



NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 309
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: BEHAVIORAL HEALTH SERVICES

FILED

10/31/2025 1:20 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Update with proper guidance per the Tool for Measuring Assertive Community Treatment (TMACT) fidelity scale

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 12/19/2025 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Angella James
503-367-6414
angella.pulkownik2@oha.oregon.gov

500 Summer St, NE
Salem, OR 97301

Filed By:
JUAN RIVERA
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2025

TIME: 11:00 AM - 11:50 AM

OFFICER: Jessica Malstrom

REMOTE HEARING DETAILS

MEETING URL: Click here to join the meeting

PHONE NUMBER: 1-669-254-5252

CONFERENCE ID: 1603955749

SPECIAL INSTRUCTIONS:

Join ZoomGov Meeting

<https://www.zoomgov.com/j/1603955749?pwd=pyXL0WhVmdUOp5JIL3QY8LQzjk2F8H.1>

Meeting ID: 160 395 5749

Passcode: 088694

call in:

16692545252

Meeting ID: 160 395 5749

Passcode: 088694

NEED FOR THE RULE(S)

Oregon was previously utilizing a modified fidelity scale; which was not producing the intended outcomes of ACT services. The Division developed a strategic plan to transition ACT Providers to a new fidelity scale called the TMACT. This evidence-based practice is recognized by SAMHSA and has an extremely large network of States who have

successfully implemented model into practice producing positive improvements. With the support of co-author of the TMACT- Dr. Maria Monroe-DaVita; The Division has incorporated Oregon based metric of measurement to establish a fidelity review process that will evaluate the entire holistic service implementation per the ACT core principles.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Additional documentation used to develop these updates are as follows:

1. TMACT Fidelity Scale: University of Washington's SPIRIT Lab: <https://uwspiritcenter.org/assertive-community-treatment-act-3/act-resources/tool-for-measurement-of-assertive-community-treatment-tmact/>
 2. Oregon adaptations for Rural & Frontier TMACT Fidelity Scale attachment
 3. South Carolina-Department of Health and Human Services- Addition of ACT Services:
<https://www.scdhhs.gov/communications/addition-assertive-community-treatment-services>
 4. National Library of Medicine: "Hospitalization of high and low inpatient service users before and after enrollment into Assertive Community Treatment teams: a naturalistic observation study"
<https://pmc.ncbi.nlm.nih.gov/articles/PMC4772328/>
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STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

ACT OAR updates will create an accountability structure to ensure any individual across the Oregon Behavioral Health spectrum, whether they are seeking to obtain this service or are admitted to receive the are afforded the rights to be properly evaluated per the outlined criteria and all decisions of entry or denial are provided in a culturally and linguistic manner with person-centered language timely. If approved for entry, these updates provide a more robust & comprehensive evaluation structure that will incentivize the implementation of best practice guidelines to support the mission of providing high quality services to some of Oregon's most vulnerable citizens.

FISCAL AND ECONOMIC IMPACT:

No anticipated impact as these practices should already be in place per ACT core principles; they just have never been fully evaluated via fidelity review. Initial fidelity reviews will be projections, therefore no negative impacts. The Division will be monitoring and evaluating data after full updates approved with intentions of including a cost analysis in collaboration with the Oregon Center for Excellence for ACT (OCEACT).

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

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

Certified Behavioral Health Providers who are accredited to provide ACT services and Care Coordinated Agencies.

2. Effect on Small Businesses:

Programs who previously did not promote community-based services in the way ACT intended by meeting a client where they are as opposed to requiring client to come to them.

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

There are currently 36 accredited ACT Programs in Oregon. All 14 Coordinated Care Organizations are equipped and funded to provide this service to their members.

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

Since this fidelity scale has never been implemented in Oregon before; the expected cost is unknown. This is a result of amendments The Division has made to alleviate burden & reduce TMACT FTE requirements in nursing requirements & administrative tasks. Data includes all Division required PHI and billable statistical information with sixteen additional ACT specific data indicators intended to capture outcomes.

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

ACT services are individualized to promote person-centered care therefore, the ACT billing code does not have a limitation in a 24hr period; the average cost is still being evaluated to avoid misinformation of proper billing structure.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Representation of Rural & Frontier ACT Teams are represented on the RAC. OHA also held three community engagement platforms specifically dedicated to Rural and Frontier input.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

309-019-0225, 309-019-0226, 309-019-0230, 309-019-0231, 309-019-0233, 309-019-0235, 309-019-0240, 309-019-0241, 309-019-0242, 309-019-0245, 309-019-0248, 309-019-0250, 309-019-0255

AMEND: 309-019-0225

RULE SUMMARY: Added new definitions and removed language no longer relevant.

CHANGES TO RULE:

309-019-0225

Assertive Community Treatment (ACT) Definitions ¶¶

(1) In addition to the definitions in OAR 309-019-0105, when used and not otherwise defined in OAR 309-019-0225 through OAR 309-019-0255, the following terms shall have the meaning given in this section.¶¶

(2) "24/7 Crisis Coverage" means the ACT Team will develop internal procedures to ensure ACT participants have access to the on-call ACT staff if they are experiencing a mental health crisis 24 hours a day, 7 days a week, 365

days a year;¶¶

(a) ~~The ACT Teams will staff accordingly to ensure availability to receive these crisis calls from participants.~~ ACT Teams must be readily available to assist with de-escalation strategies and have direct access to treatment & crisis plans created for that participant to ensure full ACT benefit of service. This could include dispatching out to the individual in need;¶¶

(b) The ACT Team is required to document all received crisis coverage calls and dispatches by the ACT Team as part of this service delivery.¶¶

(3) "Admission" means for ACT service implementation is when a person is deemed fully eligible for ACT services and the service is available to be received immediately by going through the entire Standardize Referral Process for ACT services. This includes notification of first appointment within seven (7) calendar days.-¶¶

(4) "Assertive Community Treatment" or "ACT" means an intensive and highly integrated Community-Based outpatient service that upholds the integrity of the evidence-based practice and recovery-oriented mental health service. It is a person-centered approach with a Multidisciplinary Team concept. Program operations are held to a fidelity standard based on the Division approved fidelity scale.¶¶

(5) "Capacity" for ACT services means an ¶¶

(6) "Community-Based" means services and supports that must be provided in a participant's home and/or surrounding community. This can include but not limited to virtual telehealth, or in the community where the participant feels most comfortable. This is person-centered and will be tailored to the participants discretion.-¶¶

(67) "Competitive Integrated Employment" means full-time or part time work with the following criteria:¶¶

(a) At minimum wage or higher;¶¶

(b) At a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees;¶¶

(c) With eligibility for the level of benefits provided to other employees and that the position is open to the public to ensure competitiveness;¶¶

(d) Internships that are open to anyone. This includes work-study opportunities with colleges and or trade schools;¶¶

(e) Seasonal employment that is consistent with that industry of work;¶¶

(f) Self-Employment when income is reported to the government and taxes can be filed if income generated met those requirements.¶¶

(g) Employment from temporary agencies that community members use is counted if that agency and/or industry typically hires from the temporary services. This option does not replace the Employment Specialists roles per fidelity scale.-¶¶

(h) Employment services are integrated within an active Mental Health treatment plan.-¶¶

(78) "Comprehensive Assessment" means the organized process of gathering and analyzing current and past information with each individual and any other informal support deemed relevant with analytic evaluation process that the ACT clinician must do during the Screening portion within the Standardize Referral Process. This includes but not limited to gathering collateral information and analyzing current and past progression and/or decompensation in stability and self awareness for each individual. This assessment may also include interviews with both Informal & Natural Supports. ACT clinician has the autonomy to identify what information is deemed relevant for the Comprehensive Assessment due to intent to create an Individual Treatment Plan per (19) of this rule set with the following:¶¶

(a) Mental and functional status;¶¶

(b) Effectiveness of past treatment;¶¶

(c) Current treatment, rehabilitation, and support needs to achieve person-centered goals and support recovery; and¶¶

(d) The range of individual strengths (e.g., knowledge gained from dealing with adversity, personal or professional roles, talents, personal traits) that may act as resources to the participant and the recovery plan in pursuing goals. The results of the information gathered, and analysis are used to:¶¶

(A) Establish immediate and long-term service needs with each ACT Participant;¶¶

(B) Set goals and develop the first person directed recovery plan with each ACT participant; and,¶¶

(C) Optimize benefits that can be derived from existing strengths and resources of the participant, family, and natural support network in the community.¶¶

(89) "Co-Occurring Disorders (COD) Specialist" means the core staff identified within the ACT Team to conduct integrated assessments and treatment strategies for ACT Participants who have co-occurring mental health and substance use conditions. This team member must have proper credentials per Behavioral Health Outpatient OAR's: Chapter 309, Division 019 and licensed in the State of Oregon.-¶¶

(910) Crisis Plan: A document accessible by all ACT Team members & clearly identifiable as the Crisis Plan for that individual. This document must include at minimum:¶¶

(a) Identification of triggers and any known risk factors (e.g history of aggression, self harm etc).-¶¶

