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- 309-108-0010** Policy
- 309-108-0015** Procedures
- 309-108-0020** Notice to Patients, Residents, and Employees

DIVISION 112

USE OF RESTRAINT FOR PATIENTS IN STATE INSTITUTIONS

- 309-112-0000** Purpose and Statutory Authority
- 309-112-0005** Definitions
- 309-112-0010** General Policies Concerning Use of Restraint
- 309-112-0015** Use of Restraint in Emergencies
- 309-112-0017** Use of Restraint as Part of Planned Treatment or Training Programs
- 309-112-0020** Use of Security Transportation
- 309-112-0025** Use of Restraint for Acute Medical Conditions
- 309-112-0030** Restraint Review Committee
- 309-112-0035** Notice to Patients and Employees

DIVISION 114

INFORMED CONSENT TO TREATMENT AND TRAINING BY PATIENTS IN STATE INSTITUTIONS

- 309-114-0000** Purpose
- 309-114-0005** Definitions
- 309-114-0010** General Policy on Obtaining Informed Consent to Treatment and Training
- 309-114-0015** Administration of Significant Procedures without Informed Consent in Emergencies
- 309-114-0020** Involuntary Administration of Significant Procedures to Persons Committed to the Division with Good Cause
- 309-114-0025** Contested Case Hearing
- 309-114-0030** Notice to Patients and Employees

DIVISION 118

GRIEVANCE PROCEDURES FOR USE IN STATE INSTITUTIONS

- 309-118-0000** Purpose and Statutory Authority
- 309-118-0005** Definitions
- 309-118-0010** Policy Statement

- 309-118-0015** Non-Grievable Issues
- 309-118-0020** Grievance Procedures
- 309-118-0025** Emergency Grievances
- 309-118-0030** Representatives
- 309-118-0035** Staff Role in Grievance Procedures
- 309-118-0040** Review by Courts
- 309-118-0045** Grievance Committee
- 309-118-0050** Posting of Grievance Procedures

DIVISION 120

PATIENT TRANSFERS

- 309-120-0070** Purpose
- 309-120-0075** Definitions
- 309-120-0080** Procedures for Transfer
- 309-120-0200** Purpose
- 309-120-0205** Definitions
- 309-120-0210** Administrative Transfers (Mentally Ill Inmates)
- 309-120-0215** Hearings Process
- 309-120-0220** Representation
- 309-120-0225** Notice of Hearing
- 309-120-0230** Investigation
- 309-120-0235** Documents/Reports
- 309-120-0240** Witnesses
- 309-120-0245** Postponement
- 309-120-0250** Findings
- 309-120-0255** Hearing Record
- 309-120-0260** Superintendent's Review
- 309-120-0265** Extension of Transfer
- 309-120-0270** Handling of Inmate Money and Personal Property
- 309-120-0275** Visiting Privileges
- 309-120-0280** Short-Term Transitional Leaves, Emergency Leaves and Supervised Trips
- 309-120-0285** Releases from a State Mental Hospital
- 309-120-0290** Reporting of Unusual Incidents
- 309-120-0295** Confidentiality and Sharing of Information

DIVISION 8

CERTIFICATION OF BEHAVIORAL HEALTH TREATMENT SERVICES

309-008-0100

Purpose and Scope

(1) Purpose. These rules establish procedures for the application, initial certification, renewal of certification, review, and other actions on a certificate including revocation, denial, suspension, and placement of conditions for the behavioral health treatment services for the types listed in subsection (2) of this rule.

(2) Scope. These procedural rules apply to providers of behavioral health treatment services seeking certification to provide services the following of certificates issued under the referenced service delivery rules:

(a) OAR 309-014-0000 to 0040 (Mental Health Division Community Mental Health and Developmental Disability Services Contractors);

(b) OAR 309-019-0100 to 0220 (Outpatient Addictions and Mental Health Services);

(c) OAR 309-022-0100 to 0190 (Intensive Treatment Services for Children and Adolescents);

(d) OAR 309-022-0195 to 0230 Children's Emergency Safety Intervention Specialist);

(e) OAR 309-033-0700 to 0740 (Community Hospital and Nonhospital Facilities to provide Seclusion and Restraint to Committed Persons and Persons in Custody or in Diversion);

(f) OAR 309-039-0500 to 0580 (Non-Inpatient Mental Health Treatment Services);

(g) OAR 415-020-0000 to 0090 (Out-Patient Opioid Treatment Programs);

(h) OAR 415-054-0020 to 0580 (DUII Alcohol/Other Drug Information and DUII Alcohol/Other Drug Rehabilitation Programs);

(i) OAR 415-054-0400 to 0580 (Alcohol and Drug Evaluation and Screening Specialist);

(j) OAR 415-055-0000 to 0035 (Recommendations For Restricted License For Driving Under The Influence of Intoxicants and Other Related Suspensions and/or Revocations; and

(k) OAR 415-057-0020 to 0150 (Adult Prison-Based Alcohol and Other Drugs Treatment Programs for the Department of Corrections).

(3) These rules do not establish procedures for other health care services types or licenses not listed in subsection (2) of this rule and specifically do not establish procedures for:

(a) Licensing a residential facility under ORS 443.410 or 443.725;

(b) Licensing or certifying an individual behavioral health care practitioner otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board; or

(c) Licensing or certifying a behavioral health treatment services provider comprised exclusively of health care practitioners or behavioral health care practitioners otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board.

(4) These rules apply to applications, initial certifications, renewals of certification, reviews, and other actions that were pending or initiated on or after July 1, 2016.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 12-2016(Temp), f. & cert. ef. 7-29-16 thru 12-27-16

309-008-0200

Definitions

(1) "ASAM PCC" means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care, and incorporated by reference in these rules.

(2) "Applicant" means any provider with an existing certificate listed in OAR 309-008-0100(2) to provide behavioral health treatment services or any person, organizational provider, tribal organization, or Community Mental Health Program seeking initial certification listed in OAR 309-008-0100(2) by submitting an application to provide behavioral health treatment services.

(3) "Behavioral Health" means mental health, mental illness, addictive health, and addiction and gambling disorders.

(4) "Behavioral Health Treatment Services" means mental health treatment, substance use disorder treatment, and problem gambling treatment services.

(5) "Certificate" means the document or documents issued by the Division, which identifies and declares certification of a provider pursuant to these rules. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

(6) "Certification Review" means an assessment of a provider or applicant by the Division or by another state agency or contractor on behalf of the Division, for the purpose of assessing compliance with these rules, with applicable service delivery rules, and other applicable regulations.

(7) "Community Mental Health Program" (CMHP) means the organization of various services for persons with a mental health diagnosis or addictive disorders, operated by, or contractually affiliated with, a local mental health authority and operated in a specific geographic area of the state under an agreement with the Division pursuant to OAR 309-014-0000.

(8) "Condition" means a provision attached to a new or existing certificate that limits or restricts the scope of the certificate or imposes additional requirements on the applicant or provider.

(9) "Coordinated Care Organization" (CCO) means an entity that has been certified by the Authority to provide coordinated and integrated health services.

(10) "Director" means the Director of the Oregon Health Authority or the Director's designee.

(11) "Division" means the Health Systems Division (HSD) of the Oregon Health Authority or the Division's designee.

(12) "Division Staff" means those staff employed by the Division to conduct certification activities under these rules or a contracted entity delegated the authority by the Division to conduct certification activities under these rules.

(13) "Individual" means the person requesting or receiving behavioral health treatment services from a provider certified by the Division pursuant to these rules.

(14) "Individual Services Records" means documentation, written or electronic, regarding an individual including information relating to entry, assessment, orientation, services and supports planning, services and supports provided, and transfer.

(15) "Initial Certification" means a certificate issued to a new provider.

(16) "Non-Inpatient Provider" means a provider not contractually affiliated with the Division, a CMHP, or other contractor of the Division, providing behavioral health treatment services under group health insurance coverage which seeks or maintains Division approval under ORS 743A.168)

(17) "Oregon Health Authority" (Authority) means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, divisions of the Oregon Health Authority include the Public Health Division and the Health Systems Division.

(18) "Plan of Correction" (POC) means a written plan and attached supporting documentation created by the provider when required by the Division to address findings of noncompliance with these rules or applicable service delivery rules.

(19) "Provider" means a person, organizational provider as defined in ORS 430.637(1)(b), tribal organization, or CMHP that holds a current certificate listed in OAR 309-008-0100(2) to provide behavioral health treatment services pursuant to these and applicable service delivery rules.

(20) "Program Staff" includes employees of the provider, persons who provide services by contract with the provider, program administrators, directors, or others who manage the provision of services, and the provider itself where the provider is a person or a group of persons.

(21) "Program Director" means a person with appropriate professional qualifications and experience as regulated by the applicable service delivery rules listed on the certificate, who is designated to manage the operation of a program.

(22) "Public Funds" means financial support, in part or in full, provided directly or indirectly by a local, state, or federal government.

(23) "Regulatory Standard" means a rule, condition, or requirement describing the following information for products, systems, or practices:

- (a) Classification of components;
- (b) Specification of materials, performance, or operations; or
- (c) Delineation of procedures.

(24) "Service Delivery Rules" means the OAR describing the specific regulatory standards for each of the types of behavioral health treatment services the Division certifies under these rules and as listed in OAR 309-008-0100(2).

(25) "Service Delivery Location" means the office, facility, location, or other physical premises where the applicant or provider intends to provide or currently provides behavioral health treatment services.

(26) "Services" means those activities and treatments intended to assist the individual's transition to recovery from a substance use disorder, gambling disorder or mental health condition, and to pro-

mote resiliency, and rehabilitative and functional individual and family outcomes.

(27) "Substantial Compliance" means a level of adherence to applicable administrative rules, statutes, and other applicable regulations which even if one or more requirements is not met, does not, in the determination of the Division:

(a) Constitute a danger to the health, welfare or safety of any individual or to the public;

(b) Constitute a willful, negligent, or ongoing violation of the rights of any individuals as set forth in administrative rules; or

(c) Constitute impairment to the accomplishment of the Division's purposes in approving or supporting the applicant or provider.

(28) "Substantial Failure to Comply" means a level of adherence to applicable administrative rules, statutes, contractual requirements, and other applicable regulations, which in the determination of the Division:

(a) Constitutes a danger to the health, welfare or safety of any individual or to the public;

(b) Constitutes a willful, negligent, or ongoing violation of the rights of individuals as set forth in applicable administrative rules; or

(c) Constitutes impairment to the accomplishment of the Division's purposes in approving or supporting the applicant or provider.

(29) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0250

Required Certifications for Behavioral Health Treatment Services

(1) A current certificate is required for each provider offering behavioral health treatment services by contract with the Division, by contract with a public body, or by receipt of other public funds except as provided in subsection (4) of this rule. A provider is considered to contract with a public body or receive public funds where:

(a) The provider operates under an intergovernmental agreement, a direct contract with the Division, or a direct contract with one or more CCOs;

(b) The provider receives funds administered by the Division or one or more CCOs;

(c) The provider is a community hospital, regional acute care psychiatric facility, or nonhospital facility providing care, custody, and treatment for a committed person in custody, or a person on diversion pursuant to ORS 426.070 & 426.140; and

(d) The provider is a CMHP operating under 309-014-0000.

(2) A current certificate is required for each provider offering behavioral health treatment services by contract with the Division, by contract with a public body, or by receipt of other public funds for residential mental health treatment services offering mental health treatment services beyond the scope of their residential licensure issued under OAR 309-035-0000; and

(3) An applicant or provider not described in subsection (1) or (2) of this rule offering behavioral health treatment services regulated by the service delivery rules listed in 309-008-0100(2), and reimbursable under group health coverage as set forth in ORS 743A.168, may seek certification pursuant to these rules in order to establish reimbursement eligibility.

(4) A certificate under these rules is not required for the following types of providers regardless of whether public funds are received:

(a) An individual behavioral health care practitioner otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board; or

(b) A behavioral health treatment services provider comprised exclusively of health care practitioners or behavioral health care practitioners otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board; independent of payer or funding source.

(5) Certificates are not a substitute for a required license, such as those required in ORS 443.410 and 443.725 for residential facilities.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.140, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 743.556, 813.021, & 813.260

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 12-2016(Temp), f. & cert. ef. 7-29-16 thru 12-27-16

309-008-0300

Terms of Certification

(1) Each applicant and provider agrees, as a term of certification:

(a) To permit Division staff to inspect the service delivery location(s) where the applicant or provider intends to provide or currently provides behavioral health treatment services:

(A) During regular business hours and at any other reasonable hour to verify information contained in the application or to ensure compliance with all applicable statutes, administrative rules, other applicable regulations, or contractual obligations; and

(B) For immediate entry and inspection, extending to any premises the Division has reason to believe a provider provides behavioral health treatment services.

(b) To permit Division staff to inspect, audit, assess and collect data or copies from all records maintained by the applicant or provider in relation to the certificate including but not be limited to:

(A) Financial records;

(B) Individual Service Records;

(C) Records related to the supply, storage, disbursement, and administration of prescribed and over-the-counter medications;

(D) Records of utilization and quality assurance reviews conducted by the applicant, provider, or other accredited entity;

(E) Employee records including, but not limited to:

(i) Academic degrees;

(ii) Professional licenses;

(iii) Supervision notes, disciplinary actions, and logs; and

(iv) Criminal background checks;

(v) All documentation required by applicable service delivery rules, statute, other applicable regulations, and administrative rules;

(vi) Additional documentation deemed necessary by the Division to determine compliance with this or any other applicable administrative rules, statutes, or other applicable regulations;

(c) That the provider is certified to provide only those services which are specified in the scope of services and conditions listed on the certificate

(d) To post the certificate or a legible copy and any accompanying letter noting approved service delivery locations or applicable conditions in a public space of each approved service delivery location to be available for inspection at all times;

(e) That the certificate does not create an express or implied contract in the absence of a fully executed written contract; and

(f) That the certificate is not transferable to any other person, provider, or service delivery location without Division approval.

(2) Nondiscrimination; Special Populations: The Division shall not discriminate in its review procedures or services on the basis of race, color, national origin, age, or disability. The Division may issue certificates to specialized programs to assure maximum benefit for special populations, in which case, the Division may identify that special population in the certificates and impose applicable program criteria under the applicable service delivery rules.

(3) A certificate is void immediately:

- (a) Upon voluntary closure by a provider;
- (b) Upon change in the provider's majority or controlling ownership; or
- (c) Upon the listed expiration date of the certificate if the provider fails to timely submit a complete application for certification renewal pursuant to these rules;
- (4) Discontinuation of services:
 - (a) A provider discontinuing services voluntarily must:
 - (A) Notify the Division at least 60 days prior to the date of voluntary closure and provide a written plan to comply with record retention standards set out in OAR 309-014-0035(4) and 42 CFR Part 2, "Federal Confidentiality Regulations" as applicable;
 - (B) Make reasonable and timely efforts to obtain alternative treatment placement or other services for individuals currently being served; and
 - (C) Make reasonable and timely efforts to contact individuals on waitlists and refer them to other treatment services; and
 - (d) A provider discontinuing services must provide individuals with a minimum 30-day written notice regarding discontinuation of services. In circumstances where undue delay might jeopardize the health, safety, or welfare of individuals or the public, including where the Division has revoked or immediately suspended the certificate pursuant to OAR 309-008-1100, the provider must notify individuals regarding the discontinuation of services as soon as possible.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.
Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.
Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0400

The Application Process

- (1) Application Required. An applicant seeking initial certification or certification renewal, and an existing provider seeking to expand its certified scope of services, relocate an existing service delivery location, or open new service delivery location(s) must submit a completed application to the Division.
- (2) The Division will furnish an application with instructions, and provide appropriate technical assistance to facilitate completion of the application, upon:
 - (a) Request from an applicant seeking initial certification;
 - (b) Request from an existing provider seeking certification renewal congruent with timelines established by these rules;
 - (c) Request from an existing provider seeking to add or relocate service delivery location(s); and
 - (d) Request from an existing provider seeking to change the scope of services approved on the current certificate.
- (3) An applicant with multiple service delivery locations must submit documentation with the application sufficient for the Division to evaluate each service delivery location. A separate application for each service delivery location is not required.
- (4) The application must be legible and completed on the forms furnished by the Division, in the manner specified by the Division. Each application must include:
 - (a) A detailed plan outlining the implementation of the proposed services congruent with these rules, applicable service delivery rules, other applicable regulations, and OAR and ORS noted herein;
 - (b) Written attestation by the applicant that all applicable rules of the Division for provision of the proposed services will be met and maintained in substantial compliance with applicable service delivery rules;
 - (c) Other documentation required by applicable OAR, ORS, other applicable regulations, local regulations, contract or by judgment of the Division to assess applicant's compliance with administrative rules; and
 - (d) Complete and current copies of the following documents:
 - (A) A description of the applicant's service delivery location(s) describing the type and scope of behavioral health treatment

- services provided or proposed by the applicant at each service delivery location;
 - (B) Applicant's policies regarding credentialing practices of individual practitioners;
 - (C) Applicant's liability insurance coverage listing all covered service delivery location(s);
 - (D) Applicant's policies and procedures regarding seclusion and restraint practices; and
 - (E) Applicant's Code of Conduct.
 - (5) Where applicable, the Division will maintain copies of the documents listed in subsection (4)(d) of this rule within the Division's CCO document bank.
 - (6) Timeframe for application submission:
 - (a) Initial Certification: An applicant seeking initial certification under these rules must submit a completed application at least six months in advance of the applicant's desired date of certification;
 - (b) Certification Renewal: An applicant seeking to renew its certificate must:
 - (A) Request an application from the Division; and
 - (B) Submit a complete application at least six months prior to the expiration of the existing certificate.
- Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.
Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.
Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0500

Response to Application

- (1) Upon receipt of application materials, the Division will conduct a comprehensive audit of the application materials to determine compliance with these rules.
 - (a) Complete Application. Within 60 days of the Division's receipt of a complete application compliant with these rules:
 - (A) The Division will notify the applicant that the application has been accepted as complete; and
 - (B) The Division will contact the applicant to schedule a certification review.
 - (b) Incomplete Application. Within 60 days of the Division's receipt of an incomplete application, the Division will provide written feedback describing any necessary amendment to the application prior to resubmission. To resubmit, the applicant must submit an amended application to the Division for review within 21 calendar days of receipt of the Division's written feedback.
- (2) When an application is denied, the Division will issue a written notice of denial within 14 days of the determination in accordance with ORS 183.
- (3) Applications for certification will be denied where:
 - (a) The applicant's proposed behavioral health treatment services are not subject to the service delivery rules listed in OAR 309-008-0100(2) and therefore are not subject to certification under these rules;
 - (b) The applicant fails to demonstrate substantial compliance with applicable statutes, administrative rules, or other applicable regulations.
 - (c) The applicant fails to re-submit complete application materials within 21 calendar days of receipt of the Division's written feedback;
 - (d) The applicant timely re-submits the application but the Division finds the re-submitted application remains incomplete or fails to demonstrate substantial compliance with applicable statutes, administrative rules, or other applicable regulations;
 - (e) The applicant submits an application within 180 days of a prior application denial or certificate revocation under these rules by the Division.
- (4) The Division may elect to deny an application prior to review when:
 - (a) The applicant has previously had any certification or license suspended or revoked by the Division, Oregon Health Authority, the Oregon Department of Human Services, or any other similar state agency outside of Oregon;

(b) The applicant has been denied certification due to failure to submit complete application materials two or more times within the previous three calendar years;

(c) The applicant is listed on any current Medicaid exclusion list under OAR 410-120-1380(1)(c)(J); or

(d) The applicant submits false or inaccurate information to the Division.

(5) Withdrawal of Application. An applicant may withdraw an initial or renewal application at any time prior to the Division acting on the application unless the Division has determined that the applicant submitted false or misleading information in which case the Division may refuse to accept the withdrawal and may issue a notice of proposed denial in accordance with this rule.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0600

Appealing Denial of Application for Certification

(1) Hearing. Where the Division has denied an application under these rules, the Division must notify the applicant in writing and provide the applicant the opportunity to request a hearing under ORS Chapter 183. Any request for a contested case hearing must be submitted in writing to the Division by the applicant according to the deadline set out in the notice of denial.

(2) Review by the Division. Where the Division has denied an application under these rules, in addition to, or in lieu of, a hearing under ORS Chapter 183, an applicant may request, in writing, an appeal review by the Director.

(a) To obtain review, the applicant must submit a written request for the appeal review to the Division within fourteen (14) calendar days of receipt of the notice of denial;

(b) The Director, whose decision is final, must conduct an appeal review meeting within 30 days of receipt of the applicant's written request;

(c) If the Director overturns the denial, the Division will issue written notice to the applicant within fourteen (14) calendar days of the appeal review meeting. The notice will inform the applicant of the outcome of their appeal hearing and will either:

(A) Include an approved certification per these rules; or

(B) Include written notice of required amendment to application materials and a timeframe for re-submission per these rules.

(d) If the Director affirms the denial, the notice of denial will become final, the application closed, and a notice of the appeal review outcome mailed to the applicant within fourteen (14) days of the appeal review meeting.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0700

Types of Reviews

(1) The Division may conduct the following types of certification reviews as appropriate:

(a) Initial Certification Review. After receipt of a complete application and consistent with OAR 309-008-0500(1)(a)(B), Division staff will complete a comprehensive audit of the required application documentation and the service delivery location(s). The Division will not issue an initial certification without a completed Initial Certification Review;

(b) Certification Renewal Review. After receipt of a complete application and consistent with OAR 309-008-0500(1)(a)(B), Division staff will complete a comprehensive audit of the required application documentation and the service delivery location(s). For continued certification, Certification Renewal Reviews must occur prior to the expiration of the existing certificate and at least once every three years;

(c) Discretionary Certification Reviews. The Division may conduct Discretionary Certification Reviews with reasonable notice to ensure compliance with applicable statute, administrative rules, other applicable regulations, and contractual obligations.

(A) Discretionary Certification Reviews may be conducted by the Division with or without notice for the following reasons:

(i) The Division has reasonable concern the provider may act to alter records or make them unavailable for inspections;

(ii) The Division has received a complaint or information which suggest or allege conditions or practices which could threaten the health, safety, rights, or welfare of individuals; or

(iii) The Division has reason to believe a certification review is necessary to ensure a provider is in substantial compliance with these rules, service delivery rules, other applicable administrative rules, contractual obligations or with conditions placed upon the certificate;

(5) If Division staff are not permitted access to records or service delivery location(s) for the purpose of conducting a certification review consistent with these rules, the Division may take action on the certificate up to and including the application of conditions, suspension, or revocation.

(6) Inspections By Other Agencies: A provider or applicant must permit state or local fire inspectors and state or local health inspectors to enter and inspect the service delivery location(s) as required by administrative rule, state fire code, or local regulations.

(7) Desk Reviews. At the sole discretion of the Division, Division staff may complete a certification review partially or fully via a desk review process. A desk review process is where Division staff conduct a certification review based on the provider or applicant's submission of required documentation and telephonic interviews where Division staff do not physically visit the service delivery location(s).

(a) The Division will furnish a list of documentation necessary to complete the desk review to the applicant or provider;

(b) The applicant or provider must submit all requested documents to the Division in compliance with state and federal privacy and data transmission regulations;

(c) The Division may elect to schedule telephone interviews deemed necessary to fulfill the objectives of a certification review; and

(d) Upon completion of the desk review, the Division will securely dispose of documentation containing protected health information submitted by the applicant or provider.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0800

Conduct of Certification Reviews

(1) The Division will employ review procedures deemed adequate to determine applicant or provider compliance with applicable administrative rules, statutes, other applicable regulations, and as necessary, contractual obligations. These procedures may include but are not limited to:

(a) Entry and inspection of any service delivery location(s);

(b) Review of documents pursuant to this rule; and

(c) Interviews with or a request for completion of a questionnaire, by persons knowledgeable of the provider or applicant. Individuals interviewed may include program staff, managers, governing or advisory board members, allied agencies, individuals, their family members, and significant others;

(2) Program staff must cooperate with Division staff during a certification review.

(3) Within 30 days following the completion of each discretionary review the Division may, at their discretion, issue a report and require a Plan of Correction congruent with section (4) of this rule.

(4) Within 30 days following the completion of each initial or renewal certification review the Division will issue a report including:

(a) A statement of deficiency including a description of the review findings related to non-compliance with applicable administrative rules, statutes, other applicable regulations and any required corrective actions where applicable;

(b) Conditions the Division intends to include on a certificate, when applicable;

(c) The Plan of Correction (POC): When pursuant to a certification review, the Division determines a provider or applicant is not operating in substantial compliance with all related statutes, administrative rules and other applicable regulations and the plan of correction process is appropriate, the Division may require the provider or applicant to submit a POC. The Division will provide written notice of the requirement to submit a POC and the provider or applicant must prepare and submit a POC according to the following terms:

(A) The provider or applicant must submit the POC to the Division within 30 days of receiving the statement of deficiency. The Division may issue up to a 90 day extension to the existing certification to allow the provider or applicant to complete the plan of correction process.

(B) The POC must address each finding of non-compliance and must include:

(C) The planned action(s) or action(s) already taken to correct each finding of non-compliance;

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

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

(F) The person(s) responsible for ensuring the implementation of each corrective action within the plan of correction;

(d) POC Clarification Necessary. If the Division finds that clarification or supplementation to the POC is required prior to approval, Division staff will contact the provider or applicant to provide notice of requested clarification or supplementation, and the provider or applicant will submit an amended plan of correction within 14 calendar days of notification.

(e) The provider must submit a sufficient POC approved by Division prior to receiving a certificate. Upon the Division's approval of the POC, the Division will issue the appropriate certification pursuant to these rules.

(f) Failure to Submit POC. The Division may deny, suspend, or revoke an applicant or provider's certification if the provider fails to submit an adequate POC within the timeframes established in this rule.

(5) Substantial Compliance. When the Division determines a provider or applicant to be in substantial compliance with all related statutes, administrative rules and other applicable regulations, the Division will not require a POC. For certification reviews conducted for purposes of initial certification or renewal of a certification, the Division will issue a certificate pursuant to these rules.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0900 Issuing Certificates

(1) Issuing Certificates. The Division will issue an approved applicant a certificate to provide behavioral health treatment services as follows:

(2) Every certificate will;

(a) Be signed by the Director;

(b) Apply to all approved service delivery locations listed in the accompanying letter;

(c) List the service delivery rules under which the applicant or provider is approved to provide services;

(d) List the effective and expiration dates of the certificate;

(e) List any conditions applied to the certificate;

(f) List any variances approved by the Division; and

(g) Be accompanied by a letter from the Division noting:

(A) All service delivery locations approved under the certificate; and

(B) Approved alternative practices related to variances listed on the certificate

(3) Initial Certification. After conduct of the certification review, the Division will issue initial certificates to new applicants that demonstrate substantial compliance with applicable administrative rules and statutes:

(a) For up to one (1) calendar year from the date of initial certification; and

(b) Initial certifications may be issued with conditions pursuant to this rule.

(4) Certification Renewal. After conduct of the certification review, and the plan of correction process where applicable, the Division will renew the certificate of an applicant with a current certification that demonstrate substantial compliance with applicable administrative rules, or statutes:

(a) For up to three (3) calendar years from the date of renewal; and

(b) Renewal certifications may be issued with conditions pursuant to this rule.

(5) Certificates with Conditions. The Division may elect at any time and at its discretion to place time-limited conditions on a certificate upon a finding that:

(a) The applicant or provider employs or contracts with any program staff who has mistreated or otherwise engaged in abusive behavior or has been substantiated for abuse or mistreatment;

(b) The applicant or provider employs or contracts with any program staff that fails to meet relevant minimum qualifications per the applicable service delivery rule(s);

(c) The applicant or provider is substantiated for abuse or mistreatment;

(d) The applicant or provider operates such that there is a threat to the health, welfare, or safety of an individual or the public;

(e) The applicant or provider fails to operate in substantial compliance with these or other applicable administrative rules or regulations;

(f) The applicant or provider fails to fully implement or adequately maintain a corrective action required by an approved POC;

(g) The Division has issued the applicant or provider through two or more consecutive certification reviews substantially similar finding(s) of non-compliance with these rules, service delivery rules, or other applicable administrative rules, statutes or regulations;

(h) There is a need for increased regulatory oversight of the applicant or provider;

(i) The applicant or provider fails to comply with any reporting requirements relating to funding or certification; or

(j) The applicant or provider is unable to comply with applicable rules or regulations due to staffing shortfalls; or

(k) The applicant or provider qualifies for placement of a condition on the certificate pursuant to applicable service delivery rules.

(6) The Division will consider the sum of the circumstances, including the following criteria, when deciding whether to issue a certificate with conditions as opposed to denying, suspending, refusing to renew, or revoking a certificate;

(a) The expressed willingness and demonstrated ability of the applicant or provider to gain and maintain compliance with all applicable administrative rules and regulations;

(b) Submission of a POC prescribing reasonable, sustained and timely resolution to areas of non-compliance;

(c) The relative availability of alternative providers to address any service needs that would be unmet if the applicant or provider is not issued a certificate with conditions as an alternative to revocation or refusal to award a certificate; or

(d) The applicant or provider's historical compliance with Division rules, previous conditions placed on certificates, and previous POCs.

(7) Conditions to the certificate may include:

(a) Requiring corrective actions with associated timeframes for completion necessary for the applicant or provider to correct areas of non-compliance or concern identified by the Division;

(b) Limiting the total number of individuals enrolled in services or on a waitlist for services;

(c) Limiting the demographics including the age range of individuals who may be the applicant or provider;

(d) Limiting the scope and type of services that the applicant or provider may provide;

(e) Other conditions deemed necessary by the Division to ensure the health and safety of individuals and the public; and

(f) Other conditions deemed necessary by the Division for the purpose of ensuring regulatory compliance with this or other applicable administrative rules and regulations.

(8) The Division will:

(a) List the conditions on the certificate;

(b) Notify the applicant or provide in writing the condition(s) imposed; and

(c) The duration of the condition(s), and actions required for the removal of the condition from the certificate.

(9) Duration of Conditions. The Division will determine the duration of each condition listed on a certificate. Conditions will:

(a) Be issued for no longer than one (1) year;

(b) Be removed from the certificate when the applicant or provider demonstrates the successful completion of actions required the Division.

(10) Extension of Conditions. Upon an applicant or provider's application, the Division may in its discretion grant a request for an extension for no longer than six (6) months beyond the initial condition period.

(a) The applicant or provider's request for extension must be in writing and received by the Division at least 30 calendar days prior to the expiration date of the condition listed on the certificate;

(b) The applicant or provider's request for extension must include a detailed explanation of the following for each condition to which the applicant or provider seeks an extension:

(A) Actions taken by the applicant or provider to complete the required action necessary for removal of the condition;

(B) An explanation of why any required actions will not be completed prior to the condition's expiration date;

(C) A plan detailing how and when the applicant or provider will complete the required actions necessary to remove the extended condition, not to exceed six (6) months; and

(D) An explanation as to the extenuating circumstances prohibiting the applicant or provider's timely completion of the required actions.

(c) Conditions will not be extended:

(A) Where the request for extension is not received by the Division in advance of the condition expiration date;

(B) Where the Division has already granted one extension;

(C) Where the Division finds that an extension would perpetuate significant health and safety issues;

(D) Where the condition is the result of repeated findings of non-compliance; or

(E) Where the Division finds that If the applicant or provider fails to demonstrate extenuating circumstances.

(11) The Division may deny, suspend, and refuse to renew, or revoke the certificate where the provider or applicant fails to timely complete required corrective actions for removal of the condition(s).

(12)(a) When the Division orders a condition be placed on a certificate under the provisions of this rule, the applicant or provider is entitled to request a hearing in accordance with ORS Chapter 183;

(b) In addition to, or in lieu of, requesting a hearing in accordance with ORS Chapter 183, an applicant or provider may request an informal conference with the Division per the informal conference process found in OAR 309-008-0600.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.
Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.
Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1000

Modification to Certification

(1) Modifying Certificates. A provider with a current certificate seeking to open new service delivery location(s), relocate current service delivery locations, provide additional types of treatment services under different service delivery rules must submit a written request for Division approval prior to any such changes.

(a) The Division must receive the written request for such changes at least 60 days prior to the desired effective date for any such changes.

(b) The Division will make reasonable efforts to make final determination for approval or disapproval of changes to the certificate within 45 days of receiving the written request;

(2) A provider with a current certificate seeking to designate a new Program Director must submit a written request for Division approval prior to making such a designation.

(a) The provider must include copies of relevant qualifications with its written request when designating a new Program Director.

(b) The Division will make every reasonable effort to review documents and make a final determination regarding whether the proposed Program Director meets applicable service delivery rule requirements and qualifications within 30 days of receipt of the provider's written request. The Division will provide written notice of its determination;

(c) When an emergency requires a provider to designate a new Program Director prior to Division approval:

(A) The provider must make every reasonable effort to expediently designate a new Program Director and must submit a request for the designation to the Division within 15 calendar days of the new designation and include copies of relevant qualifications of the new Program Director; and

(B) The Division will make every reasonable effort to expediently review the provider's request for the designation and make a final determination whether the proposed Program Director meets applicable service delivery rule requirements. The Division will provide written notice of its determination.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.
Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.
Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1100

Suspension and Revocation of Certification

(1)(a) Immediate Revocation or Suspension. Immediate Revocation or Suspension of a certificate, may occur when the Division finds there is substantial failure to comply with applicable statutes, administrative rules, service delivery rules, or other applicable regulations, such that, the Division finds that there is a serious danger to the public health or safety:

(b) Has demonstrated substantial failure to comply with these administrative rules and other applicable regulations such that the health or safety of individuals is jeopardized to the degree that immediate cessation of services by the provider is considered necessary to prevent harm to the individual.

(2) Revocation, Suspension, and Refusal to Renew Certificates with Notice. The Division may, with a 30 day notice to revoke, suspend or refuse to renew a certificate or one or more service delivery locations listed on the certificate when the Division determines a provider:

(a) Has demonstrated substantial failure to comply with these administrative rules and other applicable regulations such that the health or safety of individuals is jeopardized to the degree that cessation of services by the provider is considered necessary to prevent harm to the individual;

(b) Has demonstrated a substantial failure to comply with applicable rules and regulations such that the health or safety of individuals is found to be jeopardized during two certification reviews within a six-year period;

(c) Has failed to maintain any State of Oregon license which is a prerequisite for providing services that were approved;

(d) Has a direct contract with the Division and the Division has terminated its agreement or contract with the provider;

(e) Has failed to correct the issues detailed in a certificate with conditions within the allotted time;

(f) Has failed to submit a POC sufficient to come into substantial compliance with these and other applicable rules or regulations;

(g) Has submitted falsified or incorrect information to the Division;

(h) Has refused to allow access to information for the purpose of verifying compliance with applicable statutes, administrative rules or other applicable regulations, within a specified date or fails to submit such information following the date specified for such a submission in the written notification.

(3) When the Division determines the need to revoke, suspend, or deny renewal of a certificate issued under these rules, a notice of intent to take action on the certificate will be issued to the provider.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1200

Informal Conference

(1) Informal Conference. Within ten (10) calendar days of the Division issuance of a notice of intent to apply a condition, revoke, suspend, or refusal to renew the certificate to an applicant or provider pursuant to these rules, the Division must offer the applicant or provider an opportunity for an informal conference. The applicant or provider must make its request for an informal conference in writing within seven (7) days of the issuance of notice. Upon receipt of a timely written request, the Division will select a location and time for such a conference, provided that the conference occurs within 14 days of the Division's receipt of the request.

(2) Following such a conference, the Division may:

(a) Approve the application or renewal, or set conditions to certification as described as allowed by these rules an alternative to denying or revoking certification;

(b) Continue to proceed with action on the provider's certificate up to and including applying conditions, suspension, revocation, or refusal to renew the certificate.

(3) The Division will provide written notice of its decision under subsection (2) of this rule within fourteen (14) calendar days of the informal conference.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1300

Hearings

(1) An applicant or provider issued a notice of intent to apply a condition, revoke, suspend, or refusal to renew its certificate under these rules shall be entitled to request a hearing in accordance with ORS Chapter 183.

(2) When the Division orders the immediate suspension or denial of a certificate under the provisions of this rule, the provider shall be entitled to request a hearing in accordance with ORS Chapter 183.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1400

Information to CCOs and Other Health Plans

(1) Upon completion of the site review process and the issuance of a certificate, the Division will make copies of the following information available to Coordinated Care Organizations and other health plans for the purpose of credentialing a provider:

(a) A current program description that reflects the type and scope of behavioral health treatment services provided by the provider;

(b) Provider policies and procedures regarding the provider's credentialing practices of individual clinicians;

(c) Statements of provider's liability insurance coverage;

(d) An attestation from the Division verifying that the provider has passed a screening and meets the minimum requirements to be a Medicaid provider, where applicable;

(e) Reports detailing the findings of the Division's certification review of the provider;

(f) The provider's Medicaid Vendor Identification Number issued by the Division, where applicable;

(g) Copies of the provider's policies and procedures regarding seclusion and restraint practices; and

(h) Copies of the provider's Code of Conduct.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1500

Complaints

(1) Complaints Concerning Providers. Any person may file a complaint with the Division concerning a provider holding a certificate under these rules. The Division may require the complainant to exhaust grievance procedures available through the provider and, if applicable, the Medicaid payer, prior to initiating an investigation.

(2) Complaint Investigation. The Division will only investigate a complaint concerning a provider falling within the Division's scope and regulatory authority;

(a) The Division will investigate and respond to a complaint pursuant to Division policies and procedures.

(b) The Division will refer the complainant to the appropriate entity if the complaint pertains to a provider falling outside the Division's scope or regulatory authority or otherwise regulated by another state or local entity.

(3) Consequences of a substantiated complaint related to the health, safety, or welfare of an individual or the public may result in the suspension, revocation, denial, or refusal to renew an applicant or provider's application or certificate.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1600

Variance

(1) An applicant or provider may request a variance to these rules, applicable service delivery rules, or other applicable regulations.

(2) Variance Submission. The applicant or provider must submit the variance request directly to the Division along with the application documents submitted to the Division. The variance request must include:

(a) A description and applicable details of the variance requested, including the applicable section of the rule for which the variance is sought;

(b) The rationale and necessity for the requested variance;

(c) The alternative practice proposed, where relevant; and
(d) The proposed duration of the variance, including a plan and timetable for compliance with the rule exempted or adjusted by the variance.

(3) Outcome of Requests for Variance. The Director, whose decision is final, will approve or deny the variance request and include an expiration date for the variance not to exceed the length of the provider’s current certificate.

(4) Variance Expiration. A variance granted by the Division becomes part of the certificate. Continuance of the variance will not be automatic, and will be re-considered at the expiration of the variance, or when the certification is being considered for renewal, whichever comes first.

(5) Variance Renewal. Requesting renewal of a variance in advance of current variance expiration is the responsibility of each provider.

(6) Failure to Implement Variance. Failure by the provider to implement approved alternative practices or otherwise demonstrate noncompliance with an approved variance may result in the Division withdrawing approval for a variance.

(7) Failure by the provider to implement approved alternative practices or otherwise demonstrate noncompliance with an approved variance such that the health or safety of individuals is jeopardized to the degree that cessation of services by the provider is considered necessary to prevent harm to the individual may result in the Division taking action on the certificate pursuant to OAR 309-008-1100

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.
Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.
Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

DIVISION 11

ADMINISTRATIVE PRACTICES

309-011-0000

Organizational Description

(1) Purpose. This rule describes the organization of the Addictions and Mental Health Division (Division). The Addictions and Mental Health Division was previously known as the Mental Health and Developmental Disability Services Division.

(2) Statutory Authority. This rule is authorized by ORS 413.042 and carries out the provisions of ORS 183.330.

(3) Goal and Organization:

(a) The goal of the Division is to promote mental health and to reduce the negative consequences of mental or emotional disturbances and developmental disabilities;

(b) The Division is under the supervision and control of the Administrator. The Administrator is an Assistant Director of the Oregon Health Authority and is responsible for the state’s mental health and developmental disability programs. The Administrator is ultimately responsible for prevention, treatment, and rehabilitation programs supported by public funds;

(c) The following positions, with the Administrator, comprise the Executive Council of the Division: Deputy Administrator, Assistant Administrator for the Office of Mental Health Services, Assistant Administrator for the Office of Developmental Disability Services, Assistant Administrator for Administrative Services, Superintendent of Dammasch State Hospital, Superintendent of Oregon State Hospital, Superintendent of Fairview Training Center, Superintendent of Eastern Oregon Psychiatric and Training Center, Assistant Administrator of Personnel Services, Communications Manager, and Manager, Office of Client Rights. The Executive Council meets regularly to assist the Administrator in the management of the state’s mental health and developmental disability programs. The Administrator has the ultimate responsibility for all decisions;

(d) The Deputy Administrator is responsible for assisting the Administrator in directing, managing, coordinating programs for the Division, and supervising the Computer Services Section;

(e) The Program Offices are responsible for planning, designing, and developing resources for programs throughout the state and ensuring the quality, effectiveness, and efficiency of those programs. Each Program Office is directed by an Assistant Administrator. The Office of Mental Health Services was previously known as the Program Office for Mental or Emotional Disturbances and the Office of Developmental Disability Services was previously known as the Program Office for Mental Retardation and Other Developmental Disabilities;

(f) The Assistant Administrator for Administrative Services is responsible for the following administrative and support functions: Managing the Division’s contractual relationship with providers of local mental health and developmental disability services; legal and financial compliance audits and for managing the budgeting and business operations of the Division to expedite the effective delivery of services. The functions performed by the Office of Administrative Services support all Division programs;

(g) The Superintendents of the five state institutions are responsible for the operation, control, and management of those institutions;

(h) The Assistant Administrator of Personnel Services is responsible for directing Division-wide labor relations activities; personnel services; personal services position information control system (PICS); classification and allocation; and affirmative action/equal employment opportunity (EEO) to assure compliance with federal and state laws, merit system principles, and labor union contracts;

(i) The Communications Manager is responsible for developing and coordinating a statewide communications plan for the Division, producing informational materials; providing communications counseling and assistance to staff. The position serves as spokesperson for the Division and works as a communications liaison to the Oregon Health Authority;

(j) The Manager, Office of Client Rights is responsible for independent investigations of patient and resident abuse cases, conducting investigations on behalf of the Administrator, and liaison with the various family and consumer advocacy groups representing the Division’s clients.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 183.330
Hist.: MHD 6, f. 2-18-72, ef. 3-11-72; MHD 19, f. 5-31-74, ef. 6-25-74; MHD 18-1980, f. & ef. 12-2-80; MHD 19-1983, f. & ef. 9-23-83; MHD 4-1990, f. 4-26-90, cert. ef. 4-30-90

309-011-0010

Obtaining Information

(1) Purpose. This rule prescribes the method whereby the public may obtain information or make submissions or requests of the Division.

(2) Statutory Authority. This rule is authorized by ORS 179.040 and carries out the provisions of ORS 183.330.

(3) Obtaining Information. The public may obtain information or make submissions or requests of the Division by contacting the Communications Manager, Addictions and Mental Health Division, 500 Summer St. NE, E-86, Salem, OR 97310.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 183.330
Hist.: MHD 6, f. 2-18-72, ef. 3-11-72; MHD 20, f. 5-31-74, ef. 6-25-74; MHD 9-1986, f. & ef. 9-26-86; MHD 5-1990, f. 4-26-90, cert. ef. 4-30-90

309-011-0019

Membership on Task Forces, Commissions, Advisory Groups and Committees

(1) As defined in ORS 174.109, at least 20 percent of the membership of all task forces, commissions, advisory groups and committees established by Division shall be consumers, with representation balanced by age.

(2) This rule applies only to task forces, commissions, advisory groups and committees that:

- (a) Primarily relate to persons with mental health or addiction issues; and
- (b) Are subject to ORS 192.630.
- (3) Membership is subject to the limitations outlined in ORS 430.073.

Stat. Auth.: ORS 413.042 & 430.078
Stats. Implemented: ORS 430.078
Hist.: MHS 10-2010, f. & cert. ef. 7-22-10, Renumbered from 309-011-014, MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0024

Purpose and Scope

The purpose of these rules is to implement ORS 430.073, related to the Addiction and Mental Health (AMH) Division’s Consumer Advisory Council (CAC). The scope of these rules is limited strictly to the CAC, and will clarify CAC’s purpose, scope, membership, roles, and responsibilities, and those of AMH.

Stat. Auth.: ORS 413.042 & 430.073
Stats. Implemented: ORS 430.073
Hist.: MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0026

Definitions

- (1) “Administrative Support” means the tasks provided by AMH, which are detailed in OAR 309-011-0230(b) below.
- (2) “Advise” means to recommend, suggest or inform.
- (3) “AMH Representative” means the individual(s) identified by AMH to provide administrative support to CAC.
- (4) “CAC” means the Consumer Advisory Council authorized by ORS 430.073 and comprised of consumers appointed by the Director.
- (5) “Consumer” means a person who has received or is currently receiving mental health or addiction services.
- (6) “Director” means the Director of the Oregon Health Authority or his or her designee.
- (7) “Director’s Designee” means the Director of the Addictions and Mental Health (AMH) Division.
- (8) “Majority Vote” means a decision agreed upon by the majority of the quorum present.
- (9) “Present”, related to meetings, means being physically present, or connected to the meeting process via conference call or tele-conference.
- (10) “Public Meeting” means those meetings open to the public and governed by ORS 192.610 through 192.690.

Stat. Auth.: ORS 413.042 & 430.073
Stats. Implemented: ORS 430.073
Hist.: MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0028

CAC Roles

- (1) The role of CAC is to provide to the Director’s Designee advice on the provision of mental health services by AMH.
- (2) CAC may provide evaluation and feedback on site reviews related to mental health services provided by AMH.
- (3) CAC shall work in cooperation with the Director’s Designee or other designated AMH representative to promote, support and communicate AMH’s mission, vision and values.
- (4) CAC shall adhere to public meeting laws.
- (5) CAC may develop a mission statement and goals, which shall not contradict the authorizing statutes or these rules.
- (6) After the first of each calendar year, the CAC shall, in consultation with the AMH Representative, develop and adopt a work plan for the ensuing twelve months.
- (7) CAC may establish committees to investigate and report back to CAC regarding areas of interest to CAC.
- (8) CAC shall not establish AMH policies, rules, internal directives or procedures.

Stat. Auth.: ORS 413.042 & 430.073
Stats. Implemented: ORS 430.073
Hist.: MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0031

CAC Responsibilities

- (1) CAC shall meet at least once every two months.

(2) A meeting may continue without a quorum participating, but authorities granted to CAC may not be exercised without a quorum.

(3) Advice to the Director’s Designee shall be provided in writing when CAC has a recommendation accepted by a majority of the quorum.

(4) Advice to the Director’s Designee shall be signed and dated by the chair or vice-chair.

(5) CAC in collaboration with the AMH Representative may determine the procedures related to conducting CAC business.

Stat. Auth.: ORS 413.042 & 430.073
Stats. Implemented: ORS 430.073
Hist.: MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0032

Memberships: Selection and Terms

(1) Members shall be appointed by the Director’s Designee, considering CAC recommendations, and shall be appointed for a two year term following a written acceptance of the offer.

(2) CAC shall consist of between 15 and 25 consumers, and selection shall strive to represent:

- (a) A broad range of ages, parents or guardians of children, youth in transition (ages 16 to 25), adults age 55 or older;
- (b) A variety of cultures and ethnicities;
- (c) An approximate division of gender; and
- (d) A balance of geographic areas within the state.

(3) AMH may appoint any member for a second two year term.

(4) No person shall be excluded from serving as a member of CAC due to affiliation with any organization or institution, or on the basis of race, ethnic origin, religious affiliation, gender, age, disability or sexual orientation.

(5) Only the Director’s Designee may remove a person from CAC prior to the end of his or her current two year term.

(6) Members of CAC are not entitled to compensation or reimbursement of expenses under ORS 292.495. [2007 c.805, 2; 2009 c.595 463]

Stat. Auth.: ORS 413.042 & 430.073
Stats. Implemented: ORS 430.073
Hist.: MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0034

Chair and Vice-Chair: Election and Duties

(1) The CAC shall elect by a majority of participating votes, one of its members as chair and one as vice-chair, to serve for a two year term each, with the possibility of re-election for one additional consecutive term.

(2) The chair shall have the powers and duties necessary for the performance of the office. These duties shall include, but not be limited to the following:

- (a) Facilitate CAC meetings;
- (b) Assign members to panels or committees;
- (c) Ensure the content of CAC meetings remain within the boundaries of its scope, purpose and authorities;
- (d) Identify meeting agenda items, in collaboration with the AMH representative;
- (e) Call special meetings
- (f) Sign documents from CAC addressed to the Director’s Designee;
- (g) Make membership recommendations, in collaboration with the CAC and AMH representative.
- (h) With approval from the AMH Representative, the Chair may represent CAC by responding to requests for information or participation pertaining to CAC.

(3) The vice-chair shall be responsible for the chair’s duties in his or her absence.

(4) Early termination or resignation of the chair or vice-chair’s position shall be filled by a majority vote of those present, to serve a two year term.

Stat. Auth.: ORS 413.042 & 430.073
Stats. Implemented: ORS 430.073
Hist.: MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0036

AMH Responsibilities

- (1) AMH shall provide:
 - (a) Necessary training and orientation to CAC members, including but not limited to the following subject areas:
 - (A) AMH’s mission, vision, goals, roles and scope of business.
 - (B) CAC’s purpose and scope of business;
 - (C) CAC’s internal protocol and practices;
 - (D) Lobbying restrictions;
 - (E) Conflict of interest;
 - (F) Public meeting laws;
 - (G) These administrative rules; and
 - (H) Other administrative rules, AMH policies and procedures, internal management directives, and state and federal laws related to topics CAC is considering as part of a recommendation to the Director’s Designee.
 - (b) Administrative support such as but not limited to:
 - (A) Secure meeting spaces;
 - (B) Public meeting notices in accordance with public meeting laws;
 - (C) Take attendance;
 - (D) Scribe, distribute and maintain records of approved minutes;
 - (E) Participate in the development of CAC meeting agendas; and
 - (F) Send and receive communications to and from the Director’s Designee.
- (2) The Director’s Designee shall respond in writing within 60 days following receipt of CAC’s recommendations.

Stat. Auth.: ORS 413.042 & 430.073
 Stats. Implemented: ORS 430.073
 Hist.: MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0040

Purpose and Statutory Authority

- (1) Purpose. These rules describe the organization and responsibilities of the Mental Health Advisory Board.
- (2) Statutory Authority. These rules are authorized by ORS 413.042 and carry out the provisions of ORS 430.050.

Stat. Auth.: ORS 413.042
 Stats. Implemented: ORS 430.050
 Hist.: MHD 6-1982, f. & ef. 3-23-82; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90

309-011-0045

Definitions

- As used in these rules:
- (1) “Administrator” means the Assistant Director of the Addictions and Mental Health Division, Oregon Health Authority.
 - (2) “Consumer” means a person receiving or eligible to receive services under rules of the Division.
 - (3) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority.
 - (4) “Mental Health Advisory Board” means a board appointed by the Administrator and approved by the Governor to study the problems of persons with mental illness or developmental disabilities, assist in planning, and make recommendations to the Administrator for the development of policies and procedures with respect to the state mental health services, and developmental disabilities services programs.
 - (5) “Disabled Person” means any person who:
 - (a) Has a physical or mental impairment which substantially limits one or more major life activities;
 - (b) Has a record of such an impairment; or
 - (c) Is regarded as having such an impairment.

Stat. Auth.: ORS 413.042 & 430.050
 Stats. Implemented: 430.050
 Hist.: MHD 6-1982, f. & ef. 3-23-82; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 4-1995, f. 5-31-95, cert. ef. 6-1-95

309-011-0050

Organization

- (1) The Mental Health Advisory Board shall be composed of at least 15 but not more than 20 lay and professionally trained individuals.
- (2) The Administrator, with the approval of the Governor, shall appoint the board members.
- (3) Board members shall provide a balanced representation of program areas and populations served, and shall reflect the diverse ethnic, age and disability characteristics of consumers of services provided in Division programs.
- (4) At least two members of the Board shall be disabled persons, one of whom is a consumer of mental health services and one of whom is a consumer of developmental disability services. Two additional members of the Board shall be consumers or family members of consumers.
- (5) Members of the board shall serve for terms of four years expiring on the last day of odd numbered years.
- (6) Members are entitled to compensation and expenses as provided in ORS 292.495.
- (7) The Administrator may remove any member of the board for misconduct, incapacity or neglect of duty. Any member who is absent from three consecutive meetings of the Board may be removed, at the Administrator’s discretion.
- (8) The Administrator may make provision for technical and clerical assistance to the Mental Health Advisory Board and for the expense of such assistance.
- (9) The board shall meet at least twice each year.

Stat. Auth.: ORS 413.042 & 430.050
 Stats. Implemented: 430.050
 Hist.: MHD 6-1982, f. & ef. 3-23-82; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 4-1995, f. 5-31-95, cert. ef. 6-1-95

309-011-0055

Responsibilities

- (1) The board shall assist the Division in planning and preparation of administrative rules for the assumption of responsibility for psychiatric care in state and community hospitals by community mental health programs, in accordance with ORS 430.630.
- (2) The board shall study the problems of mental health services, and developmental disabilities services and make recommendations for the development of policies and procedures with respect to these programs.
- (3) The board shall review state laws and legislative concepts relative to state mental health services and developmental disabilities services programs.
- (4) The board shall review and consider funding of state mental health services, and developmental disabilities services programs and make recommendations.
- (5) The board shall advise the Administrator on the relationship of mental health and developmental disability programs to other state, local and private services and make recommendations for collaborative or joint program developments.
- (6) The board shall serve as a consulting body to the Administrator.
- (7) The board shall encourage public understanding and acceptance of state mental health services, and developmental disabilities services programs.

Stat. Auth.: ORS 413.042 & 430.050
 Stats. Implemented: 430.050 & 430.630
 Hist.: MHD 6-1982, f. & ef. 3-23-82; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90

309-011-0105

Purpose

- (1) The purpose of OAR 309-011-0105 to 309-011-0115 is to establish the standards by which the Addictions and Mental Health (AMH) Division and it’s designees approve payments to licensed residential programs, funded by the Division or it’s designee, for adult consumers of mental health services.
- (2) OAR 309-011-0105 to 309-011-0115 will facilitate a system of residential services and supports driven by individual needs promoting recovery and wellness.

Stat. Auth.: ORS 430.210, 413.042 & 443.450

Chapter 309 Oregon Health Authority, Health Systems Division: Mental Health Services

Stats. Implemented: ORS 443.400 - 443.460 & 443.991
Hist.: MHS 9-2010, f. 6-30-10, cert. ef. 7-1-10

309-011-0110

Definitions

(1) “Adult” means a person 18 years of age or older, an emancipated minor and individuals in the Young Adults in Transition (YAT) programs as designated in contract.

(2) “Community Mental Health Program” (CMHP) means an entity that is responsible for planning and delivery of services for individuals with substance use disorders or mental health diagnoses, operated in a specific geographic area of the state under an inter-governmental agreement or direct contract with the Division.

(3) “Division” means the Addictions and Mental Health (AMH) Division of the Department.

(4) “Individual Services and Support Plan” (ISSP) means a comprehensive plan for services and supports coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of services.

(5) “Occupied” means a specific individual is actively residing in a designated program living space and is receiving services as defined in OAR 309-016-0600 to 309-016-0755.

(6) “Occupancy Rate” means the calculated minimum rate of occupancy in a residential program’s Operating Budget that reflects the percentage of occupancy needed to meet expenses.

(7) “Operating Budget” means a division approved budget utilizing division prescribed forms for the purpose of setting rates in residential programs.

(8) “Population Designation” means any term used to describe an individual in terms of their legal status or other category, to include but not limited to those who are civilly committed, admitted voluntarily or under the jurisdiction of the Psychiatric Security Review Board (PSRB).

(9) “Provider” means an organizational entity, or qualified person who is contractually affiliated with a Community Mental Health Program (CMHP) or contracted directly with the Division for the delivery of mental health services to individuals.

(10) “Residential Program” means all licensed Secure Residential Treatment Facilities, Residential Treatment Facilities and Residential Treatment Homes funded by the Addictions and Mental Health (AMH) Division or it’s designee, to provide services for mental health individuals approved by the Division or it’s designee.

(11) “Services” means those activities and treatments described in the Individual Services and Support Plan (ISSP) that are intended to assist the individual to transition to recovery from a substance use disorder, problem gambling disorder or mental health condition.

(12) “Supervision” means the observation and monitoring of individuals by program staff, at intervals necessary in order to maintain safety and an awareness of the individual’s personal interaction and use of time.

(13) “Vacancy Rate” means the vacancy percentage calculated in a residential program’s Operating Budget that reflects the vacant days available per month without impact on funding.

(14) “Wellness” means an approach to healthcare and lifestyle that emphasizes optimal and holistic physical and mental health and which encourages optimal quality of life while preventing illness and prolonging life.

Stat. Auth.: ORS 413.042 & 443.450
Stats. Implemented: ORS 430.210, 443.400 - 443.460 & 443.991
Hist.: MHS 9-2010, f. 6-30-10, cert. ef. 7-1-10

309-011-0115

Provider Compensation

(1) Residential program providers will be compensated for services as defined in OAR 309-016-0600 to 309-016-0755.

(2) Only one provider may be compensated for each day. Individuals absent from the residential program on activities under the supervision of the program staff shall be considered as occupying their designated living space.

(3) The Division may make a Reserved Service Capacity Payment due to an acute care/respite admission or based on an Order

of Revocation issued by the Psychiatric Security Review Board. In order to receive such funding the provider must:

(a) Notify the Division within 48 hours by submitting a Reserved Service Capacity Payment form via email to: car.amh@state.or.us. The Division will approve/deny the request within 2 business days of receiving the request.

(b) Receive approval from the Division prior to receiving such payment.

(c) For payment request, submit a contract amendment request and the approved Reserved Service Capacity Payment Request Form with the Client Status portion completed, at the end of each approval period.

(d) Use policies, procedures and forms prescribed by the Division for the notification and request for payment.

(4) All residential program living spaces funded by the Division or it’s designee will be available to any consumer approved by the Division or its designee without regard to their population designation or County of Responsibility.

Stat. Auth.: ORS 413.042 & 443.450
Stats. Implemented: ORS 430.210, 443.400 - 443.460 & 443.991
Hist.: MHS 9-2010, f. 6-30-10, cert. ef. 7-1-10

309-011-0120

Purpose

These rules prescribe standards to be implemented by the Addictions and Mental Health (AMH) Division in order to establish the Self-Determination Policy as used in ORS 430.071.

Stat. Auth.: ORS 413.042 & 430.078
Stats. Implemented: ORS 430.078
Hist.: MHS 10-2010, f. & cert. ef. 7-22-10; MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0125

Definitions

As used in these rules:

(1) “Director” means the Director of the Addictions and Mental Health (AMH) Division of the Oregon Health Authority (Authority), or his or her designee.

(2) “Consumer” means a person who has received or is receiving mental health or addiction services.

(3) “Consumer Advisory Council” means the council appointed by the Assistant Director to advise the Division on the provision of mental health services.

(4) “Division” means the Addictions and Mental Health (AMH) Division of the Oregon Health Authority.

(5) “Olmstead v. L.C.” means the 1999 Supreme Court decision under which states are required to place persons with disabilities in community settings rather than in institutions when the State’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual and the placement can be reasonably accommodated, taking into account the resources of the State and needs of others with disabilities.

(6) As used in ORS 430.075, these terms have the following meanings:

(a) “Task force” means a group or committee, usually composed of experts or specialists, formed for analyzing, investigating, or solving a specific problem or objective;

(b) “Commission” means a group of individuals that meet on a regular basis, and that are officially authorized to perform certain duties or functions;

(c) “Advisory group” means a collection of individuals who bring unique knowledge and skills, and who are appointed to support a particular service or function, or to investigate, report on, or act upon a particular matter; and

(d) “Committee” means a body of persons that are officially delegated or assigned to consider, investigate, act on, or report on a particular service or function.

Stat. Auth.: ORS 413.042 & 430.078
Stats. Implemented: ORS 430.078
Hist.: MHS 10-2010, f. & cert. ef. 7-22-10; MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0130

Policy

The Addictions and Mental Health (AMH) Division shall adopt a policy that supports and promotes self-determination for persons receiving mental health services. The policy shall be designed to remove barriers that:

(1) Segregate persons with disabilities from full participation in the community in the most integrated setting in accordance with the United States Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999); and

(2) Prevent persons with disabilities from enjoying a meaningful life, the benefits of community involvement and citizen rights guaranteed by law.

Stat. Auth.: ORS 413.042 & 430.078

Stats. Implemented: ORS 430.078

Hist.: MHS 10-2010, f. & cert. ef. 7-22-10; MHS 17-2012, f. & cert. ef. 12-28-12

DIVISION 12

ADMINISTRATIVE PRACTICE AND PROCEDURE

309-012-0025

Procedures for Appeals of Reimbursement Orders

(1) Purpose. This rule prescribes procedures for appeals of Reimbursement Orders issued by the Division.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 179.640, 413.042 & 179.040 and carries out the provisions of ORS 179.610 to 179.770.

(3) Definitions. As used in this rule:

(a) "Administrator" means the Administrator of the Addictions and Mental Health Division;

(b) "Authorized Representative" means those parties named in ORS 305.240, or those parties who are determined to have the authority to represent the person;

(c) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority;

(d) "Hearing" means the hearing authorized by ORS 179.640 for the purpose of review of Reimbursement Orders and modified Reimbursement Orders issued pursuant to ORS 179.640;

(e) "Hearings Officer" means any person designated by the Administrator to hold hearings on matters coming before the Division. Staff of the Reimbursement Section of the Division may not be designated as hearings officers;

(f) "Informal Conference" means a proceeding held before the appeal hearing to allow the person to obtain a review of the action or proposed action without the necessity of a formal hearing;

(g) "Person" means:

(A) A patient who is receiving or has received treatment or care at a state institution for the mentally ill;

(B) A current or former resident at a state institution for the mentally retarded;

(C) The estate of the person;

(D) Any other individual or entity having a financial interest in contesting a Reimbursement Order.

(h) "Reimbursement Order" means the order issued to determine the person's ability to pay pursuant to ORS 179.640;

(i) "Service" means deposit of a Reimbursement Order by U.S. mail, state mail, or deposit with a state institution for hand delivery;

(j) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(4) Authorization for Hearing: A hearing before the Administrator or a Hearings Officer shall be granted to a person who appeals to the Administrator in the following instances:

(a) A person may appeal the Division's determination or redetermination of the person's ability to pay the state's charges for institutional care and maintenance. The appeal must be submitted within 60 days of the service of the Reimbursement Order;

(b) The Division, on or about the time of the person's discharge, shall determine whether or not any of the funds previously paid by the person or on his or her behalf to the State of Oregon to cover his or her cost of care should be reimbursed to the person to satisfy his or her financial needs upon release, or whether any of the previous Reimbursement Orders for the current hospitalization should be modified. This redetermination may be appealed within 60 days of service.

(5) Request for Hearing:

(a) No particular format for a request for a hearing is required, but, to be considered, each request must be in writing and must specify:

(A) The name and address of the person requesting the hearing;

(B) The action being appealed, including:

(i) The year or years involved;

(ii) A reference to any Division correspondence on the subject known to the person;

(iii) Why the action being appealed is claimed to be incorrect;

(iv) The specific relief requested.

(b) The request for a hearing must be signed by the person or his or her authorized representative;

(c) All requests for hearings shall be filed by mailing or delivering the appeal to the Reimbursement Section, Addictions and Mental Health Division, 500 Summer St. NE, E-86, Salem, OR 97301;

(d) If the request for a hearing is considered insufficient in content by the Division, the Division may require the request to be reasonably supplemented with additional information before any further action is taken on the appeal;

(e) Prior to the time of an appeal hearing, if there is no objection by the person, the Hearings Officer may refer the matter in controversy for an informal conference for settlement or simplification of issues.

(6) Authorization for Informal Conference:

(a) A person who has requested an appeal hearing pursuant to section (5) of this rule may request that he or she have an informal conference with a representative from the Reimbursement Section before the formal appeal hearing. Any request for an informal conference may be granted at the discretion of the Division;

(b) Such conferences are informal. A person may represent himself or herself or may choose someone to act as his or her representative. The purpose of the conference is to allow a person to obtain a review of the action or proposed action (without the necessity of a formal appeal hearing), if he or she believes that an action made or proposed by the Division is incorrect;

(c) Payment of the proposed charge for institutional care and maintenance will not jeopardize a conference request or decision.

(7) Request for Informal Conference:

(a) A conference request may be filed either with a hearing request required in section (5) of this rule or subsequent to the hearing request but at least 14 days before the date of a scheduled hearing;

(b) The conference request shall be in writing and must specify:

(A) The name and address of the person requesting the conference;

(B) The reason for the request, including:

(i) In what respect the action or proposed action of the Division is erroneous;

(ii) Reference to any prior Division correspondence on the subject.

(c) If a hearing has been requested, the material submitted as part of the request for a hearing may be used at the informal conference;

(d) The conference request should be addressed to the Reimbursement Section, Addictions and Mental Health Division, 500 Summer St. NE, E-86, Salem, OR 97301.

(8) Conduct of Informal Conference. A conference shall be held at a place designated by the Division. To the extent practical, the conference will be held at a location convenient to the person.

The conference shall begin with a statement from the Division. The person requesting the conference shall then state his or her position, the facts as he or she knows them, and his or her questions of persons present to clarify the issues.

(9) Disposition of Informal Conference:

(a) After the conference, the Reimbursement Section will issue a proposed order disposing of the appeal for approval by the Administrator. The written order, approved by the Administrator, will be sent to the person within 14 days of the conference, unless during the conference the Division action is conceded by the person to be correct;

(b) The person's request for a hearing will be stayed pending the outcome of the conference, at which time the request for a hearing will either be withdrawn by the person should he or she no longer desire to proceed, or the hearing will be rescheduled;

(c) When a decision favors the person, the person will receive a refund;

(d) The person may request within 30 days that the decision made at an informal conference be reconsidered by the Administrator. The person should set forth the specific ground or grounds for requesting the reconsideration.

(10) Subpoenas and Depositions:

(a) The Division shall issue subpoenas to any party to a hearing upon request. Witnesses appearing pursuant to subpoena, other than parties or employees of the Division, shall receive fees and mileage as prescribed by law for witnesses in a civil action;

(b) Depositions may be taken on petition of any party to a hearing.

(11) Conduct of Appeal Hearing:

(a) To the extent practical, the Division, in designating the location of the hearing, shall designate a place convenient for the person;

(b) The hearing shall be conducted by and shall be under the control of the Hearings Officer;

(c) The Hearings Officer shall administer an oath or affirmation of the witnesses;

(d) A verbatim record shall be made of all testimony and rulings. Parties who wish a transcription of the proceedings should make arrangements with the Division. If the Division determines the record is no longer needed, the Division may destroy the record after 180 days following the issuance of a final order, unless within the 180-day period arrangements are made by the person for further retention by the Division;

(e) The hearing shall begin with a statement of the facts and issues involved. The statement shall be given by a person requested to do so by the Hearings Officer;

(f) The Hearings Officer may set reasonable time limits for oral presentation and may exclude or limit testimony that is cumulative, repetitious or immaterial.

(12) Evidentiary Rules:

(a) All evidence of a type commonly relied upon by reasonably prudent persons in conduct of their serious affairs shall be admissible;

(b) The Hearings Officer shall receive all physical and documentary evidence presented by parties where practicable. All offered evidence is subject to the Hearings Officer's power to exclude or limit cumulative, repetitious or immaterial matter;

(c) Evidence objected to may be received by the Hearings Officer, and rulings on its admissibility or exclusion may be made at the time a final order is issued;

(d) At the time of the hearing, the person will be notified that any exhibit introduced as evidence at the hearing will be destroyed after 180 days following the issuance of a final order, unless within the 180-day period, written request is made by the person presenting the exhibit for the return of the exhibit;

(e) The burden of presenting evidence to support a fact or position in a hearing rests on the proponent of the fact or position.

(13) Disposition of Appeal:

(a) After a hearing has been held, the Hearings Officer shall issue a proposed order, including findings of fact and conclusions of law. If the proposed order is adverse to the person, it shall be

served upon the person and an opportunity afforded to the person to file exceptions and present written argument to the Administrator before a final order is issued. A person has a ten-day period in which to file exceptions and/or written argument to a proposed order;

(b) Final orders on a hearing shall be in writing and shall include:

(A) Rulings on admissibility of offered evidence;

(B) Findings of fact — Those matters which are either agreed as fact or which, when disputed, are determined by the Administrator, on substantial evidence, to be a fact over contentions to the contrary;

(C) Conclusions of law — Applications of the controlling law to the facts found and the legal results arising there from;

(D) The action taken by the Division as a result of the findings of fact and conclusions of law; and

(E) Notice of the person's right to judicial review of the order.

(c) Parties to a hearing and their attorneys shall be mailed a copy of the final order and accompanying findings and conclusions.

(14) Administrative Review of Final Order:

(a) A person may file a petition for administrative review of the final order with the Division within 30 days after the order is served. The petition shall set forth the specific ground or grounds for requesting the review. The petition may be supported by a written argument. Examples of sufficient grounds are:

(A) The Division action is not supported by the written findings, or the written findings are inaccurate; or

(B) Pertinent information was available at the time of the original hearing which, through no fault of the party, was not considered; or

(C) The action of the Division is inconsistent with its rules or policies or is contrary to law; and

(D) The matters raised on appeal may have an effect on the original decision.

(b) The Division may grant a rehearing petition if sufficient reason therefore is made to appear. The rehearing may be limited by the Division to specific matters. If a rehearing is held, an amended order shall be entered;

(c) If the Division denies the appeal, it shall inform the person in writing of the denial;

(d) If the administrative review has been requested, the Division order is not final until the administrative review is granted or denied.

(15) Time Extensions. Where any provision of this rule specifies a particular time period in which a person must act, for good cause shown, the Hearings Officer may, in his or her discretion, allow a reasonable extension of time if so doing is not inconsistent with ORS 179.640 to 179.650.

(16) Appeal. An appeal from the final order of the Division may be taken as provided by law. *Caution:* Either ORS 179.650 or 183.482 may be applicable. See *League of Women Voters v. Lane County Boundary Commission*, 32 Or. App. 53, 573P.2d 1255, rev. denied, 283 Or. 503 (1978).

Stat. Auth.: ORS 179.770, 413.042 & 430.021

Stats. Implemented: 179.610 – 179.770

Hist.: MHD 6-1979(Temp), f. & ef. 9-20-79; MHD 1-1980, f. & ef. 1-14-80

309-012-0030

Purpose and Statutory Authority

(1) Purpose. Individuals admitted to the Division institutions are liable for the full cost of their care, but are required to pay only what they are able to pay. This rule establishes guidelines for determining a person's ability to pay for the cost of care in a state institution.

(2) Statutory Authority. This rule is made necessary by ORS 179.610, authorized by ORS 413.042 and carries out the provisions of ORS 179.610 to 179.770.

Stat. Auth.: ORS 179.770, 413.042

Stats. Implemented: ORS 179.610 – 179.770

Hist.: MHD 5-1980(Temp), f. & ef. 4-18-80; MHD 14-1980, f. & ef. 6-24-80; MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0031

Definitions

As used in these rules:

(1) "Ability to Pay" means the ability of a person in a state institution to pay past, current, or ongoing cost of care, as determined by the Division in accordance with these rules.

(2) "Assets" means, excluding income, the total value of an individual's equity in real and personal property of whatever kind or nature. Assets include, but are not limited to the individual's stocks, bonds, cash, accounts receivable, moneys due, or any other interests, whether they are self-managed, or held by the individual's authorized representative, or by any other individual or entity on behalf of the individual. "Assets" held in trust are subject to laws generally applicable to trusts.

(3) "Authorized Representative" means an individual or entity appointed under authority of ORS 125, as guardian or conservator of a person, who has the ability to control the person's finances, and any other individual or entity holding funds or receiving benefits or income on behalf of any person.

(4) "Benefits from Health Insurance" means payments from insurance programs with the limited purpose of paying for the cost of care provided to an individual by a hospital or other health care provider. Benefits of this type include, but are not limited to payments from:

- (a) Private and group health insurance policies;
- (b) The Medicare and Medicaid programs;
- (c) Any other policies or programs with the purpose of paying for the costs of inpatient and/or outpatient care.

(5) "Charges" means the amount the Division has determined that the person is required to pay toward the cost of care based on his or her ability to pay.

(6) "Cost of Care" means the person's full liability for care as determined by the Division using the rates established in accordance with ORS 179.701.

(7) "Dependents" means individuals whom a person has a legal duty to support. "Dependents" may include non-emancipated children and spouse of a person, as well as any other individual for whom a person would be allowed a personal exemption under federal or Oregon personal income tax laws.

(8) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(9) "Fair Market Value" means the cash price a capable and diligent individual could obtain in a reasonable amount of time for an asset after negotiating with those accustomed to buying such property.

(10) "Funds for Personal Support Following Release" means the cash that a person will need following his/her release from a state institution to live in the community in a reasonable manner for a period of time, not normally to exceed six months.

(11) "Income" means all funds received by an individual, or for an individual by his or her authorized representative, from any source, whether earned or unearned, after making applicable deductions for state and federal taxes. "Income" includes benefits from both income protection insurance which replaces the person's earned income when he or she is unable to work, and governmental retirement or disability insurance, such as Social Security, Veterans, and Railroad Retirement benefits.

(12) "Legal Obligations" means any financial duty imposed by law. "Legal obligations" include, but are not limited to, loan or mortgage contracts for which an individual is responsible, as well as liabilities arising out of other contracts or legal duties to pay money. "Legal obligations" include administratively or judicially ordered child and/or spousal support.

(13) "Moral Obligations" means any payments that an individual feels a moral duty to pay, but for which the individual does not have a legal duty to pay.

(14) "Person" means:

(a) A current or former patient at a state institution for the mentally and emotionally disturbed;

(b) A current or former resident at a state institution for the developmentally disabled.

(15) "Person's Representative" means:

(a) Any individual who is the person's authorized representative as defined in section (3) of this rule; and/or

(b) Any other individual who has the person's written authority to represent the person.

(16) "Personal Expense Allowance" means the cash allowed for the reasonable miscellaneous expenses the person has while he or she is in the state institution, including but not limited to expenses for personal grooming and hygiene items; books, newspapers, or other publications; snacks or refreshments not provided by the state institution; and minor entertainment or excursions.

(17) "Primary Personal Automobile" means the automobile, if the person has more than one, which the person would choose to keep if required to sell all but one. If the person has only one, it is the primary personal automobile.

(18) "Primary Personal Residence" means the home the person owns, or is purchasing, and in which the person lived prior to entering the state institution, and/or in which the person will live after leaving the state institution.

(19) "Special Authorized Expense Allowance" means the cash needed for the reasonable personal expenses of the person which cannot be met by the personal expense allowance, and which the Division determines are necessary.

(20) "State Institution" means Dammasch State Hospital in Wilsonville; Eastern Oregon Psychiatric Center in Pendleton; Eastern Oregon Training Center in Pendleton; Fairview Training Center in Salem; and Oregon State Hospital in Salem.

(21) "Support for Dependents" means the cash necessary to meet the reasonable needs of the dependents, less the amounts the dependents receive from any other sources. Support for dependents excludes administratively or judicially ordered child and/or spousal support.

Stat. Auth.: ORS 179.770, 413.042

Stats. Implemented: ORS 179.610 – 179.770

Hist.: MHD 5-1980(Temp), f. & ef. 4-18-80; MHD 14-1980, f. & ef. 6-24-80; MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0032

Requirements for Obtaining Financial Information

(1) Information Obtained from the Person and/or the Person's Representative. The Division shall require the person and/or the person's representative to submit financial information on forms provided by the Division. Financial information required by the Division shall include, but shall not be limited to the following:

- (a) A description of the person's assets, and their values;
- (b) A description of the person's liabilities, the dates they were incurred, the total amounts owing, and a schedule of actual or planned payment dates and amounts;
- (c) The sources and amounts of the person's income;
- (d) The sources of available benefits from health insurance;
- (e) A description and the amounts of the person's expenses;
- (f) The names and ages of any dependents, and the sources and amounts of income and assets, other than those of the person, which are available for their support; and
- (g) The income, assets, and liabilities of the person's spouse or other individual who shares the person's expenses;

(h) Other information the person and/or the person's representative considers important to the determination of the person's ability to pay.

(2) Information Obtained from Other Sources. In addition, the Division may obtain financial information regarding the person from other sources the Division considers to be reliable. These sources may include, but are not limited to, the Social Security and Veterans Administrations, Oregon Department of Revenue, and other Oregon Health Authority agencies.

Stat. Auth.: ORS 179.770, 413.042

Stats. Implemented: ORS 179.610 – 179.770

Hist.: MHD 5-1980(Temp), f. & ef. 4-18-80; MHD 14-1980, f. & ef. 6-24-80; MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0033

Procedures for Determining Ability-to-Pay for Cost of Care

(1) Ability-to-Pay Orders — Based on the financial information received or obtained, the Division will determine the person's ability to pay. If the person, and/or the person's authorized representative fails to provide sufficient information to show the person cannot pay the full cost of care, the Division may determine the person has the ability to pay the full cost of care. The determination of the person's ability to pay shall be set forth in an Ability-to-Pay Order. The four types of Ability-to-Pay orders are Determination of Charges, Modification to Charges, Return of Funds for Personal Support Following Release, and Waiver of Charges. Each Order shall be given one of these titles to identify the type of determination it sets forth, and it shall be based on the factors and criteria described in the following sections.

(2) Limit on Charges — The amount determined by the Division to be the person's charges shall not exceed the full cost of care for the dates of service covered by the Ability-to-Pay Order, less payments and/or credits from any other sources the Division has received, or reasonably anticipates receiving.

(3) Determination of Charges — An Ability-to-Pay Order which sets forth a determination of the person's charges for the care received which is made either while the person is in the state institution, or after the person's release from the state institution. A Determination of Charges may be issued any time during the person's stay in the state institution. A Determination of Charges will be issued after the person's release if none was issued during the person's stay, or if the person's financial circumstances change to enable the person to pay cost of care which exceeds amounts charged by previous Ability-to-Pay Orders. When issuing a Determination of Charges, the Division will consider the following factors:

(a) Factors relating to the person's eligibility for and coverage by benefits from health insurance;

(b) Factors relating to the person's assets:

(A) Except as otherwise provided in this section, charges will be assessed using the person's equity in all assets whether the asset is controlled by the person, or by the person's authorized representative. The Division will determine the person's equity in each asset by deducting from the fair market value of the asset any bona fide encumbrance against the asset;

(B) Charges will be assessed using the person's equity in a primary personal residence only if:

(i) Information is provided by the treatment staff at the state institution stating the person cannot reasonably be expected to return to the residence to live at any time following discharge from the institution; and

(ii) None of the following individuals is residing in the residence:

(I) The person's spouse;

(II) The person's child or children under age 21, or blind or disabled;

(III) The person's sibling or siblings who own an interest in the residence, and who lived in the residence for at least one year immediately prior to the person's admission to the state institution;

(IV) The person's parents or emancipated children who are unable to work to maintain themselves as declared in ORS 109.010.

(C) No charge will be assessed using the person's equity in a primary personal automobile;

(D) The value of an asset which has great sentimental value to the person (such as a family heirloom or gift from a loved one) may be disregarded if selling the asset would cause the person great emotional distress. The Division shall confer with the person's treatment staff to decide whether or not to make this disregard;

(E) When assets are used as the basis for ongoing charges, the Division will estimate the length of time the assets are expected to last. During the final 60 days of that time period, the Division will review the person's financial circumstances in preparation for modifying the person's charges.

(c) Factors relating to the person's income:

(A) Charges will be assessed using the total amount of all income received either by the person, or for the person by the person's authorized representative;

(B) Income received at intervals other than monthly may be prorated for use in a calculation of a monthly charge to the person.

(d) Factors relating to the person's legal and moral obligations:

(A) For legal obligations other than administratively or judicially ordered child and/or spousal support, the person must have demonstrated an intent to pay the obligation, either by showing a history or regular payments toward the full amount owing, or by providing a plan showing dates and amounts of payments to be made in the future;

(B) The Division shall seek the advice of treatment staff as to whether or not, in the interest of the person's rehabilitation, welfare, and/or treatment, the person's need to satisfy declared moral obligations should be given priority over the person's obligation to pay the cost of care;

(C) Any deduction allowed by the Division for legal or moral obligations must be used to satisfy the current obligation. It may not be accumulated by, or on behalf of the person, or used for purposes other than that for which it was approved.

(e) Factors relating to the person's obligation to provide financial support for dependents:

(A) Before approving a deduction for financial support for a dependent, the Division shall determine how much money is required to reasonably support the dependent. From that amount, the Division shall subtract any funds available from sources other than the person, such as the dependent's own income and assets, or any form of governmental aid such as public assistance payable to, or on behalf of the dependent;

(B) Any deduction allowed by the Division for the financial support of dependents must be used to provide current support. It may not be accumulated by, or on behalf of the person, and it may not be used for other purposes.

(f) Factors relating to the person's personal and special authorized expenses while in the state institution:

(A) The personal expense allowance while the person is in the state institution shall be established by the Division to reflect the Supplemental Security Income Program's payment limit for institutionalized individuals (The allowance was \$30 per month as of July 1, 1988.);

(B) Special authorized expense allowances while the person is in the state institution shall be approved based on the following criteria:

(i) The state institution treatment staff's advice that satisfying the need will not interfere in any way with the successful treatment or general welfare of the person, and it may enhance the person's ability to meet the goals of the treatment plan; and

(ii) There are no other resources available to meet the need.

(g) Factors related to the person's need for funds for personal support following release from the state institution when the Division is issuing any Ability-to-Pay Order after release or when release is scheduled within 30 days:

(A) As necessary, funds for personal support following release will be allowed to pay for the following items:

(i) Rental costs including the monthly rent payment, as well as one time deposits or fees, or mortgage payments related to the purchase of a residence;

(ii) Food for the person and dependents;

(iii) Utilities such as heating fuel, water, electricity, garbage service, basic telephone service, and basic television cable service;

(iv) Transportation and related insurance coverage;

(v) Routine household maintenance and insurance coverage;

(vi) Health and dental care and related insurance coverage for the person and dependents;

(vii) Clothing and entertainment for the person and dependents; and

(viii) Other personal expenses which the person shows to be reasonable and necessary, including payments toward moral obli-

gations and legal obligations (other than mortgage contracts), as described in subsection (d) of this section.

(B) The funds allowed for personal support following release shall be based on what a reasonable and prudent individual would spend for the items given the resources available to the individual;

(C) The amount approved for support of the dependents shall take into consideration all other resources available to meet the dependent's needs.

(h) Factors relating to the time period during which the Division may assess charges, and the time period during which the person is required to pay assessed charges:

(A) Ability-to-Pay Orders issued after release which establish an ongoing monthly charge based on the person's ability to pay after release shall not add new charges beyond the 36th month following the month in which the person was released from the state institution;

(B) The person is required to pay beyond the 36 month period, any assessed charges not paid prior to release or during the 36 month period after release.

(4) Modification to Charges — An Ability-to-Pay Order which sets forth a modification to the person's charges established by a prior Ability-to-Pay Order. A Modification to Charges will be made to reflect either a change in the person's financial circumstances which affects the person's ability-to-pay ongoing monthly charges, or the Division's receipt of benefits from health insurance that were not recognized in a prior Ability-to-Pay Order, which cause established charges to exceed the maximum cost of care chargeable to the person in accordance with section (2) of this rule. When issuing a Modification to Charges, the Division will consider the same factors used for a Determination of Charges as described in section (3) of this rule.

(5) Return of Funds for Personal Support Following Release — An Ability-to-Pay Order which sets forth a determination by the Division regarding the return of funds paid toward the person's charges to provide the person with adequate funds for personal support following his or her release from the state institution. When issuing a Return of Funds for Personal Support Following Release, the Division will use the following criteria:

(a) A Return of Funds for Personal Support Following Release is subject to the following conditions:

(A) The person or the person's representative has made payments toward the cost of care provided by the state institution.

NOTE: Returned funds for personal support following release cannot exceed the total amount paid from the person's own income and assets. Benefits from health insurance are not included in the amounts paid.

If charges are due, but the person or the person's representative has made no payment, funds for personal support following release will be considered under the provisions for Waiver of Charges;

(B) The person will be discharged from the state institution within the next 30 days, or he/she was discharged from the state institution within the last 60 days;

(C) The person has financial obligations following release from the state institution as described in subsection (3)(g) of this rule which cannot be immediately satisfied with other available resources.

(b) Funds for personal support following release will be provided for a limited amount of time, not normally to exceed six months, during which time the person will be expected to become otherwise supported through employment, public assistance, or other available programs;

(c) Funds for personal support following release for a period of time exceeding six months will be considered only if the Division receives information which shows the person's circumstances require such consideration.

(6) Waiver of Charges — An Ability-to-Pay Order which sets forth a determination by the Division regarding waiver of collection of part or all of the person's unpaid charges based upon the best interest of the person or the Division:

(a) A waiver of charges should be granted when the Division, after considering information regarding extraordinary circumstances pertaining either to the person's financial situation, or the person's physical, psychological, or sociological well-being, determines:

(A) Charges assessed by prior Ability-to-Pay Orders are unpaid, and a subsequent change in the person's circumstances shows that collection of all or part of the unpaid charges would be detrimental to the best interests of the person or of the Division;

(B) Charges assessed by prior Ability-to-Pay Orders are unpaid, and the Division either receives a written statement from the person's treating physician, or accepts, on a case-by-case basis, a non-physician mental health professional's written statement, which indicates the person's physical, psychological, and/or sociological condition is interfering with the person's ability to satisfy the outstanding obligation, and further efforts by the Division to collect the unpaid charges would be harmful to the person; or

(C) Charges have not been assessed by a prior Ability-to-Pay Order extraordinary circumstances as described in paragraph (A) and/or (B) of this subsection are present, and based on those circumstances the charges should not be assessed.

(b) In accordance with ORS 179.640(4), charges may be assessed or reassessed at a later time by a new Determination of Charges Ability-to-Pay Order if the basis for waiver under this section ceases to exist.

Stat. Auth.: ORS 179.770, 413.042

Stats. Implemented: ORS 179.610 – 179.770

Hist.: MHD 5-1980(Temp), f. & ef. 4-18-80; MHD 14-1980, f. & ef. 6-24-80; MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0034

Delivery of Ability-to-Pay Orders and Factors Relating to Appeals

(1) Delivery to the Person — The original Ability-to-Pay Order shall be delivered to the person, unless the person has an authorized representative.

(2) Delivery to the Authorized Representative — If the person has an authorized representative, the original Ability-to-Pay Order shall be delivered to the authorized representative, and a copy shall be delivered to the person. Any Ability-to-Pay Order delivered to an authorized representative shall include an explanation of the Division's right to demand payment of the charges assessed by the Order, and the consequences to the authorized representative of failing to comply, as provided by ORS 179.653.

(3) Appeal Rights — The Ability-to-Pay Order shall include an explanation of the person's right to appeal the determination set forth by the Order.

(4) Successor Authorized Representative — If the person's authorized representative does not pay or appeal the charges assessed by an Ability-to-Pay Order, and he or she is subsequently replaced by a new authorized representative, the successor authorized representative shall be provided with the opportunity to either pay the assessed charges, or to appeal the determination set forth by the Order. The Division will take the following actions when notified there is a successor authorized representative:

(a) Deliver copies of all Ability-to-Pay Orders not fully paid to the successor authorized representative with a letter which describes the delivery of the Order(s) to the previous authorized representative(s), and any actions taken by the previous representative(s) with regard to the Order(s);

(b) Include with the Order copies, an explanation of the successor authorized representative's right to appeal the determination(s) set forth by the Ability-to-Pay Order(s).

(5) Resolving Appeals — If the person or the person's authorized representative appeals a determination set forth by an Ability-to-Pay Order, the Division will attempt to resolve the appeal by issuing a new Ability-to-Pay Order which takes into consideration the information on which the appeal is based. If the appeal cannot be resolved by issuing a new Order, it will be addressed through the contested case appeal process.

Stat. Auth.: ORS 179.770, 413.042

Stats. Implemented: ORS 179.610 – 179.770

Hist.: MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0035

Enforcement of Recoupment Liens

(1) Purpose. This rule establishes procedures for implementing recoupment liens used in carrying out Reimbursement Orders issued by the Division.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 179.770 and carries out the provisions of ORS 179.653 and 179.655.

(3) Definitions. As used in this rule:

(a) "Cost of Care" means the cost determined by the Division in accordance with ORS 179.701;

(b) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority;

(c) "Person" means:

(A) A patient who is receiving or has received treatment or care at a state institution for the mentally ill;

(B) A current or former resident at a state institution for the mentally retarded.

(d) "Person's Representative" means a conservator, guardian of the person, or estate of the person in a state institution, or an individual who has been appointed by a court in this or another state or by Federal Court to serve as the legal representative of a person in a state institution, and also includes an individual whom a person in a state institution has designated to receive the notice of information involved in the particular transaction;

(e) "Recoupment Lien" means a charge or security or encumbrance upon real or personal property that can be used to satisfy the amount due for the person's cost of care;

(f) "Reimbursement Order" means the order issued to determine the person's ability to pay pursuant to ORS 179.640(1) and (2);

(g) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton;

(h) "Warrant" means the document issued by the Division directed to the sheriff of any county of the state commanding the sheriff to levy upon and sell the real and personal property which is subject to satisfaction of the recoupment lien.

