) Meet the following minimum qualifications:

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

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

(C) Graduate degree in psychology, social work, recreational art or music therapy, or behavioral science field;

(D) An equivalent degree as evidenced by providing transcripts indicating applicable coursework meeting the required competencies and approved by a Division certified behavioral health provider; or

(E) Qualify as a Mental Health Intern, as described in these rules.

(d) Receive clinical supervision that documents progress towards certification and recertification.

(14) Mental Health Intern (MHI) program staff shall:

(a) Be currently enrolled in a graduate program for a master's degree in psychology, social work, or related field of behavioral science;

(b) Have a collaborative educational agreement between the Division certified provider and the graduate program for the student;

(c) Demonstrate cultural responsiveness, effective communication and competence in care coordination, development of working alliances with individuals, inter- and intra-agency collaboration, and the rendering of services and supports within their scope and in accordance with the service plan, including transition planning; and

(d) Work within the scope of practice and competencies identified by collaborative educational agreement and the policies and procedures for the credentialing of clinical staff as established by the provider and the graduate program;

(15) Student Intern program staff shall:

(a) Be currently enrolled in an educational program for an undergraduate degree in a behavioral health field;

(b) Have a collaborative education agreement between the Division certified provider and the educational institute for the student;

(c) Demonstrate cultural responsiveness, effective communication and competence in care coordination, development of working alliances with individuals, inter- and intra-agency collaboration, and the rendering of services and supports within their scope and in accordance with the service plan, including transition planning;

(d) Work within the scope of practice and competencies identified by the collaborative educational agreement and the policies and procedures for the credentialing of clinical staff as established by the provider; and

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

(f) Render services and supports under the direct supervision of a qualified supervisor employed by the provider of services, within the scope of practice and competencies identified by the collaborative educational agreement, and within the policies and procedures for the credentialing of program staff as established by the provider.

(16) Intern program staff shall:

(a) Be working towards obtaining a behavioral health credential;

(b) Demonstrate cultural responsiveness, effective communication and competence in care coordination, development of working alliances with individuals, inter-and intra-agency collaboration, and the rendering of services and supports within their scope and in accordance with the service plan, including transition planning;

(c) Work within the scope of practice and competencies identified by the applicable Division recognized credentialing body and the policies and procedures for the credentialing of clinical staff as established by the provider; and

(d) Render services and supports under the direct supervision of a qualified supervisor employed by the provider of services, within the scope of practice and competencies identified by the applicable Division recognized credentialing body, and within the policies and procedures for the credentialing of program staff as established by the provider.

(17) Community Health Workers working in substance use disorders treatment and recovery programs shall be certified as described in OAR 410-180-0310 and who:

(a) Has expertise or experience in behavioral health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the members of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community members in receiving the care they need;

(g) CHW staff may:

(A) Give peer assistance and guidance on health including behavioral health behaviors; and

(B) Provide skills restoration services.

(18) Peer Support Specialists and Peer Wellness Specialists, including family and youth support and wellness specialists, shall meet the requirements in OAR 410-180-0300 to 0380 for certification and continuing education, and:

(a) A Peer Support Specialist and Peer Wellness Specialist shall be:

(A) Someone self-identified as currently or formerly receiving mental health, problem gambling or substance use services;

(B) Someone self-identified as in recovery from a substance use disorder;

(C) Someone self-identified as in recovery from problem gambling; or

(D) Someone who has experience parenting a child who:

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

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

(b) A Peer Support Specialist and Peer Wellness Specialist shall demonstrate:

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

(B) Personal life experience and tools of self-directed recovery and resiliency; and

(C) Demonstrate cultural responsiveness and effective communication.

(19) “Youth support specialist” means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(a) Is not older than 30 years of age; and

(b) Is a current or former consumer of mental health or addiction treatment; or

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

(d) A “youth support specialist” may be a peer wellness specialist or a peer support specialist.