- (b) Procedures and strategies to defuse & de-escalate¶¶
- (c) Intervention tactics to minimize the likelihood of self harm & harm to others.¶¶
- (d) Medications and any known allergies.¶¶
- (e) Key contact list with at minimum, emergency personnel and avenue for escalation pathway of emergency commitment.¶¶
- (f) All action items or strategies need to be precise language for quick reading to promote safety for participant, others and ACT staff.¶¶
- (101) "Division" means the Behavioral Health Division within Adult Mental Health of the Oregon Health Authority.¶¶
- (112) "Division Approved Reviewer" means the Division's contracted entity that is responsible for conducting ACT fidelity reviews, training, and technical assistance to support new and existing ACT programs statewide.¶¶
- (123) "Employment Specialist" means the staff identified on the ACT Team to provide Employment Support Services and is a direct part of the Multidisciplinary Team per the fidelity scale. This staff member provides employment specific supportive services per (32) of this rule set and is typically supervised by Team Lead within the ACT program, unless they are part of a solo Individual Placement and Supports (IPS) Team. However, even if part of an IPS Team, the Employment Specialist is still considered as part of the Multidisciplinary team of ACT service implementation.¶¶
- (134) "Face to Face" means that a personal interaction where communication between at least two-person(s) can be had either in-person or virtually through telehealth services per Medicaid OAR 410-120-1990 rule set. Virtual Telehealth meetings for Face-to-Face therapy fidelity measurement purposes will be counted and accepted as face-to-face as long as documentation supports the meeting followed Medicaid standards cited within this definition.¶¶
- (145) "Fidelity" means the ACT Program is able to reproduce service implementation that is faithful to the evidence-based practice model approved by the Division in a way that they can obtain the minimum benchmark score on the comprehensive fidelity evaluation report from the Division Approved Reviewer¶¶
- (156) "Fidelity Tool" means the documents used to score and evaluate programs fidelity based on the Division approved fidelity scale.¶¶
- (167) "Fixed Point of Responsibility" means the ACT Team provides virtually all needed mental health treatment services, rather than sending participants to different service deliveries even if those other service deliveries are within the same agency. If the ACT Team cannot provide a treatment service, the program will accommodate.¶¶
- (178) "Frontier ACT Team" for ACT services means the ACT Team capacity or clients served is predominantly in a geographical area with six or fewer people per square mile. ¶¶
- (19) "Full-Time Equivalent" or "FTE" means for ACT fidelity purposes, a way to calculate the needed time for a staff member's duties to be dedicated to the ACT program service implementation for ACT participants, with a measurement based on a 40-hour work week regardless of program job description FTE status. The consistency of 40 hours is part of the evidence-based practice and ensures equitable scoring for all Teams within the State.¶¶
- (1820) "Hospital Discharge Planning" means collaboration between the ACT Team, the Oregon State Hospital (OSH) or any other acute care psychiatric hospital for care coordination and discharge planning, developed and implemented through a person-centered planning process for active ACT Participant's or Oregonian's seeking to receive ACT services through the Standardized Referral Process.¶¶
- (219) "Informal Support System" means a person(s) (often another professional) outside of ACT program that supports the participant, such as, landlord, shelter staff, employer, or other key person(s) identified by the participant or ACT staff for the purposes of care coordination and/or treatment plan development.¶¶
- (202) "Individualized Treatment Plan" means a document that the entire ACT Team have direct access to as needed that reflects all clinically relevant information about each participant. This document is considered an evolving document and updates made as deemed clinically necessary and is person-centered. Initially it should include information gathered during the "Comprehensive Assessment" as defined in (10) of this rule set along with:¶¶
 - (a) Person centered goals that clearly identify a realistic benchmark for success based on capacity of understanding for the participant to reference;¶¶
 - (b) The benchmarks will be focused on preferences and not used as a mechanism of enforcing any sort of compliance to receive ACT services. They will be culturally and linguistically specific as identified by ACT Participants.¶¶
- (213) "Large ACT Team" means an ACT team serving between 80 to 120 individuals is the category identifier for an ACT team who has 81- 120 active participants. ¶¶
- (224) "Life Skills Training" means training that assists individuals develop the necessary and meaningful skills with intention to promote independence so that a participant can enhance their quality of life within the community and social environments that are deemed relevant and important to them.¶¶
- (25) "Medication Administration" means for ACT services when an ACT team member, who is medically trained

and licensed team member per their State Licensing & Certification Board oversight, dispenses medication for the participant. This can include dispensing single or multiple doses, injections or direct application of ointment/barrier balm¶¶

(236) "Medication Management" means the that the ACT Team may be directly providing supports for the Participant such as prescribing, administering, and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. For the purposes of ACT, Medication Management is a collaborative effort between the individual receiving services and the prescribing psychiatrist or psychiatric nurse practitioner with the ACT treatment program.¶¶

(247) "Mid-Size Act Team" means an ACT team serving between 41 and 79 individuals. "Medication Supports" means for ACT services that a participant relies on the ACT Team for reminders, cueing and distribution in order for participant to sustain ability to self-administer their medications. This can include care coordination assistance with navigating pharmacies, and assistance navigating insurance related to medications or directly hand deliver medications for self-administering. There is no physical intervention aside from hand off of medication provided.¶¶

(28) "Mid-Size Act Team" is the category identifier for an ACT team that has between 41 and 80 actively enrolled.¶¶

(259) "Natural Supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for individuals. This includes but not limited to family relationships, friendships reflecting the diversity of the neighborhood and the community, association with fellow students or coworkers in regular classrooms, and associations developed through participation in clubs, organizations, and other civic activities.¶¶

(2630) "Priority Service Population" for ACT services is the intended criteria of identified criteria for triaging purposes to ensure most vulnerable individuals with a serious mental illness (SMI) are connected to services as quickly as possible. Priority population for ACT services is an adult 18 years of age or older and having a primary diagnosis per the current DSM of at least one of the following:¶¶

(a) Schizophrenia Spectrum Disorder¶¶

(a) Meets criteria having a psychiatric diagnosis according to the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM). This excludes diagnosis related to alcohol or drug disorders, organic brain syndromes, developmental disabilities.¶¶

(b) Have significant functional impairments that exhibit lack of awareness or anosognosia to the extent of requiring intensive outreach supports multiple times a week to monitor as a result of interfering in one's life in at least one of the following ways:¶¶

(A) Self-Care: Significant challenges in personal hygiene, diet, clothing, securing healthcare or having the future mindfulness to plan and carry out medical advice.¶¶

(B) Activities of Daily Living: history of evictions and/or inability to maintain stable residence, struggles to independently utilize transportation services, managing day-to-day finances or accessing needed community services.¶¶

(bC) Bipolar¶¶

(c) Major Depressive Disorder with psychotic features Social Functioning: Difficulty maintaining or establishing social relationships, including but not limited to family or friends and may struggle with recognizing social cues, or not knowing how to respond to others appropriately using social tailoring verbal communication.¶¶

(dD) Anxiety Disorder Concentration and Persistence: history limited to obsessive compulsive disorder (OCD) and Post-Traumatic Stress Disorder (PTSD)¶¶

(27y of difficulty in follow-through from start to finish of basic tasks independently or timely. Has a history of dysregulated interactions or inability to manage emotional responses in a constructive manner that is counterproductive and can result in isolation¶¶

(E) History of Symptoms: Documented history of showing clear indication that condition and/or symptoms were visible for minimum of twelve-months or longer.¶¶

(31) "Projection Fidelity" means for ACT a mock or unofficial fidelity review with the objective of providing a hypothetical fidelity score. This report will be used as a baseline snapshot of that Teams implementation practices in order to create a Technical Assistance plan to support the ACT Team with identified steps they can take to achieve the minimum benchmark score, while also providing highlights of accomplishments.¶¶

(328) "Psychiatry Services" means the prescribing and administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. Psychiatry services shall be provided by a psychiatrist, or a psychiatric nurse practitioner licensed by the Oregon Medical Board.¶¶

(2933) "Rural ACT Team" means the ACT Team's capacity or clients served, are predominantly in a geographical area with ten or more miles from a population center of 40,000 people or more.¶¶

(34) "Screening" for ACT services is the second step of the sStandardize rReferral pProcess. It is the comprehensive evaluation of status and needs of a potential and at minimum must include a face-to-face

interview with a prospective ACT Participant to promote consideration of the whole person. The face-to-face interview is intended to provide the prospective ACT participants an opportunity to receive direct minimum screenings must include a Face-to-Face information about ACT services and obtain permission to gather collateral information from alternative sources that are not the referring party. The interview must be conducted by an ACT clinician with qualified credentials to assess eligible criteria. Properly assess Level of Care eligible criteria.

Alternative sources for information during the Screening phase can also include but not limited to:

(a) Obtaining additional clinical information from other sources that are not the referring party;

(b) Care Coordination meetings or community outreach to any legal authority (e.g. Any legal authority that is assigned to prospective ACT participant (e.g. parole, probation offer, etc))

(b) Family or friends who remain connected to the parole, probation offer, etc) prospective participant.

(c) Additional items listed sources in (a) & (b) of this ruleset cannot delay the best practice timeline per ASAM screening process.

(305) "Single Point of Contact (SPOC)" means the entity that is not directly part of the certified ACT Team and designated to orchestrate the receipt of the Universal Referral Form on behalf of the ACT Team to streamline ease of access for the community. This coordination of supports is in collaboration with the Coordinated Care Organizations (CCO), and/or the certified ACT Program. The SPOC is not a Decision Maker per OAR 309-019-0248.

(316) "Small ACT Team" means is the category identifier for an ACT team serving that has between 10 to 40 individual active participants.

(327) "Symptom Management" for ACT service implementation means to educate or strategize techniques to alleviate or control the specific symptoms experienced by an ACT Participant. This can include but not limited to medication education and/or prescribing, therapy, promote lifestyle and self-care strategies.

(338) "Telehealth" means services that are delivered using secure HIPAA compliant audio and video communication. All allowable accommodations will be made for any individuals with any hearing, visual or physical impairments or disabilities who agree to utilize services in this manner per Medicaid compliance within OAR 410-120-1990 rule set.

(349) "Time-unlimited Services" means services that are not provided on the basis of predetermined timelines but based on medically appropriateness.

(3540) "Urban ACT Team" means for ACT services the ACT Team capacity or clients served is predominantly in a geographical area that is less than 10 miles from the the center of a population center of 40,000 people or more.

(41) "Vocational Services" means the duties performed by the Employment Specialist that leads to Competitive Integrated Employment as defined in 309-019-0225(7)(a) -(g).