(4) Enforcement of Lien by Issuance of Warrant. The Division shall enforce its recoupment lien created by ORS 179.653 by issuance of a warrant in the manner stated in 179.655. Any warrant issued by the Division pursuant to 179.655 shall clearly provide that the sheriff or other person executing the warrant shall not levy upon and sell any real or personal property that would be exempt under Oregon law from execution pursuant to a judgment. However, the Division shall not issue a warrant pursuant to 179.655 where:

(a) The amount due to the Division for the cost of care of a person in a state institution is not at least 30 days overdue;

(b) Provision has been made to secure the payment by bond or deposit or otherwise in conformance with section (5) of this rule;

(c) The person has exercised the right to appeal the Reimbursement Order pursuant to OAR 309-012-0025(6) and that appeal is still pending;

(d) Sixty-one days have not passed since the issuance of the Reimbursement Order;

(e) The person or the person's representative has not been given at least ten days' prior written notice that the Division intends to issue such a warrant.

(5) Methods of Securing Satisfaction of Reimbursement Order:

(a) The issuance of a warrant to the sheriff to enforce collection of delinquent money due the Division for the cost of care for a person in a state institution will be stayed either by paying the amount due and accrued interest after it becomes due or by securing payment of that amount by bond or deposit or otherwise;

(b) The bond given by the person must be for an amount not less than the amount due, plus interest for a reasonable period determined by the Division:

(A) The bond must be executed by:

(i) A surety company which is registered with, and under the supervision of, the Insurance Commissioner of the State of Oregon; or

(ii) By two or more individual sureties, each of whom shall be a resident and homeowner or holder of an interest in land within the state and each of whom shall be worth sums specified in the under-taking, exclusive of property exempt from execution and over and above all valid debts and liability.

(B) The Division may allow more than two sureties to justify several amounts less than that expressed in the undertaking, if the whole justification is equivalent to that of two sufficient undertakings.

(c) Any one of the following items, or combination of items acceptable to the Division, equal to the amount due, plus accrued interest thereon, may be deposited with the Division:

(A) A deposit of money;

(B) A certified check or checks on any state or national bank within the State of Oregon payable to the Division;

(C) Satisfactory bonds negotiable by delivery, or obligations by the U.S. Government negotiable by delivery; or

(D) Any other security satisfactory to the Division.

(d) The Division may require additional security whenever, in its opinion, the value of the security pledged is no longer sufficient to adequately secure the payment of the amount due, plus accrued interest thereon.

(6) Release of Tax Lien and Clouds on Title. Any request made to the Division for the release of a warrant, where such warrant is not in fact a lien on title to the real property in question but merely a cloud on the title to such real estate, shall be accompanied by a statement. This statement shall show the facts affecting the title to the real property in question that render the Division's warrant a cloud on the title to such real property and the reasons the warrant does not actually constitute a lien thereon:

(a) This type of request for release of a warrant should be accompanied by a current title report;

(b) The Division may require other documentary proof showing the present condition of the title to the property in question.

Stat. Auth.: ORS 179.770, 413.042

Stats. Implemented: ORS 179.610 – 179.770

Hist.: MHD 8-1980(Temp), f. & ef. 4-18-80; MHD 15-1980, f. & ef. 6-24-80

309-012-0070

Policy

(1) Requests for copies of medical records must be made in writing with proper consent and must be specific to assure that only the essential portions of the medical record are copied and released.

(2) A patient or resident shall not be denied access to the medical record because of inability to pay. The patient may review his or her record in the Medical Record Department at no charge.

(3) A copy of the most recent release summary shall be furnished free of charge to authorized persons or agencies providing follow-up care.

(4) A copy of required portions of medical records may be provided without charge to the following agencies and individuals. When a substantial part or all of a medical record is requested, the Division may charge for copies in accordance with OAR chapter 943-003:

(a) Community mental health programs;

(b) Courts;

(c) Hospitals;

(d) Individuals or agencies providing follow-up care for the patient;

(e) Insurance carriers paying for patient's or resident's care; and

(f) Physicians.

(5) All other requests for public records shall be charged in accordance with OAR 943-003.

Stat. Auth.: ORS 179.770, 413.042 & 431.120

Stats. Implemented: ORS 179.610 – 179.770

Hist.: MHD 2-1983(Temp), f. & ef. 2-18-83; MHD 10-1983, f. & ef. 6-8-83; MHS 4-2007, f. & cert. ef. 5-25-07

309-012-0100

Purpose and Statutory Authority

(1) Purpose. These rules establish the amount of earned income the Division excludes when calculating ability-to-pay for cost of care at a mental health institution. The purpose of this earned income exclusion is to reduce the disincentive to work for patients and residents.

(2) Statutory Authority. These rules are authorized by ORS 413.042 and carry out the provisions of ORS 179.770.

Stat. Auth.: ORS 179.770, 413.042
Stats. Implemented: ORS 179.610 – 179.770
Hist.: MHD 11-1985, f. & ef. 6-19-85

309-012-0105

Definitions

As used in these rules:

(1) “Earned Income” means money received by a patient or resident in a mental health institution in return for services rendered, while receiving care or treatment at the institution.

(2) “Mental Health Institution” means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

Stat. Auth.: ORS 179.770, 413.042
Stats. Implemented: ORS 179.610 – 179.770
Hist.: MHD 11-1985, f. & ef. 6-19-85

309-012-0110

Earned Income in Calculation of Ability-to-Pay

The Division includes earned income as income in the calculation of ability-to-pay, as described in OAR 309-012-0030.

Stat. Auth.: ORS 179.770, 413.042
Stats. Implemented: ORS 179.610 – 179.770
Hist.: MHD 11-1985, f. & ef. 6-19-85

309-012-0115

Earned Income Exclusion

The Division allows a patient or resident to retain a portion of any income earned while in a mental health institution. The amount of earned income to be excluded in the calculation of ability-to-pay is determined by subtracting \$65 from earned income. An additional \$25 will be subtracted from the total income (both earned and unearned) as an allowance for personal need.

Stat. Auth.: ORS 179.770, 413.042
Stats. Implemented: ORS 179.610 – 179.770
Hist.: MHD 11-1985, f. & ef. 6-19-85

309-012-0130

Purpose and Scope

(1) Purpose. These rules establish procedures for approval of the following kinds of organizations:

(a) Any mental health service provider which is, or seeks to be, contractually affiliated with the Division or community mental health authority for the purpose of providing services described in ORS 430.630(3);

(b) Performing providers under OAR ;

(c) Organizations seeking Division approval of insurance reimbursement as provided in ORS 743A.168; and

(d) Holding facilities.

(2) These rules do not establish procedures for residential licensure under ORS 443.410 and 443.725.

(3) These rules do not establish procedures for regulating behavioral health care practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes.

(4) These rules do not establish procedures for regulating practices exclusively comprised of behavioral healthcare practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes.

Stat. Auth.: ORS 179.040, 430.640, 743A.168
Stats. Implemented: ORS 179.505, 430.010 & 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; MHS 9-2015(Temp), f. & cert. ef. 11-25-15 thru 5-20-16; Administrative correction, 6-

21-16; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0140

Definitions

As used in these rules:

(1) “Applicant” is any entity potentially eligible to be approved as a provider under these rules and who has requested, in writing, a Certificate of Approval.

(2) “Certificate of Approval” is the document awarded under these rules signifying that a specific, named organization is judged by the Division to operate in compliance with applicable rules. A “Certificate of Approval” for mental health services is valid only when signed by the Assistant Administrator of the Division and, in the case of a subcontract provider of a CMHP, the CMHP director.

(3) “Community Mental Health Program” or “CMHP” means the organization of all services for persons with mental or emotional disturbances, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an agreement or contract with the Division.

(4) “Direct Contract” or “Contract” is the document describing and limiting the relationship and respective obligations between an organization other than a county and the Division for the purposes of operating the mental health program area within a county’s boundaries, or operating a statewide, regional, or specialized mental health services.

(5) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority.

(6) “Holding Facility” means hospitals or other facilities, including Division contracted acute care facilities, providing care, custody, and treatment of allegedly mentally ill persons under the emergency provisions of ORS 426.070 & 426.140.

(7) “Intergovernmental Agreement” or “Agreement” is the document describing and limiting the contractual relationship and respective obligations between a county or other government organization and the Division for the purpose of operating mental health services.

(8) “Letter of Approval” is the document awarded to service providers which states that the provider is in compliance with applicable administrative rules of the Division. Letters of Approval issued for mental health services are obsolete upon their expiration date, or upon the effective date of this rule, whichever is later. OAR 309-012-0010 is repealed upon the effective date of these rules.

(9) “Local Mental Health Authority” means the county court or board of county commissioners of one or more counties who operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public agency or private corporation with whom the Division directly contracts to provide the mental health services program area.

(10) “Mental Health Program Area” means the organization of all services for persons with mental or emotional disturbances, operated by or contractually affiliated with, a local mental health authority, in a specific geographic area of the state.

(11) “Mental Health Services Provider” means a corporate, or government entity, which provides a service defined in a Division administrative rule, under a contract or agreement with the Division, or CMHP.

(12) “Non-Inpatient Provider” means an organization not contractually affiliated with the Division, a CMHP, or other contractor of the Division providing services under group health insurance coverage for mental or nervous conditions which seeks or maintains Division approval under ORS 743.556(3).

(13) “Provider” means either a mental health services provider, holding facility, or a non-inpatient provider.

(14) “Service Element” means a distinct service or group of services for persons with mental or emotional disturbances which is defined in administrative rule and is included in a contract or agreement issued by the Division.

(15) “Subcontract” is the document describing and limiting the relationship and obligations between a government or other

entity having an agreement or contract with the Division and a third organization (subcontractor) for the purpose of delivering some or all of the services specified in the agreement or contract with the Division.

(16) "Substantial Compliance" means a level of adherence to Division rules applicable to the operation of a service which, while not meeting one or more of the requirements in an exact, literal manner, does not, in the determination of the Division, constitute a danger to the health or safety of any person, is not a willful or a potentially continuing violation of the rights of service recipients as set forth in administrative rules, or will not prevent the accomplishment of the State's purposes in approving or supporting the subject service. "Substantial failure to comply" is used in this rule to mean the opposite of "substantial compliance."

Stat. Auth.: ORS 179.040, 179.505
Stats. Implemented: 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0150

Applicability of Certificates of Approval

Certificates of Approval are awarded to mental health services providers and non-inpatient providers that are found to be in substantial compliance with applicable administrative rules:

(1) Mental health services providers are required to maintain Certificates of Approval as follows:

(a) Each community mental health program or provider operating under an Intergovernmental Agreement or a direct contract with the Division must maintain a Certificate of Approval as set forth in these rules;

(b) Each local mental health service provider operating under subcontract with a CMHP must maintain a Certificate of Approval as set forth in these rules in order to receive funds administered by the Division through the local subcontract relationship.

(2) Hospitals and other facilities which operate as holding facilities in providing care, custody, and treatment of allegedly mentally ill persons under the emergency provisions of ORS 426.070 & 426.140 must maintain a Certificate of Approval as set forth in these rules.

(3) A provider not described above which offers services that may be reimbursable under group health coverage as set forth in ORS 743A.168 for mental or emotional conditions may seek to obtain a Division Certificate of Approval in order to establish reimbursement eligibility.

(4) Certificates of Approval are not awarded as a substitute for a license such as those required in ORS 443.410 and 443.725 for residential facilities. However, the Division may require such licensed providers to obtain a Certificate of Approval if services exceeding those required for licensure are provided in return for Division financial support as set forth in section (1) of this rule.

(3) These rules do not establish procedures for regulating behavioral health care practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes.

(4) These rules do not establish procedures for regulating practices exclusively comprised of behavioral healthcare practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes.

Stat. Auth.: ORS 179.040, 179.505
Stats. Implemented: 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0160

Award of Certificates of Approval for New Applicants

(1) County governments and applicants for direct contracts with the Division. Counties not operating under an agreement with the Division, or those electing to add Division service elements which are not included in their agreement, and other organizations seeking to become direct contractors of the Division following the Division's request for such contractors, may be awarded Certificates of Approval based upon the following:

(a) A plan for the implementation of the proposed services which meets the specifications of the Division;

(b) Written assurance, by an officer with authority to obligate the applicant, that all applicable rules of the Division for operation of the proposed services will be met, or if not, operated in compliance with a waiver awarded by the Division; and

(c) Other reviews, such as those described in OAR 309-012-0190(3), which in the judgment of the Division may assist to predict compliance of the applicant's proposed services with administrative rules;

(d) Following the completion of the application process, and any reviews deemed necessary by the Division, the Division will make one of the following determinations:

(A) That the applicant may be awarded a Certificate of Approval based on demonstration of its capacity and willingness to operate in compliance with applicable administrative rules;

(B) That the applicant may be awarded a Certificate of Approval with specified conditions as described in OAR 309-012-0200; or

(C) That the applicant will not be awarded a Certificate of Approval because it has not demonstrated that it will comply with applicable administrative rules.

(2) Community mental health subcontracted providers, holding facilities, and performing providers:

(a) A provider seeking a Certificate of Approval for the first time, in order to operate as a CMHP subcontractor, performing provider under OAR 309-016-0070, or holding facility shall submit an application to the CMHP in the county in which the service will be offered;

(b) Upon a determination by the CMHP to subcontract with the provider for the purpose of providing a mental health service, for the purpose of operating as a performing provider under OAR 309-016-0070, or as a holding facility, the CMHP shall apply to the Division for a Certificate of Approval for the program;

(c) The CMHP application to the Division must include the following:

(A) Provider identifying information including corporate name, address, telephone number, and name of manager or director;

(B) Written assurance from an officer with authority to obligate the applicant that the applicant will operate in compliance with all administrative rules applicable to the services which will be subcontracted to the provider, or a request for a variance to the applicable administrative rules with which the provider will not comply.

(d) The Division may initiate other reviews such as those described in OAR 309-012-0190(3) and may negotiate with the CMHP, ongoing monitoring activities to be conducted to ensure the provider's compliance;

(e) Following the completion of the application process described above, and any reviews deemed necessary by the Division, the Division will make one of the following determinations:

(A) That the applicant may be awarded a Certificate of Approval based on demonstration of its capacity and willingness to comply with applicable administrative rules;

(B) That the applicant may be awarded a Certificate of Approval with specified conditions for action by the applicant for reaching substantial compliance with applicable administrative rules, and/or specific monitoring activities which have been negotiated with the CMHP as described in subsection (2)(d) of this rule;

(C) That the applicant will not be awarded a Certificate of Approval because it has failed to demonstrate that it will comply with applicable administrative rules, or that the kind and amount of monitoring proposed by the CMHP will not assure the applicant's compliance.

(f) Certificates of Approval awarded to CMHP subcontractors are issued jointly between the Division and the CMHP. To be valid, such a Certificate must bear the signature of the Assistant Administrator of the Division and the CMHP director.

(3) Non-inpatient providers seeking Division approval for insurance reimbursement purposes as provided in ORS 743.556(3). Non-inpatient providers seeking Division approval for insurance reimbursement purposes may correspond with the Division specifically requesting application instructions for Division approval as provided in ORS 743.556(3). Following a review of application materials submitted by the provider, the Division may:

(a) Deny the application, in writing, to the applicant because of a failure to pay the application fee described in subsection (d) of this section; because the application materials demonstrate that the provider does not comply with OAR 309-039-0500 through 309-039-0580; or because of the provider's failure to submit materials specified in the application instructions; or

(b) Following review of the application, the Division may:

(A) Schedule reviews such as those described in OAR 309-012-0190(4) by Division personnel; or

(B) Notify the applicant of other agencies or individuals with whom they may contract for the purpose of conducting a review and providing a report of program compliance to the Division;

(C) Notify the applicant of placement on a waiting list for review when Division staff or other agencies or individuals are available to conduct a review.

(c) Following the reviews in paragraph (b)(A) or (B) of this section, the Division will award or refuse to award a Certificate of Approval to the applicant based on the findings of the review;

(d) The Division may require payment of an application fee and a certification fee by non-inpatient programs applying or reapplying for a Certificate of Approval under these rules, provided the collection of such fees has been authorized for the Division budget by the Legislative Assembly or the Emergency Board.

Stat. Auth.: ORS 179.040, 179.505

Stats. Implemented: 430.620

Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0170

Award of Certificates of Approval to Providers at the Time These Rules are Adopted

(1) Mental health services providers. Upon adoption of these rules, the Division may issue Certificates of Approval to mental health services providers that are operating under an Intergovernmental Agreement, direct contract, or at the request of the CMHP, to current subcontractors of the CMHP.

(2) Non-inpatient providers described in ORS 743.556 and holding facilities. Letters of Approval awarded under ORS 743.556 and those awarded to holding facilities which remain in effect at the time these rules are adopted, are the equivalent of a Certificate of Approval. These may be maintained and renewed as Certificates of Approval as set forth in these rules.

Stat. Auth.: ORS 179.040, 179.505

Stats. Implemented: 430.620

Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0180

Duration and Renewal of Certificates of Approval

(1) Mental health services providers. Unless revoked pursuant to OAR 309-012-0210 or unless otherwise specified on the Certificate, Certificates of Approval for mental health services providers are valid for three years.

(2) Non-inpatient providers. Certificates of Approval for providers described in ORS 743.556(3) are valid for up to three years or as otherwise specified on the Certificate. When a non-inpatient provider seeks a Certificate of Approval to be in effect at the expiration date of a Letter of Approval or a prior Certificate of Approval, an application conforming to the instructions of the Division must be received no later than 90 days prior to the expiration of the earlier Letter of Approval or Certificate.

Stat. Auth.: ORS 430.640(i) & 430.640(h)

Stats. Implemented:

Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0190

Conduct of Periodic and Interim Reviews

(1) Review Schedules:

(a) Periodic reviews of mental health service providers will be routinely conducted every three years;

(b) Periodic reviews of non-inpatient providers approved under ORS 743.556 will be conducted following the provider's submission of an application for recertification as set forth in OAR 309-012-0180;

(c) Interim reviews of any provider holding a Certificate of Approval may be conducted at any time at the discretion of the Division, or in the case of a subcontractor of a CMHP, at the discretion of either Division or the CMHP.

(2) Notification of Review. Notification that a review will be conducted, along with all instructions and requests for information from the provider, will be made in writing by the designee of the Assistant Administrator of the Division. For reviews of subcontractors initiated by the CMHP, notification and instructions will be made by the designee of the director of the CMHP.

(3) Initiation of Reviews:

(a) Reviews of new applicants, and periodic reviews will be scheduled with at least one month's notice from the Division to the CMHP, direct contractor, or non-inpatient provider. Subcontractors will be notified by the CMHP;

(b) The Division and, in the case of a subcontractor, the CMHP may conduct an interim review without prior notification when there is reason to believe any of the following conditions have occurred or may occur:

(A) Operations of the service provider threaten the health or safety of any person;

(B) The provider may act to alter records or make them unavailable for inspections.

(c) Interim reviews other than those specified in subsection (b) of this section will be initiated with at least two week's notice by the Division to the CMHP or direct contractor.

(4) Review Procedures. The Division, and in the case of reviewing a subcontractor, the CMHP, may employ review procedures which it deems adequate to determine compliance with applicable administrative rules. These procedures may include but are not limited to:

(a) Entry and inspection of any facility used in the delivery of approved services;

(b) A request for the submission to the Division or CMHP, of a copy of any document required by applicable administrative rules or needed to verify compliance with such rules, or access to such documents for on-site review. Such documentation could include, for example, records of utilization and quality assurance reviews, copies of portions of selected consumer records, and copies of staff academic degrees or professional licenses;

(c) The completion by the provider of self-assessment checklists reporting compliance or non-compliance with specific rule requirements; and

(d) Conduct of interviews with, and administration of questionnaires to persons knowledgeable of service operations, including, for example, staff and management of a provider, governing and advisory board members, allied agencies, service consumers, their family members, and significant others;

(e) In the case of subcontracts and reviews initiated by the county, the county may request Division assistance in conducting the reviews.

(5) Organizational Provider Assessment Information

(a) In addition to the review procedures outlined in Section 309-012-0057, the Division will ensure that the following minimum information will be obtained during the site reviews;

(b) A current program description that reflects the type and scope of behavioral health services provided by the applicant;

(c) Provider policies regarding credentialing practices of individual practitioners. The policies must reflect current credentialing standards as defined by nationally accepted accrediting bodies

such as The Joint Commission, the National Committee for Quality Assurance, and/or URAC;

- (d) Copies of the provider’s liability insurance coverage;
 - (e) Copies of the provider’s policies and procedures regarding seclusion and restraint practices; and
 - (f) Copies of the provider’s Code of Conduct.
- (6) Reports of Review Findings:

(a) Completion Deadlines. The Division will issue a completed report of review findings, a Certificate of Approval, and any conditions to approval, or denial of approval within 60 days of the completion of an on-site review, or within 60 days of the date of submission of all review materials which have been requested for the purpose of conducting the review, whichever is later;

(b) Content and scope of reports. Reports of reviews will include the following:

(A) A description of the review findings regarding program operations relative to applicable administrative rules, and contract or agreement provisions;

(B) A specification of any conditions set as described in OAR 309-012-0200, which the provider must meet, and the time permitted to meet the conditions;

(C) A statement clarifying the provider’s approval status; and

(D) An appendix containing any report of findings or observations clearly qualified as unrelated to the provider’s approval status which may be useful as information and recommendations to the service provider or the CMHP.

(c) Transmittal of Reports. Each report shall be issued along with a document of transmission signed by the Assistant Administrator of the Division, and any Certificates of Approval being awarded;

(d) Report Distribution. The Division will address and issue reports as follows:

(A) Reports of reviews of a directly operated or subcontracted portion of a community mental health program will be issued to the local mental health authority;

(B) Reports of reviews of direct contractors of the Division will be issued to the signator(s) of the direct contract; and, the Chairperson of the Board of Directors of the contractor;

(C) Reports of reviews of holding facilities which are not subcontractors of a community mental health program, and reviews of non-inpatient providers will be issued to the provider’s officer or employer requesting the review.

Stat. Auth.: ORS 179.040, 179.505, 430.010, 430.640

Stats. Implemented: 430.620

Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0200

Establishment of Conditions to the Award of Certificates of Approval

Based upon a finding that a provider does not operate in compliance with an applicable administrative rule, other than as set forth in OAR 309-012-0210(1), the Division may establish conditions to the award and/or continuation of a Certificate of Approval:

(1) Division Discretion. The Division, and, in the case of a subcontractor, the Division and CMHP, may elect to place conditions on approval of a provider in situations in which the alternative would be denial or revocation of approval because of a failure to substantially comply with applicable rules as described in OAR 309-012-0210(2). The decision to employ special conditions rather than revoke or refuse to award approval will be based on criteria such as the following:

(a) The expressed willingness of the provider to gain compliance with applicable rules;

(b) The apparent adequacy of actions proposed by the provider to gain compliance;

(c) The availability of alternative providers to address any service needs that would be unmet if the provider were not allowed

conditions to approval as an alternative to revocation or refusal to award a Certificate of Approval;

(d) The provider’s historical compliance with Division rules and conditions.

(2) Method of Establishment:

(a) Conditions to approval shall be communicated in writing and issued along with a document of transmission signed by the Assistant Administrator of the Office of Division;

(b) Each written condition shall specify the time period allowed to gain compliance and any interim steps for obtaining such compliance.

Stat. Auth.: ORS 179.040, 179.505, 430.010, 430.640

Stats. Implemented: 430.620

Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0210

Certificate Denial or Revocation

(1) Immediate Denial or Revocation. The Division, or in the case of a subcontractor provider, either the Division or the CMHP may refuse to renew or may immediately revoke a Certificate of Approval, without a prior notice or hearing when the applicant or provider:

(a) Has demonstrated substantial failure to comply with applicable rules such that the health or safety of individuals is jeopardized and the applicant fails to correct the noncompliance within the time specified by the Division;

(b) Has demonstrated a substantial failure to comply with applicable rules such that the health or safety of individuals is jeopardized during two reviews within a six-year period;

(c) Has failed to maintain any State of Oregon license which is a prerequisite for providing services that were approved;

(d) Is a county, or direct contractor that has terminated its agreement or contract with the Division for the provision of the approved services, or when the approval is to a subcontract provider of such a county or direct contractor;

(e) Is approved to provide a service as a CMHP subcontractor, whose subcontract is terminated;

(f) Continues to employ personnel who have been convicted of any felony, or a misdemeanor associated with the provision of mental health services;

(g) Falsifies information required by the Division regarding services to consumers, or information verifying compliance with rules; or

(h) Refuses to submit or allow access to information for the purpose of verifying compliance with applicable rules when notified to do so as set forth in OAR 309-012-0190(2), or fails to submit such information following the date specified for such a submission in the written notification.

(2) Denial or Revocation with Notice. Following a Division finding that there is a substantial failure to comply with applicable rules beyond the conditions in section (1) of this rule, such that, in the Division’s view the state’s purposes in approving the services are not or will not be met, the Division may, with 30 days notice, refuse to award or renew, or may revoke a Certificate of Approval.

(3) Informal Conference. Within ten calendar days following a 30-day notice issued under section (2) of this rule, the Division shall give the provider an opportunity for an informal conference at a location of the Division’s choosing. Following such a conference, the Division may proceed with denial or revocation effective on the 30th day following the notice issued under section (2) of this rule, or may approve the provider, or set conditions to approval as described in OAR 309-012-0200 rather than denying or revoking approval.

(4) Hearing. Following issuance of a notice of Certificate revocation or denial, the Division shall provide the opportunity for a hearing as set forth in OAR 309-012-0220.

(5) A county may employ process consistent with the above, or processes adopted by resolution of the local mental health authority for revoking the approval of a subcontract provider.

Stat. Auth.: ORS 179.040, 179.505, 430.010, 430.640, 413.032-413.033, 413.042
Stats. Implemented: 183.415, 183.430, 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 9-2015(Temp), f. & cert. ef. 11-25-15 thru 5-20-16; Administrative correction, 6-21-16; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

ACCOUNTING AND BUSINESS PRACTICES

309-013-0030 Management of Trust Accounts and Patient Funds in State Institutions

(1) Purpose. This rule establishes standards and procedures to be observed by Superintendents and their employees in the management of trust accounts and patient funds in state institutions, as well as make applications on behalf of patients for Social Security or Veterans Administration benefits or be appointed representative payee for a patient's Social Security or Veterans Administration benefit payments.

(2) Statutory Authority and Procedure. This rule is authorized by and carries out the provisions of ORS 179.510 to 179.530.

(3) Definitions. As used in this rule:

(a) "Agency trust account" means an account established in the name of a patient by the Superintendent of a state institution under ORS 179.510 to retain funds deposited with the Superintendent by or for the named patient;

(b) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority;

(c) "Patient's Designee" means a person designated by the patient in a state institution in writing to receive duplicate copies of documents sent to the patient relating to the patient's funds;

(d) "Representative or Indirect Payee Trust Account" means a trust account established in the name of a patient by the Superintendent of a state institution or other staff representative or indirect payee to retain the patient's Social Security or Veterans benefits paid to the representative payee;

(e) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton;

(f) "Superintendent" means the executive head of the state institution as listed in subsection (3)(e) of this rule;

(g) "Treatment Team" means the group whose membership consists of professional and direct care staff.

(4) Admission to State Institution. Upon admission or readmission to a state institution, the patient, a guardian or conservator, and the patient's designee, if any, shall be provided with written notices containing the following information:

(a) The patient's obligation under state law to reimburse the state for the actual cost of the patient's care and maintenance, according to the patient's ability to pay, whichever is less;

(b) The patient's option to place money in either an agency trust account or other suitable depository outside the state institution. The agency trust account withdrawal and deposit procedures and the Superintendent's powers with respect to such accounts shall be explained therein;

(c) In the event the patient requests the state institution to forward funds outside the state institution to other than a bank or secure financial institution and, in the clinical judgment of the Superintendent, the patient is not able to understand the implications of the patient's request, the Superintendent shall provide notice that the patient's funds have been placed in an agency trust account; and a proceeding to have a conservator appointed will be commenced within ten days from the date of the notice;

(d) Copies of all relevant state laws and rules regarding handling of patient funds and institutional reimbursement shall be made available to the patient, a guardian or conservator, and the patient's designee on request;

(e) The patient, a guardian, or a conservator may designate another responsible person to be representative or indirect payee for benefits and/or to receive duplicate copies of all further documents detailing procedures, agency trust account transactions, applications by the Superintendent for patient benefits, or documents otherwise related to the institutional reimbursement process as it affects the patient. A form for designating one other person to receive such documents shall be provided upon request.

309-012-0220

Hearings

(1) Request for Hearing. Upon written notification by the Division of revocation or denial to issue or renew a Certificate, pursuant to OAR 309-012-0210(1) and (2), the provider shall be entitled to a hearing in accordance with ORS Chapter 183. The request for hearing shall include an admission or denial of each factual matter alleged by the Division and shall affirmatively allege a short, plain statement of each relevant affirmative defense the provider may have.

(2) Hearing rights under OAR 309-012-0210(1). The immediate suspension or denial of a Certificate under OAR 309-012-0210(1) is made pending a fair hearing not later than the tenth day after such suspension or denial.

(3) Issue at hearing after immediate suspension or denial pursuant to OAR 309-012-0210(1)(a). The issue at a hearing on Certificate denial or revocation pursuant to this rule is limited to whether the provider was or is in compliance at the end of the time specified by the Division following the finding of substantial failure to comply.

Stat. Auth.: ORS 179.040, 179.505, 430.010, 430.640, 413.032-413.033, 413.042
Stats. Implemented: 183.430, 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 9-2015(Temp), f. & cert. ef. 11-25-15 thru 5-20-16; Administrative correction, 6-21-16; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0230

Availability of Information to Coordinated Care Organizations and Other Health Plans

Upon completion of the site review process and the issuance of a Certificate of Approval for Mental Health Services, the Division shall make copies of the following information available to Coordinated Care Organizations and other health plans for the purpose of credentialing a provider:

(1) A current program description that reflects the type and scope of behavioral health services provided by the applicant;

(2) Provider policies and procedures regarding the provider's credentialing practices of individual clinicians;

(3) Statements of provider's liability insurance coverage;

(4) An attestation from the Authority verifying that the provider has passed a screening and meets the minimum requirements to Medicaid provider;

(5) Reports detailing the findings of the Division's site review of the provider;

(6) The provider's Medicaid Vendor Identification Number issued by the Authority;

(7) Copies of the provider's policies and procedures regarding seclusion and restraint practices; and

(8) Copies of the provider's Code of Conduct.

Stat. Auth.: ORS 413.042 & 430.256
Stats. Implemented: ORS 430.01030, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

(5) Agency Trust Account Transactions. A monthly statement indicating the deposits and withdrawals during the prior month of the agency trust account shall be delivered to the patient, a guardian or conservator, and the patient's designee, if any.

(6) Representative or Indirect Payee Trust Account Transactions. A monthly statement indicating the deposits and withdrawals during the prior month of the representative or indirect payee trust account shall be delivered to the patient, a guardian or conservator, and the patient's designee, if any.

(7) Determination of Patient's Capability to Manage Funds:

(a)(A) If an investigation indicates the patient is incapable of managing his or her funds, the relevant Social Security Administration or Veterans Administration form and recommendation shall be forwarded to the Superintendent's office. Upon receiving the form, the Superintendent or the Superintendent's designee shall cause notice of the proposed application to be sent as indicated in section (8) of this rule;

(B) Inquiries may be made of attending doctors and other reliable persons who deal with the patient frequently.

(b) When, after investigation, in the opinion of the Superintendent, a patient is or has become incompetent and/or incapable of making an informed consent or incapable of managing funds, and there is no person legally responsible for the patient (such as a guardian or conservator), the Superintendent may:

(A) Apply to have a representative or indirect payee appointed under section (8) of this rule; and/or

(B) Commence proceedings to establish a guardianship or conservatorship.

(8) Application for Benefits or Notification of Incapacity to Manage Funds:

(a) When, after investigation pursuant to section (7) of this rule, the Superintendent determines that such a step would be in the best interests of the patient, the Superintendent or the Superintendent's designee may apply for Social Security or Veterans benefits on behalf of a patient. Before each application, the patient, a guardian or conservator, and the patient's designee, if any, shall be mailed notice of the proposed application. Notice shall include the following:

(A) A statement of the intention to apply for such benefits;

(B) A copy of the proposed application, indicating the reason for the application and the evidence relied upon in determining that an application is warranted;

(C) If the applicant seeks to be selected as representative or indirect payee, a statement that this will mean that the representative of the federal agency concerned will determine whether it is in the best interests of the patient that a payee be appointed;

(D) A statement that the patient, a guardian or conservator, or the patient's designee, if any, may submit to the Superintendent a written statement including written evidence why the application should not be made. This statement and evidence must be submitted not more than 12 days from the date of the notice; and

(E) A statement that any such written statement submitted on behalf of the patient and received within the time specified shall be considered by the Superintendent or other official in the decision to submit the proposed application.

(b) After such notice has been given, and either:

(A) Twelve days have elapsed without response from the patient, a guardian or conservator, or the patient's designee, if any; or

(B) The statement or written evidence submitted pursuant to paragraph (8)(a)(D) of this rule has been received, the Superintendent or the Superintendent's designee shall consider all the evidence submitted and decide whether an application would be in the patient's best interest. If it is decided that the application should be made, the patient, a guardian or conservator, and the patient's designee, if any, shall receive copies of the application and any supporting materials thereof.

(c) The response of the Social Security Administration or Veterans Administration to the application shall likewise be forwarded, along with information concerning the rights of patients and other interested persons regarding Social Security or Veterans Adminis-

tration benefits, to the patient, a guardian or conservator, and the patient's designee, if any.

(9) Deposit of Social Security Administration and Veterans Administration Checks:

(a) Checks for which the patient is the payee must be deposited directly into the patient's agency trust account if the patient has elected to have such an account. In the event the patient has elected a suitable depository outside the state institution, arrangements for forwarding the patient's funds to that depository are the responsibility of the patient, a guardian or conservator, or the patient's designee, if any. Notification of receipt of the check and the deposit thereof in the agency trust account shall be made in the next monthly statement to the patient, a guardian or conservator, and the patient's designee, if any. When such Social Security or Veterans funds are deposited in the agency trust account, the funds shall be clearly designated as Social Security Administration or Veterans Administration benefit money;

(b) Social Security or Veterans funds in the agency trust account may be taken to pay the patient's bill for care and maintenance at the state institution only when the patient (if not judicially or factually incompetent) or the patient's guardian or conservator has executed a written consent for that particular transaction. "Blanket" or continuing consents will not be honored insofar as they affect Social Security or Veterans benefits;

(c) Checks payable to the Superintendent or the Superintendent's designee as indirect or representative payee may be deposited directly into the patient's representative or indirect payee trust account. Notification of receipt of the check and the deposit thereof in the representative or indirect payee trust account shall be made in the next quarterly statement to the patient, a guardian or conservator, and the patient's designee, if any.

(10) Discharge from State Institution. At or before discharge from a state institution, each patient, a guardian or conservator, and the patient's designee, if any, shall be provided with a statement containing the following information:

(a) The patient's continuing obligation under state law to reimburse the state for the actual cost of the patient's care and maintenance, according to the patient's ability to pay;

(b) The patient may contest payments made to the State of Oregon for charges for institutional care and maintenance during the period of recent hospitalization;

(c) Copies of the relevant state laws and administrative rules regarding the patient's post-discharge right to contest payments made to the State of Oregon for charges for institutional care and maintenance will be made available to the patient or other interested party on request;

(d) Copies of monthly statements of transactions concerning the activity in the patient's agency trust account and quarterly statement of representative or indirect payee trust account may be made available to the patient, legal representative, or other designated person not otherwise prohibited from seeing them upon request.

(11) Incapacity to Perform:

(a) The patient's treatment team at the state institution may certify in writing that a patient's mental illness or mental retardation has rendered the patient incapable of even minimal understanding of any of the notices provided for in this rule. Notwithstanding any other provision of this rule, should such certification occur, the Division or state institution is not required to provide the patient with the various forms of notice otherwise required by this rule;

(b) Certification that a patient's mental illness or mental retardation renders the patient incapable of understanding the notice provided by this rule shall be reviewed and redetermined annually by the Superintendent as part of the patient's annual plan of care.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.510 - 179.530

Hist.: MHD 42(Temp), f. & ef. 9-9-76; MHD 9-1980(Temp), f. & ef. 4-18-80; MHD 16-1980, f. & ef. 6-24-80

309-013-0035

Purpose and Statutory Authority

(1) Purpose. The Pay for Patient and Resident Workers Program was established to support the goals or the patient's or res-

ident's treatment/training plan. These rules establish standards and procedures for administering the agency payroll system for patient and resident workers in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 413.042, and carry out the provisions of ORS 179.440, 426.385 and 427.031.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 426.385, 179.440
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0040

Definitions

As used in these rules:

(1) "Appointment Notice" means the form used at the institution to enter a patient or resident worker into the agency payroll system.

(2) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(3) "Patient Worker" means a person in a state institution for the mentally or emotionally disturbed who performs work for pay that is of therapeutic benefit to the patient.

(4) "Resident Worker" means a person in a state institution for the mentally retarded and other developmentally disabled who performs work for pay that is of training benefit to the resident.

(5) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 426.385, 179.440
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0045

Wage Standards

(1) State institutions will use the first step of the state wage scale, which corresponds with the existing state classification of the job to be performed, to calculate payments for work performed by patient and resident workers.

(2) Patients and residents whose productivity is lower than the productivity normally required to perform the job will be paid a percentage of the first step amount. The percentage will be commensurate with the level of productivity as calculated by the institution, and consistent with the Personnel Division Compensation Plan.

(3) Patients and residents who are paid an amount equal to less than the first step of the state wage scale for the existing classification will be allowed, upon request, to review their record with regard to the calculation of their productivity level.

(4) Wages will be paid based either on the time spent doing the job or on the rate established for completing a specific task multiplied by the number of tasks completed.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 426.385, 179.440
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0055

Hiring Procedure

(1) Prior to employment, all patient and resident workers must be informed verbally, and in writing, of their rights with respect to their working relationship with the state institution. Those rights are as follows:

(a) To receive reasonable compensation for all work performed, other than personal housekeeping chores;

(b) To receive overtime compensation for work performed in excess of an eight hours per day or 40 hours per week;

(c) To refuse any work except personal housekeeping chores and, that which is essential for their treatment or training;

(d) To review their productivity rating if less than 100 percent.

(2) The institution must complete an appointment notice for each patient and resident worker.

(3) Each patient worker and resident worker must complete a Form W-4.

(4) Each patient and resident worker without a Social Security number must apply for and receive one prior to employment.

(5) Each patient and resident worker who receives Social Security benefits (SSI or SSD), or is eligible for Title XIX, must be informed that an earnings record will be sent to those offices for possible payment adjustment.

(6) Each patient and resident worker under 18 years of age must have a work permit prior to employment.

(7) If applicable, the patient or resident worker must sign, in the presence of a witness, the Notice to Patient/Resident Worker form, (MHD-ADM-0169), prior to beginning work. No billing for cost of care based on agency earnings will predate the delivery of this notice.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 426.385, 179.440
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0060

Payroll Procedure

(1) Each state institution will use a gross payroll system for processing the agency payroll for patient and resident workers. Biennial budgets for agency payroll will be based on expected gross payroll expenses.

(2) The work supervisor will keep a record of each patient or resident worker's work times and/or specific tasks completed.

(3) Each institution shall adopt written procedures, approved by the Division Administrator, to prepare, distribute, and account for agency payroll payments.

(4) Payroll records will be maintained in accordance with the appropriate record retention requirements of the Secretary of State's Archives Division.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 426.385, 179.440
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0075

Purpose and Statutory Authority

(1) Purpose. These rules prescribe procedures for handling cases of fraud and embezzlement involving Division employees working in the central office or state institutions, persons working under personal service contracts with the Division, and service providers and subcontractors of service providers contracting with the Division.

(2) Statutory Authority. These rules are authorized by ORS 179.040 and 413.042, and carry out the provisions of 430.021(2).

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 430.021
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0080

Definitions

As used in these rules:

(1) "Central Office" means all organizational elements of the Addictions and Mental Health Division which are not a part of a state institution.

(2) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(3) "Embezzlement" means any action to willfully take or convert to one's own use, money or property of another, which the wrongdoer acquired lawfully through some office or employment or position of trust.

(4) "Fraud" means any action by an individual to knowingly, willfully and with deceitful intent take or use for their own personal gain money or property which does not belong to them.

(5) "Service Provider" means a public or private community agency or organization that provides a particular mental health service (such as preschool services for the developmentally disabled, a detoxification center, or a day treatment program) approved by the Division. An agency organization may provide more than one service element, and more than one agency or organization in a county may provide the same service element.

(6) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training

Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 430.021
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0085

Reporting of Suspected Fraud and Embezzlement

(1) Upon discovery, all cases of suspected fraud and embezzlement related to the central office shall be referred, along with all related information, to the Administrator. The Administrator shall review the case, call upon appropriate sources to investigate, and notify appropriate authorities.

(2) In case of suspected fraud or embezzlement involving a state institution, the superintendent of the institution shall review the case, call upon appropriate sources to investigate, and notify appropriate authorities. All cases under review shall be reported to the Administrator.

(3) Each service provider contracting with the Division shall report in writing the details of all cases of suspected fraud and embezzlement involving its employees and/or the employees of its subcontractors to the Division's Administrator not later than one working day after the date the alleged activity comes to their attention. The report shall describe the incident and action being taken to resolve the problem.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 430.021
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0090

Investigation of Suspected Fraud and Embezzlement

(1) In cases of suspected fraud and embezzlement involving funds and resources of the Division:

(a) The Administrator shall begin the investigation immediately and may, in the course of investigation, call upon the services of appropriate law enforcement agencies, the Attorney General, the Division Audit Unit, and/or other who may be of assistance in developing the case;

(b) A service provider which has contracted with the Division is responsible for developing cases of suspected fraud and embezzlement involving its employees and/or the employees of its subcontractors, and is responsible for referral to the proper authorities. However, the Division may assume control of any case not handled to the Division's satisfaction.

(2) In cases of suspected fraud and embezzlement which do not involve funds and resources of the Division:

(a) The aggrieved parties shall seek their own resolution, and the Division will not become involved in development of the case or prosecution, except it may intervene in cases involving resources of clients of service providers;

(b) The Division shall review the case to determine whether the lack of internal controls which allowed fraud or embezzlement to occur might also endanger Division resources. If that possibility exists, the service provider shall be required to adopt and follow procedures which the Division decides are needed to minimize chances for recurrence of the fraud or embezzlement. Failure of the service provider to adopt and follow such procedures shall constitute grounds for refusing to contract with the service provider in the future, and for terminating the existing contract.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 430.021
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0095

Consequences of Failure to Adopt Procedures

Failure of a service provider to adopt and follow procedures which the Division decides are needed to minimize chances for fraud and embezzlement of Division resources shall constitute grounds for terminating any contract between the Division and that service provider. If the service provider is a subcontractor of a service provider contracting with the Division, then such failure on the part of the subcontractor shall constitute grounds for stipulation

by the Division that no Division managed funds be used for payment to that subcontractor.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 430.021
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0100

Disclosure Requirement

Disclosure must be made to the Division before a contract is entered into, or at the time it becomes known, of the name of any person who has ownership or control interest of five percent or more, or is an officer, director, agent, or managing employee, and has been convicted of a criminal offense related to the involvement of such person in any such program, including theft of patient funds. Failure to make this disclosure shall constitute grounds for terminating that contract.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 430.021
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0105

Disciplinary Action

Fraud or embezzlement of Division resources and/or patient or resident funds committed by Division employees shall constitute grounds for disciplinary action. The type and extent of disciplinary action will be determined in accordance with the Division's collective bargaining agreements and "Personnel Relations Law, Personnel Rules and Personnel Policies." Notwithstanding any portion of these rules, existing agreements with unions representing the employee(s) involved, governing complaint investigation, shall be observed.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 430.021
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0120

Purpose and Statutory Authority

(1) Purpose. These rules establish a Division procedure for audits of community mental health programs, mental health organizations and their subcontractors and vendors and any service provider agreeing to offer services through direct contract with the Division. These rules also establish basic record keeping standards for programs subject to audit under these rules, establish procedures for appealing audit findings, and set out a process to implement the findings of the final audit report.

(2) Statutory Authority. These rules are authorized by ORS 179.040, 413.042 & 430.640 and are promulgated to enable the Division to carry out its responsibilities under ORS 414.018 to 414.024 and 430.610 through 430.695.

Stat. Auth.: ORS 179.040 & 413.042 & 430.640
Stats. Implemented: ORS 414.018 & 430.610-430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0130

Definitions

(1) "Audit" means the examination of documents, records, reports, systems of internal control, accounting and financial procedures, and other evidence for one or more of the following purposes:

(a) To ascertain whether the financial statements present fairly the financial position and the results of financial operations of the fund types and/or account groups in accordance with Generally Accepted Accounting Principles and federal and state rules and regulations;

(b) To determine compliance with applicable laws, rules, regulations and contract provisions;

(c) To review the efficiency and economy with which operations are carried out; and

(d) To review effectiveness in achieving program results.

(2) "Capital Construction" is an expenditure related to construction or remodeling of physical facilities with a projected cost of \$250,000 or more.

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(3) “Capital Improvement” is an expenditure related to construction or remodeling of physical facilities with a projected cost of more than \$5,000 but less than \$250,000.

(4) “Capital Outlay” are purchases of equipment and tangible personal property of a non-expendable nature which have a useful life of more than one year. The minimum dollar threshold for determining if a purchase is capital outlay can not exceed the amount set for state purchases of capital outlay. The current threshold for the State of Oregon is \$5,000, however, a lesser amount may be used.

(5) “Community Mental Health Program (CMHP)” means the organization of all services for individuals with mental or emotional disturbances, developmental disabilities or chemical dependency, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(6) “Direct Contractor” means a person or organization which operates under a direct contract with the Division to provide services to persons with mental or emotional conditions and/or developmental disabilities.

(7) “Internal Auditor” means auditors within the Audit Unit of the Division.

(8) “Internal Control Structure” means the plan of organization including all of the methods and measures adopted within a business to safeguard its assets, check the accuracy and reliability of its accounting data, and promote operational efficiency and adherence to management’s policies.

(9) “Local Mental Health Authority (LMHA)” means the county court or board of county commissioners of one or more counties who choose to operate a CMHP; or, if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation which contracts with the Division to operate a CMHP for that county.

(10) “Addictions and Mental Health Division (Division)” means the Oregon Health Authority (Authority) Agency responsible for the administration of the State mental health and developmental disability services to persons who qualify for certain programs under federal and state laws, rules and regulations.

(11) “Mental Health Organization (MHO)” means a Prepaid Health Plan under contract with the Division to provide covered services under the Oregon Health Plan Medicaid Demonstration Project. MHOs can be Fully Capitated Health Plans (FCHPs), CMHPs or private MHOs or combinations thereof.

(12) “Non-allowable Expenditures” means expenditures made by a contractor or subcontractor of the Division which are not consistent with relevant federal and state laws, rules, regulations and contract provisions. To be allowable, expenditures must be necessary and reasonable for the proper and efficient performance of the contracted services. If only state funds are involved, expenditures will be evaluated based on state laws and rules, the contract provisions, and whether they are necessary and reasonable for the proper and efficient performance of the contracted services. When federal funds are involved, determination of allowable expenditures includes, but is not limited to, those rules and regulations itemized and referred to in applicable Office of Management and Budget circulars.

(13) “Office of Medical Assistance Programs (OMAP)” means the office of the Oregon Health Authority responsible for coordinating the Medical Assistance Program within the State of Oregon.

(14) “Reasonable Cost” means a cost that in nature or amount does not exceed that which would be incurred by a prudent person under the circumstance prevailing at the time the decision was made to incur the cost. Consideration shall be given to whether the cost is of a type generally recognized as ordinary and necessary for the operation of the organization; what restraints or requirements exist such as those imposed by factors of generally accepted sound business practices, federal and state laws and regulations, and terms and conditions of the contract; whether the individuals concerned acted with prudence in the circumstances, considering their responsibilities to the organization, their employer, their clients,

the public and the governments; and whether significant deviations from the organization’s established practices unjustifiably increase costs.

(15) “Service Element” means a distinct service or combination of services as defined in Part III of the Intergovernmental Agreement for persons with mental or emotional conditions and or developmental disabilities provided in the community setting by a contract with the Division or through a subcontract with a local mental health authority.

(16) “Service Provider” means a public or private community agency or organization contracted by the Division that provides recognized mental health or developmental disability service(s) and is approved by the Division or other appropriate agency to provide these service(s). For the purpose of this rule, “provider” or “program” is synonymous with “service provider.”

Stat. Auth.: ORS 179.040 & 413.042 & 430.640

Stats. Implemented: ORS 414.018 & 430.610–430.695

Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0140

Scope and Application of the Rule

Under these rules, the Division may audit any service provider that provides any part of the community mental health program including the community mental health program itself, Mental Health Organizations providing services under the Oregon Health Plan including subcontractors and vendors providing mental health services, or any direct contractor. The scope of the audit shall include only Division funds or related matching funds. However, Division may include other funds in its tests to the extent necessary to audit Division funds or matching funds. These rules shall be read and applied consistently with OAR 309-014-0000 (Community Mental Health Contractors) or the Division of Medical Assistance Programs general rules (OAR 410-120-0000 through 410-120-1980) when these are applicable.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610–430.695

Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0150

Revenue

(1) A service provider shall maintain a revenue account for each income source which results from the operation of the service or is used to support the service. For example, separate revenue accounts shall be established for each service element for which the provider receives payment from Division or the Division of Medical Assistance Programs, direct federal payments, donations, fees, interest earned, rentals collected from subleases and parking lots, sales of capital equipment, training grants or any other source of income.

(2) Only cash revenue may be used to match state funds unless the Division gives prior authorization in writing to use contributed services or property to match state funds.

Stat. Auth.: ORS 179.040 & 413.042 & 430.640

Stats. Implemented: ORS 414.018 & 430.610–430.695

Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0160

Expenses

(1) A service provider subject to audit under these rules shall keep its accounting records consistent with Generally Accepted Accounting Principles. Accounting records shall be retained for three years from the date of the expiration of the Division’s agreement or from the finalization of an audit, whichever comes later. Allocation methods for expenses shall be documented. Relevant calculations representing allocations shall be shown. The allocation method shall reasonably distribute expenses which are shared by service providers or service elements. Charges assessed against a service provider by a related organization shall be justified by the related organization as to the method and reason for relevant cost allocation. The expense invoice shall list the location where

services and supplies purchases are delivered for any item in excess of \$1,000.

(2) Record requirements for Personal Services:

(a) Reports reflecting the distribution of labor of each employee must be maintained for all staff members, professional and nonprofessional, whose compensation is charged in whole or in part to Division funds. To support the allocation of indirect costs, such reports must also be maintained for other employees whose work involves two or more functions or activities if a distribution of their compensation between such functions or activities is needed in the determination of the organization's indirect cost rate(s). Reports maintained to satisfy these requirements must meet the following standards:

(A) The reports must reflect an after-the-fact determination of the actual activity of each employee. Budget estimates (i.e., estimates determined before the services are performed) do not qualify as support for charges to Division funds;

(B) Each report must account for the total activity for which employees are compensated and which is required in fulfillment of their obligations to the organization;

(C) The reports must be signed by the individual employee, or by a responsible supervisory official having first-hand knowledge of the activities performed by the employee, to attest that the distribution of activity represents a reasonable distribution of the actual work performed by the employee during the periods covered by the reports;

(D) The reports must be prepared at least monthly and must coincide with one or more pay periods;

(E) Periodic time studies, in lieu of ongoing time reports, may be used to allocate salary and wage costs. However, the time studies used must meet the following criteria:

(i) A minimally acceptable time study must encompass at least one full week per month of the cost reporting period;

(ii) Each week selected must be a full work week (e.g., Monday to Friday, Monday to Saturday or Sunday to Saturday);

(iii) The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period three of the 12 weeks in the study must be the first week beginning in the month, three weeks the second week beginning in the month, three weeks the third and three weeks the fourth;

(iv) No two consecutive months may use the same week for the study, (e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months);

(v) The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years;

(vi) The time study must apply to a specific provider. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

(b) Any person being compensated for services to a service provider who is not an employee of the organization shall have a written contract with the service provider. The contract shall set forth the specific services being purchased, the contract time period, the rate at which compensation will be paid and an hourly rate where applicable.

(3) Record Requirements for Capital Expenditures:

(a) Depreciation for capital outlay, capital improvements, and capital construction shall be documented in a depreciation schedule. The depreciation schedule at a minimum shall include a description of the asset, date of acquisition, cost basis, depreciation method, estimated useful life, annual depreciation expense and accumulated depreciation.

(b) Any capital expenditures purchased by a service provider using Division funds shall be listed on an inventory system showing location of item and reference to purchase invoice and

payment receipt location. The inventory shall be checked annually and verification of the inventory list signed by the inventory control person. All capital items purchased with Division funds must be used in an Division approved program.

(4) Reasonable Procedures will be established to ensure the security of cash, blank checks, purchase orders, check protector machines, and signature stamps.

(5) A service provider must expend funds consistent with an intergovernmental agreement or direct contract, these rules, the required program or licensing rule, and federal and state requirements. For service elements contracted with a predetermined rate, Division funds not used in delivering the service of the required quantity and quality shall be classified as carryover. Carryover of Division administered funds shall be spent for Division services. These funds shall be kept in restricted accounts in the financial records. Funds spent on unallowed costs shall be considered non-compliance and shall be returned to Division.

(6) All travel expenses shall be supported by a system of authorized trip reports, receipts, and/or other documentation. Authorization is indicated by approval of the travel expenditure by the Director (or person with delegated authority) of the service provider.

Stat. Auth.: ORS 179.040 & 413.042 & 430.640
Stats. Implemented: ORS 414.018 & 430.610-430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

**309-013-0170
Audit Process and Reports**

(1) Any person, organization, or agency, including the Division, may request an audit of a community mental health program or any service provider offering a service thereunder or any direct contractor by submitting an audit request in writing to the Division Internal Audit Unit Coordinator. The request shall clearly identify the service provider to be audited, setting forth its name, location, program director, the period for which the audit is requested and the reason for the request.

(2) The Internal Audit Unit Coordinator shall review the request and arrange for scheduling if an audit is considered appropriate. The Internal Audit Unit Coordinator shall notify appropriate Assistant Administrators of the audit schedule.

(3) The Assistant Administrator of the Division for the Office of Finance has the discretion to notify the appropriate community mental health program director of the scheduled audit in advance. The Division retains the right to perform an audit without prior notice to the subject service provider.

(4) Upon completion of the audit, the Internal Audit Unit Coordinator shall prepare a report setting forth the findings, recommendations, and auditee responses where applicable. Audit work papers shall be available showing the details of the audit findings.

Stat. Auth.: ORS 179.040 & 413.042 & 430.640
Stats. Implemented: ORS 414.018 & 430.610-430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

**309-013-0180
Disposition of Audit Findings**

(1) To the extent an audit documents non-allowable expenditures in non-capitated programs, the Division shall recover such funds.

(2) To the extent an audit report evidences non-compliance with applicable program and/or licensing rules, the audit findings may be referred to the Administrator of the Division to assess civil penalties, where applicable, or for other corrective action deemed necessary by the program office.

(3) Notwithstanding any other provisions of these rules, to the extent an audit report reveals non-compliance with Generally Accepted Accounting Principles or these rules, the Division may require corrective action to bring the deficiencies into compliance with state and federal rules and regulations. Non-compliance which results in substantial misrepresentation of financial activities may result in termination of the license and/or contract upon con-

sultation with Division program offices and/or the local mental health authority.

Stat. Auth.: ORS 179.040 & 413.042 & 430.640
Stats. Implemented: ORS 414.018 & 430.610–430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0190

Provider Appeals

(1) A provider may appeal certain decisions affecting the provider by making a written request to the Division Assistant Administrator for the Office of Finance. The request must state whether the provider wants an administrative review, and/or a contested case hearing, as outlined in the OMAP General Rules OAR 410-120-1560, Provider Appeals, through 410-120-1840, Provider Hearings–Role of Hearings Officer. If the subject service provider decides to appeal the audit, it shall set forth in writing the reasons for its appeal within 30 days of receipt of the report.

(2) When the Division seeks to recover funds under these rules, the Division shall negotiate the terms and conditions of repayment with the audited service provider, after consultation with the community mental health program director or the MHO director (if applicable).

Stat. Auth.: ORS 179.040 & 413.042 & 430.640
Stats. Implemented: ORS 414.018 & 430.610–430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0200

Basic Accounting Records

A service provider subject to audit under these rules shall maintain a chart of accounts that defines all items included in determining the cost for each service element. The chart of accounts shall list all revenues and expense accounts. The organization shall have bank deposit records and documentation to verify the source of revenue. Revenue and expense accounts, with related asset, liability, and equity accounts, shall account for all expenditures related to delivery of the service. All basic accounting records shall be retained for at least three years following the expiration of the contract or from the finalization of an audit including any appeal, whichever is later.

Stat. Auth.: ORS 179.040 & 413.042 & 430.640
Stats. Implemented: ORS 414.018 & 430.610–430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0210

Internal Controls

Establishing and maintaining an internal control structure is the responsibility of the service provider. Effective internal controls are considered essential to achieving the proper conduct of business with full accountability for the resources made available. Internal controls shall be implemented and maintained to provide reasonable assurance that:

(1) The provider identifies, assembles, classifies, records, analyzes, and reports its transactions in conformity with Generally Accepted Accounting Principles or appropriate regulatory requirements for preparing financial statements and other required financial reports;

(2) Losses or misappropriations of assets due to errors or irregularities in processing transactions and handling the related assets are prevented or detected;

(3) Noncompliance with applicable federal and state laws and rules and regulations and terms of the contract is prevented or detected;

(4) State and federal funds are reasonably, prudently and economically spent; and

(5) All costs are appropriately allocated among programs, departments, and other benefiting units.

Stat. Auth.: ORS 179.040 & 413.042 & 430.640
Stats. Implemented: ORS 414.018 & 430.610–430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0220

Independent Audit Reports

The Division may, in its discretion, accept an independent audit, in lieu of a Division audit, if it determines the workpapers and procedures of the independent auditor meet Government Auditing Standards (where applicable), Generally Accepted Auditing Standards and other audit standards which may be adopted by the Division.

Stat. Auth.: ORS 179.040 & 413.042 & 430.640
Stats. Implemented: ORS 414.018 & 430.610–430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

DIVISION 14

COMMUNITY MENTAL HEALTH PROGRAMS

309-014-0000

Purpose and Statutory Authority

(1) Purpose. These rules prescribe general administrative standards for Division community mental health and developmental disability services contractors and their component parts.

(2) Statutory Authority. These rules are authorized by ORS 413.042 & 430.640 and carry out the provisions of 430.610 to 430.695.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; MHD 14-1982, f. & ef. 7-7-82, Sections (3) thru (13) Renumbered to 309-014-0005 thru 309-014-0040; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0005

Definitions

As used in these rules:

(1) “Administrator” means the Assistant Director of Addictions and Mental Health Division.

(2) “Client” means a person receiving services under these rules.

(3) “Community Mental Health and Developmental Disability Advisory Committee” means the advisory committee to a local mental health authority.

(4) “Community Mental Health and Developmental Disability Contractor” means an entity which provides or contracts for a distinct service or group of services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated in the community under a contract or a subcontract with the Division.

(5) “Community Mental Health and Developmental Disability Contractor Budget” means the financial plan of projected expenditures and projected revenues for community mental health and developmental disability service elements submitted by the local mental health authority.

(6) “Community Mental Health and Developmental Disability Contractor Plan” means the plan for community mental health and developmental disability service elements submitted by the local mental health authority.

(7) “Community Mental Health and Developmental Disability Program” means an entity that is responsible for planning and delivery of services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse in a specific geographic area of the state under a contract with the Division or a local mental health authority.

(8) “Community Mental Health and Developmental Disability Program Area” means the organization of all services for persons with either mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, or alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under a contract with the Division.

(9) “Community Mental Health and Developmental Disability Program Director” means the director of a community mental

health and developmental disability program which operates or contracts for all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems under the omnibus contract with the Division.

(10) "Developmental Disability Services" means services for people with developmental disabilities as defined by the Division in administrative rule or contract terms.

(11) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(12) "Local Mental Health Authority" means the county court or board of county commissioners of one or more counties who operate a community mental health and developmental disability program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health and developmental disability program, the board of directors of a public or private corporation.

(13) "Local Revenues" means all money, other than state or federal grant or contract funds, expended by a local mental health authority and any of its subcontractors for community mental health and developmental disability services and included in the approved community mental health and developmental disability contractor plan and budget. However, federal funds expended for alcoholism treatment and rehabilitation services provided under ORS 430.345 to 430.380 in accordance with ORS 430.359(3) by community mental health and developmental disability contractors shall be considered local revenues.

(14) "Omnibus Contract" means the Financial Assistance Grant Agreement or contract between the Addictions and Mental Health Division and a local mental health authority for all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated in a specific geographic area.

(15) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services provided by the community mental health and developmental disability contractor.

(16) "Service Element" means a distinct service or group of services for person with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated in the community under a contract with the Addictions and Mental Health Division, or under contract with a local mental health authority.

(17) "Service Provider" means an entity or person that delivers services funded wholly or in part by the Division under a contract with a community mental health and developmental disability program, a local mental authority, or the Division.

(18) "State Institution" means Oregon State Hospital in Portland and Salem, and Eastern Oregon Psychiatric Center and Training Center in Pendleton.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 430.610 – 430.640

Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(3), MHD 14-1982, f. & ef. 7-7-82; MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00 cert. ef. 9-16-00

309-014-0010

Purpose of a Community Mental Health and Developmental Disability Program

The purpose of a community mental health and developmental disability program is to provide a system of appropriate, accessible, coordinated, effective, efficient services to meet the mental health needs of the citizens of the community.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.640

Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(4), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0015

Division Responsibility for Community Addictions and Mental Health

The Division shall assist the local mental health authority in establishing and operating community mental health and developmental disability services and shall integrate such services with other mental health system components in the state by:

(1) Assessing needs for community mental health and developmental disability services in the state.

(2) Identifying priorities among needs and preparing state plans for community mental health and developmental disability services.

(3) Conducting the Division's activities in the least costly and most efficient manner so that delivery of services to the mentally or emotionally disturbed, mentally retarded and developmentally disabled, alcohol abuser, alcoholic, drug abuser and drug-dependent persons shall be effective, coordinated and integrated with other services within the Oregon Health Authority.

(4) Establishing and enforcing minimum standards for community mental health and developmental disability services.

(5) Obtaining resources and contracting with local mental health authorities for the operation of community mental health and developmental disability service.

(6) Subject to the availability of funds, providing public information, program consultation, technical assistance, and training concerning community mental health and developmental disability services.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.640

Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(4) & (7), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0020

Standards for Management of Community Mental Health and Developmental Disability Programs

Each community mental health and developmental disability contractor providing a community mental health and developmental disability program under an omnibus contract with the Division is required to meet the following standards for management:

(1) Community Mental Health and Developmental Disability Program Director:

(a) The community mental health and developmental disability program director shall be a full time employee of the local mental health authority or the public or private corporation operating the community mental health and developmental disability program;

(b) The community mental health and developmental disability program director shall meet the following requirements:

(A) Hold at least a master's degree in a behavioral, social, health science, special education, public administration, or human service administration; and

(B) Have a minimum of five years of experience in human services programs, two of which are in community mental health and developmental disability and two of which are program managerial experience in human services; and

(C) Present references documenting experience, training, and ability to manage a community mental health and developmental disability program.

(c) When the position of community mental health and developmental disability program director becomes vacant, an interim director shall be appointed to serve until a permanent director is appointed.

(2) Program Management for Developmental Disability Services:

(a) Program Manager. The local mental health authority or the public or private corporation operating the community mental health and developmental disability services program shall designate a full-time employee who will, on at least a part-time basis, be responsible for management of developmental disability services.

(b) Program Manager Qualifications. The program manager for developmental disability services shall meet the following qualifications for employment:

(A) Hold at least a bachelor's degree in a behavioral, social, health science, special education, public administration, or human service administration; and have a minimum of four years experience, with at least two of those in developmental disability services, that provided recent experience in program management, fiscal management, and staff supervision.

(B) On an exceptional basis, the county may hire an individual who does not meet these program manager qualifications if the county and the Division have mutually agreed on a training and technical assistance plan which assures that the individual will quickly acquire all needed skills and experience.

(C) When the position of program manager for developmental disability services becomes vacant, an interim program manager shall be appointed to serve until a permanent program manager is appointed. The community mental health and developmental disability services program shall request a variance as provided in these rules if the individual(s) appointed interim program manager do not meet the qualifications and the term of the appointment(s) total more than 180 days.

(c) Management Functions. In addition to other duties as may be assigned in the area of developmental disability services, the community mental health and developmental disability services program shall, at a minimum, assure the following duties are performed:

(A) Develop plans as may be needed to provide a coordinated and efficient use of resources available to serve people with developmental disabilities;

(B) Develop positive and cooperative working relationships with families, advocates, service providers, the Division, and other state and local agencies with an interest in developmental disability services;

(C) Develop programs funded by the Division to encourage pursuit of defined program outcomes and monitor the programs to assure service delivery that is in compliance with related contracts and applicable local, state, and federal requirements;

(D) Assure collection and timely reporting of information as may be needed to conduct business with the Division, including but not limited to information needed to license foster homes, to collect federal funds supporting services, and to investigate complaints related to services or suspected client abuse; and

(E) Develop and assure use of procedures that attempt to resolve disputes and grievances involving persons or organizations that are associated with developmental disability services.

(d) Management Plan. The community mental health and developmental disability services program shall maintain a plan assigning responsibility for the management functions and duties described in this section. The community mental health and developmental disability services program shall assure that the functions and duties are assigned to people who have the knowledge and experience necessary to perform them.

(3) Community Mental Health and Developmental Disability Advisory Committee. Each community mental health and developmental disability program shall have a mental health and developmental disability advisory committee appointed by the local mental health authority:

(a) The committee shall meet at least quarterly;

(b) The membership of the committee shall be broadly representative of the community, with a balance of age, sex, ethnic, socioeconomic, geographic, professional and consumer interests represented. Membership shall include advocates for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems;

(c) The Community Mental Health and Developmental Disability Advisory Committee shall advise the local mental health authority and the community mental health and developmental disability program director on community needs and priorities for services and shall assist in planning and in review and evaluation of services.

(4) Organization:

(a) Each community mental health and developmental disability program shall have an up-to-date organizational chart showing the line of authority and responsibility from the local mental health authority to the community mental health and developmental disability program director and to each of the components of the community mental health and developmental disability program;

(b) Contracts:

(A) For all components of the community mental health and developmental disability program operated by agencies other than the local mental health authority, there shall be a contract between the local mental health authority and the service provider specifying the authorities and responsibilities of each party and conforming to the requirements of any Division rule or contract requirement pertaining to operation and delivery of services.

(B) In keeping with the principles of family support expressed in ORS 417.342, and notwithstanding 430.670(2) or 291.047(3), an entity operating a community mental health and developmental disability program may purchase services for an individual from a service provider without first providing an opportunity for competition among other service providers if the service provider is selected by the individual, the individual's family or the individual's guardian, as long as the service provider has been approved by the Division to provide such service.

(C) Limit on contract requirements. When a community mental health and developmental disability program contracts with a public agency or private corporation for delivery of developmental disability services, the community mental health and developmental disability program shall include in the contract only terms that are substantially similar to model contract terms established by the Division. The community mental health and developmental disability program may not add contractual requirements, including qualifications for contractor selection, that are nonessential to the service element(s) being provided under the contract. The community mental health and developmental disability program shall specify in contracts with service providers that disputes, which arise from these limitations, shall be resolved according to procedures contained in these rules. For purposes of this section, the following definitions apply:

(i) "Model contract terms established by the Division" means all applicable material terms and conditions of the omnibus contract, as modified to appropriately reflect a contractual relationship between the service provider and community mental health and developmental disability program, and any other requirements approved by the Division as local options under procedures established in these rules.

(ii) "Substantially similar to model contract terms" means that the terms developed by the community mental health and developmental disability program and the model contract terms require the service provider to engage in approximately the same type activity and expend approximately the same resources to achieve compliance.

(iii) "Nonessential to the service element(s) being provided" means requirements that are not substantially similar to model contract terms developed by the Division.

(D) Local Option. The community mental health and developmental disability program may, as a local option, impose on a public agency or private corporation delivering developmental disability services under a contract with the community mental health and developmental disability program, a requirement that is in addition to or different from requirements specified in the omnibus contract if all of the following conditions are met:

(i) The community mental health and developmental disability program has provided the affected contractors with the text of the proposed local option as it would appear in their contract, including the date upon which the local option would become effective, and a complete written description of how the local option would improve client independence, productivity, or integration into the community, or how it would improve protection of client health, safety, or rights;

(ii) The community mental health and developmental disability program has sought input from the affected contractors concerning ways the proposed local option will impact client services;

(iii) The community mental health and developmental disability program, with assistance from the affected contractors, has assessed the impact on the operations and financial status of the contractors if the local option is imposed;

(iv) The community mental health and developmental disability program has sent a written request for approval of the proposed local option to the Division's Assistant Administrator that includes:

(I) A copy of the information provided to the affected contractors;

(II) A copy of any written comments and a complete summary of oral comments received from the affected contractors concerning the impact of the proposed local option; and

(III) The text of the proposed local option as it would appear in contracts with service providers, including the proposed date upon which the requirement would become effective.

(v) The Division has notified the community mental health and developmental disability program that the new requirement is approved as a local option for that program; and

(vi) The community mental health and developmental disability program has advised the affected contractors of their right and afforded them an opportunity to request mediation as provided in these rules before the local option is imposed.

(E) Notice of Appeal.

(i) If a service provider believes that the contract offered by the community mental health and developmental disability program contains terms or conditions that are not substantially similar to those established by the Division in the model contract, the service provider may appeal imposition of the disputed terms or conditions by sending a written notice of appeal to the Division's Assistant Administrator within 30 calendar days after the effective date of the contract requirement. The notice of appeal shall include:

(I) A copy of the contract and any pertinent contract amendments;

(II) Identification of the specific term(s) that are in dispute; and

(III) A complete written explanation of the dissimilarity between terms.

(ii) The service provider shall send a copy of its notice of appeal to the community mental health and developmental disability program. Upon receipt of this notice, the community mental health and developmental disability program shall suspend enforcement of compliance with any contract requirement under appeal by the contractor until the appeal process is concluded.

(F) Appeal Process. The Assistant Administrator or designee, shall offer to meet with both to mediate a solution. If a solution can not be mediated, the Assistant Administrator shall declare an impasse through written notification to all parties and immediately appoint a panel to consider arguments from both parties. The panel shall include, at a minimum, a representative from the Division, a representative from another community mental health and developmental disability program, and a representative from another service provider organization. The panel shall meet with the parties, consider their respective arguments, and send written recommendations to the Administrator of the Division within 45 business days after an impasse was declared. If an appeal requiring panel consideration has been received from more than one contractor, the Division may organize materials and discussion in any manner it deems necessary, including combining appeals from multiple contractors, to assist the panel in understanding the issues and operating efficiently. The Administrator shall notify all parties of his/her decision within 15 business days after receipt of the panel's recommendations. The decision of the Administrator is final. The community mental health and developmental disability program shall take immediate action to amend contracts as needed to comply with the Administrator's decision.

(G) Expedited Appeal Process. The community mental health and developmental disability program or the contractor may

request an expedited appeal process that provides a temporary resolution, if it can be shown that the time needed to follow procedures to reach a final resolution would cause imminent risk of serious harm to individuals or organizations. The request shall be made in writing to the Division's Assistant Administrator. It shall describe the potential harm and level of risk that will be incurred by following the appeal process. The Division shall notify all parties of its decision to approve an expedited appeal process within two business days. If an expedited process is approved, the Administrator shall notify all parties of his/her decision concerning the dispute within three additional business days. The Administrator's decision resulting from an expedited appeal process shall be binding, but temporary, pending completion of the appeal process. All parties shall act according to the Administrator's temporary decision until notified of a final decision.

(H) Exception to limit on contract requirements for facilities. The community mental health and developmental disability program may add contract requirements that the community mental health and developmental disability program considers necessary to ensure the siting and maintenance of residential facilities in which client care is provided. These requirements shall be consistent with all applicable state and federal laws and regulations related to housing.

(5) Needs Assessment and Planning. The community mental health and developmental disability program shall assess local needs for services to persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, and shall plan for meeting those needs within the constraints of resources available. The local mental health authority shall review and approve the plan before it is submitted to the Division.

(6) Monitoring. The local mental health authority shall monitor all community mental health and developmental disability service elements to assure that:

(a) Service elements are provided as specified in the contract with the Division; and

(b) Service elements are in compliance with these rules and other applicable Division administrative rules.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.640

Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5),

(6), (9), (10) & (12), MHD 14-1982, f. & ef. 7-7-82; MHD 8-2000(Temp), f. 3-

20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-

00

309-014-0025

Standards for Management of All Community Mental Health and Developmental Disability Program Areas

Each community mental health and developmental disability contractor providing a community mental health and developmental disability program area under a contract with the Division is required to meet the following standards for management:

(1) Organizations:

(a) Each community mental health and developmental disability program area contractor shall have an up-to-date organization chart showing the line of authority and responsibility from the local mental health authority to the community mental health and developmental disability program area director and to each of the components of the community mental health and developmental disability program area contractor;

(b) For all components of the community mental health and developmental disability program area contractor operated by agencies other than the local mental health authority, there shall be a contract between the local mental health authority and the sub-contract agency specifying the authorities and responsibilities of each party and conforming to the requirements of any Division rule pertaining to contracts.

(2) Needs Assessment and Planning: When the Division contracts for a community mental health and developmental disability program area, the contractor shall assess local needs for services to persons within that program area, and shall plan to effectively and efficiently meet those needs within the constraints of available

resources. The local mental health authority shall review and approve the plan before it is submitted to the Division.

(3) Monitoring: The local mental health authority shall monitor all community mental health and developmental disability service elements within the program area to assure that:

(a) Service elements are provided as specified in the contract with the Division; and

(b) Service elements are in compliance with these rules and other applicable Division administrative rules.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.640

Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5) & (6), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0030

Standards for Management of All Service Elements

All contractors providing community mental health and developmental disability service elements under a contract with the Division are required to meet the following standards for management:

(1) Fee Policy. For all community mental health and developmental disability service elements, except local administration and those provided by a public education district, the agency providing the service element shall:

(a) Determine the cost of each type of service element provided;

(b) Establish a schedule of fees for service elements based on the costs of the service elements, adjusted on the basis of the client's ability to pay;

(c) At the time the service elements is initiated, inform the client of the agency fee policy, the agency fee schedules, and the fee rate to be collected from the client in the event that third party payments do not cover the cost of the client's service elements;

(d) Billings for Title XIX funds shall in no case exceed the customary charges to private clients for any like item or service charged by the service element; and

(e) Charge fees for service elements as follows:

(A) Except where expressly prohibited by federal law or regulation, when third party payments do not cover the full fee for the service elements provided, charge the client or those legally responsible for the cost of the client's care, in an amount which is the lesser of:

(i) The balance of the fee charged to but not paid by the third party payor(s); or

(ii) A fee adjusted on the basis of the client's ability to pay.

(B) Charge any third party payor in the amount of the full fees for the service elements provided. Should the sum of any third party payments and client payments exceed the fee, a refund of the excess payment shall be given to the client.

(2) Quality Assurance. Each provider of community mental health and developmental disability service elements shall implement and maintain a quality assurance program.

(3) Internal Management. Each provider of community mental health and developmental disability service elements funded by the Division shall meet the following internal management standards:

(a) There shall be an up-to-date organization chart showing lines of authority and responsibility for the services within the agency;

(b) There shall be up-to-date, written position descriptions for all staff providing community mental health and developmental disability services;

(c) If four or more staff provide community mental health and developmental disability services, there shall be written personnel policies and procedures concerning:

(A) Recruitment and termination of employees;

(B) Compensation plan;

(C) Performance appraisals, promotions and merit increases, and staff development;

(D) Employee benefits; and

(E) Grievance procedures.

(d) Each employee providing community mental health and developmental disability services shall have the opportunity for in-service training with pay;

(e) There shall be up-to-date accounting records for each mental health service element accurately reflecting all revenue by source, all expenses by object of expense, and all assets, liabilities, and equities, consistent with generally accepted accounting principles and conforming to the requirements of OAR 309-013-0120 to 309-013-0220;

(f) There shall be written statements of policy and procedure as are necessary and useful to assure compliance with any Division administrative rule pertaining to fraud and embezzlement and abuse of patients, residents, and clients; and

(g) There shall be such other written statements of policy and procedure as are necessary and useful to enable the agency to accomplish its mental health service objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.640

Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5) & (6), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0035

General Standards for Delivery of Community Mental Health and Developmental Disability Service Elements

All community mental health and developmental disability contractors providing community mental health and developmental disability service elements under a contract with the Division are required to meet the following general standards for delivery of community mental health and developmental disability service elements:

(1) Eligibility for Service:

(a) In accordance with the Civil Rights Act of 1964, community mental health and developmental disability services shall not be denied any person on the basis of race, color, creed, sex, national origin or duration of residence. Community mental health and developmental disability contractors shall also comply with Section 504 of the Rehabilitation Act of 1973 as implemented by 45 CFR 84.4, which states in part, "No qualified person shall, on the basis of handicap, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance";

(b) No person shall be denied services or be discriminated against on the basis of age or diagnostic or disability category unless predetermined clinical or program criteria for service restrict the service to specific age or diagnostic groups or disability category;

(c) No person shall be denied community mental health and developmental disability services based on ability to pay;

(d) Any person eligible for community mental health and developmental disability services provided by one agency shall also be eligible for other community mental health and developmental disability services provided by any other agency, unless admission to the service is subject to diagnostic or disability category or age restrictions based on predetermined criteria.

(2) Continuity and Coordination:

(a) Each agency providing community mental health and developmental disability services shall make pertinent clinical and financial eligibility information concerning a client of the agency readily available to other community mental health and developmental disability service agencies responsible for the client's care, consistent with state statutes and federal laws and regulations concerning confidentiality;

(b) In the event that a person seeking or receiving services from one community mental health and developmental disability contractor requires services not provided by the contractor, the person shall be referred to an available appropriate agency which can provide the needed services;

(c) Planning and implementation of service for clients of the community mental health and developmental disability contractor

shall be coordinated between components of the community mental health and developmental disability contractor, and other human service agencies, and between components of the community mental health and developmental disability contractor and state institutions. Each community mental health and developmental disability program or community mental health and developmental disability program area contractor shall maintain a written agreement with state institutions serving the county. The agreement shall include, but need not be limited to:

(A) The procedures to be followed to assure necessary communication between the state institution and the community mental health and developmental disability program or community mental health and developmental disability program area contractor when a client is admitted to, and discharged from, the state institution and during the period of care, treatment or training;

(B) The type of client information which will be shared by the community mental health and developmental disability program or community mental health developmental disability program area contractor and the state institution, the manner in which the information will be transmitted and the times when such information will be provided;

(C) The names of the staff members from the state institution and the community mental health and developmental disability program, or program area contractor, who will have principal responsibility for liaison and implementation of the agreement; and

(D) Each agreement between the state institution and a community mental health and developmental disability program, or program area contractor, shall be reviewed and renewed at least once a year.

(3) Service Records. A record shall be maintained for each client who receives direct treatment training and/or care services. The record shall contain client identification, problem assessment, treatment, training and/or care plan, medical information when appropriate; and progress notes.

(4) Retention of Records. Records shall be retained in accordance with OAR 166-005-0000 through 166-040-0010 (State Archivist). Financial records, supporting documents, statistical records, and all other records (except client records) shall be retained for a minimum of three years after the close of the contract period, or until audited. Client records shall be kept for a minimum of seven years.

(5) Confidentiality of Client Records. Client records shall be kept confidential in accordance with ORS 179.505, 45 CFR 205.50 and 42 CFR Part 2, any Division administrative rule pertaining to client records, and the most current edition of the Division Handbook on Confidentiality.

(6) Client Rights. Each agency providing any community mental health and developmental disability service shall have written procedures to assure:

(a) Protection of client privacy and dignity;

(b) Confidentiality of records consistent with state statutes and federal statutes and regulations;

(c) Involvement of the client in planning the service through the provision of information, presented in general terms, which explains the following:

(A) The training or treatment to be undertaken;

(B) Alternative training or treatment methods available, if any; and

(C) Risks that may be involved in the training or treatment, if any.

(d) Client's right to refuse service unless otherwise ordered by a court; and

(e) Client is provided with information, presented in general terms, concerning the agency fee policies.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.640

Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(8) & (11), MHD 14-1982, f. & ef. 7-7-82 ; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0037

Dispute Resolution

(1) The community mental health and developmental disability program shall adopt a dispute resolution policy that pertains to disputes that may arise from contracts with service providers that deliver services funded by the Division for the community mental health and developmental disability program. Procedures implementing this policy shall be included in the contract with any such service provider.

(2) When a dispute exists between a county or a community mental health and developmental disability program and a service provider regarding the terms of their contract or the interpretation of an administrative rule of the Division relating to Division programs under ORS Chapter 430, and local dispute resolution efforts have been unsuccessful, either party may request assistance from the Division in mediating the dispute.

(a) Procedure. The parties shall demonstrate a spirit of cooperation, mutual respect, and good faith in all aspects of the mediation process. Mediation shall be conducted as follows:

(A) Request. The party requesting mediation shall send a written request to the Division administrator, the community mental health and developmental disability program director, and the provider agency director, unless other persons are named as official contact persons in the specific rule or contract under dispute. The request shall describe the nature of the dispute and identify the specific rule or contract provisions that are central to the dispute.

(B) Arrangements. The division administrator, or designee, shall arrange the first meeting of the parties at the earliest possible date. The agenda for the first meeting should include:

(i) Consideration of the need for services of an outside mediator. If such services are desired, agreement should be made on arrangements for obtaining these services.

(ii) Development of rules and procedures that will be followed by all parties during the mediation;

(iii) Agreement on a date by which mediation will be completed, unless extended by mutual agreement.

(C) Cost. Unless otherwise agreed to by all parties:

(i) Each party shall be responsible for the compensation and expenses of their own employees and representatives; and

(ii) Costs that benefit the group, such as services of a mediator, rental of meeting space, purchase of snack food and beverage, etc. shall be shared equally by all parties.

(b) Final Report. A written statement documenting the outcome of the mediation shall be prepared. This statement shall consist of a brief written statement signed by all parties or separate statements from each party declaring their position on the dispute at the conclusion of the mediation process. In the absence of written statements from other parties, the Division representative shall prepare the final report. The final report on each mediation shall be retained on file at the Division. The Division will, from time to time, or as requested by the legislature or others, prepare summary reports that describe the success of mediation in resolving disputes.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.640

Hist.: MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0040

Variations

A variance from these rules may be granted to a community mental health and developmental disability program in the following manner:

(1) An agency requesting a variance shall submit, in writing, through the community mental health and developmental disability program to the appropriate program or administrative office:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the local mental health authority indicating its support of the proposed variance.

(2) The assistant administrator of the program or administrative office shall approve or deny the request for variance.

(3) The program or administrative office shall notify the community mental health and developmental disability program of the decision. The community mental health and developmental disability program will forward the decision and reasons therefore to the program requesting the variance. This notice shall be given the program within 30 days of receipt of the request by the program or administrative office with a copy to other relevant sections of the Division.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Division, whose decision shall be final.

(5) A variance granted by the Division shall be attached to, and become part, of the contract for that year.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(13), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0300

Purpose and Scope

These rules relate to the implementation of Chapter 418, Oregon Laws 2011 sections 13 through 20. The scope is limited to the creation of the Central Health Council and the implementation of the Central Oregon Health Improvement Plan.

Stat. Auth.: ORS 413.042
Stats. Implemented: SB 204
Hist.: MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12; MHS 3-2012, f. & cert. ef. 2-23-12

309-014-0310

Definitions

- (1) "Authority" means the Oregon Health Authority (OHA).
- (2) "Central Oregon Health Council" (COHC) means a council which shall, as a minimum, conduct a regional health assessment and adopt a regional health improvement plan to serve as a strategic population health and health care system service plan for the region served by the council.
- (3) "Commission" means the Commission on Children and Families.
- (4) "Council" means the Central Oregon Health Council (COHC).
- (5) "Plan" means the Regional Health Improvement Plan.

Stat. Auth.: ORS 413.042
Stats. Implemented: SB 204
Hist.: MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12; MHS 3-2012, f. & cert. ef. 2-23-12

309-014-0320

Regional Health Improvement Plan

(1) The Regional Health Improvement Plan (RHIP) submitted by the Central Oregon Health Council, defined in OAR 309-014-0300, must include, but need not be limited to the following:

- (a) Federally required components;
- (b) Health policy;
- (c) System design;
- (d) Outcome and quality improvement;
- (e) Integration of service delivery and
- (f) Workforce development.

(2) Any additional requirements to the RHIP will be agreed upon in advance by the Council, the Authority and the Commission.

Stat. Auth.: ORS 413.042
Stats. Implemented: SB 204
Hist.: MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12; MHS 3-2012, f. & cert. ef. 2-23-12

309-014-0330

Central Oregon Health Council

(1) The council may not convene until the governing body of each county adopts a resolution signifying the body's intention to do so.

(2) Subsequent to the formation of the council, a county that is adjacent to Crook, Deschutes or Jefferson County may join the council if:

(a) The governing body of the county seeking to join the council adopts a resolution signifying the body's intention to include a portion of that county in the region served by the council;

(b) The portion of the county to be included in the region is part of a natural health care referral pattern with the other counties on the council; and

(c) The authority and the council approve.

(3) The COHC shall consist of no more than 11 members, including:

(a) A formative council consisting of:

(A) One member each from the governing bodies of Crook, Deschutes and Jefferson Counties, appointed by each body;

(B) The chief executive officer, or a designee of the chief executive officer, of the health care system serving the region; and

(C) The chief executive officer, or a designee of the chief executive officer, of the Medicaid contractor serving the region; and

(b) At least three members appointed by the formative council established under paragraph (3)(a)(A) of this rule. Members appointed under this section shall be representatives of:

- (A) Consumers of physical and behavioral health services;
- (B) Health care professionals;
- (C) School districts or educational service districts;
- (D) The business community; or
- (E) A member from the governing body of each county that joins the council defined in (3)(a)(A) of this rule.

(4) The term of office of the members of the council is four years.

(5) A majority of the members of the council constitutes a quorum for the transaction of business.

(6) The council shall elect a member of the council to serve as the chairperson.

(7) If there is a vacancy for any cause, the appointing authority shall make an appointment to the vacated position to become effective immediately.

(8) The council may enter into necessary contracts, apply for and receive grants, hold and dispose of property and take other actions necessary to carry out the activities, services and responsibilities assumed by the council.

(9) The council may adopt rules necessary for the operation of the council.

Stat. Auth.: ORS 413.042
Stats. Implemented: SB 204
Hist.: MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12; MHS 3-2012, f. & cert. ef. 2-23-12

309-014-0340

Central Oregon Health Improvement Plan (COHIP)

(1) The COHC shall develop a health improvement plan as detailed in OAR 309-017-0030.

(2) The COHIP will replace all prior plans required by the Authority in ORS 430.630, 430.640, 431.385 and 624.510 and plans required by the State Commission on Children and Families under ORS 417.705 through 417.801.

(3) The COHC will submit the plan no later than March 1, 2012 to the Authority.

(4) The Authority shall have 45 days from the date the plan is submitted to review the plan and return it to the Council either approved or with suggested modifications.

(a) If modifications are suggested the Council will have 45 days to respond to the suggestions and resubmit the plan.

(b) The Authority will have a final 30 days to review the plan.

(5) The plan is effective July 1, 2012.

(6) New plans must be submitted every four years if the sunset in the enabling legislation is removed by the Legislative Assembly.

Stat. Auth.: ORS 413.042
Stats. Implemented: SB 204
Hist.: MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12; MHS 3-2012, f. & cert. ef. 2-23-12

DIVISION 15

MEDICAID PAYMENT FOR PSYCHIATRIC HOSPITAL INPATIENT SERVICES

309-015-0000

Purpose and Statutory Authority

(1) Purpose. These rules prescribe the eligibility criteria, methods, and standards for payments to psychiatric hospitals through the Division of Medical Assistance Programs, Oregon Health Authority. The rules apply to provision of psychiatric hospital inpatient services for persons eligible for medical assistance under Medicaid (Title XIX of the Social Security Act).

(2) Statutory Authority. These rules are authorized by ORS 413.042 and carry out the provisions of ORS 414.025, 414.065, and 414.085 and Title XIX of the Social Security Act and 42 CFR 441, Subparts C and D.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 12-1985(Temp), f. & ef. 7-1-85; MHD 7-1987, f. & ef. 12-30-87;

MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0005

Definitions

As used in these rules:

(1) "Active Treatment" means implementation of a professionally developed and supervised plan of care that is in effect within 14 days of admission and designed to achieve the patient's discharge at the earliest possible time. Custodial care is not active treatment.