(20) Program staff include:

(a) Oregon Licensed Medical Professional (LMP) licensed by the Oregon Medical Board;

(b) Oregon Licensed Practical Nurse (LNP) licensed by the Oregon Board of Nursing;

(c) Oregon Registered Nurse (RN) licensed by the Oregon Board of Nursing;

(d) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(e) Psychologist licensed by the Oregon Board of Psychology;

(f) Professional Counselor (LPC) or Marriage and Family Therapist (LMFT) licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(g) Clinical Social Worker (CSW) licensed by the Oregon Board of Licensed Social Workers;

(h) Licensed Master Social Worker (LCSW) licensed by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;

(i) Licensed Psychologist Associate granted independent status as described in OAR 858-010-0039;

(j) Licensed Occupational Therapist licensed by the Oregon Occupational Therapy Licensing Board;

(k) Board registered interns, including:

(A) Psychologist Associate Residents as described in OAR 858-010-0037;

(B) Licensed Psychologist Associate under continued supervision as described in OAR 858-010-0038;

(C) Licensed Professional Counselor Associate or Marriage and Family Therapist Associate registered with the Oregon Board of Licensed Professional Counselors and Therapists as described in OAR 833-050-0011;

(D) Certificate of Clinical Social Work Associate issued by the Oregon Board of Licensed Social Workers as described in OAR 877-020-0009;

(E) Registered Bachelor of Social Work issued by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105.

(l) Qualified Mental Health Professional (QMHP) as defined in OAR 309-019-0125(8);

(m) Qualified Mental Health Associate (QMHA) as defined in OAR 309-019-0125(7);

(n) Mental health intern as defined in OAR 309-019-0105;

(o) Problem Gambling treatment staff registered with the Mental Health and Addiction Certification Board of Oregon (MHACBO), which includes:

(A) Certified Gambling Addiction Counselor-Registered (CGAC-R);

(B) Certified Gambling Addiction Counselor-I (CGAC-I); or

(C) Certified Gambling Addiction Counselor-II (CADC-II).

(p) Substance Use Disorders (SUD) Treatment Staff, which includes:

(A) Certified Alcohol and Drug Counselor-Registered (CADC-R);

(B) Certified Alcohol and Drug Counselor-I (CADC-I);

(C) Certified Alcohol and Drug Counselor-II (CADC-II); and

(D) Certified Alcohol and Drug Counselor-III (CADC-III).

(q) Peer-Support Specialist (PSS) as defined in OAR 410-180-0305;

(r) Peer Wellness Specialist;

(s) Peer Delivered Services Supervisor;

(t) Tribal Traditional Health Worker; and

(u) Youth Support Specialist.

(21) Milieu staff are not required to have credentials. Milieu staff shall have or obtain training and education in de-escalation, mental health symptoms, substance use disorder symptoms, and suicide ideation identification to maintain a safe, supportive and effective treatment environment, and shall demonstrate effective:

(a) Knowledge of substance use disorders, including the ability to identify drugs and paraphernalia, post-acute withdrawal symptoms, triggers and relapse warning signs;

(b) Interpersonal boundaries, communication and coordination within the interdisciplinary team;

(c) Application of the program's Code of Conduct, philosophy, guidelines, policies, procedures, standards and expectations;

(d) Safe, trauma informed and respectful interpersonal communications and behaviors; and

(e) Identification of symptoms, behaviors and circumstances that require notification of or consultation with a program or medical treatment staff.

Statutory/Other Authority: ORS 413.042, 430.640 & 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549 & 743A.168

309-018-0135

Rule Action: Amend
Title **Entry**

Brief Summary of changes Streamlining and clarifying requirements for entry into SUD and PG residential programs.

(1) The providergram mustshall utilize an entry procedure that at a minimum willshall ensure the ~~provision and documentation of the~~ following:

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

(c) The provider may not deny entry to individuals based on the individual's decision to continue their currently prescribed medication to treat opioid dependence while receiving residential substance use disorder services.

(2) Except as permitted by law in emergencies, informed consent for services must be obtained prior to services. Written, voluntary informed consent for services shall be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason and any further attempts to obtain informed consent shall be documented in the service record.