(3642) "Waitlisted" means for ACT service implementation when an individual is deemed eligible for ACT services, however the ACT Team currently has the max/highest capacity of participants per their ACT Team ratio size within OAR 309-019-0225(21,24,30).

(437) "Young Adult" means an individual who is 18 years to 25 years old at time of service.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 430.630

AMEND: 309-019-0226

RULE SUMMARY: Updated language for clarity.

CHANGES TO RULE:

309-019-0226

Assertive Community Treatment (ACT) Overview ¶¶

(1) The ACT Model is an evidence-based practice with a specified Service Priority Population per 309-019-0225(26) and is Community Based. This service is designed to be a long-term support; therefore, this service is not intended to be a solution for an immediate or short-term crisis. The clinical evaluation is comprised of specific criteria based on the evidence-based model.¶¶

(a) Operating as a Multidisciplinary Team and Fixed-Point of Responsibility per OAR 309-019-0225(16);¶¶

(b) A recommendation per best practice of at least 10:1 client to staff ratio, to consistently provide necessary staffing diversity and coverage;¶¶

(c) Time-unlimited services;¶¶

(d) Flexible service delivery;¶¶

(e) 24/7 ~~C~~crisis ~~Coverage~~availability.¶¶

(2) ACT Programs must adhere to the following:¶¶

(a) Providing explicit admission criteria that aligns with Oregon Administrative Rules (OAR) with the Service Priority Population as defined in 309-019-0225-(26~~8~~) utilizing the Universal Referral Form provided by the Division per 309-019-0248;¶¶

(b) The admission process and Universal Referral Form must be published for any public person(s) and/or community partners to freely access on program websites to ensure equitable access for all community members.¶¶

(c) Provide a space for group therapy and/or skill building workshops for participants per the fidelity standard requirements. These spaces can be in agency owned buildings; however, majority of other service delivery such as skill building and other core concepts of ACT need to take place within a community setting outside of an office-like atmosphere.

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

REPEAL: 309-019-0230

RULE SUMMARY: Removed this entire section and moved under 309-019-0233.

CHANGES TO RULE:

~~309-019-0230~~

~~ACT Provider Qualifications ¶¶~~

~~(1) In order to be eligible for Medicaid or State General Funds for ACT reimbursement, ACT services shall be provided only by those programs meeting the following minimum qualifications:¶¶~~

~~(2) The program shall hold and maintain a certificate issued under the Oregon Health Authority established in OAR Chapter 309, Division 008 for the purpose of providing Outpatient Behavioral Health Treatment Services; and¶¶~~

~~(3) The provider must hold and maintain a certificate issued by the Division under OAR 309-019-0225 through 309-019-0255 for the purpose of providing ACT; and¶¶~~

~~(4) A provider certified to provide ACT services must be reviewed for fidelity adherence by the Division Approved Reviewer and may not bill Medicaid or use General Funds for the provision of ACT services unless they complete the fidelity review process as outlined within OAR 309-019-0235.~~

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

~~Statutes/Other Implemented: ORS 109.675, 161.390 – 161.400, 428.205 – 428.270, 430.010, 430.205 – 430.210, 430.254 – 430.640, 430.850 – 430.955, 743A.168~~

RULE SUMMARY: Updated language for clarity & renumbered per new definitions moved language from 309-019-0242.

CHANGES TO RULE:

309-019-0231

ACT Program Operational Standards

(1) Operate continuous 24/7 crisis coverage as defined in OAR 309-019-0225(2) that includes direct after-hours on-call system with staff experienced in skilled crisis intervention procedures.¶

(a) The ACT team shall have the capacity to triage crisis calls and respond accordingly, either in person or by telephone depending on the participants needs in the moment of crisis event and have direct access to Crisis Plan per 309-019-0225(9).¶

(b) To ensure ACT Participants have direct access to the ACT Team; the provider shall utilize a single crisis phone line system. If the ACT Team is utilizing a third party to assist in meeting the need of escalation dispatching, the ACT Team will need to ensure appropriate HIPAA agreements are in place to release the Crisis Plan to the third party.¶

(c) ACT program staff shall document any crisis dispatches or calls they receive within the participant's chart as soon as possible. Items to include but not limited to: identify location, description of situation & individual, any relevant parties and outcome.¶

(d) If the ACT staff respond to a call and need additional supports, they may coordinate with other Mental Health community programs and/or Law Enforcement as per clinical judgement to ensure the crisis is properly handled for the individual in need. Collaboration and resourcing out for additional supports while responding to crisis will not count against fidelity as long as it is properly documented why additional supports were needed.¶

(2) Service Intensity:¶

(a) The ACT team shall have the capacity to provide the frequency and duration of staff-to-participant Face to Face contacts as clinically deemed necessary in alignment with evidence-based model which is captured on the fidelity scale.¶

(b) The ACT team shall have the capacity to increase and decrease Face to Face contacts based upon daily assessment of the individual's clinical need with a goal of maximizing independence.¶

(c) The team shall have the capacity to provide multiple contacts to participants in high need and a rapid response to early signs of relapse.¶

(d) Natural supports and Informal Support System contacts as defined in OAR 309-019-0225 will be utilized as part of the treatment goal at the participants discretion of communicating HIPAA protected information.¶

(e) The ACT team Psychiatrist and the Psychiatric Nurse Practitioner (PNP) shall have scheduling flexibility to accommodate individual needs. If the individual will not come to meet the Psychiatrist or the PNP at the ACT office, the Psychiatrist or PNP shall provide services as clinically indicated for that participant in the community. Secure telepsychiatry may be used when clinically indicated.¶

(f) The ACT team shall have the capacity to provide services via group modalities that are Face to Face as defined 309-019-0225(13).¶

(3) The ACT Team shall ensure that services are designed to meet participants cultural and linguistic needs and are developmentally appropriate. This includes collaboration and/or MOU's with local Tribal Communities or other diverse community partners within the ACT program's service area that would benefit participants treatment goals.¶

(4) Core staffing requirements for ACT teams:¶

(a) ACT is a low client/staff ratio that is recommended to not exceed 10:1; if there is a vacancy longer than 30 calendar days that impacts this ratio, the program must communicate this to Division Approved Reviewer to discuss possibility of submitting a Variance to The Division per 309-019-0240 and seek Technical Assistance and support on filling that core position to ensure quality of evidence-based services.¶

(b) A single ACT program will not serve more than 120 participants.¶

(c) ACT Program must hire the appropriate number of staff to meet the minimum 1:10 staff ratio for individuals served.¶

(d) Programs may not create multiple teams unless the program is at or above the 120 individuals served unless:¶

(A) this was permitted by The Division under the previous rules update prior to 2023. :¶

(B) The service area spans across large geographical landscape or¶

(C) The program expands services to a specialized targeted population that is person centered, and an additional team is needed to meet that need.¶

(e) A Small ACT Team per OAR 309-019-0225(34) is recommended to have no more than 10 staff¶

(f) A Mid-Size ACT Team per OAR 309-019-0225(26) is recommended to have no more than 12 staff¶

- (g) A Large ACT Team per OAR 309-019-0225(22) is recommended to have no more than 14 staff.¶
- (5) No individual ACT staff member shall be assigned less than .20 FTE for their role on the team.¶
- (6) ACT Team must include the following Core staff:¶
 - (a) A Team Lead position is recommended to be occupied by one individual per team. The team lead is a clinical staff who at minimum:¶
 - (A) Is certified as a Qualified Mental Health Professional (QMHP) or per OAR 309-019-0125 & 877-001-0006 as a clinical supervisor for the ACT team members who are identified as Mental Health Professionals under 877-001-0006;¶
 - (B) Exception of this supervision is the psychiatric care provider(s) and/or the nurse(ing) team members as these roles are beyond the scope of a QMHP oversight.¶
 - (b) Psychiatric Care Provider (Psychiatrist or PNP) FTE is calculated by the number of individuals served by the ACT team based on The Division approved fidelity scale. This staff must be licensed by the State of Oregon.¶
 - (c) The Nurse FTE is calculated by the number of individuals served by the ACT team based on The Division approved fidelity scale. The nurse must be licensed by the Oregon Board of Nursing. Recommendation is to have at least one Registered Nurse as part of the team to ensure all nursing tasks can be completed.¶
 - (d) The Co-Occurring Disorder Specialist FTE is calculated by the number of individuals served by the ACT team based on The Division approved fidelity scale and has completed required trainings per credentialing per OAR 309-019-0145 with tasks to include at minimum:¶
 - (A) Conducting Substance Use assessment and substance use diagnosis education & treatment;¶
 - (B) Principles of Integrated Dual Disorder Treatment, stages of change and practices of harm reduction;¶
 - (C) Knowledge and application of motivational interviewing strategies.¶
 - (e) The Employment Specialist FTE is calculated by the number of individuals served by the ACT team based on The Division Approved Fidelity Scale. An Employment Specialist specialized competencies shall include a Focus on the Vocational Services;¶
 - (A) Complete a Career Profile assessment for any participant that communicates interest in employment;¶
 - (B) Job exploration and matching to individual's interest and strengths and ensure all employment possibilities explored are Competitive and Integrated Employment.¶
 - (C) Skills development related to choosing, securing, and maintaining employment.¶
 - (f) Certified Peer Support Specialist or Peer Wellness Specialist as described in OAR 410-180-0300 to 0380 and defined in OAR 309-019-0105(81) and 309-019-0105(84). A registry of certified Peer Support Specialist Specialists and Peer Wellness Specialists may be found at the Office of Equity and Inclusion's Traditional Health Worker's website.¶
 - (g) The ACT Team may identify other mental health Generalists staff as deemed necessary to account for treatment needs and client/staff ratio calculations. These staff will have identified roles per the evidence-based practice to account for being a Fixed-Point of Responsibility.¶
- (7) ACT Team Staffing Core Competencies:¶
 - (a) Upon hiring, all clinical staff on an ACT team shall have experience in providing direct services related to the treatment and recovery of individuals with a serious and persistent mental illness. Clinical staff shall have demonstrated competencies in clinical documentation and engagement interventions;¶
 - (b) All new staff shall complete ACT 101 within the first three-months of hire from the Division Approved Reviewer. Any staff who are a direct part of the referral & intake process shall complete the Standardize Referral Process training from the Division within two-months of hire. ¶
 - (c) Attend & complete identified trainings within the ACT Programs technical assistance plan. ¶
 - (8) The ACT team shall conduct organizational staff meetings: The Division recommends at least four times per week. These meetings shall be conducted per evidence-based practice.¶
 - (a) The ACT team shall maintain in writing:¶
 - (A) A roster of the participants served in the program; and¶
 - (B) For each participant, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the individual's status that day.¶
 - (b) During the organizational staff meeting, the ACT team shall plan for emergency and crisis situations and add service contacts to the daily staff assignment schedule.¶
 - (9) The ACT team shall conduct treatment planning meetings under the supervision of the team leader that include the input from the Psychiatrist or PNP. These treatment planning meetings shall occur at least annually or as needed per the participants progression in the program. The Division recommends more frequent meetings on new admissions. The ACT Participants presence is needed to ensure the identified treatment plan is an approved pathway for the individual and attainable;¶
 - (a) Convene at regularly scheduled times per a written schedule set by the team leader;¶
 - (b) Occur and be scheduled when the majority of the team members can attend, including the psychiatrist or psychiatric nurse practitioner, team leader, and all members of the treatment team including any Peer Support