(2) "Actual Costs" means all legitimate Medicaid expenditures. Since Oregon's Addictions and Mental Health Division utilizes Medicare cost finding principles, actual costs will be the same as "Medicaid Allowable Costs" as defined in this rule.

(3) "Allowable Costs" means the costs applicable to the provision of psychiatric inpatient services as described in OAR 309-015-0050(3). They are derived using the Medicare cost finding principles located in the **Medicare Provide Reimbursement Manual**.

(4) "Annual Cost Report" means a financial report submitted to the Medicare/Medicaid Fiscal Intermediary by a hospital, on forms provided by the Fiscal Intermediary. This report details the actual revenues and expenses of the hospital during the latest fiscal period.

(5) "Base Year" means July 1, 1981 through June 30, 1982.

(6) "Disproportionate Share Adjusted Medicaid Rate" (DSR) means the weighted average Medicaid per diem rate (interim, year-end settlement or final settlement) for disproportionate share hospitals. This rate does not include the disproportionate share payment of uncompensated costs of participating hospital programs as provided in these rules.

(7) "Disproportionate Share Costs" means costs that are reimbursable under federal disproportionate share statutes and regulations. These costs are limited to costs of participating hospital programs which have not already been reimbursed by Medicare, Medicaid, insurance, or the patient's own resources.

(8) "Disproportionate Share Hospital" means a psychiatric hospital which has a low income utilization rate exceeding 25 percent as described in OAR 309-015-0035(5).

(9) "Disproportionate Share Payment" means the payment made quarterly to reimburse participating hospital programs for disproportionate share costs. This payment is subject to recalculation at the time of each year-end or final settlement payment.

(10) "Distinct Program" means a specialized inpatient psychiatric treatment program with unique admission standards approved by the Division. If a participating psychiatric hospital has a specialized program based upon patient age or medical condition, contains 50 or more beds, has a nursing staff specifically assigned to the program which has experience or training in working with the specialized population, and has record keeping systems adequate to separately account for expenditures and revenue to that program

relative to the entire hospital, the Division may approve it as a distinct program.

(11) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(12) "Fiscal Intermediary" means:

(a) Blue Cross of Oregon for Medicare, Parts A and B; and

(b) Division for Medicaid services provided under the provisions of this rule;

(c) The Division's Assistant Administrator for Administrative Services, is the designated Fiscal Intermediary.

(13) "Inpatient Psychiatric Services" means active treatment services provided under the direction of a licensed physician by a participating psychiatric hospital.

(14) "Interim Per Diem Rate" means the daily rate established with and paid to each provider for the agreement period during which reimbursable services are to be provided.

(15) "Low Income Utilization Rate" means the sum of the ratio of a hospital's Medicaid revenues (plus governmental subsidies) to total revenue added to the ratio of a hospital's proportion of charity care expenditures (less governmental subsidies) to total inpatient psychiatric services charges (as outlined in OAR 309-015-0035(5)).

(16) "Maximum Allowable Rate" means the statewide average per diem cost for services as derived in accordance with OAR 309-015-0020 and 309-015-0021.

(17) "Medicaid" means Title XIX of the Social Security Act.

(18) "Medicaid Allowable Costs" means that portion of total costs determined to be eligible for Medicaid reimbursement. Medicaid allowable costs are determined based on the amount of allowable cost for inpatient services by making the following calculations:

(a) For all providers, determine the reasonable cost of covered services furnished by multiplying the ratio of Medicaid patient days to total patient days by total allowable inpatient costs;

(b) For proprietary providers, determine the allowable return on equity capital invested and used for the provision of patient care by following the general rule outlined in 42 CFR 413.157(b);

(c) Adding the results of the calculations in subsections (a) and (b) of this section to establish the full Medicaid allowable cost.

(19) "Medicaid Intermediary" for the purpose of services provided under this rule, means the Assistant Administrator for Administrative Services, Addictions and Mental Health Division.

(20) "Medicaid Patient Days" means the accumulated total number of days, including therapeutic leave days, during which psychiatric inpatient services were provided to Medicaid eligible patients during a cost reporting period. The Fiscal Intermediary shall determine the total number of Medicaid patient days on the basis of dates of service per patient by provider and fiscal period.

(21) "Medicaid Inpatient Utilization Rate" means the following fraction (expressed as a percentage) for a hospital:

(a) "Numerator": The hospital's number of inpatient days attributable to patients who (for such days) were eligible for Title XIX medical assistance under the state Medicaid plan and for whom the Division of Medical Assistance Programs made payment during the fiscal period;

(b) "Denominator": The total number of the hospital's inpatient days for the same period.

(22) "Medicare Market Basket Percentage Increase" means the annual allowable increase factor for a standard array of hospital services nationwide as published annually by the Health Care Financing Administration. The percentage is a component of the "Target Rate Percentage Increase" as defined in section (29) of this rule.

(23) "Non-Allowable Costs" means any costs excluded under the provisions of state and federal statutes, regulations, and administrative rules.

(24) "Participating Psychiatric Hospital" means those portions of a licensed psychiatric hospital certified to provide services to Medicaid patients.

(25) "Patient Eligibility" means persons eligible for medical assistance under Medicaid who meet the criteria for admission to

psychiatric hospital inpatient services as defined in these rules and OAR 309-031-0200 through 309-031-0255.

(26) "Resident in the Hospital" means a patient who is in the facility at least 12 hours of each day, including the hours of sleep. The day of admission is exempt from this 12 hour rule; however, to be counted for residence purposes, the day of admission must extend through midnight (2,400 hours). The day of discharge is not counted.

(27) "Sanction" means:

(a) Termination of contract with the Division to provide psychiatric hospital services for Medicaid eligible patients;

(b) Suspension of contract with the Division to provide psychiatric hospital services for Medicaid eligible patients; or

(c) Suspension or withholding of payments to a provider. (See OAR 309-015-0052 for further information.)

(28) "Separate Cost Entity" means an entity of a hospital for which Medicare has approved the submission of a separate cost report.

(29) "Target Rate Percentage Increase" means the annual allowable increase factor applied to the previous year's maximum allowable rate for psychiatric hospitals and hospital units excluded from the prospective payment system. This percentage includes the Medicare market basket percentage increase as a component and is published annually by the Health Care Financing Administration.

(30) "Therapeutic Leave Days" means a planned and medically authorized period of absence from the hospital not exceeding 72 hours in seven consecutive days.

(31) "Total Patient Days" means the accumulated total number of days, excluding non-Medicaid therapeutic leave days, during which psychiatric inpatient services were provided to patients during a cost reporting period. The fiscal intermediary shall determine the total number of patient days on the basis of dates of service per patient by provider and fiscal period.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0007

General Conditions of Eligibility and Treatment

In order for payment to be made by the Division, the following conditions must be met:

(1) Medicaid-eligible age. The patient must be eligible for Medicaid benefits, be aged 65 or over, aged 20 or under, or aged 21 and receiving services at the time of reaching age 21.

(2) Written plan of care. A professionally developed written plan of care for each patient will describe treatment objectives and prescribe an integrated program of appropriate therapy activities and experiences designed to improve the patient's condition to the extent that inpatient care is no longer necessary.

(3) Unemancipated minor consultation. If the patient is under 18 years of age and not emancipated, the facility shall consult with the parent(s), legal guardian or others into whose care or custody the person will be released following discharge. The consultation shall be documented in the hospital records.

(4) Conformance with these rules. The Division has determined that admission and care of the patient who is eligible for Medicaid benefits is in accordance with these rules and regulations as evidenced by the hospital record.

(5) Service provider requirements. The service provider must meet all requirements for participation under OAR 309-015-0010.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0010

Conditions of Service Provider Participation

(1) Medicaid certification. A service provider must be certified by the responsible state or federal authority as meeting federal Medicaid certification requirements for psychiatric hospital inpatient services.

(2) Written agreement with the Division. A service provider must provide medically prescribed psychiatric hospital inpatient services to patients eligible for Medicaid benefits under terms of a written agreement with the Division. The agreement must assure that the psychiatric hospital and the services provided comply with all applicable state and federal requirements. No billing for Medicaid payment will be paid until a service provider has fully executed a written agreement with the Division.

(3) Legislative compliance. A service provider must be in compliance with:

(a) Title VI of the Civil Rights Act of 1964;

(b) Section 504 of the Rehabilitation Act of 1973;

(c) The Age Discrimination Act of 1975;

(d) The Americans with Disabilities Act of 1990; and

(e) Any other applicable federal and state laws.

(4) Medicaid vendor number. A service provider must request a vendor number from the Division. No billing for Medicaid payment will be paid until a service provider has secured a Medicaid vendor number.

(5) Patient admission. A service provider must obtain approval for the admission of patients to the psychiatric hospital as required by Addictions and Mental Health Division's OARs 309-031-0200 through 309-031-0255 (Admission and Discharge of Mentally Ill Persons).

(6) Clinical records. A service provider must maintain clinical records which are adequate to document the need for psychiatric hospital inpatient services, and the specific services provided, including mental health assessment, diagnosis, and treatment plans.

(7) Fiscal records. A service provider must maintain fiscal records in accordance with generally accepted accounting principles.

(8) Patient funds. A service provider must provide an accounting for any funds accepted from the patient for safekeeping. Such accounts will be available for inspection by personnel designated by the Division.

(9) Records review. A service provider must maintain the availability of financial and treatment records for review without notice by authorized personnel of the Medicaid Intermediary and of the United States Department of Health and Human Services during normal business hours at the location of its licensed psychiatric hospital.

(10) Reimbursement for services. A service provider must accept payment from the Division through the Division of Medical Assistance Programs as full and total reimbursement for the Medicaid services provided.

(11) Annual cost reports. A service provider must submit annually to the Division a Medicaid cost report accompanied by a copy of the provider's Medicare cost report.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90

309-015-0020

Establishing the Base Year and the Initial Maximum Allowable Rate

(1) Base year. In order to establish a base year rate, the Medicaid Intermediary used cost statements which overlapped the base period (July 1, 1981 through June 30, 1982) for all Oregon hospitals who were either:

(a) Licensed as psychiatric hospitals on the effective date of these rules (10-1-83) and in operation during the base period; or

(b) Were applicants for Joint Commission on Accreditation of Hospitals (JCAH) accreditation as a psychiatric hospital on the first effective date of these rules and had operated as a licensed hospital during the base period.

(2) Reporting period adjustments. If a psychiatric hospital's cost report was for a period either longer or shorter than 12 months, the Medicaid allowable costs were reduced or increased, as appropriate, by multiplying the total allowable costs by the ratio that 12

months bore to the number of months in the hospital's report period. This procedure resulted in a prorated 12-month cost projection for use in establishing the statewide average per diem rate for the base period.

(3) Inflation factor adjustments. If a psychiatric hospital had a fiscal period other than the base period, the hospital's Medicaid allowable costs were adjusted by applying the relevant inflation factors from the Medicare market basket index so that the Medicaid costs corresponded to the base period. The inflation factors were applied to the interval between the mid-point of the hospital's fiscal period and the mid-point of the base period. The number of Medicaid patient days in the hospital's fiscal period were used as the number of days in the base period.

(4) Rate calculation. The total Medicaid allowable costs from all hospitals included in the base period divided by the total number of Medicaid patient days from all hospitals included in the base period yielded the statewide average per diem cost (maximum allowable rate) for the base period.

Stat. Auth.: ORS 413.042
 Stats. Implemented: ORS 414.025 & 414.065
 Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 6-1989, f. & cert. ef. 11-17-89

**309-015-0021
 Establishing the Maximum Allowable Rate for Years Following the Base Period**

(1) Base rate usage. The statewide average per diem cost for the base period has been used as the fixed base for determining the maximum allowable reimbursement rate for all fiscal periods following the base period.

(2) Subsequent period rate calculations. The maximum allowable reimbursement rate for each new fiscal period affected by these rules is now calculated by inflating the maximum allowable reimbursement rate for the previous period by the annual Health Care Financing Administration target percentages for PPS — excluded hospitals (as published in the Federal Register). This percentage increase is applied from the mid-point of the previous period to the mid-point of the 12-month period for which the rate is being established.

(3) Hospitals with other fiscal periods. When a psychiatric hospital has a fiscal period other than that used by the State of Oregon, July 1 through June 30, the applicable maximum allowable rate for each month will be the same as the maximum allowable rate in effect that month for hospitals operating under the state fiscal period.

Stat. Auth.: ORS 413.042
 Stats. Implemented: ORS 414.025 & 414.065
 Hist.: MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90

**309-015-0023
 Interim Rate Setting**

Rate establishment process. At least annually, the Medicaid intermediary will establish an interim Medicaid per diem rate for each participating psychiatric hospital, separate cost entity or distinct program within a hospital:

(1) A hospital may request an interim per diem rate or rates. If a review of the hospital's prior year Medicaid cost report (adjusted for inflation, changes in patient populations and programs and other relevant factors) does not justify the requested rate(s), the Medicaid Intermediary may establish different interim rate(s):

(a) Actual expenditures for the most recent fiscal period available will be used to determine salary and wage and total expense distribution for each cost center included in the total expenditures. Any other directly relevant event, such as facility restructuring, will be considered as well;

(b) The Division will apply the proportions from subsection (a) of this section to total anticipated expenditures for the new period to determine salary and wage expense distribution for each cost center during the new period;

(c) The Division will establish and apply capital allowances and other adjustments to total anticipated expenditures for the new period from subsection (b) of this section;

(d) If the hospital has separate cost entities or distinct programs, the hospital will provide estimates to the Division of a weighted average interim rate. The average will be developed by multiplying each proposed interim rate by estimated Medicaid patient days for that rate, summing all of the products, and dividing that sum by the total annual estimated Medicaid patient days for the hospital;

(e) The interim or weighted average interim per diem rate may not exceed the maximum allowable rate unless the hospital meets the criteria for reimbursement above the maximum allowable rate as a disproportionate share hospital (see OAR 309-015-0035(5)). In that case, the interim or average interim Disproportionate Share adjusted Medicaid Rate (DSR) may include estimated costs up to 135 percent of the maximum allowable Medicaid rate except for hospitals meeting criteria set forth in the following paragraph;

(f) If a psychiatric hospital has a low-income rate of 60 percent and also receives 60 percent or more of its service revenue from any combination of the following:

- (A) Public funds, excluding Medicare and Medicaid;
- (B) Bad debts; or
- (C) Free care.

(g) The hospital qualifies to receive disproportionate share payment at a rate based on 100 percent of the costs of uncompensated care during the facility's previous fiscal year, subject to a disproportionate share allotment established for Oregon by the Health Care Financing Administration;

(h) The Division will base quarterly disproportionate share reimbursements on the estimated costs for each facility during the current fiscal year and will review and adjust the reimbursements, after conclusion of the fiscal period, to correspond with actual costs encountered during the period. Total reimbursement from disproportionate share and other sources will not exceed actual costs.

(2) If a hospital does not request an interim rate, the Medicaid Intermediary will establish an interim rate based on the hospital's prior year cost report using the same factors listed in section (1) of this rule.

Stat. Auth.: ORS 413.042
 Stats. Implemented: ORS 414.025 & 414.065
 Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 12-1985(Temp), f. & ef. 7-1-85; MHD 7-1987, f. & ef. 12-30-87, Renumbered from 309-015-0015; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

**309-015-0025
 Retrospective Settlement Rate Setting (Year End and Final)**

(1) Year-end settlement process. The year-end settlement process will be as follows:

(a) Upon receipt of an audited Medicaid cost report from the Supervisor of the Division Audit Section, the Revenue and Rates Manager of the Institutional Revenue Section will determine a retrospective year-end settlement rate for each participating hospital, separate cost entity or distinct program within a hospital on the basis of Division review of actual allowable Medicaid costs reported in the hospital's cost statement for the previous year;

(b) The year-end settlement rate for a non-disproportionate share hospital will be calculated by using the following procedure:

(A) Divide the applicable Title XIX allowable costs for each participating hospital, separate cost entity, or distinct program by the applicable number of Title XIX patient days, including therapeutic leave days;

(B) If the hospital has more than one distinct program, divide the applicable Medicaid allowable costs by the applicable number of Medicaid patient days, including therapeutic leave days for each program. Then determine the weighted average Medicaid settlement rate for the entire hospital. This is accomplished by multiplying each proposed year-end settlement rate by Medicaid patient days for that rate, adding the products together, and dividing the resulting sum by total Medicaid patient days for the hospital;

(C) If the year-end Medicaid settlement rate or the average year-end Medicaid settlement rate from above is less than the max-

imum allowable Medicaid rate for psychiatric hospitals during the current fiscal year, use the lower rate;

(D) If the year-end Medicaid settlement rate or the average year-end settlement rate from above exceeds the maximum allowable rate established for psychiatric hospitals during the current fiscal year, use the maximum allowable rate as the retrospective year-end settlement rate for the hospital.

(c) The year-end settlement rate may exceed the maximum allowable rate if the Division determines the hospital meets the criteria listed in OAR 309-015-0035(5) as a disproportionate share hospital;

(d) In that case, the disproportionate share adjusted year-end settlement rate will be calculated as follows:

(A) Actual costs up to 135 percent of the maximum allowable rate; or

(B) Actual costs up to 100 percent of the cost of uncompensated care during the facility's previous fiscal year, subject to a disproportionate share allotment established yearly by the Health Care Financing Administration, if the psychiatric hospital has a low-income rate of 60 percent and also receives 60 percent or more of its service revenue from any combination of the following:

- (i) Public funds, excluding Medicare and Medicaid;
- (ii) Bad debts; or
- (iii) Free care.

(e) The year-end settlement will be determined by multiplying the settlement "rate" calculated above by the total number of Medicaid patient days, including therapeutic leave days or, for disproportionate share hospitals, multiplying the disproportionate share adjusted rate by the total number of Medicaid patient days, including therapeutic leave days. The result will be compared to the amount of reimbursement paid to the hospital during the fiscal period. If the result favors the hospital, the Division will pay the difference to the hospital. If the result favors the Division, the hospital will pay the difference to the Division. In either case, payments shall be made within 30 days approval of the year-end Medicaid cost report by the Medicaid Intermediary.

(2) Final settlement process. The final settlement process will be as follows:

(a) Upon receipt of the final Medicare Cost Report from the Medicare Intermediary, the hospital provider will prepare the final Medicaid cost report. The Medicaid report will reflect all relevant adjustments made to the Medicare cost report;

(b) Using the final Medicaid cost report developed in subsection (a) of this section, the Division will calculate the final settlement rate and settlement for each participating hospital, separate cost entity or distinct program within a hospital, following the steps outlined in subsections (1)(a) through (d) of this rule.

(3) Upon completion of each settlement, both year-end and final, the Division will review the disproportionate share costs and make any necessary adjustments to quarterly disproportionate share payments. The Division will review all factors relevant to the disproportionate share payments, including actual costs of services, amounts already paid and charges reimbursed from other sources during the time period included in the Medicaid cost settlement.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0030

Billing Requirements

(1) Bill submission time limits. Bills shall be submitted to the Division through the Division of Medical Assistance Programs, on forms designated by the Medicaid Intermediary, as soon as possible after the date service is rendered. Payment shall not be made for services which were provided more than 12 months prior to presentation of the claim unless the hospital shows that the delay was caused by factors outside its control.

(2) Billing charge limits. Billings to the Division shall in no case exceed the customary charges to private patients for any like item or service charged by the hospital.

(3) Customary charge criteria. In determining the customary charges to a private patient for use in billings or calculating interim or settlement rates, the following criteria will be applied:

(a) The private patient billing rate must be for items and services comparable to the items and services included in the rate for Medicaid services;

(b) When private patient rates are based on the number of beds in a room, the Medicaid intermediary considers the lowest room charge as the usual and customary charge for services;

(c) When ancillary charges are made to private patients in addition to a basic charge, the Medicaid Intermediary considers the usual and customary charge to be the lowest basic room charge plus the average ancillary charge for those items included in the Medicaid rate. The average ancillary charge is determined by dividing the ancillary costs by the number of patient days; or

(d) Where charges are based on the classification of the patient (i.e., Medicare, Medicaid and Private), the Medicaid Intermediary considers the usual and customary charge to be the rate for private patients exclusive of ancillary charges.

(4) Payment restrictions. Payment will be made only for those days a patient is actually in residence at the hospital in active treatment or when a patient is on therapeutic leave.

(5) Payment credit. Any payment received by the hospital prior to the submission of an invoice to the Division of Medical Assistance Programs shall be indicated as a credit on the invoice.

(6) Post-payment receipt of funds. Any payments to the provider from any source subsequent to payment by the Division of Medical Assistance Programs shall be reported to that Division on an adjustment form specified by the Division of Medical Assistance Programs, giving full particulars. Failure to report such payments will be considered concealment of material facts and is grounds for recovery and/or sanction (see OAR 309-015-0052).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0035

Payments

(1) Timing. Payments to providers will be made following the month of service, based on the invoice submitted by the provider to the Division of Medical Assistance Programs.

(2) Eligible services. Payments will be made for the provision of active psychiatric inpatient treatment services for persons eligible for such services under Medicaid.

(3) Non-eligible services. If review of a psychiatric hospital's Medicaid patient records by a Professional Standards Review Organization reveals that a patient received an inappropriate level of care, (i.e., less than active treatment), payment will not be allowed under these rules. Any payments to the provider for patients receiving an inappropriate level of care shall be recovered by the Division. Such payments shall be reported to the Division of Medical Assistance Programs on an adjustment form specified by the Division of Medical Assistance Programs. Failure to report such payments will be considered concealment of material facts and is grounds for sanction (see OAR 309-015-0052).

(4) Payment to non-disproportionate share hospitals. The Division shall not pay more in total for psychiatric hospital inpatient services for hospitals which do not serve a disproportionate number of low-income patients with special needs than would be paid under the Medicare principles of reimbursement.

(5) Payment to disproportionate share hospitals. A participating psychiatric hospital may be reimbursed for allowable costs in excess of the maximum rate if it meets the following criteria as described in Section 1923(b)(3) of the Social Security Act: The hospital serves disproportionate numbers of low-income persons; i.e., has a low income utilization rate which exceeds 25 percent using the following formula:

(a) The total Medicaid in-patient revenues paid to the hospital, plus the amount of the cash subsidies received as payment for inpatient services directly from state and local governments in a cost

reporting period, divided by the total amount of revenues of the hospital for in-patient psychiatric services (including the amount of such cash subsidies) in the same cost reporting period. The percentage derived in paragraph (a) of this subsection shall be added to the following percentage:

(b) The total amount of the hospital's charges for in-patient psychiatric services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies for in-patient services received directly from state and local governments described in paragraph (A) of this subsection in the period attributable to in-patient hospital services, divided by the total amount of the hospital's charges for in-patient psychiatric services in the hospital in the same period. The total in-patient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical Assistance under an approved Medicaid State Plan);

(c) The sum of percentages derived in paragraphs (a) and (b) of this subsection shall exceed 25 percent in order to qualify as a disproportionate share hospital; and

(d) The hospital is efficiently and economically operated and is in compliance with treatment and program standards for psychiatric inpatient services as required by the state and federal statutes and regulations.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0040

Accounting and Record Keeping

(1) Records retention. The provider shall maintain, for a period of not less than three years following the date of submission of the annual Medicaid cost report to the Medicaid Intermediary, financial and statistical records of the period covered by such statement which are accurate and in sufficient detail to substantiate the cost data reported. If there are audit issues, the records shall be maintained for three years after the final audit settlement. The records shall be maintained in a condition that can be audited for compliance with generally accepted accounting principles and provisions of these rules. Failure to maintain records in such condition shall result in disallowance of costs.

(2) Documentation of allowable costs. Expenses reported as allowable costs must be adequately documented in the financial records of the provider or they shall be disallowed.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0045

Filing of Annual Medicaid Cost Report

(1) Timing of report. The provider shall file annually with the Medicaid Intermediary, an annual Medicaid cost report covering actual costs based on the latest fiscal period of operation of the facility. If the provider has separate cost entities or distinct programs, an annual Medicaid cost report shall be filed for each entity. A Medicaid cost report will be filed for less than an annual period only when necessitated by facilities terminating their agreement with the Division, or by a change in ownership, or by a change in fiscal period. The provider is to use the same fiscal period for the Medicaid cost report as that used for the Medicare cost report and the federal tax return. The Medicaid cost report is due within 90 days of the end of the normal fiscal period, change of ownership, or withdrawal from the program except when Medicare grants an extension of the Medicare cost report (upon which the Medicaid cost report relies). In that case, the due date for the Medicaid cost report may be extended by the Medicaid Intermediary for the same number of days as the due date for the Medicare cost report.

(2) Contents of report. The annual Medicaid cost report is a uniform cost report containing an itemized list of allowable costs to be used by all providers. It shall report the hospital's actual financial data and be completed in accordance with instructions provided by the Medicaid intermediary.

(3) Application of Medicare principles of reimbursement. Providers filing annual Medicaid cost reports with the Medicaid Intermediary shall apply Medicare principles of reimbursement.

(4) Signature. Each required annual Medicaid cost report shall be signed by the individual who normally signs the provider's federal income tax return or other reports. If the report is prepared by someone other than an employee of the provider, the individual preparing the report shall also sign and indicate his or her status with the provider.

(5) Improperly completed reports. The Medicaid Intermediary shall return improperly completed or incomplete annual Medicaid cost reports to the provider for proper completion. All providers shall return corrected or completed reports to the Division within 30 days or become subject to the same penalty as for failure to submit the cost statement.

(6) Reduction of interim per diem rate — Late reports. If the original submission of the Medicaid cost report is not made within the required 90-day time period or extended period (see section (1) of this rule), the interim per diem rate then in effect will be reduced to 80 percent of the hospital's current interim per diem rate or the rate established from the last audited or desk reviewed cost statement, whichever is lower. This rate will remain in effect until submission of the Medicaid cost report.

(7) Late-billed services. If a hospital bills for services provided during a fiscal period for which the hospital has submitted an annual Medicaid cost report, the days which are late-billed may be included in the hospital's next fiscal period.

(8) False reports. If a provider knowingly, or with reason to know, files a report containing false information, such action constitutes cause for termination of its agreement with the Division. Providers filing false reports may be referred for prosecution under applicable statutes (see OAR 309-015-0052).

(9) Maintenance of report. The Medicaid Intermediary shall maintain each required annual Medicaid cost report submitted by a provider for three years following the date of submission. In the event there are audit questions, the cost statement shall be maintained for three years after the final audit settlement.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0050

Auditing

(1) Desk review of annual Medicaid cost report. The Medicaid intermediary will analyze by desk review each annual Medicaid cost report after it has been properly completed and filed.

(2) Scope of desk review. The scope of the desk review will verify, to the extent possible:

(a) That the provider has properly included its allowable costs on the annual Medicaid cost report on the basis of generally accepted accounting principles and the provisions of these rules;

(b) That the provider has properly applied the cost finding method specified by the Medicaid Intermediary to its allowable costs determined in subsection (a) of this section; and

(c) Whether or not the analysis indicates that further auditing of the provider's financial and statistical records is needed.

(3) Allowable costs. The costs considered allowable may include part or all of the following (worksheet form numbers are correct as of the effective date of this rule):

(a) The costs stated as final values on Worksheet B, HCFA-2552, Cost Allocation for General Services Costs;

(b) Physician costs as determined by completing Worksheet A-8-2, HCFA-2552;

(c) Return on equity as determined by completing the applicable portions of Worksheet F, HCFA-2552.

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(4) Ownership changes. Payments to providers shall not be increased, solely as a result of a change of ownership, in excess of the increase which would result from applying Section 1861(v)(1)(O) of the Social Security Act as applied to owners of record on or after July 18, 1984.

(5) Field audit. All filed annual Medicaid cost reports are subject to a field audit.

(6) Scope of field audit. The scope of the field audit will, at a minimum, be sufficiently comprehensive to verify that in all material respects:

(a) Generally accepted accounting principles and the provisions of these rules have been adhered to;

(b) Reported data is in agreement with supporting records; and

(c) The report is reconcilable to the appropriate Medicare report, federal tax return, and payroll tax reports.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 10-1984(Temp), f. & ef. 12-21-84; MHD 3-1985, f. & ef. 2-25-85; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0052

Provider Sanctions

(1) Basis for sanctioning. The Division will follow the Division of Medical Assistance Program rules OAR 410-120-0000 through 410-120-1980 and Section 1902 of the Social Security Act for provider sanctions. The basis for sanctioning will include:

(a) Criminal convictions;

(b) Exclusion, by the Secretary of Health and Human Services, from participation in the Medicare program;

(c) Not meeting the federal regulatory requirements for services in an institution for mental diseases or a psychiatric hospital as set forth at 42 CFR 435.1009 and 42 CFR 441, Subparts C and D;

(d) Having deficiencies which immediately jeopardize, or may jeopardize, the health and safety of patients;

(e) Abuse and misutilization, as described in OAR 410-120-0000 through 410-120-1980;

(f) Termination:

(A) From another governmental health/medical program;

(B) For failure to repay identified overpayments; or

(C) Due to commission, by a provider formerly suspended by the Division, of additional abuse or misutilization.

(2) Sanctions. The following sanctions may be imposed on a provider by the Division, based on grounds specified in this rule and may include:

(a) Termination from participation in Oregon's Medical Assistance Program and possible initiation of appropriate civil or criminal proceedings;

(b) Suspension from participation in Oregon's Medicaid Assistance Program;

(c) Suspension or withholding of payments to a provider;

(d) Required attendance at provider education sessions.

(3) Notice to providers. The Division will notify a deficient provider of action the Division plans to take at least 15 days prior to commencement of the action; the notification will include an explanation of the provider's right to appeal the proposed action (see OAR 309-015-0055).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0055

Appeals

(1) Rate appeals. A letter will be sent notifying the provider of the interim per diem rate, the year-end settlement rate, or the final settlement rate. A provider shall notify the Division in writing within 15 days of receipt of the letter if the provider wishes to appeal the rate. Letters of appeal must be postmarked within the

15-day limit and addressed to the Assistant Administrator, Administrative Services (the Medicaid Intermediary).

(2) The Medicaid Intermediary will forward all rate appeals to the Manager of the Division's Audit Section for initial consideration. If no resolution is forthcoming, the provider will be given an opportunity for administrative review or a contested case hearing as outlined in OAR 410-120-1400 through 410-120-1600, except that final orders shall be issued by the Administrator of the Division.

(3) Monetary recovery, sanctions, or other appeals. A provider may appeal the Division's proposed action by letter within the same 15-day period as allowed for rate appeals above; address the letter to the Assistant Administrator, Administrative Services (the Medicaid Intermediary).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0060

Emergency Services in Non-Participating Hospitals

Reimbursable services. Emergency services provided in licensed psychiatric hospitals not participating in Medicaid will be reimbursed if the Division determines they meet federal requirements for Medicare reimbursement of emergency services as outlined in Subpart G, Part 424 of the Medicare regulations.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 2-1994, f. & cert. ef. 2-24-94

DIVISION 18

RESIDENTIAL SUBSTANCE USE DISORDERS AND PROBLEM GAMBLING TREATMENT AND RECOVERY SERVICES

309-018-0100

Purpose and Scope

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

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for services and supports provided in:

(a) Residential Substance Use Disorders Treatment and Recovery Services; and

(b) Residential Problem Gambling Treatment and Recovery Services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0105

Definitions

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

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

(3) "Health Systems Services and Supports" means all services and supports including but not limited to, Outpatient Community Mental Health Services and Supports for Children and Adults, Intensive Treatment Services for Children, Outpatient and Residential Substance Use Disorders Treatment Services and Outpatient and Residential Problem Gambling Treatment Services.

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

(5) “Adult” means a person 18 years of age or older, or an emancipated minor. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.

(6) “Assessment” means the process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.

(7) “ASAM PPC” means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care, and incorporated by reference in these rules.

(8) “Authority” means the Oregon Health Authority.

(9) “Behavioral Health” means mental health, mental illness, addictive health and addiction disorders.

(10) “Case Management” means the services provided to assist individuals, who reside in a community setting, or are transitioning to a community setting, in gaining access to needed medical, social, educational, entitlement and other applicable services.

(11) “Certificate” means the document or documents issued by the Division, which identifies and declares certification of a provider pursuant to OAR 309-008-0100 to 309-008-1600. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

(12) “Child” means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.

(13) “Chief Officer” means the Chief Health Systems Officer of the Health Systems Division, or his or her designee.

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

(15) “Clinical Supervisor” means a person qualified to oversee and evaluate addictions or mental health services and supports.

(16) “Co-occurring substance use and mental health disorders (COD)” means the existence of a diagnosis of both a substance use disorder and a mental health disorder.

(17) “Court” means the last convicting or ruling court unless specifically noted.

(18) “Criminal Records Check” means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.

(19) “Crisis” means either an actual or perceived urgent or emergent situation that occurs when an individual’s stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual’s mental or physical health or to prevent referral to a significantly higher level of care.

(20) “Cultural Competence” means the process by which people and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

(21) “Culturally Specific Program” means a program that is designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture.

(22) “Diagnosis” means the principal mental health, substance use or problem gambling diagnosis listed in the Diagnostic and

Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the assessment and any examinations, tests, or consultations suggested by the assessment, and are the medically appropriate reason for services.

(23) “Division” means the Health Systems Division.

(24) “DSM” means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

(26) “Entry” means the act or process of acceptance and enrollment into services regulated by this rule.

(27) “Family” means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adoption, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

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

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

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

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

(32) “HIPAA” means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

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

(34) “Individual” means any person being considered for or receiving services and supports regulated by these rules.

(35) “Informed Consent for Services” means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the individual and guardian, if applicable, have consented to the services on, or prior to, the first date of service.

(36) “Interim Referral and Information Services” means services provided by an substance use disorders treatment provider to individuals on a waiting list, and whose services are funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, to reduce the adverse health effects of substance use, promote the health of the individual and reduce the risk of disease transmission.

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

(38) “Level of Care” means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(50) "Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete a Division approved training program as required by OAR 410-180-0300 through 410-180-0300 and be:

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

(b) A self-identified person in recovery from a substance use or gambling disorder, who meets the abstinence requirements for

recovering staff in substance use disorders or gambling treatment and recovery programs; or

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

(51) "Problem Gambling Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide problem gambling treatment services that include assessment, development of a Service Plan, group and family counseling.

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

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

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

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

(56) "Publicly Funded" means financial support, in part or in full, with revenue generated by a local, state or federal government.

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

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

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

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

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

(62) "Residential Problem Gambling Treatment Program" means a publicly or privately operated program that is licensed in accordance with OAR 415-021-0100 through 415-021-0225, that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with gambling related problems.

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

(64) "Service Delivery Rules" means the OAR describing specific regulatory standards for the possible array of services covered by certificates issued under Chapter 309, Division 8 of the OAR.

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

(67) "Service Note" means the written record of services and supports provided, including documentation of progress toward intended outcomes, consistent with the timelines stated in the Service Plan.

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

(69) "Services" means those activities and treatments described in the Service Plan that are intended to assist the individual's tran-

sition to recovery from a substance use disorder, problem gambling disorder or mental health condition, and to promote resiliency, and rehabilitative and functional individual and family outcomes.

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

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

(72) "Substance Abuse Prevention and Treatment Block Grant" or "SAPT Block Grant" means the federal block grants for prevention and treatment of substance abuse under Public Law 102-321 (31 U.S.C. 7301-7305) and the regulations published in Title 45 Part 96 of the Code of Federal Regulations.

(73) "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, and to a toxin exposure. The disorders include substance use disorders such as substance dependence and substance abuse, and substance-induced disorders, including substance intoxication, withdrawal, delirium, and dementia, as well as substance induced psychotic disorder, mood disorder, etc., as defined in DSM criteria.

(74) "Substance Use Disorders Treatment and Recovery Services" means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.

(75) "Substance Use Disorders Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide substance use disorders treatment services that include assessment, development of a Service Plan, and individual, group and family counseling.

(76) "Supports" means activities, referrals and supportive relationships designed to enhance the services delivered to individuals and families for the purpose of facilitating progress toward intended outcomes.

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

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

(79) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis, that are included in the Service Plan.

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

(a) An initial test must include, at a minimum, a sensitive, rapid, and inexpensive immunoassay screen to eliminate "true negative" specimens from further consideration.

(b) A confirmatory test is a second analytical procedure used to identify the presence of a specific drug or metabolite in a urine specimen. The confirmatory test must be by a different analytical method from that of the initial test to ensure reliability and accuracy.

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

(81) "Urgent" means the onset of symptoms requiring attention within 48 hours to prevent a serious deterioration in an individual's mental or physical health or threat to safety.

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0107 Certification Required

Entities providing or seeking to provide residential treatment services under these rules must also hold or successfully obtain from the Division a certificate to provide behavioral health treatment services under 309-008-0100 to 309-008-1600 if they intend to provide an outpatient service regulated by HSD's service delivery rules.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640 & 443.450

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

Hist.: MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0110 Provider Policies

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

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

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

(a) Personnel Qualifications and Credentialing;

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

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

(d) Fee agreements;

(e) Confidentiality and compliance with HIPAA, Federal Confidentiality Regulations (42 CFR, Part 2), and State confidentiality regulations as specified in ORS 179.505 and 192.518 through 192.530;

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

(g) Grievances and Appeals;

(h) Individual Rights;

(i) Quality Assessment and Performance Improvement;

(j) Crisis Prevention and Response;

(k) Incident Reporting;

(l) Family Involvement;

(m) Trauma-informed service delivery, consistent with the AMH Trauma Informed Services Policy;

(n) Provision of culturally and linguistically appropriate services;

(o) Medical Protocols;

(p) Medication Administration, Storage and Disposal;

(q) Facility Standards; and

(r) General Safety and Emergency Procedures.

(4) Additionally, providers must establish written policies that prohibit:

- (a) Physical or other forms of aversive action to discipline an individual;
- (b) Seclusion, personal restraint, mechanical restraint and chemical restraint;
- (c) Withholding shelter, regular meals, clothing or aids to physical functioning; and
- (d) Discipline of one individual receiving services by another.
Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270
Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

**309-018-0115
Individual Rights**

- (1) In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:
 - (a) Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence;
 - (b) Be treated with dignity and respect;
 - (c) Participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written Service Plan;
 - (d) Have all services explained, including expected outcomes and possible risks;
 - (e) Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.
 - (f) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:
 - (A) Under age 18 and lawfully married;
 - (B) Age 16 or older and legally emancipated by the court; or
 - (C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs;
 - (g) Inspect their Service Record in accordance with ORS 179.505;
 - (h) Refuse participation in experimentation;
 - (i) Receive medication specific to the individual's diagnosed clinical needs;
 - (j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
 - (k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
 - (l) Have religious freedom;
 - (m) Be free from seclusion and restraint;
 - (n) Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;
 - (o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;
 - (p) Have family and guardian involvement in service planning and delivery;
 - (q) Make a declaration for mental health treatment, when legally an adult;
 - (r) File grievances, including appealing decisions resulting from the grievance;
 - (s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
 - (t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and

(u) Exercise all rights described in this rule without any form of reprisal or punishment.

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

- (a) A safe, secure and sanitary living environment;
- (b) A humane service environment that affords reasonable protection from harm, reasonable privacy and daily access to fresh air and the outdoors;
- (c) Keep and use personal clothing and belongings, and to have an adequate amount of private, secure storage space. Reasonable restriction of the time and place of use, of certain classes of property may be implemented if necessary to prevent the individual or others from harm, provided that notice of this restriction is given to individuals and their families, if applicable, upon entry to the program, documented, and reviewed periodically;

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

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

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

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

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

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

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

(i) Participate regularly in indoor and outdoor recreation;

(j) Not be required to perform labor;

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

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

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

(a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

(b) The rights, and how to exercise them, must be explained to the individual, and if appropriate, to her or his guardian; and

(c) Individual rights must be posted in writing in a common area.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

**309-018-0120
Licensing and Credentialing**

Program staff in the following positions must meet applicable credentialing or licensing standards, including those outlined in these rules:

- (1) Substance Use Disorders Treatment Staff;
- (2) Clinical Supervisors;
- (3) LMPs;
- (4) Medical Directors;

(5) Peer Support Specialists; and
(6) Problem Gambling Treatment Staff.
Stat. Auth.: ORS 430.640 & 443.450
Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 & 813.200 - 813.270
Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0125

Specific Staff Qualifications and Competencies

(1) Program Administrators or Program Directors must demonstrate competence in leadership, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, use of data, reporting, program evaluation, quality assurance, and developing and coordinating community resources.

(2) All Clinical Supervisors must demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources, group, family and individual therapy or counseling, documentation and rationale for services to promote intended outcomes and implementation of all provider policies.

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

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

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

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

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

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

- (A) Board of Medical Examiners;
- (B) Board of Psychologist Examiners;
- (C) Board of Licensed Social Workers;
- (D) Board of Licensed Professional Counselors and Therapists;

or

(E) Board of Nursing.

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

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

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

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

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

(5) Substance use disorders treatment staff must:

(a) Demonstrate competence in treatment of substance-use disorders including individual assessment and individual, group, family and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes; and

(b) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide addiction treatment

within two years of the first hire date and must make application for certification no later than six months following that date. The two years is not renewable if the person ends employment with a provider and becomes re-employed with another provider.

(c) For treatment staff holding certification in addiction counseling, qualifications for the certificate must have included at least:

(A) 750 hours of supervised experience in substance use counseling;

(B) 150 contact hours of education and training in substance use related subjects; and

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

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

- (A) Board of Medical Examiners;
- (B) Board of Psychologist Examiners;
- (C) Board of Licensed Social Workers;
- (D) Board of Licensed Professional Counselors and Therapists;

or

(E) Board of Nursing.

(6) Problem gambling treatment staff must demonstrate competence in treatment of problem gambling including individual assessment and individual, group, family and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes.

(a) For treatment staff holding certification in problem gambling counseling, qualifications for the certificate must have included at least:

(A) 100 hours of supervised experience in problem gambling counseling;

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

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

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

- (A) Board of Medical Examiners;
- (B) Board of Psychologist Examiners;
- (C) Board of Licensed Social Workers;
- (D) Board of Licensed Professional Counselors and Therapists;

or

(E) Board of Nursing.

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

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

Stat. Auth.: ORS 430.640 & 443.450
Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0130

Documentation, Training and Supervision

(1) Providers must maintain personnel records for each program staff which contains all of the following documentation:

(a) Where required, verification of a criminal record check consistent with OAR 407-007-000 through 407-007-0370;

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

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

(d) Periodic performance appraisals;

(e) Staff orientation documentation;

(f) Disciplinary documentation; and

(g) Results of a Tuberculosis screening as per OAR 333-071-0057(7)(b)(A).

(2) Providers must maintain the following documentation for contractors, interns or volunteers, as applicable:

(a) A contract or written agreement;

(b) A signed confidentiality agreement;

(c) Orientation documentation;

(d) For subject individuals, verification of a criminal records check consistent with OAR 407-007-0000 through 407-007-0370; and

(e) Results of a Tuberculosis screening as per OAR 333-071-0057(7)(b)(A).

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

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

(A) A review of crisis prevention and response procedures;

(B) A review of emergency evacuation procedures;

(C) A review of program policies and procedures;

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

(E) Mandatory abuse reporting procedures; and

(F) HIPAA, and Fraud, Waste and Abuse;

(4) Clinical Supervision: Persons providing direct services must receive supervision by a qualified Clinical Supervisor, as defined in these rules, related to the development, implementation and outcome of services.

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

(b) Documentation of two hours per month of supervision for each person supervised. The two hours must include one hour of individual face-to-face contact for each person supervised, or a proportional level of supervision for part-time program staff. Individual face-to-face contact may include real time, two-way audio visual conferencing; or

(c) Documentation of two hours of quarterly supervision for program staff holding a health or allied provider license, including at least one hour of individual face-to-face contact for each person supervised.

Stat. Auth.: ORS 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.1.68, 813.010 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0135

Entry

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

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

(b) Individuals must receive services in the most timely manner feasible consistent with the presenting circumstances; and

(c) For individuals receiving services funded by the SAPT Block Grant, entry of pregnant women to services must occur no later than 48 hours from the date of first contact, and no less than 14 days after the date of first contact for individuals using substances intravenously. If services are not available within the required timeframe, the provider must document the reason and provide interim referral and informational services as defined in these rules, within 48 hours.

(2) Entry of individuals whose services are funded by the SAPT Block Grant, must be prioritized in the following order:

(a) Women who are pregnant and using substances intravenously;

(b) Women who are pregnant;

(c) Individuals who are using substances intravenously; and

(d) Women with dependent children.

(3) Written informed consent for services must be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason must be documented and further attempts to obtain informed consent must be made as appropriate.

(4) The provider must develop and maintain adequate clinical records and other documentation which supports the specific care, items, or services for which payment has been requested.

(5) The provider must report the entry of all individuals on the mandated state data system.

(6) In accordance with ORS 179.505 and HIPAA, an authorization for the release of information must be obtained for any confidential information concerning the individual being considered for, or receiving, services.

(7) Orientation: At the time of entry, the program must offer to the individual and guardian if applicable, written program orientation information. The written information must be in a language understood by the individual and must include:

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

(b) Policies concerning grievances;

(c) Notice of privacy practices; and

(d) An opportunity to register to vote.

Stat. Auth.: ORS 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.1.68, 813.010 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0140

Assessment

(1) At the time of entry, an assessment must be completed.

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

(a) Supervisory or treatment staff in substance use disorders treatment and recovery programs, and

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

(3) Each assessment must include:

(a) Sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services

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

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

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

(4) Each assessment must be consistent with the dimensions described in the ASAM PPC, and must document a diagnosis and level of care determination consistent with the DSM and ASAM PPC.

(5) When the assessment process determines the presence of co-occurring substance use and mental health disorders, or any significant risk to health and safety, all providers must document

referral for further assessment, planning and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(6) Providers must periodically update assessments as applicable, when there are changes in clinical circumstances.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010, 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0145

Service Plan and Service Notes

(1) The Service Plan must be a written, individualized plan to improve the individual's condition to the point where the individual's continued participation in the program is no longer necessary. The Service Plan is included in the individual's service records and must:

- (a) Be completed prior to the start of services;
- (b) Reflect the assessment and the level of care to be provided;
- (c) Include the participation of the individual;
- (d) Include the participation of family members as applicable;

and

- (e) Be completed by qualified program staff as follows:
 - (A) Supervisory or treatment staff in substance use disorders treatment and recovery programs, and
 - (B) Supervisory or treatment staff in problem gambling treatment and recovery programs.

(2) At minimum, each Service Plan must include:

- (a) Individualized treatment objectives;
- (b) The specific services and supports that will be used to meet the treatment objectives;
- (c) A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter;
- (d) The type of personnel that will be furnishing the services;

and

(e) A projected schedule for re-evaluating the Service Plan.

(3) Service Notes:

(a) Providers must document each service and support. A Service Note, at minimum, must include:

- (A) The specific services rendered
- (B) The date, time of service, and the actual amount of time the services were rendered;
- (C) Who rendered the services;
- (D) The setting in which the services were rendered;
- (E) The relationship of the services to the treatment regimen described in the Service Plan; and

(F) Periodic Updates describing the individual's progress.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0150

Service Record

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

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

- (a) Identifying information, or documentation of attempts to obtain the information, including:
 - (A) The individual's name, address, telephone number, date of birth, gender, and for adults, marital status and military status;
 - (B) Name, address, and telephone number of the parent or legal guardian, primary care giver or emergency contact; and
 - (C) Contact information for medical and dental providers.

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

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

(d) A signed fee agreement, when applicable;

(e) Assessment and updates to the assessment;

(f) A Service Plan;

(g) Service notes;

(h) A Transfer Summary, when required;

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

(j) Applicable signed consents for release of information.

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

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

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

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

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

(p) A copy of the individual's most recent Service Plan, if applicable, or in the case of an emergency or crisis-respite entry, a summary of current addictions or mental health services and any applicable behavior support plans;

(q) Documentation of the individual's ability to evacuate the home consistent with the program's evacuation plan developed in accordance with the Oregon Structural Specialty Code and Oregon Fire Code;

(r) Documentation of any safety risks; and

(s) Incident reports, when required.

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

(a) Medication Administration Records as per these rules;

(b) Laboratory reports; and

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

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0155

Transfer and Continuity of Care

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

(a) Decisions to transfer individuals must be documented in a transfer summary; and

(b) The documentation must include the reason for transfer and must be consistent with ASAM criteria established in the assessment.

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

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

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

(c) Complete a Transfer Summary;

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

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

(3) Transfer Summary:

(a) A Transfer Summary must include:

(A) The date and reason for the transfer;

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

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

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

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

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

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.45

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0160

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

Providers approved under OAR 309-008-0100 to 309-008-1600 and designated to provide services and supports for individuals diagnosed with COD must provide concurrent service and support planning and delivery for substance use and mental health diagnosis, including integrated assessment, Service Plan and Service Record.

Stat. Auth.: ORS 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0165

Residential Problem Gambling Treatment Services

These services include group, individual and family treatment consistent with the following requirements:

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

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

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

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

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

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

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

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

(d) Family Counseling: Family counseling includes face-to-face or non face-to-face service sessions between a program staff member delivering the service and a family member whose life has been negatively impacted by gambling.

(A) Service sessions must address the problems of the family member as they relate directly or indirectly to the problem gambling behavior; and

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

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

(f) A financial assessment must be included in the entry process and documented in the assessment; and

(g) The service plan must include a financial component, consistent with the financial assessment.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0170

Residential Substance Use Disorders Treatment and Recovery Services

(1) Interim Referral and Information Services: Pregnant women or other individuals using substances intravenously, whose services are funded by the SAPT Block Grant, must receive interim referrals and information prior to entry, to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services must include:

(a) Counseling and education about blood borne pathogens including Hepatitis, HIV, STDs and Tuberculosis (TB); the risks of needle and paraphernalia sharing and the likelihood of transmission to sexual partners and infants;

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

(c) Referral for Hepatitis, HIV, STD and TB testing, vaccine or care services if necessary; and

(d) For pregnant women, counseling on the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco and other drug use on the fetus and referral for prenatal care.

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

(a) Serve a majority of individuals representing culturally specific populations;

(b) Maintain a current demographic and cultural profile of the community;

(c) Ensure that individuals from the identified cultural group receive effective and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language;

(d) Implement strategies to recruit, retain, and promote a diverse staff at all levels of the organization that are representative of the population being served;

(e) Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery;

(f) Ensure that a majority of the substance use disorders treatment staff be representative of the specific culture being served;

(g) Ensure that individuals are offered customer satisfaction surveys that address all areas of service and that the results of the surveys are used for quality improvement;

(h) Consider race, ethnicity, and language data in measuring customer satisfaction;

(i) Develop and implement cultural competency policies;

(j) Ensure that data on individual’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated;

(k) Develop and maintain a Governing or Advisory Board as follows:

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

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

(C) Meet at least quarterly; and

(D) Monitor agency quality improvement mechanisms and evaluate the ongoing effectiveness and implementation of culturally relevant services (CLAS) and supports within the organization.

(l) Maintain accessibility to culturally specific populations including:

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

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

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

(m) The physical facility where the culturally specific services are delivered must be psychologically comfortable for the group including:

(A) Materials displayed must be culturally relevant; and

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

(n) Other cultural differences must be considered and accommodated when possible, such as the need or desire to bring family members to the facility, play areas for small children and related accommodations; and

(o) Ensure that grievance processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0175

Residential Adolescent Substance Use Disorders Treatment and Recovery Services

Programs approved to provide adolescent substance use disorders treatment services or those with adolescent-designated service funding must meet the following standards:

(1) Development of Service Plans and case management services must include participation of parents, other family members, schools, children’s services agencies, and juvenile corrections, as appropriate;

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

(a) Family counseling;

(b) Education services;

(c) Community and social skills training; and

(d) Smoking cessation service.

(3) Continuing care services must be of appropriate duration and designed to maximize recovery opportunities. The services must include:

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

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

(c) Linkage to emancipation services when appropriate; and

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

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0180

Residential Women’s Substance Use Disorders Treatment and Recovery Programs

(1) Programs approved to provide women’s substance use disorders treatment services or those with women-specific designated service funding must meet the following standards:

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

(b) The service plan must address all areas identified in the assessment and applicable service coordination details to address the identified needs;

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

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

(A) Gender-specific services and supports;

(B) Family services, including therapeutic services for children in the custody of women in treatment;

(C) Reintegration with family;

(D) Peer delivered supports;

(E) Smoking cessation;

(F) Housing; and

(G) Transportation.

(2) Services must include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies;

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

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

(b) Parenting training; and

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

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

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

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

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

(A) Relationship issues;

(B) Sexual and physical abuse;

(C) Parenting;

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

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

(i) Their developmental needs;

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

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

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

309-018-0185

Medical Protocols in Residential Substance Use Disorders Treatment Programs

Medical protocols must be approved by a medical director under contract with a program or written reciprocal agreement with a medical practitioner under managed care. The protocols must:

- (1) Require a medical history be included in the Assessment;
- (2) Designate those medical symptoms that, when found, require further investigation, physical examinations, service, or laboratory testing;
- (3) Require that individuals admitted to the program who are currently injecting or intravenously using a drug, or have injected or intravenously used a drug within the past 30 days, or who are at risk of withdrawal from a drug, or who may be pregnant, must be referred for a physical examination and appropriate lab testing within 30 days of entry to the program. This requirement may be waived by the medical director if these services have been received within the past 90 days and documentation is provided;
- (4) Require pregnant women be referred for prenatal care within two weeks of entry to the program;
- (5) Require that the program provide HIV and AIDS, TB, sexually transmitted disease, Hepatitis and other infectious disease information and risk assessment, including any needed referral, within 30 days of entry; and
- (6) Specify the steps for follow up and coordination with physical health care providers in the event the individual is found to have an infectious disease or other major medical problem.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0190

Administration of Medications

The following guidelines must be followed in policies on administration of medications in residential programs:

- (1) Medications prescribed for one individual must not be administered to or self-administered by another individual or program staff;
- (2) When an individual self-administers medication in a residential program, self-administration must be approved in writing by a physician and closely monitored by the residential program staff;
- (3) No unused, outdated, or recalled drugs must be kept in a program. On a monthly basis any unused, outdated, or recalled drugs must be disposed of in a manner that assures they cannot be retrieved;
- (4) Disposal of prescription drugs in a residential program: A written record of all disposals of drugs must be maintained in the program and must include:
 - (a) A description of the drug, including the amount;
 - (b) The individual for whom the medication was prescribed;
 - (c) The reason for disposal; and
 - (d) The method of disposal.
- (5) Storage of Prescription Drugs in residential programs: All prescription drugs stored in the residential program must be kept in a locked stationary container. Medications requiring refrigeration must be stored in a refrigerator using a locked container; and
- (6) Written documentation of medications prescribed for the individual by a LMP must be maintained in the Individual Service Record. Documentation for each medication prescribed must include the following:
 - (a) A copy or detailed written description of the signed prescription order;
 - (b) The name of the medication prescribed;
 - (c) The prescribed dosage and method of administration;
 - (d) The date medications were prescribed, reviewed, or renewed;
 - (e) The date, the signature and credentials of program staff administering or prescribing medications; and

(f) Medication records which contain:

(A) Observed side effects including laboratory findings; and

(B) Medication allergies and adverse reaction.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0195

Building Requirements

All substance use disorders treatment and recovery programs must:

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

(2) Maintain up-to-date documentation verifying that they meet applicable local business license, zoning and building codes and federal, state and local fire and safety regulations. It is the responsibility of the program to check with local government to make sure all applicable local codes have been met;

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

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

(5) Adopt and implement emergency policies and procedures, including an evacuation plan and emergency plan in case of fire, explosion, accident, death or other emergency. The policies and procedures and emergency plans must be current and posted in a conspicuous area.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0200

Facility Standards for Substance Use Disorders Residential Treatment and Recovery Programs

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

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

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

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

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

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

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

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

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

(B) Be provided with adequate ventilation.

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

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

(B) Be provided with adequate ventilation.

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

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

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

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

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

(E) Provide permanently wired light fixtures located and maintained to give light to all parts of the room; and

(F) Provide a curtain or window shade at each window to assure privacy.

(d) Bathrooms must be provided and conveniently located in each building containing a bedroom and must:

(A) Provide a minimum of one toilet and one hand-washing sink for each eight individuals, and one bathtub or shower for each ten individuals;

(B) Provide one hand-washing sink convenient to every room containing a toilet;

(C) Provide permanently wired light fixtures located and maintained to give adequate light to all parts of the room;

(D) Provide arrangements for personal privacy for individuals;

(E) Provide a privacy screen at each window;

(F) Provide a mirror; and

(G) Be provided with adequate ventilation.

(e) A supply of hot and cold water installed and maintained in compliance with rules of, the Authority, Health Services, Office of Public Health Systems, must be distributed to taps conveniently located throughout the residential program;

(f) All plumbing must comply with applicable codes;

(g) Laundry facilities, when provided, must be separate from:

(A) Resident living areas, including bedrooms;

(B) Kitchen and dining areas; and

(C) Areas used for the storage of unrefrigerated perishable foods.

(h) Storage areas must be provided appropriate to the size of the residential program. Separate storage areas must be provided for:

(A) Food, kitchen supplies, and utensils;

(B) Clean linens;

(C) Soiled linens and clothing;

(D) Cleaning compounds and equipment; and

(E) Poisons, chemicals, insecticides, and other toxic materials, which must be properly labeled, stored in the original container, and kept in a locked storage area.

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

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

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

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

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

(A) Sheets and pillowcases;

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

(C) Towel and washcloth.

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

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

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

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

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

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

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

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

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

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

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

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

(A) Instructions for the program staff or designated resident in the event of fire, explosion, accident, death, or other emergency and the telephone numbers of the local fire department, law enforcement agencies, hospital emergency rooms, and the residential program's designated physician and on-call back-up program staff;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0205

Quality Assessment, Grievances and Variances

Providers must develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14

309-018-0210

Grievances and Appeals

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

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

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

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

(b) Assist individuals and parents or guardians, as applicable, to understand and complete the grievance process; and notify them of the results and basis for the decision;

(c) Encourage and facilitate resolution of the grievance at the lowest possible level;

(d) Complete an investigation of any grievance within 30 calendar days;

(e) Implement a procedure for accepting, processing and responding to grievances including specific timelines for each;

(f) Designate a program staff person to receive and process the grievance;

(g) Document any action taken on a substantiated grievance within a timely manner; and

(h) Document receipt, investigation and action taken in response to the grievance.

(4) Grievance Process Notice. The provider must have a Grievance Process Notice, which must be posted in a conspicuous place stating the telephone number of:

(a) The Division;

(b) Disability Rights Oregon; and

(c) The applicable managed care organization.

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

(6) Retaliation: A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.

(7) Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

(8) Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:

(a) If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable;

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

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

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

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0215

Variances

(1) Criteria for a Variance: Variances may be granted to a provider holding a license under this rule:

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

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

(2) Application for a Variance

(a) Providers may submit their variance request directly to the Division;

(b) Provider requesting a variance must submit a written application to the Division; and

(c) Variance requests must contain the following:

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

(B) The reason for the proposed variance;

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270

Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

DIVISION 19

OUTPATIENT ADDICTIONS AND MENTAL HEALTH SERVICES

309-019-0100

Purpose and Scope

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

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for behavioral health treatment services and supports provided in:

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

(b) Outpatient Substance Use Disorders Treatment Services; and

(c) Outpatient Problem Gambling Treatment Services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640

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

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0105

Definitions

(1) "Abuse of an adult" means the circumstances defined in 943-045-0250 through 943-045-0370 for abuse of an adult with mental illness.

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

(3) "Addictions and Mental Health Services and Supports" means all services and supports including but not limited to, Outpatient Behavioral Health Services and Supports for Children and Adults, Intensive Treatment Services for Children, Outpatient and Residential Substance Use Disorders Treatment Services and Outpatient and Residential Problem Gambling Treatment Services.

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

(5) "Adult" means a person 18 years of age or older, or an emancipated minor. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.

(6) "Assessment" means the process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.

(7) "ASAM PPC" means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care, and incorporated by reference in these rules.

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

(9) "Behavioral Health Treatment": means mental health treatment, substance use disorder treatment, and problem gambling treatment.

(10) "Behavior Support Plan" means the individualized proactive support strategies that are used to support positive behavior.

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

(12) "Care Coordination" means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and par-

participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.

(13) “Case Management” means the services provided to assist individuals, who reside in a community setting, or are transitioning to a community setting, in gaining access to needed medical, social, educational, entitlement and other applicable services.

(14) “Certificate” means the document or documents issued by OHA, which identifies and declares certification of a provider pursuant to OAR 309-008-0000. A letter accompanying issuance of the Certificate will detail the scope and approved locations of the Certificate.

(15) “Chief Officer” means the Chief Health Systems Officer of the Division, or his or her designee.

(16) “Child” means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.

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

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

(19) “Clinical Supervisor” means a person qualified to oversee and evaluate addictions or mental health services and supports.

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

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

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

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

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

(22)(a) “Comprehensive Assessment” means the organized process of gathering and analyzing current and past information with each individual and the family and/or support system and other significant people to evaluate:

(A) Mental and functional status;

(B) Effectiveness of past treatment;

(C) Current Treatment, rehabilitation and support needs to achieve individual goals and support recovery; and

(D) The range of individual strengths (e.g., knowledge gained from dealing with adversity, personal/professional roles, talents,

personal traits) that can act as resources to the individual and his/her recovery planning team in pursuing goals.

(b) The results of the information gathering and analysis are used to:

(A) Establish immediate and longer-term service needs with each individual;

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

(C) Optimize benefits that can be derived from existing strengths and resources of the individual and his/her family and/or natural support network in the community.

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

(24) “Co-occurring substance use and mental health disorders (COD)” means the existence of a diagnosis of both a substance use disorder and a mental health disorder.

(25) “Coordinated Care Organization (CCO)” means an entity that has been certified by the Authority to provide coordinated and integrated health services.

(26) “Conditional Release” means placement by a court or the Psychiatric Security Review Board (PSRB), of a person who has been found eligible under ORS 161.327(2)(b) or 161.336, for supervision and treatment in a community setting.

(27) “Court” means the last convicting or ruling court unless specifically noted.

(28) “Criminal Records Check” means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.

(29) “Crisis” means either an actual or perceived urgent or emergent situation that occurs when an individual’s stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual’s mental or physical health or to prevent referral to a significantly higher level of care.

(30) “Cultural Competence” means the process by which people and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

(31) “Culturally Specific Program” means a program that is designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture.

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

(33) “Diagnosis” means the principal mental health, substance use or problem gambling diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the assessment and any examinations, tests, or consultations suggested by the assessment, and is the medically appropriate reason for services.

(34) “Division” means the Health Systems Division.

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

(36) “DSM” means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(37) “Driving Under the Influence of Intoxicants (DUII) Substance Use Disorders Rehabilitation Program” means a program of treatment and therapeutically oriented education services for an individual who is either:

(a) A violator of ORS 813.010 Driving Under the Influence of Intoxicants; or

(b) A defendant who is participating in a diversion agreement under ORS 813.200.

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

(39) “Enhanced Care Services (ECS)” and “Enhanced Care Outreach Services (ECOS)” means intensive behavioral and rehabilitative mental health services to eligible individuals who reside in Aging and People with Disabilities (APD) licensed homes or facilities.

(40) “Entry” means the act or process of acceptance and enrollment into services regulated by this rule.

(41) “Family” means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adoption, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

(42) “Family Support” means the provision of supportive services to persons defined as family to the individual. It includes support to caregivers at community meetings, assistance to families in system navigation and managing multiple appointments, supportive home visits, peer support, parent mentoring and coaching, advocacy, and furthering efforts to develop natural and informal community supports.

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

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

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

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

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

(48) “HIPAA” means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

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

(50) “Individual” means any person being considered for or receiving services and supports regulated by these rules.

(51) “Informed Consent for Services” means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the individual and guardian, if applicable, have consented to the services on, or prior to, the first date of service.

(52) “Intensive Outpatient Substance Use Disorders Treatment Services” means structured nonresidential evaluation, treatment, and continued care services for individuals with substance use disorders who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services. Intensive out-

patient services may include, but are not limited to, day treatment, correctional day treatment, evening treatment, and partial hospitalization.

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

(54) “Interim Referral and Information Services” means services provided by a substance use disorders treatment provider to individuals on a waiting list, and whose services are funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, to reduce the adverse health effects of substance use, promote the health of the individual and reduce the risk of disease transmission.

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

(56) “Juvenile Psychiatric Security Review Board (JPSRB)” means the entity described in ORS 161.385.

(57) “Level of Care” means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

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

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

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

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

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

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

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

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

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

(62) “Local Mental Health Authority (LMHA)” means one of the following entities:

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

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

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

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

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

(65) “Medical Director” means a physician licensed to practice medicine in the State of Oregon and who is designated by a substance use disorders treatment program to be responsible for the

program's medical services, either as an employee or through a contract.

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

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

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

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

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

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

(68) "Mental Health Intern" means a person who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work or behavioral science field to meet the educational requirement of QMHP. The person must:

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

(b) Have a collaborative educational agreement with the CMHP, or other provider, and the graduate program;

(c) Work within the scope of his/her practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by provider; and

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

(69) "Nursing Services" means services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) within their scope of practice as defined in OAR 851-045-0060.

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

(71) "Outpatient Substance Use Disorders Treatment Program" means a program that provides assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for individuals with alcohol or other drug use disorders and their family members, or significant others.

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

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

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

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

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

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

training program as required by OAR 410-180-0300 to 0380 and be:

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

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

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

(78) "Problem Gambling Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide problem gambling treatment services that include assessment, development of a Service Plan, group and family counseling.

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

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

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

(82) "Provider" means a person, organizational provider, or Community Mental Health Program as designated under ORS 430.637(b) that holds a current Certificate to provide outpatient behavioral health treatment or prevention services pursuant to these and applicable service delivery rules.

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

(84) "Psychiatrist" means a physician licensed pursuant to ORS 677.010 to 677.228 and 677.410 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

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

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

(87) "Publicly Funded" means financial support, in part or in full, with revenue generated by a local, state or federal government.

(88) "Qualified Mental Health Associate (QMHA)" means a person delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-019-0125(7).

(89) "Qualified Mental Health Professional (QMHP)" means a LMP or any other person meeting the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-019-0125(8).

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

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

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

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

(94) "Resilience" means the universal capacity that a person uses to prevent, minimize, or overcome the effects of adversity.

Resilience reflects a person's strengths as protective factors and assets for positive development.

(95) "Respite care" means planned and emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. Respite care can be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the Service Plan.

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

(97) "Screening Specialist" means a person who possesses valid certification issued by the Division to conduct DUII evaluations.

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

(99) "Service Note" means the written record of services and supports provided, including documentation of progress toward intended outcomes, consistent with the timelines stated in the Service Plan.

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

(101) "Services" means those activities and treatments described in the Service Plan that are intended to assist the individual's transition to recovery from a substance use disorder, problem gambling disorder or mental health condition, and to promote resiliency, and rehabilitative and functional individual and family outcomes.

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

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

(104) "Substance Abuse Prevention and Treatment Block Grant" or "SAPT Block Grant" means the federal block grants for prevention and treatment of substance abuse under Public Law 102-321 (31 U.S.C. 7301-7305) and the regulations published in Title 45 Part 96 of the Code of Federal Regulations.

(105) "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, and to a toxin exposure. The disorders include substance use disorders such as substance dependence and substance abuse, and substance-induced disorders, including substance intoxication, withdrawal, delirium, and dementia, as well as substance induced psychotic disorder, mood disorder, etc., as defined in DSM criteria.

(106) "Substance Use Disorders Treatment and Recovery Services" means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.

(107) "Substance Use Disorders Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide substance use disorders treatment services that include assessment, development of a Service Plan, and individual, group and family counseling.

(108) "Successful DUII Completion" means that the DUII program has documented in its records that for the period of service deemed necessary by the program, the individual has:

- (a) Met the completion criteria approved by the Division;

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

- (c) Demonstrated 90 days of continuous abstinence prior to completion.

(109) "Supported Employment Services" are individualized services that assist individuals to obtain and maintain integrated, paid, competitive employment. Supported employment services are provided in a manner that seeks to allow individuals to work the maximum number of hours consistent with their preferences, interests and abilities and are individually planned, based on person-centered planning principles and evidence-based practices.

(110) "Supports" means activities, referrals and supportive relationships designed to enhance the services delivered to individuals and families for the purpose of facilitating progress toward intended outcomes.

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

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

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

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

(115) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis, that are included in the Service Plan.

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

- (a) An initial test must include, at a minimum, a sensitive, rapid, and inexpensive immunoassay screen to eliminate "true negative" specimens from further consideration.

- (b) A confirmatory test is a second analytical procedure used to identify the presence of a specific drug or metabolite in a urine specimen. The confirmatory test must be by a different analytical method from that of the initial test to ensure reliability and accuracy.

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

(117) "Urgent" means the onset of symptoms requiring attention within 48 hours to prevent a serious deterioration in an individual's mental or physical health or threat to safety.

(118) "Variance" means an exception from a provision of these rules, granted in writing by the Division pursuant to the process regulated by OAR 309-008-1600, upon written application from the provider. Duration of a variance is determined on a case-by-case basis.

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

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

(121) "Warm Handoff" means the process of transferring an individual from one provider to another, prior to discharge, which includes face-to-face meeting(s) with an individual, and which coordinates the transfer of responsibility for the individual's

ongoing care and continuing treatment and services. A warm handoff shall either:

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
 Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
 Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0110

Provider Policies

(1) Personnel Policies: All providers must develop and implement written personnel policies and specific procedures, compliant with these rules and other applicable rules or regulatory mandates, including:

- (a) Personnel Qualifications and Credentialing;
- (b) Mandatory abuse reporting, compliant with ORS 430.735-430.768 and OAR 943-045-0250 through 943-045-0370;
- (c) Criminal Records Checks, compliant with ORS 181.533 through 181.575 and 407-007-0000 through 407-007-0370; and
- (d) Fraud, waste and abuse in Federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510.

(2) Service Delivery Policies: All providers must develop and implement written service delivery policies and specific procedures, compliant with these rules.

(a) Service delivery policies must be available to individuals and family members upon request; and

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

- (A) Fee agreements;
- (B) Confidentiality and compliance with HIPAA, Federal Confidentiality Regulations (42 CFR, Part 2), and State confidentiality regulations as specified in ORS 179.505 and 192.518 through 192.530;
- (C) Compliance with Title 2 of the Americans with Disabilities Act of 1990 (ADA);
- (D) Grievances and Appeals;
- (E) Individual Rights;
- (F) Quality Assessment and Performance Improvement;
- (G) Trauma Informed Service Delivery, consistent with the AMH Trauma Informed Services Policy;
- (H) Provision of culturally and linguistically appropriate services;
- (I) Crisis Prevention and Response; and
- (J) Incident Reporting.

(3) Behavior Support Policies: Providers of ECS Services must develop policies consistent with 309-019-0155(3) of these rules.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
 Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0115

Individual Rights

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

(a) Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual’s liberty, that are least intrusive to the individual and that provide for the greatest degree of independence;

(b) Be treated with dignity and respect;

(c) Participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written Service Plan;

(d) Have all services explained, including expected outcomes and possible risks;

(e) Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.

(f) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:

- (A) Under age 18 and lawfully married;
- (B) Age 16 or older and legally emancipated by the court; or
- (C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs;

(g) Inspect their Service Record in accordance with ORS 179.505;

- (h) Refuse participation in experimentation;
- (i) Receive medication specific to the individual’s diagnosed clinical needs;
- (j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;

(k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

- (l) Have religious freedom;
- (m) Be free from seclusion and restraint;
- (n) Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;

(o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;

(p) Have family and guardian involvement in service planning and delivery;

(q) Make a declaration for mental health treatment, when legally an adult;

(r) File grievances, including appealing decisions resulting from the grievance;

(s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;

(t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and

(u) Exercise all rights described in this rule without any form of reprisal or punishment.

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

(a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual’s need;

(b) The rights, and how to exercise them, must be explained to the individual, and if appropriate, to her or his guardian; and

(c) Individual rights must be posted in writing in a common area.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380- 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0120

Licensing and Credentialing

Program staff in the following positions must meet applicable credentialing or licensing standards, including those outlined in these rules:

- (1) Substance Use Disorders Treatment Staff;
(2) Clinical Supervisors;
(3) LMPs;
(4) Medical Directors;
(5) Peer Support Specialists;
(6) Problem Gambling Treatment Staff;
(7) QMHAs; and
(8) QMHPs.

Stat. Auth.: ORS 428.205 - 428.270,430.256, 430.640

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, , 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0125

Specific Staff Qualifications and Competencies

(1) Program Administrators or Program Directors must demonstrate competence in leadership, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, use of data, reporting, program evaluation, quality assurance, and developing and coordinating community resources.

(2) Clinical Supervisors in all programs must demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources, group, family and individual therapy or counseling, documentation and rationale for services to promote intended outcomes and implementation of all provider policies.

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

(4) Clinical Supervisors in substance use disorders treatment programs must be certified or licensed by a health or allied provider agency as follows:

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

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

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

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

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

- (A) Board of Medical Examiners;
(B) Board of Psychologist Examiners;
(C) Board of Licensed Social Workers;
(D) Board of Licensed Professional Counselors and Therapists;

or

(E) Board of Nursing.

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

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

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

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

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

(6) Substance use disorders treatment staff must:

(a) Demonstrate competence in treatment of substance-use disorders including individual assessment and individual, group, family and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes; and

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

(c) For treatment staff holding certification in addiction counseling, qualifications for the certificate must have included at least:

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(A) 750 hours of supervised experience in substance use counseling;

(B) 150 contact hours of education and training in substance use related subjects; and

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

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

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists;

or

(E) Board of Nursing.

(7) Problem Gambling treatment staff must:

(a) Demonstrate competence in treatment of problem gambling including individual assessment and individual, group, family and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes.

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

(c) For treatment staff holding certification in problem gambling counseling, qualifications for the certificate must have included at least:

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

(B) 60 contact hours of education and training in problem gambling related subjects; and

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

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

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists;

or

(E) Board of Nursing.

(8) QMHAs must demonstrate the ability to communicate effectively, understand mental health assessment, treatment and service terminology and apply each of these concepts, implement skills development strategies, and identify, implement and coordinate the services and supports identified in a Service Plan. In addition, QMHAs must also meet the following minimum qualifications:

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

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

(c) A qualified Mental Health Intern, as defined in 309-019-0105(61).

(9) QMHPs must demonstrate the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting a mental status examination, complete a DSM diagnosis, write and supervise the implementation of a Service Plan and provide individual, family or group therapy within the scope of their training. In addition, QMHPs must also meet the following minimum qualifications:

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

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

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

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

(f) Graduate degree in a behavioral science field; or

(g) A qualified Mental Health Intern, as defined in 309-019-0105(61).

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

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

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.256, 430.640

Stats. Implemented: ORS 109.675, 413.520 - 413.522, 426.380, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 1-2015(Temp), f. & cert. ef. 3-25-15 thru 9-20-15; MHS 3-2015, f. & cert. ef. 5-28-15; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0130

Personnel Documentation, Training and Supervision

(1) Providers must maintain personnel records for each program staff which contains all of the following documentation:

(a) Where required, verification of a criminal record check consistent with OAR 407-007-0000 through 407-007-0370;

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

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

(d) Periodic performance appraisals;

(e) Staff orientation documentation; and

(f) Disciplinary documentation;

(g) Documentation of trainings required by this or other applicable rules; and

(h) Documentation of clinical and non-clinical supervision.

(2) Providers utilizing contractors, interns or volunteers must maintain the following documentation, as applicable:

(a) A contract or written agreement;

(b) A signed confidentiality agreement;

(c) Orientation documentation; and

(d) For subject individuals, verification of a criminal records check consistent with OAR 407-007-0000 through 407-007-0370.

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

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

(A) A review of crisis prevention and response procedures;

(B) A review of emergency evacuation procedures;

(C) A review of program policies and procedures;

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

(E) Mandatory abuse reporting procedures;

(F) HIPAA, and Fraud, Waste and Abuse;

(G) Planning and implementing a warm handoff; and

(H) For Enhanced Care Services, positive behavior support training.

(4) Clinical Supervision: Persons providing direct services must receive supervision by a qualified Clinical Supervisor, as

defined in these rules, related to the development, implementation and outcome of services.

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

(b) Documentation of two hours per month of supervision for each person supervised. The two hours must include one hour of individual face-to-face contact for each person supervised, or a proportional level of supervision for part-time program staff. Individual face-to-face contact may include real time, two-way audio visual conferencing;

(c) Documentation of two hours of quarterly supervision for program staff holding a health or allied provider license, including at least one hour of individual face-to-face contact for each person supervised; or

(d) Documentation of weekly supervision for program staff meeting the definition of Mental Health Intern.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.256, 430.640
Stats. Implemented: ORS 109.675, 413.520 - 413.522, 426.380, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0135

Entry and Assessment

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

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

(b) Individuals must receive services in the most timely manner feasible consistent with the presenting circumstances.

(c) Written informed consent for services must be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason must be documented and further attempts to obtain informed consent must be made as appropriate.

(d) The provider must develop and maintain adequate clinical records and other documentation which supports the specific care, items, or services for which payment has been requested.

(e) The provider must report the entry of all individuals on the mandated state data system.

(f) In accordance with ORS 179.505 and HIPAA, an authorization for the release of information must be obtained for any confidential information concerning the individual being considered for, or receiving, services.

(g) Orientation: At the time of entry, the program must offer to the individual and guardian if applicable, written program orientation information. The written information must be in a language understood by the individual and must include:

(A) An opportunity to complete a declaration for mental health treatment with the individual's participation and informed consent;

(B) A description of individual rights consistent with these rules;

(C) Policies concerning grievances;

(D) Notice of privacy practices; and

(E) An opportunity to register to vote.

(2) Entry Priority: Entry of individuals whose services are funded by the SAPT Block Grant, must be prioritized in the following order:

(A) Women who are pregnant and using substances intravenously;

(B) Women who are pregnant;

(C) Individuals who are using substances intravenously; and

(D) Women with dependent children.

(3) Assessment:

(a) At the time of entry, an assessment must be completed.

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

(A) A QMHP in mental health programs. A QMHA may assist in the gathering and compiling of information to be included in the assessment.

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

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

(c) Each assessment must include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services.

(d) For Substance Use Disorders services, each assessment must be consistent with the dimensions described in the ASAM PPC, and must document a diagnosis and level of care determination consistent with the DSM and ASAM PPC.

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

(e) Providers must periodically update assessments as applicable, when there are changes in clinical circumstances; and

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0140

Service Plan and Service Notes

(1) The Service Plan must be a written, individualized plan to improve the individual's condition to the point where the individual's continued participation in the program is no longer necessary. The Service Plan is included in the individual's service record and must:

(a) Be completed prior to the start of services;

(b) Reflect the assessment and the level of care to be provided;

(c) Include the participation of the individual and family members, as applicable;

(d) Include a description of all warm handoff planning and implementation; and

(d) Be completed by qualified program staff as follows:

(A) A QMHP in mental health programs;

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

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

(e) For mental health services, a QMHP, who is also a licensed health care professional, must recommend the services and supports by signing the Service plan within ten (10) business days of the start of services; and

(f) A LMP must approve the Service Plan at least annually for each individual receiving mental health services for one or more continuous years. The LMP may designate annual clinical oversight by documenting the designation to a specific licensed health care professional.

(2) At minimum, each Service Plan must include:

(a) Individualized treatment objectives;

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

(c) A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter;

(d) The type of personnel that will be furnishing the services; and

- (e) A projected schedule for re-evaluating the Service Plan.
- (3) Service Notes:
 - (a) Providers must document each service and support. A Service Note, at minimum, must include:
 - (A) The specific services rendered;
 - (B) The date, time of service, and the actual amount of time the services were rendered;
 - (C) Who rendered the services;
 - (D) The setting in which the services were rendered;
 - (E) The relationship of the services to the treatment regimen described in the Service Plan; and
 - (F) Periodic Updates describing the individual's progress.
 - (4) Decisions to transfer individuals must be documented, including the reason for the transfer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0145
Co-Occurring Mental Health and Substance Use Disorders (COD)

Providers approved under OAR 309-008-0000 and designated to provide services and supports for individuals diagnosed with COD must provide concurrent service and support planning and delivery for substance use, gambling disorder, and mental health diagnosis, including integrated assessment, Service Plan and Service Record.

Stat. Auth.: ORS 430.640
Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0150
Outpatient Mental Health Services to Children and Adults

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

- (a) 24 hours, seven days per week telephone or face-to-face screening to determine an individual's need for immediate community mental health services; and
- (b) 24 hour, seven days per week capability to conduct, by or under the supervision of a QMHP, an assessment resulting in a Service Plan that includes the crisis services necessary to assist the individual and family to stabilize and transition to the appropriate level of care.

(2) Available case management services must be provided, including the following:

- (a) Assistance in applying for benefits to which the individual may be entitled. Program staff must assist individuals in gaining access to, and maintaining, resources such as Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing. When needed, program staff must arrange transportation or accompany individuals to help them apply for benefits; and
- (b) Referral and coordination to help individuals gain access to services and supports identified in the Service Plan;
- (3) When significant health and safety concerns are identified, program staff must assure that necessary services or actions occur to address the identified health and safety needs for the individual.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0155
Enhanced Care Services and Enhanced Care Outreach Services

(1) Services will be provided in a facility or program approved by the Department of Human Services (DHS), Aging and People with Disabilities (APD) as follows:

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

(b) Enhanced Care Outreach Services (ECOS) must be provided to residents of DHS licensed facilities and include individualized wrap-around rehabilitative mental health services.

(2) To be eligible for ECS/ECOS an individual must:

- (a) Be APD service eligible;
- (b) Meet the diagnostic criteria of severe mental illness with problematic behavior or be approved by the Enhanced Care Services Team;

(c) Require intensive community mental health services to transition to a lower level of care;

(d) Have a history of multiple APD placements due to problematic behavior; and

(e) Be currently or have been a patient at Oregon State Hospital or have received in-patient services in an acute psychiatric unit for over 14 days and have been referred to non-enhanced APD facilities and denied admission due to severe mental illness with problematic behavior and be currently exhibiting two or more of the following: self-endangering behavior, aggressive behavior, intrusive behavior, intractable psychiatric symptoms, medication needs, sexually inappropriate behavior and elopement behavior.

(3) ECS/ECOS providers must:

(a) For ECS, provide a minimum of 12 hours per day, 7 days per week of mental health services, provided or arranged for by the contracted mental health provider. Services must include a minimum of 3 hours rehabilitative services per day;

(b) For ECOS, services based on the assessed need of the individual will not exceed 5 days per week;

(c) Coordinate Interdisciplinary team meetings (IDT) to develop the Service Plan, review the behavior support plan and to coordinate care planning with the DHS licensed provider staff, APD case manager, QMHP, prescriber and related professionals such as DHS licensed facility/program direct care staff, DHS licensed facility RN and facility administrator. IDTs in ECS programs must be held weekly and at least quarterly for ECOS;

(d) Conduct quarterly mental health in-service trainings for DHS-licensed providers and related program staff providing services to ECS/ECOS recipients; and

(e) Ensure the availability of crisis services staffed by a QMHP, or the local CMHP, available to the ECS/ECOS provider and DHS licensed facility direct care staff 24-hours per day.

(4) Behavior support services must be designed to facilitate positive alternatives to challenging behavior, and to assist the individual in developing adaptive and functional living skills. Providers must:

(a) Develop and implement individual behavior support strategies, based on a functional or other clinically appropriate assessment of challenging behavior;

(b) Document the behavior support strategies and measures for tracking progress as a behavior support plan in the Service Plan;

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

(d) Obtain informed consent from the individual or guardian, if one is appointed, in the use of behavior support strategies and communicate both verbally and in writing the information to the

individual or guardian, if one is appointed, in a language understood;

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

- (A) The use of least restrictive interventions possible; and
(B) Increasing positive behavior.

(f) Require all program staff to receive quarterly mental health in-service training in Evidence-based Practices to promote positive behavior support and related to needs of each individual; and

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

(5) Providers must develop a transition plan for each individual as part of the initial assessment process. Each individual's mental health service plan will reflect their transition goal and the supports necessary to achieve transition.

(6) Staffing requirements:

(a) Each ECS/ECOS program must have a minimum of 1 FTE QMHP for programs serving five or more individuals who is responsible for coordinating entries, transitions and required IDT's, assuring the completion of individual assessments, mental health service and behavior support plans; providing supervision of QMHP's and QMHA's and to coordinate services and trainings with facility staff;

(b) Each ECS/ECOS program must have psychiatric consultation available. For ECS programs serving more than 10 individuals, the psychiatrist must participate.

(7) In ECS programs, the CMHP and the DHS licensed provider must develop a written collaborative agreement that addresses at minimum: risk management, census management, staff levels, training, treatment and activity programs, entry and transition procedures, a process for reporting and evaluating critical incidents, record keeping, policy and procedure manuals, dispute resolution and service coordination.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 430.010, 430.205 - 430.210, 430.240- 430.640, 430.850 - 430.955, 743A.168, 813.010 - 813.052
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0160
Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board

(1) Services and supports must include all appropriate services determined necessary to assist the individual in maintaining community placement and which are consistent with Conditional Release Orders and the Agreement to Conditional Release.

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

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

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

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

(C) Within 30 days of the evaluation interview, submit the evaluation report to the PSRB or JPSRB responding to the questions asked in the Order for Evaluation; and

(D) If supervision by the provider is recommended, notify the PSRB or JPSRB of the name of the person designated to serve as the individual's Qualified Person, who must be primarily responsible for delivering or arranging for the delivery of services and the submission of reports under these rules.

(b) Monthly reports consistent with PSRB or JPSRB reporting requirements as specified in the Conditional Release Order that summarize the individual's adherence to Conditional Release requirements and general progress; and

(c) Interim reports, including immediate reports by phone, if necessary, to ensure the public or individual's safety including:

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

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

(C) Upon noting any other major change in the individual's Service Plan;

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

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

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

(4) When the individual is under the jurisdiction of the PSRB or JPSRB, providers must include the following additional documentation in the Service Record:

(a) Monthly reports to the PSRB or JPSRB;

(b) Interim reports, as applicable;

(c) The PSRB or JPSRB Initial Evaluation; and

(d) A copy of the Conditional Order of Release.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380- 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0165
Intensive Community-Based Treatment and Support Services (ICTS) for Children

(1) ICTS services may be delivered at a clinic, facility, home, school, other provider or allied agency location or other setting as identified by the child and family team. In addition to services specified by the Service Plan and the standards for outpatient mental health services, ICTS services must include:

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

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

(c) Service coordination planning, to be developed by the child and family team;

(d) Review of progress at child and family team meetings to occur at a frequency determined by the child and family team and consistent with needs;

(e) A Proactive safety and crisis plan developed by the child and family team, including:

(A) Strategies designed to facilitate positive alternatives to challenging behavior and to assist the individual in developing adaptive and functional living skills;

(B) Strategies to avert potential crisis without placement disruptions;

(C) Professional and natural supports to provide 24 hours, seven days per week flexible response; and

(D) Documented informed consent from the parent or guardian.

(2) ICTS providers must include the following additional documentation in the Service Record:

(a) Level of Service Intensity Determination;

(b) Names and contact information of the members of the child and family team;

(c) Documented identification of strengths and needs;

(d) A summary and review of service coordination planning by the participating team members; and

(e) A proactive safety and crisis plan.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 430.010, 430.205 - 430.210, 430.240- 430.640, 430.850 - 430.955

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0170
Outpatient Problem Gambling Treatment Services

These services include group, individual and family treatment consistent with the following requirements:

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

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

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

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

(b) Phone counseling must be provided by a qualified program staff within their scope of practice;

(c) Service Notes for phone counseling must follow the same criteria as face-to-face counseling and identify the session was conducted by phone and the clinical rationale for the phone session;

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

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

(4) Family Counseling: Family counseling includes face-to-face or non face-to-face service sessions between a program staff member delivering the service and a family member whose life has been negatively impacted by gambling.

(a) Service sessions must address the problems of the family member as they relate directly or indirectly to the problem gambling behavior; and

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

(5) 24-hour crisis response accomplished through agreement with other crisis services, on-call program staff or other arrangement acceptable to the Division.

(6) A financial assessment must be included in the entry process and documented in the assessment; and

(7) The service plan must include a financial component, consistent with the financial assessment.

(8) A risk assessment for suicide ideation must be included in the entry process and documented in the assessment, as well as appropriate referrals made; and

(9) The service plan must address suicidal risks if determined within the assessment process.

Stat. Auth.: ORS 161.390, 428.205 - 428.270, 430.640, 461.549

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.430 - 409.435, 426.380- 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 1-2015(Temp), f. & cert. ef. 3-25-15 thru 9-20-15; MHS 3-2015, f. & cert. ef. 5-28-15

309-019-0175

Outpatient Substance Use Disorders Treatment and Recovery Services

(1) Interim Referral and Information Services: Pregnant women or other individuals using substances intravenously, whose services are funded by the SAPT Block Grant, must receive interim referrals and information prior to entry, to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services must include:

(a) Counseling and education about blood borne pathogens including Hepatitis, HIV, STDs and Tuberculosis (TB); the risks of needle and paraphernalia sharing and the likelihood of transmission to sexual partners and infants;

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

(c) Referral for Hepatitis, HIV, STD and TB testing, vaccine or care services if necessary; and

(d) For pregnant women, counseling on the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco and other drug use on the fetus and referral for prenatal care.