(3) Per CFR~~RF~~ 440.230, the provider shall develop and maintain service records and other documentation that demonstrates amount, duration and scope of each specific services and supports provided for each individual.

~~(4) The provider shall submit the identified status and service data, including Non-Medicaid Service Data where required, in the mandated state data system according to the timelines required by the Division for each individual whose services are paid for in-full or in-part by public funds and for individuals enrolled in DUII services.~~

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

(6) In accordance with HIPAA Rules and CFR 164.520 , except as permitted by law in emergencies, p~~P~~rior to or at the start of treatment services, ~~but no later than 3 days from initial service contact~~, the program must obtain written, voluntary informed consent for services from the individual or guardian, if applicable. The provider shall offer to the individual and guardian, if applicable, written program information. The written program information shall be in a language understood by the individual and must include disclosures and description of services to be provided, as well as other information regarding the program. The written program information ~~and~~ shall include:

~~(a) Program consent, disclosure, and orientation information.~~

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

~~(c) Information on how to file grievances and appeals consistent with these rules, including an example grievance form;~~

(b~~d~~) Notice of privacy practices; ~~and~~

~~(e) Information on how to register to vote, per the National Voter Registration Act of 1993, Section 7. Provider agency will supply means to register to vote upon request.~~

~~(7) Entry requirements for providers that receive the Substance Use, Prevention, Treatment and Recovery (SUPTR) Block Grant:~~

~~(a) Providers shall maintain waitlist documentation demonstrating that individuals are prioritized for entry in the following order:~~

~~(A) Individuals who are pregnant and using substances intravenously;~~

~~(B) Individuals who are pregnant;~~

~~(C) Individuals who are using substances intravenously; and~~

~~(D) Individuals or families with dependent children.~~

~~(b) Entry of pregnant individuals shall occur no later than 48 hours from the date of first contact and entry of individuals using substances intravenously shall occur no later than 14 days after the date of first contact. If services are not available within the required timeframes, the provider shall document the reason and provide interim referral and informational services, as defined in these rules, within 48 hours; and~~

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

~~(A) An opportunity for the individual to engage in interactive social services through care coordination, peer services or other interactive supports.~~

~~(B) Educational material about blood borne pathogens including Hepatitis, HIV, STDs, and Tuberculosis (TB); the risks of needle and paraphernalia sharing; and the likelihood of transmission to sexual partners and infants;~~

~~(C) Educational information about steps that can decrease the likelihood of Hepatitis, HIV, STD, and TB transmission;~~

~~(D) Resource recommendations for addressing Hepatitis, HIV, STD, and TB testing, vaccine, or care services if necessary; and~~

~~(E) For pregnant individuals, interactive social services and educational information addressing the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco, and other drug use on the fetus and referral for prenatal care.~~

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640 & 443.450
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549 & 743A.168

309-018-0140

Rule Action: Amend
Title **Assessment**

Brief Summary of changes streamlining and clarifying requirements for assessment in residential SUD and PG programs.

(1) Per CMS Medicaid Manual Section 4221, a~~A~~t the time of entry, an intial assessment documenting a medically necessary reason for services, appropriateness for treatment by the program, and current risks must be~~the assessment process shall begin, be updated or~~ completed and signed by a qualified ~~program~~ staff. Providers must complete a full assessment that includes comprehensive biological, psychological, social and historical information for comprehensive service planning within a timeline that prioritizes immediate individual needs, but no later than 10 business days following the first date of service. - Each assessment must~~document shall~~ include~~provide record~~ clinically relevant information, or documented review of past records that contain, at minimum;

(a) ~~Sufficient information and d~~Documentation to justify the presence of a DSM-5-TR ~~or ICD-10~~ diagnosis that is the medically necessary reason for services, including identification of each DSM-5-TR- criteria established per diagnosis, and the symptoms supporting each criteria;

(B) Screening for the presence of suicide risk and interventions, as indicated ~~based on the information gathered~~; and

(C) A determination of immediate ~~the~~ need for follow-up actions, additional services and supports, and the level of safety risk to the individual or to others, as well as psychological and physical trauma risk ~~to the individual or to others~~.