Specialists:¶

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

(10) A Comprehensive Assessment and Individualized Treatment Plan is completed upon each individual's admission to the ACT program¶

(11) Service Note Content minimum standard:¶

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

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

(A) Individual's name;¶

(B) Medicaid identification number or client identification number;¶

(C) Date of service provision;¶

(D) Name of service provided;¶

(E) Type of contact;¶

(F) Place of service;¶

(G) Purpose of the contact as it relates to the goals on the individual's treatment plan;¶

(H) Description of the intervention provided if one occurred.¶

(I) Amount of time spent performing the intervention;¶

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

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

(12) Medication Management Supports provided by the ACT Program shall include at minimum the following: ¶

(a) A written order signed by a prescribing practitioner is required for any medical treatment and medications administered by Multidisciplinary Team and include at least: ¶

(A) The name of the medication¶

(B) The form of the medication to be provided;¶

(C) The dosage of the medication to be provided;¶

(D) The frequency that the medication is to be provided;¶

(E) The route or method of administration for the medication to be provided; and¶

(F) Medication orders prescribed as P.R.N. must include the reason for administration of the medication.¶

(b) Medications held and/or stored by the ACT Program must all be clearly labeled and properly secured utilizing a locking mechanism with clear protocols to track access. This should include at minimum the following: ¶

(A) Documenting the staff retrieving medications, staff who is providing the Medication Supports for self-administers and if taken off site; what medications were accepted by the participant and what medications the participant declined. ¶

(B) Written protocols for disposal of medications that cannot be used for reasons such as being outdated/expired, no longer active prescription or recalled medications. For disposal medications, these protocols must include mechanisms to prevent anyone from retrieving the discarded medications once disposed for safety purposes. ¶

(c) Medications held and/or stored by the ACT Program may not be withheld or used as reinforcement or punishment or in quantities that are excessive in relation to the amount needed to attain the participants best possible functioning. ¶

(d) Medications that are self-administered by a participant but still requires the ACT Program's support for safety reasons or require prompting Ques in order to self-administer the medication; the ACT Program staff must document information in the resident's record what medications were given, observations and/or any identified risk factors that transpired during medication supports. ¶

(e) Any ACT Core staff who provides Medication Administration to ACT Participant must have proper medical training, credentials and have a current license by the appropriate Oregon State Board oversight and conduct in compliance per the classification of the drug and method of administration per all federal and state requirements. ¶

(f) Any staff who provides Medication Supports per OAR 309-019-0225(25) must have proper first aid and CPR training in addition to training from internal medical ACT Team Members.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 430.0630

AMEND: 309-019-0233

RULE SUMMARY: Renamed and added 309-019-0230 information for ease of awareness and guidance.

CHANGES TO RULE:

309-019-0233

ACT Program Certification Accreditation Protocol

- ~~(1) Requests for re-certification are driven~~ In order to be eligible for Medicaid or State General Funds for ACT reimbursement, ACT services shall be provided only by those programs compliance with the fidelity review process as outlined in 309-019-0235. Failure to meeting the following minimum qualifications:¶
- ~~(2) The provider shall hold and maintain an official Accreditation issued by the Division established in OAR Chapter 309, Division 008 and maintain compliance with the fidelity review; will result in automatic de-certification and age~~ Outpatient Certificate of Agreement; and¶
- ~~(3) The provider must maintain compliancy~~ will no longer be recognized or able to obtain funding that is speech OAR's 309-019-0225 through 309-019-0255 for the purposes of providing ACT services as intended; and¶
- ~~(4) A provider certified to provide ACT Sservices.¶~~
- ~~(2) Certification must be reviewed for fidelity adherence by the Division will be approved for no longer than two-years from re-certification. Extensions to certification date can only be done with the Division approval which will include a letter identifying extension by Division. Approved Reviewer and may not bill Medicaid nor use General Funds for the provision of ACT services unless they complete the fidelity review process as outlined within OAR 309-019-0235. ¶~~
- ~~(5) Re-certification is driven by the program's compliance with the required fidelity review process as outlined in 309-019-0235. Failure to comply with the fidelity review; will result in automatic de-certification and the program will no longer be allowed to promote the program as an ACT provider within the State of Oregon nor or able to obtain funding that is specified for ACT Services. ¶~~
- ~~(36) Provisional Status is requested~~ A program seeking to become a Provisional Provider can do so by following the outlined procedure:¶
- ~~(a) A program must already holding a certification of approval under OAR chapter 309, division 008 may request the addition of ACT services be added to their certificate;¶~~
- ~~(b) When a program is pursuing initial certification, at minimum; ¶~~
- ~~(b) At minimum, the program must have the Team Lead, COD and one identified of the two core medical specialty staff shall receive ACT 101apprpoveal hired. The hired staff must attend and complete ACT 101 training from the Division Approved Reviewer prior to letter of request for provisional certification through Division provisionper this OAR set (4). ¶~~
- ~~(e7) Provisional status must be requested in writing on agency letter head by the intended program leadership and submitted to the Division and at minimum must contain the following:¶~~
- ~~(Aa) Geographical location(s) of intended service areas ¶~~
- ~~(Bb) First and last names of hired staff including their credentials, role on ACT Team and full-time equivalent status dedicated to implementing ACT services. ¶~~
- ~~(A) If said program only has the minimum required staff at time of provisional letter submission, they must include identifying which core specialized staff positions are vacant and ¶~~
- ~~(B) Identify the platform those vacant positions are advertised on to reflect their intent to hire. ¶~~
- ~~(c) Intended size of ACT team per OAR 309-019-0225(21,24 & 34)34,26,22), this is not to be mistaken as the intended capacity. If the team size is not referenced, the letter will be considered incomplete and returned. ¶~~
- ~~(Cd) Any specific/specialized target population demographic's (i.e. Young Adult, culturally specific, etc), ¶~~
- ~~(De) Letter of support from Division Approved Reviewer that confirms 1(c)(A)(B) and (C) of this rule set. ¶~~
- ~~(df) The request must be submitted in-at least twoone months (6030 calendar days) prior to projected provisional start date and letter must specify the projecanticipated provisional start date. ¶~~
- ~~(e8) Technical Support iswill be provided on a weekly basis throughout the provisional status by the Division Approved Reviewer;¶~~
- ~~(4) If a program does not meet fidelity requirements, as outlines in OAR 309-019-0235, before a provisional certification expires the program must apply for a new provisional certification through the Division and is required in order to maintain Provisional Status. There will be an expectation to have all core staff hired per OAR 309-019-0230 within four-months of Provisional Status approval. This will be tracked by the Division Approved Reviewer and communicated to the Division. ¶~~
- ~~(9) In the sixth-month of Provisional status, the ACT Program will receive a Projection Fidelity review per OAR 309-019-0225(27) to properly build a comprehensive technical assistance plan and prepare for the first fidelity review. ¶~~
- ~~(10) The program will have up to one calendar year to build their ACT Services per the evidence-based practice~~

model and achieve the fidelity rating based on their geographical area, as outlines in OAR 309-019-0235, before a provisional certification expires.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256, ORS 109.675, 430.640

Statutes/Other Implemented: 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

RULE SUMMARY: Updated language for clarity to already existing protocols to ensure full alignment with TMACT.