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

(a) Serve a majority of individuals representing culturally specific populations;

(b) Maintain a current demographic and cultural profile of the community;

(c) Ensure that individuals from the identified cultural group receive effective and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language;

(d) Implement strategies to recruit, retain, and promote a diverse staff at all levels of the organization that are representative of the population being served;

(e) Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery;

(f) Providers should ensure that a majority of the substance use disorders treatment staff be representative of the specific culture being served;

(g) Ensure that individuals are offered customer satisfaction surveys that address all areas of service and that the results of the surveys are used for quality improvement;

(h) Consider race, ethnicity, and language data in measuring customer satisfaction;

(i) Develop and implement cultural competency policies;

(j) Ensure that data on individual's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated;

(k) Develop and maintain a Governing or Advisory Board as follows:

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

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

(C) Meet at least quarterly; and

(D) Monitor agency quality improvement mechanisms and evaluate the ongoing effectiveness and implementation of culturally relevant services (CLAS) and supports within the organization.

(l) Maintain accessibility to culturally specific populations including:

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

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

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

(m) The physical facility where the culturally specific services are delivered must be psychologically comfortable for the group including:

(A) Materials displayed must be culturally relevant; and

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

(n) Other cultural differences must be considered and accommodated when possible, such as the need or desire to bring family members to the facility, play areas for small children and related accommodations; and

(o) Ensure that grievance processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints.

Stat. Auth.: ORS 413.042, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0180

Outpatient Adolescent Substance Use Disorders Treatment and Recovery Services

Programs approved to provide adolescent substance use disorders treatment services or those with adolescent-designated service funding must meet the following standards:

(1) Development of Service Plans and case management services must include participation of parents, other family members, schools, children’s services agencies, and juvenile corrections, as appropriate;

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

- (a) Family counseling;
- (b) Community and social skills training; and
- (c) Smoking cessation service.

(3) Continuing care services must be of appropriate duration and designed to maximize recovery opportunities. The services must include:

- (a) Reintegration services and coordination with family and schools;
- (b) Youth dominated self-help groups where available;
- (c) Linkage to emancipation services when appropriate; and
- (d) Linkage to physical or sexual abuse counseling and support services when appropriate.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640

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

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0185

Outpatient Women’s Substance Use Disorders Treatment and Recovery Programs

(1) Programs approved to provide women’s substance use disorders treatment services or those with women-specific designated service funding must meet the following standards:

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

(b) The service plan must address all areas identified in the assessment and applicable service coordination details to address the identified needs;

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

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

- (A) Gender-specific services and supports;
- (B) Family services, including therapeutic services for children in the custody of women in treatment;
- (C) Reintegration with family;
- (D) Peer delivered supports;
- (E) Smoking cessation;
- (F) Housing; and
- (G) Transportation.

(2) Services must include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies;

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

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

(b) Parenting training; and

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

(4) Programs that receive SAPT Block Grant funding must provide or coordinate the following services for pregnant women

and women with dependent children, including women who are attempting to regain custody of their children:

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

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

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

- (A) Relationship issues;
- (B) Sexual and physical abuse;
- (C) Parenting;
- (D) Access to child care while the women are receiving these services; and

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

- (i) Their developmental needs;
- (ii) Any issues concerning sexual and physical abuse, and neglect; and

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

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640

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

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0190

Community-Based Substance Use Treatment Programs for Individuals in the Criminal Justice System

(1) These services and supports are for individuals who are under the supervision of a probation officer or on parole or post-prison supervision or participating in a drug treatment court program or otherwise under the direct supervision of the court.

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

- (a) Cognitive behavioral interventions;
- (b) Motivational interventions;
- (c) Relapse prevention; and
- (d) Healthy relationships education;

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

(4) Program Directors or clinical supervisors must have experience in community-based offender treatment programs and have specific training and experience applying effective, evidence-based clinical strategies and services for individuals receiving community-based substance use disorders treatment services to individuals in the criminal justice system;

(5) Within the first six months of hire, program staff must:

- (a) Receive training on effective principles of evidenced-based practices for individuals with criminogenic risk factors; and
- (b) Have documented knowledge, skills, and abilities demonstrating treatment strategies for individuals with criminogenic risk factors.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640

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

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0195

DUII Rehabilitation Programs

(1) In addition to the general standards for substance use disorders treatment programs, those programs approved to provide DUII rehabilitation services must meet the following standards:

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

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

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

(C) Residential Treatment: Using the criteria from the ASAM PPC, the DUII program's assessment may indicate that the individual requires treatment in a residential program. When the individual is in residential treatment, it is the responsibility of the DUII program to:

(i) Monitor the case carefully while the individual is in residential treatment;

(ii) Provide or monitor outpatient and follow-up services when the individual is transferred from the residential program; and

(iii) Verify completion of residential treatment and follow-up outpatient treatment.

(2) Urinalysis Testing: A minimum of one urinalysis sample per month must be collected during the period of service, the total number deemed necessary to be determined by an individual's DUII rehabilitation program:

(a) Using the process defined in these rules, the samples must be tested for at least five controlled drugs, including alcohol;

(b) At least one of the samples is to be collected and tested in the first two weeks of the program and at least one is to be collected and tested in the last two weeks of the program;

(c) If the first sample is positive, two or more samples must be collected and tested, including one sample within the last two weeks before completion; and

(d) Programs may use methods of testing for the presence of alcohol and other drugs in the individual's body other than urinalysis tests if they have obtained the prior review and approval of such methods by the Division.

(3) Reporting: The program must report:

(a) To the Division on forms prescribed by the Division;

(b) To the screening specialist within 30 days from the date of the referral by the screening specialist. Subsequent reports must be provided within 30 days of completion or within 10 days of the time that the individual enters noncompliant status; and

(c) To the appropriate screening specialist, case manager, court, or other agency as required when requested concerning individual cooperation, attendance, treatment progress, utilized modalities, and fee payment.

(4) Certifying Completion: The program must send a numbered Certificate of Completion to the Department of Motor Vehicles to verify the completion of convicted individuals. Payment for treatment may be considered in determining completion. A certificate of completion must not be issued until the individual has:

(a) Met the completion criteria approved by the Division;

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

(c) Demonstrated 90 days of continuous abstinence prior to completion.

(5) Records: The DUII rehabilitation program must maintain in the permanent Service Record, urinalysis results and all information necessary to determine whether the program is being, or has been, successfully completed.

(6) Separation of Screening and Rehabilitation Functions: Without the approval of the Chief Officer, no agency or person may provide DUII rehabilitation to an individual who has also been referred by a Judge to the same agency or person for a DUII screening. Failure to comply with this rule will be considered a violation of ORS chapter 813. If the Chief Officer finds such a violation, the Chief Officer may deny, suspend, revoke, or refuse to renew a letter of approval.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 161.390 - 161.400, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0200

Medical Protocols in Outpatient Substance Use Disorders Treatment and Recovery Programs

Medical protocols must be approved by a medical director under contract with a program or written reciprocal agreement with a medical practitioner under managed care. The protocols must:

(1) Require a medical history be included in the Assessment;

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

(3) Require that individuals admitted to the program who are currently injecting or intravenously using a drug, or have injected or intravenously used a drug within the past 30 days, or who are at risk of withdrawal from a drug, or who may be pregnant, must be referred for a physical examination and appropriate lab testing within 30 days of entry to the program. This requirement may be waived by the medical director if these services have been received within the past 90 days and documentation is provided;

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

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

(6) Specify the steps for follow up and coordination with physical health care providers in the event the individual is found to have an infectious disease or other major medical problem.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0205

Building Requirements in Outpatient Substance Use Disorders Treatment Programs

All substance use disorders treatment programs must:

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

(2) Maintain up-to-date documentation verifying that they meet applicable local business license, zoning and building codes and federal, state and local fire and safety regulations. It is the responsibility of the program to check with local government to make sure all applicable local codes have been met;

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

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

(5) Adopt and implement emergency policies and procedures, including an evacuation plan and emergency plan in case of fire, explosion, accident, death or other emergency. The policies and procedures and emergency plans must be current and posted in a conspicuous area; and

(6) Tobacco Use: Outpatient programs must not allow tobacco use in program facilities and on program grounds.

Stat. Auth.: ORS 413.042, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0210

Quality Assessment and Performance Improvement

Providers must develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families.

Stat. Auth.: ORS 430.640
Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955

Chapter 309 Oregon Health Authority, Health Systems Division: Mental Health Services

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14

309-019-0215

Grievances and Appeals

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

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

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

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

(b) Assist individuals and parents or guardians, as applicable, to understand and complete the grievance process; and notify them of the results and basis for the decision;

(c) Encourage and facilitate resolution of the grievance at the lowest possible level;

(d) Complete an investigation of any grievance within 30 calendar days;

(e) Implement a procedure for accepting, processing and responding to grievances including specific timelines for each;

(f) Designate a program staff person to receive and process the grievance;

(g) Document any action taken on a substantiated grievance within a timely manner; and

(h) Document receipt, investigation and action taken in response to the grievance.

(4) Grievance Process Notice. The provider must have a Grievance Process Notice, which must be posted in a conspicuous place stating the telephone number of:

(a) The Division;

(b) Disability Rights Oregon; and

(c) The applicable managed care organization.

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

(6) Retaliation: A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.

(7) Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

(8) Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:

(a) If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the Division as applicable;

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0220

Variations

(1) Requirements and standards for requesting and granting variations or exceptions are found in OAR 309-008-1600.

(2) Division Review and Notification: The Chief Officer of the Division must approve or deny the request for a variance to these rules within the scope and authority The Division must be made in writing using the Division approved variance request form and following the variance request procedure compliant with OAR 309-008-1600. (3) Granting a variance for one request does not set a precedent that must be followed by the Division when evaluating subsequent requests for variance.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0225

ACT Overview

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

(a) A team approach;

(b) Community based;

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

(d) Time-unlimited services;

(e) Flexible service delivery;

(f) A fixed point of responsibility; and

(g) 24/7 crisis availability.

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

(a) Hospital discharge planning;

(b) Case management;

(c) Symptom management;

(d) Psychiatry services;

(e) Nursing services;

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

(g) Vocational services;

(h) Life skills training; and

(i) Peer support services.

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

(a) Psychiatrist or Psychiatric Nurse Practitioner;

(b) Psychiatric Nurse(s);

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

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

(e) Substance Abuse Treatment Specialist;

(f) Employment Specialist;

(g) Housing Specialist;

(h) Mental Health Case Manager; and

(i) Certified Peer Support Specialist.

(3) SAMHSA characterizes a high fidelity ACT Program as one that adheres to the following protocols:

(a) Explicit admission criteria that has an identified mission to serve a particular population and uses measurable and operationally defined criteria;

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

(c) Full responsibility for treatment services which includes, at a minimum, case management, psychiatric services,

counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services;

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

- (e) Involvement in psychiatric hospital admissions;
(f) Involvement in planning for hospital discharges; and
(g) Time-unlimited services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0230

ACT Provider Qualifications

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

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

(b) The provider must hold and maintain a current certificate, issued by the Division, under OAR 309-019-0210 through 309-019-0245, for the purpose of providing Assertive Community Treatment; and

(c) A provider certified to provide ACT services under this rule must be reviewed annually for fidelity adherence by the Division approved reviewer and achieve a minimum score of 114 on the fidelity scale. Providers shall not bill Medicaid or use General Funds unless they are subject to an annual fidelity review by the Division approved reviewer.

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

(B) The provider shall forward a copy of the annual fidelity review report to the appropriate CCO.

(2) A Provider already holding a certificate of approval under OAR 309-008 may request the addition of ACT services be added to their certificate of approval via the procedure outlined in OAR 309-008-0400 and 309-008-1000(1). In addition to application materials required in OAR 309-008 and this rule, the provider must also submit to the Division a letter of support which indicates receipt of technical assistance and training from the Division approved ACT reviewer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0235

Continued Fidelity Requirements

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

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0240

Failure to Meet Fidelity Standards

(1) In addition to any plan of correction requirements issued by the Division under 309-008-0800(4)(c); If a Provider certified under these rules to provide ACT services does not receive a minimum score of 114 on a fidelity review, the following shall occur:

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

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

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

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

(2) In addition to the standards set for suspension and revocation of a certificate in OAR 309-008-1100(1) and (2) a provider of ACT services may also have their certificate of approval suspended or revoked if the 90 day re-review results in a fidelity score of less than 114.

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0245

Admission Criteria

(1) Participants must meet the Medically Appropriate standard as designated in OAR 309-019-0105. Participants who are Medically Appropriate must have the following characteristics:

(a) Participants diagnosed with severe and persistent mental illness as listed in the Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability.

(b) Participants with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder or intellectual disabilities are not the intended client group.)

(c) Participants with significant functional impairments as demonstrated by at least one of the following conditions:

(A) Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.

(B) Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).

(C) Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

(d) Participants with one or more of the following problems, which are indicators of continuous high service needs (i.e., greater than eight hours per month):

(A) High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.

(B) Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).

(C) Coexisting substance abuse disorder of significant duration (e.g., greater than 6 months).

(D) High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).

(E) Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.

(F) Residing in an inpatient or supervised community residence in the community where ACT services are available, but 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.

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0248

Admission Process

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

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

(a) The designated single point of contact shall accept referrals and verify the required documentation supports the referral for services.

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

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

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

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

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

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

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

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

(a) An admission is indicated.

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

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

(B) The disposition of the case; and

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0250

Transition to Less Intensive Services

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

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

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205- 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0255

Reporting Requirements

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

(1) Individuals served;

(a) Individuals who are homeless at any point during a quarter;

(b) Individuals with safe stable housing for 6 months;

(c) Individuals using emergency departments during each quarter for a mental health reason;

(d) Individuals hospitalized in OSH or in an acute psychiatric facility during each quarter;

(e) Individuals hospitalized in an acute care psychiatric facility during each quarter;

(f) Individuals in jail at any point during each quarter;

(g) Individuals receiving Supported Employment Services during each quarter;

(h) Individuals who are employed in competitive integrated employment, as defined above.

(2) Individuals receiving ACT services that are not enrolled in Medicaid

(3) Referrals and Outcomes

(a) Number of referrals received during each quarter;

(b) Number of individuals accepted during each quarter;

(c) Number of individuals admitted during each quarter; and

(d) Number of individuals denied during each quarter and the reason for each denial.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640

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

Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

DIVISION 22

INTENSIVE TREATMENT SERVICES FOR CHILDREN AND ADOLESCENTS AND CHILDRENS' EMERGENCY SAFETY INTERVENTION SPECIALIST (CESIS)

309-022-0100

Purpose and Scope

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

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for services and supports provided in: Intensive Treatment Services (ITS) for Children and Adolescents.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-022-0105

Definitions

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

(2) "Health Systems Services and Supports" means all services and supports including but not limited to, Outpatient Community Mental Health Services and Supports for Children and Adults, Intensive Treatment Services for Children, Outpatient and Residential Substance Use Disorders Treatment Services and Outpatient and Residential Problem Gambling Treatment Services.

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

(4) "Assessment" means the process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.

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

(6) "Behavioral Health" means mental health, mental illness, addictive health and addiction disorders.

(7) "Behavior Support Plan" means the individualized proactive support strategies that are used to support positive behavior.

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

(9) "Care Coordination" means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by

creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.

(10) "Certificate" means the document or documents issued by the Division, which identifies and declares certification of a provider pursuant to OAR 309-008-0100 to 309-008-1600. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

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

(12) "Chief Officer" means the Chief Health Systems Officer of the Oregon Health Authority, or his or her designee.

(13) "Child" means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.

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

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

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

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

(18) "Community Mental Health Program" (CMHP) means an entity that is responsible for planning and delivery of services for individuals with substance use or mental illness diagnoses, operated in a specific geographic area of the state under an intergovernmental agreement or a direct contract with the Addictions and Mental Health Division (AMH).

(19) "Co-occurring Disorder" means the existence of both, a substance use disorder and also mental health disorder.

(20) "Coordinated Care Organization (CCO)" means an entity that has been certified by the Authority to provide coordinated and integrated health services. is a network of all types of health care providers (physical health care, addictions and mental health care and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

(21) "Community Mental Health Program (CMHP)" means an entity that is responsible for planning and delivery of services for persons with substance use disorders or a mental health diagnosis, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(22) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.

(23) "Crisis" means either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care.

(24) "Cultural Competence" means the process by which people and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity

factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

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

(26) “Diagnosis” means the principal mental health, substance use or problem gambling diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the assessment and any examinations, tests, or consultations suggested by the assessment, and are the medically appropriate reason for services.

(27) “Division” means the Health Systems Division.

(28) “DSM” means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(29) “Emergency Safety Intervention” means the use of seclusion or personal restraint under OAR 309-021-0175 of these rules, as an immediate response to an unanticipated threat of violence or injury to an individual, or others.

(30) “Emergency Safety Intervention Training” means a Division approved course that includes an identified instructor, a specific number of face-to-face instruction hours, a component to assess competency of the course materials, and an established curriculum including the following:

(a) Prevention of emergency safety situations using positive behavior support strategies identified in the individual’s behavior support plan;

(b) Strategies to safely manage emergency safety situations; and

(c) De-escalation and debriefing.

(31) “Emergency Safety Situation” means an unanticipated behavior that places the individual or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

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

(33) “Entry” means the act or process of acceptance and enrollment into services regulated by this rule.

(34) “Family” means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adoption, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

(35) “Family Support” means the provision of supportive services to persons defined as family to the individual. It includes support to caregivers at community meetings, assistance to families in system navigation and managing multiple appointments, supportive home visits, peer support, parent mentoring and coaching, advocacy, and furthering efforts to develop natural and informal community supports.

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

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

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

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

(40) “HIPAA” means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

(41) “Individual” means any person being considered for or receiving services and supports regulated by these rules.

(42) “Informed Consent for Services” means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the individual and guardian, if applicable, have consented to the services on, or prior to, the first date of service.

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

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

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

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

(47) “Juvenile Psychiatric Security Review Board (JPSRB)” means the entity described in ORS 161.385.

(48) “Level of Care” means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

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

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

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

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

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

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

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

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

(52) “Local Mental Health Authority (LMHA)” means one of the following entities:

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

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

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

(53) “Mandatory Reporter” means any public or private official, as defined in ORS 419B.005(3), who comes in contact with or has reasonable cause to believe that an individual has

suffered abuse, or that any person with whom the official comes in contact with, has abused the individual. Pursuant to 430.765(2) psychiatrists, psychologists, clergy and attorneys are not mandatory reporters with regard to information received through communications that are privileged under 40.225 to 40.295.

(54) “Mechanical restraint” means any device attached or adjacent to the resident’s body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. Mechanical restraint is prohibited in the services regulated by these rules.

(55) “Medicaid” means the federal grant-in-aid program to state governments to provide medical assistance to eligible persons, under Title XIX of the Social Security Act. (56) “Medical Supervision” means an LMP’s review and approval, at least annually, of the medical appropriateness of services and supports identified in the Service Plan for each individual receiving mental health services for one or more continuous years.

(56) “Medically Appropriate” means services and medical supplies required for prevention, diagnosis or treatment of a physical or behavioral health condition, or injuries, and which are:

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

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

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

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

(57) “Mental Health Intern” means a person who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work or behavioral science field to meet the educational requirement of QMHP. The person must:

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

(b) Have a collaborative educational agreement with the CMHP, or other provider, and the graduate program;

(c) Work within the scope of his/her practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by provider; and

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

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

(59) “Oregon Health Authority” means the Oregon Health Authority of the State of Oregon.

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

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

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

(63) “Peer Support Specialist” means a person providing peer delivered services to an individual or family member with similar

life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete a Division approved training program as required in OAR 410-180-0300 to 0380 and be:

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

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

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

(64) “Personal Restraint” means the application of physical force without the use of any device, for the purpose of restraining the free movement of an individual’s body to protect the individual, or others, from immediate harm. Personal restraint does not include briefly holding without undue force an individual to calm or comfort him or her, or holding an individual’s hand to safely escort him or her from one area to another. Personal restraint can be used only in approved ITS programs as an emergency safety intervention under OAR 309-021-0175.

(65) “Program” means a particular type or level of service that is organizationally distinct.

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

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

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

(69) “Psychiatrist” means a physician licensed pursuant to ORS 677.010 to 677.228 and 677.410 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

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

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

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

(73) “Psychologist” means a psychologist licensed by the Oregon Board of Psychologist Examiners.

(74) “Publicly Funded” means financial support, in part or in full, with revenue generated by a local, state or federal government.

(75) “Qualified Mental Health Associate (QMHA)” means a person delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-022-0125.

(76) “Qualified Mental Health Professional (QMHP)” means a LMP or any other person meeting the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-022-0125.

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

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

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

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

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

(82) “Respite care” means planned and emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. Respite care can be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the Service Plan.

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

(84) “Seclusion” means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving. Seclusion can be used only in approved ITS programs as an emergency safety intervention specified in OAR 309-022-0175.

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

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

(87) “Service Note” means the written record of services and supports provided, including documentation of progress toward intended outcomes, consistent with the timelines stated in the Service Plan.

(88) “Service Record” means the documentation, written or electronic, regarding an individual and resulting from entry, assessment, orientation, services and supports planning, services and supports provided, and transfer.

(89) “Services” means those activities and treatments described in the Service Plan that are intended to assist the individual’s transition to recovery from a substance use disorder, problem gambling disorder or mental health condition, and to promote resiliency, and rehabilitative and functional individual and family outcomes.

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

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

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

(93) “Supports” means activities, referrals and supportive relationships designed to enhance the services delivered to individuals and families for the purpose of facilitating progress toward intended outcomes.

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

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

(96) “Treatment” means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis, that are included in the Service Plan.

(97) “Urgent” means the onset of symptoms requiring attention within 48 hours to prevent a serious deterioration in an individual’s mental or physical health or threat to safety.

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

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

**309-022-0110
Provider Policies**

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

- (a) Personnel Qualifications and Credentialing;
- (b) Mandatory abuse reporting, compliant with ORS 430.735-430.768 and OAR 943-045-0250 through 943-045-0370;
- (c) Criminal Records Checks, compliant with ORS 181.533 through 181.575 and 407-007-0000 through 407-007-0370; and
- (d) Fraud, waste and abuse in Federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510.

(2) Service Delivery Policies: All providers must develop and implement written policies and procedures, consistent with these rules.

- (a) Policies must be available to individuals and family members upon request; and
- (b) Service delivery policies and procedures must include, at a minimum:
 - (A) Fee agreements;

(B) Confidentiality and compliance with HIPAA, Federal Confidentiality Regulations (42 CFR, Part 2), and State confidentiality regulations as specified in ORS 179.505 and 192.518 through 192.530;

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

(D) Grievances and Appeals;

(E) Individual Rights;

(F) Quality Assessment and Performance Improvement;

(G) Crisis Prevention and Response;

(H) Incident Reporting;

(I) Family Involvement;

(J) Trauma-informed Service Delivery, consistent with the AMH Trauma Informed Services Policy; and

(K) Provision of culturally and linguistically appropriate services.

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

(a) Medical Protocols and Medical Emergencies;

(b) Medication Administration, Storage and Disposal;

(c) General Safety and Emergency Procedures;

(d) Emergency Safety Interventions in ITS Programs; and

(e) Behavior Support Policies consistent with 309-022-0165. Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168 Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0115

Individual Rights

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

(a) Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence;

(b) Be treated with dignity and respect;

(c) Participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written Service Plan;

(d) Have all services explained, including expected outcomes and possible risks;

(e) Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.

(f) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:

(A) Under age 18 and lawfully married;

(B) Age 16 or older and legally emancipated by the court; or

(C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs;

(g) Inspect their Service Record in accordance with ORS 179.505;

(h) Refuse participation in experimentation;

(i) Receive medication specific to the individual's diagnosed clinical needs;

(j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;

(k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

(l) Have religious freedom;

(m) Be free from seclusion and restraint, except as regulated in OAR 309-021-0175.

(n) Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;

(o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;

(p) Have family and guardian involvement in Service Planning and delivery;

(q) Make a declaration for mental health treatment, when legally an adult;

(r) File grievances, including appealing decisions resulting from the grievance;

(s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;

(t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and

(u) Exercise all rights described in this rule without any form of reprisal or punishment.

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

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

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

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

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

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

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

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

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

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

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

(i) Participate regularly in indoor and outdoor recreation;

(j) Not be required to perform labor;

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

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

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

(a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

- (b) Rights, and how to exercise them, must be explained to the individual, and if appropriate, to her or his guardian; and
- (c) Individual rights must be posted in writing in a common area.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168
Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0120

Licensing and Credentialing

Program staff in the following positions must meet applicable credentialing or licensing standards, including those outlined in these rules:

- (1) CESIS;
- (2) Clinical Supervisor;
- (3) LMP;
- (4) Medical Director;
- (5) QMHA; and
- (6) QMHP.

Stat. Auth.: ORS 161.390, 413.042, 426.490 - 426.500, 428.205 - 428.270, 430.256, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168
Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0125

Specific Staff Qualifications and Competencies

(1) Program Administrators or Program Directors must demonstrate competence in leadership, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, use of data, reporting, program evaluation, quality assurance, and developing and coordinating community resources.

(2) Clinical Supervisors in all programs must demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources, group, family and individual therapy or counseling, documentation and rationale for services to promote intended outcomes and implementation of all provider policies.

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

(4) QMHAs must demonstrate the ability to communicate effectively, understand mental health assessment, treatment and service terminology and apply each of these concepts, implement skills development strategies, and identify, implement and coordinate the services and supports identified in a Service Plan.

(a) QMHAs must meet the following minimum qualifications:

- (A) Bachelor's degree in a behavioral science field; or
- (B) A combination of at least three years of relevant work, education, training or experience; or
- (C) A qualified Mental Health Intern, as defined in 309-022-0105(57).

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

(a) QMHPs must meet the following minimum qualifications:

- (A) Bachelor's degree in nursing and licensed by the State of Oregon;
- (B) Bachelor's degree in occupational therapy and licensed by the State of Oregon;
- (C) Graduate degree in psychology;

- (D) Graduate degree in social work;
- (E) Graduate degree in recreational, art, or music therapy;
- (F) Graduate degree in a behavioral science field.
- (G) A qualified Mental Health Intern, as defined in 309-022-

0105(57).

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

Stat. Auth.: ORS 161.390, 413.042, 426.490 - 426.500, 428.205 - 428.270, 430.256, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168
Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0130

Documentation, Training and Supervision

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

- (a) An employment application;
- (b) Verification of a criminal record check consistent with OAR 407-007-0200 through 407-007-0370;
- (c) A current job description that includes applicable competencies;

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

- (e) Periodic performance appraisals;
- (f) Staff orientation and development activities;
- (g) Program staff incident reports;
- (h) Disciplinary documentation;
- (i) Reference checks;

(j) Emergency contact information; and

(k) Documentation of a tuberculosis screening pursuant to OAR 333-071-0057.

(2) Providers must maintain the following documentation for contractors, interns or volunteers, as applicable:

- (a) A contract, or written agreement, if applicable;
- (b) A signed confidentiality agreement;
- (c) Service-specific orientation documentation; and
- (d) Verification of a criminal records check consistent with OAR 407-007-0200 through 407-007-0370.

(3) Training: Providers must ensure that program staff receive training applicable to the specific population for whom services are planned or delivered, to include the following minimum orientation training, within 30 days of the hire date:

- (a) A review of individual crisis response procedures;
- (b) A review of emergency procedures;
- (c) A review of program policies and procedures;
- (d) A review of rights for individuals receiving services and supports;

(e) Mandatory abuse reporting procedures;

(f) Positive behavior support training consistent with 309-022-0165.

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

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

(b) QMHP supervision: Documentation of clinical supervision for QMHP staff of no less than two hours per month. The two hours must include one hour of face-to-face contact for each person supervised, or a proportional level of supervision for part-time QMHP staff. Face-to-face contact may include real time, two-way audio visual conferencing; or

(c) Documentation of two hours of quarterly supervision for program staff holding a health or allied provider license, including at least one hour of face-to-face contact for each person supervised.

(d) QMHA supervision: Documentation of clinical supervision for each QMHA staff supervised of no less than two hours per month. The two hours must include one hour of face-to-face contact for each person supervised related to direct care responsibilities, or a proportional level of supervision for part-time QMHA staff. Face-to-face contact may include real time, two-way audio visual conferencing. Clinical supervision of a QMHA can be conducted by a Lead QMHA staff.

(e) Mental Health Intern supervision: Documentation of weekly supervision for program staff meeting the definition of Mental Health Intern.

Stat. Auth.: ORS 161.390, 413.042, 426.490 - 426.500, 428.205 - 428.270, 430.256, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0135

Entry and Assessment

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

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

(b) Individuals must receive services in the most timely manner feasible consistent with the presenting circumstances.

(c) Written informed consent for services must be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason must be documented and further attempts to obtain informed consent must be made as appropriate.

(d) The provider must establish a Service Record for each individual on the date of entry.

(e) The provider must report the entry of all individuals on the mandated state data system.

(f) In accordance with ORS 179.505 and HIPAA, an authorization for the release of information must be obtained for any confidential information concerning the individual being considered for, or receiving, services.

(2) Orientation: At the time of entry, the program must offer to the individual and guardian if applicable, written program orientation information. The written information must be in a language understood by the individual and must include:

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

(b) Policies concerning grievances and confidentiality.

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

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

(b) Children who have severe mental health conditions;

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

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

(4) Assessment:

(a) At the time of entry, an assessment must be completed prior to development of the Service Plan.

(b) The assessment must be completed by a QMHP. A QMHA may assist in the gathering and compiling of information to be included in the assessment.

(c) Each assessment must include:

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

(B) Suicide potential must be assessed and Service Records must contain follow-up actions and referrals when an individual reports symptoms indicating risk of suicide;

(C) Screening for the presence of co-occurring disorders and chronic medical conditions; and

(D) Screening for the presence of symptoms related to physical or psychological trauma.

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

(e) In addition to periodic assessment updates based on changes in the clinical circumstance, any individual continuing to receive mental health services for one or more continuous years, must receive an annual assessment by a LMP.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-022-0140

Service Planning and Coordination

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

(a) Qualified program staff must facilitate a planning process, resulting in a Service Plan that reflects the assessment.

(b) A Service Plan must be completed prior to the start of services.

(c) A licensed health care professional, must recommend the services and supports by signing the Service Plan.

(d) Individuals, and family members, must be invited to participate in the development of the Service Plan.

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

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

(g) Providers must collaborate to exchange information with any applicable physical health care providers, for the individual, to promote regular and adequate health care.

(2) Service Plan: The Service Plan must be a written, individualized plan to improve the individual's condition to the point where the individual's continued participation in the program is no longer necessary. The Service Plan is included in the individual's service records and must:

(a) Be completed prior to the start of services;

(b) Reflect the assessment and the level of care to be provided;

(c) Include the participation of the individual and family members;

(d) Be completed by a QMHP;

(e) A QMHP, who is also a licensed health care professional, must recommend the services and supports by signing the Service plan within ten (10) business days of the start of services; and

(f) A LMP must approve the Service Plan at least annually for each individual receiving mental health services for one or more continuous years. The LMP may designate annual clinical oversight by documenting the designation to a specific licensed health care professional.

(3) At minimum, each Service Plan must include:

(a) Individualized treatment objectives;

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

(c) A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter;

(d) The type of personnel that will be furnishing the services; and

(e) Proactive safety and crisis planning;

(f) A behavior support plan, consistent with OAR 309-022-0165; and

(g) The interdisciplinary team must conduct a review of progress and transfer criteria at least every 30 days from the date of entry and must document members present, progress and changes made. For Psychiatric Day Treatment Services, the review must be conducted every 30 days and the LMP must participate in the review at least every 90 days.

(4) Service Notes:

Providers must document each service and support. A Service Note, at minimum, must include:

(A) The specific services rendered;

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

(C) Who rendered the services;

(D) The setting in which the services were rendered;

(E) The relationship of the services to the treatment regimen described in the Service Plan; and

(F) Periodic Updates describing the individual's progress toward the treatment objectives; and

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0145

Service Record

(1) All providers must develop and maintain a Service Record for each individual upon entry.

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

(3) The Service Record must, at a minimum, include:

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

(A) The individual's name, address, telephone number, date of birth, and gender;

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

(C) Contact information for medical and dental providers;

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

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

(d) A signed fee agreement, when applicable;

(e) Assessment and updates to the assessment;

(f) A Service Plan, including any applicable behavior support or crisis intervention planning;

(g) Service Notes;

(h) A Transfer Summary, when applicable;

(i) Applicable signed consents for release of information;

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

(a) Medication Administration Records;

(b) Laboratory reports; and

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

(5) Providers must maintain additional Service Record documentation as follows:

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

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

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

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

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

(f) A copy of the individual's most recent Service Plan, if applicable, or in the case of an emergency or crisis-respite entry, a summary of current addictions or mental health services and any applicable behavior support plans;

(g) Documentation of the individual's ability to evacuate the home consistent with the program's evacuation plan developed in accordance with the Oregon Structural Specialty Code and Oregon Fire Code;

(h) Documentation of any safety risks;

(i) Incident reports, when required, including:

(A) The date of the incident, the persons involved, the details of the incident, and the quality and performance actions taken to initiate investigation of the incident and correct any identified deficiencies; and

(B) Any child abuse reports made by the provider to law enforcement or to the DHS Children, Adults and Families Division, documenting the date of the incident, the persons involved and, if known, the outcome of the reports.

(j) Level of Service Intensity Determination;

(k) Names and contact information of the members of the interdisciplinary team;

(l) Documentation by the interdisciplinary team that the child's ISSP has been reviewed, the services provided are medically appropriate for the specific level of care, and changes in the plan recommended by the interdisciplinary team, as indicated by the child's service and support needs, have been implemented;

(m) Emergency safety intervention records, in a separate section or in a separate format, documenting each incident of personal restraint or seclusion, signed and dated by the qualified program staff directing the intervention and, if required, by the psychiatrist or clinical supervisor authorizing the intervention; and

(n) A copy of the written transition instructions provided to the child and family on the date of transfer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0150

Minimum Program Requirements

ITS Providers must meet the following general requirements:

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

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

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

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0155

General Staffing Requirements

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

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

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

(3) Assessment of each child's medication and treatment needs, prescribe medicine or otherwise assure that case management and consultation services are provided to obtain prescriptions, and prescribe therapeutic modalities to achieve the child's Service Plan goals.

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

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

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

(b) Continuity of the child's education when treatment services interrupt the child's day to day educational environment;

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

(d) Psychiatric services;

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

(f) Medication evaluation, management and monitoring;

(g) Pre-vocational or vocational rehabilitation;

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

(i) Individual and group psychosocial skills development;

(j) Activity and recreational therapies;

(k) Nutrition;

(l) Physical health care services or coordination;

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

(n) Educational services coordination and advocacy; and

(o) Behavior support services, consistent with OAR 309-022-0165 of these rules.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0160

Program Specific Requirements

In addition to the general requirements for all ITS providers listed in OAR 309-022-0150 and 0155, the following program-specific requirements must be met:

(1) Psychiatric Residential Treatment Facilities (PRTF):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Provide nursing supervision and monitoring and psychiatric supervision at least once per week; and

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

(4) Psychiatric Day Treatment Services (PDTs):

(a) PDTs must be provided to children who remain at home with a parent, guardian or foster parent by qualified mental health

professionals and qualified mental health associates in consultation with a psychiatrist;

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0165

Behavior Support Services

Behavior support services must be proactive, recovery-oriented, individualized, and designed to facilitate positive alternatives to challenging behavior, as well as to assist the individual in developing adaptive and functional living skills. All Providers must:

(1) Develop and implement individual behavior support strategies, based on a functional or other clinically appropriate assessment of challenging behavior;

(2) Document the behavior support strategies and measures for tracking progress as a behavior support plan in the Service Plan;

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

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

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

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

(b) Increasing positive behavior.

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0170

Emergency Safety Interventions

Providers of ITS services must:

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0175

Restraint and Seclusion

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Personal Restraint:

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

(b) The order must include:

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

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

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

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

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

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

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

(g) Each incident of personal restraint must be documented in the Service Record. The documentation must specify:

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

(B) Required authorization;

(C) Events precipitating the personal restraint;

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

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

(F) Assessment of physical injury; and

(G) Individual's response to the emergency safety intervention.

(3) Seclusion: Providers must be certified by the Division for the use of seclusion.

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

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

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

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

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

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

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

(e) The individual must have regular meals, bathing, and use of the bathroom during seclusion and the provision of these must be documented in the Service Record; and

(f) Each incident of seclusion must be documented in the Service Record. The documentation must specify:

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

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

(C) The events precipitating the use of seclusion;

(D) The length of time seclusion was used;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) The room must meet State Fire Marshal fire, safety, and health standards. If sprinklers are installed, they must be recessed and covered with fine mesh screening. If pop-down type, sprinklers

must have breakaway strength of under 80 pounds. In lieu of sprinklers, combined smoke and heat detector must be used with similar protective design or installation;

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

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

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

(l) Adequate and safe bathrooms must be available.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 28.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168
Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-022-0180

Transfer and Continuity of Care

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

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

(b) Planned transfer must be consistent with the transfer criteria established by the interdisciplinary team and documented in the Service Plan.

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

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

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

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

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

(c) Complete a Transfer Summary;

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

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

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

(g) At a minimum, the provider's interdisciplinary team must:

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

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

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

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

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

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

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

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

(3) Transfer Summary:

(a) A Transfer Summary must include:

(A) The date and reason for the transfer;

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

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

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.45

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168
Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0185

Quality Assessment and Performance Improvement

(1) Each provider must develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families, including:

(a) A Quality Improvement Committee; and

(b) A Performance improvement process documented in a Performance Improvement Plan.

(2) The Quality Improvement Committee must include representatives of individuals served and their families and must meet at least quarterly to:

(a) Identify and assess the following indicators of quality:

(A) Access to services;

(B) Outcomes of services;

(C) Systems integration and coordination of services; and

(D) Utilization of services.

(b) Review incident reports, emergency safety intervention documentation, grievances and other documentation as applicable;

(c) Identify measurable and time-specific performance objectives and strategies to meet the objectives and measure progress;

(d) Recommend policy and operational changes necessary to achieve performance objectives; and

(e) Reassess and, if necessary, revise objectives and methods to measure performance on an ongoing basis to ensure sustainability of improvements.

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

(a) Performance objectives aimed at improving services; and

(b) Strategies designed to meet the performance objectives and measure progress.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168
Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0190

Grievances and Appeals

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

(2) Medicaid grievances and appeals must adhere to procedures outlined in OAR 410-141-0260 through 410-141-0266.

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

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

(b) Assist individuals and parents or guardians, as applicable, to understand and complete the grievance process; and notify them of the results and basis for the decision;

(c) Encourage and facilitate resolution of the grievance at the lowest possible level;

(d) Complete an investigation of any grievance within 30 calendar days;

(e) Implement a procedure for accepting, processing and responding to grievances including specific timelines for each;

(f) Designate a program staff person to receive and process the grievance;

(g) Document any action taken on a substantiated grievance within a timely manner; and

(h) Document receipt, investigation and action taken in response to the grievance.

(4) Grievance Process Notice: The provider must have a Grievance Process Notice, which must be posted in a conspicuous place stating the telephone number of:

(a) The Division;

(b) The CMHP;

(c) Disability Rights Oregon; and

(d) The applicable managed care organization.

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

(6) Retaliation: A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.

(7) Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

(8) Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:

(a) If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable;

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

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

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

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0195

Licensure as a Children's Emergency Safety Intervention Specialist (CESIS)

To obtain a license as a CESIS, an agency that is certified by the Division to provide intensive mental health treatment services for individuals less than 21 years of age shall make an application on behalf of the licensure applicant. The Division shall issue a license as a CESIS to each applicant who furnishes satisfactory evidence to the Division that the applicant meets the following qualifications:

(1) Is employed by or providing services under contract with a provider that is certified by the Division to provide intensive mental health treatment services for individuals under 21 years of age;

(2) Meets qualifications established by the Division by rule for Qualified Mental Health Professionals;

(3) Has successfully completed an emergency safety intervention training program approved by the Division within the past 12 months;

(4) Demonstrates the ability to assess the psychological and physical well-being of individuals less than 21 years of age;

(5) Demonstrates knowledge of federal and state rules governing the use of seclusion and personal restraint in intensive mental health treatment programs for individuals under 21 years of age.

Stat. Auth.: ORS 413.042 & 426.415

Stats. Implemented: ORS 426.415

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0200

CESIS Scope of Licensure

(1) A licensed CESIS is authorized to:

(a) Order the least restrictive intervention, including seclusion and personal restraint that is most likely to be effective in resolving an emergency safety situation if the treatment team physician is not available.

(b) Provide the federally mandated face-to-face assessment of an individual under 21 years of age's well-being within one hour of the initiation of the emergency safety intervention; and

(c) Accept verbal orders for seclusion and personal restraint from a physician or licensed practitioner who is authorized to order seclusion and personal restraint.

(2) Exclusions to Licensure:

(a) A licensed CESIS is not authorized to order or receive orders for the use of mechanical or chemical restraint.

(b) A CESIS license is only valid while the licensee is employed or contracted to provide services with the intensive mental health treatment services program that submitted the application on behalf of the licensee.

Stat. Auth.: ORS 413.042 & 426.415

Stats. Implemented: ORS 426.415

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0205

CESIS License Applications

(1) Application for licensure as a CESIS shall be made to the Division and be on forms prescribed by the Division.

(2) Application for licensure shall be accompanied by a formal written request from a provider that is certified by the Division, pursuant to OAR 309-008-0100 to 309-008-1600, to provide intensive mental health treatment services for individuals under 21 years of age with which the applicant is employed or contracted. The request must include:

(a) Official transcripts and supporting documentation as necessary showing the applicant meets qualifications established by rule for a QMHP;

(b) Verification that an emergency safety intervention course approved by the Division has been successfully completed within the past 12 months;

(c) Verification of certification in CPR and First Aid by a recognized training agency;

(d) A signed Background Check Request form as described in OAR chapter 943 division 007. The Criminal Record Check form will request information regarding criminal history and other information;

(e) Verification of employment or contracted services with a provider that is certified by the Division to provide intensive mental health treatment services for individuals under 21 years of age;

(f) A copy of the completed examination or evaluation the provider used to determine the applicant's competence to assess the psychological and physical well-being of individuals under 21 years of age; and

(g) A copy of the completed examination or evaluation the provider used to determine the applicants knowledge of the federal and state rules governing the use of seclusion and personal restraint in intensive mental health treatment programs for individuals less than 21 years of age.

Stat. Auth.: ORS 413.042 & 426.415

Stats. Implemented: ORS 426.415

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-022-0210

Issuance of a License

(1) The Division shall issue a license within 30 days of the submission of a completed application. The license shall state the name of the licensee, the provider and expiration date.

(2) The license shall be placed in the licensee's personnel file and be easily visible.

(3) An initial license is valid from the time of issuance until the expiration date, which will be September 30th of the following calendar year.

Stat. Auth.: ORS 413.042 & 426.415

Stats. Implemented: ORS 426.415

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0215

Renewal and Expiration of License

(1) A license issued under these rules is subject to renewal every 2 years.

(a) All licenses will expire on September 30th. The issuance date of the licensee's first license will determine if the license expires on an odd or even year.

(b) At least 30 days prior to the expiration of a license, a reminder notice will be sent by the Division to the licensee and the provider.

(c) A licensee seeking renewal of a license shall have a provider with whom they are employed or contracted submit on their behalf:

(A) Proof of fulfillment of the following requirements;

(i) Verification of current certification in CPR and First aid by a recognized training agency;

(ii) A copy of the evaluation completed within the last year of the applicants competence to assess the psychological and physical well-being of individuals less than 21 years of age.

(iii) A copy of the evaluation completed within the last year demonstrating the applicant's knowledge of federal and state rules

governing the use of seclusion and personal restraint in intensive mental health treatment services programs for individuals less than 21 years of age.

(B) Proof of continued employment or contract with a facility certified by the Division to provide intensive mental health treatment services for individuals less than 21 years of age.

(2) A licensee may not continue to practice as a licensed CESIS after expiration of the license.

(3) A licensee may not continue to practice as a licensed CESIS upon discontinuation of employment or contract with the provider of intensive mental health treatment services specified on the license.

(4) If the person's previous license has expired, the person must apply and qualify for a new license in the same manner as a person who has never been licensed.

Stat. Auth.: ORS 413.042 & 426.415

Stats. Implemented: ORS 426.415

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0220

Complaints

(1) Any person who believes these rules have been violated may file a complaint with the Division.

(2) The Division shall establish a protocol for investigation of complaints and make that information available to anyone who files a complaint or has a complaint filed against them. Following the Divisions investigation of a complaint, the Division may take action to:

(a) Dismiss the complaint;

(b) Issue a letter of reprimand;

(c) Direct the Provider to draft a plan of correction with the licensee; or

(d) Institute disciplinary action.

Stat. Auth.: ORS 413.042 & 426.415

Stats. Implemented: ORS 426.415

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0225

Denial, Suspension, Revocation or Non-renewal of License

(1) The Division may deny, suspend, revoke or refuse to issue or to renew any license issued under these rules upon proof that the applicant for licensure or the licensee:

(a) Has been convicted of one or more crimes described in OAR 943-007 entitled "Criminal Records Checks".

(b) Is unable to perform the duties of a CESIS by reason of mental illness, physical illness, drug addiction or alcohol abuse;

(c) Has been grossly negligent in the duties of a CESIS;

(d) Has violated one or more of the rules of the Division pertaining to the licensure of a CESIS;

(e) Has practiced outside the scope of activities for which the licensee has individual training and qualification; or

(f) Has been disciplined by a state licensing board or program in this or any other state for violation of competency or conduct standards.

(2) The Division may reprimand or impose probation on a licensee upon proof of any of the grounds for discipline provided in subsection (1) of this Section.

(3) If the Division elects to place a licensee on probation, the Division may impose:

(a) Restrictions on the scope of practice of the licensee;

(b) Requirements for specific training;

(c) Supervision of the practice of the licensee; or

(d) Other conditions the Division finds necessary for the protection of the public.

Stat. Auth.: ORS 413.042 & 426.415

Stats. Implemented: ORS 426.415

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

309-022-0230

Appeal Process

(1) An appeal of a denial, suspension, probation or revocation of a license may be requested in writing to the Division from a provider of intensive mental health treatment services for children less than 21 years of age on behalf of their employee or contractor.

(2) The Division's Director or designee shall review all material relating to the denial, suspension, revocation or non-renewal, including any written documentation submitted by the licensee and provider. Based on review of the material, the Director will decide whether to sustain the decision. If the decision is not sustained, the denial, suspension, revocation or non-renewal shall be rescinded immediately. The decision of the Division is subject to a contested case hearing under ORS Chapter 183 if requested within 90 days of the decision.

Stat. Auth.: ORS 413.042 & 426.415

Stats. Implemented: ORS 426.415

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14

DIVISION 23

PSYCHIATRIC EMERGENCY SERVICES

309-023-0100

Purpose and Scope

These rules prescribe standards of care and other requirements relating to psychiatric emergency services delivered in an emergency department at a licensed hospital or licensed hospital satellite.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

309-023-0110

Definitions

In addition to the definitions in OAR chapter 309 division 033 the following definitions apply to these rules:

(1) "Behavioral Health" means mental health, mental illness, substance use disorders, and gambling disorders.

(2) "Behavioral Health Assessment" means a process which determines a patient's need for immediate crisis stabilization through evaluation of the patient's strengths, goals, needs, and current level of functioning.

(3) "Best Practice Risk Assessment" means a research-informed methodology that provides guidelines or tools to determine an individual's level of risk for attempting or completing self-inflicted injury or death and may include tools such as the Columbia Suicide Severity Rating Scale or other tools accepted for the Substance Abuse and Mental Health Services Administration National Registry of Evidence-based Programs and Practices or the Suicide Prevention Resource Center Best Practices Registry.

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

(5) "Case Management" means the services provided to assist individuals, who reside in a community setting, or are transitioning to a community setting, in gaining access to needed medical, behavioral health, social, educational, government entitlement programs, and other applicable community services.

(6) "Crisis" means either an actual, or perceived, urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care.

(7) "Crisis Intervention" means short-term services to address an immediate crisis need.

(8) "Crisis Stabilization Plan" means an individualized written plan defining specific short-term rehabilitation objectives and pro-

posed crisis interventions derived from the patient's mental and physical health assessment.

(9) "Family" has the meaning given that term in 309-018-0150.

(10) "Hospital" has the meaning given that term in ORS 442.015.

(11) "Hospital Hold" means the taking of an individual into custody by order of a physician pursuant to ORS 426.232.

(12) "Lethal Means Counseling" means providers implement counseling strategies to help patients at risk for suicide, and their families, reduce access to lethal means, including but not limited to firearms. It includes but is not limited to several components; background on suicide data and lethal means, introduction to firearms, video presentation that models the counseling strategy, presentation and discussion on conducting a counseling session, optional role plays, and a course evaluation. (<http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means-0>).

(13) "Living Room Setting" means a care setting that reflects the relaxed, warm, welcoming and non-clinical qualities of a typical living room.

(14) "Medically Appropriate Treatment" has the meaning given that term in OAR 410-172-0630.

(15) "Mental Status Examination" means an overall assessment of an individual's mental functioning.

(16) "Peer" has the meaning given that term in OAR 410-180-0305.

(17) "Peer Delivered Services" has the meaning given that term in OAR 309-019-0100.

(18) "Peer Support Specialist" has the meaning given that term in OAR 410-180-0300 and also means an individual who has completed a Division approved training program (see OAR 410-180-0312) and is providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified clinical supervisor.

(19) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family or the community, to prevent harm to the patient or others.

(20) "Safety Plan" means a patient directed document developed through a collaborative process in which the provider assists the patient in listing strategies for the patient to use when suicide ideation is elevated or after a suicide attempt. A safety plan template is available from the Suicide Prevention Resource Center at <http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means-0>.

(21) "Transition of Care Coordination" also known as a Warm Handoff, means the process of transferring a patient from one provider to another, prior to discharge.

(22) "Trauma Informed Services" has the meaning given that term in OAR 309-018-0105(77). The Authority's trauma informed service policy may be found at <https://www.oregon.gov/oha/amh/pages/trauma.aspx>.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

309-023-0120

PES Facility Requirements

(1) For purposes of these rules, psychiatric emergency services shall be delivered in an emergency department through a hospital or hospital satellite licensed in accordance with OAR chapter 333 division 500.

(2) The PES facility shall comply with the following:

(a) Standards for Regional Acute Care Psychiatric Services for Adults pursuant to OAR 309-032-0850 to 0870.

(b) Be approved as a hospital hold facility pursuant to OAR 309-033-0500 to 0550.

(c) Meet the structural and physical requirements set forth in OAR chapter 333 division 535 and OAR 309-033-0727.

(3) The facility shall offer food and drink at regularly scheduled intervals and as needed, to patients receiving services.

(4) The facility shall develop policies and procedures annually that demonstrate collaboration with all local licensed ambulance service agencies and police departments that specify the role of each responder in managing medical, psychiatric and other emergencies. The policies and procedures shall also include a requirement for first responder training to determine if the appropriate setting for the patient should be a PES.

(5) The facility shall develop policies and procedures that demonstrate collaboration with the local community and local Coordinated Care Organizations.

(6) The facility shall have phone access available for the patient, when appropriate.

(7) The facility shall offer a care setting that is appropriate to the patient's wishes and safety needs. Care settings should include a living room setting, which may accommodate the option for lying down comfortably and allowing for more privacy. Living room settings include comfortable seating, soft lighting, and are designed to encourage a sense of safety and belonging.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

309-023-0130

Services

(1) Psychiatric emergency services may include up to 23 hours of triage and assessment, observation and supervision, crisis stabilization, crisis intervention, crisis counseling, case management, medication management, safety planning, lethal means counseling, and mobilization of peer and family support and community resources.

(2) The facility shall deliver services that are individualized, recovery-oriented, trauma informed, developmentally and medically appropriate and consistent with best practices for suicide risk assessment, intervention and treatment.

(3) Staff must promptly conduct an assessment to determine the precipitating factors that lead to the crisis and a screening assessment which shall include a best practice evaluation of risk of harm to self or others, a mental status exam, need for immediate behavioral health assessment, including depression screening, need for emergency intervention, a medical screening exam, and collection of collateral information.

(4) Staff shall develop a crisis stabilization plan that provides the most effective treatment based on the patient's provisional psychiatric condition and, to the maximum extent possible, incorporates patient or family preferences. For purposes of these rules, the term families includes families of choice. The facility shall offer peer delivered services to the patient and family and, if accepted, shall be incorporated in care coordination and crisis stabilization plan.

(5) The facility shall provide access to existing community based rehabilitation, reasonable access to peer and family support and social services that may be used to help the patient transition to the community and provide documentation of other needed interventions including crisis counseling and family counseling.

(6) Transition of care coordination shall include to the extent possible and when the patient agrees:

(a) A face-to-face meeting with a community provider and the patient, and if possible, family, and hospital staff prior to discharge.

(b) A face-to-face meeting may be accomplished via technology that provides secure, unrecorded, audio video in a private setting with a community provider and the patient, and if possible, family and hospital staff.

(7) Transition of care coordination shall include:

(a) A transitional team at the PES facility to support the patient, serve as a bridge between the hospital and a community provider and to the extent possible ensure that the patient connects with a community provider, and peer and family support services if desired by the patient and their family.

(b) For patients discharged to their home or other living environment, a member of the transition team shall determine through interviews with the patient, family, peer or family support specialists or lay caregiver the safety of that environment, potential mitigating factors to reduce risk, provide discharge instructions, including a

safety plan, and lethal means counseling to the patient, peer and family support specialist and family.

(8) Facilities shall ensure that the rights of individuals are provided pursuant to OAR 309-032-0341.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

309-023-0140

Seclusion and Restraint

(1) The facility shall be certified as a Class 1 facility pursuant to OAR 309-033-0520. A Class 1 facility is a facility that is approved under applicable administrative rules to be locked to prevent a patient from leaving the facility, to use seclusion and restraint, and to involuntarily administer psychiatric medication.

(2) The facility shall comply with seclusion and restraint requirements set forth in OAR chapter 309 division 33.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

309-023-0150

Involuntary Detainment & Informed Consent

(1) For individuals who are in custody, under a civil commitment, hospital hold or on diversion, the PES facility must comply with the administrative rules in OAR chapter 309, division 33 which govern the administration, standards of care, standards for obtaining informed consent, administration of emergency procedures without informed consent, and transportation of individuals being held in custody, whether the individual is under a civil commitment order, a hospital hold, or on diversion from a civil commitment.

(2) The facility shall have written policies concerning the care, custody, and treatment of individuals in custody or on diversion. These policies shall be reviewed as part of the Division's approval process, and be in accordance with OAR chapter 309 division 33.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

309-023-0160

Staffing Requirements

(1) An adequate number of clinical staff and on-site peer support specialists shall be available and specifically trained in psychiatric emergency services.

(2) A licensed psychiatrist shall be available to meet with patients as needed at any time and on site no less than 12 hours each day to assess individuals and initiate the development of a crisis stabilization plan and oversee patient care.

(3) At a minimum, one registered nurse, and one licensed mental health professional shall be on-site 24/7, and shall be dedicated to providing psychiatric emergency services to individuals in crisis.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

309-023-0170

Staff Training

(1) The facility shall have policies and procedures for ongoing educational programs to instruct staff regarding best practices in psychiatric emergency services.

(2) A staff training curriculum shall include, but is not limited to:

(a) Criteria for the admission of an individual who can safely be served by the facility;

(b) Recognition of indicators of violence to self or others, or assault and criteria for the transfer of the individual to or from the facility;

(c) Indicators of medical problems, identification of medication side effects, and indicators of medical problems and medical crisis;

(d) Management of aggressive behavior and de-escalation techniques;

(e) Trauma Informed care in accord with the Authority's Trauma Informed Policy at <https://www.oregon.gov/oha/amh/pages/trauma.aspx>;

(f) Practices to provide psychoeducation and post-discharge safety to patients and families;

(g) Best practice treatment for substance use disorders

(h) Staff training in best practices for:

(A) Lethal means counseling which may include the CALM (<http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means>) or similar curriculum;

(B) Collaboration with patients on development of safety plans which may include guidelines established by the Suicide Prevention Resource Center, <http://www.sprc.org/sites/default/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.pdf>.; and

(C) Risk assessment.

(3) At a minimum, staff training shall be provided at time of hire and required annually, or more often if necessary.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

309-023-0180

Quality Assessment and Improvement and Patient Outcomes

(1) Facilities must comply with the quality assessment and improvement requirements set forth in OAR 309-032-0870 (10).

(2) In addition to the quality assessment requirements in section (1) facilities shall maintain records of outcomes, for each patient, outlined in the PES provider manual.

(3) Facilities shall report annually to the Authority regarding quality assessment information set forth in OAR 309-032-0870 and outcomes described in the PES provider manual. The report shall use data to demonstrate the quality, cost-effectiveness, and patient satisfaction with PES. The Authority shall review the PES facility reports annually and may make changes to PES policy or payment based on outcome performance.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

DIVISION 31

PROGRAMS FOR MENTAL OR EMOTIONAL DISTURBANCES

309-031-0010

Forensic Psychiatric Services

(1) Purpose. This rule prescribes procedures for state institutions serving persons committed to the Division by a court of criminal jurisdiction and persons ordered to a state institution by the Psychiatric Security Review Board or Oregon Health Authority. This rule also designates the state institution to receive other dangerous persons in certain instances.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 161.390, 179.360, 179.040, and 413.042 and carries out

the provisions of 161.295 through 161.370, 161.725 to 161.735, 426.005 to 426.680, 427.175, 427.180 & 430.610 to 430.725.

(3) Definitions. As used in this rule:

(a) "Administrator" means the Assistant Director, of the Addictions and Mental Health Division.

(b) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(c) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(d) "Psychiatric Security Review Board" is the Board created by ORS 161.385.

(e) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(f) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(g) "Superintendent" means the executive head of the state institution as listed in subsection (3)(f) of this rule.

(4) Designation of State Institution for Serving Persons Under Jurisdiction of Court, the Oregon Health Authority, or Psychiatric Security Review Board:

(a) If a court orders a person committed to a state institution for an evaluation under ORS 161.365 to determine a defendant's fitness to proceed to trial, under ORS 161.315 to determine a defendant's criminal responsibility, or under ORS 161.725 to determine if a defendant is a habitual criminal, the person will be admitted to the Forensic Psychiatric Service of Oregon State Hospital according to conditions set forth in subsection (b) of this section, unless otherwise ordered by the Administrator;

(b) The Clinical Director of the Forensic Psychiatric Service may, upon finding that requests for admission to the Service pursuant to subsection (a) of this section are sufficient in number to require the establishment of a waiting list to govern admissions, establish a waiting list based on such factors as:

(A) Severity of the mental disorder;

(B) Degree to which the person presents an immediate and serious danger to others;

(C) Adequacy of the facility having custody to continue care and custody of the person; and

(D) Sequence in which the order or request for admission was received by the Forensic Psychiatric Service.

(c) If a court orders a person committed to the custody of the Superintendent of a state institution under ORS 161.370, or if a court, the Psychiatric Security Review Board, or the Oregon Health Authority orders a person committed to a state institution under ORS 161.327, 161.328, 161.336, 161.341, or 161.346, the Superintendent may:

(A) Admit the person to a state institution; or

(B) Treat the person at another facility, by agreement with the authority responsible for that facility, if the Superintendent determines that the medical needs of the person or the safety and welfare of the person or of others require that the person be served in another facility, unless otherwise ordered by the Administrator.

(5) Interinstitutional Transfers:

(a) If, in the opinion of the Superintendent of Oregon State Hospital or his designee, it is deemed to be required by the medical needs of the person or for the safety and welfare of the person or the safety of others that a patient of the Forensic Psychiatric Service be transferred within Oregon State Hospital, or to Dammasch State Hospital, Eastern Oregon Hospital and Training Center, or Fairview Training Center, the superintendent shall initiate a request for transfer on forms prescribed by the Division and, upon approval by the superintendent of the receiving institution, arrange for transfer. A patient of the Forensic Psychiatric Service may request such a transfer through a written request to the Superintendent of Oregon State Hospital. Transfers made to the Mental Retardation Section of Eastern Oregon Hospital and Training Center or Fairview Training Center shall comply with the eligibility requirements outlined in OAR 309-042-0000 to 309-042-0050

(Admission and Release of Residents), as determined by the Diagnosis and Evaluation Service of the Division;

(b) If, in the opinion of the superintendent of a state institution, it is deemed to be required by the medical needs of the person or for the safety and welfare of the person or the safety of others that a patient or resident be transferred to the Forensic Psychiatric Service, the superintendent shall initiate a request for transfer on forms prescribed by the Division and, upon approval by the Superintendent of Oregon State Hospital, arrange for transfer;

(c) If a request for transfer to or transfer from the Forensic Psychiatric Service of Oregon State Hospital is rejected by the receiving state institution, the referring institution may request the Administrator to convene the Interinstitutional Disposition Board to determine the placement consistent with the person's needs and the safety of others. The Board shall be convened as expeditiously as possible but in no case later than two weeks after such request. The decision of the chairperson shall be final;

(d) In all cases, the patient or resident shall be informed in writing of the impending transfer or rejection of the transfer request and shall be given an opportunity to request a hearing. Within seven days after a patient or resident signs a request for hearing, a hearing shall be held before the Interinstitutional Disposition Board to determine whether the patient or resident shall be transferred. The patient or resident may be transferred on an emergency basis pending the decision of the Board for a period not to exceed 15 days;

(e) The Interinstitutional Disposition Board shall not consider the request for transfer or other written evidence or oral statements unless the patient or resident has the opportunity to cross-examine the person making the statement. At the hearing before the Board, the patient or resident shall have the right to present evidence, to cross-examine all witnesses, and to be represented by an attorney upon request. These rights shall only be denied when good cause is shown;

(f) The patient or resident shall have the right to be present at the Interinstitutional Disposition Board hearing on request, except when the Board finds that the testimony of the treating physician or any other witness in the presence of the patient or resident would be damaging to the future treatment and care of the patient or resident. In that instance, the testimony and cross-examination of those witnesses shall be conducted out of the presence of the patient or resident;

(g) Based upon the testimony given before the Interinstitutional Disposition Board, the Administrator of the Division or the Administrator's designee shall determine the best placement for the patient or resident and issue a written order directing that the patient or resident be transferred or that the transfer be denied. The order shall contain a statement of the facts upon which the order is based.

(6) Interinstitutional Disposition Board:

(a) The Interinstitutional Disposition Board is composed of the following representatives:

(A) The Administrator of the Division or the Administrator's designee, who shall serve as chairperson;

(B) The Superintendent of Oregon State Hospital or alternate;

(C) The Superintendent of Dammasch State Hospital or alternate;

(D) The Superintendent of Eastern Oregon Hospital and Training Center or alternate; and

(E) The Superintendent of Fairview Training Center or alternate.

(b) The Administrator may invite such other persons to sit with the Board as the Administrator believes may be helpful in reaching a decision;

(c) The Administrator shall inform all members of the Interinstitutional Disposition Board of the standards for confidentiality of records in ORS 179.505, 192.501 to 192.505, and 42 CFR Part 2, as well as prescribed penalties for failure to comply with these standards.

(7) Release of Patient or Resident. A patient or resident who is under a court having criminal jurisdiction, the Corrections Depart-

ment, or the Psychiatric Security Review Board will not be released or otherwise discharged from the custody of the Division without the specific approval of the appropriate legal authority. This approval will be documented in the patient's or resident's clinical record.

Stat. Auth.: ORS 161.390, 179.360, 179.040 & 413.042

Stats. Implemented: ORS 161, 426.005 – 426.680

Hist.: MHD 38, f. 4-5-76, ef. 4-26-76, MHD 7-1978, f. & ef. 8-30-78; MHD 13-1982, f. & ef. 7-2-82; MHS 16-2014(Temp), f. & cert. ef. 12-12-14 thru 6-9-15; MHS 4-2015, f. & cert. ef. 5-28-15

DIVISION 32

COMMUNITY TREATMENT AND SUPPORT SERVICES

309-032-0301

Purpose and Scope

These rules prescribe the standards for community-based programs that serve individuals with a serious mental illness experiencing homelessness under the Projects for Assistance in Transition from Homelessness (PATH) program.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.695

Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

309-032-0311

Definitions

(1) "Co-Occurring Disorders" (COD) means the existence of at least one diagnosis of a substance use disorder and one diagnosis of a serious mental illness.

(2) "Community Mental Health Program" (CMHP) means an entity that is responsible for planning and delivery of services for individuals with substance use or mental illness diagnoses, operated in a specific geographic area of the state under an intergovernmental agreement or a direct contract with the Addictions and Mental Health Division (AMH).

(3) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority (OHA).

(4) "Eligible Individual" means an individual who, as defined in these rules:

(a) Is homeless or at imminent risk of becoming homeless and

(b) Who has, or is reasonably assumed to have, a serious mental illness.

(c) The individual may also have a co-occurring substance use disorder.

(5) "Enrolled" means an eligible individual who:

(a) Receives services supported at least partially with PATH funds and

(b) Has an individual service record that indicates enrollment in the PATH program.

(6) "Homeless Individual" means an individual who:

(a) Lacks housing without regard to whether the individual is a member of a family and whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations; or

(b) Is a resident in transitional housing that carries time limits.

(7) "Individual" means an individual potentially eligible for or who has been enrolled to receive services described in these rules.

(8) "Individual Service and Support Plan" (ISSP) means a comprehensive plan for services and supports provided to or coordinated for an eligible individual that is reflective of the intended outcomes of service.

(9) "Imminent Risk of Homelessness" means that an individual is:

(a) Living in a doubled-up living arrangement where the individual's name is not on the lease;

(b) Living in a condemned building without a place to move;

(c) In arrears in their rent or utility payments;

(d) Subject to a potential eviction notice without a place to move; or

(e) Being discharged from a health care or criminal justice institution without a place to live.

(10) "Individual Service Record" means the written or electronic documentation regarding an enrolled individual that summarizes the services and supports provided from point of entry to service conclusion.

(11) "Literally Homeless Individual" means an individual who lacks housing without regard to whether the individual is a member of a family, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations.

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

(a) The Board of County Commissioners of one or more counties that establishes or operates a CMHP;

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

(c) A regional LMHA comprised of two or more boards of county commissioners.

(13) "Outreach" means the process of bringing individuals into treatment who do not access traditional services.

(14) "Projects for Assistance in Transition from Homelessness" (PATH) means the Formula Grants, 42 U.S.C. 290cc-21 to 290-cc-35.

(15) "Qualified Mental Health Professional" (QMHP) means any person who meets one of the following minimum qualifications as authorized by the LMHA or designee:

(a) A Licensed Medical Practitioner;

(b) A graduate degree in psychology, social work, or recreational, art or music therapy;

(c) A graduate degree in a behavioral science field;

(d) A bachelor's degree in occupational therapy and licensed by the State or Oregon; or

(e) A bachelor's degree in nursing and licensed by the State of Oregon.

(16) "Secretary" means the Secretary of the U.S. Department of Health and Human Services.

(17) "Serious Mental Illness" means a psychiatric condition experienced by an individual who is 18 years of age or older and who is:

(a) Diagnosed by a QMHP as suffering from a serious mental disorder as defined in Oregon Revised Statutes (ORS) 426.495 which includes, but is not limited to conditions such as schizophrenia, affective disorder, paranoid disorder, and other disorders which manifest psychotic symptoms that are not solely a result of a developmental disability, epilepsy, drug abuse or alcoholism; and which continue for more than one year, or

(b) Is impaired to an extent which substantially limits the individual's consistent ability to function in one or more of the following areas:

(A) Independent attendance to the home environment including shelter needs, personal hygiene, nutritional needs and home maintenance;

(B) Independent and appropriate negotiation within the community such as utilizing community resources for shopping, recreation, transportation and other needs;

(C) Establishment and maintenance of supportive relationships; or

(D) Maintained employment sufficient to meet personal living expenses or engagement in other age appropriate activities.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.695

Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

309-032-0321

Eligible Services

(1) Effective outreach to engage people in the following array of services:

(a) Identification of individuals in need;

(b) Screening for symptoms of serious mental illness;

(c) Development of rapport with the individual;

(d) Offering support while assisting with immediate and basic needs;

(e) Referral to appropriate resources; or

(f) Distribution of information including but not limited to:

(A) Flyers and other written information;

(B) Public service announcements; or

(C) Other indirect methods of contact.

(2) Methods of active outreach including but not limited to face-to-face interaction with literally homeless people in streets, shelters, under bridges and in other non-traditional settings, in order to seek out eligible individuals.

(3) Methods of in-reach, including but not limited to placing outreach staff in a service site frequented by homeless people, such as a shelter or community resource center, where direct, face to face interactions occur, in order to allow homeless individuals to seek out outreach workers.

(4) Screening and diagnosis.

(5) Habilitation and rehabilitation services.

(6) Community mental health services.

(7) Alcohol or drug treatment services.

(8) Staff training, including the training of those who work in shelters, mental health clinics, substance abuse programs, and other sites where homeless individuals require services.

(9) Case management including the following.

(a) Preparing a plan for the provision of community mental health services to the eligible individual and reviewing the plan not less than once every three months;

(b) Assistance in obtaining and coordinating social and maintenance services for the eligible individual, including services related to daily living activities, personal financial planning, transportation, and housing services;

(c) Assistance to the eligible individual in obtaining income support services including housing assistance, food stamps and supplemental security income benefits;

(d) Referring the eligible individual for such other services as may be appropriate and

(e) Providing representative payee services in accordance with section 1631(a)(2) of the Social Security Act [42 U.S.C. 1383(a)(2)] if the eligible individual is receiving aid under title XVI of such act [42 U.S.C. 1381 et seq.] and if the applicant is designated by the Secretary to provide such services;

(10) Supportive and supervisory services in residential settings;

(11) Housing services, which shall not exceed twenty percent of all total PATH expenses and which may include:

(a) Minor renovation, expansion and repair of housing;

(b) Planning of housing;

(c) Technical assistance in applying for housing assistance;

(d) Improving the coordination of housing services;

(e) Security deposits;

(f) The costs associated with matching eligible individuals with appropriate housing situations; or

(g) One time rental payments to prevent eviction; and

(12) Referrals to other appropriate services or agencies, for those determined ineligible for other PATH services.

(13) Other appropriate services as determined by the Secretary.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.610 – 430.695

Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

309-032-0331

Staff Qualifications and Training Standards

(1) Staff delivering case management and outreach services to individuals shall have demonstrated ability to:

(a) Identify individuals who appear to be seriously mentally ill;

(b) Identify service goals and objectives and incorporate them into an ISSP; and

(b) Refer the individuals for services offered by other agencies.

(2) All staff delivering PATH services shall have training, knowledge and skills suitable to provide the services described in these rules.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

**309-032-0341
Rights of Eligible Individuals**

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

- (a) Choose from available services and supports;
- (b) Be treated with dignity and respect;
- (c) Have all services explained, including expected outcomes and possible risks;

(d) Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 192.515 and 42 CFR Part 2 and 45 CFR Part 205.50;

(e) Give informed consent to services in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law;

(f) Inspect their Individual Service Record in accordance with ORS 179.505;

(g) Not participate in experimentation;

(h) Receive medications specific to the individual's diagnosed clinical needs;

(i) Receive prior notice of service conclusion or transfer, unless the circumstances necessitating service conclusion or transfer pose a threat to health or safety;

(j) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

(k) Have religious freedom;

(l) Be informed at the start of services and periodically thereafter of the rights guaranteed by these rules;

(m) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian or representative assist with understanding any information presented;

(n) Have family involvement in service planning and delivery;

(o) Make a declaration for mental health treatment, when legally an adult;

(p) File grievances, including appealing decisions resulting from the grievance; and

(q) Exercise all rights described in this rule without any form of reprisal or punishment.

(2) The provider will give to the individual and if applicable, to the guardian, a document that describes the preceding individual rights.

(a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

(b) The rights and how to exercise them will be explained and

(c) Individual rights will be posted in writing in a common area.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

**309-032-0351
Enrollment and Record Requirements**

(1) An individual's eligibility shall be determined and documented at the earliest possible date.

(2) A record shall be maintained for each enrolled individual receiving services under this rule. The record shall contain the following:

- (a) An enrollment form which includes:
 - (A) The individual's name and PATH enrollment date;

(B) A list or description of the criteria determining the individual's PATH eligibility; and

(C) The individual's PATH services discharge date.

(b) A plan defining the enrolled individual's goals and service objectives including one or more of the following:

(A) Accessing community mental health services for the eligible individual, which includes reviewing the plan not less than once every three months;

(B) Accessing and coordinating needed services for the eligible individual, as detailed in these rules.

(C) Accessing income and income support services, including housing assistance, food stamps, and supplemental security income; and

(D) Referral to other appropriate services.

(c) Progress notes that provide an on-going account of contacts with enrolled individual, a description of services delivered, and progress toward the enrolled individual's service plan goals; and

(d) A termination summary describing reasons for the enrolled individual no longer being involved in service.

(3) A record shall be maintained for individuals served but not yet enrolled under the provisions of these rules. The record shall contain:

(a) A description of the potentially eligible individual, which may include but not be limited to:

(A) A physical description of the individual;

(B) The location where the individual was served; and

(C) A description of the individual's personal belongings.

(b) A preliminary assessment of the potentially eligible individual's needs based on available information; and

(c) A record of where and when contacts with the potentially eligible individual were made and the outcome of those contacts.

(4) Records shall be confidential in accordance with ORS 179.505, 45 CFR Part 2 and OAR 309-032-1535 pertaining to individuals' records.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

**309-032-0850
Standards for Regional Acute Care Psychiatric Services for Adults**

(1) Purpose: These rules prescribe standards and procedures for regional acute care psychiatric services for adults.

(2) Statutory Authority: These rules are authorized by ORS 413.042 and 430.640 to carry out the provisions of 430.630.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.630 & 430.640
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

**309-032-0860
Definitions**

As used in these rules:

(1) "Adult" means a person age 18 years or older.

(2) "Clinical record" means a separate file established and maintained under these rules for each patient.

(3) "Community mental health program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the Division.

(4) "Council" means an organization of persons, with a mission statement and by-laws, comprised of representatives of the regional acute care psychiatric service, state hospital, community mental health programs served, consumers, and family members. The Council is advisory to the regional acute care facility for adults.

(5) "Diagnosis" means a DSM diagnosis determined through the mental health assessment and any examinations, laboratory,

medical or psychological tests, procedures, or consultations suggested by the assessment.

(6) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(7) "DSM" means the current edition of the "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association.

(8) "Goal" means the broad aspirations or outcomes toward which the patient is striving, and toward which all services are intended to assist the patient.

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

(10) "Independent medical practitioner" means a medically trained person who is licensed to practice independently in the State of Oregon and has one of the following degrees: MD (Medical Doctor), DO (Doctor of Osteopathy), or NP (Nurse Practitioner).

(11) "Legally incapacitated" means having been found by a court of law under ORS 126.103 or 426.295 to be unable, without assistance, to properly manage or take care of one's personal affairs.

(12) "Linkage agreement" means a written agreement between the regional acute care psychiatric services, the local community mental health programs, and state hospitals which describes the roles and responsibilities each assumes in order to assure that the goals of the regional acute care psychiatric services are achieved.

(13) "Medical director" means a board eligible psychiatrist who oversees the patient care program. The medical director shall have the final authority concerning inpatient medical care including admissions, continuing care, and discharges.

(14) "Medical history" means a review of the patient's current and past state of health as reported by the patient or other reliable sources, including, but not limited to:

(a) History of any significant illnesses, injuries, allergies, or drug sensitivities; and

(b) History of any significant medical treatments, including hospitalizations and major medical procedures.

(15) "Mental health assessment" means a process in which the person's need for mental health services is determined through evaluation of the patient's strengths, goals, needs, and current level of functioning.

(16) "Mental status examination" means an overall assessment of a person's mental functioning that includes descriptions of appearance, behavior, speech, mood and affect, suicidal/homicidal ideation, thought processes and content, and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, memory, concentration, general knowledge, abstraction abilities, judgment, and insight.

(17) "Objective" means an interim level of progress or a component step the specification of which is necessary or helpful in moving toward a goal.

(18) "Office" means the Office of Mental Health Services of the Division.

(19) "OPRCS" means the Oregon Patient/Resident Care System. OPRCS is a Division operated, on-line computerized information system which accepts, stores and returns information about patients from state operated institutions and other designated inpatient services.

(20) "Patient" means a person who is receiving care and treatment in a regional acute care psychiatric service.

(21) "Person committed to the Division" means a patient committed under ORS 161.327 or 426.130.

(22) "Program administrator" means a person, with appropriate professional qualifications and experience, appointed by the governing body to manage the operation of the regional acute care psychiatric services.

(23) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.492 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(24) "Qualified mental health professional" or "QMHP" means a person who is one of the following:

(a) Psychiatrist or physician, licensed to practice in the State of Oregon; an individual with a graduate degree in psychology, social work, or other mental health related field; a registered nurse with a graduate degree in psychiatric nursing, licensed in the State of Oregon; an individual with registration as an occupational therapist; an individual with a graduate degree in recreational therapy; or

(b) Any other person whose education, experience, and competence have been documented by the CMHP director or designee as able to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social, and work relationships, conduct a mental status assessment; document a DSM diagnosis; write and supervise a rehabilitation plan; and provide individual, family, and/or group therapy.

(25) "Regional acute care psychiatric service" or "service" means a Division funded service provided under contract with the Division or county, and operated in cooperation with a regional or local council. A regional acute care psychiatric service must include 24 hour-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults ages 18 and older with severe psychiatric disabilities in a designated region of the State. For the purpose of these rules, a state hospital is not a regional acute care psychiatric service. The goal of a regional acute care service is the stabilization, control and/or amelioration of acute dysfunctional symptoms or behaviors that result in the earliest possible return of the person to a less restrictive environment.

(26) "Supervisor" means a person who has two years of experience as a qualified mental health professional and who, in accordance with Section 309-032-0870 of these rules, reviews the services provided to patients by qualified persons.

(27) "Treatment plan" means an individualized, written plan defining specific rehabilitation objectives and proposed service interventions derived from the patient's mental health assessment.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.630 & 430.640

Hist. MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0870

Standards for Approval of Regional Acute Care Psychiatric Service

(1) State approvals and licenses. The facility in which a regional acute care psychiatric service is provided shall maintain state approvals and licenses as required by Oregon law for the health, safety, and welfare of the persons served. Non-hospital facilities shall be licensed by the Division as required by ORS 443.410. The facility must also be approved under OAR 309-033-0530 Approval of Hospitals and Nonhospital Facilities that Provide Services to Committed Persons and to Persons in Custody or on Diversion and OAR 309-033-0540, Administrative Requirements for Hospitals and Nonhospital Facilities Approved to Provide Services to Persons in Custody, Psychiatric Hold or Certified for 14 Days of Intensive Treatment.

(2) Clinical record management. A regional acute care psychiatric service shall maintain clinical records as follows:

(a) Clinical records are confidential, as set forth in ORS 179.505 and 192.502 and any other applicable state or federal law, except as otherwise indicated by applicable rule or law. For the purposes of disclosure from non-medical individual records, both the general prohibition against disclosure of "information of a personal nature" and limitations to the prohibition in ORS 192.502 shall be applicable.

(b) Clinical records shall be secured, safeguarded, stored, and retained in accordance with OAR 166-030-1015.

(c) Clinical record entries required by these rules must be signed by the staff providing the service and making the entry. Each signature must include the person's academic degree or professional status and the date signed.

(3) Clinical record content. The clinical record shall contain:

(a) Identifying demographic information, including, if available, who to contact in an emergency and the names of persons who encompass the support system of the patient.

(b) Consent to release information and explanation of fee policies. At the time of admission staff shall present the patient with forms for obtaining consent so that information may be shared with family and others. An explanation of fee policies shall also be provided in written form at the earliest time possible. The patient shall be asked to sign each. If the patient is unwilling or unable to sign, staff shall record that the person is unable or unwilling to do so.

(c) Admitting mental health assessment. An admitting mental health assessment shall be completed, by or under the supervision of an independent medical practitioner with supervised training or experience in a mental health related setting, within 24 hours of admission. The admitting mental health assessment shall include a description of the presenting problem(s), a mental status examination, an initial DSM diagnosis, and an assessment of the resources currently available to the person. The assessment shall result in a plan for the initial services to be provided. The admitting mental health assessment shall also include documentation that a medical history and physical examination of the person has been performed within 24 hours after admission by a physician, physician assistant, or nurse practitioner. If the independent medical practitioner believes a new medical history and physical examination are not necessary, and if within 30 days of admission a complete physical history has been recorded and a complete physical examination has been performed, the signed report of the history and examination may be placed in the clinical record and may be considered to constitute an appropriate physical health assessment.

(d) Psycho-social assessment. A psycho-social assessment shall be completed for each patient within 72 hours of admission. If the patient stays less than 72 hours, a psycho-social assessment need not be written. The assessment must be completed by a qualified mental health professional or supervisor. The assessment does not need to be a single document but must include the following elements:

(A) A description of events precipitating admission and any goal(s) of the patient in seeking or entering services.

(B) When relevant to the patient's service needs, historical information including: mental health history; medical history; substance use and abuse history; developmental history; social history, including family and interpersonal history; sexual and other abuse history; educational, vocational, employment history; and legal history.

(C) An identification of the patient's need for assistance in maintaining financial support, employment, housing, and other support needs.

(D) Recommendations for discharge planning and any additional services, interventions, additional examinations, tests, and evaluations that are needed.

(e) Treatment plan. A treatment plan, individually developed with the patient from the findings of the admitting mental health assessment and psycho-social assessment, must be completed by a QMHP or supervisor within 72 hours of the person's admission. The plan must be written at a level of specificity that will permit its subsequent implementation to be efficiently monitored and reviewed. The recorded plan shall contain the following components:

(A) The rehabilitation and other goals, including those articulated by the patient.

(B) Specific objectives, including discharge objectives, and the measurable or observable criteria for determining when each objective is attained;

(C) Specific services to be used to achieve each objective;

(D) The projected frequency and duration of services;

(E) Identification of the QMHP or supervisor assigned to the patient who is responsible for coordinating services;

(F) The signature of the patient indicating he/she has participated in the development of the plan to the degree possible. If the patient is unwilling or unable to sign the plan, staff shall record on the plan that the patient is unable or unwilling to do so.

(G) The plan must be reviewed weekly and updated with the participation of the patient when needed to reflect significant changes in the patient's status, and when significant new goals are identified.

(f) Progress notes. Progress notes shall document observations, treatment rendered, response to treatment, and changes in the patient's condition, and other significant information relating to the patient. All entries involving subjective interpretation of the patient's progress shall be supplemented by a description of the actual behavior observed.

(g) Reports of medication administration, medical treatments, and diagnostic procedures.

(h) Telephone communications about the patient, releases of information, and reports from other sources.

(i) The record shall contain medical and mental health advance directives or note that the patient has been provided this information.

(j) The record shall contain documentation that the person has been provided information on patient rights, grievance procedure, and abuse reporting.

(k) The record shall contain documentation including physician's orders and reasons for all restraint and seclusion episodes.

(l) Discharge plan. The discharge planning shall begin at the time of admission with the participation of the patient and, when indicated, the family, guardian and significant others. The discharge plan shall include the results of the admitting mental health assessment; DSM diagnoses; summary of the course of treatment, including prescribed medications; final assessment of the person's condition; recommendations and arrangements for further treatment including prescribed medications and continuing care; and documentation of the planning for, and securing of appropriate living arrangements.

(4) Patient data management. The regional acute care psychiatric service shall supply to the Division, using the Division's online Oregon Patient/Resident Client System (OPRCS), via computer and modem, information about persons admitted to and discharged from the service. Such information shall include the patient's name, DSM diagnosis, admission date, discharge date, legal status, Medicaid eligibility, Medicaid Prime Number and various patient demographics. Such information shall be entered on the day of admission and updated on the day of discharge.

(5) Professional staff standards. The regional acute care psychiatric service shall:

(a) Have sufficient appropriately qualified professional, administrative and support staff to assess and address the identified clinical needs of persons served, provide needed services, and coordinate the services provided.

(b) Designate a program administrator to oversee the administration of the services and carry out these rules.

(c) Designate a medical director to oversee the patient care program. The medical director shall have the final authority concerning inpatient medical care including admissions, continuing care, and discharges.

(d) Designate an individual responsible for maintaining, controlling and supervising medical records and be responsible for maintaining the quality of clinical records.

(e) Designate an individual responsible for the development, implementation and monitoring of a written safety management plan and program, who shall keep records of identified concerns and problems and actions taken to resolve them.

(f) Designate an individual responsible for the development, implementation and monitoring of a written infection control plan and program, who shall keep records of identified concerns and problems and action taken to resolve them.

(g) Designate, or contract with, a licensed pharmacist to be responsible for the development of pharmacy policies and procedures, and to assure that the service adheres to standards of practice and applicable state and federal laws and regulations.

(h) Maintain a schedule of unit staffing which shall be readily available to the Division for a period of at least the three previous years.

(i) Have on duty at least one registered nurse at all times.

(j) Maintain a personnel file for each patient care staff which includes a written job description; the minimum level of education or training required for the position; copies of applicable licenses, certifications, or degrees granted; annual performance appraisals; a biennial, individualized staff development plan signed by the staff; documentation of CPR training; documentation of annual training and certification in managing aggressive behavior, including seclusion and restraint; and other staff development and/or skill training received.

(k) A physician must be available, at least on-call, at all times.

(6) Policies and procedures manual. The regional acute care psychiatric service shall have a policy and procedure manual. The policy and procedure manual must be made available to any person upon request. The manual shall describe:

(a) The following policies and procedures:

(A) Governance and management, including: a table of organization describing the agency structure and lines of authority; a plan for professional services; and a plan for financial management and accountability.

(B) Procedures for the management of disasters, fire, and other emergencies.

(C) Policies and procedures required under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion addressing seclusion and restraint.

(D) Patient rights, including informed consent, access to records, and grievance procedure. The manual shall assure rights guaranteed by ORS 426.380 to 426.395 for committed persons and ORS 430.205 to 430.210 for those not committed. The grievance procedure must be in writing and include written responses, time limits for responses, use of a neutral party and a method of appeal. Programs shall post copies of the rights and grievance procedures in places accessible to all persons. Programs shall provide written copies of the rights and grievance procedure upon request.

(E) Abuse reporting for mentally ill or developmentally disabled as required by ORS 430.731 through 430.768.

(F) Clinical record content and management policies and procedures, including the requirements of these rules.

(G) Psychiatric, medical, and dental emergency services policies and procedures.

(H) Pharmacy services policies and procedures approved by a licensed pharmacist.

(I) Quality assessment and improvement processes.

(J) Procedures for documenting privileges granted by the service in personnel records or other records.

(K) Policies and procedures for transfer of patients to other hospitals.

(b) The following policies and procedures, developed and amended in consultation with the council:

(A) Patient admission and discharge criteria. Unless the service has a policy and procedure recommended by the council and approved by the Division, the service shall only admit persons age 18 and older.

(B) Quality assessment and improvement processes relating to regional admissions and discharges.

(C) Patient admission, discharge and aftercare planning; including scheduling and planning for transportation of patients to the service by the referring county and from the service to the county of residence.

(D) Procedures for admission and discharge of geropsychiatric patients and persons with physical disabilities, including designation of a county or regional geropsychiatric liaison staff member.

(E) Linkage agreements with community mental health programs it serves and state hospitals.

(F) Medical and emergency care procedures, approved by the Division.

(G) Criteria for accepting pre-admission medical screening.

(H) Billing and collecting reimbursement from patients and third-party payors.

(7) Holding allegedly mentally ill persons. The service shall have an adequate number of hold rooms but at least one holding room and hold a current Certificate of Approval to hold and treat persons who are alleged to be mentally ill under OAR 309-033-0500 through 309-033-0560, Approval of Hospital and Nonhospital Facilities that Provide Services to Committed Persons or to Persons in Custody or on Diversion.

(8) Federal rules and regulations. The facility in which a service is operated shall comply with all applicable federal rules and regulations.

(9) Medical care. If the facility in which the regional acute care psychiatric service is operated is not in a general hospital, it shall have a letter of agreement with a general hospital for both emergency and medical care, which shall be renewed every two years.

(10) Quality assessment and improvement. The regional acute care psychiatric service shall have an ongoing quality assessment and improvement program to objectively and systematically monitor and evaluate the quality of care provided to patients served, pursue opportunities to improve care and correct identified problems. The program shall include:

(a) Policies and procedures that describes the quality assessment and improvement program's objectives, organization, scope, and mechanisms for improving services.

(b) A written annual plan to monitor and evaluate services. The written plan shall result in reports of findings, conclusions, and recommendations. Reports shall address:

(A) The care of patients served, including admission and discharge planning;

(B) Resource utilization, including the appropriateness and clinical necessity of admissions and continued stay, services provided, staffing levels, space, and support services;

(C) Quality and content of clinical records;

(D) Medication usage, including records, adverse reactions, and medication errors;

(E) Accidents, injuries, safety of patients, and safety hazards; and

(F) Uses of seclusion and restraint.