(D) For updated assessments or assessments for participants returning to services ~~in less than one calendar year~~, collateral information such as previous assessments can be used to inform the current assessment. Information supporting a medically necessary reason for services~~medical necessity~~, immediate risk screening, and a physical and psychological trauma screenings~~.~~ must be verified in initial assessment interviews

(b) Should a medically necessary reason for services ~~medical necessity~~ not be possible to document at entry, the following services may be rendered by the provider prior to an assessment being completed, provided that screening for suicide risk, immediate needs, safety and trauma have been completed by the provider. The following services can be provided for up to three business days without a documented medically necessary reason for services, or ~~or~~ at any appropriate time during a treatment episode:

(A) Care coordination (such as certain types of case management);

(B) Peer mentoring;

(C) Screening; and

(D) Crisis intervention.

(c) Assessments and updated assessments are considered comprehensively complete when the following information has also been added to assessment documentation within 10 business days of the initial service date; ~~Assessments conducted over no more than ten business days are complete when the following information has also been documented within ten business days of the first assessment service date;~~

(A) Symptoms related to psychological and physical trauma;

(B) Current suicide risk;

(C) Current Substance use;

(D) Current Problem Gambling Behavior;

(E) Current Mental Health conditions, including current prescribed Psychiatric medications;

(F) Current Medical conditions, including current prescribed treatments and medications;

(G) Additional and sufficient Historical, Biological, Psychological and Social information relevant to planning services; and

(H) When indicated, documentation shall contain referral for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(d~~b~~)When the assessment and screening processes determine the presence of any of the above conditions listed in A – F, or any risk to health and safety to the individual or others:

(A) Further assessment shall be completed to determine the need for follow-up actions, additional services and supports and the level of risk to the individual or to others; and

(B) Documentation shall contain recommendations for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(2) In addition to completion of a-d above, for substance use disorder services each assessment and update thereof must~~shall~~ be a multidimensional assessment, consistent with *The ASAM Criteria, Third Edition*. An initial ASAM assessment can record information derived from observation, self-report interview, collateral information or any combination of these. ~~,~~ and include, at a minimum the following components, each consistent with *The ASAM Criteria, Third Edition*:

(a) A Level of Care recommendation for each ASAM dimension based on current and available information. ; ~~and~~

~~(b) An initial ASAM assessment can record information derived from observation, self-report interview, collateral information or any combination of these. An initial ASAM assessment will also cover, at minimum;~~

(b~~A~~) Diagnostic criteria for Substance Use Disorder if not documented in previous assessment documents in the current treatment episode; ~~s endorsed by individual in interest of supporting medical necessity for Substance Use Disorder diagnosis~~.

(c~~B~~) A consideration of the history of each substance use related risk as well as the present substance use related concern(s);

~~(C) An identification of immediate need(s) and risks;~~

(d~~D~~) A severity of risk for each dimension; and

(e~~E~~) An overall determination of the severity of risk the individual currently is experiencing.

(3~~c~~) A comprehensive and complete ASAM assessment will be completed as soon as possible but in no more than 10 business days and include full supporting historical, biological, social and psychological information for purposes of comprehensive service planning.

(d) Any changes to the ASAM Level of Care placement decision shall be justified within an update to the multidimensional assessment on file; and

(e) Providers shall update assessments within the scope of their practice when there are changes in clinical circumstances.

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640 & 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549 & 743A.168

309-018-0145

Rule Action: Amend
Title **Service Plan and Service Notes**

Brief Summary of changes Streamlining and clarifying requirements for service plans and service notes in residential SUD and PG programs.