CHANGES TO RULE:

309-019-0235

ACT Fidelity Requirements ¶

(1) All program-es Certified or granted Provisional Status to provide ACT services shall be reviewed for fidelity adherence by the Division Approved Reviewer and may not bill Medicaid or use General Funds for the provision of ACT services unless they receive a score above the benchmark achieve a rating at the minimum benchmark or higher per this rule set based on the Division Approved fidelity scale. Extension of a certification period has no bearing on the frequency or scope of fidelity reviews or re-certification reviews required under OAR chapter 309, division 008.¶

(2) Proposed All changes to any fidelity tool or best practice guidance tools and fidelity procedures by the Division Approved Reviewer that would impact scoring must be communicated to the Division at least 60 calendar days prior to being implemented.¶

(3) Fidelity reviews shall be conducted utilizing or promoted to ACT Programs.¶

(3) All applicable Fidelity Tools used to create the comprehensive fidelity outcome report shall be provided to an ACT Program at least 45 calendar days prior to scheduled fidelity review for initial or renewal of certification.¶

(4) All ACT Programs, whether Certified or Provisional Status, must achieve the following minimum ratings on the Division approved ACT Fidelity Sscale, which the Division Approved Reviewer shall make the Fidelity Tools available to providers electronically at least 45 calendar days prior to scheduled fidelity review. in order to continue being recognized as an ACT Provider: ¶

(a) Urban area ACT programs per OAR 309-019-0225(38) rating of no less than 3.4 out of a 5 ¶

(b) Rural and Frontier ACT programs per OAR 309-019-0225(17 & 31) rating no less than 3.2 out of a 5.¶

(5) If an ACT Program successfully accomplishes a 4.2 out of a 5-fidelity rating, they will be deemed a High Functioning ACT Program and incentivized with a three-year ACT Certification. ¶

(a) During this three-year period, the ACT Program will have conditions within their Certification to maintain contact with The Division Approved Reviewer and, ¶

(b) Uphold the integrity of ACT model and ¶

(c) Complete any required trainings to maintain staffing credentials or ACT specific required trainings. ¶

(46) Within 30 calendar days following thEvery behavioral health agency providing ACT services is entitled to receive a copy of their completed comprehensive fidelity review, t report. ¶

(a) The Division Approved Reviewer shall provide a comprehensive fidelity review report to the Division and the program. If the designated CCO request a copy of this will have 30 calendar days from the last day onsite day to complete the comprehensive fidelity review report. ¶

(b) At minimum, the completed report must be distributed to the ACT Team Lead and the Division Designee on the same day, which will be seen as a published report. s ¶

(c) As the governing oversight, the Division will maintain responsibility of making all decisions for amendments made to the completed comprehensive fidelity report, unless the Division Approved Reviewer shall provide a copy timely acknowledges an error, by communicating to the Division Designee prior to amending. ¶

(5d) Unless otherwise specified in CCO and program contract, the Program shall send a copy of thIf throughout the course of follow-up meetings with the ACT provider, it is identified that the Division Approved Reviewer needs to make updates to the completed report, the heading of the report must reflect there has been amendments made and the date when the report was amended. ¶

(e) If any amendments are made, the updated version of the comprehensive fidelity review report to the appropriate CCO within 7 calendar days following issuance of the fidelity review report must be redistributed to all parties who received the initial completed report. ¶

(7) It is the responsibility of the ACT Program to distribute this report to any stakeholder per private contracts.¶

(68) There will be a meeting scheduled within 20 calendar days after the publication and issuance of the comprehensive report. This meeting shall include the Division, The ACT Program and Division Approved Reviewer and ACT Program. If a CCO requests to be present, the meeting invite will be forwarded to them upon To comply with Oregon Transparency statutes, any requests made by a public citizen or stakeholder for completed fidelity reports shall comply with the Request for Information and Public Records Request per chapter 410, division 120. ¶

(a) The Division Approved Reviewer may not under any circumstances, provide completed fidelity reports, past or present, to any entity who is not referenced in this ruleset unless there is a court order by which will be provided to the Division Designee for tracking purposes. ¶

(b) If a request per (7)(a) of this ruleset is made to the Division Approved Reviewer, there will be a soft handoff to The Division Designee for appropriate response and guidance on the process to request public records.¶
(9) Any reports provided through the Request for Information and Public Records Request protocols will be in compliance per 943-014-0000 and ensure to de-identify data and redact Individually Identifying Information per prior to releasing. The Division Designee will maintain a record of these requests.

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

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

RULE SUMMARY: Renamed section & updated language for clarity to align with TMACT.

CHANGES TO RULE:

309-019-0240

ACT Failure to Meet Fidelity StandardsConditions to Maintain Certification as an ACT Provider ¶

(1) If a certified ACT program does not achieve a score above the benchmark on a fidelity review, the following shall occur:¶

~~(a) W~~Once the completed fidelity report is distributed to the required parties per OAR 309-019-0235, there will be a follow up meeting within 14 calendar days, unless otherwise extended by t with at minimum attendance of The Division, the Division Designee, t~~The Division Approved Reviewer, and the ACT program shall meet to discuss the outcome of the failed fidelity review. If a CCO requests to be involved, the host/scheduler shall forward the invite to the CCO. Team to discuss the conclusion of the report. The only exception to not include the Division Approved Reviewer or another requested stakeholder's attendance, will be made by the Division.~~ ¶

~~(b2)~~ The Division Approved Reviewer must provide technical assistance for a period of 90 days from the date of the fidelity review publication to address problem areas identified If a current certified or provisional status ACT program does not achieve the minimum fidelity rating per their geographical service area based on OAR 309-019-0235 the following shall occur:¶

(a) A Technical Assistance (TA) plan is created and must include at minimum, any items within the failed fidelity review. These areas for Technical Assistance (TA) will include any area that scores a two or below and any sections that do not meet OAR requirements per 309-019-0225 through 0255 or any other applicable statutes, administrative rules, or other regulations;¶

~~(c)~~comprehensive report that received a rating of a two or below in the following subscale categories: ¶

(A) Operations and Structure, ¶

(B) Core Practices Subscale, ¶

(C) Evidence-Based Practices Subscale and ¶

(D) Person-Centered Planning & Practices Subscale.¶

(b) If the Division has identified any non-compliance or other regulatory violations per OAR's 309-019-0225 through 0255 or any other applicable statutes, administrative rules, or other regulations, these items will be at the discretion of the Division Designee to be added to the TA plan. If other items are necessary, they must be properly reflected as addendum items.¶

(3) The ACT Program will have full access to technical assistance by The Division Approved Reviewer for a period not to exceed 90 days to make necessary improvements within areas identified within the technical assistance plan. ¶

(4) The Division will then, extend certification on a temporary basis for the 90 days to allow for period to ensure there are no impacts to billing during the technical assistance period with anticipation that corrections to program operations will be made.¶

~~(d5)~~ At the end of the 90-day technical assistance period, The Division Approved Reviewer shall conduct a follow-up re-review to include all TA identified sections per (1)(b) of this rule set which will include only the identified subscale topics identified within the TA Plan created within this rule set. If Core Team Subscale section is needed in order to verify integrity and intent to implement the other subscale items on fidelity scale, this will also be included, however communicated in the TA plan initial creation. ¶

(e6) Within 30 calendar days following the last day of onsite fidelity re-review, the Division Approved Reviewer shall provide a comprehensive amended Re-Review fidelity report to the Division and the ACT program.¶

~~(fa)~~ Unless otherwise specified in This report will include a comparison of initial fidelity review ratings with the Re-Review.¶

(b) If the ACT Program is currently serving participants from a designated CCO, that CCO can and program contract, request a copy of this report and to be included in any follow up meetings as an identified payor source.¶

(c) If the ACT Program shall send a copy achieves the minimum rating or higher per OAR 309-019-0235 of n the amended fidelity re-review report to the appropriate CCO within 7 calendar days following issuance of that amended fidelity re-review report and all other applicable statutes, administrative rules, or other regulations, the Division can approve the program for ACT Certification for up to two-years from the original expiration of certification month unless deemed a High Functioning ACT Program.¶

~~(27)~~ If the program a Provisional Status Provider per OAR 309-019-0233 does not achieves a the minimum benchmark score or above on the follow up re-review and meets the requirements of all applicable statutes, administrative rules, or other regulations, the Division shall recertify the program for one year fidelity rating on their first fidelity review, the provider has seven calendar days after the follow up meeting to communicate to the

Division one of the following: ¶

(a) Accept conclusion and reapply for Provisional Status: ¶

(b) Appeal the conclusion in writing on their agency letter head with date stamp to the Division Designee and request a re-assessment. ¶

(A) No longer publicize or in any way promote agency as an ACT Certified provider and agree to follow all necessary steps per OAR 309-019-0250 Transitions to lower level of care or care coordinate transfer of clients to a neighboring certified ACT Team. ¶

(B) This method is the alternative to the Waiver per OAR 309-019-0241 as Provisional Providers do not qualify. ¶

(8) Fidelity reviews that are stemmed from an appeal request must occur within 45 calendar days of appeal receipt by the Division. ¶

(39) The Division may deny, revoke, suspend or place conditions on the programs ACT Certificate Accreditation if the re-review results in a fidelity score below the benchmark. ¶

(4) rating that is below 2.5 out of 5 or the Division has identified a regulatory non-compliance issue per certificate of approval. ¶

(10) Congruent with the process outlined in section (1) above, if the Division determines a program is not operating in substantial outside of compliance with all applicable statutes, administrative rules or other regulations, the Division may require the program to submit a Plan of Correction (POC). The Division shall provide written notice of the requirement to submit a POC and the program shall submit a POC according to the following terms: ¶

(a) The program shall submit a POC to the Division and the appropriate CCO within 30 days of receiving a notice of requirement to submit a POC. The Division may issue up to a 90-day extension to the existing certification to allow the program to complete the POC process; and ¶

(b) The POC shall address each finding of non-compliance and shall include: ¶

(A) The planned action already taken, or to be taken, to correct each finding of non-compliance. ¶

(B) The anticipated or requested timeframe for the completion of each corrective action not yet complete at the time of POC submission to the Division; ¶

(C) A description of and plan for quality assurance activities intended to ensure ongoing compliance; and ¶

(D) The name and role of the individual responsible for ensuring the implementation of each corrective action within the POC. ¶

(11) If the Division finds that clarification or supplementation to the POC is required prior to approval, the Division shall contact the program to provide notice of requested clarification or supplementation, and the program shall submit an amended POC within 14 calendar days of receiving notification. ¶

(12) The program must submit a sufficient POC approved by the Division prior to receiving a certificate. Upon the Division's approval of the POC, the Division shall issue the appropriate certification. ¶

(13) The Division may deny, revoke, suspend, not renew, or place conditions on the program's certification and or accreditation if the program fails to submit an adequate POC within the timeframes established in this rule. ¶