(c) A report to the governing board and council, at least annually, addressing:

(A) Findings and conclusions from studies;

(B) Recommendations, action taken, and results of the action taken; and

(C) An assessment of the effectiveness of the quality assessment and improvement program; including a review of the program's objectives, scope, organization and effectiveness.

(11) Council. The regional acute care psychiatric service shall have a council to ensure appropriate and effective care and treatment. The council shall meet to assess and collaboratively plan for improving care and treatment to patients, including patient transitions into and out of the service.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.630 & 430.640

Hist. MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0890

Variances

(1) Criteria for a variance. Variances may be granted to a regional acute care psychiatric service if implementation of the proposed alternative services, methods, concepts or procedures would result in service or system that meet or exceeds the standards in these rules.

(2) Variance application. The service requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the regional acute care psychiatric service of the decision. This notice shall be given to the service, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The regional acute care psychiatric service may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented:

Hist. MHD 8-1994, f. & cert. ef. 11-28-94

DIVISION 33

INVOLUNTARY COMMITMENT PROCEEDINGS

309-033-0200

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe general standards and procedures relating to the involuntary commitment of mentally ill persons.

(2) Statutory authority. These rules are authorized by ORS 426.005 through 426.395 and carry out the provisions of 426.005 through 426.395. These rules replace OAR 309-033-0100 through 309-033-0170, which were in effect from September 2, 1992 through August 31, 1994.

Stat. Auth.: ORS 413.042, 426.005 - 426.395

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0000

309-033-0210

Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005. Whenever "administrator" appears it means the administrator or designee.

(2) "Assignment" means the designation, pursuant to ORS 426.060, by the Division or its designee of the hospital, facility or CMHP where the committed person is to receive care, custody and treatment during the commitment period.

(3) "Assistant Administrator" means the Assistant Administrator of Addictions and Mental Health Division.

(4) "Caregiver" means the person who is appointed by the court under ORS 426.125 to be allowed to care for a mentally ill person on conditional release.

(5) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(6) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(7) "Community hospital" means any hospital that is not a state hospital.

(8) "County governing body" means the county court or the board of county commissioners of one or more counties who operate a CMHP, or in the case of a Native American Reservation, the Tribal Council, or if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation selected by the county.

(9) "County of residence" means the county where the person currently maintains a mailing address or, if the person has no current mailing address within the state, the county where the person was found or the county in which a committed person has been conditionally released as defined by ORS 426.241 to 426.255.

(10) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(11) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233;

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(12) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(13) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(14) "Director of the county of commitment" means the director for the county where the person is committed.

(15) "Director of the county of placement" means the director for the county where the committed person is to be placed.

(16) "Director of the county of residence" means the director for the county of residence.

(17) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(18) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(19) "Hospital hold" means the taking of a person into custody by order of a physician pursuant to ORS 426.232.

(20) "NMI" is the notification of mental illness required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to ORS 426.234, to be submitted by the physician or the director to the court. Pursuant to ORS 426.070 and 426.234, the court commences proceedings pursuant to ORS 426.070 to 426.130 upon receipt of the NMI.

(21) "Nonhospital hold" means the taking of a person into custody by order of a director pursuant to the provisions of ORS 426.233. A director's hold and a trial visit hold are variations of a nonhospital hold.

(22) "Peace officer" means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(23) "Placement of a committed person" means the physical act of removing a committed person from the courtroom to the place where the person has been assigned to receive care, custody and treatment, or the transfer of a committed person from one loca-

tion where the person has been assigned to receive care, custody and treatment to another location for the same purpose.

(24) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

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

(26) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

- (a) Psychiatrist licensed to practice in the State of Oregon;
- (b) Physician licensed to practice in the State of Oregon;
- (c) Graduate degree in psychology;
- (d) Graduate degree in social work;
- (e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or
(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

(27) "Recertification" means the certification of continued commitment provided for under ORS 426.301.

(28) "Secure transport provider" means a secure transport provider approved according to OAR 309-033-0432, Standards for the Approval of a Secure Transport Provider to Transport a Person in Custody or on Diversion to an Approved Holding or Nonhospital Facility.

(29) "State hospital" means Oregon State Hospital in Salem and Portland, and Eastern Oregon Psychiatric Center in Pendleton.

(30) "Superintendent" means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent's capacity for the purpose of this rule.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0010; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0220

General Standards

(1) Goals. The goals of the Division in implementing these civil commitment standards are:

(a) To promote the well-being of persons who are allegedly mentally ill and who are mentally ill during involuntary care, custody and treatment of mental illness pursuant to ORS Chapter 426;

(b) To promote the protection of the civil rights of each person who is allegedly mentally ill and who is mentally ill;

(c) To encourage consistent application of ORS Chapter 426 as it specifically pertains to each of the following groups:

- (A) Persons who are alleged to be mentally ill; and
- (B) Persons who are mentally ill.

(d) To encourage the provision of care, custody and treatment of persons in the least restrictive environment that currently is available within existing resources;

(e) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through civil commitment, whenever possible;

(f) To encourage that the director monitors the commitment process in their county, is knowledgeable of the statutes and administrative rules pertaining to civil commitment, provides leadership so that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS Chapter 426;

(g) To provide for the safety of the community when threatened by a person who is dangerous as a result of mental illness.

(2) State's interest. The state's interest is to establish sufficient facts for the court to make a decision that is consistent with the intent of ORS Chapter 426.

(3) Declaration for mental health treatment. The director shall establish procedure and policy which assures that every person

who may become incapacitated by mental illness and unable to consent to treatment is educated about the Declaration for Mental Health Treatment at the time of admission or at the time of discharge from a hospital.

Stat. Auth.: ORS 413.042 & 426.060
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0030

309-033-0230

Custody of Persons Alleged to Be Mentally Ill Prior to Filing a Notification of Mental Illness

(1) Custody by a physician pursuant to ORS 426.231. A physician taking a person into custody pursuant to ORS 426.231 at a hospital approved under OAR 309-033-0550, Standards for the Approval of Hospitals Detaining Persons in Custody Pending Transport to an Approved Holding Hospital or Nonhospital Facility, shall detain the person for no more than 12 hours and during that time shall either:

(a) Authorize the person for transportation to an approved hospital and provide transportation according to the agreement required under OAR 309-033-0550; or

(b) Release the person, if the physician determines that the person no longer is dangerous to self or others.

(2) Custody by a peace officer or secure transport provider. A peace officer taking a person into custody shall remove the person to an approved hospital as directed by the director in the county where the person was taken into custody. The peace officer or approved secure transport provider shall only take a person into custody under the provisions of one of the following:

(a) Custody on peace officer's own initiative. A peace officer may take a person into custody pursuant to the provisions of ORS 426.228 when the peace officer has probable cause to believe that the person is dangerous to self or others, and is in need of immediate care, custody or treatment for a mental illness;

(b) Custody on the director's authority. The director may direct, pursuant to the provisions of ORS 426.233, a peace officer or an approved secure transport provider to take into custody a person who is dangerous to self or others and in need of immediate care, custody or treatment for mental illness;

(c) Custody of a committed person on the director's authority. The director may direct a peace officer or an approved secure transport provider to take into custody, pursuant to the provisions of ORS 426.233, a committed person who is on trial visit, outpatient commitment or conditional release in the community, who is dangerous to self or others or who is unable to provide for basic personal needs, who is not receiving the care that is necessary for health and safety, and who is in need of immediate care, custody or treatment for mental illness.

(d) A peace officer may transfer a person in custody under this section to the custody of an approved secure transport provider. The peace officer may meet the approved Secure transport provider at any location that is in accordance with ORS 426.140 to effect the transfer. When transferring a person in custody to an authorized person, the peace officer shall deliver the report required under subsection (3) of this section to the authorized person.

(3) Peace officer's written report. When taking a person into custody pursuant to ORS Chapter 426.228 by a peace officer's own initiative, a peace officer shall prepare a written report which states:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the director in the county where the person is taken into custody and a telephone number where the director may be reached at all times.

(4) Director's written report. When a peace officer or approved secure transport provider takes a person into custody pursuant to ORS Chapter 426.228 at the direction of the director, a director shall prepare a written report which states:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the director in the county where the person is taken into custody and a telephone number where the director may be reached at all times.

(5) Transportation to a hospital or nonhospital facility more than one hour away. If the peace officer determines that more than one hour is required to transport the person to a hospital or nonhospital facility approved by the Division, the peace officer or approved secure transport provider shall obtain a certificate, if possible, from a physician prior to transporting the person. A physician authorizing transport shall sign a certificate, on a form approved by the Division, only if the person's condition, in the opinion of the physician, meets all of the following requirements:

(a) The travel will not be detrimental to the person's physical health;

(b) The person is dangerous to self or others; and

(c) The person is in need of immediate care or treatment for mental illness.

(6) The director directs peace officers or approved secure transport providers to appropriate facility. The director shall adopt written procedures for directing peace officers or approved secure transport providers to transport persons taken into custody, pursuant to ORS 426.228, to an approved hospital or nonhospital facility:

(a) The written procedures shall include one of the following, whichever, in the opinion of the director, serves the best interests of persons with mental illness and the community:

(A) A list of approved hospitals or nonhospital facilities where peace officers or approved secure transport providers are to transport persons;

(B) A procedure for contacting the director 24 hours-a-day, seven days-a-week.

(b) The director shall distribute copies of the written procedures to the sheriff and the chief of police of each municipality in the county and approved secure transport providers. The procedures shall be distributed as often as the procedure is amended.

(c) The director may develop a written agreement with the law enforcement agencies in the county which designates a site or sites where the director can safely evaluate the person and determine which facility, in the director's opinion, can best serve the person's needs within the resources available. If such an agreement exists in a county, the director may direct a peace officer to transport a person in custody under ORS 426.228 to a site designated in the agreement. Once the director makes a determination, the peace officer shall transport and deliver the person to a hospital or nonhospital facility as directed by the director. The agreement shall:

(A) Designate the site or sites where the director can safely evaluate the person's needs for treatment;

(B) Define the minimum response time for the director meeting the peace officer at the site; and

(C) Be signed by all parties to the agreement.

Stat. Auth.: ORS 413.042, 426.228, 426.231 & 426.236

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0040; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0240

Initiation of the Civil Commitment Process

(1) Initiation. The civil commitment process is initiated when an NMI is filed with the circuit court. The NMI shall be filed with the court as directed below:

(a) Public petition. When an NMI is given to the director of the county where the allegedly mentally ill person resides pursuant to ORS 426.070, the director shall immediately file the NMI with the court in the county where the allegedly mentally ill person resides. The following persons may give an NMI to the director:

(A) Any two persons;

(B) A county health officer; or

(C) Any magistrate.

(b) Hospital hold with no request from director. When a physician admits or retains a person in a hospital pursuant to ORS

426.232, Hospital Hold, and the director in the county where the person resides makes no request for the physician to file the NMI in the county where the person resides, the physician shall file the NMI with the court in the county where the person is hospitalized;

(c) Hospital hold with request from director. When a physician admits or retains a person in a hospital pursuant to ORS 426.232, and the director in the county where the person resides requests the physician to do so, the physician shall file the NMI with the court in the county where the person resides;

(d) Hospital hold subsequent to peace officer custody with no request from director. When a physician admits a person to a hospital pursuant to ORS 426.232, subsequent to the person being brought to the hospital by a peace officer or approved secure transport provider, and the director of the county where the hospital is located makes no request, pursuant to ORS 426.234, the physician shall file the NMI with the court in the county where the person initially was taken into custody by the peace officer;

(e) Hospital hold subsequent to peace officer custody with request from director. When a physician admits a person to a hospital pursuant to ORS 426.232, subsequent to the person being brought to the hospital by a peace officer or approved secure transport provider, and the director of the county where the hospital is located requests the physician to do so, the physician shall file the NMI with the court in the county where the person is hospitalized.

(f) Nonhospital hold with no request from director. When a director in the county where the director admits or retains a person in a nonhospital facility pursuant to ORS 426.233, and the director in the county where the person resides makes no request for the director to file the NMI be filed in the county where the person resides, the director shall file the NMI with the court in the county where the person initially was taken into custody; and

(g) Nonhospital hold with request from director. When a director admits or retains a person in a nonhospital facility pursuant to ORS 426.233, and the director in the county where the person resides requests the director to do so, the director shall file the NMI with the court in the county where the person resides.

(2) Initiation of commitment proceedings by two persons, a county health officer or magistrate. The NMI shall be given to the director in the county where the allegedly mentally ill person resides. If the person has no residence, then the NMI shall be given to the director in the county where the person currently is located. The director shall file the original NMI with the court on the day the NMI is received or, if the NMI is received outside the court's routine business hours, the next day the court is open for business. The director shall retain a copy of the NMI in the clinical record as required by OAR 309-033-0930, Procedures for the Investigation.

(3) Initiation by hospital hold. The physician who takes a person into custody, pursuant to ORS 426.232, in a hospital approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion, shall:

(a) File an NMI with the appropriate court as described in OAR 309-033-0240, Initiation; and

(b) Immediately notify the director in the county in which the person was hospitalized, unless the person resides in a county other than the county where the person is hospitalized in which case the physician shall immediately notify the director in the county where the person resides.

(4) Initiation by nonhospital hold. The director, after authorizing the taking of a person into custody pursuant to the provisions of ORS 426.233 (the director's hold and trial visit hold), shall file a NMI with the appropriate court as described in OAR 309-033-0240.

(5) How a director requests where the NMI is filed. A director may request that the physician, in the case of a hospital hold, or the director of the county where the person was taken into custody, in the case of a nonhospital hold, file the NMI according to the provisions of ORS 426.234 by either:

(a) On a case by case basis. Making the request immediately upon receipt of the notice required by ORS 426.234; or

(b) Upon general request. Sending a written general request to a hospital or a director.

Stat. Auth.: ORS 413.042, 426.228, 426.231 & 426.236

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0050; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0250

Standards for Custody, Hospital and Nonhospital Holds, Emergency Commitment and Emergency Hospitalization of Persons Under Warrant of Detention

(1) Criteria for placement into custody. Only persons who are a danger to self or others and who are in need of treatment for mental illness shall be placed in custody at a facility approved by the Division.

(2) Warrant of detention. Upon the receipt of a warrant of detention issued by the court pursuant to ORS 426.070, the director or the sheriff of the county shall take the person into custody and remove the person to a hospital approved by the Division. Whoever takes the person into custody shall inform the person of his/her rights with regard to representation by or appointment of counsel as described in ORS 426.100 and be given the warning described under ORS 426.123 and OAR 309-033-0540, Warning.

(3) Hospital hold. Only a physician with admitting privileges or on staff at a hospital approved by the Division and who has completed a face-to-face examination of the person may retain the person in custody in the hospital as provided by ORS 426.232. When implementing hospital holds, the hospital shall assure the following:

(a) The consulting physician is not required to have admitting privileges at the hospital;

(b) The hospital shall not require the consulting QMHP to be a member of the hospital's allied staff. However, the hospital may extend allied staff privileges to the consulting QMHP;

(c) The admitting physician shall document the following information on the NMI, retaining a copy of the NMI in the clinical record:

(A) Examples of indicators that support the physician's belief that the person has a mental illness;

(B) Examples of thoughts, plans, means, actions, history of dangerousness or other indicators that support the physician's belief that the person is imminently dangerous.

(4) Peace officer custody requested by director. This section establishes standards and procedures for a director to direct a peace officer to take into custody a person who the director has probable cause to believe is dangerous to self or any other person and who the director has probable cause to believe is in need of immediate care, custody or treatment for mental illness:

(a) A county governing body may authorize the director, or a person named and recommended by the director, to direct a peace officer or approved secure transport provider to take allegedly mentally ill persons into custody. Such an authorization shall be made formally and in writing by the county governing body of the director. The director shall keep a copy of each authorization in each person's personnel file:

(b) Prior to directing a peace officer or approved secure transport provider to take a person into custody, a director shall have face-to-face contact with the person and document on forms approved by the Division, the evidence for probable cause to believe that the person is:

(A) Dangerous to self or others; and

(B) In need of immediate care, custody or treatment for a mental illness.

(5) When a person in custody can be released. A person shall who is detained, in custody, or on a hold shall be released as described:

(a) Physician's release of a person on peace officer custody. When a person is brought to a hospital by a peace officer or approved secure transport provider pursuant to ORS 426.228, Peace Officer Custody, the treating physician shall release the person if, upon initial examination prior to admission, the physician

makes the determination that the person is not dangerous to self or others. It is not necessary to notify the court of the release;

(b) Physician's release of a person on transport custody. At any time during the 12 hour detention period, the treating physician shall release a person detained pursuant to ORS 426.231, Transport Custody, whenever the physician makes the determination that the person is not dangerous to self or others. In no case shall a physician involuntarily detain a person at a hospital approved solely for Transport Custody under OAR 309-033-0550 longer than 12 hours. It is not necessary to notify the court of the release;

(c) Physician's release of a person on a hospital hold. The treating physician shall release a person retained or admitted to a hospital pursuant to ORS 426.232, Hospital Hold, whenever the physician makes the determination that the person is not dangerous to self or others. The treating physician shall immediately notify the director and the circuit court where the NMI was filed. See OAR 309-033-0240; or

(d) Director's release of a person on a nonhospital hold. The director shall release a person detained in a nonhospital facility, approved under OAR 309-033-0530, pursuant to ORS 426.233, Nonhospital Hold, whenever the director, in consultation with a physician, makes the determination that the person is not dangerous to self or others. The director shall immediately notify the circuit court.

(6) When a person in custody cannot be released. Once the person is admitted to a hospital or nonhospital facility, a person taken into custody pursuant to ORS 426.070 (warrant of detention), may only be released by the court. However, a person may be discharged from a hospital or nonhospital facility when the person is transferred to another approved facility.

Stat. Auth.: ORS 413.042, 426.070, 426.231, 426.232, 426.233 & 426.234

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0060; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0260

Diversion from Commitment Hearing

(1) Notice to court by director. The director and a psychiatrist may certify a person for diversion at any time up to three judicial days after the person has been taken into custody.

(2) Treatment plan. The director and the treating psychiatrist shall prepare a treatment plan that describes, in general terms, the types of treatment and medication to be provided during the diversion. The general treatment plan shall be descriptive of the range of services and medications to be provided, and shall include a description of:

(a) Any of the following classes of medication, if medication is to be administered:

(A) Antipsychotics;

(B) Antidepressants;

(C) Mood stabilizers;

(D) Anti-anxiety medications; or

(E) Anti-side effect medications.

(b) Mental health interventions, therapies or diagnostic procedures to be employed;

(c) The person's preferences about medications and therapies and any limitations on the specific use of medications or therapies to which the director and the treating psychiatrist have agreed;

(d) Location where treatment is to be initiated and the type of hospital or nonhospital facilities where the person may be transferred during the diversion; or

(e) Other conditions or limitations agreed to by the person and the director concerning the care or treatment that is to be provided.

(3) Notice to person. At the initiation of the diversion period, the director and the psychiatrist shall inform the person verbally, and in writing, of the usual and typical restraints or seclusion which may be employed in an emergency to assure health or safety.

(4) Psychiatrist to provide information. The psychiatrist shall provide the information described in OAR 309-033-0620, Proce-

dures for Obtaining Informed Consent and Information to be Given, when administering a specific medication.

(5) Consent for non-psychiatric care. A treating physician shall obtain the person's consent for non-psychiatric medical care and treatments which may be prescribed during the diversion. The general treatment plan for psychiatric intervention shall not include plans for non-psychiatric medical care or treatment.

(6) Refusal of treatment/demand for discharge. The person on diversion may refuse psychiatric treatment described in the general treatment plan or demand discharge at any time during the diversion by signing the form described in this paragraph or, if the person refuses to sign the form, by verbally making his or her refusal of treatment or demand for discharge known to two staff of the facility. In accepting the person's refusal of treatment or demand for discharge the staff of the facility shall:

(a) Provide the person a warning, both verbally and in writing, at the person's first indication that he/she wishes to refuse treatment or demand discharge, which states:

"If you refuse psychiatric treatment described in the general treatment plan or demand to be discharged you may be required to appear at an involuntary civil commitment hearing. It is your right to request an involuntary civil commitment hearing at this time. If a judge finds you to be a mentally ill person you may be committed for up to 180 days. However, if a judge finds you not to be a mentally ill person you may be released. The treatment in which you were to participate as a condition of avoiding a commitment hearing is described in your general treatment plan. You were given a copy of your general treatment plan when you agreed to diversion. You may see the copy of your general treatment plan on file with this facility at any time. You may talk with your attorney before you refuse this treatment, demand discharge or request a hearing."

(b) If the person refuses treatment, demands discharge or requests a hearing, offer the person the following form to sign:

"Warning

If you refuse psychiatric treatment described in your general treatment plan or demand discharge you may be required to appear at an involuntary civil commitment hearing. You have a right to request an involuntary civil commitment hearing at this time. If a judge finds you to be a mentally ill person you may be committed for up to 180 days. The psychiatric treatment in which you were to participate as a condition of avoiding a commitment hearing is described in your general treatment plan. You were given a copy of your general treatment plan when you agreed to diversion. You may see the copy of your general treatment plan on file with this facility at any time. You may talk with your attorney before you refuse this treatment, demand discharge or request a hearing.

I refuse the treatment described in my general treatment plan.

I request a hearing before the circuit court.

Signature of Certified Person."

(c) If the person refuses to sign the form described in this section and verbally or nonverbally refuses treatment, the staff of the facility shall document the person's refusal on the form and in the person's clinical record;

(d) Immediately upon the person's refusal of treatment, demand for discharge or request for a hearing, the treating physician shall treat the person as a person in custody, as provided under ORS 426.072, and shall immediately notify the director. The director shall immediately request a hearing.

(7) Director of the county of residence approval of payment for diversion. A person shall be on diversion only if payment for the care, custody and treatment is approved verbally by the director of the county of residence as provided under ORS 426.237. The director of the county of residence's approval shall be documented by a written statement, signed by the director, and distributed by the end of the diversion period as follows:

(a) The original shall be filed in the clinical record at the CMHP; and

(b) A copy shall be delivered to each facility serving the person during the diversion.

Stat. Auth.: ORS 413.042, 426.236 & 426.237

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0070

309-033-0270

Provision of Care, Custody and Treatment of Persons Committed to the Division

(1) Provision of rights. In addition to the rights provided under ORS 426.385, committed persons also have the rights provided under ORS 430.205 through 430.210 and this rule, including:

(a) A Committed Person's Right to Fresh Air. For the purpose of this rule, these terms have the following meanings:

(A) "Fresh air" means the inflow of air from outside the facility where the committed person is receiving services. "Fresh air" may be accessed through an open window or similar method as well as through access to the outdoors.

(B) "Outdoors" means an area with fresh air that is not completely enclosed overhead. "Outdoors" may include a courtyard or similar area.

(b) If a committed person requests access to fresh air and the outdoors or the committed person's treating health care provider determines that fresh air or the outdoors would be beneficial to the committed person, the facility in which the committed person is receiving services shall provide daily access to fresh air and the outdoors unless this access would create a significant risk of harm to the committed person or others.

(c) The determination whether a significant risk of harm to the committed person or others exists shall be made by the committed person's treating health care provider. The treating health care provider may find that a significant risk of harm to the committed person or others exists if:

(A) The committed person's individual circumstances and condition indicate an unreasonable risk of harm to the committed person or others which cannot be reasonably accommodated within existing programming should the committed person be allowed access to fresh air and the outdoors; or

(B) The facility's existing physical plant or existing staffing prevent the provision of access to fresh air and the outdoors in a manner than maintains the safety of the committed person or others.

(d) If a facility determines that its existing physical plant prevents the provision of access to fresh air and the outdoors in a safe manner, the facility shall make a good faith effort at the time of any significant renovation to the physical plant that involves renovation of the unit or relocation of where committed persons are treated to include changes to the physical plan or location that allow access to fresh air and the outdoors, so long as such changes do not add an unreasonable amount to the cost of the renovation.

(2) Provision of care at a state hospital. The superintendent of the state hospital serving the county of commitment shall be responsible for all admissions to the state hospital:

(a) The superintendent, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to the state hospital;

(b) The superintendent shall implement policies and procedures which afford a committed person placed in a state hospital the rights provided by ORS 426.385, 430.205 through 430.210 and this rule.

(3) Provision of care at a community hospital. The director shall assign and place a committed person only at a community hospital approved under OAR 309-033-0530:

(a) The admitting physician, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to a community hospital;

(b) The administrator shall implement policies and procedures which afford a committed person placed in a community hospital the rights provided by ORS 426.385, 430.205 through 430.210 and this rule.

(4) Provision of care at a nonhospital facility or an outpatient program. The director shall only assign and place a committed person in a nonhospital facility that is licensed or certified by the Division:

(a) The administrator, in consultation with the director, shall determine whether the best interests of a committed person are

served by an admission to a nonhospital facility or an outpatient program;

(b) The administrator shall implement policies and procedures which afford a committed person placed in a nonhospital facility or an outpatient program the rights provided by ORS 426.385, 430.205 through 430.210 and this rule;

(c) The director shall place on a trial visit a committed person who is discharged from a state hospital or a community hospital when the director assigns and places the person in a nonhospital facility;

(d) The director shall place a committed person, who the court has ordered on outpatient commitment at the commitment hearing, on outpatient commitment when the director assigns and places the person in a nonhospital facility.

(5) Provision of medical services for a committed person. The superintendent of a state hospital, the treating physician at a community hospital or the director may transfer a committed person to a general hospital, or transfer a committed person from a psychiatric ward to a medical ward for medical care:

(a) The treating physician shall only provide medical care with the consent of the committed person in accordance with OAR 309-033-0600 through 309-033-0650;

(b) The superintendent or treating physician shall transfer a committed person to a general hospital for medical services on a pass or discharge the person from the state hospital when it is determined that the person will not return to the state hospital within a reasonable length of time, or that discharge is clinically appropriate and is required for the person to have access to third-party insurance benefits;

(c) The treating physician shall immediately notify the director that a person was transferred to another hospital for medical care under this subsection.

Stat. Auth.: ORS 413.042, 426.060, 426.385 & 430.205 - 430.210
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0080; MHS 5-2009, f. & cert. ef. 12-17-09

309-033-0280

Procedures for Committed Persons on Outpatient Commitment or Trial Visit

(1) Outpatient commitment. At the time of the commitment hearing the director may place a committed person on an outpatient commitment if adequate treatment services are available in the county. The director shall be responsible for:

(a) Enrolling the committed person in treatment services and assuring that the committed person has an opportunity to participate in the development of the treatment plan;

(b) Distributing the conditions of placement as pursuant to ORS 426.278 and OAR 309-033-0280, Distribution of the Conditions of Placement, below;

(c) Monitoring and documenting the provision and consumption of services which fulfill the conditions set for the outpatient commitment;

(d) Petitioning the court for a revocation hearing if the best interests of the committed person require a modification in the conditions of placement for a treatment option which is more restrictive;

(e) With the participation of the committed person, changing the conditions to less restrictive conditions, if appropriate; and

(f) Documenting in the clinical record any conditions of placement requiring modification by means of a report which:

(A) Documents the need for a change in the conditions of outpatient commitment;

(B) Sets new conditions of commitment;

(C) Describes the reasons for the new conditions;

(D) Is signed by the committed person and the mental health professional assigned to the case, or, if the committed person refuses to sign the new conditions of placement, such fact shall be documented in the report; and

(E) Documents that a copy of the changes and the reasons for the changes was distributed to appropriate persons described in

OAR 309-033-0280, Distribution of the Conditions of Placement, below.

(2) Trial visit. The director may grant a trial visit to any committed person during a period of commitment, upon approval of the director of the county of placement. A director may grant a trial visit to any committed person during a period of community inpatient treatment. While it may be clinically advisable, the director is not required to obtain the consent or signature of the committed person:

(a) Trial visit of a committed person shall not exceed the time remaining in the period of commitment;

(b) Conditions for trial visit shall include designation of a facility, service or other provider to provide care or treatment;

(c) The director shall place the person on trial visit in accordance with OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division;

(d) The director shall evaluate any complaints received from any person concerning the behavior or treatment of a committed person on trial visit. The director shall document the results of the evaluation in the clinical record;

(e) Modification of the conditions of trial visit. The director may modify the conditions of placement for trial visit:

(A) Any modification shall not include a treatment option which is more restrictive than the current conditions of placement;

(B) The director shall petition the court for a revocation hearing if the best interests of the committed person require a modification in the conditions of placement for a treatment option which is more restrictive;

(C) The director shall document in the clinical record any conditions of placement requiring modification by means of a report which:

(i) Documents the need for a change in the conditions of outpatient commitment;

(ii) Sets new conditions of commitment;

(iii) Describes the reasons for the new conditions;

(iv) Is signed by the committed person and the mental health professional assigned to the case, or, if the committed person refuses to sign the new conditions of placement, such fact shall be documented in the clinical record; and

(v) Documents that a copy of the changes and the reasons for the changes was distributed to appropriate persons provided under ORS 426.278 and OAR 309-033-0280, Distribution of the Conditions of Placement, below.

(f) Transfer of trial visit to another county. The director may transfer a person on trial visit to another county only if the director for the county where the person will reside agrees to accept the trial visit:

(A) The director of the county where the person currently resides shall provide the director of the county where the person will reside a copy of the current treatment plan for the person on trial visit;

(B) Immediately upon accepting the trial visit the director of the county where the person will reside shall enroll the person on trial visit in treatment services and shall make any modifications in the trial visit as necessary and distribute the modified conditions of placement as required under OAR 309-033-0280, Distribution of the Conditions of Placement, below.

(3) Distribution of the conditions of placement. When a committed person is placed on conditional release, outpatient commitment or trial visit, or when the conditions of placement are modified in any manner, the current conditions of placement shall be distributed by the director to the following persons, pursuant to ORS 426.278:

(a) The committed person;

(b) The director of the county in which the committed person is to receive hospital, nonhospital or outpatient treatment;

(c) The administrator of any facility, service or other provider designated to provide care or treatment;

(d) The court of current commitment; and

(e) The appropriate court of the county in which the committed person lives during the commitment period if the person is living in

a different county than the county of the court that made the current commitment.

Stat. Auth.: ORS 413.042, 426.127, 426.273 & 426.278

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0090

309-033-0290

Assignment and Placement of Persons Committed to the Division

(1) Assignment authority. The Division, pursuant to ORS 426.060, delegates the responsibility for the assignment and placement of committed persons to the director of the county of commitment:

(a) The director may assign or transfer a committed person to any facility or program approved by the Division which, in the opinion of the director, will appropriately meet the mental health needs of the committed person;

(b) The director may discharge the committed person from commitment by notifying, in writing, the court having jurisdiction, if the director determines the person no longer is a mentally ill person as defined by ORS 426.005.

(2) Assignment outside the county of residence. The director of the county of commitment may assign the committed person to a facility in a county other than the county of residence only with the approval of the director of the county of residence and the director of the county of placement:

(a) When the director of the county of commitment assigns a committed person under this section, the director of the county of commitment shall transfer the responsibility for assignment and placement to the director of the county of placement;

(b) The Assistant Administrator shall assign a committed person under this section when the director of the county of commitment, the director of the county of residence and the director of the county of placement determine that they cannot agree on the assignment of the person and request the Division to make the assignment:

(A) The Assistant Administrator shall determine fiscal responsibility for the services to be delivered to the committed person and shall look to existing applicable laws, contracts and interagency agreements;

(B) The decision of the Assistant Administrator shall be final.

(c) When placement is determined, the director of the county of placement shall accept the responsibility for further assignment and placement;

(d) The director of the county of commitment shall petition the court in the county where the person was committed to transfer jurisdiction to the court in the county where the person is to reside, pursuant to ORS 426.275.

(3) Assignment to a state hospital. The director of the county of commitment shall only assign and place a committed person in a state hospital with the consent of the superintendent.

(4) Assignment procedure. The director of the county of commitment shall make the assignment in writing immediately upon commitment of a person by the court or at the time the placement of a committed person is changed during the commitment period. The director shall:

(a) Retain an original assignment order on file in safe keeping for seven years;

(b) Deliver a signed original copy of the assignment order to the person prior to placement;

(c) Enter into the Division's current computer data system information about the committed person including:

(A) Name and any known aliases;

(B) Date of birth;

(C) Address of current residence;

(D) Address where assigned for treatment if different from residence;

(E) Name and telephone number of the administrator of the hospital, facility or program responsible for the person's treatment; and

(F) Any other data as requested by the Division.

(d) Out of county assignments shall include a statement that assignment and placement responsibility is transferred to the director of the county of placement.

(5) Appeal of assignment procedure. At any time during the period of commitment, a committed person may appeal to the Assistant Administrator for Mental Health for a change in assignment made by a director.

(a) How to make an appeal. The committed person shall make the appeal in writing and shall include the following information in the appeal:

(A) A statement that the committed person appeals the current assignment;

(B) The reason(s) the committed person believes the current assignment is inappropriate; and

(C) The proposed alternate placement and the reasons the committed person is requesting the alternate placement.

(b) Appeal of an assignment to a community hospital or to the community. The Assistant Administrator shall make a determination of an appealed assignment for persons currently assigned to community hospitals or community placements. The Assistant Administrator shall determine the assignment for the committed person, and notify the committed person of the assignment, in writing or verbally, within five business days of the receipt of the written appeal. The Assistant Administrator's determination shall be final:

(A) In making a determination of an appealed assignment the Assistant Administrator:

(i) Shall review the written appeal;

(ii) Shall contact the director making the assignment, and consider the director's reason(s) for making the assignment;

(iii) Shall consider the opinion of the person's treating physician if the person is placed at a community hospital;

(iv) May require the director to submit a written statement which gives the reason(s) for the assignment; and

(v) May consider the consultation or opinion of any person that the Assistant Administrator believes has knowledge relevant to the case.

(B) The Assistant Administrator shall use the following criteria when making a determination of an appealed assignment:

(i) The assignment shall be in the best interests of the committed person;

(ii) The assignment shall assure the safety of the person and the community; and

(iii) The assignment shall be in the least restrictive environment that the resources of the person or Division will allow.

(c) Appeal of an assignment to a state hospital. The Administrator shall make a determination of an appealed assignment for persons currently assigned to a state hospital or where the appeal requests assignment to a state hospital. The Administrator shall determine the assignment for the committed person, and notify the committed person of the assignment, in writing or verbally, within five business days of the receipt of the written appeal. The Administrator's determination shall be final:

(A) In making a determination of an appealed assignment the Administrator shall consider the opinion of the superintendent, or designee, of the state hospital affected by the appeal, and the report of the Assistant Administrator. In making the report to the Administrator, the Assistant Administrator:

(i) Shall review the written appeal;

(ii) Shall contact the director making the assignment, and consider the director's reason(s) for making the assignment;

(iii) Shall consider the opinion of the person's treating physician if the person is placed at a community hospital;

(iv) May require the director to submit a written statement which gives the reason(s) for the assignment;

(v) May consider the consultation or opinion of any person that the Assistant Administrator believes has knowledge relevant to the case;

(vi) Shall make a recommendation about the proposed assignment; and

(vii) Shall submit the report within three business days after the Division receives the appeal.

(B) The Administrator shall use the following criteria when making a determination of an appealed assignment:

(i) The assignment shall be in the best interests of the committed person;

(ii) The assignment shall assure the safety of the person and the community; and

(iii) The assignment shall be in the least restrictive environment that the resources of the person or Division will allow.

Stat. Auth.: ORS 413.042, 426.060

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0100

309-033-0300

Transfers Between Classes of Facilities

(1) Transfers between classes of facilities. The director may transfer a committed person from one class of facility to another in the same class or in a less restrictive class as provided by ORS 426.060. However, the director shall transfer a committed person who has voluntarily agreed to placement at the facility only with the written consent of the person. The director shall transfer committed persons as provided by OAR 309-033-0400 through 309-033-0440, Standards for Transportation and Transfer of Persons in Custody or on Diversion, and OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division. The director shall modify the conditions of trial visit to reflect the change of placement and shall notify the following persons of the transfer:

(a) The committed person;

(b) The court in the county where the person was committed;

(c) The court in the county where the person is to be placed;

(d) The director in the county where the person is to reside;

(e) The administrator of the facility designated to provide care or treatment; and

(f) Any other provider designated to provide care or treatment.

(2) Transfers restricted by rule. The director may transfer a committed person from a facility of one class to another facility of a same class or lower class by:

(a) Assigning the committed person to the new facility; and

(b) Modifying the person's commitment status as follows:

(A) Persons transferred to a Class 2 or Class 3 facility. When the director transfers a committed person to a Class 2 or Class 3 facility, the director shall place the person on trial visit (see OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division);

(B) Transfers between Class 1 hospitals or facilities. The director shall transfer a person between Class 1 hospitals or facilities without placing the committed person on trial visit; or

(C) Transfer to any facility and discharged from commitment. When the director determines a committed person is no longer a mentally ill person, the director shall discharge the person from commitment (see OAR 309-033-0330, Discharge of Committed Persons from Commitment Status) and enroll the person in services voluntarily at the receiving facility.

(3) Transfers from a facility of one class to a facility of a more restrictive class:

(a) Involuntary transfers of committed persons. The director shall transfer a committed person, who is on trial visit, to a facility of a more restrictive class only:

(A) By order of the court after a hearing, pursuant to ORS 426.275; or

(B) Initiate involuntary procedures as provided in this paragraph and as provided by ORS 426.233 (see subparagraph (c) of this paragraph).

(b) Voluntary transfers of committed persons. The director may transfer a committed person, who is on trial visit, to a facility of a more restrictive class with the committed person's consent. However, if the committed person revokes his/her consent to the current more restrictive placement and requests to be placed at another facility of a less restrictive class, as soon as reasonably possible the director shall:

(A) Transfer the person to a facility where the person consents to receive services; or

(B) Initiate involuntary procedures as provided in this paragraph and by ORS 426.233.

(c) Emergency transfers of committed persons. As provided by ORS 426.233, the director may transfer a committed person, who is on trial visit, to a hospital or nonhospital facility approved by the Division when the director has probable cause to believe the person is dangerous to self or others or unable to provide for basic personal needs and is not receiving the care that is necessary for health and safety, and is in need of care, custody or treatment for mental illness. Upon the recommendation of the investigator, the director shall request the court to revoke the person's trial visit or recertify the person for continued commitment at a more restrictive facility as provided by ORS 426.275.

(4) Authority to retake persons. A Class 1 or Class 2 facility shall immediately notify a peace officer and the Division of any person who has left the facility without lawful authority and shall immediately request the assistance of a peace officer(s) in retaking and returning the person to a Division-approved hospital or facility. The director shall show the peace officer a copy of the order of commitment.

Stat. Auth.: ORS 413.042, 426.060, 426.223, 426.233, 426.273, 426.275 & 426.278

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0110

309-033-0310

Recertification for Continued Commitment

(1) Recertification for continued commitment of persons placed in a state hospital:

(a) After consulting with the director of the person's county of residence, the superintendent shall issue a recertification to:

(A) The person whose 180 day period of commitment is due to expire, if the person is still mentally ill and in need of further treatment; and

(B) The director.

(b) The superintendent shall notify the court concerning:

(A) The date the recertification was issued to the person; and

(B) Whether the person protests, within 14 days of the issuance of the recertification, to continued commitment.

(2) Recertification for continued commitment of persons placed in a community hospital or nonhospital facility:

(a) After consulting with the director of the person's county of residence, the director shall issue a recertification to:

(A) The person whose 180 day period of commitment is due to expire, if the person is still mentally ill and in need of further treatment; and

(B) The director of the person's county of residence.

(b) The director shall notify the court concerning:

(A) The date recertification was issued to the person; and

(B) Whether the person protests continued commitment, within 14 days of the issuance of the recertification.

(3) Documentation of recertification for continued commitment in the clinical record. The director or the superintendent making the recertification shall include in the clinical record:

(a) The date and time the director's approval of continued commitment was obtained prior to the recertification being issued to the person;

(b) The date and time the recertification was issued to the persons;

(c) A copy of the recertification issued to the person;

(d) Concerning the notification to the court of the date the recertification was issued to the person:

(A) The date and time that the court was notified of the issuance of the recertification to the person; and

(B) A copy of the notification.

(e) Concerning the notification to the court of whether the person protests continued commitment, within 14 days of the issuance of the recertification:

(A) The date and time that the court was notified of whether the person protests; and

(B) A copy of the notification to the court whether the person protests.

(f) If an examination is requested by the person:

(A) The name of the psychiatrist or the certified mental health examiner ordered by the court to conduct the examination;

(B) The date that the examination was conducted; and

(C) A copy of the examination report sent to the court.

(g) If the court orders continued commitment, a copy of the order continuing the commitment; and

(h) If the court orders the release of the person:

(A) A copy of the order requiring release;

(B) If the person consents to services upon discharge, a copy of an aftercare plan signed by the person and the name of the case manager responsible for arranging outpatient services; or

(C) If the person refuses services upon discharge, a statement signed by the person indicating the person's refusal of outpatient services; and

(D) The date and time the person was released from the facility.

Stat. Auth.: ORS 413.042, 426.301, 426.307

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0120

309-033-0320

Revocation of Conditional Release, Outpatient Commitment or Trial Visit

(1) Conditional release. A caregiver appointed by the court to care for a committed person on conditional release is responsible for reporting to the court any violation of the conditions of placement. If a person on conditional release, whose conditions of placement include any service agreed to be provided by a CMHP, violates the conditions of conditional release, the director shall include in the clinical record a revocation report which documents the following:

(a) The person's noncompliance with those conditions of placement that include services provided by the CMHP;

(b) Efforts by the CMHP to inform the caregiver of the non-compliance and the caregiver's response to these efforts;

(c) Requests by the caregiver for the CMHP to assist in obtaining compliance from the committed person, or in notifying the court of the person's failure to comply with the conditions of placement, and the CMHP response to the requests for assistance;

(d) Documentation of the disposition made by the court, if the caregiver submits notification to the court; and

(e) The date the person was transported to an inpatient facility, and the name of the facility, if appropriate.

(2) Outpatient commitment and trial visit. The director is responsible for reporting to the court any violation of the conditions of placement for persons on outpatient commitment (including community inpatient or outpatient treatment) or trial visit. For persons on outpatient commitment or trial visit, the director shall include in the clinical record a revocation report which includes the following:

(a) Documentation of the person's noncompliance with the conditions of placement;

(b) Documentation of efforts from all parties attempting to obtain compliance from the committed person and the response of the person to these efforts;

(c) A copy of the notification to the court of the person's failure to comply with the conditions of placement;

(d) Documentation of the disposition made by the court;

(e) Documentation of the distribution of any modified conditions of placement or disposition placing the person in inpatient treatment to all parties originally receiving copies of the conditions of placement; and

(f) Date the person was transported to an inpatient facility, and the name of the facility, if appropriate.

Stat. Auth.: ORS 413.042 & 426.275

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0130

309-033-0330

Discharge of Committed Persons, Who Are Placed in the Community, from Commitment Status

(1) Only director of county of placement may discharge. Only the director of the county of placement may change the commitment status of a committed person placed in a community hospital or other community facility:

(a) The director shall discharge a person from commitment when:

(A) Release from treating facility. The director believes the committed person is no longer a mentally ill person as defined in ORS 426.005, and the person is to be released from the treating facility.

(B) Transfer to voluntary status. The director believes it is in the best interests of the person to transfer a committed person to voluntary status, but the person is to remain at the treating facility.

(b) The director shall discharge a person from commitment by notifying the last committing court and the court of residence, pursuant to the provisions of ORS 426.300.

(2) Discharge required unless new assignment and placement made. The director of the county of commitment shall discharge a person from commitment when a committed person is discharged from a hospital, nonhospital or residential facility, or an outpatient treatment program where the person has been assigned and placed unless the director of the county of commitment assigns and places the person with another provider of service as provided by OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division.

(3) Persons required to notify director prior to discharge. The following persons shall notify the director of the county of commitment 48 hours before discharging a person from a hospital, nonhospital or residential facility, or outpatient treatment:

(a) If the committed person is in a state hospital, the superintendent or designee shall notify the director;

(b) If the committed person is in a hospital serving as a regional acute care hospital or a private hospital, the treating physician shall notify the director;

(c) If the committed person is in a nonhospital or residential facility, the administrator of the facility shall notify the director;

(d) If the person is on trial visit, outpatient commitment or conditional release receiving outpatient treatment, and is not living in a nonhospital or residential facility, the administrator of the program where the person is receiving outpatient treatment shall notify the director.

(4) Procedures for discharge. The director shall give written notice to the committed person within thirty days after the commitment was terminated. The notice shall state the date the commitment expired or was terminated. A copy of the notice shall be kept in the person's clinical record.

Stat. Auth.: ORS 413.042 & 426.300

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0140

309-033-0340

Variations

(1) Criteria for a variance. Variations may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0150

309-033-0400

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures relating to the involuntary commitment of mentally ill persons.

(2) Statutory authority. These rules are authorized by ORS 426.395.041, and 426.005 through 426.395 and carry out the provisions of ORS 426.005 through 426.395.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0000

309-033-0410

Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005. Whenever "administrator" appears it means the administrator or designee.

(2) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(3) "Community hospital" means any hospital that is not a state hospital.

(4) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(5) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer or approved secure transport provider pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer or approved secure transport provider at the direction of the director pursuant to ORS 426.233;

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(6) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer or approved secure transport provider to take a person into custody pursuant to ORS 426.233,

the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(7) "Director of the county of commitment" means the director for the county where the person is committed.

(8) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(9) "Mechanical Restraint" is any object or apparatus, device or contraption applied or affixed to the person to limit movement, and includes, but is not limited to handcuffs, leg irons, soft restraints or Posey Strait Jacket.

(10) "Secure transport provider" means any service which uses privately or publicly owned motor vehicles, other than city, county or state police, to transport Persons in Custody or on Diversion to an Approved Holding Hospital or NonHospital Facility.

(11) "State hospital" means Oregon State Hospital in Salem and Portland, and Eastern Oregon Psychiatric Center in Pendleton.

(12) "Superintendent" means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent's capacity for the purpose of this rule.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0010; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0420

Transportation and Transfer of Persons in Custody or On Diversion

(1) Notification of court. The director shall immediately inform the court of a transfer and the location of the person and of the time the person is admitted to a new hospital or nonhospital facility.

(2) Transfer of persons in custody or on diversion. The director may transfer a person who is in custody or on diversion only when:

(a) The director believes there is an approved facility available that can provide necessary care or treatment which is sufficient to meet the emergency psychiatric needs of the person;

(b) The facility is approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion, to provide care, custody and treatment of persons in custody or on diversion;

(c) The director has obtained the consent required by OAR 309-033-0420(3), Consent by Treating Physician and Receiving Physician or Director for Transfer Between Hospitals, through 309-033-0420(4), Consent by Treating Physician for Transfer from Nonhospital Facility to Hospital.

(3) Consent by treating physician and receiving physician or director for transfer between hospitals. If the transfer is from a hospital to another hospital or to a nonhospital facility, the director shall obtain the consent of the treating physician, and the receiving physician or the director of the nonhospital facility, prior to transferring the person:

(a) The treating physician shall give consent by writing in the person's clinical record an order over the physician's signature within 24 hours of giving verbal, telephonic or facsimile consent;

(b) The receiving physician at a hospital or the administrator of a nonhospital facility shall accept the transfer orally or telephonically, and shall document the acceptance in the clinical record of the person.

(4) Consent by treating physician for transfer from nonhospital facility to hospital. If the transfer is from a nonhospital facility to a hospital, the director shall obtain the consent of the receiving physician prior to transferring the person:

(a) The receiving physician shall give consent by writing in the person's clinical record an order over the physician's signature within 24 hours of giving verbal, telephonic or facsimile consent to admit the person to the hospital;

(b) The director shall provide the nonhospital facility written approval of the transfer within 24 hours of giving verbal, telephonic or facsimile approval of the transfer;

(c) The administrator of the nonhospital facility shall document the director's verbal or telephonic approval and retain written approval of the transfer in the clinical record of the person.

(5) Consent by administrator for transfer between nonhospital facilities. If the transfer is from one nonhospital facility to another nonhospital facility, the director shall obtain the verbal, telephonic or facsimile consent of the administrator of the receiving nonhospital facility prior to transferring the person:

(a) The administrator of the receiving nonhospital facility shall consent to the transfer by documenting in the person's clinical record the consent within 24 hours of giving verbal, telephonic or facsimile consent;

(b) The director shall provide the nonhospital facility written approval of the transfer within 24 hours of giving verbal, telephonic or facsimile approval of the transfer;

(c) The administrator of the sending nonhospital facility shall document the director's verbal, telephonic or facsimile approval and retain written approval of the transfer in the clinical record of the person.

(6) Notice to person to be transferred. Except in cases of emergency, twenty-four hours before the transfer is to take place, the director shall provide a notice to the person to be transferred which includes:

(a) Transfer date and time;

(b) A statement that the person may use the grievance procedure; and a brief description of how to initiate a grievance; and

(c) Justification for the transfer.

Stat. Auth.: ORS 413.042, 426.060 & 426.235

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0030

309-033-0430

Transportation of a Committed Person to a State Hospital, Community Hospital or Nonhospital Facility

(1) Transportation of a committed person to a state hospital, community hospital or nonhospital facility. The director of the county of commitment shall arrange for the transportation of committed persons to the hospital or nonhospital facility:

(a) Only committed persons who have received prior approval for admission by the superintendent may be transported to a state hospital;

(b) A guardian, friend or relative may transport the committed person to the designated facility if all the following are met:

(A) The guardian, friend, or relative requests to transport the person to the designated facility prior to or at the time of the commitment hearing;

(B) The committing judge at the commitment hearing determines that the means of transportation would not be detrimental to the welfare of the mentally ill person or to the public.

(2) Medically unstable committed persons. The costs of providing care, custody and treatment for a committed person who is unable to be transported or cannot be admitted to a state hospital because of medical necessity shall be paid by the county of residence from funds provided it by the Division for the provision of mental health services. The hospital or other facility shall charge to and collect from the county of residence only after the hospital or other facility has charged to and collected from the person, third party payers or agencies otherwise legally responsible for the costs of emergency care, custody and treatment, as it would for any other patient.

(3) Transfer of a committed person to another hospital. The administrator of a facility caring for a committed person may transfer the person only with the recommendation of the director of the county of residence and the approval of the administrator of the receiving facility.

(4) Transfer of a committed person to voluntary status or discharge for commitment. The superintendent of a state hospital, on his/her own initiative or on the request of the committed person,

shall transfer the committed person to voluntary status if the superintendent believes with reasonable medical certainty that the person will pursue voluntary treatment. The superintendent of a state hospital may discharge the person from commitment when the person meets the criteria for discharge in OAR 309-031-0210, Criteria for Admission to and Discharge from State or Other Adult Inpatient Psychiatric Hospitals:

(a) The administrator of a community hospital or nonhospital facility, other than a state hospital, caring for the committed person, in consultation with the director, may transfer the person to voluntary status or discharge the person from commitment;

(b) When a person is transferred to voluntary status, the superintendent or administrator shall notify the director and the court of the county of current commitment of such action within 72 hours;

(c) Any committed person transferred to voluntary status shall be discharged from the treating facility, at the request of the person or his legal guardian, within 72 hours of the request unless the person meets the criteria for prehearing custody and is placed in custody, thus initiating the commitment process.

(5) Grievance of transfer. The director and the superintendent shall have written procedures for resolving grievances about the transfer of committed persons from one facility to another. The director or the superintendent shall suspend the transfer of the person, until the grievance procedure is completed, unless immediate transfer is necessary for health or safety, upon the written or verbal protest of one of the following persons:

(a) The person being transferred;

(b) The legal guardian of the person being transferred.

Stat. Auth.: ORS 413.042, 426.150

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0040

309-033-0432

Standards for the Approval of a Secure Transport Provider to Transport a Person in Custody or On Diversion to an Approved Holding Hospital or Nonhospital Facility

(1) Approved Secure transport provider. A Secure transport provider must be approved by the Division under this rule in order to transport a person pursuant to the provisions of ORS 426.228, 426.231, and 426.233. A Secure transport provider approved under this rule may transport the person only to a hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion.

(2) Application for approval. A Secure transport provider shall submit a letter of application to the Division. If approved, a certificate of approval will be issued to the Secure transport provider to provide such services. This approval shall be renewed every two years subject to the application of the Secure transport provider and review by the Division.

(3) Requirements for approval include all of the following:

(a) Secure transport providers must comply with the requirements OAR 309-033-0435, Client Rights with Regards to a Secure Transport Provider, and OAR 309-033-0437, Mechanical Restraint by a Secure Transport Provider.

(b) The governing body of the county in which the secure transport is to be used shall submit a letter formally authorizing the Secure transport provider to Transport Persons in Custody or on Diversion.

(c) The director in the county in which the secure transport is to be used shall submit a letter of recommendation for approval to the Division on behalf of the Secure transport provider.

(d) The vehicles of the Secure transport provider must:

(A) Have a secured rear seat in an area separated from the driver;

(B) Have a safety shield that prohibits physical contact with the driver;

(C) Have plexiglass or secured window guards covering any windows in the secured area;

(D) Be washable and nonbreakable in the secured area;

(E) Be absent of inside locks or door handles in the secured area;

(F) Have wrist and ankle restraints (preferably soft non-metal) for use when necessary to control violent or overt behavior;

(G) Be absent of any foreign item(s) or instrument(s) in the secured area that may be used by the client to inflict harm to self, attendant or person accompanying client;

(H) Have an operating cellular phone or other communication device for use in transit;

(I) Have adequate ventilation/heating appropriate to the secured seating.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0435

Client Rights with Regards to a Secure Transport Provider

(1) A secure transport provider shall maintain written policies and procedures with regard to client rights. The policies and procedures must assure that a client has the right to be treated with consideration, respect, and full recognition of human dignity and individuality. These rights are in addition to any other rights provided for in law.

(2) The client care policies and procedures must include but are not limited to:

- (a) Considerate and respectful care;
- (b) Reasonable privacy concerning a client’s transportation and care;
- (c) Confidentiality of all communications and records relating to client transportation and care except to the extent otherwise required by law;
- (d) An environment in the secure transport that is free from recognized hazards.

(3) A secure transport provider shall keep a record of any formal complaint or report of misconduct made against an employee. The record must contain a copy of the complaint or report or a detailed written summary of the allegation. A provider shall investigate the accuracy of the complaint, report, or allegation and shall include a summary of the investigation and resulting action taken, if any, in the record. These records must be included in the driver’s file with a copy provided to the Division.

(4) A secure transport provider shall report any client abuse in accordance with OAR 943-045-0250 through 943-045-0370.

(5) A secure transport provider shall obtain criminal offender information on all employees who are Transporting a Person in Custody or on Diversion in accordance with OAR 943-007.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00; MHS 5-2007, f. & cert. ef. 5-25-07]

309-033-0437

Mechanical Restraint by a Secure Transport Provider

(1) A mechanical restraint may be used by secure transport providers in emergency situations to prevent a person from inflicting immediate and serious harm to self or others, or property. A mechanical restraint shall only be used for health and safety reasons. Mechanical restraint that results in injury to the person requires immediate written notification to the Division.

- (2) Checking a person in a mechanical restraint:
- (a) The provider shall monitor the client’s need for adequate circulation.
- (b) Staff shall document that the client was checked and appropriate attention paid to the person’s needs.

(3) A Secure transport provider shall have adequately trained employees who are transporting a person in custody or on diversion.

(a) The employee shall participate in four hours of training annually. The training curriculum shall include: the management of aggressive behavior, the proper application of mechanical restraint and standards for the proper use of mechanical restraint.

(b) The employee shall be certified in cardiopulmonary resuscitation.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0440

Variance

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

- (a) The section of the rule from which the variance is sought;
- (b) The reason for the proposed variance;
- (c) The alternative practice, service, method, concept or procedure proposed;
- (d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and
- (e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042, 426.060 & 426.235
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0050; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; Administrative correction 11-17-00

309-033-0500

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards for the approval of facilities that provide involuntary care, custody and treatment to persons in protective custody, in custody and on diversion.

(2) Statutory authority. These rules are authorized by ORS 426.395, and 426.005 through 426.395 and carry out the provisions of ORS 426.005 through 426.395.

Stat. Auth.: ORS 413.042 & 426.060 - 426.500
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0000

309-033-0510

Definitions

(1) “Administrator” means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. “Administrator” has the same meaning as “director of the facility” as that term is defined in ORS 426.005. Whenever “administrator” appears it means the administrator or designee.

(2) “Assistant Administrator” means the Assistant Administrator of Addictions and Mental Health Division.

(3) “Clinical record” means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Service Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) "Community hospital" means any hospital that is not a state hospital.

(6) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(7) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233;

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237.

(11) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(12) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

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

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

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0010

309-033-0520

Classes of Facility that Provide Care, Custody or Treatment to Committed Persons or to Persons In Custody or On Diversion

(1) Division to assign classification. The Division shall assign a classification to a facility approved to serve a person committed to the Division under ORS 426.130, or a person in custody pursuant to ORS 426.232, 426.233, or on diversion pursuant to 426.237.

(2) Class 1. A Class 1 facility is a facility that is approved under applicable administrative rules to be locked to prevent a person from leaving the facility, to use seclusion and restraint, and to involuntarily administer psychiatric medication. This class of facility includes:

(a) A state hospital;

(b) A hospital, regional acute psychiatric care facility or other nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion;

(c) A facility which, in the opinion of the Division, restricts the liberty of a person to substantially the same degree as other facilities in this class.

(3) Class 2. A Class 2 facility is a facility that is approved under applicable administrative rules to be locked to prevent a person from leaving the facility. This class of facility includes:

(a) A secure residential facility that is approved under OAR 309-035-0100 through 309-035-0190, Residential Care Facilities for Mentally or Emotionally Disturbed Persons, and that is approved by the Division to be locked to prevent a person from leaving the facility;

(b) A facility which, in the opinion of the Division, restricts the liberty of a person to substantially the same degree as other facilities in this class.

(4) Class 3. A Class 3 facility is a residential facility that is approved under OAR 309-035-0100 through 0309-035-0190, Residential Care Facilities for Mentally or Emotionally Disturbed Persons. A Class 3 facility shall not lock its doors to prevent a person from leaving the facility.

Stat. Auth.: ORS 413.042 & 426.238

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0030

309-033-0530

Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons In Custody and On Diversion

This section establishes rules for approval of hospital and nonhospital facilities which provide service to a committed person or to a person in custody or on diversion.

(1) Approved hospitals and other facilities. Only hospitals and nonhospital facilities, approved by the Division under this rule, shall provide care and treatment services for committed persons or for persons in custody or on diversion.

(2) Application for approval. Approval of hospitals or nonhospital facilities shall be accomplished by submission of a letter of application. If approved, a Certificate of Approval will be issued to the hospital or nonhospital facility to provide such services. This approval shall be reviewed on a biennial basis subject to application of the hospital or other facility and/or review by the Division.

(3) Requirements for approval. In undertaking review of the hospital or nonhospital facility for approval, the Division shall be satisfied that the hospital or nonhospital facility meets one of the following requirements:

(a) Approval to provide seclusion and restraint considered approval to provide services to committed persons and to persons in custody and on diversion. The Division shall approve, without further requirement, hospitals and nonhospital facilities currently approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) Requirements for facilities not approved to provide seclusion and restraint. The Division shall approve a nonhospital facility to serve committed persons and persons in custody and on diversion if the nonhospital facility is certified as a secure residential facility under Division rules and the nonhospital facility has the following:

(A) Written policies and procedures in place which assure that:

(i) The facility shall not admit a person who may require seclusion or physical restraint.

(ii) A person who develops the need for seclusion and restraint is immediately removed to a hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital

Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(iii) Each person admitted to the facility has a physician who is responsible for treating the person during the person's stay at the facility and who examines the person within 24 hours of the person's admission to the facility.

(iv) A staff person shall provide direct care for consumers only when that staff person is trained in the curriculum approved by the psychiatrist or psychiatric nurse practitioner. The staff shall receive the training within the last six months prior to providing direct consumer care.

(v) A staff person shall participate in the training approved by the psychiatrist or psychiatric nurse practitioner quarterly.

(B) A psychiatrist or a licensed psychiatric nurse practitioner, who is employed by the facility or has a contract with the facility, to provide medical oversight of admission policies and procedures, and staff training.

(C) A staff training curriculum which is approved by the psychiatrist or nurse practitioner and includes:

(i) Criteria for the admission of a person who can safely be served by the nonhospital facility;

(ii) Recognition of indicators of violence or assault and criteria for the transfer of person to a more secure facility;

(iii) Indicators of medical problems, identification of medication side effects, and indicators of medical problems and medical crisis; and

(iv) Management of aggressive behavior and de-escalation techniques.

(D) Two qualified mental health associates who are available on-site 24 hours-a-day, seven days-a-week.

(E) Alarmed doors and windows which have been approved by the Division.

(F) A written agreement with a law enforcement agency to respond to emergencies that provides:

(i) Emergency response time within 15 minutes of the nonhospital facility's request.

(ii) Agreement by the law enforcement agency to retake a person who elopes and to return the person to the nonhospital facility or remove the person to a hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion, as directed by the administrator of the nonhospital facility.

(G) Documentation of fire marshal approval to operate as a secure facility.

Stat. Auth.: ORS 413.042, 426.228, 426.232, 426.233 & 426.236

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0040

309-033-0540

Administrative Requirements for Hospitals and Nonhospital Facilities Approved to Provide Services to Persons In Custody

(1) Written policies. Each hospital or nonhospital facility shall have written policies concerning the care, custody, and treatment of persons in custody or on diversion. These policies shall be written to provide for the comfort and safety of the person being provided care and for the safety of the facility staff providing care to that person. These policies shall detail staff responsibilities, person's rights, and emergency procedures. All staff involved in the care of these persons shall be fully familiar with these policies and procedures. These policies shall be reviewed as part of the Division's approval process.

(2) Warning. Each hospital or nonhospital facility shall:

(a) Have a physician, nurse or QMHP give the person the following warning:

"You are being held in this hospital because someone is concerned that you may hurt yourself or other people. Anything the staff of this hospital observes you do or say while you are in custody here may be used as evidence in a court of law to determine whether you should be committed as a mentally ill person. You have a right to legal counsel. If you cannot afford an attorney one will be provided for you by the court."

(b) Have the warning given at the time of admission and at times when it is determined that the person will reasonably understand the notice, and as often as it is determined necessary to assure that the person has been given an opportunity to be aware of the notice.

(c) Have the warning given to the person in writing, as required by ORS 426.123. An attempt shall be made to have the person sign the written warning. A copy of the signed written warning shall be given to the person and the original shall be kept in the clinical record. The person's inability to sign the written warning or refusal to sign the written warning shall be documented on the written warning below the place where the person's signature would be normally found, clearly stating the reasons the signature was not obtained. The written warning shall include a place where the person, by making a mark, may request legal counsel.

(3) Notification of next of kin. If the person consents, a physician, nurse or QMHP at a hospital shall make every effort to notify the person's next of kin of the location and condition of the person as required under ORS 426.234.

(4) Notification of the court of hospital hold. The admitting physician, if the person is at a hospital, shall immediately notify the circuit court in writing. The admitting physician shall also immediately notify the director in the county where the hospital is located so that an investigation can be conducted.

(5) Notification of the court of nonhospital hold. The director, if the person is at a nonhospital facility, shall notify, in writing, the circuit court in the county where the person was taken into custody.

(6) Log. Each hospital or nonhospital facility shall maintain a log of persons in custody that includes: name, date of birth, date of admission, type of admission and a notation of the use of restraints.

(7) Posted warning and rights. Each hospital or nonhospital facility shall post a copy of the person's rights in the holding room behind protective unbreakable plastic or in another location clearly visible from the holding room which, at a minimum, states:

(a) The warning described in OAR 309-033-0540;

(b) The person's right to be free from electro-shock therapy or unduly hazardous procedures.

(8) Clinical records. Each hospital or nonhospital facility shall maintain a clinical record which accurately documents the care, custody and treatment of a person in custody. These records shall include:

(a) A copy of the hold form which documents the reasons for the hold, including specific behaviors which indicate the person:

(A) Is dangerous to self or another person; and

(B) Is in need of immediate care, custody or treatment for mental illness.

(b) Documentation that the warning described in OAR 309-033-0540 has been given to the person.

(c) Documentation of the potential effects and the observed effects of any medication administered which may substantially affect the person to prepare for or function effectively at the commitment hearing, signed by the treating physician.

(d) A report of physical examination and relevant laboratory tests.

(e) Daily medical progress notes.

(f) Twenty-four hour nursing notes.

(g) Documentation, signed by the treating physician, of each use of any mechanical restraints and the specific reasons which justify the use.

(h) Documentation of the psychiatric history which, whenever possible, shall include:

(A) History of present illness, including specific prodromal symptoms;

(B) Medical history;

(C) Family history;

(D) Past psychiatric history;

(E) Substance use and abuse history;

(F) History of legal difficulties; and

(G) Social history including current support system.

(i) A report of mental status.

- (j) A diagnostic impression.
- (k) A treatment plan.
- (9) Access to clothing before release of persons in custody.

Each hospital or nonhospital facility shall allow the person in custody to have access to his/her clothing before being released to attend the commitment hearing.

Stat. Auth.: ORS 413.042, 426.123, 426.232, 426.233, 426.234 & 426.236
 Stats. Implemented: ORS 426.005 - 426.395
 Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0050

309-033-0550

Standards for the Approval of Hospitals Detaining Persons In Custody Pending Transport to an Approved Holding Hospital or Nonhospital Facility

(1) Approved hospitals. Only hospitals approved by the Division under this rule may detain a person pending transport pursuant to the provisions of ORS 426.231. A hospital approved under this rule may transport the person only to a hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion. Hospitals approved under OAR 309-033-0530 are also approved under this rule to detain a person pending transport and may transport a person to another hospital or nonhospital facility approved under OAR 309-033-0530.

(2) Application for approval. Approval of hospitals shall be accomplished by submission of a letter of application in accordance with administrative rules on letters of approval. If approved, a certificate of approval will be issued to the hospital to provide such services. This approval shall be renewed on a biennial basis subject to the application of the hospital or review by the Division.

(3) Requirements for approval. The director in the county in which the hospital is located shall submit a letter of recommendation for approval on behalf of the hospital. The letter of recommendation shall clearly state that the director and the hospital have a written agreement which includes the following:

(a) The procedures to be followed when a person is detained or transported to another hospital or nonhospital facility, with the parties responsible for performing the procedures clearly identified. The procedures shall state whether or not the hospital is required to give notice to the director prior to the release of the person.

(b) The party or parties responsible for transporting the person to another hospital or nonhospital facility and the means by which such transportation is initiated and authorized.

(c) The services to be provided by the hospital when a person is detained and transported to another hospital or nonhospital, and the payment the hospital is to receive for these services.

(d) The hospital shall have a room which meets OAR 309-033-0720, Application and Requirements for Approval to Provide Seclusion and Restraint, or shall provide an attendant to provide continuous face-to-face monitoring of the person.

(4) Responsibilities of the physician. The physician shall complete a face-to-face examination of the person. Once the physician determines that the person is dangerous to self or any other person and in need of emergency care or treatment for mental illness, the physician shall:

(a) Assure the detention of the person in safe and humane quarters for no longer than 12 hours;

(b) Assure that the person is monitored face-to-face every 15 minutes;

(c) Consult with a physician who has admitting privileges at a receiving hospital or nonhospital facility approved by the Division to determine that the receiving physician:

(A) Agrees that the person appears to be dangerous to self or any other person; and

(B) Consents to receive the person for further evaluation for involuntary emergency care and treatment for mental illness.

(d) If the person is to be sent to the receiving hospital, complete a written statement that states:

(A) The physician has examined the person within the preceding 12 hours;

(B) The reasons the physician has found the person to be dangerous to self or any other person and is in need of emergency care or treatment for mental illness; and

(C) The name of the admitting physician at the receiving hospital who has agreed to transporting the person for further evaluation and possible admission.

(e) Retain a copy of the written statement in the person's clinical record. The original written statement shall accompany the person to the receiving hospital and shall serve as authorization for transport.

(5) Release when person is no longer dangerous. If the physician at the hospital where the person is detained and is awaiting transport believes the person is no longer dangerous to self or any other person, then the physician shall release the person as soon as possible. If the physician cannot locate a receiving hospital where a physician agrees to receive the person for evaluation, then the person shall be released within twelve hours of the time the person was originally detained.

Stat. Auth.: ORS 413.042 & 426.231
 Stats. Implemented: ORS 426.005 - 426.395
 Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0060

309-033-0560

Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042
 Stats. Implemented: ORS 426.005 - 426.395
 Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0070

309-033-0600

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for community hospitals, nonhospital facilities and residential facilities relating to obtaining informed consent to treatment from a committed person, and for the administration of significant procedures without obtaining the informed consent of a committed person.

(2) Statutory authority. These rules are authorized by ORS 426.385, and carry out the provisions of 426.005 through 426.395.

Stat. Auth.: ORS 413.042 & 426.385
 Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0000

309-033-0610

Definitions

(1) “Administrator” means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. “Administrator” has the same meaning as “director of the facility” as that term is defined in ORS 426.005(1)(a). Whenever “administrator” appears it means the administrator or designee.

(2) “Assistant Administrator” means the Assistant Administrator of the Addictions and Mental Health Division.

(3) “Clinical record” means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) “CMHP” means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) “Community hospital” means any hospital that is not a state hospital.

(6) “Court” means the circuit court acting pursuant to ORS Chapter 426.

(7) “Custody” means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) “Designee” means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) “Director” means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. “Director” also means a person who has been authorized by the director to act in the director’s capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority.

(11) “Legally incapacitated person” means a person who has been found by the court to be unable to give informed consent to medical treatment and the court has appointed a guardian to make such decisions on the person’s behalf pursuant to ORS 126.127.

(12) “Material risk” means the risk may have a substantial adverse effect on the patient’s psychological and/or physical health. Tardive dyskinesia is a material risk of neuroleptic medication.

(13) “Nurse” means a registered nurse or a psychiatric nurse practitioner licensed by the Oregon Board of Nursing, but does not include a licensed practical nurse or a certified nurse assistant.

(14) “Person” means a consumer of mental health services committed to the Division who is admitted to a community hospital, nonhospital facility or residential facility for care, custody or treatment of mental illness.

(15) “Psychiatrist” means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical

Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(16) “Psychologist” means a clinical psychologist licensed by the Oregon Board of Psychologist Examiners.

(17) “QMHP” means a qualified mental health professional that meets the following minimum qualifications:

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

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

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

(18) “Significant procedure” means a diagnostic or treatment modality which poses a material risk of substantial pain or harm to the patient or resident such as, but not limited to, psychotropic medication and electro-convulsive therapy.

(19) “Superintendent” means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent’s capacity for the purpose of this rule.

Stat. Auth.: ORS 413.042 & 426.385

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0010

309-033-0620

Obtaining Informed Consent to Treatment From a Person and the Administration of Significant Procedures Without the Informed Consent of a Committed Person

(1) Basic rule for obtaining informed consent to treatment from a person. A person or a guardian, on behalf of a legally incapacitated committed person, may refuse any significant procedure and may withdraw at any time consent previously given to any significant procedure.

(2) Documentation of withdrawal of consent. Any refusal or withdrawal or withholding of consent shall be documented in the person’s record.

(3) Exceptions to obtaining informed consent from a person. Personnel of a facility shall not administer a significant procedure to a committed person unless informed consent is obtained from or on behalf of the person in the manner prescribed in OAR 309-033-0620, except as follows:

(a) Administration of significant procedures without informed consent in emergencies (OAR 309-033-0630); and

(b) Involuntary administration of significant procedures with good cause to persons committed to the Division (OAR 309-033-0640).

(4) Capacity of the committed person. Unless adjudicated legally incapacitated for all purposes or for the specific purpose of making treatment decisions, a person shall be presumed competent to consent to, or refuse, withhold, or withdraw consent to significant procedures.

(a) A physician shall deem a person unable to consent to or refuse, withhold, or withdraw consent to a significant procedure only if the person currently demonstrates an inability to comprehend and weigh the risks and benefits of the proposed procedure, alternative procedures, or no treatment at all or other information disclosed pursuant to OAR 309-032-0620. Such inability is to be documented in the person’s record and supported by documented statement or behavior of the person.

(b) A person committed to the Division shall not be deemed unable to consent to or refuse, withhold, or withdraw consent to a significant procedure merely by reason of one or more of the following facts:

(A) That the person has been involuntarily committed to the Division;

(B) That the person has been diagnosed as mentally ill;

(C) That the person has disagreed or now disagrees with the treating physician's diagnosis; and

(D) That the person has disagreed or now disagrees with the treating physician's recommendation regarding treatment.

(c) If a court has determined that a committed person is legally incapacitated with regard to medical treatment decisions, then consent shall be sought from the legal guardian.

(5) Procedures for obtaining informed consent and information to be given.

(a) The person from whom informed consent to a significant procedure is sought, as required by ORS 677.097, shall be given information regarding:

(A) The nature and seriousness of the committed person's mental illness or condition;

(B) The purpose and method of the significant procedure, its intended outcome and the risks and benefits of the procedure and when neuroleptic medication is prescribed, that tardive dyskinesia is a risk;

(C) Any alternatives that are reasonably available and reasonably comparable in effectiveness; and

(D) Any additional information concerning the proposed significant procedure requested by the person.

(b) The physician intending to administer a significant procedure shall document in the person's chart that the information required in OAR 309-033-0620 was explained and that the person or guardian of a legally incapacitated person or resident explicitly consented, refused, withheld or withdrew consent.

(6) Voluntary consent. Consent to a proposed significant procedure must be given voluntarily, free of any duress or coercion. Subject to the provisions of OAR 309-033-0640, Involuntary Administration of Significant Procedures to Committed Person with Good Cause, and 309-033-0260, Diversion from Commitment Hearing, the decision to refuse, withhold or withdraw consent previously given shall not result in the denial of any other benefit, privilege, or service solely on the basis of refusing withholding to or withdrawing consent. A voluntary person may be discharged from the facility if offered procedures are refused.

(7) Obtaining consent with respect to legally incapacitated persons. A facility may not administer a significant procedure to a legally incapacitated committed person without the consent of the guardian, except in the case of an emergency.

(8) Reports of progress. The person or the guardian of a legally incapacitated person shall, upon request, be informed of the progress of the person during administration of the significant procedure.

(9) Right to appeal. A person has the right to appeal the application of any provision of these rules as provided in the grievance policies and procedures of the facility. If the committed person is legally incapacitated, the guardian has the right to appeal the application of any provision of these rules by using the grievance procedures.

Stat. Auth.: ORS 413.042 & 426.385

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0030

309-033-0625

Administration of Medication and Treatment without the Informed Consent of a Person in Custody

(1) Hospitals or Nonhospital Facilities Authorized. Only a physician at a hospital or nonhospital facility approved under OAR 309-033-0500 through 309-033-0560 may administer medication and treatment without the informed consent of a person in custody.

(2) What constitutes an emergency. The fact that a person is in custody under the provisions of ORS 426.232 or 426.233 shall not be the sole justification that an emergency exists. An emergency exists if in the opinion of the physician, and either a consulting physician or qualified mental health profession:

(a) Immediate action is required to preserve the life or physical health of the person and it is not practical to obtain informed consent as provided in OAR 309-033-0620; or

(b) Immediate action is required because the behavior of the person creates a substantial likelihood of immediate physical harm to the person, or others in the facility and it is not practical to obtain informed consent as provided in OAR 309-033-0620.

(3) Grounds for the administration of medication and treatment without informed consent. As provided by ORS 426.072(2)(c), a physician shall administer medication and treatment to a person in custody without obtaining prior informed consent, only in the following circumstances:

(a) If an emergency exists as described in OAR 309-033-0625, or

(b) If the physician, in consultation with another physician or qualified mental health profession, the person is unable to give informed consent as described in OAR 309-033-0620.

(4) Procedures and limitations for the administration of medication or treatment without the informed consent of a person in custody, the physician shall:

(a) Administer medication and treatment in accordance with medical standards in the community;

(b) Not administer electro-shock therapy or unduly hazardous treatment as set forth in ORS 426.072;

(c) Document in the person's record the specific nature of each emergency and the procedure that was used to deal with the emergency, or if the person is unable to give consent, document that fact in the person's record;

(d) If the person is a minor or has a guardian, make a reasonable effort to contact the legal guardian prior to the administration of medication or treatment, but if efforts to contact the guardian are not successful, the physician may only administer medication or treatment in an emergency and shall notify the legal guardian as soon as possible, otherwise the physician shall not administer medication until consent is obtained from the guardian;

(e) Review the medication and treatment with the treatment team within a reasonable period of time after the medicine or treatment is administered without consent and, if applicable, administer medication or treatment designed to correct the behavior creating the emergency;

(f) Not continue to administer medication or treatment after the emergency has subsided or the person has regained the ability to consent to treatment, without obtaining the person's informed consent; and

(g) Immediately proceed as provided in OAR 309-033-0600 through 309-033-0650 if the person who was in custody is committed and the physician believes the person remains unable to give consent and it is necessary to continue involuntary administration of medication or treatment; the physician may only continue the administration of medication or treatment under the provisions of 309-033-0625 for seven days pending a decision under 309-033-0640.

Stat. Auth.: ORS 413.042, 426.072, 426.231 & 426.236

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHS 5-2007, f. & cert. ef. 5-25-07

309-033-0630

Administration of Significant Procedures in Emergencies Without the Informed Consent of a Committed Person

(1) Hospitals or nonhospital facilities authorized. The following facilities that serve committed persons and which administer significant procedures in emergencies, without obtaining informed consent, shall be subject to the provisions of 309-033-0630:

(a) A hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Approval of Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) A hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities To Provide Services to Committed Persons and to Persons in Custody or on Diversion.

(c) Secure residential facilities licensed by the Division, or licensed by the Aging and People with Disabilities Division (APD).

(d) Intermediate care facilities or enhanced care facilities licensed by the APD.

(2) What constitutes an emergency. An emergency exists if in the opinion of the responsible physician or nurse:

(a) Immediate action is required to preserve the life or physical health of the committed person and it is impracticable to obtain informed consent as provided in OAR 309-033-0620; or

(b) Immediate action is required because the behavior of the committed person creates a substantial likelihood of immediate physical harm to the committed person or others in the facility and it is impracticable to obtain informed consent as provided in OAR 309-033-0620, Procedures for Obtaining Informed Consent and Information to be Given.

(3) Administering a significant procedure. If an emergency exists, the responsible physician or nurse may administer a significant procedure to a committed person without obtaining prior informed consent in the manner otherwise required by these rules, provided:

(a) The physician or designee shall document in the person's clinical record the specific nature of each emergency and the procedure which was used to deal with the emergency.

(b) If the person is legally incapacitated, the physician or designee shall make reasonable effort to contact the legal guardian prior to the administration of the significant procedure. If contact is not possible, the physician or designee shall notify the legal guardian as soon as possible.

(c) Within a reasonable period of time after an emergency procedure is administered, the treatment team shall review the treatment and, if practicable, implement treatment designed to correct the behavior creating the emergency.

(d) The responsible physician or nurse shall not administer a significant procedure after the emergency situation has subsided, without obtaining informed consent.

Stat. Auth.: ORS 413.042 & 426.236

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0040

309-033-0640

Involuntary Administration of Significant Procedures to a Committed Person With Good Cause

(1) Hospitals or nonhospital facilities authorized. Only the following facilities that serve committed persons shall involuntarily administer significant procedures with good cause under the provisions of 309-033-0640:

(a) A hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Approval of Hospitals and Nonhospital Facilities To Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) A hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities To Provide Services to Committed Persons and to Persons in Custody or on Diversion.

(c) Secure residential facilities licensed by the Division or licensed by the APD.

(d) Intermediate care facilities or enhanced care facilities licensed by SPD which have a variance from SPD to provide involuntary medication.

(2) Good cause. Good cause exists to administer a significant procedure to a person committed to the Division without informed consent if, in the opinion of the treating physician, after consultation with the treatment team:

(a) The person is deemed unable pursuant to OAR 309-033-0620 to consent to, refuse, withhold or withdraw consent to the significant procedure.

(b) The proposed significant procedure will likely restore, or prevent deterioration of, the person's mental or physical health, alleviate extreme suffering, or save or extend the person's life.

(c) The proposed significant procedure is the most appropriate treatment for the person's condition according to current clinical practice, and all other less intrusive procedures have been considered and all criteria and information set forth in OAR 309-033-0620,

Procedures for Obtaining Informed Consent and Information to be Given, are considered.

(d) The treating physician has made a conscientious effort to obtain informed consent to the significant procedure from the person.

(3) Independent review. Prior to granting approval for the administration of a significant procedure for good cause to a person committed to the Division, the administrator shall obtain consultation and approval from an independent examining physician.

(a) The administrator shall maintain a list of independent examining physicians and shall seek consultation and approval from independent examining physicians selected on a rotating basis from the list. The independent examining physician shall:

(A) Be a psychiatrist;

(B) Not be in a position to provide primary or on-call care or treatment to the person who is subject of the independent review;

(C) Not be an employee of the facility;

(D) Have been subjected to review by medical staff executive committee as to qualifications to make such an examination; and

(E) Have read and received training from the medical staff regarding the meaning and the application of these rules.

(b) Prior to seeking consultation and approval of an examining physician, the administrator shall provide written notice to the committed person who is subject to the proposed significant procedure without the person's consent.

(4) Independent physician activities. The physician selected to conduct the independent consultation shall:

(a) Review the person's clinical record, including the records of efforts made to obtain the person's informed consent;

(b) Personally examine the person;

(c) Interview the person to determine the extent of the need for the procedure and the nature of the person's refusal, withholding, or withdrawal or inability to consent to the significant procedure;

(d) Consider additional information, if any, presented prior to or at the time of examination or interview as may be requested by the person; and

(e) Make a determination whether the factors required under these rules exist for the particular person or that one or more factors are not present. If the physician determines that the person does not have capacity to give consent to treatment, the physician shall review the proposed significant procedure. The physician shall make his/her determination of capacity, approval or disapproval of the proposed significant procedure to:

(A) The administrator; and

(B) The person to whom a significant procedure is proposed to be administered, with a copy being made part of the person's record.

(5) Administrator determination. The administrator shall approve or disapprove of the administration of the significant procedure to a person committed to the Division based on good cause, provided:

(a) The administrator shall not approve the significant procedure and it shall not be performed when the independent examining physician found that one or more of the factors required by OAR 309-033-0640 were not present or otherwise disapproved of the procedure.

(b) Approval of the significant procedure shall terminate if there is a substantial increase in risk, as determined by a physician, of administering the significant procedure or at any time the person regains capacity to give informed consent/refusal. Approval of the significant procedure shall terminate at the end of the person's commitment but in no case longer than 180 days. Disapproval shall be only so long as no substantial change occurs in the person's condition.

(c) Written notice of the administrator's determination shall be provided to the person and made part of the committed person's clinical records.

(d) A copy of the independent examining physician's report shall be made part of the committed person's clinical record.

(6) Ninety-day right to review. The administrator shall adopt procedures which assure that the committed person may request

independent review of the approval once every ninety days after the initial approval. Within 14 days of a verbal or written request from the committed person, the administrator shall initiate an independent review of the approval, as in OAR 309-033-0640.

(7) Transfer of approval. The administrator, or the superintendent of a State hospital, shall transfer the approval of the administration of a significant procedure when a committed person is transferred to another hospital or nonhospital facility described in OAR 309-033-0640.

(a) The administrator, or the superintendent, of the sending hospital or nonhospital facility shall transfer the approval by sending copies of all approval documents to the administrator of the receiving facility.

(b) The administrator, or the superintendent, of the receiving hospital or nonhospital facility shall assure that the treating physician at that facility reexamines the committed person and verifies that the need for the approval continues to exist as described in OAR 309-033-0620, Procedures for Obtaining Informed Consent and Information to be Given, and 309-033-0640, Good Cause. The receiving hospital or nonhospital facility may administer the significant procedure if the need for the procedure continues in accordance with OAR 309-033-0640, Involuntary Administration of Significant Procedures to a Committed Person with Good Cause.

(c) In no event shall the approval of a significant procedure continue beyond 180 days from the date of the original approval without reestablishing the need for the approval by following the procedures prescribed in OAR 309-033-0640, Involuntary Administration of Significant Procedures to Committed Persons with Good Cause.

(8) Administrative procedures.

(a) Utilization summary. Every four months the administrator shall make a summary of the use of OAR 309-033-0630 and 309-033-0640 that includes:

(A) Each type of proposed significant procedure for which consultation with an independent examining physician was sought;

(B) The number of times consultation was sought from a particular independent examining physician or disposition board for each type of proposed significant procedure;

(C) The number of times each independent examining physician approved and disapproved each type of proposed significant procedure; and

(D) The number of times the approved and disapproved each type of proposed significant procedure.

(b) Outside reviewer’s access to summaries. The administrator shall provide a copy of a utilization summary to the federally-mandated advocacy and protection agency for Oregon, which is appointed by the Governor and which currently is the Oregon Advocacy Center, and the Division. The Division may only distribute the report to any other person or organization authorized by the Division which in the opinion of the Assistant Administrator:

(A) Has substantial interest in the advocacy and protection of the rights of persons with mental illness; and

(B) Whose access to the summaries will provide a substantial and material benefit to the citizens of Oregon.

Stat. Auth.: ORS 413.042 & 426.385

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0050

309-033-0650

Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042 & 426.385

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-

0060

309-033-0700

Purpose and Scope

(1) This section establishes rules pursuant to ORS 426.072, 426.236, 426.228, 426.232, 426.233 and 426.234, 426.385 for certification of hospitals and facilities which provide care, custody, and treatment to committed persons and to persons in custody or on diversion.

(2) Seclusion or restraint may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or other individuals.

Stat. Auth.: ORS 413.042, 426.236, 426.385 & 430.021

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0000; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0710

Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs in a nonhospital facility. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or his or her designee.

(2) "Authority" means the Oregon Health Authority (OHA).

(3) "Clinical Record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Service Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "CMHP" means the community mental health program which organizes all services for persons with mental disorders or substance use disorders, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) "Community Hospital" means any hospital that is not a state hospital.

(6) "Council" means a regional acute care psychiatric facility organization with a mission statement and bylaws, comprised of facility representatives, consumers and family members. The council is advisory to the facility.

(7) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(8) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233(1);

(b) A health care facility licensed under ORS Chapter 431 and certified by the Division, pursuant to 426.231;

(c) A state hospital pursuant to ORS 426.232;

(d) A community hospital pursuant to ORS 426.072 or 426.232; or

(e) A regional acute care psychiatric or non-hospital facility pursuant to ORS 426.072 or 426.233.

(9) "Director" means the community mental health program director who has been authorized by the local mental health authority to direct the CMHP.

(10) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(11) "Division" means the Addictions and Mental Health (AMH) Division of the Oregon Health Authority (OHA).

(12) "Emergency" means, in the opinion of the treating physician, immediate action is required to preserve the life or physical health of a person, or because the behaviors of that person creates a substantial likelihood of immediate physical harm to self, or to others in the facility. The fact that a person is in custody under the provisions of ORS 426.072, 426.232 or 426.233 must not be the sole justification that an emergency exists.

(13) "Hospital or Facility" means the community hospital, regional acute care psychiatric facility, or non-hospital facility eligible for, or presently certified for, the use of seclusion or

restraints to committed persons and persons in custody or on diversion.

(14) "NMI" means "Notice of Mental Illness" required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to 426.234, to be submitted by the physician or the director to the court. Pursuant to 426.070 and 426.234, the court commences proceedings pursuant to 426.070 to 426.130 upon receipt of the NMI.

(15) "Non-Hospital Facility" means any facility, other than a hospital, that is certified by the Authority to provide adequate security, psychiatric, nursing and other services to persons under ORS 426.232 or 426.233.

(16) "Nurse" means a registered nurse or a psychiatric nurse practitioner licensed by the Oregon Board of Nursing, but does not include a licensed practical nurse or a certified nurse assistant.

(17) "P.R.N." (pro re nata) means that a medication or medical treatment has been ordered to be given as needed.

(18) "Patient Days" means the day of admission plus each additional day of stay, but not the day of discharge, unless it is also the day of admission.

(19) "Peace officer" means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(20) "Physician" means a person who holds a degree of Doctor of Medicine, Doctor of Osteopathy, or Doctor of Podiatric Medicine, if the context in which the term "physician" is used does not authorize or require the person to practice outside the scope of a license issued under ORS 677.805 through 677.840.

(21) "Physician Assistant" means a person who is licensed as such in accordance with ORS 677.265, 677.495, 677.505, 677.510, 677.515, 677.520, and 677.525.

(22) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(23) "Regional Acute Care Psychiatric Facility" means a facility certified by the Division to provide services for adults as described in OAR 309-033-0850 through 309-033-0890, and is operated in cooperation with a regional or local council. A regional acute care psychiatric facility must include 24 hour per day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults aged 18 or older with severe psychiatric disabilities in a designated region of the state. For the purpose of these rules, a state hospital is not a regional acute care psychiatric service. The goal of a regional acute care service is the stabilization, control and/or amelioration of acute dysfunctional symptoms or behaviors that result in the earliest possible return of the person to a less restrictive environment.