(1) The Service Plan shall be a written, individualized plan to improve the individual's condition to the point where the individual's continued participation in the program or level of care is no longer necessary. Per Oregon State Plan, brief services may be provided prior to completion of a Service Plan. Per CMS State Medicaid Manual, section 4221, services not documented in a Service Plan may be provided with documented explanation. The Service Plan is included in the individual's service record and shall:

(a) Be started prior to the rendering of treatment services, and provider must document reason for any delay in the service record ;

(b) Reflect the initial or comprehensive assessment in its' most updated form;

(c) Address areas of concern identified in the assessment that the individual agrees to address;

(d) Include a safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the Service Plan;

(e) Include the participation, and reflect agreement, of the individual and family members as applicable; and

(f) Be completed and signed by qualified program staff as follows:

(A) Supervisory or treatment staff in substance use disorders treatment and recovery programs; and

(B) Supervisory or treatment staff in problem gambling treatment and recovery programs.

(2) ~~At minimum~~ Per CMS State Medicaid Manual, section 4221, a~~A~~t minimum, each service plan, in addition to requirements in 309-019-0135 (1) -above- , each service plan shall include:

(a) Treatment objectives that are:

(A) Individualized to meet the assessed needs of the individual.

(B) Comprehensive service plans must be written within ten business days from entry. Comprehensive service plans must~~will~~ be measurable, with inclusion of baseline measurements, for the purpose of evaluating individual progress, as well as;

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

(c) The expected frequency, quantity and duration of each type of planned service or support; and

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

(3) Providers shall document ~~each service and support~~ in a service note each service and support that ~~to~~ includes the following:

(a) The specific services rendered;

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

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

(d) The personnel rendering the services, including the name, credentials and signature;

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

(f) Periodic updates describing the individual's progress.

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640 & 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549 & 743A.168

309-018-0150

Rule Action: Amend
Title **Service Record**

Brief Summary of changes streamlining and clarifying requirements for service records in residential SUD and PG programs.

(1) Documentation shall 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) All providers shall develop and maintain a Service Record for each individual. The record shall, at a minimum, include:

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

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

(B) First and last n~~N~~ame, address, and telephone number of the parent or legal guardian, primary care giver or emergency contact; and

(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) 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;

(f) 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;

(g) 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;

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

(i) 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;

(j) Documentation of any safety risks;

(k) Documentation of follow-up actions and referrals when an individual reports symptoms indicating risk of suicide; and

(l) Critical Incidents shall be reported to the Division through submission of an incident report and as applicable, to the Office of Training Investigation and Safety (OTIS), and other authorities:

(A) In at least the following examples of circumstances:

(i) Death, including by suicide or overdose;

(ii) Severe injury, overdose resulting in hospitalization or needing medical attention, and emergency services needed;

(iii) Ongoing risk to health (for example: environmental risks such as certain~~black~~ molds that pose risks to health);

(iv) Police involvement;

(v) Extensive damage to the facility or other substantial change in living conditions; and

(vi) Where abuse or neglect is suspected, including unethical client and staff relationships; and

(vii) Relationships between individuals that result in harm to at least one individual or that are sexual in nature.

(B) Within 24 hours of the event;

(C) On the original, unredacted incident report;

(D) All incident reports shall be maintained in the corresponding service record and in a common file for quality improvement purposes and review by the Division; and

(E) In accordance with privacy rules and regulations, incident reports filed in service records shall not contain protected health information belonging to any other individual.

(3) Incident reports shall contain, at a minimum, the following information:

(a) The time and date of the event;

(b) The time and date of when the incident report form was completed;

(c) Name and title of staff who filled out the report;

(d) Identification of all staff involved in the incident and the response to the incident, and their titles;

(e) Identification of each individual involved;

(f) Description of event;

(g) Description of program response;

(h) Description of which policies and procedures were followed and when appliable, any that were not followed;

(i) Identification of staff who were notified, and their titles;

(j) Identification of which authorities the event was reported to; and

(k) Description of administrative response and follow-up.

(4) When medical services are provided by the program or a community provider, the following documents shall be part of the Service Record as applicable:

(a) Medication administration records as per these rules;

(b) Laboratory reports;

(c) LMP orders for medication, protocols or procedures; and

(d) Documentation of medical screenings, assessments, consultations, interventions, and procedures.

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640 & 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549 & 743A.168