(14) When the Division determines the need to deny, revoke, not renew, or place conditions on the program's certificate accreditation issued under these rules, a notice of intent to take action on the certificate accreditation shall be issued to the program. ¶

(15) Immediate suspension may occur if the Division finds there is a serious danger to the public health and safety during a specified period of time and/or there is a substantial failure to comply with applicable statutes, administrative rules, or other applicable regulations. ¶

(a) The program may request a contested case hearing to contest the immediate suspension order in accordance with ORS Chapter 183. ¶

(b) Requests for a hearing must be received by the Division within 90 days from the date the immediate suspension order was served on the program personally, or by certified or registered mail. ¶

(16) When the Division issues an Order of Suspension, a notice of intent to revoke, notice of intent to deny an application or notice of refusal to renew the certificate to a program pursuant to these rules, the Division shall offer the program an opportunity for an informal conference. The program shall make its request for an informal conference in writing within 14 calendar days of the issuance of the notice of intent or Order of Suspension. ¶

(a) Upon receipt of a timely written request, the Division shall select a location and time for such conference. Following the conference, the Division may: ¶

(A) withdraw or amend the notice of intent or suspension order; or ¶

(B) not withdraw the notice of intent or suspension order. ¶

(b) the Division shall provide written notice of its decision within 14 calendar days following the informal conference. ¶

(17) A program who is issued a notice of intent to deny, revoke, refuse to renew, or apply a condition on programs certificate under these rules shall be entitled to request a hearing in accordance with ORS Chapter 183. ¶

~~(916)~~ A Variance per OAR 309-019-0220 and 309-008-1600 is not an allowable for failure to meet fidelity for ACT programs. It can be used to substitute and/or contract program core staffing structure per OAR 309-019-0226 (1) & (2), but the request must be done in time of need as a proactive effort of the program to maintain ACT fidelity standards and quality of services.¶¶

~~(a) If a program meets the above criteria and contracts key positions to fulfill the ACT fidelity standards, a Variance must be submitted to Division within 30 calendar days of known agreement and/or contracted position.¶¶~~

~~(b) A Variance submission must be submitted in at least 60 days prior to scheduled fidelity review; unless there are unforeseen circumstances that result in termination and/or resignation of a core position on the ACT Team. This must be communicated in advance in response to an agency's inability to meet minimum fidelity rating for ACT service accreditation to Division Approved Reviewer and The Division.¶¶~~

~~(c) If a Variance is needed for this intended purpose, The Division cannot approve for a period that may not exceed approval of 1 year and may only be used for ACT Programs within context of OAR 309-019-0241.~~

Statutory/Other Authority: ORS 413.042, 430.256, 430.640

Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

AMEND: 309-019-0241

RULE SUMMARY: Clarity provided for existing procedures and alignment with TMACT.

CHANGES TO RULE:

309-019-0241

~~Waiver of Minimum Fidelity Requirement~~ Modifications to Existing Accreditation & Substitution Alternatives ¶

(1) The Division may at its discretion, grant a waiver or variance of minimum ACT fidelity requirements and extend an ACT program's certificaccreditation period if the waiver to the requirementidentified substitution or modification or program operations does not diminish the effectiveness of the ACT model, violate the purposes of the program, or adversely affect the program participants' health and welfare:¶

(a2) ~~Waivers mayand Variances shall~~ not be granted ~~thatif they~~ are inconsistent with the individual participant's rights ~~orper OAR 309-019-0115 or any~~ federal, state, or local laws and regulations;¶

(b3) ~~The Division shall review waivers toand variances based on~~ minimum fidelity requirements on a case-by-case basis.¶

(24) ~~Waivers granted to ACT minimum fidelity requirements shall result in an extension to~~ will be requested no later than the date of the fidelity follow up meeting per OAR 309-019-0240. The Division Designee will provide the ACT program's certification period. An ACT program that has an appropriate form with instructions & deadline to submit Waiver request back to Division Designee. ¶

(5) ~~If the Waiver is approved waiver by~~ the Division, isthe provider will remain eligible to receive Medicaid and State General Fund reimbursement for ACT services if the ACT program meets the following criteria:¶

(a) ~~The ACT program shall receiveas long as the provider engages and makes efforts to comply with technical assistance fromguidance by both the Division a~~ Approved r ~~Reviewer and develop a plan to meet the minimum fidelity requirements at the end of the Waiver period. As a result of the approved Waiver, the 90-day follow-up re-review is suspended per OAR 309-019-0240;~~¶

(b) ~~The ACT program shall notify the appropriate CCO that the program is operating under the Division approved waiver of minimum fidelity requirements per their contractual agreements.~~¶

(3) ~~The Division shall grant waivers of minimum fidelity requirements for a period that may not exceed 180 days.~~ Division Designee¶

(6) ~~If the Waiver is approved, the extension to accreditation may not exceed 180 calendar days. As part of approval, the Division will acknowledge in writing that the 90-day re-review requirement in OAR 309-019-0240 will be suspended.~~ ¶

(a) ~~At the end of the 180-day waiver period, the Division Approved Reviewer shall conduct a fidelity re-review of all areas that on initial fidelity report scored less than a two~~ that had a two or below rating and any areas that are out of compliance with OAR's 309-019-0225 through 0255.¶

(b) ~~If the program achieves atthe minimum scoreerating on theis fidelity re-review and meets the requirements of all applicable statutes, administrative rules or other regulations, the Division shall re-certify the program for one year per original annual certification date~~ new ACT Accreditation per OAR 309-019-0240.¶

(47) ~~A waiver of minimum fidelity requirements may only be granted to ACT programs that have received a fidelity review within 12 months prior to the request.~~¶

(5) ~~Requests for a waiver ofone time during their renewal of accreditation.~~ ¶

(8) ~~If a program does not meet fidelity after a Waiver period the Division may immediately suspend or revoke certification.~~¶

(9) ~~A variance to communicate a modification or adaption to ACT operations must be done as a proactive step in order for the program to mainimum fidelity requirements shall betain the quality and integrity of ACT model standards as laid out in OAR's 309-019-0225 through 0255.~~ ¶

(10) ~~A variance can be used to submstituted to the Division for approval.~~ core staffing and/or contract core staffing needs per OAR 309-019-0226 (1) & (2) and ¶

(6a) ~~If a program does not meet fidelity after a Waiver period the Division may immediately suspend or revoke certification~~ formulate a contract with a separate entity for core staffing positions to fulfill the ACT fidelity standards, a Variance must be submitted to Division within 30 calendar days of known agreement to ensure to identify ACT Multidisciplinary team includes external partners. ¶

(b) ~~The Variance submission should not include copies of private contracts or MOU's for ACT substitutions.~~ ¶

(11) ~~A variance submission must be submitted in at least 30 days prior to a scheduled fidelity review.~~¶

(12) ~~The ACT Provider must be in good standing with Certificate of Approval per chapter 309, division 008 to be approved for a Variance.~~ ¶

(13) ~~Variance approval period cannot exceed one calendar year.~~

Statutory/Other Authority: ORS 413.042, 430.256, 430.640

Statutes/Other Implemented: ORS 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168

RULE SUMMARY: Removed this section and moved it up to 0231 to provide clarity and a flow to the rules.

CHANGES TO RULE:

~~309-019-0242~~

~~ACT Program Operational Standards ¶¶~~

~~(1) Operate continuous 24/7 crisis coverage as defined in OAR 309-019-0225(2) that includes direct after-hours on-call system with staff experienced in skilled crisis intervention procedures.¶¶~~

~~(a) The ACT team shall have the capacity to triage crisis calls and respond accordingly, either in person or by telephone depending on the participants needs in the moment of crisis event and have direct access to Crisis Plan per 309-019-0225(9).¶¶~~

~~(b) To ensure ACT Participants have direct access to the ACT Team; the provider shall utilize a single crisis phone line system. If the ACT Team is utilizing a third party to assist in meeting the need of escalation dispatching, the ACT Team will need to ensure appropriate HIPAA agreements are in place to release the Crisis Plan to the third party. ¶¶~~

~~(c) ACT program staff shall document any crisis dispatches or calls they receive within the participant's chart as soon as possible. Items to include but not limited to: identify location, description of situation & individual, any relevant parties and outcome,¶¶~~

~~(d) If the ACT staff respond to a call and need additional supports, they may coordinate with other Mental Health community programs and/or Law Enforcement as per clinical judgement to ensure the crisis is properly handled for the individual in need. Collaboration and resourcing out for additional supports while responding to crisis will not count against fidelity as long as it is properly documented why additional supports were needed.¶¶~~

~~(2) Service Intensity:¶¶~~

~~(a) The ACT team shall have the capacity to provide the frequency and duration of staff to participant Face to Face contacts as clinically deemed necessary in alignment with evidence-based model which is captured on the fidelity scale. ¶¶~~

~~(b) The ACT team shall have the capacity to increase and decrease Face to Face contacts based upon daily assessment of the individual's clinical need with a goal of maximizing independence;¶¶~~

~~(c) The team shall have the capacity to provide multiple contacts to participants in high need and a rapid response to early signs of relapse;¶¶~~

~~(d) Natural supports and Informal Support System contacts as defined in OAR 309-019-0225 will be utilized as part of the treatment goal at the participants discretion of communicating HIPAA protected information.¶¶~~

~~(e) The ACT team Psychiatrist and the Psychiatric Nurse Practitioner (PNP) shall have scheduling flexibility to accommodate individual needs. If the individual will not come to meet the Psychiatrist or the PNP at the ACT office, the Psychiatrist or PNP shall provide services as clinically indicated for that participant in the community. Secure telepsychiatry may be used when clinically indicated;¶¶~~

~~(f) The ACT team shall have the capacity to provide services via group modalities that are Face to Face as defined 309-019-0225(13).¶¶~~