(24) "Restraint" means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. Restraint may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

(25) "Seclusion" is the involuntary confinement of a patient alone in a room or area, from which the patient is physically prevented leaving. Seclusion may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

(26) "State Hospital" means each campus of the Oregon State Hospital.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110, 426.232, 426.236

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0010; MHS 5-2008, f. & cert. ef. 6-27-08; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0720

Application, Training and Minimum Staffing Requirements

(1) Only the following facilities shall be certified to use seclusion or restraint:

(a) Community hospitals licensed by the Public Health Division;

(b) Regional acute care facilities for adults certified by the Division pursuant to OAR 309-032-0850 through 309-032-0890; and

(c) Non-hospital facilities certified by the Division pursuant to OAR 309-033-0500 through 309-033-0550.

(2) Applications. Certification for the use of seclusion and restraints must be accomplished by submission of an application, and by the application process described in OAR 309-016. Continued certification is subject to hospital or facility reviews at frequencies determined by the Division.

(3) Requirements for Certification. In order to be certified for the use of seclusion and restraint, the Division must be satisfied that the hospital or facility meets the following requirements:

(a) Medical staffing. An adequate number of nurses, direct care staff, physicians, nurse practitioners or physician assistants shall be available at the hospital or facility, to provide emergency medical services which may be required. For hospitals, a letter from the chief of the medical staff or medical director of the hospital or facility, ensuring such availability, shall constitute satisfaction of this requirement. For non-hospital facilities, a written agreement with a local hospital, to provide such medical services may fulfill this requirement. When such an agreement is not possible, a written agreement with a local physician to provide such medical services may fulfill this requirement.

(b) Direct Care Staff Training. A staff person must be trained and able to demonstrate competency in the application of restraints and implementation of seclusion during the following intervals:

(A) A new staff person must be trained within the six months prior to providing direct patient care or as part of orientation; and

(B) Subsequently on a periodic basis consistent with the hospital or facility policy.

(c) Documentation in the staff personnel records must indicate the training and demonstration of competency were successfully completed.

(d) Trainer Qualifications. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address a person's behaviors.

(e) Training Curriculum. The training required for direct care staff must include:

(A) Standards for the proper use of seclusion and restraints as described in OAR 309-033-0730;

(B) Identification of medication side effects;

(C) Indicators of medical problems and medical crisis;

(D) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion;

(E) The use of non-physical intervention skills;

(F) Choosing the least restrictive intervention based on an individualized assessment of the person's medical, or behavioral status or condition;

(G) The safe application and use of all types of restraint or seclusion used in the hospital or facility, including training in how to recognize and respond to sign of physical or psychological distress;

(H) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;

(I) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the hospital or facility policies and procedures; and

(J) The use of first aid techniques and certification in the use of cardio-pulmonary resuscitation, including periodic recertification.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0030; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0725

Medical Services

(1) A physician must be available 24 hours per day, seven days per week to provide medical supervision of the services provided.

(a) In accordance with state law, those physicians authorized to order seclusion or restraint pursuant to the facility policy, must at minimum have a working knowledge of the hospital policy regarding the use of seclusion and restraint.

(b) A physician must examine a person admitted to the facility within 24 hours of the person's admission.

(2) At least one registered nurse must be on duty at all times.

(3) The facility must maintain a personnel file for each patient care staff which includes a written job description; the minimum level of education or training required for the position; copies of applicable licenses, certifications, or degrees granted; annual performance appraisals; a biennial, individualized staff development plan signed by the staff; documentation of CPR training; documentation of annual training and certification in managing aggressive behavior, including seclusion and restraint; and other staff development and/or skill training received.

(4) Health Care Supervisor. The facility must appoint as Health Care Supervisor a physician, a psychiatric nurse practitioner, a master's level registered nurse or a registered nurse certified by the American Nursing Association. The health care supervisor shall review and approve policies and procedures relating to:

(a) The reporting of indicators of medical problems to a physician; and

(b) Curriculum for the staff training, as identified in these rules.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0727

Structural and Physical Requirements

(1) The hospital or other facility which provides care, custody and treatment for persons who are considered dangerous to themselves or others shall have available at least one room which meets the following requirements:

(a) The room must be of adequate size, not isolated from regular staff of the facility, and provided with an adequate locking device on all doors and windows.

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

(c) The room shall contain no protruding objects, such as doorknobs, towel or clothes bars, hooks, or racks. There shall be no exposed curtains, drapes, rods, or furniture, except a portable bed which can be removed, if necessary. In case of the removal of the bed frame, a fireproof mattress shall be placed on the floor. Beds which are securely fastened to the floor must have no protrusions such as bed posts or sharp corners.

(d) Any windows shall be made of unbreakable or shatterproof glass, or plastic. Non-shatterproof glass shall be protected by adequate detention type screening, such as Chamberlain Detention Screen.

(e) There shall be no exposed pipes or electrical wiring in the room. Electric outlets shall be permanently capped or covered with a metal shield which opens with a key. Ceiling and wall lights shall be recessed and covered with safety-type glass or unbreakable plastic. Any cover, cap or shield shall be secured by tamper-proof screws or other means approved by the Division.

(f) The room shall contain no combustible material, such as matches, lighters, cigarettes, etc. Smoking shall not be allowed in the room, except under direct supervision of staff.

(g) The room shall meet fire, safety, and health standards. If sprinklers are installed, they shall be recessed and covered with a fine mesh metal screening. If pop-down type, sprinklers must have breakaway strength of under 80 pounds. In lieu of sprinklers, a combined smoke and heat detector shall be used. Documentation

of the breakaway strength of sprinklers must be on file at the facility.

- (2) Bathroom requirements include:
 - (a) Adequate toilet and sanitary facilities shall be available.
 - (b) The bathroom shall contain no shower rods, shower curtains, window curtain rods, curtains, or towel rods, unless used only with direct staff supervision.
 - (c) The bathroom shall not lock from the inside and, if connected to the room, shall be locked when not in use.
 - (3) No sharp objects, such as razor blades, scissors, knives, nail files, etc., shall be available to the patient, except under direct staff supervision. No poisons or cleaning materials shall be kept in the room or in the bathroom available for the room.

Stat. Auth.: ORS 426.236, 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHS 13-2014, f. & cert. ef. 9-29-14

**309-033-0730
Seclusion and Restraint Procedures**

(1) Certified facilities shall not use seclusion and restraint except in an emergency and only then subject to the conditions and limitations of these rules.

- (2) General procedures.
 - (a) Only a physician, nurse practitioner, physician assistant or nurse may initiate seclusion or restraint procedures.
 - (b) Each use of seclusion or restraint shall be monitored and supervised by a physician or a nurse.
 - (c) A physician responsible for the patient’s care must order the use of seclusion or restraint within one hour of the administration of the procedure. This approval must be documented in the person’s medical record. The physician’s order may occur by the following methods:
 - (A) Verbally, in person or via telephone;
 - (B) By Computerized Medical Record; or
 - (C) By a written order.
 - (d) Within one hour after the initiation of the seclusion or restraint intervention, the patient must be seen face-to-face by a physician, a registered nurse or physician assistant who has been trained in accordance with these rules.

(e) If the face-to-face evaluation is performed by a registered nurse or physician assistant, the evaluator must consult with the attending physician as soon as possible following the face-to-face evaluation.

- (f) The face-to-face evaluation must include the following:
 - (A) An evaluation of the patient’s immediate situation;
 - (B) The patient’s reaction to the intervention;
 - (C) The patient’s medical and behavioral condition; and
 - (D) The need to continue or terminate the restraint or seclusion

sion
Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0040; MHS 13-2014, f. & cert. ef. 9-29-14

**309-033-0732
Time Limits**

(1) The maximum time limit for each restraint or seclusion order — before consideration of a renewal, and up to a maximum of 24 hours — is as follows:

- (a) 4 hours for adults 18 years of age or older;
- (b) 2 hours for children and adolescents 9 to 17 years of age;
- or
- (c) 1 hour for children under 9 years of age.

(2) Orders may be renewed according to time limits for a maximum 24 hours verbally, by telephone, facsimile, or thru a computerized medical record. After each 24 hours of continuous restraint or seclusion, and prior to further extension of the restraint or seclusion, an examination and second opinion must occur by a second physician.

(3) The physician responsible for the care of the patient shall examine a person within 24 hours of the administration of seclusion or restraint and the person must be examined by a nurse every two hours until such time as the physician examines the person and

either makes new orders for seclusion nor restraint or for releasing the patient from seclusion or restraint. The physician must document reasons for the use of the seclusion or restraint over the physician’s signature.

(4) A physician shall not order physical restraint on an as required basis, i.e. a physician shall not make “p.r.n.” orders for physical restraint.

(5) No form of restraint shall be used as punishment, for the convenience of staff, or as a substitute for activities, treatment or training.

(6) Medication will not be used as a restraint, but will be prescribed and administered according to acceptable medical, nursing and pharmaceutical practices.

(7) Patients shall not be permitted to use restraint on other patients.

(8) Physical restraint must be used in accordance with sound medical practice to assure the least risk of physical injury and discomfort. Any patient placed in physical restraint shall be protected from self-injury and from injury by others.

(9) 15 Minute Checks:

(a) A patient in restraint or seclusion must be checked at least every 15 minutes.

(b) 15 minute checks include circulation checks, during waking hours adequate range of motion, and partial release of restraint to permit motion and exercise without endangering the patient or staff.

(c) Attention must be paid to the patient’s basic personal needs (such as regular meals, personal hygiene and sleep) as well as the person’s need for good body alignment and circulation.

(d) Staff must document that the patient was checked and appropriate attention paid to the person’s needs.

(e) The patient must be released as soon as the patient is assessed by a nurse, physician, or nurse practitioner to not present imminent dangerousness to themselves or others.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHS 13-2014, f. & cert. ef. 9-29-14

**309-033-0733
Documentation**

(1) No later than the end of their work shifts, the persons who obtained authorization and carried out the use of restraint shall document in the person’s chart including but not necessarily limited to the following:

(a) The specific behavior(s) which required the intervention of seclusion or restraint;

(b) Less restrictive alternatives used before deciding seclusion or restraint was necessary;

(c) The methods of intervention used and the patient’s responses to the interventions; and

(d) Findings and recommendations from the face-to-face evaluation discussed in OAR 309-033-0730(d) through (f) above.

(2) Within 24 hours after the incident resulting in the use of restraint, the treating physician who ordered the intervention must review and sign the order.

(3) Each use of restraint must be reported daily to the health care supervisor.

(4) Any death that occurs while a patient is in seclusion or restraint must be reported to AMH within 24 hours of the death.

(5) Restraint/Seclusion Review Committee. Each facility must have a Restraint/Seclusion Review Committee. The committee may be one formed specifically for the purposes set forth in this rule, or the duties prescribed in this rule may be assigned to an existing committee. The purpose and duty of the Restraint/Seclusion Review Committee is to review and evaluate, at least quarterly, the appropriateness of all such interventions and report its findings to the health care supervisor.

Stat. Auth.: ORS 426.236, 426.385 & 430.021
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0735

Quarterly Reports

(1) Every facility certified under these rules must report to the Division and to the Council within 30 days of each quarter's end, the following information:

(a) The number of seclusion and the number of restraint incidents; and

(b) The number of patient days in the quarter.

(2) The Division must compile the information from all facilities approved under this rule and make available to the public statewide aggregate data. The information may be divided according to facility types.

Stat. Auth.: ORS 426.236, 426.385 & 430.021

Stats. Implemented: ORS 426.005 - 426.309

Hist.: MHS 17-2007(Temp), f. 12-28-07, cert. ef. 1-1-08 thru 6-29-08; MHS 5-2008, f. & cert. ef. 6-27-08; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0740

Variations

(1) Variations may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the Council indicating its position on the proposed variance.

(3) The AMH Director, or his or her designee, will approve or deny the request for a variance.

(4) Appeal application. Appeal of the denial of a variance request shall be made in writing to the AMH Director, whose decision shall be final.

(5) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(6) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.236, 426.385

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0050; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0800

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for the denial of payment for persons in custody or on diversion.

(2) Statutory authority. These rules are authorized by ORS 426.241 and 413.042 and carry out the provisions of 426.241.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236

Stats Implemented: ORS 426.241

Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0000

309-033-0810

Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005. Whenever "administrator" appears it means the administrator or designee.

(2) "Assistant Administrator" means the Assistant Administrator of the Division.

(3) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental

Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "Community hospital" means any hospital that is not a state hospital.

(5) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(6) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(7) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237.

(8) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(9) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

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

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236

Stats. Implemented: ORS 426.241

Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0010

309-033-0820

Denial of Payment for Services to Persons In Custody or On Diversion

(1) Assistant Administrator denial. The Assistant Administrator shall deny part or all payment for services for a person in custody or on a diversion only when the Assistant Administrator determines that evidence required by OAR 309-033-0820, Information Payer Must Submit, and the evidence required by 309-033-0820, Clinical Records to be Submitted, does not reasonably support the belief that the person in custody demonstrated:

(a) Mental illness; and

(b) Dangerousness to self or others as evidenced by thoughts, plans, means, actions, history of dangerousness or other indicators of imminent dangerousness which Division believes are within accepted community standards of professional knowledge.

(2) Assistant Administrator consultation with psychiatrist or psychologist. When making a determination under this rule which is primarily based on accepted community standards of professional knowledge, the Assistant Administrator shall consult with a psychiatrist or a psychologist.

(3) Information payer must submit. When making a request for denial of payment the payer responsible for the services provided to the person in custody or on diversion under ORS 426.241 shall submit the following to the Assistant Administrator:

(a) A statement requesting the Division review the appropriateness of the hold or diversion for the purpose of approving denial of part or all payment for services rendered.

(b) An explanation of why the payer believes the services provided to the person in custody or on diversion do not meet criteria described in ORS 426.232, 426.233 or 426.237.

(c) Any documentation which supports the payer's belief that the services provided to the person in custody or on diversion were inappropriate.

(4) Clinical records to be submitted. At the request of the Division, as provided by ORS 426.241(5)(b), the following shall submit clinical records and other documents requested relating to the services in question to the Division:

(a) A hospital or a nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion.

(b) A physician or person providing services to the person in custody or on diversion.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236
Stats. Implemented: ORS 426.241
Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0030

309-033-0830

Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

- (a) The section of the rule from which the variance is sought;
- (b) The reason for the proposed variance;
- (c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236
Stats. Implemented: ORS 426.241
Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0040

309-033-0900

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures relating to the investigation and examination of a person alleged to be a mentally ill person during the involuntary civil commitment process.

(2) Statutory authority. These rules are authorized by ORS 426.005–426.395 and carry out the provisions of 426.005–426.395.

Stat. Auth.: ORS 413.042, 426.060 - 426.500
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0000

309-033-0910

Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator"

has the same meaning as "director of the facility" as that term is defined in ORS 426.005. Whenever "administrator" appears it means the administrator or designee.

(2) "Assistant Administrator" means the Assistant Administrator of Addictions and Mental Health Division.

(3) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) "Community hospital" means any hospital that is not a state hospital.

(6) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(7) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(11) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(12) "NMI" is the notification of mental illness required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to ORS 426.234, to be submitted by the physician or the director to the court. Pursuant to ORS 426.070 and 426.234, the court commences proceedings pursuant to ORS 426.070 to 426.130 upon receipt of the NMI.

(13) "Peace officer" means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(14) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(15) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

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

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

(c) Graduate degree in psychology;

- (d) Graduate degree in social work;
- (e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;
- (f) Graduate degree in another mental health-related field; or
- (g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

Stat. Auth.: ORS 413.042, 426.060 - 426.500

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0010

309-033-0920

Certification of Mental Health Investigators

(1) Investigation only by a certified investigator. Only a person certified by the Division shall conduct an investigation of a person alleged to be a mentally ill person as required by ORS 426.070(3)(c) and 426.074.

(2) Certification of a mental health investigator. The Division shall certify as a qualified mental health investigator, for three years or until such time as the Division terminates the certificate, any person who meets the following:

(a) Is recommended by a director for certification as a mental health investigator; and

(b) Is a QMHP, or on January 1, 1988, has been employed by a CMHP as an investigator for a minimum of two years; and

(c) Has established individual competence through training provided by the Division and within 6 months of the training has passed an examination conducted by the Division in the following areas:

(A) The role and duties of an investigator and the process of investigation;

(B) Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons;

(C) Establishing probable cause for mental disorder;

(D) The mental status examination; and

(E) The assessment of suicidality, assaultiveness, homicidality and inability to care for basic needs.

(3) Certification of a senior mental health investigator. The Division shall certify as a senior mental health investigator, for five years or until such time as the Division terminates the certificate, a person who meets the following:

(a) Is recommended by a director for certification as a senior mental health investigator;

(b) Is a QMHP;

(c) Has been certified as a mental health investigator for three years; and

(d) Has completed the training required under OAR 309-033-0920 during the six months prior to application for certification.

(4) Certification of a mental health investigator resident. The Division shall certify as a mental health investigator resident for a non-renewable period of six months, or until such time as the Division terminates the certificate, a person who meets the following:

(a) Is recommended by a director for certification as a mental health investigator;

(b) Is a QMHP;

(c) Has passed an examination conducted by the Division regarding Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons; and

(d) Is supervised by a certified senior mental health investigator. The senior mental health investigator shall review each investigation conducted by the mental health investigator resident and co-sign each investigation report as evidence that the senior mental health investigator believes the report meets OAR 309-033-0940, The Investigation Report.

(5) Qualifications for recertification. The Division may recertify a mental health investigator or a senior mental health investigator who is currently employed by a CMHP, is recommended by the director for recertification and who, during the period of certification, has completed eight hours of training or education in the

assessment of mental disorder or the assessment of dangerousness which is approved by the Division.

(6) Residents cannot be recertified. The Division shall not recertify a mental health investigator resident.

(7) Termination of certification. The Division may terminate the certification of a mental health investigator, senior mental health investigator, or a mental health investigator resident when, in the opinion of the assistant administrator:

(a) The person no longer can competently perform the duties required by this rule, or

(b) The person has exhibited a behavior or a pattern of behavior which violates the rights, afforded by statute, of persons being investigated.

Stat. Auth.: ORS 413.042, 426.060 - 426.500

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0030

309-033-0930

Investigation of Person Alleged to Be a Mentally Ill Person

(1) Initiation and timelines for investigation. Upon receipt of an NMI the CMHP shall conduct an investigation of the person to determine probable cause for mental disorder. The person conducting the investigation shall not be the same as the person filing the NMI.

(a) Investigation of NMIs by two persons, a county health officer or a magistrate. At a minimum, if the person can be located, the investigator must contact the person by telephone within three judicial days of the receipt of the NMI by the director.

(A) The investigator shall complete an investigation and submit an investigation report to the circuit court within 15 days of the director's receipt of the NMI.

(B) The investigator may request an extension from the court if a treatment option less-restrictive than involuntary inpatient commitment is actively being pursued or if the person cannot be located.

(b) Investigation of persons in custody. The investigator shall investigate persons in custody in an approved hospital under ORS 426.232 or 426.033 as soon as reasonably possible but no later than one judicial day after the initiation of the detention and 24-hours prior to the hearing. Whenever feasible, the investigator shall:

(A) Make face-to-face contact with the person within 24 hours of admission to a hospital or nonhospital facility, including weekends; and

(B) Meet with the person one additional time prior to making a recommendation for the court to hold a commitment hearing.

(2) Procedures for the investigation. Only certified mental health investigators, senior mental health investigators or mental health investigator residents shall conduct an investigation of a person.

(a) While conducting an investigation, the investigator shall:

(A) Present photo identification, authorized and provided by the county mental health authority, to the person; and

(B) Explain the reason for the investigation orally and, if doing so would not endanger the investigator, in writing.

(b) Information from relatives. The investigator shall solicit information about the person from person's parents and relatives, whenever feasible.

(c) Disclosure of names. The investigator shall disclose the names of the persons filing the NMI to the allegedly mentally ill person except when, in the opinion of the investigator, disclosure will jeopardize the safety of the persons filing the NMI. The investigator may withhold any information that is used in the investigation report, only until the investigation report is delivered to the court and others as required under ORS 426.074. The investigator may withhold any information that is not included in the investigation report if the investigator determines that release of the information would constitute a clear and immediate danger to any person (see ORS 426.370).

(d) Encourage voluntary services. The director shall attempt, as appropriate, to voluntarily enroll in the least restrictive community mental health services a person for whom an NMI has been filed.

(e) Clinical record required. The director shall maintain a clinical record for every person investigated under this rule. The clinical record shall document to the extent possible the following:

(A) A brief summary of the events leading to the filing of an NMI, the circumstances and events surrounding the interview of the person and the investigator's attempts to engage the person in voluntary mental health services;

(B) Identifying information about the person;

(C) A copy of the NMI;

(D) A copy of the investigation report submitted to the court;

(E) Names, addresses and telephone numbers of family, friends, relatives or other persons who the investigator interviewed for pertinent information. This list shall include the names of the persons filing the NMI with the director; and

(F) Summary of the disposition of the case.

(f) Coordination of services. In the event the person is released or agrees to voluntary treatment, the investigator shall coordinate with the CMHP for the purpose of referral and offering voluntary treatment services to the person as soon as reasonably possible.

(3) Access to clinical records. The investigator shall have access to clinical records of the person being investigated as follows:

(a) When the person is in custody. The investigator shall have access only to clinical records compiled during the hold period. Without valid consent, the investigator shall not have access to clinical records compiled as part of treatment that is provided to the person at any time outside the hold period except as provided by OAR 309-033-0930(3)(b).

(b) When the person investigated is eligible for commitment pursuant to ORS 426.074. The investigator shall have access to any clinical record necessary to verify the existence of the criteria which make the person eligible for commitment pursuant to ORS 426.074.

Stat. Auth.: ORS 413.042, 426.060 - 426.500

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0040

309-033-0940

The Investigation Report

(1) Evidence required in report. The investigator shall include in a report to the court, if relevant or available, evidence and the source of that evidence in the following areas:

(a) Evidence which describes the present illness and the course of events which led to the filing of the NMI and which occurred during the investigation of the person.

(b) Evidence to support or contradict the allegation that the person has a mental disorder.

(c) Evidence to support or contradict the allegation that the person is a danger to self or others, or is unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety.

(2) Documentation of manifestation of mental disorder. The evidence which describes the present illness shall include:

(a) The situation in which the person was found and the most recent behaviors displayed by the person which lead to and support the filing of an NMI;

(b) The sequence of events affecting the person during the investigation period including dates of admission, transfer or discharge from a hospital or nonhospital facility;

(c) Any change in the mental status of the person during the course of the investigation; and

(d) Attempts by the investigator to engage the person in voluntary treatment in lieu of civil commitment and their outcome.

(3) Documentation of mental disorder. Evidence to support or contradict the allegation that the person has a mental disorder shall include the results of a mental status examination and a psychosocial history.

(a) Mental status examination. A mental status examination shall review the presence of indicators of mental disorder in the following areas:

(A) Appearance. Features of the person's dress, physical condition which may indicate the presence of a mental disorder.

(B) Behavior. Features of the person's behavior, movement or rate of speech which may indicate the presence of mental disorder.

(C) Thought content. Features of the content of the person's speech such as delusions and hallucinations which may indicate the presence of a mental disorder.

(D) Thought process. Features of the person's expressed thoughts which may indicate that the person is unable to think in a clear logical fashion and which may indicate the presence of a mental disorder.

(E) Insight. Features of the person's understanding of his/her current mental state which may indicate the presence of a mental disorder.

(F) Judgment. Features of the person's judgment about social situations and dangerous situations which may indicate the presence of a mental disorder.

(G) Cognitive testing. Features of the person's ability to concentrate, ability to remember recent and historical events, ability to use abstract thinking, and ability to use or remember generally known information which may indicate the presence of a mental disorder.

(H) Emotions. Features of the person's emotions, such as being inappropriate to the situation, which may indicate the presence of a mental disorder.

(b) Psychosocial History. A psychosocial history shall discuss the presence of indicators of mental disorder in the following areas:

(A) Psychiatric history.

(i) History of psychiatric or mental health treatment;

(ii) History of commitments for mental disorder including verification from the Division if available; and

(iii) Current participation in mental health treatment.

(B) Family history.

(i) Members of the person's family who have a history of psychiatric or mental health treatment;

(ii) Members of the person's family who have a history of commitment for mental disorder; or

(iii) Reports of family members who appear to have had an untreated mental disorder.

(C) History of alcohol or drug abuse.

(i) History of abusing alcohol or drugs;

(ii) Behaviors which the person may have displayed during the course of the investigation, which are substantially similar to behaviors that indicate the presence of a mental disorder, that may be attributable to the use of alcohol or drugs; or

(iii) If the person appears to have a mental disorder, the effect of the person's current use of alcohol or drugs on behaviors that may indicate the presence of a mental disorder.

(D) History of a loss of function.

(E) Social function.

(F) Personal finances.

(i) Availability of financial resources to provide for basic needs such as food and shelter;

(ii) Use of financial resources to meet needs for food and shelter; or

(iii) Other features of the manner in which the person uses money which would indicate the presence of a mental disorder.

(G) Medical issues.

(i) Medical conditions that may produce behaviors which are substantially similar to behaviors that indicate the presence of a mental disorder; or

(ii) Medical conditions which contribute to the seriousness of a mental disorder which appears to be present.

(4) Documentation of dangerousness and/or inability to provide for basic needs. Evidence to support or contradict the allegation that the person is a danger to self or others, or is unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety shall include the results of an assessment of dangerousness.

(a) An assessment of dangerousness to self shall consider the following areas:

- (A) History of thoughts, plans or attempts at suicide;
- (B) Presence of thoughts, plans or attempts at suicide;
- (C) Means and ability to carry out the plans for suicide;
- (D) The potential lethality of the plan;
- (E) The probable imminence of an attempt at suicide; and
- (F) Available support systems which may prevent the person from acting on the plan.

(b) An assessment of dangerousness to others shall consider the following areas:

- (A) History of thoughts, plans, attempts or acts of assaultiveness or violence;
- (B) Presence of thoughts, plans, attempts or acts of assaultiveness or violence;
- (C) Means and ability to carry out the plans for assaultiveness or violence;
- (D) The potential lethality of the plan;
- (E) The probable imminence of an attempt at assault or violence; and
- (F) Available support systems which may prevent the person from attempting an assault or an act of violence.

(c) An assessment of the person's ability to provide for basic personal needs shall consider the following areas:

- (A) History of the person's ability to provide for basic personal needs;
- (B) The person's current use of resources to obtain food, shelter, and health care necessary for health and safety;
- (C) Behaviors which result in exposure to danger to self or others;
- (D) Available support systems which may provide the person care necessary for health and safety; and
- (E) If the person appears to lack capacity to care for self, the availability of a guardian who can assure the provision of such care.

(5) Additional report requirements. The investigation report shall also include the following:

- (a) The person's consent or objection to contact with specific third parties.
- (b) If appropriate and if available from the Division, verification of the person's eligibility for commitment under ORS 426.005(c).
- (6) Report availability. The investigation report shall be made available to the facility with custody of the person if the person is committed.

(7) Investigator's responsibilities to the circuit court. The investigator shall file the investigation report with the circuit court twenty-four hours before the hearing and shall appear at the civil commitment hearing.

Stat. Auth.: ORS 413.042, 426.060 - 426.500
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0050

309-033-0950 Certification of Mental Health Examiners

(1) Psychiatrists exempt from certification. A psychiatrist may serve as an examiner as provided by ORS 426.110. Division certification is not necessary for psychiatrists serving as mental health examiners.

(2) Qualifications for certification of persons other than psychiatrists. The Division shall certify, as a qualified mental health examiner for three years or until such time as the Division terminates the certificate, a QMHP who meets all of the following:

- (a) Has at least three years clinical experience in the diagnosis and treatment of severely mentally ill adults who suffer primarily from a psychotic disorder;
- (b) Presents acceptable written references from two persons who have the above qualifications and can demonstrate direct knowledge of the person's qualifications;
- (c) Is recommended by the director to be an examiner in the county; and
- (d) Has established individual competence through training provided by the Division in the following areas:

- (A) The role and duties of an examiner and the process of examination;
- (B) Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons;
- (C) Establishing clear and convincing evidence for mental disorder;

- (D) The mental status examination; and
- (E) The assessment of suicidality, assaultiveness, homocidality and inability to care for basic needs.

(3) Qualifications for recertification. The Division may recertify for three years, or until such time as the Division terminates the certificate of, any mental health examiner who meets the following:

- (a) The examiner has been an examiner certified by the Division after July 1, 1988;
- (b) The examiner has successfully completed eight hours of training provided by the Division relating to the assessment and diagnosis of mental disorder and, changes in statutes and administrative rules relating to civil commitment; and
- (c) The director recommends the person to be an examiner in the county.

(4) Examination. The examiner shall conduct an examination in a manner that elicits the data necessary for establishing a diagnosis and a plan for treatment. Only certified examiners shall conduct an examination of an allegedly mentally ill person.

(5) Termination of certification. The Division may terminate the certification of any mental health examiner when, in the opinion of the assistant administrator:

- (a) The person no longer can competently perform the duties required by this rule; or
- (b) The person has exhibited a behavior or a pattern of behavior which violates the rights, afforded by statute, of persons being investigated.

Stat. Auth.: ORS 413.042, 426.060 - 426.500
Stats. Implemented: ORS 426.005 - 426.395
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0060

309-033-0960 Mental Health Examiner's Report to the Court

(1) Examiner assessment of evidence. The examiner shall provide in a report to the court the examiner's opinion whether the evidence supports or contradicts:

- (a) The allegation that the person has a mental disorder;
- (b) The allegation that the person is a danger to self or others, or is unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety; and
- (c) That the person would cooperate with and benefit from voluntary treatment.

(2) Mental status examination and psychosocial history. In addition to considering other evidence presented at the hearing, the examiner shall conduct a mental status examination and a psychosocial history to determine whether the person alleged to be mentally ill has a mental disorder.

(a) Mental status examination. A mental status examination shall include review of the presence of indicators of mental disorder in the following areas:

- (A) Appearance. Features of the person's dress, physical condition which may indicate the presence of a mental disorder.
- (B) Behavior. Features of the person's behavior, movement or rate of speech which may indicate the presence of mental disorder.
- (C) Thought content. Features of the content of the person's speech such as delusions and hallucinations which may indicate the presence of a mental disorder.
- (D) Thought process. Features of the person's expressed thoughts which may indicate that the person is unable to think in a clear logical fashion and which may indicate the presence of a mental disorder.

(E) Insight. Features of the person's understanding of his/her current mental state which may indicate the presence of a mental disorder.

(F) Judgment. Features of the person's judgment about social situations and dangerous situations which may indicate the presence of a mental disorder.

(G) Cognitive testing. Features of the person's ability to concentrate, ability to remember recent and historical events, ability to use abstract thinking, and ability to use or remember generally known information which may indicate the presence of a mental disorder.

(H) Emotions. Features of the person's emotions, such as being inappropriate to the situation, which may indicate the presence of a mental disorder.

(b) Psychosocial history. A psychosocial history shall consider the presence of indicators of mental disorder in the following areas:

(A) Psychiatric history.

(i) History of psychiatric or mental health treatment;

(ii) History of commitments for mental disorder including verification from the Division if available; and

(iii) Current participation in mental health treatment.

(B) Family history.

(i) Members of the person's family who have a history of psychiatric or mental health treatment;

(ii) Members of the person's family who have a history of commitment for mental disorder; or

(iii) Reports of family members who appear to have had an untreated mental disorder.

(C) History of alcohol or drug abuse.

(i) History of abusing alcohol or drugs;

(ii) Behaviors the person may have displayed during the course of the investigation which are substantially similar to behaviors that indicate the presence of a mental disorder that may be attributable to the use of alcohol or drugs; or

(iii) If the person appears to have a mental disorder, the effect of the person's current use of alcohol or drugs on behaviors that may indicate the presence of a mental disorder.

(D) History of a loss of function.

(E) Social function.

(F) Personal finances.

(i) Availability of financial resources to provide for basic needs such as food and shelter;

(ii) Use of financial resources to meet needs for food and shelter; and

(iii) Other features of the manner in which the person uses money which would indicate the presence of a mental disorder.

(G) Medical issues.

(i) Medical conditions that may produce behaviors which are substantially similar to behaviors that indicate the presence of a mental disorder; or

(ii) Medical conditions which contribute to the seriousness of a mental disorder which appears to be present.

(3) Assessment of dangerousness and ability to provide basic needs. In addition to considering other evidence presented at the hearing, the examiner shall conduct an assessment of the danger the person represents to self or others and an assessment of the person's ability to provide for basic personal needs.

(a) An assessment of dangerousness to self shall consider the following areas:

(A) History of thoughts, plans or attempts at suicide;

(B) Presence of thoughts, plans or attempts at suicide;

(C) Means and ability to carry out the plans for suicide;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at suicide; and

(F) Available support systems which may prevent the person from acting on the plan.

(b) An assessment of dangerousness to others shall consider the following areas:

(A) History of thoughts, plans, attempts or acts of assaultiveness or violence;

(B) Presence of thoughts, plans, attempts or acts of assaultiveness or violence;

(C) Means and ability to carry out the plans for assaultiveness or violence;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at assault or violence; and

(F) Available support systems which may prevent the person from attempting an assault or an act of violence.

(c) An assessment of the person's ability to provide for basic personal needs shall consider the following areas:

(A) History of the person's ability to provide for basic personal needs;

(B) The person's current use of resources to obtain food, shelter, and health care necessary for health and safety;

(C) Behaviors which result in exposure to danger to self or other;

(D) Available support systems which may provide the person care necessary for health and safety; and

(E) If the person appears to lack capacity to care for self, the availability of a guardian who can assure the provision of such care.

Stat. Auth.: ORS 413.042, 426.060 - 426.500

Stats. Implemented: ORS 426.005 - 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0070

309-033-0970

Variations

(1) Criteria for a variance. Variations may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.060 - 426.500

Stats. Implemented: ORS 426.005 - 426.309

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0080

DIVISION 35

RESIDENTIAL TREATMENT FACILITIES FOR MENTALLY OR EMOTIONALLY DISTURBED PERSONS

309-035-0100

Purpose and Scope

(1) Purpose. These rules prescribe standards by which the Health Systems Division of the Oregon Health Authority (OHA)

licenses community based residential treatment facilities (RTF) and community based residential treatment homes (RTH) for adults with mental or emotional disorders. The standards promote optimum health, mental and social well-being, and recovery of adults with mental or emotional disorders through the availability of a wide range of home and community based residential settings and services. They prescribe how services will be provided in safe, secure and homelike environments that recognize the dignity, individuality and right to self-determination of each individual.

(a) These rules incorporate and implement the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services for home and community based services (HCBS) authorized under section 1915(i) of the Social Security Act.

(b) These rules establish requirements to ensure individuals receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving HCBS consistent with the standards set out in OAR Chapter 411, Division 4.

(2) Scope. These rules apply to all residential treatment homes and residential treatment facilities providing services to adults with mental or emotional disorders regardless of whether the program receives public funds. These rules prescribe distinct standards in some areas for secure residential treatment facilities or based on the number of individuals receiving services in the program.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 10-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; MHS 5-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0105

Definitions

As used in these rules the following definitions apply:

(1) "Abuse" includes but is not limited to:

(a) Any death caused by other than accidental or natural means or occurring in unusual circumstances;

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(c) Willful infliction of physical pain or injury;

(d) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program, or provider, or other caregiver and the adult. For situations other than those involving an employee, provider, or other caregiver and an adult, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical conduct directed toward the adult;

(e) Neglect that leads to physical harm through withholding of services necessary to maintain health and wellbeing;

(f) Abuse does not include spiritual treatments by a duly accredited practitioner of a recognized church or religious denomination when voluntarily consented to by the individual.

(2) "Program Administrator" means the person designated by the provider as responsible for the daily operation and maintenance of RTH or RTF or the program administrator's designee.

(3) "Adult" means a person 18 years of age or older.

(4) "Aid to Physical Functioning" means any special equipment ordered for an individual by a Licensed Medical Professional (LMP) or other qualified health care professional which maintains or enhances the individual's physical functioning.

(5) "Applicant" means the person(s) or entity, including the Division, who owns, seeks to own, seeks to operate or maintains and operates a program and is applying for the license.

(6) "Approved" means authorized or allowed by the Director of OHA or his or her designee.

(7) "Authority" means the Oregon Health Authority or its designee.

(8) "Building Code" means the Oregon Structural Specialty Code adopted by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(9) "Care" means services such as supervision; protection; assistance with activities of daily living such as bathing, dressing, grooming or eating; management of money; transportation; recreation; and the providing of room and board.

(10) "CMS" means the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

(11) "Community Mental Health Program (CMHP)" means the organization of all or a portion of services for persons with mental or emotional disorders, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(12) "Competitive Integrated Employment" means work that is performed on a full-time or part-time basis (including self-employment):

(a) For which an individual:

(A) Is compensated at a rate that:

(i) Is not less than the higher of the rate specified in federal, state, or local minimum wage law, and also is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not persons with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; or

(ii) In the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities, and who are self-employed in similar occupations or on similar tasks and who have similar training, experience, and skills; and

(B) Is eligible for the level of benefits provided to other employees.

(b) That is at a location where the individual interacts with other persons who are not persons with disabilities (not including supervisory personnel or persons providing services to such individual) to the same extent that persons who are not persons with disabilities and who are in comparable positions interact with others; and

(c) That, as appropriate, presents opportunities for advancement that are similar to those for other employees who are not persons with disabilities and who have similar positions.

(13) "Contract" means a formal written agreement between the CMHP, CCO, Oregon Health Plan contractor or the Division and a provider.

(14) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.

(15) "Crisis-Respite Services" means the provision of services to individuals for up to 30 days.

(16) "Controlled" means a provider requires an individual to receive services from the provider or requires the individual to receive a particular service as a condition of living or remaining in the HCB setting.

(17) "Designated Representative" means:

(a) Any adult who is not the individual's paid provider, who:

(A) The individual has authorized to serve as his or her representative; or

(B) The individual's legal representative has authorized to serve as the individual's representative.

(b) The power to act as a designated representative is valid until the individual or the individual's legal representative modifies the authorization and notifies the Division of the modification, the individual or the individual's representative notifies the provider that the designated representative is no longer authorized to act on his or her behalf, or there is a change in the legal authority upon which the designation was based. Notice must include the individual's or the representative's signature as appropriate.

(c) An individual, or the individual's legal representative, is not required to appoint a designated representative.

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(18) “DSM” means the “Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),” published by the American Psychiatric Association.

(19) “Deputy Director” means the Deputy Director of the Health Systems Division of the Oregon Health Authority or his or her designee.

(20) “Division” means the Health Systems Division of the Oregon Health Authority or its designee.

(21) “Division Staff” means those staff employed by the Division or persons delegated the authority by the Division to conduct licensing activities under these rules.

(22) “Direct Care Staff Person” means a program staff responsible for providing services an individual.

(23) “Emergency Admission” means an admission to a program made on an urgent basis due to the pressing service needs of the individual.

(24) “Evacuation Capability” means the ability of occupants, including individuals and program staff as a group, to either evacuate the building or relocate from a point of occupancy to a point of safety as defined in the Oregon Structural Specialty Code. The category of evacuation capability is determined by documented evacuation drill times or scores on National Fire Protective Association (NFPA) 101A 2000 edition worksheets. There are three categories of evacuation capability:

(a) Impractical (SR-2): A group, even with staff assistance, that cannot reliably move to a point of safety in a timely manner, determined by an evacuation capability score of five or greater or with evacuation drill times in excess of 13 minutes.

(b) Slow (SR-1): A group that can move to a point of safety in a timely manner, determined by an evacuation capability score greater than 1.5 and less than five or with evacuation drill times over three minutes but not in excess of 13 minutes.

(c) Prompt: A group with an evacuation capability score of 1.5 or less or equivalent to that of the general population or with evacuation drill times of three minutes or less. The Division is authorized to determine evacuation capability for programs in accordance with the NFPA 101A 2000 edition. Programs that are determined to be “Prompt” may be used in Group R occupancies classified by the building official, in accordance with the building code.

(25) “Fire Code” means the Oregon Fire Code as adopted by the State of Oregon Fire Marshal.

(26) “HCB” means Home and Community Based.

(27) “HCBS” means Home and Community-Based Services as defined in OAR chapter 411, division 4. HCBS are services provided in the home or community of an individual.

(28) “Home and Community-Based Settings” or “HCB Settings” means a physical location meeting the qualities of OAR 411-004-0020 where an individual receives Home and Community-Based Services.

(29) “Home-like” means an environment that promotes the dignity, security, and comfort of individuals through the provision of personalized care and services, and encourages independence, choice, and decision-making by the individual.

(30) “Individual” means any person being considered for placement or currently residing in a licensed program receiving residential services regulated by these rules on a 24-hour basis, except as excluded under ORS 443.400.

(31) “Individual Service Record” means an individual’s records maintained by the program as required and established in OAR 309-035-0117(4).

(32) “Individually-Based Limitation” means a limitation to a quality listed in OAR 411-004-0020(2)(c) to (2)(g) and as incorporated in OAR 309-035-0161 applied in accordance with applicable requirements provided in OAR 309-035-0161. An individually-based limitation is based on specific assessed need and only implemented with the informed consent of the individual or, as applicable, the individual’s legal representative, as described in OAR 411-004-0040 and these rules. These qualities include the individual’s right to:

(a) Live under a legally enforceable agreement with protections substantially equivalent to landlord/tenant laws;

(b) The freedom and support to access food at any time;

(c) Have visitors of the individual’s choosing at any time;

(d) Have a lockable door in the individual’s unit, which may be locked by the individual;

(e) Choose a roommate when sharing a unit;

(f) Furnish and decorate the individual’s unit according to the Residency Agreement;

(g) The freedom and support to control the individual’s schedule and activities; and

(h) Privacy in the individual’s unit.

(33) “Informed Consent” means:

(a) Options, risks, and benefits of the services outlined in these rules have been explained to an individual and, as applicable, the individual’s legal representative, in a manner that the individual and, as applicable, the individual’s legal representative comprehends; and

(b) The individual and, as applicable, the individual’s legal representative, consents to a person-centered service plan of action, including any individually-based limitations to the rules, prior to implementation of the initial or updated person-centered service plan or any individually-based limitation.

(34) “Legal Representative” means a person who has the legal authority to act for an individual and only within the scope and limits to his or her authority as designated by the court or other agreement. A legal representative may include:

(a) For an individual under the age of 18, the parent, unless a court appoints another person or agency to act as the guardian; or

(b) For an individual 18 years of age or older, a guardian appointed by a court order or an agent legally designated as the health care representative.

(35) “Licensed Medical Professional (LMP)” means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Holds at least one of the following educational degrees and valid licensures:

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

(B) Nurse Practitioner licensed to practice in the State of Oregon; or

(C) Physician’s Assistant licensed to practice in the State of Oregon; and

(b) Whose training, experience and competence demonstrate the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.

(36) “Local Mental Health Authority (LMHA)” means the county court or board of county commissioners of one or more counties operating a CMHP or MHO; or, if the county declines to operate or contract for all or part of a CMHP or MHO, the board of directors of a public or private corporation which contracts with the Division to operate a CMHP or MHO for that county.

(37) “Medication” means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance either internally or externally by any person.

(38) “Mental or Emotional Disorder” means a primary Axis I or Axis II DSM diagnosis, other than mental retardation or a substance abuse disorder that limits an individual’s ability to perform activities of daily living.

(39) “Mental Health Assessment” means a determination by a Qualified Mental Health Professional (QMHP) of a person’s need for mental health services. It involves collection and assessment of data pertinent to the person’s mental health history and current mental health status obtained through interview, observation, testing, and review of previous treatment records. It concludes with determination of a DSM diagnosis or other justification of priority for mental health services, or a written statement that the person is not in need of community mental health services.

(40) “Mental Health Organization (MHO)” means an approved organization that provides most mental health services through a capitated payment mechanism under the Oregon Health Plan. MHOs may be fully capitated health plans, community mental

health programs, private mental health organizations or combinations thereof.

(41) “Mistreatment” means the following behaviors, displayed by, program staff when directed toward an individual:

(a) “Abandonment” means desertion or willful forsaking when the desertion or forsaking results in harm or places the individual at a risk of serious harm.

(b) “Financial Exploitation” means:

(A) Wrongfully taking the assets, funds, or property belonging to or intended for the use of an individual.

(B) Alarming an individual by conveying a threat to wrongfully take or appropriate money or property of the individual if the individual would reasonably believe that the threat conveyed would be carried out.

(C) Misappropriating, misusing, or transferring without authorization any money from any account held jointly or singly by an individual.

(D) Failing to use the income or assets of an individual effectively for the support and maintenance of the individual. “Effectively” means use of income or assets for the benefit of the individual.

(c) “Involuntary Restriction” means the involuntary restriction of an individual for the convenience of a program staff or to discipline the individual. Involuntary restriction may include but is not limited to placing restrictions on an individual’s freedom of movement by restriction to his or her room or a specific area, or restriction from access to ordinarily accessible areas of the setting, residence or program, unless agreed to by the treatment plan. Restriction may be permitted on an emergency or short-term basis when an individual’s presence would pose a risk to health or safety to the individual or others.

(d) “Neglect” means active or passive failure to provide the care, supervision, or services necessary to maintain the physical and mental health of an individual that creates a significant risk of harm to an individual or results in significant mental injury to an individual. Services include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of the individual.

(e) “Verbal Mistreatment” means threatening significant physical harm or emotional harm to an individual through the use of:

(A) Derogatory statements, inappropriate names, insults, verbal assaults, profanity or ridicule.

(B) Harassment, coercion, punishment, deprivation, threats, implied threats, intimidation, humiliation, mental cruelty, or inappropriate sexual comments.

(C) A threat to withhold services or supports, including an implied or direct threat of termination of services. “Services” include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of an individual.

(D) For purposes of this definition, verbal conduct includes but is not limited to the use of oral, written, or gestured communication that is directed to an individual or within their hearing distance of sight, regardless of the individual’s ability to comprehend. In this circumstance the assessment of the conduct is based on a reasonable person standard.

(E) The emotional harm that can result from verbal abuse may include but is not limited to anguish, distress or fear.

(f) “Wrongful Restraint” means a use of physical or chemical restraint, except for:

(A) An act of restraint prescribed by a licensed physician pursuant to OAR 309-033-0730; or

(B) A physical emergency restraint to prevent immediate injury to an individual who is in danger of physically harming himself or herself or others, provided that only the degree of force reasonably necessary for protection is used for the least amount of time necessary.

(42) “Nursing Care” means the practice of nursing by a licensed nurse, including tasks and functions that are delegated by

a registered nurse to a person other than a licensed nurse, which are governed by ORS Chapter 678 and rules adopted by the Oregon State Board of Nursing in OAR Chapter 851.

(43) “Person-Centered Service Plan” means written documentation that includes details of the supports, desired outcomes, activities, and resources required for an individual to achieve and maintain personal goals, health, and safety as described in OAR 411-004-0030.

(44) “Person-Centered Service Plan Coordinator” means the person, which may be a case manager, service coordinator, personal agents or other person, designated by the Division to provide case management services or person-centered service planning for and with an individual.

(45) “P.R.N. (pro re nata) Medications and Treatments” means those medications and treatments which have been ordered to be given as needed.

(46) “Program” means the Residential Treatment Facility or Residential Treatment Home licensed by the Division and may refer to the provider grounds, caregiver, staff and/or services as applicable to the context.

(47) “Program Staff” means an employee, volunteer, direct care staff or person who, by contract with a program, provides a service to an individual.

(48) “Progress Notes” means the notations in the individual’s record documenting significant information concerning the individual and summarizing progress made relevant to the objectives outlined in the residential service plan.

(49) “Protection” means the necessary actions taken by the program to prevent abuse, mistreatment, or exploitation of the individuals, to prevent self-destructive acts, and to safeguard individuals, property and funds when used in the relevant context.

(50) “Provider” means the program administrator, person, or organizational entity, licensed by the Division for the purpose of providing services to an individual through the program. The provider is legally responsible for the operation of the program and the provision of services.

(51) “Representative” refers to both “Designated Representative” and “Legal Representative” as defined in these rules, unless otherwise stated.

(52) “Residency Agreement” means the written, legally enforceable agreement between a provider and an individual or the individual’s representative when the individual receives services. The Residency Agreement identifies the rights and responsibilities of the individual and the provider. The Residency Agreement provides the individual protection from eviction substantially equivalent to landlord-tenant laws.

(53) “Residential Service Plan” means an individualized, written plan outlining the care and treatment to be provided to an individual in or through the program based upon an individual assessment of care and treatment needs. The residential service plan may be a section or subcomponent of the individual’s overall mental health treatment plan when the program is operated by a mental health service agency that provides other services to the individual.

(54) “Residential Treatment Facility (RTF)” means a program that is licensed by the Division and operated to provide services on a 24-hour basis for 6 to 16 individuals as described in ORS 443.400(9). A RTF does not include the entities set out in ORS 443.405.

(55) “Residential Treatment Home (RTH)” means a program that is licensed by the Division and operated to provide services on a 24-hour basis for up to five individuals as defined in ORS 443.400(10). A RTH does not include the entities set out in ORS 443.405.

(56) “Restraints” means any chemical or physical methods or devices that are intended to restrict or inhibit the movement, functioning, or behavior of an individual.

(57) “Room and Board” means compensation for the provision of meals, a place to sleep, and tasks, such as housekeeping and laundry.

(58) "Seclusion" means placing an individual in a locked room. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock, or physically holding the door shut.

(59) "Secure Residential Treatment Facility (SRTF)" means any Residential Treatment Facility, or portion thereof, approved by the Division that restricts an individual's exit from the setting through the use of approved locking devices on individual exit doors, gates or other closures.

(60) "Services" means the care and treatment provided to individuals by a program.

(61) "Setting" means one or more buildings and adjacent grounds on contiguous properties that are used in the operation of a program.

(62) "Supervision" a program staff's observation, and monitoring of an individual or oversight of a program staff by the program administrator applicable to the context.

(63) "Termination of Residency" means the time at which the individual ceases to live in the program, and includes the transfer of the individual to another program, but does not include absences from the setting for the purpose of taking a planned vacation, visiting family or friends, or receiving time-limited medical or psychiatric treatment.

(64) "Treatment" means a planned, individualized program of medical, psychological or rehabilitative procedures, experiences and activities consistent with ORS 443.400(12).

(65) "Unit" means the personal space and bedroom of an individual receiving services from a program, as agreed to in the Residency Agreement.

(66) "Volunteer" means a person who provides a service or who takes part in a service provided to an individual receiving supportive services in a program or other provider, and who is not a paid employee of the program or other provider.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 6-2007(Temp), f. & cert. ef. 5-25-07 thru 11-21-07; MHS 13-2007, f. & cert. ef. 8-31-07; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 10-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; MHS 5-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0107

Required Home-like Qualities

This rule becomes effective July 1, 2016 and enforceable as described in OAR 309-035-0110(17).

(1) A program, except for a SRTF, must have all of the following qualities:

(a) The setting is integrated in and supports the individual's same degree of access to the greater community as people not receiving HCBS, including opportunities for an individual to:

(A) Seek employment and work in competitive integrated employment settings;

(B) Engage in greater community life;

(C) Control personal resources; and

(D) Receive services in the greater community.

(b) The program is selected by an individual or, as applicable, the legal or designated representative of the individual, from among available setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options must be:

(A) Identified and documented in the person-centered service plan for the individual;

(B) Based on the needs and preferences of the individual; and

(C) Based on the available resources of the individual for room and board.

(c) The program ensures individual rights of privacy, dignity, respect, and freedom from coercion and restraint.

(d) The program optimizes, but does not regiment, individual initiative, autonomy, self-direction, and independence in making life choices including, but not limited to, daily activities, physical environment, and with whom to interact.

(e) The program facilitates individual choice regarding services and supports, and individual choice as to who provides the services and supports.

(2) The individual, or the individual's representative, must have the opportunity to select from among available setting options, including non-disability specific settings and an option for a private unit in a setting. The setting options must be:

(a) Identified and documented in the person-centered service plan for the individual;

(b) Based on the needs and preferences of the individual; and

(c) Based on the available resources of the individual for room and board.

(3) The provider must take reasonable steps to ensure that the program maintains the qualities identified in subsections (2) and (3) of these rules. Failure to take reasonable steps may include, but is not limited to:

(a) Failure to maintain a copy of the person centered plan at the setting;

(b) Failure to cooperate or provide necessary information to the person centered planning coordinator; or

(c) Failure to attend or schedule a person centered planning meeting where applicable.

(4) Additional Requirements. A program must maintain the following:

(a) The setting must be physically accessible to an individual.

(b) The provider must provide the individual a unit of specific physical place that the individual may own, rent, or occupy under a legally enforceable Residency Agreement.

(c) The provider must provide and include in the Residency Agreement that the individual has, at a minimum, the same responsibilities and protections from an eviction that a tenant has under the landlord-tenant law of Oregon, and other applicable laws or rules of the county, city, or other designated entity. For a setting in which landlord-tenant laws do not apply, the Residency Agreement must provide substantially equivalent protections for the individual and address eviction and appeal processes. The eviction and appeal processes must be substantially equivalent to the processes provided under landlord-tenant laws.

(d) The provider must provide each individual with privacy in his or her own unit.

(e) The provider must maintain units with entrance doors lockable by the individual. The program must ensure that only the individual, the individual's roommate (where applicable), and only appropriate staff, as described in the individual's person-centered plan, have keys to access the unit.

(f) The provider must ensure that individuals sharing units have a choice of roommates.

(g) The provider must provide and include in the Residency Agreement that individuals have the freedom to decorate and furnish his or her own unit

(h) The provider must allow each individual to have visitors of his or her choosing at any time.

(i) The provider must ensure each individual has the freedom and support to control his or her own schedule and activities.

(j) The provider must ensure each individual has the freedom and support to have access to food at any time.

(5) An SRTF is not required to maintain the qualities or meet the obligations identified in subsections (d), (e), (f), (h), or (i) of section 4 of this rule. The provider is not required to seek an individually based limitation to comply with these rules.

(6) A provider is not required to maintain the qualities or meet the obligations identified in subsections (b) or (c) of section 4 of this rule when providing crisis respite services to an individual. The provider is not required to seek an individually based limitation for such an individual to comply with these rules.

(7) When a provider is unable to meet a quality described under sections (4)(e) to (4)(j) of this rule due to threats to the health and safety of the individual or others, the provider may seek an individually-based limitation with the consent of the individual or, as applicable, the individual's legal representative, through the process set out in OAR 411-004-0040 and incorporated by 309-035-

0161. The provider may not apply an individually-based limitation until the limitation is approved and documented as required by OAR 309-035-0000.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.465 & 443.991

Hist.: MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0110

Licensing

(1) License Required. The Division will license a program that meets the definition of a RTF or RTH and demonstrates compliance with these and all applicable laws and rules. No person or governmental unit acting individually or jointly with any other person or governmental unit will establish, maintain, manage, or operate a program without a license issued by the Division.

(2) Where a program serves or seeks to serve another category of individuals, in addition to adults with a mental or emotional disorder, the Directors of OHA and DHS shall determine the Department responsible for licensure.

(3) Initial Application. An application for a license must be accompanied by the required fee and submitted to the Division using the forms or format required by the Division. The following information must be included in the application:

(a) Full and complete information as to the identity and financial interest of each person, including stockholders, having a direct or indirect ownership interest of five percent or more in the program and all officers and directors in the case of a program operated or owned by a corporation.

(b) Name and resume of the program administrator;

(c) Location (street address) of the setting and mailing address;

(d) Maximum number of individuals to be served at any one time, their age range and evacuation capability;

(e) Proposed annual budget identifying sources of revenue and expenses;

(f) Signed criminal record authorizations for all persons involved in the operation of the program who will have contact with the individuals including but not limited to caregivers;

(g) A complete set of policies and procedures;

(h) Setting plans and specifications; and

(i) Such other information as the Division may reasonably require.

(4) Plans and Design Approval. A complete set of plans and specifications must be submitted to the Division at the time of initial application, whenever a new structure or addition to an existing structure is proposed, or when significant alterations to an existing facility are proposed. Plans will meet the following criteria:

(a) Plans will be prepared in accordance with the Building Code and requirements of OAR 309-035-0125;

(b) Plans will be to scale and sufficiently complete to allow full review for compliance with these rules; and

(c) Plans will bear the stamp of an Oregon licensed architect or engineer when required by the Building Code.

(5) Necessary Approvals. Prior to approval of a license for a new or renovated setting, the applicant must submit the following to the Division:

(a) One copy of written approval to occupy the setting issued by the city or county building codes authority having jurisdiction;

(b) One copy of the fire inspection report from the State Fire Marshal or local jurisdiction indicating that the setting complies with the Fire Code;

(c) When the setting is not served by an approved municipal water system, one copy of the documentation indicating that the state or county health agency having jurisdiction has tested and certified safe the water supply in accordance with OAR chapter 333, Health Services rules to public water systems.

(d) When the setting is not connected to an approved municipal sewer system, one copy of the sewer or septic system approval from the Department of Environmental Quality or local jurisdiction.

(6) Required Fees. The following fees must be submitted with an initial or renewal application:

(a) The RTF license application fee for initial or renewal licensing is \$60. No fee is required in the case of a governmentally operated RTF.

(b) The RTH license application fee for initial or renewal licensing is \$30. No fee is required in the case of a governmentally operated RTH.

(7) Renewal Application. A license is renewable upon submission of a renewal application in the form or format required by the Division and a non-refundable fee as set out in subsection (6), except that no fee will be required of a governmentally operated program.

(a) Filing of an application for renewal 60 days before the date of expiration extends the effective date of the current license until the Division takes action upon the renewal application.

(b) The Division must deny renewal of a license if the program is not in substantial compliance with these rules, or if the State Fire Marshal or authorized representative has given notice of noncompliance.

(8) Review Process. Upon receipt of an application and fee, the Division will conduct an application review. Initial action by the Division on the application will begin within 30 days of receipt of all application materials. The review will:

(a) Include a complete review of application materials;

(b) Determine whether the applicant meets the qualifications outlined in ORS 443.420 including:

(A) Demonstrates an understanding and acceptance of these rules;

(B) Is mentally and physically capable of providing services for individuals;

(C) Employs or utilizes only persons whose presence does not jeopardize the health, safety, or welfare of individuals; and

(D) Provides evidence satisfactory to the Division of financial ability to comply with these rules.

(c) Include a site inspection; and

(d) Conclude with a report stating findings and a decision on licensing of the program.

(9) Findings of Noncompliance. The provider must submit and complete a plan of correction for each finding of noncompliance with these rules.

(a) If the finding(s) of noncompliance substantially impact the welfare, health and/or safety of individuals, the provider must submit plan of correction and will be approved by the Division prior to issuance of a license. In the case of a currently operating program, such findings may result in suspension or revocation of a license.

(b) If it is determined that the finding(s) of noncompliance do not threaten the welfare, health or safety of individuals and the program meets other requirements of licensing, the Division may issue or renew a license with may be issued or renewed, with the plan of correction submitted and completed as a condition of licensing.

(c) The Division will specify required documentation and set the time lines for the submission and completion of plans of correction in accordance with the severity of the finding(s).

(d) The Division will review and evaluate each plan of correction. If the plan of correction does not adequately remedy the finding(s) of noncompliance, the Division may require a revised plan of correction, and/or take action to apply civil penalties or deny, revoke or suspend the license.

(e) The Provider owner may appeal the finding of noncompliance or the disapproval of a plan of correction by submitting a request for reconsideration in writing to the Division. The Division will make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Division will be final.

(10) Variance. The Division, in its discretion, may grant a variance to these rules based upon a demonstration by the applicant or provider that an alternative method or different approach provides equal or greater program effectiveness and does not adversely impact the welfare, health or safety of individuals.

(a) Variance Application. The provider seeking a variance must submit, in writing, an application to the Division which identifies the section of the rules from which the variance is sought, the reason for the proposed variance, the proposed alternative method or different approach, and signed documentation from the CMHP indicating approval of the proposed variance.

(b) Division Review. The Director or designee, will review and approve or deny the request for a variance.

(c) Notification of Decision. The Division will notify the provider of the decision in writing within 30 days after receipt of the application. A variance may be implemented only after receipt of written approval from the Division.

(d) Appeal of Decision. The provider may appeal the denial of a variance request by submitting a request for reconsideration in writing to the Assistant Director of the Division. The Assistant Director of the Division will make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Assistant Director of the Division will be final.

(e) Duration of the Variance. A variance will be reviewed by the Division at least every two years and may be revoked or suspended based upon a finding that the variance adversely impacts the welfare, health or safety of the individuals.

(11) Issuance of License. Upon finding that the applicant is in substantial compliance with these rules, the Division will issue a license.

(a) The license issued will state the name of the provider, the name of the program administrator, the address of the setting to which the license applies, the maximum number of individuals to be served at any one time and their evacuation capability, the type of program, and such other information as the Division deems necessary.

(b) A program license will be effective for two years from the date issued unless sooner revoked or suspended.

(c) A program license is not transferable or applicable to any setting, location, or management other than that indicated on the application and license.

(12) Conditions of License. The license will be valid only under the following conditions:

(a) The provider must not operate or maintain the program in combination with a nursing facility, hospital, retirement facility, or other occupancy unless licensed, maintained, and operated as a separate and distinct part. Each program will have sleeping, dining and living areas for use only by its own individuals, caregivers and invited guests.

(b) The provider must maintain the license posted in the setting and available for inspection at all times.

(c) A license is void immediately upon suspension or revocation of the license by the Division, or if the operation is discontinued by voluntary action of the provider, or if there is a change of ownership.

(13) Site Inspections. Division staff will visit and inspect every setting at least, but not limited to, once every two years to determine whether it is maintained and operated in accordance with these rules. The provider or applicant must allow Division staff entry and access to the setting and individuals for the purpose of conducting the inspections.

(a) Division staff will review methods of individual care and treatment, records, the condition of the setting and equipment, and other areas of operation.

(b) All records, unless specifically excluded by law, must be available to the Division for review.

(c) The State Fire Marshal or authorized representative(s) will, upon request, be permitted access to the setting, fire safety equipment within the setting, safety policies and procedures, maintenance records of fire protection equipment and systems, and records demonstrating the evacuation capability of setting occupants.

(14) Investigation of Complaints and Alleged Abuse. Incidents of alleged abuse covered by ORS 430.735 through 430.765 will be reported and investigated in accordance with OAR 410-009-0050 through 410-009-0160. Division staff will investigate complaints

and other alleged abuse made regarding a program, will file a report to be filed, and will take appropriate action under these rules. The Division may delegate the investigation to a CMHP or other appropriate entity.

(15) Denial, Suspension or Revocation of License. The Division may deny, suspend or revoke a license where it finds there has been substantial failure to comply with these rules; or where the State Fire Marshal or authorized representative certifies that there is failure to comply with the Fire Code.

(a) In cases where there exists an imminent danger to the health or safety of an individual or the public, a license may be suspended immediately.

(b) Such revocation, suspension, or denial will be done in accordance with ORS 183.

(16) Reporting Changes. The provider must report promptly to the Division any significant changes to information supplied in the application or subsequent correspondence. Such changes include, but are not limited to, changes in the setting or program name, provider, program administrator, telephone number and mailing address. Such changes also include, but are not limited to, changes in the physical nature of the setting, policies and procedures or staffing pattern when such changes are significant or impact the health, safety or well-being of individuals.

(17) Enforcement of Home and Community Based Services and Settings Requirements.

(a) All programs licensed on or after July 1, 2016 must be in full compliance with all regulatory requirements under these rules at the time of initial licensure;

(b) All programs licensed prior to July 1, 2016 must come into compliance with rules as follows:

(A) All programs must be in full compliance with these rules no later than January 1, 2017.

(B) For the rules designated by the Division to become effective July 1, 2016, the provider must make measureable progress towards compliance with those rules. The Division will not issue sanctions and penalties for failure to meet those rules effective July 1, 2016 or the obligations imposed by OAR chapter 411, division 4 until January 1, 2017 if the provider is making measureable progress towards compliance.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0113 Contracts and Rates

(1) Contracts. A provider receiving service payments must enter into a contract with the local CMHP, statewide coordinated care organizations, the Division or other Division-approved party. The contract does not guarantee that any number of individuals eligible for Division funded services will be referred to or maintained in the program.

(2) Rates. The provider must specify in a fee policy and procedure rates for all services and the procedures for collecting payments from individuals and/or payees. The fee policy and procedures must describe the schedule of rates, conditions under which rates may be changed, acceptable methods of payment, and the policy on refunds at the time of termination of residency.

(a) For individuals whose services are funded by the Division, reimbursement for services will be made according to the rate schedule outlined in the contract. Room and board payments for individuals receiving Social Security benefits or public assistance will be in accordance with rates determined by the Division.

(b) For private paying individuals, the program will enter into a signed agreement with the individual, and/or if applicable individual's designated representative or legal representative. This agreement must include but not be limited to a description of the services to be provided; the schedule of rates; conditions under which the rates may be changed; and policy on refunds at the time of termination of residency.

(c) Before increasing rates or modifying payment procedures, the program will provide 30 days' advance notice of the change to all individuals, individuals, representatives, payees, guardians or conservators, as applicable.

Stat. Auth.: ORS 413.042 & 443.450
Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)
Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0115

Administrative Management

(1) Provider. The provider is responsible for ensuring, and must ensure, that the program and setting are maintained and operated in compliance with these rules and all other applicable federal, state and local laws and regulations.

(2) Program Administrator. The provider must employ a program administrator who meets the following qualifications and complies with the following standards:

(a) Background including special training, experience, and other demonstrated ability in providing care and treatment appropriate to the individuals served in the program;

(b) Documented approved criminal records checks processed in compliance with the procedures required by OAR 407-007-0000 through 407-007-0370 and no history of abusive behavior;

(c) Ensure that the program operates in accordance with the standards outlined in these rules;

(d) Oversee the daily operation and maintenance of the program and will be available to perform administrative duties at the setting at least 20 hours per week;

(e) Develop and administer written policies and procedures to direct the operation of the program and the provision of services to individuals;

(f) Ensure that qualified program staff are available, in accordance with the staffing requirements specified in these rules;

(g) Supervise or provide for the supervision of program staff and others involved in the operation of the program;

(h) Maintain setting, personnel and individual service records;

(i) Report regularly to the provider on the operation of the program; and

(j) Delegate authority and responsibility for the operation and maintenance of the program to a responsible staff person whenever the Program Administrator is absent from the setting. This authority and responsibility may not be delegated to an individual.

(3) Policies and Procedures. The provider must develop and update policies and procedures and maintain a copy, in a location easily accessible for staff reference, and made available to others upon reasonable request. They must be consistent with requirements of these rules, and must address at minimum:

(a) Personnel practices and staff training;

(b) Individual screening, admission and termination;

(c) Fire drills, emergency procedures, individual safety and abuse reporting;

(d) Health and sanitation;

(e) Records maintenance and confidentiality;

(f) Residential service plan, services and activities;

(g) Behavior management, including the use of seclusion or restraints;

(h) Food Service;

(i) Medication administration and storage;

(j) Individual belongings, storage and funds;

(k) Individual rights and advance directives;

(l) Complaints and grievances;

(m) Setting maintenance;

(n) Evacuation capability determination; and

(o) Fees and money management.

(4) House Rules. The provider must develop reasonable house rules outlining operating protocols concerning, but not limited to, meal times, night-time quiet hours, guest policies, smoking and as follows:

(a) House rules must be consistent with individual rights as delineated in OAR 309-035-0155.

(b) House rules must be posted in an area readily accessible to individuals.

(c) House rules must be reviewed and updated, as necessary.

(d) Individuals must be provided an opportunity to review and provide input into any proposed changes to house rules before the revisions become effective.

(e) Effective July 1, 2016 and enforceable according to 309-035-0110(17), house rules may not restrict or limit the program qualities identified in OAR 309-035-0105.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 9-1984 (Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; ; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0117

Records

(1) General Requirements. Records must be maintained to document the legal operation of the program, personnel practices and individual services. All records must be properly obtained, accurately prepared, safely stored and readily available within the facility. All entries in records required by these rules will be in ink, indelible pencil, or approved electronic equivalent prepared at the time, or immediately following, the occurrence of the event being recorded; be legible; and be dated and signed by the person making the entry. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent.

(2) Program Records. Records documenting the legal operation of the program will include, but not be limited to:

(a) Written approval for occupancy of the setting by the county or city having jurisdiction, any building inspection reports, zoning verifications, fire inspection reports or other documentation pertaining to the safe and sanitary operation of the program issued during the development or operation of the program;

(b) Application for license, related correspondence and site inspection reports;

(c) Program operating budget and related financial records;

(d) Payroll records, program staff schedules and time sheets;

(e) Materials Safety and Data Sheets;

(f) Fire drill documentation;

(g) Fire alarm and sprinkler system maintenance and testing records;

(h) Incident reports; and

(i) Policy and procedure manual.

(3) Personnel Records. Records documenting personnel actions will include:

(a) Job descriptions for all positions; and

(b) Separate program staff records including, but not limited to, written documentation of program staff identifying information and qualifications, criminal record clearance, T.B. test results, Hepatitis B status, performance appraisals, and documentation of pre-service orientation and other training.

(4) Individual Service Record. An individual service record must be maintained for each individual and include:

(a) An easily accessible summary sheet which includes, but is not limited to the individual's name, previous address, date of admission to the program, sex, date of birth, marital status, legal status, religious preference, Social Security number, health provider information, evacuation capability, diagnosis(es), major health concerns, medication allergies, information indicating whether advance mental health and health directives and/or burial plan have been executed, and the name of person(s) to contact in case of emergency;

(b) The names, addresses and telephone numbers of the individual's representative, legal guardian or conservator, parent(s), next of kin, or other significant person(s); physician(s) or other medical practitioner(s); dentist; CMHP case manager or therapist; day program, school or employer; and any governmental or other agency representative(s) providing services to the individual;

(c) A mental health assessment and background information identifying the individual's residential service needs;

(d) Advance mental health and health directives, burial plans or location of these (as available);

(e) A Residential Service Plan and copy(ies) of plan(s) from other service provider(s);

(f) Effective July 1, 2016 and enforceable as described in OAR 309-035-0110(17), a Person-Centered Service Plan;

(g) Documentation of the individual's progress and any other significant information including, but not limited to, progress notes, progress summaries, any use of seclusion or restraints, and correspondence concerning the individual; and

(h) Health-related information and up-to-date information on medications in accordance with OAR 309-035-0175.

(5) Referral and Response Documentation: The program must retain all referral packets, screening materials, and screening responses/placement determinations for a minimum of three years from the date of the referral.

(6) Records for Crisis-respite Individuals. For an individual receiving crisis-respite services, the provider must obtain and maintain records as outlined in OAR 309-035-0117(4). Because it may not be possible to assemble complete records during the crisis-respite individual's short stay, the program will, at a minimum, maintain records in accordance with requirements outlined in OAR 309-035-0145, 309-035-0150, 309-035-0159, and 309-035-0175.

(7) Storage. All individual service records must be stored in a weatherproof and secure location. Access to records must be limited to the Program Administrator and direct care staff unless otherwise allowed in these rules.

(8) Confidentiality. All individual service records must be kept confidential as required by law. A signed release of information must be obtained for any disclosure from an individual service records in accordance with all applicable laws and rules.

(9) Individual Access to Own Record. An individual, or the individual's representative (as applicable), must be allowed to review and obtain a copy of his/her individual service record as required by ORS 179.505(9).

(10) Transfer of Records. Pertinent information from records of an individual who is being transferred to another facility will be transferred with the individual. A signed release of information must first be obtained in accordance with applicable laws and rules.

(11) Maintenance of Records. The program must keep all records, except those transferred with an individual, for a period of three years.

(12) Administrative Changes. If a program changes ownership or Program Administrator, all individual and personnel records will remain at the setting. Prior to the dissolution of any program, the Program Administrator must notify the Division in writing as to the location and storage of individual service records or those records will be transferred with the individuals.

(13) Individual Contributions to Record. If an individual or an individual's representative (as applicable) disagrees with the content of the individual service record, or otherwise desires to provide documentation for the record, the individual or representative (as applicable) may provide material in writing that then will become part of the individual service record.

(14) Record Preparation. The program must establish an individual service record upon the individual's admission. Prior to admission, within five days after an emergency admission, or within 24 hours of a crisis-respite admission, the program must determine with whom communication needs to occur and make good faith efforts to obtain the needed authorizations for release of information. The record established upon admission must include the materials reviewed in screening the individual, the summary sheet and any other available information. The program must make every effort to complete the individual service record consistent with OAR 309-035-0117(4) in a timely manner. The assessment and residential service plan must be completed in accordance with OAR 309-035-0159. Records on prescribed medications and health needs must be completed as specified in OAR 309-035-0175.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0120

Staffing

(1) Staff Qualifications. The provider must maintain a written job description for each staff position which specify the position's qualifications and job duties.

(a) A direct care staff person must be at least 18 years of age, be capable of implementing the setting's emergency procedures and disaster plan, and be capable of performing other duties of the job as described in the job description.

(b) A staff person who will have contact with an individual must have a documented approved criminal record clearance, in accordance with OAR 943-007-0001 through 943-007-0501. The provider must maintain documentation of approved criminal records clearance for each applicable staff person.

(c) In accordance with OAR 333-071-0057 and 437, Division 2, Subdivision Z, 4f (1)(2), a program staff who may have contact with an individual must be tested for tuberculosis within two weeks of first employment, additional testing will take place as deemed necessary; and the employment of program staff who test positive for tuberculosis will be restricted if necessary.

(d) All program staff must meet other qualifications when required by a contract or financing arrangement approved by the Division.

(2) Personnel Policies. Personnel policies will be made available to all program staff and will describe hiring, leave, promotion and disciplinary practices.

(3) Program Staff Training. The program administrator must provide or arrange a minimum of 16 hours pre-service orientation and 8 hours in-service training annually for each program staff, including:

(a) Pre-service training for direct care staff will include, but not be limited to, a comprehensive tour of the setting; a review of emergency procedures developed in accordance with OAR 309-035-0130; a review of setting house rules, policies and procedures; background on mental and emotional disorders; an overview of individual rights; medication management procedures; food service arrangements; a summary of each individual's assessment and residential service plan; and other information relevant to the job description and scheduled shift(s).

(b) In-service training will be provided on topics relevant to improving the care and treatment of individuals in the program and meeting the requirements in these administrative rules. In-service training topics include, but are not limited to, implementing the residential service plan, behavior management, daily living skills development, nutrition, first aid, understanding mental illness, sanitary food handling, individual rights, identifying health care needs, and psychotropic medications.

(4) General Staffing Requirements. The provider and program administrator are responsible for assuring that an adequate number of program staff are available at all times to meet the treatment, health and safety needs of individuals. Regardless of the minimum staffing requirements outlined below, program staff must be scheduled to ensure safety and to correspond to the changing needs of individuals. Minimum staffing requirements are as follows:

(a) In RTHs serving 1 to 5 individuals, there must be at least 1 direct care staff person on duty at all times.

(b) In RTFs serving 6 to 16 individuals, there must be at least 1 direct care staff on duty at all times.

(c) In the case of a specialized program, staffing requirements outlined in the contractual agreement for specialized services must be implemented.

(d) Class I and Class II SRTFs must ensure staffing levels are congruent with the requirements set in Chapter 309, Divisions 32 and 33;

(e) Program staff on night duty must be awake and dressed at all times. In settings where individuals are housed in two or more detached buildings, program staff must monitor each building at least once an hour during the night shift. An approved method for

alerting program staff to problems must be in place and implemented. This method must be accessible to and usable by the individuals.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85;

MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05;

MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-

7-16 thru 3-3-17

309-035-0125

Setting Requirements

(1) Compliance with Building and Fire Codes. The provider must ensure that the setting meets the requirements for approved Group SR or I occupancies in the Building Code and the Fire Code in effect at the time of original licensure. When a change in setting use results in a new building occupancy classification, the program's setting must meet the requirements for approved Group SR or I occupancies in the Building Code in effect at the time of such change. If occupants are capable of evacuation within three minutes refer to Group R occupancies.

(2) Accessibility for Persons with Disabilities. Programs must be accessible as follows:

(a) Those settings, or portions of settings, that are licensed, constructed or renovated after January 26, 1992, and that are covered multi-family dwellings or public accommodations, must meet the physical accessibility requirements in Chapter 11 of the Oregon Structural Specialty Codes. These codes specify requirements for public accommodations as defined in the Americans with Disabilities Act under Title III and for buildings qualifying as multi-family dwellings as defined in the Fair Housing Act, as amended in 1988.

(b) In order to ensure program accessibility under Title II of the Americans with Disabilities Act, the Division may require additional accessibility improvements.

(c) Any accessibility improvements made to accommodate an identified individual will be in accordance with the specific needs of the individual.

(3) Outdoor Areas. An accessible outdoor area is required and will be made available to all individual. For programs, or portions thereof, licensed on or after June 1, 1998, a portion of the accessible outdoor area will be covered and have an all-weather surface, such as a patio or deck.

(4) General Storage. The setting must have sufficient and safe storage areas. These will include but not be limited to:

(a) Storage for a reasonable amount of individual belongings beyond that available in individual's unit must be provided appropriate to the size of the setting;

(b) All maintenance equipment, including yard maintenance tools, must be maintained in adequate storage space. Equipment and tools which pose a danger to individuals must be kept in locked storage;

(c) Storage areas necessary to ensure a functional, safe and sanitary environment consistent with OAR 309-035-0125, 309-035-0130, 309-035-0135, 309-035-0140, 309-035-0170, and 309-035-0175.

(5) Hallways. For programs initially licensed on or after June 1, 1998, all individual use areas and individual units must be accessible through temperature controlled common areas or hallways with a minimum width of 36 inches except that a minimum width of 48 inches will be provided along the route to accessible bedrooms and bathrooms and between common areas and required exits.

(6) Administrative Areas. The Setting must have sufficient space will be provided for confidential storage of both individual service records and business records, for program staff use in completing record-keeping tasks, and for a telephone. Other equipment including fire alarm panels and other annunciators must be installed in an area readily accessible to staff in accordance with the Fire Code.

(7) Individual Units. The provider must provide a unit for each individual, although the program may maintain units to be shared by more than one individual, consistent with these rules.

The unit must include sleeping accommodations for the individual and be separated from other areas of the setting by an operable door with an approved latching device. The provider must maintain units as follows:

(a) For programs licensed prior to June 1, 1998, units must be a minimum of 60 square feet per resident and allow for a minimum of three feet between beds.

(b) For programs, or portions thereof, initially licensed on or after June 1, 1998, units must be limited to one or two individuals. At least ten percent of units, but no less than one unit, must be accessible for individuals with mobility disabilities. All units must include a minimum of 70 square feet per individual exclusive of closets, vestibules and bathroom facilities and allow a minimum of three feet between beds.

(c) The provider must provide a lockable entrance door(s) to each unit for the individual's privacy as follows:

(A) The locking device must release with a single-action lever on the inside of the room, open to a hall or common-use room;

(B) The provider must provide each individual with a personalized key that operates only the door to his or her unit from the corridor side.

(C) The provider must maintain a master key to access all of the units that is easily and quickly available to the provider, program administrator, and appropriate program staff.

(E) The provider may not disable or remove a lock to a unit without first obtaining consent from the individual, or the individual's representative, through the individually based limitations process described in OAR 411-004-0040(2) and incorporated by 309-035-0161; and

(F) Section (7)(c) of these rules and its subsections are effective July 1, 2016 and enforceable as described in OAR 309-035-0110(17).

(d) A clothes closet, with adequate clothes hanging rods will be accessible within each unit for storage of each individual's clothing and personal belongings. For programs initially licensed on or after June 1, 1998, built-in closet space will be provided totaling a minimum of 64 cubic feet for each individual. In an accessible unit, the clothes hanging rod height must be adjustable or no more than 54 inches in height to ensure accessibility for an individual using a wheelchair.

(e) Each unit must have exterior window(s) with a combined area at least one-tenth of the floor area of the room. Unit windows must be equipped with curtains or blinds for privacy and control of light. For programs, or portions of programs, initially licensed on or after June 1, 1998, an escape window must be provided consistent with Building Code requirements.

(8) Bathrooms. Bathing and toilet facilities must be conveniently located for individual use, provide permanently wired light fixtures that illuminate all parts of the room, provide individual privacy for individuals, provide a securely affixed mirror at eye level, be adequately ventilated, and include sufficient facilities specially equipped for use by individuals with a physical disability in buildings serving such individuals.

(a) In programs licensed prior to June 1, 1998, a minimum of one toilet and one lavatory will be available for each eight individuals, and one bathtub or shower will be available for each ten individuals.

(b) In programs, or portions of programs, initially licensed on or after June 1, 1998, a minimum of one toilet and one lavatory will be available for each six individuals, and a minimum of one bathtub or shower will be available for each ten individuals, where these fixtures are not available in units. At least one centralized bathroom along an accessible route will be designed for disabled access in accordance with Chapter 11 of the Oregon Structural Specialty Code.

(9) Common Use Rooms. The setting must include lounge and activity area(s) for social and recreational use, exclusively by individuals, program staff and invited guests, totaling no less than 15 square feet per individual.

(10) Laundry and Related Space. Laundry facilities must be separate from food preparation and other individual use areas.

When residential laundry equipment is installed, the laundry facilities may be located to allow for both individual and staff use. In programs initially licensed on or after June 1, 1998, separate residential laundry facilities will be provided when the primary laundry facilities are located in another building, are of commercial type, or are otherwise not suitable for individual use. The following will be included in the primary laundry facilities:

(a) Countertops or spaces for folding table(s) sufficient to handle laundry needs for the facility;

(b) Locked storage for chemicals and equipment;

(c) Outlets, venting and water hook-ups according to state building code requirements. Washers will have a minimum rinse temperature of 155 degrees Fahrenheit (160 degrees Fahrenheit recommended) unless a chemical disinfectant will be used; and

(d) Sufficient storage and handling space to ensure that clean laundry is not contaminated by soiled laundry.

(11) Kitchen. Kitchen facilities and equipment in a setting may be of residential type except as required by the state building code and Fire Code or local agencies having jurisdiction. The setting's kitchen must have:

(a) Dry storage space, not subject to freezing, in cabinets or a separate pantry for a minimum of one week's supply of staple foods;

(b) Sufficient refrigeration space maintained at 45 degrees Fahrenheit or less and freezer space for a minimum of two days' supply of perishable foods;

(c) A dishwasher will be provided (may be approved residential type) with a minimum final rinse temperature of 155 degrees Fahrenheit (160 degrees recommended), unless chemical disinfectant is used.

(d) A separate food preparation sink and hand washing sink will;

(e) Smooth, nonabsorbent and cleanable counters for food preparation and serving;

(f) Appropriate storage for dishes and cooking utensils designed to be free from potential contamination;

(g) Stove and oven equipment for cooking and baking needs; and

(h) Storage for a mop and other cleaning tools and supplies used for food preparation, dining and adjacent areas. Such cleaning tools will be maintained separately from those used to clean other parts of the setting.

(12) Dining Area. The setting must have a separate dining room or area where meals are served will be provided for the exclusive use of individuals, employees, and invited guests.

(a) In programs licensed prior to June 1, 1998, the setting's dining area must seat at least half of the individuals at one time with a minimum area of 15 square feet per individual.

(b) In programs, or portions of programs, initially licensed on or after June 1, 1998, the setting's dining space must seat all residents with a minimum area of 15 square feet per individual, exclusive of serving facilities and required exit pathways.

(13) Details and Finishes. All details and finishes will meet the finish requirements of applicable sections of the Building Code and the Fire Code.

(a) Surfaces. Surfaces of all walls, ceilings, windows and equipment will be nonabsorbent and readily cleanable.

(b) Flooring. The setting's, flooring, thresholds and floor junctures must be designed and installed to prevent a tripping hazard and to minimize resistance for passage of wheelchairs and other ambulation aids. In addition, hard surface floors and base must be free from cracks and breaks, and bathing areas will have non-slip surfaces.

(c) Doors. In programs, or portions of programs, initially licensed on or after June 1, 1998:

(A) All doors to units, bathrooms and common use areas must provide a minimum clear opening of 32 inches.

(B) Lever type door hardware must be provided on all doors used by individuals.

(C) Locking door levers. Locks used on doors to individual units must will be interactive to release with operation of the inside

door handle and comply with the requirements established by OAR 309-035-0125(7)(c)(A), (B), (C), and (D);

(D) Exit doors must not include locks which prevent evacuation except in accordance with Building Code and Fire Code requirements and with written approval of the Division;

(E) An exterior door alarm or other acceptable system may be provided for security purposes and to alert staff when individuals(s) or others enter or exit the setting.

(d) Handrails. Handrails must be provided on all stairways as specified in the Building Code.

(14) Heating and Ventilating. All areas of the setting must be adequately ventilated and temperature controlled in accordance with the Mechanical and Building Code requirements.

(a) Temperature Control. Each setting must have and maintain heating equipment capable of maintaining a minimum temperature of 68 degrees Fahrenheit at a point three inches above the floor. During times of extreme summer heat, fans will be made available when air conditioning is not provided.

(b) Exhaust Systems. All toilet and shower rooms must be adequately ventilated with a mechanical exhaust fan or central exhaust system which discharges to the outside.

(c) Fireplaces, Furnaces, Wood Stoves and Boilers. Where used, design and installation will meet standards of the Oregon Mechanical Specialty Code and the Boiler Specialty Code, as applicable.

(d) Water Temperature. In individual-use areas, hot water temperatures must be maintained within a range of 110 to 120 degrees Fahrenheit. Hot water temperatures in laundry and kitchen areas will be at least 155 degrees Fahrenheit.

(15) Electrical. All wiring systems and electrical circuits must meet the standards of Oregon Electrical Specialty Code in effect on the date of installation, and all electrical devices will be properly wired and in good repair. The provider must ensure the following:

(a) When not fully grounded, circuits in individual use areas must be protected by GFCI type receptacles or circuit breakers as an acceptable alternative.

(b) A sufficient supply of electrical outlets will be provided to meet individual and staff needs.

(c) N more than one power strip may be utilized for each electrical outlet;

(d) Connecting power strips to one another or use of other outlet expansion devices is prohibited;

(e) Extension cord use in units and common use rooms is prohibited;

(f) Lighting fixtures will be provided in each individual unit and bathroom, switchable near the entry door, and in other areas as required to meet task illumination.

(g) Lighting fixtures that illuminate evacuation pathways must be operable within 10 seconds during a failure of the normal power supply and provide illumination for a period of at least two hours.

(16) Plumbing. All plumbing must meet the Oregon Plumbing Specialty Code in effect on the date of installation, and all plumbing fixtures must be properly installed and in good repair.

(17) Telephones. The program must provide adequate access to telephones for private use by individuals. The program must not limit the hours of availability for phone use. A program may establish guidelines for fair and equal use of a shared telephone. Each individual, or individual's representative, (as applicable) will be responsible for payment of long distance phone bills where the calls were initiated by the individual, unless other mutually agreed arrangements have been made.

(18) Smoking. All licensed programs must comply with the Division's Tobacco Freedom Policy, state and local regulations concerning proximity of smoking to program. Smoking is not allowed within the setting, including within buildings or on the grounds.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef.; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-

2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0130

Safety

(1) Training on Safety Procedures. The provider must train all program staff will be trained in staff safety procedures prior to beginning their first regular shift. Every individual will be trained in individual safety procedures as soon as possible within the first 72 hours of residency.

(2) Emergency Procedure and Disaster Plan. The program must develop and implement a written procedure and disaster plan will be authorized by the State Fire Marshal or authorized representative. The plan must cover such emergencies and disasters as fires, explosions, missing persons, accidents, earthquakes and floods. The program must post the plan will be posted by the phone and be immediately available to the program administrator and program staff. The plan must include diagrams of evacuation routes, and these will be posted. The plan must specify where staff and individuals will reside if the setting becomes uninhabitable. The program must update the plan and will include:

- (a) Emergency instructions for employees;
(b) The telephone numbers of the local fire department, police department, the poison control center, the administrator, the administrator's designee, and other persons to be contacted in emergencies; and

(c) Instructions for the evacuation of individuals and employees.

(3) Combustible and Hazardous Materials. Noncombustible and nonhazardous materials will be used whenever possible. When necessary to the operation of the facility, flammable and combustible liquids and other hazardous materials will be safely and properly stored in clearly labeled, original containers in areas inaccessible to individuals in accordance with the Fire Code. Any quantities of combustible and hazardous materials maintained will be the minimum necessary.

(4) Poisonous and Other Toxic Materials. Non-toxic cleaning supplies will be used whenever available. Poisonous and other toxic materials will be properly labeled and stored in locked areas distinct and apart from all food and medications.

(5) Evacuation Capability. Evacuation capability categories are based upon the ability of the individuals and program staff as a group to evacuate the building or relocate from a point of occupancy to a point of safety. Buildings will be constructed and equipped according to a designated evacuation capability for occupants. Categories of evacuation capability include "Impractical" (SR- 2) or "Slow" (SR- 1). The evacuation capability designated for the facility will be documented and maintained in accordance with NFPA 101A.

(a) Only individuals assessed to be capable of evacuating in accordance with the designated facility evacuation capability will be admitted to the program.

(b) Individuals experiencing difficulty with evacuating in a timely manner will be provided assistance from staff and offered environmental and other accommodations, as practical. Under such circumstances, the program must consider increasing staff levels, changing staff assignments, offering to change the individuals room assignment, arranging for special equipment, and taking other actions that may assist the individual. The program must assist individuals who still cannot evacuate the building safely in the allowable period of time will be assisted with transferring to another facility with an evacuation capability designation consistent with the individual's documented evacuation capability.