~~(3) The ACT Team shall ensure that services are designed to meet participants cultural and linguistic needs and are developmentally appropriate. This includes collaboration and/or MOU's with local Tribal Communities or other diverse community partners within the ACT program's service area that would benefit participants treatment goals.¶¶~~

~~(4) Core staffing requirements for ACT teams:¶¶~~

~~(a) ACT is a low client/staff ratio that is recommended to not exceed 10:1; if there is a vacancy longer than 30 calendar days that impacts this ratio, the program must communicate this to Division Approved Reviewer to discuss possibility of submitting a Variance to The Division per 309-019-0240(9) and seek Technical Assistance and support on filling that core position to ensure quality of evidence-based services.¶¶~~

~~(b) A single ACT program will not serve more than 120 participants.¶¶~~

~~(c) ACT Program must hire the appropriate number of staff to meet the minimum 1:10 staff ratio for individuals served.¶¶~~

~~(d) Programs may not create multiple teams unless the program is at or above the 120 individuals served unless:¶¶~~

~~(A) this was permitted by The Division under the previous rules update prior to 2023.; ¶¶~~

~~(B) The service area spans across large geographical landscape or ¶¶~~

~~(C) The program expands services to a specialized targeted population that is person centered, and an additional team is needed to meet that need.¶¶~~

~~(e) A Small ACT Team per OAR 309-019-0225(29) is recommended to have no more than 10 staff¶¶~~

~~(f) A Mid-Size ACT Team per OAR 309-019-0225(24) is recommended to have no more than 12 staff¶¶~~

- (g) A Large ACT Team per OAR 309-019-0225(21) is recommended to have no more than 14 staff.¶
- (5) No individual ACT staff member shall be assigned less than .20 FTE for their role on the team.¶
- (6) ACT Team must include the following Core staff:¶
 - (a) A Team Lead position that shall be occupied by only one individual per team. The team leader is a QMHP level clinician qualified to provide direct supervision to all ACT staff except the psychiatric care provider and nurse.¶
 - (b) Psychiatric Care Provider (Psychiatrist or PNP) FTE is calculated by the number of individuals served by the ACT team based on The Division Approved Fidelity Scale. This staff must be licensed by the State of Oregon.¶
 - (c) The Nurse FTE is calculated by the number of individuals served by the ACT team based on The Division Approved Fidelity Scale. The nurse must be licensed by the Oregon Board of Nursing¶
 - (d) The Co-Occurring Specialist FTE is calculated by the number of individuals served by the ACT team based on The Division Approved Fidelity Scale.¶
 - (e) Tasks shall include:¶
 - (A) Conducting Substance Use assessment and substance use diagnosis education & treatment;¶
 - (B) Principles of Integrated Dual Disorder Treatment and practices of harm reduction;¶
 - (C) Knowledge and application of motivational interviewing strategies.¶
 - (f) The Employment Specialist FTE is calculated by the number of individuals served by the ACT team based on The Division Approved Fidelity Scale. An Employment Specialist specialized competencies shall include a Focus on the Vocational Services;¶
 - (A) Complete a Career Profile assessment for any participant that communicates interest in employment;¶
 - (B) Job exploration and matching to individual's interest and strengths and ensure all employment possibilities explored are Competitive and Integrated Employment.¶
 - (C) Skills development related to choosing, securing, and maintaining employment.¶
- (g) Certified Peer Support Specialist or Peer Wellness Specialist as described in OAR 410-180-0300 to 0380 and defined in OAR 309-019-0105(81) and 309-019-0105(84). A registry of certified Peer Support Specialist Specialists and Peer Wellness Specialists may be found at the Office of Equity and Inclusion's Traditional Health Worker's website.¶
- (h) The ACT Team may identify other mental health Generalists staff as deemed necessary to account for treatment needs and client/staff ratio calculations. These staff will have identified roles per the evidence-based practice to account for being a Fixed Point of Responsibility is upheld.¶
- (7) ACT Team Staffing Core Competencies:¶
 - (a) Upon hiring, all clinical staff on an ACT team shall have experience in providing direct services related to the treatment and recovery of individuals with a serious and persistent mental illness. Staff shall be selected consistent with the ACT core operating principles and values. Clinical staff shall have demonstrated competencies in clinical documentation and engagement interventions;¶
 - (b) All staff shall demonstrate basic core competencies in designated areas of practice, including the Assertive Community Treatment core principles, integrated mental health and substance abuse treatment, supported employment, psychoeducation, and wellness self-management;¶
- (8) The ACT team shall conduct organizational staff meetings: The Division recommends at least four times per week. These meetings shall be conducted per evidence-based practice.¶
 - (a) The ACT team shall maintain in writing:¶
 - (A) A roster of the participants served in the program; and¶
 - (B) For each participant, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the individual's status that day.¶
 - (b) During the organizational staff meeting, the ACT team shall plan for emergency and crisis situations and add service contacts to the daily staff assignment schedule.¶
- (9) The ACT team shall conduct treatment planning meetings under the supervision of the team leader that include the input from the Psychiatrist or PNP. These treatment planning meetings shall occur at least annually or as needed per the participants progression in the program. The Division recommends more frequent meetings on new admissions. The ACT Participants presence is needed to ensure the identified treatment plan is an approved pathway for the individual and attainable;¶
 - (a) Convene at regularly scheduled times per a written schedule set by the team leader;¶
 - (b) Occur and be scheduled when the majority of the team members can attend, including the psychiatrist or psychiatric nurse practitioner, team leader, and all members of the treatment team including any Peer Support Specialists;¶
 - (c) Require individual staff members to present and systematically review and integrate an individual's information into a holistic analysis and prioritize problems.¶
- (10) A Comprehensive Assessment and Individualized Treatment Plan is completed upon each individual's admission to the ACT program¶
- (11) Service Note Content:¶

- (a) More than one intervention, activity, or goal may be reported in one service note, if applicable;¶¶
- (b) ACT team staff shall complete a service note for each contact or intervention provided to an individual. Each service note shall include all the following:¶¶
- (A) Individual's name;¶¶
- (B) Medicaid identification number or client identification number;¶¶
- (C) Date of service provision;¶¶
- (D) Name of service provided;¶¶
- (E) Type of contact;¶¶
- (F) Place of service;¶¶
- (G) Purpose of the contact as it relates to the goals on the individual's treatment plan;¶¶
- (H) Description of the intervention provided if one occurred.¶¶
- (I) Amount of time spent performing the intervention;¶¶
- (J) Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goal;¶¶
- (K) Signature and credentials and/or job title of the staff member who provided the service.
- Statutory/Other Authority: ORS 413.042
- Statutes/Other Implemented: ORS 430.630

RULE SUMMARY: Updated language for clarity to already existing rules & renumbered.

CHANGES TO RULE:

309-019-0245

ACT Admission Criteria ¶¶

(1) ~~Service Priority Population shall meet the~~ ACT Programs will triage referrals based on the Service Priority Population per OAR 309-019-0225(28) and medically appropriate standard as designated in OAR 309-019-0105 with the following characteristics:¶¶

(a) Participants who meet the Service Priority Population per OAR 309-019-0225(26~~8~~) are the primary target population for ACT services per evidence-based model; however, individuals with serious mental illness' that are not listed as Service Priority Population should not be ruled out as a possible candidate for admission until properly evaluated. Primary diagnosis outside of the priority population will still need to meet the heightened acuity level of psychosis symptoms ACT model is designed to support. ¶¶

(b) Individuals with a primary diagnosis of a substance use disorder intellectual developmental disabilities, traumatic brain injury, personality disorder, or an autism spectrum disorder are not the intended recipients of ACT. Diagnostic must include a primary ~~to meet within the~~ Service Priority Population. ¶¶

(~~ε~~2) Participants with significant level of functional impairments as demonstrated by at least one of the following conditions the following circumstances that is either reoccurring or confirmed to not be an isolated brief-episode as the interventions or circumstances would require minimum of 6 service hours a week:¶¶

(Aa) Significant difficulty consistently performing on an ongoing daily basis, the range of practical daily living tasks required for basic adult functioning ~~in the community or conflict with basic survival instincts~~ (e.g., caring for personal business affairs; obtaining medical, legal, housing services; recognizing common dangers or hazards meeting nutritional needs; maintaining personal hygiene) ~~or persistent or recurrent d.~~ ¶¶

(b) ~~Significantly performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives;~~¶¶

(B) ~~Significant difficulty maintaining consistent employment and negative impacts to living situations or ability to maintain~~ at a self-sustaining level ~~or significant difficulty consistently carrying out activities needed for independent living~~ (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities);¶¶

(C) ~~Significant difficulty maintaining a safe living situation as a direct result of lack of self-awareness, forward thinking resulting in safety or health risks due to inability to plan or recognize needs~~ (e.g., repeated evictions or loss of housing).¶¶

(2) ~~Participants with one or more of the following problems, which are indicators of continuous high service needs (e.g., greater than eight hours per month): that is beyond a poor choice decision.~~ ¶¶

(ac) High use of acute care psychiatric hospitals or emergency departments for psychiatric reasons, including psychiatric emergency services as defined in OAR 309-023-0110(18) (e.g., two or more readmissions in a six-month period);¶¶

(bd) Intractable (e.g., persistent or very recurrent) severe major symptoms, affective, psychotic, suicidal;¶¶

(ee) Coexisting substance use disorder of significant duration (e.g., greater than six months);¶¶

(df) High risk of judicial involvement or history of criminal justice involvement (e.g., arrest, incarceration); with the exception of violence or assault directed at the ACT staff during the screening process only if action results in physical injury of the staff member or significantly impairs the ability to provide treatment services to the individual¶¶

(e) ~~Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless;~~¶¶

(fg) Residing in an inpatient or supervised community residence in the community, and clinically assessed to be able to live in a more independent living situation if intensive services are provided or requiring a residential or institutional placement if more intensive services are not available;¶¶

(gh) Difficulty effectively utilizing traditional office-based outpatient services.¶¶

(3) The ACT program shall provides community-based, long-term, ~~or and~~ time-unlimited services.¶¶

(4) If an individual is unable to maintain in community without 1:1 constant care; this is beyond the scope of what ACT could provide. ACT program may deny if the care requires 1:1 intervention on a continuum of care that is beyond the scope of ACT and make proper recommendations for higher level of care.