(6) Evacuation Drills. The program must ensure that every individual will participate in an unannounced evacuation drill each month. (See Section 408.12.5 of the fire code.)

(a) At least once every three months, the program must conduct a drill will be conducted during individual sleeping hours.

(b) Drills will be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes.

(c) Any individual failing to evacuate within the established time limits will be provided with special assistance and a notation made in the individual service record.

(d) Written evacuation records will be maintained for at least three years. They will include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.

(7) Unobstructed Egress. All stairways, halls, doorways, passageways, and exits from rooms and from the building will be unobstructed.

(8) Fire Extinguishers. The program must provide and maintain one or more 2A10BC fire extinguishers on each floor in accordance with the Fire Code.

(9) Fire Alarms and Smoke Detectors. Approved fire alarms and smoke detectors will be installed according to Building Code and Fire Code requirements. These alarms will be set off during each evacuation drill. The program must provide appropriate signal devices for persons with disabilities who do not respond to the standard auditory alarms. All of these devices will be inspected and maintained in accordance with the requirements of the State Fire Marshal or local agency having jurisdiction.

(10) Sprinkler Systems. The program must install and maintain sprinkler systems compliant with the Building Code and maintained in accordance with rules adopted by the State Fire Marshal. The program must maintain an automated sprinkler system as follows:

(a) RTFs must have and maintain a sprinkler system regardless of the initial date of licensure;

(b) The Division recommends that RTHs, licensed prior to July 1, 2017 install and maintain sprinkler systems.

(c) A program licensed after July 1, 2017 must have and maintain a sprinkler system.

(11) First Aid Supplies. First aid supplies will be readily accessible to staff. All supplies will be properly labeled.

(12) Portable Heaters. Portable heaters are a recognized safety hazard and must not be used.

(13) Safety Program. The provider must develop and implement a safety program will be developed and implemented to identify and prevent the occurrence of hazards at the facility. Such hazards may include, but are not limited to, dangerous substances, sharp objects, unprotected electrical outlets, use of extension cords or other special plug-in adapters, slippery floors or stairs, exposed heating devices, broken glass, inadequate water temperatures, overstuffed furniture in smoking areas, unsafe ashtrays and ash disposal, and other potential fire hazards.

Stat. Auth.: ORS 413.042, 443.450
Stats. Implemented: ORS 413.032443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984 (Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0135

Sanitation

(1) Water Supply. The water supply in the facility will meet the requirements of the current rules of Health Services governing domestic water supplies.

(a) A municipal water supply will be utilized if available.

(b) When the facility is not served by an approved municipal water system, and the facility qualifies as a public water system according to OAR 333-061-0020(127), Oregon Health Services rules for public water systems, then the provider must comply with the OAR Chapter 333 rules of the Oregon Health Services pertaining to public water systems. These include requirements that the drinking water be tested for total coliform bacteria at least quarterly, and nitrate at least annually, and reported to Health Services. For adverse test results, these rules require that repeat samples and corrective action be taken to assure compliance with water quality standards, that public notice be given whenever a violation of the water quality standards occurs, and that records of

water testing be retained according to the Oregon Health Services requirements.

(2) Surfaces. All floors, walls, ceilings, windows, furniture, and equipment will be kept in good repair, clean, sanitary, neat and orderly.

(3) Plumbing Fixtures. Each bathtub, shower, lavatory, and toilet will be kept clean, in good repair and regularly sanitized.

(4) Disposal of Cleaning Waste Water. No kitchen sink, lavatory, bathtub, or shower will be used for the disposal of cleaning waste water.

(5) Soiled Laundry. Soiled linens and clothing will be stored in an area or container separate from kitchens, dining areas, clean linens, clothing, and food.

(6) Pest Control. All necessary measures will be taken to prevent rodents and insects from entering the setting. The provider must take appropriate action to eliminate rodents or insects.

(7) Grounds Maintenance. The grounds of the setting must be kept orderly and reasonably free of litter, unused articles, and refuse.

(8) Garbage Storage and Removal. Garbage and refuse receptacles will be clean, durable, watertight, insect and rodent proof, and will be kept covered with tight-fitting lids. All garbage and solid waste must be disposed of at least weekly and in compliance with the current rules of the Department of Environmental Quality.

(9) Sewage Disposal. All sewage and liquid wastes will be disposed of in a municipal sewage system where such facilities are available. If a municipal sewage system is not available, sewage and liquid wastes will be collected, treated, and disposed of in compliance with the current rules of the Department of Environmental Quality. Sewage lines, and septic tanks or other non-municipal sewage disposal systems where applicable, will be maintained in good working order.

(10) Biohazardous Waste. Biohazardous waste will be disposed of in compliance with the rules of the Department of Environmental Quality.

(11) Infection Control. Precautions will be taken to prevent the spread of infectious and/or communicable diseases as defined by the Centers for Disease Control and to minimize or eliminate exposure to known health hazards. In accordance with OAR 437, Division 2, Subdivision Z, Section 1910.1030 of the Oregon Occupational Safety and Health Code, staff will employ universal precautions whereby all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

(12) Infection Control for Pets and Other Household Animals. If pets or other household animals reside at a setting, sanitation practices will be implemented to prevent health hazards.

(a) Such animals must be vaccinated in accordance with the recommendations of a licensed veterinarian. Documentation of such vaccinations must be maintained on the premises.

(b) Animals not confined in enclosures will be under control and maintained in a manner that does not adversely impact individuals or others.

(c) No live animal will be kept or allowed in any portion of the setting where food is stored or prepared, except that aquariums and aviaries will be allowed if enclosed so as not to create a public health problem.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.455 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0140

Individual Furnishings

(1) Bedroom/Unit Furniture. The program must permit an individual to use the individual's own furniture within space limitations of the individual's unit. Otherwise, furniture will be provided or arranged for each individual, maintained in good repair and include:

(a) A bed, including a frame and a clean mattress and pillow;

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

(c) Locked storage for the individual's small, personal belongings. For programs initially licensed before June 1, 1998, this locked storage may be provided in a place other than the Individual's unit. The provider must provide the individual with a key or other method to gain access to his/her locked storage space.

(2) Linens. The program must provide linens will be provided for each individual and must include:

(a) Sheets, pillowcase, other bedding appropriate to the season and individual individual's comfort;

(b) Availability of a waterproof mattress or waterproof mattress cover; and

(c) Towels and washcloths.

(3) Personal Hygiene Items. The provider must assist each individual in obtaining personal hygiene items in accordance with individual needs. These must be stored in a clean and sanitary manner, and may be purchased with the individual's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, and menstrual supplies (if needed).

(4) Supplies Provided by Provider. Sufficient supplies of soap, shampoo and toilet paper for all individuals must be provided.

(5) Common Area Furniture. An adequate supply of furniture for individual use in living room, dining room and other common areas must be maintained in good condition.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0145

Admission to Program

(1) Provider Responsibility for Admission Process.

(a) The provider must specify in its admission policy and procedures will the program staff responsible for each component of the admission information-gathering and decision-making process. The program must allocate responsibilities to promote effective processing of referrals and admissions.

(b) The provider must develop and implement admission policies and procedures that support a prospective individual's right to pick and choose from available service settings.

(c) The provider must support the individual's right to select a program by assisting the person-centered service plan coordinator in identifying and documenting program options in the person-centered service plan including providing information regarding program services and rates.

(d) The provider may close admissions to the program when accepting an additional prospective individual would cause the program to exceed its reasonable waitlist. When admissions are closed, the provider is not required to accept referrals, conduct screenings, or evaluate admissions criteria as directed by these rules.

(2) Referrals. Unless limited by contractual agreement with the Division or other Division-approved party, the program may accept referrals from a variety of sources. Individuals whose services will be funded by the Division must be approved for placement by the CMHP or other local entity given responsibility for this function by contract with the Division, and/or approval of the Division.

(3) Release of Information. In accordance with ORS 179.505 and the 42 CFR, Part 2, the program must obtain an authorization for the release of information for disclosure for any confidential information concerning a prospective individual.

(4) Non-Discrimination. The program must consider an individual will be considered for admission without regard to race, color, sex or sexual orientation (except as may be limited by room arrangement), religion, creed, national origin, age (except under 18 years), familial status, marital status, source of income, or disability in addition to the mental or emotional disorder.

(5) Screening. Prior to accepting an individual for admission to the program, the program administrator must determine that the individual meets admission criteria.

(a) Opportunity for Screening. The provider must offer each individual referred for placement at the program an opportunity to participate in a screening interview prior to being accepted or denied placement at a program. The screening is intended to provide information about the program and the services available as well as to obtain information from the prospective individual, a relative and/or agencies currently providing services to the individual sufficient to determine eligibility for admission and service needs.

(b) Screening Information. The provider will receive screening packets for each individual referred for placement. At minimum, screening packets will include:

(A) Written documentation that the prospective individual has, or is suspected of having, a mental or emotional disorder;

(B) Background information including a mental health assessment, description of previous living arrangements, service history, behavioral issues and service needs;

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

(D) Copies of documents, or other documentation, relating to guardianship, conservatorship, commitment status, advance directives, or any other legal restrictions (as applicable);

(E) A copy of the prospective individual's most recent mental health treatment plan, or in the case of an emergency or crisis-respite admission, a summary of current mental health treatment involvement; and

(F) Documentation of the prospective individual's ability to evacuate the building consistent with the facility's designated evacuation capability and other concerns about potential safety risks.

(b) Requirements for Screenings. The provider must ensure that screenings comply with the following:

(A) The screening must be conducted at the prospective program setting unless;

(i) Travel arrangements cannot be made due to inclement weather; or

(ii) The individual, or the individual's representative, requests a phone screening or screening at the individual's current location.

(b) The provider must make contact with the referring agency for the purpose of scheduling a screening appointment within 48 hours of receipt of the referral packet;

(c) The provider must coordinate with the referring agency to schedule a screening appointment to occur within 14 calendar days from the date of receipt of the referral packet;

(d) The provider must provide the following to each individual referred for placement:

(i) Materials explaining conditions of residency;

(ii) Services available to individuals residing in the program; and

(iii) An opportunity to meet with a prospective roommate if the program uses a shared room model.

(e) The screening meeting must include the program administrator, the prospective individual and the individual's representative (as applicable). With the prospective individual's consent, the meeting may also include family member(s), other representative(s) as appropriate, representative(s) of relevant service-providing agencies, and others with an interest in the individual's admission.

(6) Crisis-Respite. In the case of an individual referred for emergency or crisis-respite admission, the information obtained may be less comprehensive than for regular admissions but must be sufficient to determine that the individual meets admission criteria and that the setting and program is appropriate considering the individual's needs. The program must document the reasons for incomplete information.

(7) Admission Criteria. Prior to admission, the provider must evaluate and determine whether a prospective individual is eligible for admission based on the following criteria:

(a) The individual must be assessed to have a mental or emotional disorder, or a suspected mental or emotional disorder;

(b) The individual must be at least 18 years of age;

(d) The individual must not require continuous nursing care, unless a reasonable plan to provide such care exists, the need for residential treatment supersedes the need for nursing care, and the Division approves the placement;

(e) The individual must have evacuation capability consistent with the setting's SR Occupancy classification; and

(f) The individual must meet additional criteria required or approved by the Division through contractual agreement or condition of licensing.

(7) Criteria for Denial of Admission. The provider may deny an individual admission to its program for the following reasons:

(a) Failure to meet admission criteria established by these rules;

(b) Inability to pay for services due to lack of presumed Medicaid eligibility or other funds;

(c) Documented instances of behaviors within the last 14 calendar days that would pose a reasonable and significant risk to the health, safety and wellbeing of another individual or another person should the individual be admitted;

(d) Lack of availability of necessary services required to maintain the health and safety of the individual (no nursing etc.) or lack of an opening at the setting; or

(e) Individual declines the offer for screening;

(8) Improper Denial of Admission. The program may not deny an individual admission to its program as follows:

(a) Prior to offering a face to face screening or other screening process as allowed by these rules; or

(b) Due to county of origin, responsibility or residency.

(9) Procedure for Admission Decisions. The provider's admission decision must be made as follows:

(a) The program's decision must be based on review of screening materials, information gathered during the face to face screening meeting, evaluation of the admission criteria;

(b) The program must inform the prospective individual and the individual's representative (as applicable) of the admission decisions within 72 hours of the screening meeting;

(c) When the program denies admission, the program must inform the prospective applicant, the individual's representative (as applicable), and the referring entity in writing of the basis for the decision and the individual's right to appeal the decision in accordance with OAR 309-035-0157;

(d) When the program approves admission, the program must inform the prospective applicant, the individual's representative (as applicable), and the referring entity through an acceptance notification that includes:

(A) When not waitlisted or 1st on the waitlist, an estimated date of admission;

(B) When waitlisted, the number on the waitlist.

(10) Management of waitlists.

(a) The program must establish admissions waitlists of reasonable length;

(b) The program must document actions taken in the management of their waitlist;

(b) The program must contact waitlisted individuals the individual's representative and the referring entity monthly to determine if the individual has been placed elsewhere;

(c) The program must prioritize admissions on a waitlist as follows:

(A) First Priority: The program must give first priority to those individuals under current civil commitment or under the jurisdiction of the Psychiatric Security Review Board seeking to transition from the Oregon State Hospital or other hospital level of care into the community;

(B) Second Priority. The program must give second priority for admission to individuals seeking admission to programs as an

alternative or to prevent civil commitment or placement at the Oregon State Hospital;

(c) The program must determine priority for admission based on the priorities described above and on a first-come first-served model. The program may not take into account the individual's county of origin, responsibility or residency;

(d) Within 72 hours of a provider learning of a pending opening, the program must notify the first individual on the waitlist, the individual's representative, and the referring entity of the expected opening. The individual must respond within three business days of the provider's notification. If any of the following occurs, the program may offer the opening to the next individual on the wait list: (1) the program receives no response from the individual, the individual's representative, or the referring entity with three business days; (2) the individual will not be ready to transition into the program within one week; or (3) the individual no longer desires placement at the program.

(11) Informed Consent for Services. The program must obtain informed consent for services from the individual or the individual's legal representative (as applicable), prior to admission to the program, unless the individual's ability to consent is legally restricted.

(12) Orientation. Upon admission, the program administrator must provide and document an orientation to each new individual that includes, but is not limited to:

- (a) A complete tour of the setting;
- (b) Introductions to other individuals and program staff;
- (c) Discussion of house rules;
- (d) Explanation of the laundry and food service schedule and policies;
- (e) Review of individuals rights;
- (f) Review of grievance procedures;
- (g) Completion of a residency agreement congruent with this rule;
- (h) Discussion of the conditions under which residency would be terminated;
- (i) General description of available services and activities;
- (j) Review of advance directives will be explained. If the individual does not already have any advance directive(s), the program must provide an opportunity to complete advanced directive(s);
- (k) Emergency procedures in accordance with OAR 309-035-0130(2).
- (l) Review of the person centered planning process;
- (m) Review of the process for imposing individually based limitations on certain program obligations to the individual.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85;

MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05;

MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0146

Residency Agreement

This rule becomes effective July 1, 2016 and enforceable as described in OAR 309-035-0110(17).

(1) The provider must enter into a written residency agreement with each individual or the individual's representative, admitted to the program consistent with the following procedures:

(a) The written residency agreement must be signed by the program administrator and the individual, or the individual's representative, prior to or at the time of admission;

(b) The provider must provide a copy of the signed agreement to the individual, or the individual's representative, and the provider must retain the original signed agreement within the individual's service record;

(c) The provider must give written notice to an individual, or the individual's representative (as applicable), at least 30 calendar days prior to any general rate increases, additions, or other modifications of the rates; and

(d) Updates to Residency Agreements: The provider must update residency agreements at least annually and also when social

security rates change or an individual's finances change such that the amount paid for room and board changes.

(2) The residency agreement must include, but is not be limited to, the following terms:

(a) Room and Board. The residency agreement must include the room and board agreement including the room and board rate describing the estimated public and private pay portions of the rate.

(A) Where an individual's social security or other funding is not active at the time of admission to the program, the program must prepare the room and board agreement based upon the estimated benefit to be received by the individual; and

(B) If, when funding is later activated, actual income of the individual varies from the estimated income noted on the residency agreement, the agreement must be updated and resigned by all the applicable parties.

(b) Services and supports to be provided in exchange for payment of the room and board rate;

(c) Conditions under which the program may change the rates;

(d) The provider's refund policy in instances of an individual's hospitalization, death, transfer to a nursing facility or other care facility, and voluntary or involuntary move from the program;

(e) A statement indicating that the individual is not liable for damages considered normal wear and tear;

(f) The program's policies on voluntary moves and whether written notification of a non-Medicaid individual's intent to not return is required;

(g) The potential reasons for involuntary termination of residency in compliance with this rule and individual's rights regarding the eviction and appeal process as described in OAR 309-035-0150(3);

(h) Any policies the program may have on the presence and use of alcohol, cannabis, and illegal drugs of abuse;

(i) Policy regarding tobacco smoking in compliance with the Tobacco Freedom Policy established by the Division;

(j) Policy addressing pet and service animals. The program may not restrict animals that provide assistance or perform tasks for the benefit of a person with a disability. Such animals are often referred to as services animals, assistance animals, support animals, therapy animals, companion animals, or emotional support animals.

(k) Policy regarding the presence and use of legal medical and recreational marijuana at the setting;

(l) Schedule of meal times. The provider may not schedule meals with more than a fourteen (14)-hour span between the evening meal and the following morning's meal (OAR 411-050-0645);

(m) Policy regarding refunds for residents eligible for Medicaid services, including pro-rating partial months and if the room and board payment is refundable;

(n) Any house rules or social covenants required by the program which may be included in the document or as an addendum;

(o) Statement informing the individual of the freedoms authorized by 42 CFR 441.301(c)(2)(xiii) & 42 CFR 441.530(a)(1)(vi)(F), which must not be limited without the informed, written consent of the individual or the individuals legal representative, and include the right to:

(A) Live under a legally enforceable agreement with protections substantially equivalent to landlord/tenant laws;

(B) The freedom and support to access food at any time;

(C) To have visitors of the individual's choosing at any time;

(D) Have a lockable door in the individual's unit, which may be locked by the individual;

(E) Choose a roommate when sharing a unit;

(F) Furnish and decorate the individual's unit according to the Residency Agreement;

(G) The freedom and support to control the individual's schedule and activities; and

(H) Privacy in the individual's unit.

(3) The provider may not propose or enter into a residency agreement that:

(a) Charges or ask for application fees, refundable deposits, or non-refundable deposits;

(b) Includes any illegal or unenforceable provisions or ask or require an individual to waive any of the individual's rights or agree to waive the program's liability for negligence; or

(C) Conflicts with individual rights or these rules.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)

Hist.: MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0150

Termination of Residency

(1) Responsibility for Termination Process. Each program's termination policy and procedures must designate the program staff responsible for each step of the process for terminating residency. The provider must designate responsibilities will be organized and assigned to promote a fair and efficient termination process. Unless otherwise designated as a condition of licensing or in contract language approved by the Division, the program administrator will be responsible for initiating and coordinating termination proceedings. The provider must make reasonable efforts will be made to prevent unnecessary terminations by making reasonable accommodations within the program and setting.

(2) Voluntary Termination of Residency. A resident or guardian (as applicable) may terminate residency in a facility upon providing at least 30 days' notice. Upon mutual agreement between the administrator and the resident or guardian (as applicable), less than 30 days notice may be provided.

(3) Emergency Termination of Residency. If an individual's behavior poses a serious and immediate threat to the health or safety of others in or near the program or setting, the program administrator, after providing 24 hours written notice specifying the causes to the individual or an individual's representative (as applicable), may immediately terminate the residency. The notice will specify the individual's right to appeal the emergency termination decision in accordance with OAR 309-035-0157.

(4) Other Terminations of Residency. When other circumstances arise providing grounds for termination of residency, the under this subsection, the program administrator must discuss these grounds with the individual, the individual's representative (as applicable), and with the individual's permission, other persons with an interest in the individual's circumstances. If a decision is made to terminate residency, the program administrator must provide at least 30 days' written notice specifying the causes to the individual or the individual's legal or designated representative as applicable). This notice will also specify the individual's right to appeal the termination decision in accordance with OAR 309-035-0157. Upon mutual agreement between the program administrator and the individual's representative (as applicable), termination may occur with less than 30 days notice may be provided. The program must make reasonable efforts will be made to establish a reasonable termination date in consideration of both the program's needs and the individual's need to find alternative living arrangements. Grounds for termination include:

(a) Individual no longer needs or desires services provided by the program and/or expresses a desire to move to an alternative setting;

(b) Individual is assessed by a Licensed Medical Professional or other qualified health professional to require services, such as continuous nursing care or extended hospitalization, that are not available, or cannot be reasonably arranged, at the facility;

(c) Individual 's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others and these behavioral concerns cannot be adequately addressed with services available at the setting or services that can be arranged outside of the program or setting;

(d) The individual cannot safely evacuate the setting in accordance with the setting's SR Occupancy Classification after efforts described in OAR 309-035-0130(5)(b) have been taken;

(e) Nonpayment of fees in accordance with program's fee policy; and

(f) The individual continuously and knowingly violates house rules resulting in significant disturbance to others.

(5) Pre-termination Meeting. Except in the case of an emergency terminations or a crisis-respite individual, a pre-termination meeting will be held with the individual, the individual's representative (as applicable), and with the individual's permission, others interested in the individual's circumstances. The purpose of the meeting is to plan any arrangements necessitated by the termination decision. The meeting will be scheduled to occur at least two weeks prior to the termination date. In the event a pre-termination meeting is not held, the reason will be documented in the individual service record.

(6) Documentation. Documentation of discussions and meetings held concerning termination of residency and copies of notices will be maintained in the individual service record.

(7) Disposition of Personal Property. At the time of termination of residency, the individual will be given a statement of account, any balance of funds held by the program and all property held in trust or custody by the program.

(a) In the event of pending charges (such as long distance phone charges or damage assessments), the program may hold back the amount of funds anticipated to cover the pending charges. Within 30 days after residency is terminated or as soon as pending charges are confirmed, the program must provide the individual with a final financial statement along with any funds due to the individual.

(b) In the case of an individual's property left at the setting for longer than seven days after termination of residency, the program will make a reasonable attempt to contact the individual, or the individual's representative (as applicable). The program must allow the individual, or the individual's representative (as applicable) at least 15 days to make arrangements concerning the property. If the program determines that the individual has abandoned the property, the program may then dispose of the property. If the property is sold, proceeds of the sale, minus the amount of any expenses incurred and any amounts owed the program by or on behalf of the individual, will be forwarded to the individual or the individual's representative (as applicable).

(8) Crisis-respite Services. Because crisis-respite services are time-limited, the planned end of services will not be considered a termination of residency and subject to requirements in OAR 309-035-0150(2), (4) and (5). Upon admission to crisis-respite services, the individual or the individual's representative (as applicable) will be informed of the planned date for discontinuation of services. This date may be extended through mutual agreement between the program administrator and the individual or individual's representative (as applicable). A program providing crisis-respite services must implement policies and procedures that specify reasonable time frames and the grounds for discontinuing crisis-respite services earlier than the date planned.

(9) Absences without Notice. If an individual moves out of the setting without providing notice, or is absent without notice for more than seven consecutive days, the provider may terminate residency in the manner provided in ORS 105.105 to 105.168 after seven consecutive days of the individual's absence. The provider must make an attempt to contact the individual, or the individual's representative (as applicable) and/or other person interested in the individual's circumstances to confirm the individual's intent to discontinue residency.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0155

Individual Rights

(1) Statutory and Constitutional Rights. Each individual must be assured the same civil and human rights accorded to other citizens. These rights must be assured unless expressly limited by a court in the case of an individual who has been adjudicated incom-

petent and not restored to legal capacity. The rights described in paragraphs (2) and (3) of this section are in addition to, and do not limit, all other statutory and constitutional rights which are afforded to all citizens including, but not limited to, the right to vote, marry, have or not have children, own and dispose property, enter into contracts and execute documents.

(2) A provider must actively work to support and ensure each individual's rights described in this rule are not limited or infringed upon by the provider except where expressly allowed under these rules.

(3) Rights of Individuals. In accordance with ORS 430.210, an individual had the right to:

(a) Choose from available services those which are appropriate, consistent with the plan developed in accordance with paragraphs (b) and (c) of this subsection, and provided in a setting and under conditions that are least restrictive to the person's liberty, that are least intrusive to the person and that provide for the greatest degree of independence;

(b) An individualized written service plan, services based upon that plan and periodic review and reassessment of service needs;

(c) Ongoing participation in planning services in a manner appropriate to the person's capabilities, including the right to participate in the development and periodic revision of the plan described in paragraph (b) of this subsection, and the right to be provided with a reasonable explanation of all service considerations;

(d) Not receive services without informed consent except in a medical emergency or as otherwise permitted by law;

(e) Not participate in experimentation without informed voluntary written consent;

(f) Receive medication only for the individual's clinical needs;

(g) Not be involuntarily terminated or transferred from services without prior notice, notification of available sources of necessary continued services and exercise of a grievance procedure;

(h) A humane service environment that affords reasonable protection from harm and affords reasonable privacy;

(i) Be free from abuse or neglect and to report any incident of abuse without being subject to retaliation;

(j) Religious freedom;

(k) Not be required to perform labor, except personal house-keeping duties, without reasonable and lawful compensation;

(l) Visit with family members, friends, advocates and legal and medical professionals;

(m) Exercise all rights set forth in ORS 426.385 and 427.031 if the individual is committed to the Division;

(n) Be informed at the start of services and periodically thereafter of the rights guaranteed by this section and the procedure for reporting abuse, and to have these rights and procedures prominently posted in a location readily accessible to the individual and made available to the individual's guardian and any representative designated by the individual;

(o) Assert grievances with respect to infringement of the rights described in this section, including the right to have such grievances considered in a fair, timely and impartial grievance procedure;

(p) Have access to and communicate privately with any public or private rights protection program or rights advocate; and

(q) Exercise all rights described in this section without any form of reprisal or punishment.

(4) Additional Rights. An individual also has a right to:

(a) Adequate food, shelter and clothing, consistent with OAR 309-035-0159;

(b) A reasonable accommodation if, due to their disability, the housing and services are not sufficiently accessible;

(c) Confidential communication, including receiving and opening personal mail, private visits with family members and other guests, and access to a telephone with privacy for making and receiving telephone calls;

(d) Express sexuality in a socially appropriate and consensual manner;

(e) Access to community resources including recreation, religious services, agency services, employment and day programs, unless such access is legally restricted;

(f) Be free from seclusion and restraint, except as outlined in OAR 309-035-0167.

(g) To review the program's policies and procedures; and

(h) Not participate in research without informed voluntary written consent.

(5) HCBS Rights. An individual also has the following rights:

(a) Live under a legally enforceable residency agreement in compliance with protections substantially equivalent to landlord/tenant laws as described in this rule;

(b) Have visitors of the individual's choosing at any time and the freedom to visit with guests within the common areas of the setting and the individual's unit;

(c) The freedom and support to control the individual's own schedule and activities including but not limited to: Accessing the community without restriction;

(d) Have a lockable door in the individual's unit, which may be locked by the individual and only appropriate program staff have a key to access the unit;

(e) A choice of roommates when sharing a unit;

(f) Furnish and decorate the individual's unit according to the Residency Agreement; and

(g) The freedom and support to have access to food at any time;

(h) Privacy in the individual's unit.

(i) Section (5) of these rules and its subsections are effective July 1, 2016 and enforceable as described in OAR 309-035-0110(17).

(6) An SRTF is not required to maintain the qualities or obligations identified in subsections (b), (c), (d), (e), (h) of section 5 of this rule. The provider is not required to seek an individually based limitation to comply with these rules.

(7) A provider is not required to comply with section (5)(a) of this rule when providing an individual with crisis respite services. The provider is not required to seek an individually based limitation for such an individual to comply with these rules.

(8) The Individual's Right to Fresh Air. For the purpose of this rule, these terms have the following meanings:

(a) "Fresh air" means the inflow of air from outside the facility where the individual is receiving services. "Fresh air" may be accessed through an open window or similar method as well as through access to the outdoors.

(b) "Outdoors" means an area with fresh air that is not completely enclosed overhead. "Outdoors" may include a courtyard or similar area.

(c) If an individual requests access to fresh air and the outdoors or the individual's treating health care provider determines that fresh air or the outdoors would be beneficial to the individual, the program in which the individual is receiving services shall provide daily access to fresh air and the outdoors unless this access would create a significant risk of harm to the individual or others.

(d) The determination whether a significant risk of harm to the individual or others exists shall be made by the individual's treating health care provider. The treating health care provider may find that a significant risk of harm to the individual or others exists if:

(A) The individual's individual circumstances and condition indicate an unreasonable risk of harm to the individual or others which cannot be reasonably accommodated within existing programming should the individual be allowed access to fresh air and the outdoors; or

(B) The program's existing physical setting or existing staffing prevents the provision of access to fresh air and the outdoors in a manner that maintains the safety of the individual or others.

(e) If a provider determines that its existing physical setting prevents the provision of access to fresh air and the outdoors in a safe manner, the provider shall make a good faith effort at the time

of any significant renovation to the physical setting that involves renovation of the unit or relocation of where individual are treated to include changes to the physical setting or location that allow access to fresh air and the outdoors, so long as such changes do not add an unreasonable amount to the cost of the renovation.

(5) Program Requirements. The program must have and implement written policies and procedures which protect individuals' rights, and encourage and assist individuals to understand and exercise their rights. The program must post a listing of individual rights under these rules in a place readily accessible to all individual s and visitors.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.455 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 5-2009, f. & cert. ef. 12-17-09; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0157

Individual Grievances and Appeals

(1) Procedures. The provider must develop and implement a written policy and procedures concerning the individual grievance and appeal process. A copy of the grievance and appeal process will be posted in a place readily accessible to individuals. A copy of the grievance and appeal process will be provided to each individual and guardian (as applicable) at the time of admission to the program.

(2) Grievances. A provider's process for grievances must, at a minimum, include the following:

(a) Individuals will be encouraged to informally resolve complaints through discussion with program staff.

(b) If the individual is not satisfied with the informal process or does not wish to use it, the individual may proceed as follows:

(A) The individual may submit a complaint in writing to the Program Administrator. The individual may receive assistance in submitting the complaint from any person whom the individual chooses. If requested by the individual, program staff will be available to assist the individual.

(B) The written complaint will go directly to the program administrator without being read by other program staff, unless the individual requests or permits other program staff to read the complaint.

(C) The complaint will include the reasons for the grievance and the proposed resolutions. No complaint will be disregarded because it is incomplete.

(D) Within five days of receipt of the complaint, the individual, the program administrator must meet with the individual to discuss the complaint. The individual may have an advocate or other person of his/her choosing present for this discussion.

(E) Within five days of meeting with the individual, the program administrator must provide a written decision to the individual. As part of the written decision, the program administrator will provide information about the appeal process.

(F) In circumstances where the matter of the complaint is likely to cause irreparable harm to a substantial right of the individual before the grievance procedures outlined in OAR 309-035-0157(2)(b)(D) and (E) are completed, the individual may request an expedited review. The program administrator will review and respond in writing to the grievance within 48 hours. The written decision will include information about the appeal process.

(3) Appeals. An individual, an individual's legal representative (as applicable) and a prospective individual (as applicable) will have the right to appeal admission, termination and grievance decisions as follows:

(a) If the individual is not satisfied with the decision, the individual may file an appeal in writing within ten days of the date of the program administrator's decision to the complaint or notification of admission denial or termination (as applicable).

(b) If program services are delivered by a person or entity other than the Division, the appeal will be submitted to the CMHP Director or designee in the county where the program is located.

(A) The individual may receive assistance in submitting the appeal. If requested by the individual, program staff will be available to assist the individual.

(B) The CMHP Director or designee will provide a written decision within ten days of receiving the appeal.

(C) If the individual is not satisfied with the CMHP Director's decision, the individual may file a second appeal in writing within ten days of the date of the CMHP Director's written decision to the Deputy Director of the Division or designee. The decision of the Deputy Director of the Division will be final.

(c) If program services are delivered by the Division, the appeal will be submitted to the Deputy Assistant Director or designee.

(A) The individual may receive assistance in submitting the appeal. If requested by the individual, program staff will be available to assist the individual.

(B) The Deputy Director or designee will review and approve or deny the appeal.

(C) The Division will notify the individual of the decision in writing within 10 days after receipt of the appeal.

(D) If the individual is not satisfied with the Deputy Assistant Director's or designee's decision, the individual may submit a second appeal in writing within ten days of the date of the written decision to the Assistant Director of the Division. The decision of the Assistant Director of the Division will be final.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)

Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0159

Individual Assessment and Residential Service Plan

(1) Assessment. The program must complete an assessment for each individual within 14 days after admission to the program, unless admitted to the program for crisis-respite services.

(a) The assessment must be based upon an interview with the individual to identify strengths, preferences and service needs; observation of the individual's capabilities within the residential setting; a review of information in the individual service record; and contact with representatives of other involved agencies, family members and others, as appropriate. All contacts with others will be made with proper authorization for the release of information.

(b) Assessment findings must be summarized in writing and included in the individual service record. Assessment findings must include, but not be limited to, diagnostic and demographic data; identification of the individual's medical, physical, emotional, behavioral and social strengths, preferences and needs related to independent living and community functioning; and recommendations for residential service plan goals.

(c) The provider must provide assessment findings to the person centered service plan coordinator to assist in the development of the person centered service plan.

(2) Person centered service plan assessment. Within 30 days of the date of admission the person centered service plan coordinator, under contract with the Division, and assigned to the individual or program site will schedule and conduct an assessment of the individual for the purpose of developing a Person Centered Service Plan. The provider must support the person centered service plan coordinator efforts to develop the plan and provide information as necessary.

(3) Residential Service Plan. The provider must develop and implement an individualized plan, for the purpose of implementing and documenting the provision of services as well as any individualized limitations contained within the Person Centered Service Plan, identifying the goals to be accomplished through the services provided, will be prepared for each individual, unless admitted to the facility for crisis-respite services, within 30 days after admission.

(a) The residential service plan must be based upon the findings of the individual assessment, be developed with participation of individual and the individual's representative (as applicable),

and be developed through collaboration with the individual's primary mental health treatment provider. With consent of the individual or the individual's representative (as applicable), family members, representatives from involved agencies, and others with an interest in the individual's circumstances must be invited to participate. All contacts with others will be made with proper, prior authorization from the individual.

(b) The residential service plan must include the following:

(A) Set out necessary steps and actions of the provider for the implementation and provision of services consistent and as required by the Person Centered Service Plan;

(B) Identify the individual's service needs, desired outcomes and service strategies to address the following: physical and medical needs, medication regimen, self-care, social-emotional adjustment, behavioral concerns, independent living capability and community navigation, all areas identified in the Person Centered Service Plan, and any other areas.

(c) The residential service plan must be signed by the individual, the individual's representative (as applicable), the program administrator or other designated program staff person, and others, as appropriate, to indicate mutual agreement with the course of services outlined in the plan.

(d) The provider must attach the Residential Service Plan to the Person Centered Service Plan as an addendum.

(4) Crisis-respite Assessment and Residential Service Plan Requirements. For an individual admitted to a program for 30 days or less for the purpose of receiving crisis-respite services, an assessment and residential service plan must be developed within 48 hours of admission which identifies service needs, desired outcomes and the service strategies to be implemented to resolve the crisis or address other needs of the individual that resulted in the short term service arrangement.

(5) Progress Notes. The provider must maintain progress notes within each individual's service record and documenting significant information relating to all aspects of the individual's functioning and progress toward desired outcomes identified in the residential service plan. The provider must enter a progress note will be entered in the individual's record at least once each month.

(6) Re-assessments and Revisions to the Residential Service Plan. The provider must review and update the assessment and residential service plan will be reviewed and updated at least annually. On an ongoing basis, the provider must update the residential service plan will be updated, as necessary, based upon changing circumstances or upon the individual's request for reconsideration.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.455 & 443.991(2)

Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0160

Person-Centered Service Plan

This rule becomes effective July 1, 2016 and enforceable as described in OAR 309-035-0110(17).

(1) PERSON-CENTERED SERVICE PLANNING PROCESS.

When developed as described in subsections (2) and (3), a Person-Centered Service Plan must be developed through a person-centered service planning process. The person-centered service planning process:

(a) Is driven by the individual;

(b) Includes people chosen by the individual;

(c) Provides necessary information and supports to ensure the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions;

(d) Is timely, responsive to changing needs, occurs at times and locations convenient to the individual, and is reviewed at least annually;

(e) Reflects the cultural considerations of the individual;

(f) Uses language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual and, as applicable, the individual's representative;

(g) Includes strategies for resolving disagreement within the process, including clear conflict of interest guidelines for all planning participants, such as:

(A) Discussing the concerns of the individual and determining acceptable solutions;

(B) Supporting the individual in arranging and conducting a person-centered service planning meeting;

(C) Utilizing any available greater community conflict resolution resources;

(D) Referring concerns to the Office of the Long-Term Care Ombudsman; or

(E) For Medicaid recipients, following existing, program-specific grievance processes.

(h) Offers choices to the individual regarding the services and supports the individual receives, and from whom, and records the alternative HCB settings considered by the individual;

(i) Provides a method for the individual or, as applicable, the individual's representative, to request updates to the person-centered service plan, as needed;

(j) Is conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare;

(k) Identifies the strengths and preferences, service and support needs, goals, and desired outcomes of the individual;

(l) Includes any services that are self-directed, if applicable;

(m) Includes, but is not limited to, individually identified goals and preferences related to relationships, greater community participation, employment, income and savings, healthcare and wellness, and education;

(n) Includes risk factors and plans to minimize any identified risk factors; and

(o) Results in a Person-Centered Service Plan documented by the Person-Centered Services Plan Coordinator, signed by the individual or, as applicable, the individual's representative, participants in the person-centered service planning process, and all persons responsible for the implementation of the person-centered service plan. The person-centered service plan is distributed to the individual, and, as applicable, the individual's representative, and other people involved in the person-centered service plan.

(2) PERSON-CENTERED SERVICE PLANS.

(a) To avoid conflict of interest, the person-centered service plan may not be developed by the provider for individuals receiving Medicaid. The Division may grant an exception where it has determined that the provider is the only willing and qualified entity to provide case management and develop the person-centered service plan.

(b) Where the provider is responsible for developing the person-centered service plan, the provider must ensure that the plan includes the following:

(A) HCBS and setting options based on the needs and preferences of the individual, and for residential settings, the available resources of the individual for room and board;

(B) The HCBS and settings are chosen by the individual and are integrated in, and support full access to, the greater community;

(C) Opportunities to seek employment and work in competitive integrated employment settings for those individuals who desire to work. If the individual wishes to pursue employment, a non-disability specific setting option must be presented and documented in the person-centered service plan;

(D) Opportunities to engage in greater community life, control personal resources, and receive services in the greater community to the same degree of access as people not receiving HCBS;

(E) The strengths and preferences of the individual;

(F) The service and support needs of the individual;

(G) The goals and desired outcomes of the individual;

(H) The providers of services and supports, including unpaid supports provided voluntarily;

(I) Risk factors and measures in place to minimize risk;

(J) Individualized backup plans and strategies, when needed;

(K) People who are important in supporting the individual;

(L) The person responsible for monitoring the person-centered service plan;

(M) Language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual receiving services and, as applicable, the individual's representative;

(N) The written informed consent of the individual or, as applicable, the individual's representative;

(O) Signatures of the individual or, as applicable, the individual's representative, participants in the person-centered service planning process, and all persons and entities responsible for the implementation of the person-centered service plan as described below in subsection (2)(f) of this section;

(P) Self-directed supports; and

(Q) Provisions to prevent unnecessary or inappropriate services and supports.

(c) Where the provider is not responsible for the developing the person-centered service plan but provides or will provide services to the individual, the provider must provide relevant information and provide necessary support for the person-centered service plan coordinator or other person developing the plan to fulfill the characteristics described in part (b) of this subsection.

(d) The individual or, as applicable, the individual's representative, decides on the level of information in the person-centered service plan that is shared with providers. To effectively provide services, providers must have access to the portion of the person-centered service plan that the provider is responsible for implementing.

(e) The person-centered service plan is distributed to the individual and, as applicable, the individual's representative, and other people involved in the person-centered service plan as described below in subsection (2)(f) of this section.

(f) The person-centered service plan must justify and document any individually-based limitation to be applied as described in 309-035-0161 when conditions under 309-035-0161(2) may not be met due to threats to the health and safety of the individual or others.

(g) The person-centered service plan must be reviewed and revised:

(A) At the request of the individual or, as applicable, the individual's representative;

(B) When the circumstances or needs of the individual change; or

(C) Upon reassessment of functional needs as required every 12 months.

(3) Crisis Respite Individuals. Because it may not be possible to assemble complete records and develop a person-centered service plan during the crisis-respite individual's short stay, the provider is not required to develop a person-centered service plan under these rules, but must, at a minimum, develop an assessment and residential service plan as required by OAR 309-035-0159(4) to identify service needs, desired outcomes, and service strategies to resolve the crisis or address the individual's other needs that caused the need for crisis-respite services. In addition, the provider must provide relevant information and provide necessary support for the person-centered service plan coordinator as described in section (2)(b) of this rule.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.455 & 443.991(2)

Hist.: MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0161

Individually-Based Limitations

This rule becomes effective on July 1, 2016 and enforceable as described in OAR 309-035-0110(17).

(1) When the program qualities described below create a threat to the health and safety of an individual or others, a provider may seek to apply an individually-based limitation through the process described in this rule. The program qualities subject to a potential individually-based limitation include the individual's right to:

(a) The freedom and support to access food at any time;

(b) Have visitors of the individual's choosing at any time;

(c) Have a unit entrance door that is lockable by the individual with only appropriate staff having access;

(d) Choose a roommate when sharing a unit;

(e) Furnish and decorate the individual's unit as agreed to in the Residency Agreement;

(f) The freedom and support to control the individual's schedule and activities; and

(g) Privacy in the individual's unit.

(2) Minimum Requirements for Applying Individually-Based Limitation: A provider may only apply an individually-based limitation if:

(a) The program quality threatens the health or safety of the individual or others;

(b) The individually-based limitation is supported by a specific assessed need;

(d) The individual or the individual's legal representative consents;

(e) The limitation is directly proportionate to the specific assessed need and

(f) The individually-based limitation will not cause harm to the individual.

(3) The provider must demonstrate and document that the individually-based limitation meets the requirements of subsection (2) of this rule and the measures described below in the person centered service plan. The provider must submit and sign a program-created form that includes the following:

(a) The specific and individualized assessed need justifying the individually-based limitation;

(b) The positive interventions and supports used prior to consideration of any individually-based limitation;

(c) Documentation that the provider or other entities have tried other less intrusive methods but did not work;

(d) A clear description of the limitation that is directly proportionate to the specific assessed need;

(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation;

(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary;

(g) The informed consent of the individual or, as applicable, the individual's legal representative, including any discrepancy between the wishes of the individual and the consent of the legal representative; and

(h) An assurance that the interventions and support do not cause harm to the individual.

(4) The provider must:

(a) Maintain a copy of the completed and signed form documenting the consent to the individually-based limitation described in subsection (3) of this rule. The form must be signed by the individual, or, if applicable, the individual's legal representative;

(b) Regularly collect and review the ongoing effectiveness of and the continued need for the individually-based limitation; and

(c) Request review of the individually-based limitation by the Person-Centered Service Plan Coordinator when a new individually-based limitation is indicated, or change or removal of an individually-based limitation is needed, but no less than annually.

(5) The qualities described in sections (1)(b)-(g) do not apply to an individual receiving services at a SRTF, including but not limited to, an individual receiving crisis-respite services in a secure residential setting. A provider need not seek an individually based limitation to comply with these rules.

(6) The qualities described in sections (1)(d) and (g) do not apply to an individual receiving crisis-respite services and a provider need not seek an individually based limitation to comply with these rules.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.455 & 443.991(2)

Hist.: MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0165

Individual Services and Activities

(1) General Requirements. The provider must make services and activities available at the program will include care and treatment consistent with ORS 443.400 and those services individually specified for the individual in the residential service plan developed as outlined in OAR 309-035-0159 and 309-035-0160. The provider must encourage individuals to care for their own needs to the extent possible. The provider will provide all services and activities will be provided in a manner that respects residents' rights, promotes recovery and affords personal dignity.

(2) Services and Activities to Be Available. Services and activities to be available will include but not be limited to:

- (a) Provision of adequate shelter consistent with OAR 309-035-0125 through 309-035-0140;
- (b) At least three meals per day, seven days per week, provided in accordance with OAR 309-035-0170;
- (c) Assistance and support, as necessary, to enable individuals to meet personal hygiene and clothing needs;
- (d) Laundry services, which may include access to washer(s) and dryer(s) so individuals can do their own personal laundry;
- (e) Housekeeping essential to the health and comfort of individuals;
- (f) Activities and opportunities for socialization and recreation both within the setting and in the larger community;
- (g) Health-related services provided in accordance with OAR 309-035-0175;
- (h) Assistance with community navigation and transportation arrangements;
- (i) Assistance with money management, where requested by an individual, to include accurate documentation of all funds deposited and withdrawn when funds are held in trust for the individual;
- (j) Assistance with acquiring skills to live as independently as possible;
- (k) Assistance with accessing other additional services, as needed; and
- (l) Any additional services required under contract the Division.

Stat. Auth.: ORS 413.042, 443.450
 Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)
 Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0167

Use of Seclusion or Restraints

(1) General Prohibition. The use of seclusion or restraints is prohibited, except in SRTFs with the Division's approval.

(2) Approval of Use in Secure Residential Treatment Facilities. A SRTF provider or applicant may submit an application to the Division for approval to use seclusion or restraints pursuant to OAR 309-033-0700 through 309-033-0740. Approval by the Division will be based upon the following:

- (a) A determination that the individuals served, or proposed to be served, have a history of behavioral concerns involving threats to the safety and well-being of themselves or others;
- (b) The applicant demonstrates that the availability of seclusion or restraints is necessary to safely accommodate individuals who would otherwise be unable to experience a community residential program; and
- (c) The applicant demonstrates an ability to comply with OAR 309-033-0700 through 309-033-0740 and 309-033-0500 through 309-033-0560. These rules include special requirements for staffing, training, reporting, policies and procedures, and the setting's physical environment.

(3) Conditions of Use. Seclusion or restraints may only be used in an approved SRTF when an emergency occurs in accordance with OAR 309-033-0700 through 309-033-0740 and 309-033-0500 through 309-033-0560. In such emergency situations, seclusion and restraint will be used as a last resort behavior management

option after less restrictive behavior management interventions have failed, or in the case of an unanticipated behavioral outburst, to ensure safety within the program. An approved SRTF must implement policies and procedures approved by the Division outlining the circumstances under which seclusion or restraints may be used and the preventive measures to be taken before such use. All incidents involving the use of seclusion or restraints will be reported to the Division. To use seclusion or restraints with an individual who is not in state custody under a civil commitment proceedings, the individual must be placed on a hold.

Stat. Auth.: ORS 413.042, 443.450
 Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)
 Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0170

Food Services

(1) Well-balanced Diet. The provider must plan and serve meals in accordance with the recommended dietary allowances found in the United States Department of Agriculture Food Guide Pyramid.

(2) Modified or Special Diets. The provider must obtain an order from a LMP will be obtained for each individual who, for health reasons, is on a modified or special diet. The provider must plan such diets in consultation with the individual.

(3) The provider must support the individual's right to access food at any time. The provider may only apply an individually-based limitation where the circumstances meet, and the provider complies with, the standards and requirements of OAR 309-035-0161. This subsection is effective July 1, 2016 and enforceable as described in OAR 309-035-0110(17).

(4) If an individual misses a meal at a scheduled time, the provider must make an alternative meal available.

(5) Menus. The provider must prepare menus at least one week in advance and will provide a sufficient variety of foods served in adequate amounts for each individual at each meal and adjusted for seasonal changes. The provider must file and maintain records of menus, as served, will be filed and maintained in the facility for at least 30 days. The provider must consider individual preferences and requests will be considered in menu planning. The provider must reasonably accommodate religious and vegetarian preferences will be reasonably accommodated.

(6) Supply of Food. The provider must maintain adequate supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days will be maintained at the setting.

(7) Sanitation. The provider must store, prepare and serve food will in accordance with Health Services Food Sanitation Rules.

Stat. Auth.: ORS 413.042, 443.450
 Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)
 Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0175

Health Services

(1) General. The program administrator must ensure that all individuals are offered medical attention when needed. The provider must arrange for health services will be made with the informed consent of the individual or the individual's representative (as applicable). The program must arrange for physicians or other qualified health care professionals to be available in the event the individual's regular physician or other health care professional is unavailable. The provider must identify a hospital emergency room that may be used in case of emergency.

(2) Initial Health Screening. The provider must ensure that each individual admitted to the program will be screened by a LMP or other qualified health care professional to identify health problems and to screen for communicable disease. The provider must maintain documentation of the initial health screening will be placed in the individual service record.

(a) The health screening must include a brief history of health conditions, current physical condition and a written record of current or recommended medications, treatments, dietary specifications and aids to physical functioning.

(b) For regular admissions, the health screening will be obtained prior to the individual's admission and include the results of testing for tuberculosis and Hepatitis B.

(c) For emergency admissions, including crisis-respite admissions, the health screening will be obtained as follows:

(A) For individuals experiencing psychiatric or medical distress, a health screening will be completed by a LMP or other qualified health care professional prior to the individual's admission or within 24 hours of the emergency placement. The health screening will confirm that the individual does not have health conditions requiring continuous nursing care, a hospital level of care, or immediate medical assistance. For each crisis-respite individual who continues in the program for more than seven consecutive days, a complete health examination will be arranged if any symptoms of a health concern exist.

(B) For other individuals who are admitted on an urgent basis due to a lack of alternative supportive housing, the health screening will be obtained within 72 hours after the individual's admission.

(C) The health screening criteria may be waived for individuals admitted for crisis-respite services who are under the active care of an LMP or other qualified health care professional if it is the opinion of the attending health care professional that the crisis-respite placement presents no health risk to the individual or other individuals in the program. Such a waiver must be provided in writing and be signed and dated by the attending health care professional within 24 hours of the individual's admission.

(3) Regular Health Examinations. Except for crisis-respite individuals, the program will ensure that each individual has a primary physician or other qualified health care professional who is responsible for monitoring his/her health care. Regular health examinations will be done in accordance with the recommendations of this primary health care professional, but not less than once every three years. Newly admitted individuals will have a health examination completed within one year prior to admission or within three months after admission. Documentation of findings from each examination will be placed in the individual's service record.

(4) Written Orders for Special Needs. A written order, signed by a physician or other qualified health care professional, is required for any medical treatment, special diet for health reasons, aid to physical functioning or limitation of activity.

(5) Medications. A written order signed by a physician or other qualified health care professional is required for all medications administered or supervised by program staff. This written order is required before any medication is provided to an individual. Medication will not be used for the convenience of staff or as a substitute for programming. Medications will not be withheld or used as reinforcement or punishment, or in quantities that are excessive in relation to the amount needed to attain the client's best possible functioning.

(a) Medications will be self-administered by the individual if the individual demonstrates the ability to self-administer medications in a safe and reliable manner. In the case of self-administration, both the written orders of the prescriber and the residential service plan will document that medications will be self-administered. The self-administration of medications may be supervised by program staff who may prompt the individual to administer the medication and observe the fact of administration and dosage taken. When supervision occurs, program staff will enter information in the individual's record consistent with section (5)(h) below.

(b) Program staff who assist with administration of medication will be trained by a Licensed Medical Professional on the use and effects of commonly used medications.

(c) Medications prescribed for one individual will not be administered to, or self-administered by, another individual.

(d) The program may not maintain stock supplies of prescription medications. The facility may maintain a stock supply of non-prescription medications.

(e) The program must develop and implement a policy and procedure which assures that all orders for prescription drugs are reviewed by a qualified health care professional, as specified by a physician or other qualified health care professional but not less often than every six months. Where this review identifies a contraindication or other concern, the individual's primary physician, LMP or other primary health care professional will be immediately notified. Each individual receiving psychotropic medications will be evaluated at least every three months by the LMP prescribing the medication, who must note, for the individual's record, the results of the evaluation and any changes in the type and dosage of medication, the condition for which it is prescribed, when and how the medication is to be administered, common side effects (including any signs of tardive dyskinesia, contraindications or possible allergic reactions), and what to do in case of a missed dose or other dosing error.

(f) The provider must dispose of all unused, discontinued, outdated or recalled medications, and any medication containers with worn, illegible or missing labels. The provider must dispose medications in a safe method, consistent with any applicable federal statutes, and designed to prevent diversion of these substances to persons for whom they were not prescribed. The provider must maintain a written record of all disposals will be maintained and specifying the date of disposal, a description of the medication, its dosage potency, amount disposed, the name of the individual for whom the medication was prescribed, the reason for disposal, the method of disposal, and the signature of the program staff person disposing the medication. For any medication classified as a controlled substance in schedules 1 through 5 of the Federal Controlled Substance Act, the disposal must be witnessed by a second staff person who documents her or his observation by signing the disposal record.

(g) The provider must properly and securely store all medications in a locked space for medications only in accordance with the instructions provided by the prescriber or pharmacy. Medications for all individuals must be labeled. Medications requiring refrigeration must be stored in an enclosed locked container within the refrigerator. The provider must ensure that individuals have access to a locked, secure storage space for their self-administered medications. The program will note in its written policy and procedures which persons have access to this locked storage and under what conditions.

(h) For all individuals taking prescribed medication, the provider must record in the medical record each type, date, time and dose of medication provided. All effects, adverse reactions and medications errors will be documented in the individual's service record. All errors, adverse reactions or refusals of medication will be reported to the prescribing professional within 48 hours.

(i) P.r.n. medications and treatments will only be administered in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

(6) Delegation of Nursing Tasks. Nursing tasks may be delegated by a Registered Nurse to direct care staff within the limitations of their classification and only in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.455 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0185

Civil Penalties

(1) Applicability of Long Term Care Statute. For purposes of imposing civil penalties, programs licensed under ORS 443.400 to 443.455 and subsection (2) of ORS 443.991 are considered to be long-term care facilities subject to ORS 441.705 to 441.745.

(2) Sections of Rule Subject to Civil Penalties. Violations of any requirement within any part of the following sections of the rule may result in a civil penalty:

- (a) 309-035-0110;
- (b) 309-035-0113;
- (c) 309-035-0115;
- (d) 309-035-0117;
- (e) 309-035-0120;
- (f) 309-035-0125;
- (g) 309-035-0130;
- (h) 309-035-0135;
- (i) 309-035-0140;
- (j) 309-035-0145;
- (k) 309-035-0150;
- (l) 309-035-0155;
- (m) 309-035-0157;
- (n) 309-035-0159;
- (o) 309-035-0165;
- (p) 309-035-0167;
- (q) 309-035-0170; and
- (r) 309-035-0175.

(3) Assessment of Civil Penalties. Civil penalties will be assessed in accordance with the following guidelines:

(a) Civil penalties, not to exceed \$250 per violation to a maximum of \$1,000, may be assessed for general violations of these rules.

(b) A mandatory penalty up to \$500 will be assessed for falsifying individual service records or program records or causing another to do so;

(c) A mandatory penalty of \$250 per occurrence will be imposed for failure to have direct care staff on duty 24 hours per day;

(d) Civil penalties up to \$1,000 per occurrence may be assessed for substantiated abuse;

(e) In addition to any other liability or penalty provided by the law, the Division may impose a penalty for any of the following:

- (A) Operating the program without a license;
- (B) Operating with more individuals than the licensed capacity; and

(C) Retaliating or discriminating against an individual, family member, employee, or other person for making a complaint against the program.

(f) In imposing a civil penalty, the following factors will be taken into consideration:

(A) The past history of the provider incurring the penalty in taking all feasible steps or procedures to correct the violation;

(B) Any prior violations of statutes, rules or orders pertaining to the program;

(C) The economic and financial conditions of the provider incurring the penalty;

(D) The immediacy and extent to which the violation threatens or threatened the health, safety or welfare of one or more residents; and

(E) The degree of harm caused to individuals.

(4) Notification. Any civil penalty imposed under this section will become due and payable ten days after notice is received, unless a request for a hearing is filed. The notice will be delivered in person, or sent by registered or certified mail and will include a reference to the particular section of the statute or rule involved, a brief summary of the violation, the amount of the penalty or penalties imposed, and a statement of the right to request a hearing.

(5) Request for Hearing. The person to whom the notice is addressed will have 20 days from the date of receipt of the notice to request a hearing. This request must be in writing and submitted to the Assistant Director of the Division. If the written request for a hearing is not received on time, the Division may issue a final order by default.

(6) Hearings. All hearings will be conducted pursuant to the applicable provisions of ORS 183.310 and 183.411 to 183.502 and 183.745.

(7) Judgment. Unless the penalty is paid within ten days after the order becomes final, the order constitutes a judgment and may be recorded by the County Clerk which becomes a lien upon the title to any interest in real property owned by the person. The Division may also take action to revoke the license upon failure to comply with a final order.

(8) Judicial Review. Civil penalties are subject to judicial review under ORS 183.480, except that the court may, at its discretion, reduce the amount of the penalty.

(9) Disposition of Funds. All penalties recovered under ORS 443.790 to 443.815 will be paid into the State Treasury and credited to the General Fund.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0190

Criminal Penalties

(1) Specification of Criminal Penalty. Violation of any provision of ORS 443.400 through 443.455 is a Class B misdemeanor.

(2) Grounds for Law Suit. In addition, the Division may commence an action to enjoin operation of a program:

(a) When a program is operated without a valid license; or

(b) When a program continues to operate after notice of revocation has been given and a reasonable time has been allowed for placement of individuals in other program.

Stat. Auth.: ORS 413.042, 443.450

Stats. Implemented: ORS 413.032, 443.400 - 443.460 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0250

Purpose, Scope and Statutory Authority

(1) Purpose. These rules prescribe standards by which the Addictions and Mental Health Division of the Oregon Health Authority approves residential treatment homes for adults with mental or emotional disorders. The standards promote the well-being, health and recovery of adults with mental or emotional disorders through the availability of a wide range of residential service options. They prescribe how services will be provided in safe, secure and homelike environments that recognize the dignity, individuality and right to self-determination of each resident.

(2) Scope. These rules apply to residential treatment homes for five or fewer residents.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; MHS 10-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; MHS 5-2012, f. 5-3-12, cert. ef. 5-4-12; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0260

Definitions

As used in these rules the following definitions apply:

(1) "Abuse" includes but is not limited to:

(a) Any death caused by other than accidental or natural means or occurring in unusual circumstances;

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(c) Willful infliction of physical pain or injury;

(d) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program, or provider, or other caregiver and the adult. For situations other than those involving an employee, provider, or other caregiver and an adult, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical conduct directed toward the adult;

(e) Neglect that leads to physical harm through withholding of services necessary to maintain health and well being;

(f) Abuse does not include spiritual treatments by a duly accredited practitioner of a recognized church or religious denomination when voluntarily consented to by the individual. (2) “Administrator” means the person designated by the licensee as responsible for the daily operation and maintenance of the Residential Treatment Home (RTH).

(3) “Adult” means an individual 18 years of age or older.

(4) “Aid to Physical Functioning” means any special equipment ordered for a resident by a Licensed Medical Professional or other qualified health care professional which maintains or enhances the resident’s physical functioning.

(5) “Applicant” means the person(s) or entity that owns the business and is applying for the license.

(6) “Approved” means authorized or allowed by the Department.

(7) “Authority” means the Oregon Health Authority.

(8) “Building Code” means the state building code as defined in ORS 455.010 and includes the Oregon Structural Specialty Code, One and Two Family Dwelling Code and other specialty codes adopted by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(9) “Care” means services such as supervision; protection; assistance with activities of daily living such as bathing, dressing, grooming, or eating; management of money; transportation; recreation; and the providing of room and board.

(10) “Caregiver” means an employee, program staff, provider or volunteer of a licensed Residential Treatment Facility (RTF), Residential Treatment Home (RTH) or Adult Foster Home (AFH).

(11) “Community Mental Health Program (CMHP)” means the organization of all or a portion of services for persons with mental or emotional disorders, and operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(12) “Contract” means a formal written agreement between the community mental health program, Mental Health Organization or the Addictions and Mental Health Division and a Residential Treatment Home (RTH) owner.

(13) “Crisis-Respite Services” means the provision of services to individuals for up to 30 days. Individuals receiving crisis-respite services are RTH residents.

(14) “DSM” means the “Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)” published by the American Psychiatric Association.

(15) “Direct Care Staff Person” means an employee responsible for providing services to residents.

(16) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority.

(17) “Electrical Code” means the Uniform Building and Fire Codes adopted on October 1, 2004 by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(18) “Emergency Admission” means an admission to an RTH made on an urgent basis due to the pressing service needs of the individual.

(19) “Employee” means a person who is employed by a licensed Residential Treatment Home (RTH) who receives wages, a salary, or is otherwise paid by the RTH for providing the service. The term also includes employees of other providers delivering direct services to clients of RTHs.

(20) “Evacuation Capability” means the ability of occupants, including residents and staff as a group, to either evacuate the building or relocate from a point of occupancy to a point of safety as defined in the Oregon Structural Specialty Code. The category of evacuation capability is determined by documented evacuation drill times or scores on National Fire Protective Association (NFPA) 101A 2000 edition worksheets. There are three categories of evacuation capability:

(a) Impractical (SR- 2): A group, even with staff assistance, that cannot reliably move to a point of safety in a timely manner,

determined by an evacuation capability score of five or greater or with evacuation drill times in excess of 13 minutes.

(b) Slow (SR- 1 for more than 16 residents) and (SR-4 for 6 to 16 residents): A group that can move to a point of safety in a timely manner, determined by an evacuation capability score greater than 1.5 and less than five or with evacuation drill times over three minutes but not in excess of 13 minutes. SR-3 occupancies are those homes with five or fewer occupants having evacuation capabilities of impractical or slow with assistance.

(c) Prompt: A group with an evacuation capability score of 1.5 or less or equivalent to that of the general population or with evacuation drill times of three minutes or less. The Division shall determine evacuation capability for RTH’s in accordance with the National Fire Protection Association (NFPA) 101A 2000 edition. Facilities that are determined to be “Prompt” may be used in Group R occupancies classified by the building official, in accordance with the building code.

(21) “Fire Code” means the Oregon Fire Code as adopted by the Office of State Fire Marshal and as amended by local jurisdictions.

(22) “Home” means the building and grounds where the Residential Treatment Home program is operated.

(23) “Individual” means any person being considered for or receiving residential and other services regulated by these rules.

(24) “Licensed Medical Professional (LMP)” means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Holds at least one of the following educational degrees and valid licensures:

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

(B) Nurse Practitioner licensed to practice in the State of Oregon; or

(C) Physician’s Assistant licensed to practice in the State of Oregon; and

(b) Whose training, experience, and competence demonstrate the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.

(25) “Licensee” means the person or entity legally responsible for the operation of the RTH to which the Division has issued a license.

(26) “Local Mental Health Authority (LMHA)” means the county court or board of county commissioners of one or more counties who choose to operate a CMHP or MHO; or, if the county declines to operate or contract for all or part of a CMHP or MHO, the board of directors of a public or private corporation which contracts with the Division to operate a CMHP or MHO for that county.

(27) “Mechanical Code” means the Oregon Mechanical Specialty Code adopted by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(28) “Medication” means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance either internally or externally by any person.

(29) “Mental or Emotional Disorder” means a primary Axis I or Axis II DSM diagnosis, other than mental retardation or a substance abuse disorder that limits an individual’s ability to perform activities of daily living.

(30) “Mental Health Assessment” means a determination by a Qualified Mental Health Professional of the client’s need for mental health services. It involves collection and assessment of data pertinent to the client’s mental health history and current mental health status obtained through interview, observation, testing, and review of previous treatment records. It concludes with determination of a DSM diagnosis or other justification of priority for mental health services, or a written statement that the person is not in need of community mental health services.

(31) “Mental Health Organization (MHO)” means an approved organization that provides most mental health services through a capitated payment mechanism under the Oregon Health Plan. MHOs may be fully capitated health plans, community mental

health programs, private mental health organizations or combinations thereof.

(32) “Mistreatment” means the following behaviors, displayed by an employee, program staff, provider or volunteer of an RTH when directed toward an individual:

(a) “Abandonment” means desertion or willful forsaking when the desertion or forsaking results in harm or places the individual at a risk of serious harm.

(b) “Financial exploitation” means:

(A) Wrongfully taking the assets, funds, or property belonging to or intended for the use of an individual.

(BI) Alarming an individual by conveying a threat to wrongfully take or appropriate money or property of the individual if the individual would reasonably believe that the threat conveyed would be carried out.

(C) Misappropriating, misusing, or transferring without authorization any money from any account held jointly or singly by an individual.

(D) Failing to use the income or assets of an individual effectively for the support and maintenance of the individual. “Effectively” means use of income or assets for the benefit of the individual.

(c) “Involuntary Restriction” means the involuntary restriction of an individual for the convenience of a caregiver or to discipline the individual. Involuntary restriction may include but is not limited to placing restrictions on an individual’s freedom of movement by restriction to his or her room or a specific area, or restriction from access to ordinarily accessible areas of the facility, residence or program, unless agreed to by the treatment plan. Restriction may be permitted on an emergency or short term basis when an individual’s presence would pose a risk to health or safety to the individual or others.

(d) “Neglect” means active or passive failure to provide the care, supervision, or services necessary to maintain the physical and mental health of an individual that creates a significant risk of harm to an individual or results in significant mental injury to an individual. Services include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of the individual.

(e) “Verbal Mistreatment” means threatening significant physical harm or emotional harm to an individual through the use of:

(A) Derogatory or inappropriate names, insults, verbal assaults, profanity, or ridicule.

(B) Harassment, coercion, punishment, deprivation, threats, implied threats, intimidation, humiliation, mental cruelty, or inappropriate sexual comments.

(C) A threat to withhold services or supports, including an implied or direct threat of termination of services. “Services” include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of an individual.

(D) For purposes of this definition, verbal conduct includes but is not limited to the use of oral, written, or gestured communication that is directed to an individual or within their hearing distance or sight, regardless of their ability to comprehend. In this circumstance the assessment of the conduct is based on a reasonable person standard.

(E) The emotional harm that can result from verbal abuse may include but is not limited to anguish, distress, or fear.

(f) “Wrongful Restraint” means:

(A) A wrongful use of a physical or chemical restraint excluding an act of restraint prescribed by a licensed physician pursuant to OAR 309-033-0730.

(B) Wrongful restraint does not include physical emergency restraint to prevent immediate injury to an individual who is in danger of physically harming himself or herself or others, provided that only the degree of force reasonably necessary for protection is used for the least amount of time necessary.

(33) “Nursing Care” means the practice of nursing by a licensed nurse, including tasks and functions that are delegated by a registered nurse to a person other than a licensed nurse, which are governed by ORS Chapter 678 and rules adopted by the Oregon Board of Nursing in OAR chapter 851.

(34) “Owner” means the person or entity including the Division that is legally responsible for the operation of the facility.

(35) “Plumbing Code” means the Oregon Plumbing Specialty Code adopted by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(36) “P.R Nn. (pro re nata) Medications and Treatments” means those medications and treatments that have been ordered to be given as needed.

(37) “Program” means the Residential Treatment Home and may refer to the owner, staff, or services as applicable to the context.

(38) “Program staff” means an employee or person who, by contract with an RTH, provides a service and who has the applicable competencies, qualifications, and certification, required by the Integrated Services and Supports Rule (ISSR) (OAR 309-032-1500 to 309-032-1565) to provide the service.

(39) “Progress Notes” means the notations in the resident record documenting significant information concerning the resident and summarizing progress made relevant to the objectives outlined in the residential service plan.

(40) “Protection” means the necessary actions taken by the program to prevent abuse, mistreatment, or exploitation of the residents, to prevent self-destructive acts, and to safeguard residents, property, and funds.

(41) “Provider” means a qualified individual or an organizational entity operated by or contractually affiliated with a community mental health program, or contracted directly with the Division for the direct delivery of mental health services and supports to adults receiving residential and supportive services in an RTH.

(42) “Qualified Health Care Professional” means a health care professional licensed to practice in the state of Oregon who is approved to perform certain health care tasks referenced in the relevant section of these rules consistent with the scope of practice specified by the licensing board for the profession. In accordance with the referenced health care task, the qualified health care professional may include a physician, a physician’s assistant, a nurse practitioner, a registered nurse, or a pharmacist.

(43) “Qualified Mental Health Professional (QMHP)” means a Licensed Medical Practitioner (LMP) or any other person meeting the following minimum qualifications as documented by the LMHA or designee:

(a) Graduate degree in psychology;

(b) Bachelor’s degree in nursing and licensed by the State of Oregon;

(c) Graduate degree in social work;

(d) Graduate degree in behavioral science field;

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

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

(g) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise a Treatment Plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family, and group therapy within the scope of his or her practice.

(44) “Resident” means any adult residing in the RTH who receives services on a 24-hour basis, except as excluded under ORS 443.400(3).

(45) “Residential Service Plan” means an individualized, written plan outlining the care and treatment to be provided to a resident in or through the RTH based upon an individual assessment of care and treatment needs. The residential service plan may be a section or subcomponent of the individual’s overall mental health

treatment plan when the RTH is operated by a mental health service agency that provides other services to the resident.

(46) "Residential Treatment Home (RTH)" means a home that is operated to provide services on a 24-hour basis for five or fewer residents.

(47) "Restraints" means any chemical or physical methods or devices that are intended to restrict or inhibit the movement, functioning, or behavior of a resident.

(48) "Seclusion" means placing an individual in a locked room. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock, or physically holding the door shut.

(49) "Secure Residential Treatment Facility" means any residential treatment facility, or portion thereof, that restricts a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates or other closures.

(50) "Services" means the care and treatment provided to residents as part of the RTH program.

(51) "Supervision" means the daily observation, and monitoring of residents by direct care staff or oversight of staff by the administrator or administrator's designee, as applicable to the context.

(52) "Termination of Residency" means the time at which the resident ceases to live in the RTH and includes the transfer of the resident to another facility, but does not include absences from the RTH for the purpose of taking a planned vacation, visiting family or friends, or receiving time-limited medical or psychiatric treatment.

(53) "Treatment" means a planned, individualized program of medical, psychological or rehabilitative procedures, experiences and activities consistent with ORS 443.400(12).

(54) "Volunteer" means a person who provides a service or who takes part in a service provided to individuals receiving supportive services in an RTH or other provider, and who is not a paid employee of the RTH or other provider. The services must be non-clinical unless the person has the required credentials to provide a clinical service.

Stat. Auth.: ORS 413.042 & 443.450

Stats. Implemented: ORS 443.400 - 443.455, 443.875, 443.991

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; MHS 6-2007(Temp), f. & cert. ef. 5-25-07 thru 11-21-07; MHS 13-2007, f. & cert. ef. 8-31-07; MHS 10-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; MHS 5-2012, f. 5-3-12, cert. ef. 5-4-12; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0270

Licensing

(1) License Required. The Division will license any home that meets the definition of a residential treatment home and serves adults with a mental or emotional disorder. In the case of a home serving another category of residents in addition to adults with a mental or emotional disorder, the Division responsible for licensure will be determined by the Director of the Oregon Health Authority. No person or governmental unit acting individually or jointly with any other person or governmental unit will establish, maintain, manage, or operate a residential treatment home without a license issued by the Division.

(2) Initial Application. An application for a license will be accompanied by the required fee and submitted to the Division using the forms or format required by the Division. The following information will be required in the application:

(a) Full and complete information as to the identity and financial interest of each person, including stockholders, having a direct or indirect ownership interest of five percent or more in the RTH and all officers and directors in the case of RTHs operated or owned by a corporation.

(b) Location (street address) of the home and mailing address;

(c) Maximum number of residents to be served at any one time, their age range and evacuation capability;

(d) Proposed annual budget identifying sources of revenue and expenses;

(e) Signed criminal record authorizations for all persons involved in the operation of the RTH who will have contact with the residents;

(f) A complete set of policies and procedures;

(g) Facility plans and specifications; and

(h) Such other information as the Division may reasonably require.

(3) Plans and Design Approval. A complete set of plans and specifications will be submitted to the Division at the time of initial application, whenever a new structure or addition to an existing structure is proposed, or when significant alterations to an existing facility are proposed. Plans will meet the following criteria:

(a) Plans will be prepared in accordance with the Building Code and requirements of OAR 309-035-0320;

(b) Plans will be to scale and sufficiently complete to allow full review for compliance with these rules; and

(c) Plans will be to scale and carry the stamp of an Oregon licensed architect or engineer when required by the Building Code and ORS Chapters 671 and 672 (laws relating to the practice of architecture and engineering).

(4) Necessary Approvals. Prior to approval of a license for a new or renovated home, the applicant will submit the following to the Division:

(a) One copy of written approval to occupy the home issued by the city, county or state building codes authority having jurisdiction;

(b) One copy of the fire inspection report from the State Fire Marshal or local jurisdiction indicating that the home complies with the Fire Code;

(c) When the home is not served by an approved municipal water system, one copy of the documentation indicating that the state or county health agency having jurisdiction has approved the water supply in accordance with OAR chapter 333, Public Health Division rules for public water systems.

(d) When the home is not connected to an approved municipal sewer system, one copy of the sewer or septic system approval from the Department of Environmental Quality or local jurisdiction.

(5) Required Fees. The fee for each residential treatment home license application is \$30. No fee is required in the case of a governmentally operated residential treatment home.

(6) Renewal Application. A license is renewable upon submission of a renewal application in the form or format required by the Division and a non-refundable fee of \$30, except that no fee will be required of a governmentally operated RTH. Filing of an application for renewal before the date of expiration extends the effective date of the current license until the Division takes action upon the renewal application.

(7) Review Process. Upon receipt of an application and fee, the Division will conduct an application review. Initial action by the Division on the application will begin within 30 days of receipt of all application materials. The review will:

(a) Include a complete review of application materials;

(b) Determine whether the applicant meets the qualifications outlined in ORS 443.420 including:

(A) Demonstrates an understanding and acceptance of these rules;

(B) Is mentally and physically capable of providing services for residents;

(C) Employs or utilizes only individuals whose presence does not jeopardize the health, safety, or welfare of residents; and

(D) Provides evidence satisfactory to the Division of financial ability to comply with these rules.

(c) Include a site inspection; and

(d) Conclude with a report stating findings and a decision on licensing of the RTH.

(8) Findings of Noncompliance. The Division will require an owner to submit and complete a plan of correction for each finding of noncompliance with these rules.

(a) If the finding(s) of noncompliance substantially impacts the welfare, health and/or safety of residents, the plan of correction

will be submitted and completed prior to issuance of a license. In the case of a currently operating RTH, such findings may result in suspension or revocation of a license.

(b) If it is determined that the finding(s) of noncompliance do not threaten the welfare, health or safety of residents and the facility meets other requirements of licensing, a license may be issued or renewed, and the plan of correction will be submitted and completed as a condition of licensing.

(c) The Division will specify required documentation and set the time lines for the submission and completion of plans of correction in accordance with the severity of the finding(s).

(d) The Division will review and approve each plan of correction. If the plan of correction does not adequately remedy the finding of noncompliance, the Division may require a revised plan of correction.

(e) The RTH owner may appeal the finding of noncompliance or the disapproval of a plan of correction by submitting a request for reconsideration in writing to the Administrator of the Division. The Administrator of the Division or designee will make a decision on the appeal within 30 days of receipt of the appeal.

(9) Variance. The Authority may grant a variance to these rules based upon a demonstration by the applicant that an alternative method or different approach provides equal or greater program effectiveness and does not adversely impact the welfare, health or safety of residents.

(a) Variance Application. The RTH owner requesting a variance will submit, in writing, an application to the Division which identifies the section of the rules from which the variance is sought, the reason for the proposed variance, the proposed alternative method or different approach, and signed documentation from the CMHP indicating approval of the proposed variance.

(b) Additions and Health Division Review. The Assistant Administrator for the Division's Office of Mental Health Division, or designee, will review and approve or deny the request for a variance.

(c) Notification of Decision. The Division will notify the RTH owner of the decision in writing within 30 days after receipt of the application. A variance may be implemented only after receipt of written approval from the Division.

(d) Appeal of Decision. The RTH owner may appeal the denial of a variance request by submitting a request for reconsideration in writing to the Administrator of the Division. The Administrator of the Division will make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Administrator of the Division will be final.

(e) Duration of the Variance. A variance will be reviewed by the Division at least every two years and may be revoked or suspended based upon a finding that the variance adversely impacts the welfare, health or safety of the RTH residents.

(10) Issuance of License. Upon finding that the applicant is in substantial compliance with these rules, the Division will issue a license.

(a) The license issued will state the name of the owner of the RTH, the name of the administrator, the address of the home to which the license applies, the maximum number of residents to be served at any one time and their evacuation capability, the type of home, and such other information as the Division deems necessary.

(b) A residential treatment home license will be effective for two years from the date issued unless sooner revoked or suspended.

(c) The residential treatment home license is not transferable or applicable to any location, facility, or management other than that indicated on the application and license.

(11) Conditions of License. The license will be valid under the following conditions:

(a) The residential treatment home will not be operated or maintained in combination with a nursing facility, hospital, retirement facility, or other occupancy unless licensed, maintained, and operated as a separate and distinct part. Each residential treatment home will have sleeping, dining and living areas for use only by its own residents, employees and invited guests.

(b) The license will be retained in the home and available for inspection at all times.

(c) Each license will be considered void immediately upon suspension or revocation of the license by the Division, or if the operation is discontinued by voluntary action of the licensee, or if there is a change of ownership.

(12) Site Inspections. Division staff will visit and inspect every residential treatment home at least, but not limited to, once every two years to determine whether it is maintained and operated in accordance with these rules. The RTH owner/applicant will allow Division staff entry and access to the home and residents for the purpose of conducting the inspections.

(a) Division staff will review methods of resident care and treatment, records, the condition of the facility and equipment, and other areas of operation.

(b) All records, unless specifically excluded by law, will be available to the Division for review.

(c) The State Fire Marshal or authorized representative(s) will, upon request, be permitted access to the home, fire safety equipment within the home, safety policies and procedures, maintenance records of fire protection equipment and systems, and records demonstrating the evacuation capability of RTH occupants.

(13) Investigation of Complaints and Alleged Abuse. Incidents of alleged abuse covered by ORS 430.731 through 430.768 will be reported and investigated in accordance with OAR 407-045. Division staff will investigate complaints and other alleged abuse made regarding residential treatment homes, will cause a report to be filed, and will take appropriate action under these rules. The Division may delegate the investigation to a CMHP or other appropriate entity.

(14) Denial, Suspension or Revocation of License. The Division will deny, suspend or revoke a license when it finds there has been substantial failure to comply with these rules; or when the State Fire Marshal or authorized representative certifies that there is a failure to comply with the Fire Code or Building Code.

(a) The Division may immediately suspend a license where there exists an imminent danger to the health or safety of residents.

(A) The Division will provide written notice of the suspension to the licensee citing the violation and stating the corrective action necessary in order for the license to be re-instated.

(B) The licensee may request a review of the decision to immediately suspend a license by submitting a request, in writing, within 10 days of the suspension notice. Within 10 days of receipt of the licensee's request for a review, the Division administrator or designee will review all material relating to the suspension and determine whether to sustain the decision. If the administrator does not sustain the decision, the suspension will be rescinded immediately. The decision of the administrator can be appealed within 90 days as a contested case under ORS 183.310 and 183.400 to 183.502.

(b) The Division will take action to deny or revoke a license in accordance with the following procedures:

(A) The Division will provide written notice of the denial or revocation citing the violation(s), and specifying the effective date (in the case of a currently operating RTH).

(B) The licensee will be entitled to a contested case hearing under ORS 183.310 and 183.400 to 183.502 prior to the effective date of revocation or denial if the licensee requests a hearing in writing, within 21 days after receipt of the written notice. If no such request is received, the decision will be sustained.

(C) A license subject to revocation or denial based upon review of a renewal application, will remain valid during an administrative hearings process, unless suspended, even if the hearing and final order are not issued until after the expiration date of the license.

(D) If an initial license is denied, the applicant will be entitled to a contested case hearing under ORS 183.310 and 183.400 to 183.502 if the applicant requests a hearing in writing within 60 days of receipt of the denial notice. If no such request is received, the decision to deny the license application will be sustained.

(i) In cases where there exists an imminent danger to the health or safety of residents, a license may be suspended immediately.

(ii) Such revocation, suspension, or denial will be done in accordance with rules of the Division under ORS Chapter 183.

(15) Reporting Changes. Each licensee will report promptly to the Division any significant changes to information supplied in the application or subsequent correspondence. Such changes include, but are not limited to, changes in the RTH name, owner entity, administrator, telephone number and mailing address. Such changes also include, but are not limited to, changes in the RTHs physical plant, policies and procedures or staffing pattern when such changes are significant or impact the health, safety or well-being of residents.

Stat. Auth.: ORS 443.450
Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

**309-035-0280
Contracts and Rates**

(1) Contracts. Residential treatment home operators providing services funded by the Division will enter into a contract with the local community mental health program, the Division or other Division-approved entity. The contract does not guarantee that any number of persons eligible for Division funded services will be referred to or maintained in the home.

(2) Rates. Rates for all services and the procedures for collecting payments from residents and/or payees will be specified in a fee policy and procedures. The fee policy and procedures will describe the schedule of rates, conditions under which rates may be changed, acceptable methods of payment, and the policy on refunds at the time of termination of residency.

(a) For residents whose services are funded by the Division, reimbursement for services will be made according to the rate schedule outlined in the contract. Room and board payments for residents receiving Social Security benefits or public assistance will be in accordance with and not more than rates determined by the Division.

(b) For private paying residents, the program will enter into a signed agreement with the resident, and/or if applicable, resident's guardian, payee or conservator. This agreement will include but not be limited to a description of the services to be provided; the schedule of rates; conditions under which the rates may be changed; and policy on refunds at the time of termination of residency.

(c) Before an RTH increases rates or modifies payment procedures, the program will provide 30 days advance notice of the change to all residents, and their payees, guardians or conservators, as applicable.

Stat. Auth.: ORS 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

**309-035-0290
Administrative Management**

(1) Licensee. The licensee will be responsible for insuring that the RTH is operated in compliance with these rules and all other applicable federal, state and local laws and regulations.

(2) Administrator. The licensee will employ an administrator who:

(a) Has background including special training, experience, and other demonstrated ability in providing care and treatment appropriate to the residents served in the facility;

(b) Has a documented criminal record clearance and no history of abusive behavior;

(c) Will ensure that the RTH operates in accordance with the standards outlined in these rules;

(d) Will oversee the daily operation and maintenance of the RTH and will be available to perform administrative duties at the RTH at least 20 hours per week at the RTH or provide an adminis-

trative plan which documents an equivalent level of available supervision.

(e) Will develop and administer written policies and procedures to direct the operation of the RTH and the provision of services to residents;

(f) Will ensure that qualified staff are available, in accordance with the staffing requirements specified in these rules;

(g) Will supervise or provide for the supervision of staff and others involved in the operation of the program;

(h) Will maintain program, personnel and resident records;

(i) Will report regularly to the licensee on the operation of the RTH; and

(j) Will delegate authority and responsibility for the operation and maintenance of the facility to a responsible staff person whenever the Administrator is absent from the RTF. This authority and responsibility will not be delegated to a resident.

(3) Policies and Procedures. Policies and procedures will be developed, updated as necessary, maintained in a location easily accessible for staff reference, and made available to others upon reasonable request. They will be consistent with requirements of these rules, and address, but not be limited to:

(a) Personnel practices and staff training;

(b) Resident selection, admission and termination;

(c) Fire drills, emergency procedures, resident safety and abuse reporting;

(d) Health and sanitation;

(e) Records;

(f) Residential service plan, services and activities;

(g) Behavior management, including prohibition of the use of seclusion or restraints;

(h) Food Service;

(i) Medication administration and storage;

(j) Resident belongings, storage and funds;

(k) Resident rights and advance directives;

(l) Complaints and grievances;

(m) Facility maintenance;

(n) Evacuation capability determination; and

(o) Fees and money management.

(4) House Rules. The RTH will develop reasonable house rules outlining operating protocols concerning, but not limited to, meal times, night-time quiet hours, guest policies, smoking and phone use. The house rules will be consistent with resident rights as delineated in OAR 309-035-0380 and are subject to approval by the Division. House rules will be posted in an area readily accessible to residents. House rules will be reviewed and updated, as necessary. Residents will be provided an opportunity to review and provide input into any proposed changes to house rules before the revisions become effective.

Stat. Auth.: ORS 443.450
Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

**309-035-0300
Records**

(1) General Requirements. Records will be maintained to document the legal operation of the program, personnel practices and resident services. All records will be properly obtained, accurately prepared, safely stored and readily available within the RTH. All entries in records required by these rules will be in ink, indelible pencil, or approved electronic equivalent and prepared at the time, or immediately following, the occurrence of the event being recorded; be legible; and be dated and signed by the person making the entry. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent.

(2) Program Records. Records documenting the legal operation of the RTH will include, but not be limited to:

(a) Written approval for occupancy of the building by the county or city having jurisdiction, any building inspection reports, zoning verifications, fire inspection reports or other documentation pertaining to the safe and sanitary operation of the RTH;

(b) Application for license, related correspondence and site inspection reports;

(c) Program operating budget and related financial records;

(d) Payroll records, employee schedules and time sheets;

(e) Materials Safety and Data Sheets;

(f) Fire drill documentation;

(g) Fire alarm and sprinkler system maintenance and testing records;

(h) Incident reports; and

(i) Policy and procedure manual.

(3) Personnel Records. Records documenting personnel actions will include:

(a) Job descriptions for all positions; and

(b) Individual employee records including, but not limited to, written documentation of employee identifying information and qualifications, criminal record clearance, tuberculosis test results, Hepatitis B vaccinations in accordance with the Oregon Occupational Safety and Health Code, performance appraisals, and documentation of pre-service orientation and other training.

(4) Resident Records. Except as indicated in OAR 309-035-0300, an individual resident record will be maintained for each resident and include:

(a) An easily accessible summary sheet which includes, but is not limited to the resident's name, previous address, date of admission to the facility, sex, date of birth, marital status, legal status, religious preference, Social Security number, health provider information, evacuation capability, diagnosis(es), major health concerns, medication allergies, information indicating whether advance mental health and health directives and/or burial plan have been executed, and the name of person(s) to contact in case of emergency;

(b) The names, addresses and telephone numbers of the resident's legal guardian or conservator, parent(s), next of kin, or other significant person(s); physician(s) or other medical practitioner(s); dentist; CMHP case manager or therapist; day program, school or employer; and any governmental or other agency representative(s) providing services to the resident;

(c) A mental health assessment and background information identifying the resident's residential service needs;

(d) Advance mental health and health directives, burial plans or location of these (as available);

(e) Residential service plan and copy(ies) of plan(s) from other relevant service provider(s).

(f) Documentation of the resident's progress and any other significant information including, but not limited to, progress notes, progress summaries, any use of seclusion or restraints, and correspondence concerning the resident;

(g) Health-related information and up-to-date information on medications in accordance with OAR 309-035-0440;

(h) Any authorizations obtained for the release of confidential information.

(5) Records for Crisis-respite Residents. For residents receiving crisis-respite services, an individual resident record will be maintained for each resident and include:

(a) A referral form or forms which include the resident's name; previous address; date of admission; sex; date of birth; marital status; social security number; health care provider names and phone numbers (including primary care physician, psychiatrist, prescriber (if different), and any other known health care providers); health insurance information; entitlements and/or eligibility; source and amount of income; diagnosis(es); major health concerns; current medications; medication or other allergies; name(s) of person(s) to contact in case of emergency; name, address and phone number of guardian or conservator (as applicable); and other information pertinent to the resident's crisis-respite stay;

(b) A mental health assessment and plan which include the reason for placement in crisis-respite care, the nature of crisis necessitating placement, an evaluation of risk for harm to self or others, the residential treatment plan for the crisis-respite stay, the expected duration of the crisis-respite placement, and the discharge plan;

(c) Current written orders by a qualified health care professional for all medications and a plan for obtaining any prescribed medications which are not in the resident's possession in original labeled containers;

(d) A signed resident agreement indicating informed consent for treatment; and

(e) Any authorizations obtained for the release of confidential information.

(6) Storage. All resident records will be stored in a weatherproof and secure location. Access to records will be limited to the Administrator and direct care staff unless otherwise allowed in these rules.

(7) Confidentiality. All resident records will be kept confidential. A signed release of information will be obtained for any disclosure from resident records in accordance with all applicable laws and rules.

(8) Resident Access to His/Her Record. A resident, or guardian (as applicable), will be allowed to review and obtain a copy of his/her resident record as allowed in ORS 179.505.

(9) Transfer of Records. Pertinent information from records of residents who are being transferred to another program will be transferred with the resident. A signed release of information will be obtained in accordance with applicable laws and rules.

(10) Maintenance of Records. The RTH will keep all records, except those transferred with a resident, for a period of three years.