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

RULE SUMMARY: Updated title & clarity in already existing protocols.

CHANGES TO RULE:

309-019-0248

ACT Admission Standardize Referral Process ¶¶

(1) The ACT Program shall complete a Comprehensive Assessment that demonstrates medical appropriateness prior to the provision of this service. If a substantially equivalent assessment is available that reflects current level of functioning and contains standards consistent with OAR 309-019-0135 to include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services, the equivalent assessment may be used to determine admission eligibility for the ACT program. ¶

(2) A referral for The ACT Program is managed and coordinated, as defined in these rules: ¶

(a) The CCO, Single Point of Contact (SPOC) and or ACT Program shall accept all referrals utilizing the Universal Referral Form provided by the Division and verify the required documentation that supports ACT criteria. The referral must include when an approximate, reasonable date of admission and/or Intake for further evaluation for the ACT program is anticipated. ¶

(b) Based on the CCO and ACT Program's published referral process and contractual language, the deciding entity shall have 14 calendar days of receipt of a referral to the date of request to maintain due-diligence for Care Coordination purposes and communicate to referring party and requested participant of final determination. This determin referral can be moved forward into the Screening phase. This communication shall must reference applicable OAR's for acceptance or to move forward for further evaluation, pending or a denial. If there is insufficient information to process the referral make this decision, the deciding entity will respond to referring party requesting the additional information, which will be referred to as a "Pending rReferral". ¶

(c) If a pending referral is resubmitted, with requested information the deciding entity based on their published referral process, will have an additional 14 calendar days after receipt of this resubmission. A final determination on the referral must be made by t to determine if referral moves on to Screening Phase. The ssecond resubmission timeframe based on relevant Administrative Rules to communicat iding entity cannot pend referring party more than once therefore a decision must be made if the-referral moves on for furtheforward for sScreening for entry or if it is denied. ¶

(3d) The final determination on the referral must: ¶

(a) Be a written response addressed to the requested participant and referring party; only if HIPAA allows for care ea A referral can be reflective as "pending" if there is more than 60 days until discharge from an acute care setting and the ACT Team requests monitor ordination purposes or if legal status allows such communication. ¶

(b) This determination must cite applicable administrative rule and criteria to support a final determination if conclusion is a denial and must be formally g for progression. If this option is utilized, the ACT program must document and site this OAR while also continuing to be actively involved in care coordination and will provide a final determination in good faith prior to discharge or end of jurisdiction date to ensure decision does not interfere written. If determination is to h discharge process. ¶

(3) If it is determined that the referral moves forward withinto the screening process; the written response objective will be to notify of the next steps; including but not limited to Face-to-Face appointment; collateral information being gathered; Release of Information signed etc. ¶

(ea) A referral can be reflective as "pThe Screening" if there is more than 60 days until discharge from an acute care setting and the ACT Team requests monitoring for Phase can only be completed by a clinical ACT Team member. ¶

(b) This progr gression. If this option is utilized, the ACT program must document and site this OAR while also continuing to be actively involved in care coordination and will provide a cannot be delegated outside the ACT Team to ensure equity of evaluation per evidence-based practices and criteria of ACT services. ¶

(4) The final determination ion good faith prior to discharge or end of jurisdiction date to ensure decision does not interfere with discharge process. ¶

(4) Referrals shall be accepted from mental health outpatient programs, residential treatment facilities or homes, families or individuals, and other community sources. ¶

(5) After further screening is completed; the ACT Program designated staff; the referral is communicated per best practice standards within 30 calendar days after care coordination communication of moving into Screening Phase. ACT Clinicians may expedite this process based on severity of needs and circumstances of the individual.: ¶

(5) Final determination must at minimum be completed by an ACT Team member with proper clinical credentials; ¶

(a) Final determination shall notify the individual of final decision for entry or admission to ACT services of

admission or denial. ¶

(b) The final Decision must be in written format per the individuals preferred language and capacity of understanding. ¶

(a) If approved (c) This determination must cite applicable administrative rule and criteria to support a final determination if conclusion is a denial and must be signed by the Decision Maker. ¶

(6) If approved for admission; the written response must have an anticipated start date less than seven (7) calendar days of letter. ¶

(b) If denied And the ACT Program shall, in good faith, attempt to coordinate any medication need;s all applicable OAR's must be cited, agency letter head and signed by decision maker and/or refills prior to first official appointment with an ACT Team Member. This includes updating electronic health record and medication administration record. ¶

(67) Given the severity of mental illness and functional impairment of individuals who qualify for ACT services, the final decision to admit a referral can rest with the CCO based on contractual language with said provider. Any decision in this capacity by a CCO will include written notification to ACT Program and Individual that is reflective of all applicable OAR's for admission or waitlisted. ¶

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

(89) ACT Program Capacity in a geographic region or identified service area is not a sufficient reason for not providing ACT services to an ACT eligible individual. If an individual who is ACT eligible cannot be served due to max capacity per Team Size in 0225 (22,26,34), they will be placed on a Waitlist per OAR 309-019-0225(3640). If this occurs, the responsible entity shall provide the individual or legal representative avenues to monitor the status on the waitlist. ¶

(910) The ACT eligible individual who is on the waitlist due to Team size capacity shall be offered alternative community-based rehabilitative services as described in the Oregon Medicaid State Plan that includes evidence-based practices to the extent possible per OAR 410-141-3515(21). ¶

(101) The Division shall monitor each regional waiting list until sufficient ACT program capacity is developed to meet the needs of the ACT eligible population per OAR 410-141-3515(21). ¶

(112) In addition, if an individual is denied ACT services the individual or their guardian may appeal the decision by filing a grievance in the manner set forth in OAR 309-008-1500 or for an Administrative Hearing which will be documented on The Division's form number MSC 0443 by either the Program, CCO or The Division and submitted through appropriate channels.

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

AMEND: 309-019-0250

RULE SUMMARY: Renamed section & updated

CHANGES TO RULE:

309-019-0250

ACT Transition to Less Intensive Services and DischargeClosure of ACT Services

(1) ~~Planned~~ transitions to less intensive services shall occur if the individual has confirmed they no longer require ACT level of care and requests a voluntarily discharge.

(2) The ACT Program may transition to lower level of care and graduate an individual when the participant has:

(a) Successfully reached individually established goals ~~for full transition~~ that identify level of functioning capabilities and enhanced self-awareness that no longer requires the intensity of ACT services;

(b) Successfully demonstrated an ability to function in all major role areas including but not limited to work, social, and self-care without ongoing assistance from the ACT Program;

(c) Requests discharge or declines or refuses services after offering follow-up attempts;

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

(3) The Individual is incarcerated or institutionalized for more than ~~three~~ two months with a date of discharge and/or release longer than ~~six~~ four months out.

(4) The ACT Program may discharge a Participant for behavior that is abusive to the point that the continued enrollment seriously impairs the provider's ability to furnish services to the participant:

(a) The Participant commits physical violence directed at ACT staff;

(b) If an ACT Program discharges a participant for abusive violent behavior, they must provide a copy of the discharge notice per 309-019-0250(4) to The Division and appropriate CCO.

(5) If there have been unsuccessful documented attempted contacts by the ACT program that last up to 90 days that indicates whereabouts unknown the Participant may be discharged;

(a) These attempts must be documented and ACT Programs in good faith, have attempted all forms of communication that includes but not limited to:

(A) In-person,

(B) Mail,

(C) Phone calls and

(D) Outreach to Natural Supports and/or Informal Support System.

(b) If an individual is discharged for whereabouts unknown and they make contact after the discharge date, the program has discretion on readmittance or re-referral.

(6) Documentation of discharge or transition to lower levels of care even for graduation purposes shall follow OAR 410-120-1865 and include at minimum the following:

(a) The reasons for discharge or graduation citing administrative rule

(b) The individual's biopsychosocial status at discharge or transition.

(c) A plan for follow-up treatment developed in conjunction with the individual.

(d) The ACT program, in good faith, must provide a copy of discharge or transition to lower level of care to the participant:

(A) Mailed or electronic copy as long as HIPAA approved/permission given to communicate electronically.

(B) Mailed or faxed to facility of known incarceration/institutionalization.

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

AMEND: 309-019-0255

RULE SUMMARY: Updated language for clarity.

CHANGES TO RULE:

309-019-0255

ACT Reporting Requirements ¶¶

(1) ACT Programs certified by the Division to provide ACT services shall submit quarterly outcome data using forms and procedures prescribed by the Division.¶¶

(2) ACT Programs shall submit all data within the Division mandated state data system per 309-022-0135: Additional fidelity and program specific data outside of state data system will include quantitative data submission of the following:¶¶

(a) Number of Participants served or Current Capacity:¶¶

~~(b) That are not enrolled in:¶¶~~

(b) Qualitative data those through Medicaid and non- Medicaid.¶¶

(c) Referrals data:¶¶

(A) Number of total referrals received during each quarter;¶¶

(B) Number of participants on the waitlist during each quarter and length of duration on the waitlist;¶¶

(C) Number of participants admitted during each quarter; and¶¶

(D) Number of participants denied during each quarter and the reason for each denial;¶¶

(d) Number of participants no longer on services. Two categories will be:-¶¶

(A) Graduated with successful transition to lower level of care¶¶

(B) Discharged without meeting all goals to graduate.-¶¶

(e) Crisis calls and dispatches by ACT Team for ACT Participants. This does not include any other crisis service delivery that an ACT Team member may be part of or if a different service delivery is attending to crisis.

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