(11) Administrative Changes. If an RTH changes ownership or Administrator, all resident and personnel records will remain in the home. Prior to the dissolution of any RTH, the Administrator will notify the Division in writing as to the location and storage of resident records or those records will be transferred with the residents.

(12) Resident Contributions to Record. If a resident or guardian (as applicable) disagrees with the content of the resident record, or otherwise desires to provide documentation for the record, the resident or guardian (as applicable) may provide material in writing that then will become part of the resident record.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0310

Staffing

(1) Staff Qualifications. A job description will be available for each staff position and specify qualifications and job duties.

(a) Any staff person hired to provide direct care to residents will be at least 18 years of age, be capable of implementing the RTHs emergency procedures and disaster plan, and be capable of performing other duties of the job as described in the job description.

(b) In accordance with OAR 943-007-0001 through 943-007-0501, all RTH staff who will have contact with residents will provide evidence of a criminal record clearance prior to starting employment.

(c) In accordance with OAR 333-071-0057 and 437-002-0368 through 437-002-2226, all RTH staff who will have contact with residents will be tested for tuberculosis and Hepatitis B within two weeks of first employment; additional testing will take place as deemed necessary; and the employment of staff who test positive for tuberculosis will be restricted if necessary.

(d) In accordance with the Oregon Occupational Safety and Health Code, chapter 437-002-0368 through 437-002-2226, Hepatitis B vaccinations will be offered within ten working days of initial employment to RTH staff who will have contact with residents. Training about bloodborne pathogens and related safety practices will be completed prior to offering the vaccination.

(e) All staff will meet other qualifications when required by a contract or financing arrangement approved by the Division.

(2) Personnel Policies. Personnel policies will be made available to all staff and will describe hiring, leave, promotion and disciplinary practices.

(3) Staff Training. The administrator will provide or arrange a minimum of 16 hours pre-service orientation and eight hours in-service training annually for each employee.

(a) Pre-service training for direct care staff will include, but not be limited to, a comprehensive tour of the home; a review of emergency procedures developed in accordance with OAR 309-035-0330; a review of RTH house rules, policies and procedures; background on mental and emotional disorders; an overview of resident rights; assessment of resident risk factors; medication management procedures; food service arrangements; a summary of each resident's assessment and residential service plan; and other information relevant to the job description and scheduled shift(s).

(b) In-service training will be provided on topics relevant to improving the care and treatment of residents in the RTH and meeting the requirements in these administrative rules. In-service training topics include, but are not limited to, implementing the residential service plan, behavior management, daily living skills development, nutrition, first aid, understanding mental illness, sanitary food handling, resident rights, identifying health care needs, and psychotropic medications.

(4) General Staffing Requirements. The licensee and administrator are responsible for assuring that an adequate number of staff are available at all times to meet the treatment, health and safety needs of residents. Regardless of the minimum staffing requirements, staff will be scheduled to ensure safety and to correspond to the changing needs of residents. At a minimum, there will be at least one direct care staff person on duty at all times.

(a) In the case of a specialized RTH, staffing requirements outlined in the contractual agreement for specialized services will be implemented.

(b) Direct care staff on night duty will be awake and dressed at all times. In homes where residents are housed in two or more detached buildings, direct care staff will monitor each building at least once an hour during the night shift. An approved method for alerting staff to problems will be in place. This method must be accessible to and usable by the residents.

Stat. Auth.: ORS 413.042 & 443.450
Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0320

Physical Environment Requirements

(1) Compliance with Building and Fire Codes. Each residential treatment home established on or after December 1, 1999, will meet the requirements for approved Group SR occupancies in the Building Code and the Fire Code in effect at the time of licensure. RTHs licensed as adult foster homes by the Division before the effective date of these rules will demonstrate that the home was in compliance with the Building Code and Fire Code in effect at the time of the original Division licensure. When renovation or a change in the home's use results in a new building occupancy classification, the home will meet the requirements for approved Group SR occupancies in the Building Code in effect at the time of such change.

(2) Accessibility for Persons with Disabilities. RTHs will be accessible as follows:

(a) Those homes that are licensed, constructed or renovated after January 26, 1992, and that are covered multi-family dwellings or public accommodations, will meet the physical accessibility requirements in Chapter 11 of the Oregon Structural Specialty Code. This code specifies requirements for public accommodations as defined in the Americans with Disabilities Act under Title III and for buildings qualifying as multi-family dwellings as defined in the Fair Housing Act, as amended in 1988.

(b) In order to ensure program accessibility under Title II of the Americans with Disabilities Act, the Division may require additional accessibility improvements.

(c) Any accessibility improvements made to accommodate an identified resident will be in accordance with the specific needs of the resident and will comply with the Building Code.

(3) Outdoor Areas. An accessible outdoor area is required and will be made available to all residents. For RTHs licensed on or after December 1, 1999, a portion of the accessible outdoor area will be covered and have an all weather surface, such as a patio or deck.

(4) General Storage. The home will include sufficient and safe storage areas. These will include but not be limited to:

(a) Storage for a reasonable amount of resident belongings beyond that available in resident sleeping rooms will be provided. For homes licensed on or after December 1, 1999, this storage will include 24 cubic feet per resident.

(b) All maintenance equipment stored on site, including yard maintenance tools, will be maintained in adequate storage space. Equipment and tools which pose a danger to RTH residents will be kept in locked storage.

(c) Storage areas necessary to ensure a functional, safe and sanitary environment consistent with OAR 309-035-0320, 309-035-0330, 309-035-0340, 309-035-0350, 309-035-0430, and 309-035-0440.

(5) Hallways. For RTHs initially licensed on or after December 1, 1999, all resident use areas and resident units will be accessible through temperature controlled common areas or hallways with a minimum width of 36 inches.

(6) Administrative Areas. Sufficient space will be provided for confidential storage of both resident and business records, for staff use in completing record-keeping tasks, and for a telephone. Other equipment including fire alarm panels and other annunciators will be installed in an area readily accessible to staff in accordance with the Fire Code.

(7) Resident Sleeping Rooms. Resident sleeping quarters will be provided in rooms separated from other areas of the facility by an operable door with an approved latching device.

(a) For homes licensed prior to December 1, 1999, resident sleeping rooms will include a minimum of 60 square feet per resident and allow for a minimum of three feet between beds.

(b) For homes initially licensed on or after December 1, 1999, each resident sleeping room will be limited to one or two residents. At least ten per cent, but no less than one, of the resident sleeping rooms will be accessible for persons with mobility disabilities. All resident sleeping rooms will include a minimum of 70 square feet per resident exclusive of closets, vestibules and bathroom facilities and allow a minimum of three feet between beds.

(c) A clothes closet, with adequate clothes hanging rods will be accessible within each sleeping room for storage of each resident's clothing and personal belongings. For homes initially licensed on or after December 1, 1999, built-in closet space will be provided totaling a minimum of 64 cubic feet for each resident. In accessible sleeping rooms, the clothes hanging rod height will be adjustable or no more than 54 inches in height to ensure accessibility for persons in wheelchairs.

(d) Each resident sleeping room will have exterior window(s) with a combined area at least one-tenth of the floor area of the room. Sleeping room windows will be equipped with curtains or blinds for privacy and control of light. For homes initially licensed on or after December 1, 1999, an operable, opening window for emergency egress will be provided consistent with Building Code requirements.

(e) When locking devices are used on resident sleeping room doors, they will meet the requirements of the Building Code.

(8) Bathrooms.

(a) Bathing and toilet facilities will be conveniently located for resident use, provide permanently wired light fixtures that illuminate all parts of the room, provide individual privacy for residents, provide a securely affixed mirror at eye level, be adequately ventilated by a mechanical exhaust system or operable windows, and include sufficient facilities specially equipped for use by persons with a physical disability in buildings serving such persons.

(b) A minimum of one toilet, one lavatory and one bathtub or shower will be available for residents.

(9) Common Use Rooms. The home will include lounge and activity area(s), such as a living room or parlor, as required in the Building Code or totaling 25 square feet per resident, whichever is greater, for social and recreational use exclusively by residents, staff and invited guests.

(10) Laundry and Related Space. Laundry facilities will be separate from food preparation and other resident use areas. When residential laundry equipment is installed, the laundry facilities may be located to allow for both resident and staff use. The following will be included in the laundry facilities:

(a) Countertops or folding table(s) sufficient to handle laundry needs for the facility;

(b) Locked storage for chemicals and equipment;

(c) Outlets, venting and water hook-ups according to state building code requirements. Washers will have a minimum rinse temperature of 140 degrees Fahrenheit; and

(d) Sufficient, separate storage and handling space to ensure that clean laundry is not contaminated by soiled laundry.

(11) Kitchen. Kitchen facilities and equipment will be of residential type except as otherwise approved by the Division. For all kitchens, the following will be included:

(a) Dry storage space, not subject to freezing, in cabinets or a separate pantry for a minimum of one week's supply of staple foods;

(b) Sufficient refrigeration space maintained at 45 degrees Fahrenheit or less and freezer space for a minimum of two days' supply of perishable foods;

(c) A dishwasher (may be approved residential type) with a minimum final rinse temperature of 140 degrees Fahrenheit;

(d) Smooth, nonabsorbent and cleanable counters for food preparation and serving;

(e) Appropriate storage for dishes and cooking utensils designed to be free from potential contamination;

(f) Stove and oven equipment for cooking and baking needs; and

(g) Storage for a mop and other cleaning tools and supplies used for food preparation, dining and adjacent areas. Such cleaning tools will be maintained separately from those used to clean other parts of the facility.

(12) Dining Area.

(a) A separate dining room or area where meals are served will be provided for the exclusive use of residents, employees, and invited guests.

(b) Dining space will be provided to seat all residents with a minimum area of 20 square feet per resident, exclusive of serving facilities and required exit pathways.

(13) Details and Finishes. All details and finishes will meet the finish requirements of applicable sections of the Building Code and the Fire Code.

(a) Surfaces. Surfaces of all walls, ceilings, windows and equipment will be readily cleanable. The walls, floors and ceilings in the kitchen, laundry and bathing areas will be nonabsorbent, and readily cleanable.

(b) Flooring. In homes initially licensed on or after December 1, 1999, flooring, thresholds and floor junctures will be designed and installed to prevent a tripping hazard. In addition, hard surface floors and base will be free from cracks and breaks, and bathing areas will have non-slip surfaces.

(c) Doors. In homes initially licensed on or after December 1, 1999, all doors to accessible resident sleeping rooms, bathrooms and common use areas will provide a minimum clear opening of 32 inches. Lever type door hardware will be provided on all doors used by residents in accessible areas. If locks are used on doors to resident sleeping rooms, they will be interactive to release with operation of the inside door handle and be master-keyed from the corridor side. Exit doors will not include locks which prevent evacuation. An exterior door alarm or other acceptable system may be provided for security purposes and to alert staff when resident(s) or others enter or exit the home.

(d) Handrails. Handrails will be provided on all stairways as specified in the Building Code.

(14) Heating and Ventilating. All areas of the home will be adequately ventilated and temperature controlled consistent with Mechanical and Building Code requirements in effect at the time of installation.

(a) Temperature Control. All habitable rooms will include heating equipment capable of maintaining a minimum temperature of 68 degrees Fahrenheit at a point three feet above the floor. During times of extreme summer heat, fans will be made available when air conditioning is not provided.

(b) Exhaust Systems. All toilet and shower rooms will be ventilated by a mechanical exhaust system or operable windows.

(c) Fireplaces, Furnaces, Wood Stoves and Boilers. Where used, design and installation will meet standards of the Mechanical Code and the Boiler and Pressure Vessel Law in effect at the time of their installation, as applicable.

(d) Water Temperature. In resident areas, hot water temperatures will be maintained within a range of 110 to 120 degrees Fahrenheit. Hot water temperatures for washing machines and dishwashers will be at least 140 degrees Fahrenheit.

(15) Electrical. All electrical systems will meet the standards of the Electrical Code in effect on the date of installation, and all electrical devices will be properly wired and in good repair.

(a) When not fully grounded, circuits in resident areas may be protected by GFCI type receptacles or circuit breakers as an acceptable alternative.

(b) All electrical circuits will be protected by circuit breakers or non-interchangeable circuit-breaker-type fuses in fuse boxes.

(c) A sufficient supply of electrical outlets will be provided to meet resident and staff needs without the use of extension cords or outlet expander devices. (See Office of State Fire Marshal and Department of Health Services policy for extension cords.)

(d) Lighting fixtures will be provided in each resident bedroom and bathroom, switchable near the entry door, and in other areas as required to meet task illumination needs.

(16) Plumbing. All plumbing will meet the Plumbing Code in effect on the date of installation, and all plumbing fixtures will be properly installed and in good repair.

(17) Telephones. The home will provide adequate access to telephones for private use by residents. In homes initially licensed on or after December 1, 1999, a phone for resident use will be provided in addition to the phone used by staff. The RTH may establish reasonable house rules governing phone use to ensure equal access by all residents. Each resident or guardian (as applicable) will be responsible for payment of long distance phone bills where the calls were initiated by the resident, unless other mutually agreed arrangements have been made.

(18) Smoking. Smoking is not allowed in sleeping areas. If there is a designated smoking area, it will be separated from other common areas. Indoor smoking areas will be equipped with a mechanical exhaust fan or central exhaust system which discharges to the outside. Furniture used in designated smoking areas will be non-flammable and without crevasses. In homes initially licensed on or after December 1, 1999, indoor smoking areas will be separated from other parts of the home by a self-closing door, contain sprinkler protection or heat detectors, and contain only non-combustible furnishings and materials.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0330

Safety

(1) Training on Safety Procedures. All staff will be trained in staff safety procedures prior to beginning their first regular shift. All residents will be trained in resident safety procedures as soon as possible during their first 72 hours of residency.

(2) Emergency Procedure and Disaster Plan. A written procedure and disaster plan will be developed to cover such emergencies and disasters as fires, explosions, missing persons, accidents, earthquakes and floods. The plan will be posted by the phone and immediately available to the administrator and employees. The

plan will specify where staff and residents will go if the home becomes uninhabitable. The plan will be kept up to date and will include:

- (a) Emergency instructions for employees;
- (b) The telephone numbers of the local fire department, police department, the poison control center, the administrator, the administrator's designee, and other persons to be contacted in emergencies; and
- (c) Instructions for the evacuation of residents and employees.

(3) Combustible and Hazardous Materials. Noncombustible and nonhazardous materials will be used whenever possible. When necessary to the operation of the home, flammable and combustible liquids and other hazardous materials will be safely and properly stored in clearly labeled, original containers in areas inaccessible to residents in accordance with the Fire Code. Any quantities of combustible and hazardous materials maintained will be the minimum necessary.

(4) Poisonous and Other Toxic Materials. Non-toxic cleaning supplies will be used whenever available. Poisonous and other toxic materials will be properly labeled and stored in locked areas distinct and apart from all food and medications.

(5) Evacuation Capability. Evacuation capability categories are based upon the ability of the residents and staff as a group to evacuate the home or relocate from a point of occupancy to a point of safety. Homes will be constructed and equipped according to the Building Code occupancy classification for the designated evacuation capability for occupants. Occupancy classification categories of evacuation capability include "Impractical" and "Slow" (SR-3). "Prompt" homes are regulated by the building and fire codes as R-3 occupancies. The evacuation capability designated for the facility will be documented and maintained in accordance with requirements for Group SR Occupancies in the Building Code.

(a) Only persons assessed to be capable of evacuating in accordance with the designated facility evacuation capability will be admitted to the RTH.

(b) Persons experiencing difficulty with evacuating in a timely manner will be provided assistance from staff and offered environmental and other accommodations, as practical. Under such circumstances, the RTH will consider increasing staff levels, changing staff assignments, offering to change the resident's room assignment, arranging for special equipment, and taking other actions that may assist the resident. Residents who still cannot evacuate the home safely in the allowable period of time will be assisted with transferring to another program with an evacuation capability designation consistent with the individual's documented evacuation capability.

(6) Evacuation Drills. Every resident will participate in an unannounced evacuation drill each month. (See Section 408.12.5 of the Fire Code.)

(a) At least once every three months, the drill will be conducted during resident sleeping hours.

(b) Drills will be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes.

(c) Any resident failing to evacuate within the established time limits will be provided with special assistance and a notation made in the resident record.

(d) Written evacuation records will be retained for at least three years. They will include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.

(7) Unobstructed Egress. All stairways, halls, doorways, passageways, and exits from rooms and from the home will be unobstructed.

(8) Fire Extinguishers. The program will install and maintain one or more 2A:10B:C fire extinguishers on each floor in accordance with the Fire Code.

(9) Fire and Smoke Alarms and Detectors. Approved fire and smoke alarms and detectors will be installed according to Building Code and Fire Code requirements. These alarms will be tested during each evacuation drill. The RTH will provide appropriate signal devices for persons with disabilities who do not respond to the standard auditory alarms. All of these devices will be inspected and maintained in accordance with the requirements of the State Fire Marshal or local agency having jurisdiction.

(10) Sprinkler Systems. Sprinkler systems, if used, will be installed in compliance with the Building Code and maintained in accordance with rules adopted by the State Fire Marshal.

(11) First Aid Supplies. First aid supplies will be readily accessible to staff. All supplies will be properly labeled.

(12) Portable Heaters. Portable heaters are a recognized safety hazard and will not be used, except as approved by the State Fire Marshal or authorized representative.

(13) Safety Program. A safety program will be developed and implemented to identify and prevent the occurrence of hazards. Such hazards may include, but are not limited to, dangerous substances, sharp objects, unprotected electrical outlets, use of extension cords or other special plug-in adapters, slippery floors or stairs, exposed heating devices, broken glass, inadequate water temperatures, overstuffed furniture in smoking areas, unsafe ashtrays and ash disposal, and other potential fire hazards.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0340 Sanitation

(1) Water Supply. The water supply in the home will meet the requirements of the current rules of the Health Division governing domestic water supplies.

(a) A municipal water supply will be utilized if available.

(b) When the home is not served by an approved municipal water system, and the home qualifies as a public water system according to OAR 333-061-0020(127), Public Health Division rules for public water systems, then the home will comply with the OAR chapter 333 rules of the Public Health Division pertaining to public water systems. These include requirements that the drinking water be tested for total coliform bacteria at least quarterly, and nitrate at least annually, and reported to Public Health Division. For adverse test results, these rules require that repeat samples and corrective action be taken to assure compliance with water quality standards, that public notice be given whenever a violation of the water quality standards occurs, and that records of water testing be retained according to the Public Health Division requirements.

(2) Surfaces. All floors, walls, ceilings, windows, furniture, and equipment will be kept in good repair, clean, neat and orderly.

(3) Plumbing Fixtures. Each bathtub, shower, lavatory, and toilet will be kept clean, in good repair and regularly sanitized.

(4) Disposal of Cleaning Waste Water. No kitchen sink, lavatory, bathtub, or shower will be used for the disposal of cleaning waste water.

(5) Soiled Laundry. Soiled linens and clothing will be stored in an area or container separate from kitchens, dining areas, clean linens, clothing, and food.

(6) Pest Control. All necessary measures will be taken to prevent rodents and insects from entering the home. Should pests be found in the home, appropriate action will be taken to eliminate them.

(7) Grounds Maintenance. The grounds of the home will be kept orderly and reasonably free of litter, unused articles, and refuse.

(8) Garbage Storage and Removal. Garbage and refuse receptacles will be clean, durable, watertight, insect and rodent proof, and will be kept covered with tight-fitting lids. All garbage and solid waste will be disposed of at least weekly and in compliance with the current rules of the Department of Environmental Quality.

(9) Sewage Disposal. All sewage and liquid wastes will be disposed of in accordance with the Plumbing Code to a municipal

sewage system where such facilities are available. If a municipal sewage system is not available, sewage and liquid wastes will be collected, treated, and disposed of in compliance with the current rules of the Department of Environmental Quality. Sewage lines, and septic tanks or other non-municipal sewage disposal systems where applicable, will be maintained in good working order.

(10) Biohazardous Waste. Biohazardous waste will be disposed of in compliance with the rules of the Department of Environmental Quality.

(11) Infection Control. Precautions will be taken to prevent the spread of infectious and/or communicable diseases as defined by the Centers for Disease Control and to minimize or eliminate exposure to known health hazards.

(a) In accordance with OAR 437-002-0368 through 437-002-2226 of the Oregon Occupational Safety and Health Code, staff will employ universal precautions whereby all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

(b) Bathroom facilities will be equipped with an adequate supply of toilet paper, soap and towels.

(12) Infection Control for Pets and Other Household Animals. If pets or other household animals exist at the home, sanitation practices will be implemented to prevent health hazards.

(a) Such animals will be vaccinated in accordance with the recommendations of a licensed veterinarian. Proof of such vaccinations will be maintained on the premises.

(b) Animals not confined in enclosures will be under control and maintained in a manner that does not adversely impact residents or others.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0350

Resident Furnishings

(1) Bedroom Furniture. Residents will be allowed to use their own furniture within space limitations of the resident sleeping room. Otherwise, furniture will be provided or arranged for each resident, maintained in good repair and include:

(a) A bed, including a frame and a clean mattress and pillow;

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

(c) Locked storage for the resident's small, personal belongings. In homes initially licensed before December 1, 1999, this locked storage may be provided in a place other than the resident's bedroom. The resident will be provided with a key or other method to gain access to his/her locked storage space.

(2) Linens. Linens will be provided for each resident and will include:

(a) Sheets, pillowcase, other bedding appropriate to the season and individual resident's comfort;

(b) Availability of a waterproof mattress or waterproof mattress cover; and

(c) Towels and wash cloths.

(3) Personal Hygiene Items. Each resident will be assisted in obtaining personal hygiene items in accordance with individual needs. These will be stored in a clean and sanitary manner, and may be purchased with the resident's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, and menstrual supplies (if needed).

(4) Supplies Provided by RTH. Sufficient supplies of soap, shampoo and toilet paper for all residents will be provided.

(5) Common Area Furniture. An adequate supply of furniture for resident use in living room, dining room and other common areas will be maintained in good condition.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0360

Admission to Home

(1) Responsibility for Admission Process. Each RTHs admission policy and procedures will specify who is responsible for each component of the admission information-gathering and decision-making process. Responsibilities will be organized and assigned to promote effective processing of referrals and admissions.

(2) Referrals. Unless limited by contractual agreement with the Division or other Division-approved party, referrals may be accepted from a variety of sources. Residents whose services will be funded by the Division must be approved for placement by the CMHP or other local entity given responsibility for this function by contract with the Division.

(3) Release of Information. In accordance with ORS 179.505 and the 45 Code of Federal Registry, Part 164, an authorization for the release of information will be obtained for any confidential information concerning a prospective resident.

(4) Nondiscrimination. Persons will be considered for admission without regard to race, color, sex or sexual orientation (except as may be limited by room arrangement), religion, creed, national origin, age (except under 18 years), familial status, marital status, source of income, or disability in addition to the mental or emotional disorder.

(5) Screening. Prior to accepting a resident for admission to the RTH, the administrator or his/her designee will determine that the resident meets admission criteria. The prospective resident will receive an explanation of the program, be given a copy of materials explaining conditions of residency, and be offered the opportunity to visit the home. Sufficient information will be obtained from the prospective resident, a relative and/or agencies providing services to determine eligibility for admission and service needs. In the case of individuals referred for emergency or crisis-respite admission, the information obtained may be less extensive than for regular admissions but must be sufficient to determine that the resident meets admission criteria and that the RTH is appropriate considering the individual's needs. Screening information will include, but not be limited to, the following:

(a) Written documentation that the prospective resident has, or is suspected of having, a mental or emotional disorder;

(b) Background information including a mental health assessment and describing previous living arrangements, service history, behavioral issues and service needs;

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

(d) Copies of documents, or other documentation, relating to guardianship, conservatorship, commitment status, advance directives, or any other legal restrictions (as applicable);

(e) A copy of the prospective resident's most recent mental health treatment plan, or in the case of an emergency or crisis-respite admission, a summary of current mental health treatment involvement; and

(f) Documentation of the prospective resident's ability to evacuate the building consistent with the RTHs designated evacuation capability and other concerns about potential safety risks.

(6) Admission Criteria. Persons considered for admission will:

(a) Be assessed to have a mental or emotional disorder, or a suspected mental or emotional disorder;

(b) Be in need of care, treatment and supervision;

(c) Be at least 18 years of age;

(d) Not require continuous nursing care, unless a reasonable plan to provide such care exists, the need for residential treatment supersedes the need for nursing care, and the Division approves the placement;

(e) Have an evacuation capability consistent with the RTHs SR Occupancy classification; and

(f) Meet additional criteria required or approved by the Division through contractual agreement or condition of licensing.

(7) Admission Decisions. A decision to admit a resident to the RTH will be made as follows:

(a) For regular admissions, the decision will be made based upon a review of screening materials at a pre-admission meeting and a determination that the resident meets the admission criteria. A pre-admission meeting will be scheduled to include the RTH administrator or designee, the potential resident and his/her legal guardian (as applicable). With the prospective resident's consent, the pre-admission meeting may also include family member(s) or other representative(s) as appropriate, representative(s) of relevant service providing agency(ies), and others with an interest in the resident's admission. The potential resident, legal guardian (as applicable) and authorized representative will be informed of the admission decision within 72 hours. If a decision is deferred or postponed, the potential resident, legal guardian (as applicable) and authorized representative will be informed of the potential resident's application status within one week of the pre-admission meeting, and weekly thereafter (as necessary). When admission is denied, the prospective resident, their legal guardian (as applicable) and authorized representative will be informed in writing of the basis for the decision and their right to appeal the decision in accordance with OAR 309-035-0390.

(b) For crisis-respite admissions, the decision will be made based upon a review of the referral materials by the RTH administrator or designee and a determination that the resident meets the admission criteria. Due to the urgent nature of crisis-respite admissions, decisions will be made on an immediate basis. The prospective resident, their legal guardian (as applicable) and authorized representative will be directly informed of the decision and their right to appeal in accordance with OAR 309-035-0390.

(8) Informed Consent for Services. The RTH will obtain informed consent for services upon admission to the RTH from each resident, or his/her guardian (as applicable), unless the resident's ability to do so is legally restricted. If such consent is not obtained, the reason will be documented and further attempts to obtain informed consent will be made as appropriate.

(9) Orientation. Upon admission, the administrator or his/her designee will provide an orientation to each new resident that includes, but is not limited to, a complete tour of the home, introductions to other residents and staff, discussion of house rules, explanation of the laundry and food service schedule and policies, review of resident rights and grievance procedures, explanation of the fee policy, discussion of the conditions under which residency would be terminated, and a general description of available services and activities. During the orientation, advance directives will be explained. If the resident does not already have any advance directive(s), she/he will be given an opportunity to complete them. Orientation will also include a description of the RTHs emergency procedures in accordance with OAR 309-035-0330.

(10) Record Preparation. A resident record will be established concurrent with the resident's admission. Prior to a regular admission, within five days after an emergency admission, or within 24 hours of a crisis-respite admission, the program will determine with whom communication needs to occur and will attempt to obtain the needed authorizations for release of information. The record established upon admission will include the materials reviewed in screening the resident, the summary sheet and any other available information. Every effort will be made to complete the resident record consistent with OAR 309-035-0300 in a timely manner. The assessment and residential service plan will be completed in accordance with 309-035-0400. Records on prescribed medications and health needs will be completed as specified in 309-035-0440.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0370

Termination of Residency

(1) Responsibility for Termination Process. Each RTHs termination policy and procedures will specify who is responsible for each step of the process for terminating residency. Responsibilities will be organized and assigned to promote a fair and efficient termination process. Unless otherwise designated as a condition of licensing or in contract language approved by the Division, the Administrator will be responsible for initiating and coordinating termination proceedings. An effort will be made to prevent unnecessary terminations by making reasonable accommodations within the RTH.

(2) Crisis-respite Services. Because crisis-respite services are time-limited, the planned end of services will not be considered a termination of residency and will not be subject to requirements in OAR 309-035-0370. Upon admission to crisis-respite services, the resident or guardian (as applicable) will be informed of the planned date for discontinuation of services. This date may be extended through mutual agreement between the administrator and the resident or guardian (as applicable). RTHs providing crisis-respite services will implement policies and procedures that specify reasonable time frames and the grounds for discontinuing crisis-respite services earlier than the date planned.

(3) Voluntary Termination of Residency. A resident or guardian (as applicable) may terminate residency in the RTH upon providing at least 30 days notice. Upon mutual agreement between the administrator and the resident or guardian (as applicable), less than 30 days notice may be provided.

(4) Emergency Termination of Residency. If a resident's behavior poses a serious and immediate threat to the health or safety of others in or near the RTH, the administrator, after providing 24 hours written notice specifying the causes to the resident or guardian (as applicable), may immediately terminate the residency. The notice will specify the resident's right to appeal the emergency termination decision in accordance with OAR 309-035-0390.

(5) Other Terminations of Residency. When other circumstances arise providing grounds for termination of residency, the administrator will discuss these grounds with the resident, the resident's guardian (as applicable), and with the resident's permission, other persons with an interest in the resident's circumstances. If a decision is made to terminate residency, the administrator will provide at least 30 days written notice specifying the causes to the resident or guardian (as applicable). This notice will also specify the resident's right to appeal the termination decision in accordance with OAR 309-035-0390. Upon mutual agreement between the administrator and the resident or guardian (as applicable), less than 30 days notice may be provided. An effort will be made to establish a reasonable termination date in consideration of both program needs and the needs of the terminated resident to find alternative living arrangements. Criteria establishing grounds for termination include:

(a) Resident no longer needs or desires services provided at the RTH and/or expresses a desire to move to an alternative setting;

(b) Resident is assessed by a Licensed Medical Professional or other qualified health professional to require services, such as continuous nursing care or extended hospitalization, that are not available, or can not be reasonably arranged, at the RTH;

(c) Resident's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others and these behavioral concerns cannot be adequately addressed with services available at the RTH or services that can be arranged outside of the RTH;

(d) Resident cannot safely evacuate the home in accordance with the RTHs SR Occupancy Classification after efforts described in OAR 309-035-0330 have been taken;

(e) Nonpayment of fees in accordance with program's fee policy; and

(f) Resident continuously and knowingly violates house rules resulting in significant disturbance to others.

(6) Pre-termination Meeting. Except in the case of emergency terminations or crisis-respite services, a pre-termination meeting will be held with the resident, guardian (as applicable), and with the resident's permission, others interested in the resident's circumstances. The purpose of the meeting is to plan any arrangements necessitated by the termination decision. The meeting will be scheduled to occur at least two weeks prior to the termination date. In the event a pre-termination meeting is not held, the reason will be documented in the resident's record.

(7) Documentation. Documentation of discussions and meetings held concerning termination of residency and copies of notices will be maintained in the resident's record.

(8) Disposition of Personal Property. At the time of termination of residency, the resident will be given a statement of account, any balance of funds held by the RTH and all property held in trust or custody by the RTH.

(a) In the event of pending charges (such as long distance phone charges or damage assessments), the program may hold back the amount of funds anticipated to cover the pending charges. Within 30 days after residency is terminated or as soon as pending charges are confirmed, the resident will be provided a final financial statement along with any funds due to the resident.

(b) In the case of resident belongings left at the RTH for longer than seven days after termination of residency, the RTH will make a reasonable attempt to contact the resident, guardian (as applicable) and/or other representative of the resident. The RTH must allow the resident, guardian (as applicable) or other representative at least 15 days to make arrangements concerning the property. If it is determined that the resident has abandoned the property, the RTH may then dispose of the property. If the property is sold, proceeds of the sale, minus the amount of any expenses incurred and any amounts owed the program by or on behalf of the resident, will be forwarded to the resident or guardian (as applicable).

(9) Absences without Notice. If a resident moves out of the RTH without providing notice, or is absent without notice for more than seven consecutive days, the administrator may terminate residency in the manner provided in ORS 105.105 to 105.168 after seven consecutive days of the resident's absence. An attempt will be made to contact the resident, guardian (as applicable) and/or other person interested in the resident's circumstances to confirm the resident's intent to discontinue residency.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0380 Resident Rights

(1) Statutory and Constitutional Rights. Each resident will be assured the same civil and human rights accorded to other citizens. These rights will be assured unless expressly limited by a court in the case of a resident who has been adjudicated incompetent and not restored to legal capacity. The rights described in paragraphs (2) and (3) of this section are in addition to, and do not limit, all other statutory and constitutional rights which are afforded to all citizens including, but not limited to, the right to vote, marry, have or not have children, own and dispose property, enter into contracts and execute documents.

(2) Rights of Service Recipients. In accordance with ORS 430.210, residents will have the right to:

(a) Choose from available services those which are appropriate, consistent with the plan developed in accordance with paragraphs (b) and (c) of this subsection, and provided in a setting and under conditions that are least restrictive to the person's liberty, that are least intrusive to the person and that provide for the greatest degree of independence;

(b) An individualized written service plan, services based upon that plan and periodic review and reassessment of service needs;

(c) Ongoing participation in planning services in a manner appropriate to the person's capabilities, including the right to par-

ticipate in the development and periodic revision of the plan described in paragraph (b) of this subsection, and the right to be provided with a reasonable explanation of all service considerations;

(d) Not receive services without informed consent except in a medical emergency or as otherwise permitted by law;

(e) Not participate in experimentation without informed voluntary written consent;

(f) Receive medication only for the person's individual clinical needs;

(g) Not be involuntarily terminated or transferred from services without prior notice, notification of available sources of necessary continued services and exercise of a grievance procedure;

(h) A humane service environment that affords reasonable protection from harm and affords reasonable privacy;

(i) Be free from abuse or neglect and to report any incident of abuse without being subject to retaliation;

(j) Religious freedom;

(k) Not be required to perform labor, except personal house-keeping duties, without reasonable and lawful compensation;

(l) Visit with family members, friends, advocates and legal and medical professionals;

(m) Exercise all rights set forth in ORS 426.385 and 427.031 if the individual is committed to the Division;

(n) Be informed at the start of services and periodically thereafter of the rights guaranteed by this section and the procedure for reporting abuse, and to have these rights and procedures prominently posted in a location readily accessible to the person and made available to the person's guardian and any representative designated by the person;

(o) Assert grievances with respect to infringement of the rights described in this section, including the right to have such grievances considered in a fair, timely and impartial grievance procedure;

(p) Have access to and communicate privately with any public or private rights protection program or rights advocate; and

(q) Exercise all rights described in this section without any form of reprisal or punishment.

(3) Additional Rights in RTHs. Residents will also have a right to:

(a) Adequate food, shelter and clothing, consistent with OAR 309-035-0410;

(b) A reasonable accommodation if, due to their disability, the housing and services are not sufficiently accessible;

(c) Confidential communication, including receiving and opening personal mail, private visits with family members and other guests, and access to a telephone with privacy for making and receiving telephone calls;

(d) Express sexuality in a socially appropriate and consensual manner;

(e) Access to community resources including recreation, religious services, agency services, employment and day programs, unless such access is legally restricted;

(f) Be free from seclusion and restraint;

(g) To review the RTHs policies and procedures; and

(h) Not participate in research without informed voluntary written consent.

(4) The Resident's Right to Fresh Air. For the purpose of this rule, these terms have the following meanings:

(a) "Fresh air" means the inflow of air from outside the facility where the resident is receiving services. "Fresh air" may be accessed through an open window or similar method as well as through access to the outdoors.

(b) "Outdoors" means an area with fresh air that is not completely enclosed overhead. "Outdoors" may include a courtyard or similar area.

(c) If a resident requests access to fresh air and the outdoors or the resident's treating health care provider determines that fresh air and the outdoors would be beneficial to the resident, the facility in which the resident is receiving services shall provide daily access

to fresh air or the outdoors unless this access would create a significant risk of harm to the resident or others.

(d) The determination whether a significant risk of harm to the resident or others exists shall be made by the resident's treating health care provider. The treating health care provider may find that a significant risk of harm to the resident or others exists if:

(A) The resident's individual circumstances and condition indicate an unreasonable risk of harm to the resident or others which cannot be reasonably accommodated within existing programming should the resident be allowed access to fresh air and the outdoors; or

(B) The facility's existing physical plant or existing staffing prevent the provision of access to fresh air and the outdoors in a manner that maintains the safety of the resident or others.

(e) If a facility determines that its existing physical plant prevents the provision of access to fresh air or the outdoors in a safe manner, the facility shall make a good faith effort at the time of any significant renovation to the physical plant that involves renovation of the unit or relocation of where residents are treated to include changes to the physical plan or location that allow access to fresh air and the outdoors, so long as such changes do not add an unreasonable amount to the cost of the renovation.

(5) Program Requirements. The program will have and implement written policies and procedures which protect residents' rights, and encourage and assist residents to understand and exercise their rights. The program will post a listing of resident rights under these rules in a place readily accessible to all residents and visitors.

Stat. Auth.: ORS 443.450
Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; MHS 5-2009, f. & cert. ef. 12-17-09; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0390

Grievances and Appeals

(1) Procedures. The RTH will have a written policy and procedures concerning the resident grievance and appeal process. A copy of the grievance and appeal process will be posted in a place readily accessible to residents. A copy of the grievance and appeal process will be provided to each resident and guardian (as applicable) at the time of admission to the RTH.

(2) Grievances. A RTH's process for grievances must, at a minimum, include the following:

(a) Residents will be encouraged to informally resolve complaints through discussion with RTH staff.

(b) If the resident is not satisfied with the informal process or does not wish to use it, the resident may proceed as follows:

(A) The resident may submit a complaint in writing to the RTH administrator. The resident may receive assistance in submitting the complaint from any person whom the resident chooses. If requested by the resident, RTH staff will be available to assist the resident.

(B) The written complaint will go directly to the RTH administrator without being read by other staff, unless the resident requests or permits other staff to read the complaint.

(C) The complaint will include the reasons for the grievance and the proposed resolutions. No complaint will be disregarded because it is incomplete.

(D) Within five days of receipt of the complaint, the RTH administrator will meet with the resident to discuss the complaint. The resident may have an advocate or other person of his/her choosing present for this discussion.

(E) Within five days of meeting with the resident, the RTH administrator will provide a written response to the resident. As part of the written response, the Administrator will provide information about the appeal process.

(F) In circumstances where the matter of the complaint is likely to cause irreparable harm to a substantial right of the resident before the grievance procedures outlined in OAR 309-035-0390 are completed, the resident may request an expedited review. The RTH administrator will review and respond in writing to the

grievance within 48 hours. The written response will include information about the appeal process.

(3) Appeals. Residents, their legal guardians (as applicable) and prospective residents (as applicable) will have the right to appeal admission, termination and grievance decisions as follows:

(a) If the resident is not satisfied with the decision, the resident may file an appeal in writing within ten days of the date of the RTH administrator's response to the complaint or notification of admission denial or termination (as applicable). The appeal will be submitted to the CMHP director or designee in the county where the RTH is located.

(b) The resident may receive assistance in submitting the appeal. If requested by the resident, RTH staff will be available to assist the resident.

(c) The CMHP director or designee will provide a written response within ten days of receiving the appeal.

(d) If the resident is not satisfied with the CMHP director's decision, the resident may file a second appeal in writing within ten days of the date of the CMHP director's written response to the Administrator of the Division or designee. The decision of the Administrator of the Division will be final.

Stat. Auth.: ORS 443.450
Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0400

Resident Assessment and Residential Service Plan

(1) Assessment. An assessment will be completed for each resident within 30 days after admission to the RTH, unless admitted to the RTH for crisis-respite services.

(a) The assessment will be based upon an interview with the resident to identify strengths, preferences and service needs; observation of the resident's capabilities within the residential setting; a review of information in the resident record; and contact with representatives of other involved agencies, family members and others, as appropriate. All contacts with others will be made with proper authorization for the release of information.

(b) Assessment findings will be summarized in writing and included in the resident's record. Assessment findings will include, but not be limited to, diagnostic and demographic data; identification of the resident's medical, physical, emotional, behavioral and social strengths, preferences and needs related to independent living and community functioning; and recommendations for residential service plan goals.

(2) Residential Service Plan. An individualized plan, identifying the goals to be accomplished through the services provided, will be prepared for each resident, unless admitted to the RTH for crisis-respite services, within 30 days after admission.

(a) The residential service plan will be based upon the findings of the resident assessment, be developed with participation of the resident and his/her guardian (as applicable), and be developed through collaboration with the resident's primary mental health treatment provider. With consent of the resident or guardian (as applicable), family members, representatives from involved agencies, and others with an interest in the resident's circumstances will be invited to participate. All contacts with others will be made with proper, prior authorization from the resident.

(b) The residential service plan will identify service needs, desired outcomes and service strategies to address, but not be limited to, the following areas: physical and medical needs, medication regimen, self-care, social-emotional adjustment, behavioral concerns, independent living capability and community navigation.

(c) The residential service plan will be signed by the resident, the administrator or other designated RTH staff person, and others, as appropriate, to indicate mutual agreement with the course of services outlined in the plan.

(3) Crisis-respite Requirements. For residents admitted to RTHs for 30 days or less, an assessment and residential service plan must be developed within 48 hours of admission which identifies service needs, desired outcomes and the service strategies to be

implemented to resolve the crisis or address other needs of the individual that resulted in the short term service arrangement.

(4) Progress Notes. Progress notes will be maintained within each resident's record and document significant information relating to all aspects of the resident's functioning and progress toward desired outcomes identified in the residential service plan. A progress note will be entered in the resident's record at least once each month for regular residents and at least daily for crisis-respite residents.

(5) Re-assessments and Revisions to the Residential Service Plan. The assessment and residential service plan will be reviewed and updated at least annually. On an ongoing basis, the residential service plan will be updated, as necessary, based upon changing circumstances or upon the resident's request for reconsideration.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0410

Resident Services and Activities

(1) General Requirements. The services and activities available at the RTH will include care and treatment consistent with ORS 443.400 and those services individually specified for the resident in the residential service plan developed as outlined in OAR 309-035-0400. Residents will be encouraged to care for their own needs to the extent possible. All services and activities will be provided in a manner that respects residents' rights, promotes recovery and affords personal dignity.

(2) Services and Activities to Be Available. Services and activities to be available will include but not be limited to:

(a) Provision of adequate shelter consistent with OAR 309-035-0320 through 309-035-0350;

(b) At least three meals per day, seven days per week, provided in accordance with OAR 309-035-0430;

(c) Assistance and support, as necessary, to enable residents to meet personal hygiene and clothing needs;

(d) Laundry services, which may include access to washer(s) and dryer(s) so residents can do their own personal laundry;

(e) Housekeeping essential to the health and comfort of residents;

(f) Activities and opportunities for socialization and recreation both within the facility and in the larger community;

(g) Health-related services provided in accordance with OAR 309-035-0440;

(h) Assistance with community navigation and transportation arrangements;

(i) Assistance with money management, where requested by a resident, to include accurate documentation of all funds deposited and withdrawn when funds are held in trust for the resident;

(j) Assistance with acquiring skills to live as independently as possible;

(k) Assistance with accessing other additional services, as needed; and

(l) Any additional services required under contract with the Division.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0420

Prohibition of Seclusion and Restraints

General Prohibition. The use of seclusion or restraints is prohibited in Residential Treatment Homes. Only Secure Residential Treatment Facilities approved by the Division in accordance with OAR 309-035-0100 through 309-035-0190 will be allowed to use seclusion and restraints.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0430

Food Services

(1) Well-balanced Diet. Meals will be planned and served in accordance with the recommended dietary allowances found in the United States Department of Agriculture Food Guide Pyramid.

(2) Modified or Special Diets. An order from a Licensed Medical Professional will be obtained for each resident who, for health reasons, is on a modified or special diet. Such diets will be planned in consultation with the resident.

(3) Menus. Menus will be prepared at least one week in advance and will provide a sufficient variety of foods served in adequate amounts for each resident at each meal and adjusted for seasonal changes. Records of menus, as served, will be filed and maintained in the RTH for at least 30 days. Resident preferences and requests will be considered in menu planning. Religious and vegetarian preferences will be reasonably accommodated.

(4) Supply of Food. Adequate supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days will be maintained on the premises.

(5) Sanitation. Food will be stored, prepared and served in accordance with the Public Health Division's Food Sanitation Rules.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0440

Health Services

(1) General. The administrator will be responsible for assuring that all residents are offered medical attention when needed. Arrangements for health services will be made with the informed consent of the resident and/or guardian (as applicable). The RTH will arrange for physicians or other qualified health care professionals to be available in the event the resident's regular physician or other health care professional is unavailable. A hospital emergency room will be identified and may be used in case of emergency.

(2) Initial Health Screening. Each resident admitted to the RTH will be screened by a qualified health care professional to identify health problems and to screen for communicable disease. Documentation of the initial health screening will be placed in the resident record.

(a) The health screening will include a brief history of health conditions, current physical condition and a written record of current or recommended medications, treatments, dietary specifications, and aids to physical functioning.

(b) For regular admissions, the health screening will be obtained prior to the resident's admission and include the results of testing for tuberculosis and Hepatitis B.

(c) For emergency admissions, including crisis-respite admissions, the health screening will be obtained as follows:

(A) For individuals experiencing psychiatric or medical distress, a health screening will be completed by a qualified health care professional prior to the resident's admission or within 24 hours of the emergency placement. The health screening will confirm that the individual does not have health conditions requiring continuous nursing care, a hospital level of care, or immediate medical assistance. For each crisis-respite resident who continues in the RTH for more than seven consecutive days, a complete health examination will be arranged if any symptoms of a health concern exist.

(B) For other individuals who are admitted on an urgent basis due to a lack of alternative supportive housing, the health screening will be obtained within 72 hours after the resident's admission.

(C) The health screening criteria may be waived for individuals admitted for crisis-respite services who are under the active care of an LMP or other qualified health care professional if it is the opinion of the attending health care professional that the crisis-respite placement presents no health risk to the individual or other residents in the RTH. Such a waiver must be provided in writing

and be signed and dated by the attending health care professional within 24 hours of the resident's admission.

(3) Regular Health Examinations. Except for crisis-respite residents, the program will ensure that each resident has a primary physician or other qualified health care professional who is responsible for monitoring his/her health care. Regular health examinations will be done in accordance with the recommendations of this primary health care professional, but not less than once every three years. New residents will have a health examination completed within one year prior to admission or within three months after admission. Documentation of findings from each examination will be placed in the resident's record.

(4) Written Orders for Special Needs. A written order, signed by a physician or other qualified health care professional, is required for any medical treatment, special diet for health reasons, aid to physical functioning or limitation of activity.

(5) Medications. A written order signed by a physician or other qualified health care professional is required for all medications administered or supervised by RTH staff. This written order is required before any medication is provided to a resident. All medication maintained in the RTH will be provided to residents in accordance with the applicable written orders.

(a) Medications will be self-administered by the resident if the resident demonstrates the ability to self-administer medications in a safe and reliable manner. In the case of self-administration, both the written orders of the prescriber and the residential service plan will document that medications will be self-administered. The self-administration of medications may be supervised by RTH staff who may prompt the resident to administer the medication and observe the fact of administration and dosage taken. When supervision occurs, staff will enter information in the resident's record consistent with section OAR 309-035-0440 below.

(b) Staff who assist with administration of medication will be trained by a Licensed Medical Professional or other qualified health care professional on the use and effects of commonly used medications.

(c) Medications prescribed for one resident will not be administered to, or self-administered by, another resident. Medication will not be used for the convenience of staff or as a substitute for programming. Medications will not be withheld or used as reinforcement or punishment.

(d) Stock supplies of prescription medications will not be maintained. The RTH may maintain a stock supply of non-prescription medications.

(e) The RTH will provide and implement a policy and procedure which assures that all orders for prescription drugs are reviewed by a qualified health care professional, as specified by a physician or other qualified health care professional, but not less often than every six months. Where this review identifies a contraindication or other concern, the resident's primary physician, LMP or other primary health care professional will be immediately notified.

(f) Each resident receiving psychotropic medications will be evaluated at least every three months by the LMP prescribing the medication. The RTH will obtain from the LMP the results of this evaluation and any changes in the type and dosage of medication, the condition for which it is prescribed, when and how the medication is to be administered, common side effects (including any signs of tardive dyskinesia, contra-indications or possible allergic reactions), and what to do in case of a missed dose or other dosing error.

(g) All unused, discontinued, outdated or recalled medications, and any medication containers with worn, illegible or missing labels will be disposed. The method of disposal will be safe, consistent with any applicable federal statutes, and designed to prevent diversion of these substances to persons for whom they were not prescribed. A written record of all disposals will be maintained and specify the date of disposal, a description of the medication, its dosage potency, amount disposed, the name of the individual for whom the medication was prescribed, the reason for disposal, the method of disposal, and the signature of the staff person disposing

the medication. For any medication classified as a controlled substance in schedules 1 through 5 of the Federal Controlled Substance Act, the disposal must be witnessed by a second staff person who documents their observation by signing the disposal record.

(h) All medications will be properly and securely stored in a locked space for medications only in accordance with the instructions provided by the prescriber or pharmacy. Medications for all residents will be labeled. Medications requiring refrigeration must be stored in an enclosed locked container within the refrigerator. The RTH will assure that residents have access to a locked, secure storage space for their self-administered medications. The RTH will note in its written policy and procedures which persons have access to this locked storage and under what conditions.

(i) For all residents taking prescribed medication, staff will record in the medical record each type, date, time and dose of medication provided. All side effects, adverse reactions and medication errors will be documented in the resident's record. All serious adverse reactions or errors will be reported immediately to the prescribing health care professional. All other errors, adverse reactions or refusals of medication will be reported to the prescribing professional within 48 hours.

(j) P.r.n. medications and treatments will only be administered in accordance with the parameters specified by the prescribing health care professional, or in cases where a nurse assigns or delegates p.r.n. medication or treatment administration, in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

(6) Delegation of Nursing Tasks. Where a nurse is involved in the care of an RTH resident, nursing tasks may be assigned or delegated by a Registered Nurse to direct care staff in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0450

Civil Penalties

(1) Applicability of Long Term Care Statute. For purposes of imposing civil penalties, RTHs licensed under ORS 443.400 to 443.465 and 443.991 are considered to be long-term care facilities subject to 441.705 to 441.745.

(2) Sections of Rule Subject to Civil Penalties. Violations of any requirement within any part of the following sections of the rule may result in a civil penalty:

- (a) 309-035-0270 Licensing;
- (b) 309-035-0280 Contracts and Rates;
- (c) 309-035-0290 Administrative Management;
- (d) 309-035-0300 Records;
- (e) 309-035-0310 Staffing;
- (f) 309-035-0320 Physical Environment Requirements;
- (g) 309-035-0330 Safety;
- (h) 309-035-0340 Sanitation;
- (i) 309-035-0350 Resident Furnishings;
- (j) 309-035-0360 Admission to Home;
- (k) 309-035-0370 Termination of Residency;
- (l) 309-035-0380 Resident Rights;
- (m) 309-035-0390 Grievances and Appeals;
- (n) 309-035-0400 Resident Assessment and Residential Service Plan;

- (o) 309-035-0410 Resident Services and Activities;
- (p) 309-035-0420 Prohibition of Seclusion or Restraints;
- (q) 309-035-0430 Food Services; and
- (r) 309-035-0440 Health Services.

(3) Assessment of Civil Penalties. Civil penalties will be assessed in accordance with the following guidelines:

(a) Civil penalties, not to exceed \$250 per violation to a maximum of \$1,000, may be assessed for general violations of these rules. Such penalties will be assessed after the procedures outlined in OAR 309-035-0270(8) have been implemented;

(b) A mandatory penalty up to \$500 will be assessed for falsifying resident or facility records or causing another to do so;

(c) A mandatory penalty of \$250 per occurrence will be imposed for failure to have direct care staff on duty 24 hours per day;

(d) Civil penalties up to \$1,000 per occurrence may be assessed for substantiated abuse;

(e) In addition to any other liability or penalty provided by the law, the Division may impose a penalty for any of the following:

(A) Operating the RTH without a license;

(B) Operating with more residents than the licensed capacity; and

(C) Retaliating or discriminating against a resident, family member, employee, or other person for making a complaint against the program.

(f) In imposing a civil penalty, the following factors will be taken into consideration:

(A) The past history of the person incurring the penalty in taking all feasible steps or procedures to correct the violation;

(B) Any prior violations of statutes, rules or orders pertaining to the RTH;

(C) The economic and financial conditions of the person incurring the penalty;

(D) The immediacy and extent to which the violation threatens or threatened the health, safety or welfare of one or more residents; and

(E) The degree of harm caused to residents.

(4) Notification. Any civil penalty imposed under this section will become due and payable ten days after notice is received, unless a request for a hearing is filed. The notice will be delivered in person, or sent by registered or certified mail and will include a reference to the particular section of the statute or rule involved, a brief summary of the violation, the amount of the penalty or penalties imposed, and a statement of the right to request a hearing.

(5) Request for Hearing. The person to whom the notice is addressed will have ten days from the date of receipt of the notice to request a hearing. This request must be in writing and submitted to the Administrator of the Division. If the written request for a hearing is not received on time, the Division will issue a final order by default.

(6) Hearings. All hearings will be conducted pursuant to the applicable provisions of ORS 183.310 to 183.550, Administrative Procedure and Rules for Civil Penalties.

(7) Judgment. Unless the penalty is paid within ten days after the order becomes final, the order constitutes a judgment and may be recorded by the County Clerk which becomes a lien upon the title to any interest in real property owned by the person. The Division may also take action to revoke the license upon failure to comply with a final order.

(8) Judicial Review. Civil penalties are subject to judicial review under ORS 183.480, except that the court may, at its discretion, reduce the amount of the penalty.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0460

Criminal Penalties

(1) Specification of Criminal Penalty. Violation of any provision of ORS 443.400 through 443.465 is a Class B misdemeanor.

(2) Grounds for Law Suit. In addition, the Division may commence an action to enjoin operation of a RTH:

(a) When a RTH is operated without a valid license; or

(b) When a RTH continues to operate after notice of revocation has been given and a reasonable time has been allowed for placement of residents in other programs.

Stat. Auth.: ORS 443.450

Stats. Implemented: ORS 443.400 - 443.465 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0500

Residential Facilities

(1) Effective September 1, 1988, and except as otherwise provided in this rule, the capacity of all **Residential Facilities** or home for adults, including foster care homes, group care facilities or residential treatment, training or care facilities, located throughout the state shall not exceed a target based on the number of beds available in 1979, updated at the rate of ten percent per year, as distributed on the basis of the Oregon population by county. The distribution shall be determined by the Oregon Health Authority annually.

(2) Where a county possesses less than one percentile of the State population, then the county with the lowest percentile within an Authority's region shall be grouped until such time as the group reaches one percentile of the State population in determining the distribution target.

(3) Nothing in this rule is intended to prevent placement of a person who was not initially a resident of the county in a domiciliary care facility in the county. The targeted number of beds shall not require reduction in any domiciliary care facility capacity existing on October 4, 1977. No domiciliary care facility will be required to suspend operations, nor will the Authority support be denied such facilities on the basis of the facility being located in a county or county grouping which exceeds the distribution target.

(4) Adult Foster Care Homes as described in section (1) of this rule does not include Adult Foster Care Homes in which the clients of these homes are directly related by blood or marriage to the operator of the homes.

(5) In cases for which the distribution target for residential facilities, except Adult Foster Care Homes, allows for additional capacity in a county or county grouping and such additional capacity is less than ten beds, then one additional facility of the same type of ten-bed capacity may be authorized.

(6) This rule applies only to those residential care facilities as described in sections (1) and (4) of this rule which are established by, contracted for, or operated by the Oregon Health Authority or any of its divisions.

(7) Nothing in this rule will exempt any residential facility from the regulations of funding limitations of the Oregon Health Authority or any of its divisions.

(8) Subject to the appropriate licensing requirements, the governing body of a county may authorize a residential facility located in the county to exceed the capacity limit upon:

(a) Request of an individual or organization operating or proposing to operate a residential facility;

(b) Consultation with an advisory committee appointed by the governing body and consisting of persons who are particularly interested in the type of residential facility contemplated; and

(c) Finding of good cause following notice and public hearing.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: HR 1-1978, f. & ef. 2-16-78; HR 17-1979, f. & ef. 11-19-79; HR 5-1988, f. & cert. ef. 9-1-88; Renumbered from 410-004-0001, MHS 7-2007, f. & cert. ef. 5-25-07; Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0550

Purpose

(1) OAR 309-035-0550 through 309-035-0600 establish a long-range goal wherein ultimately residential care and adult foster home clients of the Oregon Health Authority, whose primary service needs are associated with mental retardation or other developmental disabilities, or mental or emotional disturbance, or alcohol or drug abuse or dependence, will reside in Adult Residential Care Facilities and Adult Foster Homes under the jurisdiction of the Division serving only such category of residents. Those clients not having such primary service needs will reside in facilities under the jurisdiction of the Aging and People with Disabilities Division, serving only such category of residents.

(2) The goal is realized by assigning certain facilities to the jurisdiction of the Division with interim procedures for case man-

agement of mixed clients and by prescribing those facilities to which new placements will be made.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85;
Renumbered from 410-005-0080, MHS 7-2007, f. & cert. ef. 5-25-07;
Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0560

Definitions

As used in OAR 309-035-0550 through 309-035-0600:

(1) "Mental Retardation" means:

(a) A person with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered mentally retarded if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the Manual on Terminology and Classification in Mental Retardation of the American Association on Mental Deficiency, 1977 Revision, by this reference made a part hereof. Mental retardation is synonymous with mental deficiency;

(b) For community case management and program purposes, mental retardation includes those persons of borderline intelligence who have a history of residency in a state training center.

(2) "Developmental Disability" means a disability attributable to mental retardation, cerebral palsy, epilepsy, or other neurological handicapping conditions which require training similar to that required by mentally retarded individuals, and the disability:

(a) Originates before the individual attains age 22 except that in the case of mental retardation the condition must be manifested before the age of 18;

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the individual's ability to function in society.

(3) "Mental or Emotional Disturbance" means a disorder of emotional reactions, thought processes, behavior, or relationships (excluding mental retardation, alcoholism and drug abuse or dependency) which results in substantial subjective distress, impaired perceptions of reality, or impaired ability to control or appreciate the consequences of one's behavior, and which constitutes a substantial impairment of personal, interpersonal, work, educational or civic functioning. If a medical diagnosis is made, classification shall be consistent with the current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association 1980, by this reference made a part hereof.

(4) "Alcohol or Drug Abuse" or "Dependence" means a person who has lost the ability to control the use of alcohol or controlled substances or other substances with abuse potential, or who uses alcohol or such substances to the extent that the person's health or that of others is substantially impaired or endangered or the person's social or economic functions are substantially disrupted. An alcohol or drug dependent person may be physically dependent, a condition in which the body requires a continuing supply of alcohol, a drug, or controlled substance to avoid characteristic withdrawal symptoms, or psychologically dependent, a condition characterized by an overwhelming mental desire for continued use of alcohol, a drug, or a controlled substance.

(5) "Residents" mean persons who are clients of the Oregon Health Authority who reside in Adult Residential Care Facilities and Adult Foster Homes.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85;
Renumbered from 410-005-0085, MHS 7-2007, f. & cert. ef. 5-25-07;
Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0570

Jurisdiction Over Homes and Centers

(1) The Division shall have jurisdiction over and shall license all Adult Residential Care Homes and Centers and certify Adult

Foster Homes having residents 60 percent or more of which have primary service needs associated with mental retardation or other developmental disabilities, or mental or emotional disturbance or alcohol or drug abuse dependence.

(2) Adult Residential Care Homes and Centers and Adult Foster Homes not within the criteria in section (1) of this rule shall be under the jurisdiction of and be licensed or certified by Aging and People with Disabilities Division.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85;
Renumbered from 410-005-0090, MHS 7-2007, f. & cert. ef. 5-25-07;
Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0580

Case Management

(1) Those residents in homes and centers under the jurisdiction of Addictions and Mental Health Division, whose primary service needs are not associated with mental retardation or other developmental disabilities, or mental or emotional disturbances or alcohol or drug abuse or dependence shall be Aging and People with Disabilities Division clients and shall receive case management from such Division. All other residents in such facilities shall be Addictions and Mental Health Division clients and shall receive case management from such Division.

(2) Those residents in Adult Residential Care Homes and Centers and Adult Foster Homes under the jurisdiction of Aging and People with Disabilities Division whose primary service needs are associated with mental retardation or other developmental disabilities, or mental or emotional disturbance or alcohol or drug abuse or dependence, shall be Division clients and shall receive case management from such Division. All other residents in such facilities shall be Aging and People with Disabilities Division clients and receive case management from such Division.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85;
Renumbered from 410-005-0095, MHS 7-2007, f. & cert. ef. 5-25-07;
Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0590

Placement

(1) Residential Care and Adult Foster Home clients shall be newly placed on the basis of primary service needs — Those having such needs as those described in OAR 309-035-0100 to 309-035-0190 will be placed in the facilities described in that paragraph and those not having such needs shall be placed in those facilities described in OAR 309-035-0250 to 309-035-0460.

(2) Exceptions may be made only when a client cannot be placed because of the unavailability of an appropriate facility and the facility in which the client is placed is capable of serving the needs of the client. Exceptions will be granted by the Division responsible for the receiving facility.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85;
Renumbered from 410-005-0100, MHS 7-2007, f. & cert. ef. 5-25-07;
Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-035-0600

Effective Date

OAR 309-035-0550 through 309-035-0590 are prospective as well as retroactive to July 1, 1982. Such prospective and retroactive effect is each severable of the other.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85;
Renumbered from 410-005-0105, MHS 7-2007, f. & cert. ef. 5-25-07;
Suspended by MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

DIVISION 36

COMMUNITY MENTAL HEALTH HOUSING FUND

309-036-0100

Statement of Purpose

These rules prescribe standards for the development, renovation and administration of the Community Mental Health Housing Program and the Community Mental Health Housing Fund under ORS 426.502–426.508. The Community Mental Health Housing Fund, supported in part by the Community Housing Trust Account, shall be administered by the Oregon Health Authority (Authority), through its Addictions and Mental Health Division.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 426.502–426.508

Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03; MHS 7-2010, f. & cert. ef. 6-7-10

309-036-0105

Definitions

As used in these rules:

(1) “Assistant Director” means the Assistant Director of the Addictions and Mental Health Division.

(2) “Care provider” means an individual or entity that provides services and support for a person or persons with serious mental illness under a residential service agreement, contract or other similar arrangement.

(3) “Community housing” means real property, improvements and related equipment that are used or could be used to house persons with a serious mental illness in community-based settings consistent with ORS 426.502. It includes single-family housing, multiple-unit residential housing and residential facilities. It does not include hospitals, nursing homes, correctional facilities and other institutional housing except as provided in these rules. Consistent with the designated housing model, community housing may include accommodations for care providers and resident managers.

(4) “Community Housing Development” means efforts or assistance, financial or otherwise, that result in the establishment of community housing as defined in OAR 309-036-0105.

(5) “Community Mental Health Housing Fund” or “Fund” means the fund established by ORS 426.506

(6) “Community Housing Renovation” means efforts that result in the improvement of real property, the use of which is restricted to community housing for persons with serious mental illness. Such improvement includes, but is not limited to, replacing worn or non-functional components, making repairs to improve health and safety, expanding the building to accommodate more residents or provide more adequate living quarters, and installing equipment necessary to the operation of the community housing.

(7) “Construct” includes, but is not limited to building, installing, assembling, expanding, altering, converting, repairing, replacing or relocating community housing development, renovation or administration. It can also mean to install equipment and necessary infrastructure to prepare a site.

(8) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority (Authority).

(9) “Equipment” means permanently installed fixtures or appliances acquired for the community housing.

(10) “Institutional housing” means housing located at an Oregon State Hospital campus or the Blue Mountain Recovery Center, including buildings, grounds, leased facilities, infrastructure and ancillary facilities.

(11) “Person with serious mental illness” means an individual who is:

(a) Diagnosed by a Qualified Mental Health Professional as suffering from a chronic mental disorder as defined by ORS 426.495 which includes, but is not limited to, conditions such as chronic schizophrenia, chronic affective disorder, chronic paranoid disorder, and other disorders which manifest symptoms that are not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism; which continue for more

than one (1) year, or on the basis of a specific diagnosis, are likely to continue for more than one (1) year; and

(b) Is impaired to an extent which substantially limits the person’s consistent functioning in one (1) or more of the following areas:

(A) Home environment: independently attending to shelter needs, personal hygiene, nutritional needs and home maintenance;

(B) Community negotiation: independently and appropriately utilizing community resources for shopping, recreation and other needs;

(C) Social relations: establishing and maintaining supportive relationships;

(D) Vocational: maintaining employment sufficient to meet personal living expenses or engaging in other age appropriate activities.

(12) “Qualified Mental Health Professional (QMHP)” means a Licensed Medical Practitioner (LMP) or any other person meeting one (1) or more of the following minimum qualifications as authorized by the Local Mental Health Authority or designee:

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

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

(c) Graduate degree in psychology;

(d) A Graduate degree in social work;

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

(f) A Graduate degree in a behavioral science field.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 426.502–426.508

Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03; MHS 7-2010, f. & cert. ef. 6-7-10

309-036-0110

Community Mental Health Housing Fund, Community Mental Health Housing Trust Account, Income and Expenditures

(1) Community Mental Health Housing Fund. The Community Mental Health Housing Fund shall be maintained in the State Treasury. All earnings on investments of moneys in the Fund, including earnings in the Community Housing Trust Account, shall accrue to the Fund. All moneys in the Fund shall be continuously appropriated to the Division to carry out the provisions of ORS 426.504 for the purpose of providing housing for persons with serious mental illness.

(a) Income to the Fund shall consist of:

(A) The proceeds, less costs to the state, received from the sale of the F.H. Dammasch State Hospital property under ORS 426.508;

(B) Moneys appropriated to the Fund by the Legislative Assembly;

(C) Proceeds from the sale, transfer or lease of any surplus real property owned, operated or controlled by the Division and used for community housing;

(D) Money reallocated from other areas of the Division’s budget;

(E) Interest and earnings credited to the fund; and

(F) Gifts of money or other property from any source, to be used for the purposes of developing housing for persons with serious mental illness. Except as provided by ORS 426.506, income to the fund may be restricted to deposit in the Community Housing Trust Account or may be available for expenditure.

(b) Gifts and other deposits may be designated by the contributor to be used for community housing purposes or institutional housing purposes. Such deposits may also be restricted to the Community Housing Trust Account or may be non-restricted and available for expenditure from the Fund, or may be designated for a specific expenditure purpose in the Fund. Any gifts restricted or designated by a contributor shall not be available for re-allocation except as may be specified by the contributor.

(c) When it is determined that community housing established or assisted consistent with ORS 426.504 is no longer suitable for continued use as community housing, any proceeds realized from

the disposition of the property shall be deposited into the Fund and used for community housing purposes.

(2) Community Housing Trust Account. The Community Housing Trust Account exists within the Community Mental Health Housing Fund and shall consist of:

(a) At least ninety-five (95) percent of the proceeds received from the sale of the F.H. Dammasch State Hospital property under ORS 426.508; and

(b) Any other funds deposited into the account for the restricted purpose of staying in the Fund for perpetuity.

(3) Amounts Available for Expenditure. Amounts available from the Fund for expenditure shall consist of:

(a) Up to five (5) percent of the sale proceeds received by the Oregon Health Authority for credit to the account from the Oregon Department of Administrative Services from the sale of the F.H. Dammasch State Hospital property under ORS 426.508; and

(b) All other deposited, unrestricted funds or account earnings unless a specific deposit is designated by its maker to be placed in the restricted portion of the Community Housing Trust Account.

(4) Expenditure of Community Housing Trust Account Interest Earnings. Interest earned on moneys in the Community Housing Trust Account may be expended in the following manner: Seventy (70) percent of interest earned on deposits in the Community Housing Trust Account shall be expended for community housing purposes in accordance with these rules. Thirty (30) percent of interest earned on deposits in the Community Housing Trust Account shall be expended for institutional housing purposes in accordance with these rules.

(5) Limitations on Expenditure. Interest earned on deposits in the account shall not be used to support operating expenses of the Division.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 426.502–426.508

Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03; MHS 7-2010, f. & cert. ef. 6-7-10

309-036-0115

Funds for Community Housing

(1) General Provision. In general, the Division will work through community partners to develop community housing and not acquire or operate community housing directly. In circumstances where a particular type of community housing is desired and no community partner has been identified, the Division may acquire or directly operate community housing.

(2) Eligible Uses for Community Housing. The community housing to be assisted with funds from the Community Mental Health Housing Fund shall include a variety of types of housing integrated into residential neighborhoods of local communities throughout Oregon. The Division may establish priorities for the types of housing to be assisted based on an analysis of housing needs of persons with serious mental illness. The community housing types to be considered for funding include, but are not limited to, single-family housing, multiple-unit residential housing, residential facilities and other residences for persons with serious mental illness. Housing for persons with serious mental illness may include improvements and related equipment to enable a provider to offer services on site. Where services are not offered on site, the community housing provider must demonstrate that access to services is available elsewhere in the community.

(a) New and Existing Community Housing. Funds may be used to develop new community housing or to preserve or renovate existing community housing for persons with serious mental illness. To this end, funding may be used toward acquisition, remodeling, maintenance, repair, permanently installed fixtures or appliances and equipment.

(b) Occupancy of Community Housing. The community housing to be assisted with funds from the Community Mental Health Housing Fund must be made available for occupancy by persons with serious mental illness. Consistent with the designated housing model, additional individuals, such as resident managers, care providers, family members and roommates, may also reside in the housing to the extent allowed under ORS 426.502.

(c) Exclusions. Funds from the Community Mental Health Housing Fund cannot be used to support service provision at the community housing.

(3) Allocation of Funds for Community Housing Purposes. The Assistant Director shall annually identify the amount of funds available in the Community Mental Health Housing Fund for community housing purposes.

(a) Allocation Plan. The Assistant Director or designee shall establish, with advice and input from the Community Mental Health Housing Fund Advisory Committee (CMHHFAC), a plan for allocating funds. This allocation plan shall designate amounts available for new development and renovation awards, geographic distribution goals and any desired housing types or resident population priorities.

(b) Distribution Plan. As funds become available, it shall be the intent of the Division to distribute funds in a fair and equitable manner with respect to geographic and service population considerations. To this end, regional distribution goals will be established by the Division with input from the CMHHFAC. These goals will be established based upon the general population distribution in Oregon, Division data on the number of persons with serious mental illness served in each region of the state and other factors relating to housing needs. The distribution plan goals will be published in the application materials. If after considering all applications for a region, the resulting awards do not award all funds in accordance with these goals, then remaining funds may be re-allocated to other regions.

(4) Housing Needs Assessment. Unless targeted for a specific purpose by the Oregon Legislative Assembly, financial assistance for community housing by the Division shall be based on the assessment of housing needs for people with serious mental illness. In assessing housing needs, the Division will conduct surveys, review available data, and seek input from advisory bodies that include consumers, family members, service providers, housing providers, citizens and other interested persons. The Division may prioritize types of housing and specify subpopulations of persons with serious mental illness for occupation in the community housing that will receive financial assistance.

(5) Application Process and Award of Funds. The Division shall implement an application and award process which may include, but is not limited to, an open process such as a first come – first reviewed solicitation, a demonstration program, or a competitive application process. The Division may also award emergency funds when necessary to insure the completion of development or continued operation of community housing. The application and award process will be consistent with the following guidelines:

(a) Notification. For the open application process, the Division shall announce the availability of funding from the Community Mental Health Housing Fund and provide instructions for applying for such funding. The announcement of funding shall include a description of the fund, the allocation plan, eligible community housing, application rating criteria, and application materials.

(b) Application. An application for funding shall contain all information required by the division, including, but not limited to:

(A) A description of the proposed community housing project, including, but not limited to, type of unit or units, number of residents who will be persons with serious mental illness, proposed rents, site location, the services to be available to residents and project amenities;

(B) Documentation of the applicant's experience with developing and operating housing;

(C) A statement identifying the length of time the unit or units will be dedicated for use by persons with serious mental illness;

(D) An operating budget showing anticipated revenues and expenses;

(E) The development plan, including a development budget with all sources of funding identified; and

(F) Documentation describing how the proposed community housing is consistent with allocation plan priorities. Applicants will have a minimum of sixty (60) days to complete and return applications.

(c) Funding Decision. Completed applications shall be submitted to the Assistant Director or designee.

(A) Applications shall be reviewed and rated by a review panel established by the Assistant Director or designee. The review panel will include at least three (3) members of the Community Mental Health Housing Fund Advisory Committee. The review panel shall make recommendations for funding decisions to the Assistant Director.

(B) For applications made on an emergency basis under these rules, the Division may use an expedited review process that includes review and comment by at least three (3) members of the Community Mental Health Housing Fund Advisory Committee. Results of the review will be presented to the Assistant Director who will make the final funding decisions. Applicants will receive written notice of funding decisions.

(d) Appeal of Funding Decisions. Applicants who do not agree with funding decisions are encouraged to discuss their application with Division staff. If the issue is not resolved, applicants may submit a request for appeal of the decision to the Deputy Assistant Director or designee, as follows:

(A) The applicant requesting an appeal will submit a written request to the Deputy Assistant Director or designee within seven (7) business days after receiving the written funding decision.

(B) Division Review and Notification: The Deputy Assistant Director will approve or deny the request for an appeal and will notify the applicant in writing of the decision to approve or deny the requested appeal, within fifteen (15) business days of receipt of the appeal.

(C) Appeal to the Assistant Director: Appeal of the decision of the Deputy Assistant Director will be made in writing to the Assistant Director of the Division, whose decision will be final and will be provided in writing within fifteen (15) business days of receipt of the appeal.

(D) The decision to grant the appeal in favor of the applicant for one (1) request does not set a precedent that must be followed by the Division when evaluating subsequent requests for appeal.

(6) Disbursement of Funds. The Division will develop procedures for the disbursement of funds consistent with prudent accounting practices and the Division's financial procedures.

(7) Security of Investment. All funds disbursed in amounts greater than five thousand dollars (\$5,000) for the purpose of community housing shall be secured by a trust deed or other instrument to secure the investment and insure continuing use of the property, improvements and related equipment in accordance with the purposes of the award.

(8) Non-discrimination. Recipients of funding for community housing shall ensure that all eligible persons with serious mental illness shall be considered for residency without regard to:

- (a) Race;
- (b) Color;
- (c) Sex or sexual orientation, except as may be limited by room arrangement;
- (d) Religion;
- (e) Creed;
- (f) National origin;
- (g) Age;
- (h) Familial status;
- (i) Marital status;
- (j) Source of income; or
- (k) Disability in addition to the serious mental illness.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 426.502-426.508

Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03; MHS 7-2010, f. & cert. ef. 6-7-10

309-036-0120

Funds for Institutional Housing

(1) Eligible Uses for Institutional Housing. The institutional housing to be assisted with thirty (30) percent of interest earnings from the Community Housing Trust Account and any other funds restricted to institutional housing purposes shall be for occupancy by persons with serious mental illness.

(2) Allocation of Funds for Institutional Housing Purposes. The Division's Assistant Director or designee will annually identify the amount of funds available in the Community Mental Health Housing Fund for institutional housing purposes.

(a) Allocation Plan. The superintendents of the state psychiatric hospital facilities shall submit prioritized requests for funding of institutional housing improvements to the Assistant Director or designee. The Assistant Director or designee shall create an allocation plan based on a consolidated prioritized list of requests.

(b) Distribution of Funds for Institutional Housing Purposes. As funds become available, they will be distributed to state psychiatric hospital facilities for improvements in accordance with the allocation plan.

(3) Advisory Committee Review. The Community Mental Health Housing Fund Advisory Committee shall review the allocation plan and make recommendations to the Assistant Director regarding distribution of funds for institutional housing purposes; the Assistant Director shall make the final funding decisions.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 426.502-426.508

Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03; MHS 7-2010, f. & cert. ef. 6-7-10

309-036-0130

Real Property for Community Housing

(1) Property Reserved under ORS 426.508. In accordance with ORS 426.508, the Oregon Department of Administrative Services, in coordination with the City of Wilsonville and the Division, shall reserve not more than ten (10) acres from the sale of the property formerly known as the F.H. Dammasch State Hospital for transfer to the Division. The Division will use the reserved land to develop community housing for persons with serious mental illness. The Division will coordinate with the City of Wilsonville to identify the specific real property reserved from the sale. Development of the land reserved for community housing will be consistent with the Dammasch Area Transportation Efficient Land Use Plan described in ORS 426.508.

(2) Application Process. When one (1) or more specific lots of land reserved for community housing are confirmed on the proposed subdivision plat, the Division will distribute the property through a process which may include, but is not limited to, an open process such as a first come-first reviewed solicitation, a demonstration program, a competitive review process, or as emergency funds when necessary to ensure development or continued operation of community housing on the site.

(3) Applications shall be reviewed and rated by a review panel established by the Assistant Director or designee. The review panel will include at least three (3) members of the Community Mental Health Housing Fund Advisory Committee. The review panel shall make recommendations for funding decisions to the Assistant Director who shall make the final funding decisions.

(4) The applicant selected as a result of the application process will own the community housing site. The selected applicant will be responsible for coordinating the development of the community housing designated for the site with oversight by the Division.

(5) Award to Selected Applicant. In awarding the reserved land to the selected applicant, the Division will restrict the property's use to community housing for people with serious mental illness. The Division will transfer the property title with a deed restriction, or another legal restriction approved by the Oregon Department of Justice.

(6) Title Transfers. When the property title is transferred to the selected applicant, the terms of the property transfer agreement, promissory note and trust deed shall restrict the property's use to community housing for people with serious mental illness and provide the Division with a right to reclaim the property in the event of non-performance.

(7) Disbursement of Funds. The Division will develop procedures for the disbursement of funds consistent with prudent accounting practices and the Division's financial procedures.

(8) Security of Investment. All funds disbursed in amounts greater than five thousand dollars (\$5,000) for the purpose of community housing shall be secured by a trust deed or other instrument to secure the investment and insure continuing use of the property, improvements and related equipment in accordance with the purposes of the award.

(9) Non-discrimination. Recipients of funding for community housing shall ensure that all eligible persons with serious mental illness shall be considered for residency without regard to:

- (a) Race;
- (b) Color;
- (c) Sex or sexual orientation, except as may be limited by room arrangement;
- (d) Religion;
- (e) Creed;
- (f) National origin;
- (g) Age;
- (h) Familial status;
- (i) Marital status;
- (j) Source of income; or
- (k) Disability in addition to the serious mental illness.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 426.502-426.508
Hist.: MHS 7-2010, f. & cert. ef. 6-7-10

**309-036-0135
Monitoring of Community Housing Awarded Financial Assistance**

(1) Monitoring. The Division will confirm annually, or more frequently at its discretion, that the community housing developed with financial assistance from the Division continues to operate according to the agreed terms of the financial assistance.

(2) Non-performance. If the Division determines through its monitoring or otherwise that the community housing is not operating according to the agreed terms, the owner will be provided with an opportunity for remedy. If the remedy proves unsuccessful, the Division will consider the project in default.

(3) Default. A project shall be considered in default when it is no longer operated consistent with the terms of the financial assistance after the operator has been provided an opportunity for remedy. When a project is in default, the Division will take action to recover any payment or settlement owed per the terms of the executed security document or contractual agreement.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 426.502-426.508
Hist.: MHS 7-2010, f. & cert. ef. 6-7-10

**309-036-0140
Community Mental Health Housing Fund Advisory Committee**

(1) Membership and Term. The Community Mental Health Housing Fund Advisory Committee (CMHHFAC) shall be comprised of not less than eleven (11) members who shall be appointed by the Assistant Director or designee. Each member shall be appointed for a term of four (4) years. Members may be reappointed for two (2) additional four (4) year terms.

(2) Committee Composition. CMHHFAC members shall consist of at least one (1) Division employee who shall be responsible for convening the committee. The Division shall provide clerical support to the committee. Additional members shall include, but not be limited to, at least one (1) state psychiatric hospital representative, three (3) consumer advocates, one (1) family advocate, one (1) representative from the Housing and Community Services Department, one (1) community mental health service provider, one (1) nonprofit housing provider, and two (2) members of the public at large.

(3) Meeting Schedule. The CMMHFAC shall meet not less than two (2) times per year.

(4) Responsibilities. The CMHHFAC shall be responsible for:
(a) Recommending an allocation plan for funding awards from the Community Mental Health Housing Fund;

(b) Recommending maximum award amounts;

(c) Reviewing and evaluating the award decisions for community housing and institutional housing awards and making recommendations regarding the award process;

(d) Making policy recommendations for the operation and investment of the fund; and

(e) Such other advisory actions as might be assigned by the Assistant Director.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 426.502-426.508
Hist.: MHS 7-2010, f. & cert. ef. 6-7-10

DIVISION 39

STANDARDS FOR THE APPROVAL OF PROVIDERS OF NON-INPATIENT MENTAL HEALTH TREATMENT SERVICES

**309-039-0500
Purpose and Scope**

These rules apply to certifications of provider organizations that render non-inpatient mental health treatment services. The certifications exist solely for the purpose of qualifying for insurance reimbursement. Agencies that contract with the Oregon Health Authority (OHA), subcontract with OHA, or contract with a Community Mental Health Program are not eligible for the "non-inpatient" certification.

Stat. Auth.: ORS 413.042 & 743A.168
Stats. Implemented: ORS 743A.160 & 743.168
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

**309-039-0510
Definitions**

As used in these rules:

(1) "Community Mental Health Program" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(2) "Certificate" means the document or documents issued by the Division, which identifies and declares certification of a provider pursuant to OAR 309-008-0100 to 309-008-1600. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

(3) "Division" means the Health Systems Division of the Oregon Health Authority.

(4) "Facility" means a corporate or other entity which provides services for the treatment of mental health conditions.

(5) "Non-Related Adult" means any person over 18 years of age who is not related by blood, marriage or living situation. Foster parents and adults co-habiting with a child may be considered to be related adults.

(6) "Outpatient Program" means a program that provides evaluation, treatment and rehabilitation on a regularly scheduled basis or in response to crisis in a setting outside an inpatient program, residential program, day treatment or partial hospitalization program which is certified by the Division pursuant to OAR 309-008-0100 to 309-008-1600.

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

(8) "Provider" means a program operated by either a licensed business or a corporation that provides mental health services.

(9) "Qualified Mental Health Associate (QMHA)" means a person delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-019-0125(7).

(10) "Qualified Mental Health Professional (QMHP)" means a LMP or any other person meeting the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-019-0125(8).

(11) "Qualified Supervisor" means any person meeting the following qualifications:

(a) A medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon and who is board eligible for the practice of psychiatry;

(b) A psychologist licensed by the State Board of Psychologist Examiners;

(c) A registered nurse certified as a psychiatric nurse practitioner by the Oregon State Board of Nursing;

(d) A clinical social worker licensed by the State Board of Clinical Social Workers;

(e) A Licensed Professional Counselor (LPC) licensed by the State of Oregon; or

(f) A Licensed Marriage and Family Therapist (LMFT), licensed by the State of Oregon.

(12) "Residential Program" means a program that provides room, board, and an organized full-day program of mental health services in a facility for six or more persons who do not require 24-hour nursing care.

Stat. Auth.: ORS 413.042 & 743A.168

Stats. Implemented: ORS 743A.160 & 743.168

Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-039-0520

Eligible Providers

(1) Agencies that currently hold a Certificate of Approval for the provision of mental health services as a contractor of OHA, a subcontractor of OHA, or a contractor of a Community Mental Health Program, or a license to provide residential or adult foster care services, are not eligible for the "non-inpatient" certification.

(2) Certification as a non-inpatient mental health provider is not a substitute for the certification and Medicaid provider enrollment processes that are required to render services to individuals enrolled in the Oregon Health Plan, or to individuals whose services are otherwise funded by the State.

(3) Only providers as defined in OAR 309-039-0510(10) are eligible for approval under 309-039-0500 through 309-039-0580. An eligible provider must:

(a) Control the office space, such as by owning, renting or leasing it;

(b) Control the intake to the program and determine which therapist provides assessment and treatment;

(c) Control all clinical records, including storage;

(d) Do all the billing and collect all fees, including deductibles and co-payments;

(e) Pay staff for clinical services provided; and

(f) Display the provider name on the premises so as to be clearly visible to clients.

(4) An individual operating as a private practitioner, whether or not a licensed business or corporation, is not eligible for approval under these rules.

Stat. Auth.: ORS 413.042 & 743A.168

Stats. Implemented: ORS 743A.160 & 743.168

Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14

309-039-0530

Approval Process

(1) Request for initial certification or certification renewal shall be submitted to the Division compliant with the process governed by OAR 309-0080100 to 309-008-1600. In addition to the requirements set in OAR 309-008 the applicant will include with the application a check or money order in the amount of \$600.00

payable to the Division. This application fee shall be non-refundable irrespective of whether the provider is issued a Certificate of Approval.

(a) Any provider submitting an application for initial certification or renewal after the effective date of this rule shall pay the application and certification fees;

(b) The fees shall be increased biennially at the same rate as approved by the Legislative Assembly or the Emergency Board for other services and programs of the Division.

(2) A Certificate is valid for up to three years, shall be issued to the provider when the administrative and certification reviews of the program by the Division indicate the provider is in compliance with the applicable parts of OAR 309-039-0500 through 309-039-0580. The Certificate will be issued pursuant to the process governed OAR 309-008-0100 to 309-008-1600.

(4) The award, renewal, and duration of Certificates of Approval as well as periodic and interim reviews, establishment of conditions, denial, revocation and hearings shall comply with OAR 309-008-0100 to 309-008-1600.

Stat. Auth.: ORS 413.042 & 743A.168

Stats. Implemented: ORS 743A.160 & 743.168

Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-039-0540

General Standards

Each provider is required to meet all applicable standards from the following standards:

(1) Specific Staff Qualifications and Competencies, detailed in OAR 309-019-0125; and

(2) Personnel Documentation, Training and Supervision, detailed in OAR 309-019-0130.

Stat. Auth.: ORS 413.042 & 743A.168

Stats. Implemented: ORS 743A.160 & 743.168

Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14

309-039-0560

Standards for Mental Health Partial Hospitalization and Day Treatment Programs

In addition to OAR 309-039-0500 through 309-039-0540, each provider operating a mental health partial hospitalization or day treatment program shall comply with the following standards:

(1) Facility standards. The facility shall meet all applicable state and local fire, safety, and health standards.

(2) Treatment standards. Each provider shall provide four hours a day, five days a week, structured treatment activities which address mental health conditions and which includes the following services each week:

(a) Daily group therapy for mental health conditions;

(b) Individual counseling with a primary therapist;

(c) Family therapy, as appropriate to the individual needs of the client;

(d) Psychotropic medication management or monitoring; and

(e) Skills training, vocational training, socialization or structured recreational/physical fitness activities.

Stat. Auth.: ORS 413.042 & 743A.168

Stats. Implemented: ORS 743A.160 & 743.168

Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14

309-039-0570

Standards for Mental Health Residential Programs

In addition to meeting OAR 309-039-0500 through 309-039-0540 each provider operating a mental health residential program shall meet the following standards:

(1) Facility standards. Each provider shall meet OAR 309-035-0100 through 309-035-0190.

(2) Treatment standards. Each provider shall provide eight hours of structured services out of every 12 hours from 8 a.m. to 8 p.m. which, each week, includes:

(a) Daily group therapy which addresses the mental health or nervous condition;

(b) Individual counseling which addresses the mental health or nervous condition with a primary therapist two times per week;

(c) Family therapy, as appropriate to the individual needs of the client;

(d) Psychotropic medication management or monitoring, as appropriate to the individual needs of the client;

(e) One hour per day of structured recreational/physical fitness activities; and

(f) Structured skills training, vocational training, or socialization activities.

(3) Treatment standards for children and adolescents:

(a) Each provider shall comply with OAR 309-035-0100 through 309-035-0190;

(b) Each residential facility serving children or adolescents shall meet the standards described by OAR 413-210-0100 through 413-210-0250, Standards for reviewing, inspecting and licensing those private child caring agencies which are for residential care and treatment services for children and which are subject to the provisions of ORS Chapter 418, for licensure by the Children's Services Division.

(4) Staffing standards. Each provider shall:

(a) Provide staff coverage 24 hours-a-day, seven days-a-week;

(b) Employ sufficient qualified mental health professionals to maintain a maximum caseload of no more than eight clients;

(c) Have a mental health associate on site, and awake, from 8 p.m. to 8 a.m.; and

(d) Have available a mental health professional on-call from 8 p.m. to 8 a.m.

Stat. Auth.: ORS 413.042 & 743A.168

Stats. Implemented: ORS 743A.160 & 743.168

Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14;

MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14

**309-039-0580
Variance**

A variance to these rules may be requested and granted to a provider via the process governed by OAR 309-008-1600.

Stat. Auth.: ORS 413.042 & 743A.168

Stats. Implemented: ORS 743A.160 & 743.168

Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

DIVISION 40

ADULT FOSTER HOMES

**309-040-0300
Purpose and Scope**

(1) Purpose. These rules prescribe standards by which the Health Systems Division (HSD) of the Oregon Health Authority (OHA) licenses community based Adult Foster Homes (AFHs) for adults with mental or emotional disorders. The care and services standards are designed to promote the individual's right to independence, choice, and decision making while providing a safe, secure, homelike environment. The provider must address the individual's needs in a manner that enables the individual to function at the highest level of independence possible.

(a) These rules incorporate and implement the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services for home and community based services authorized under section 1915(i) of the Social Security Act.

(b) These rules establish requirements to ensure individuals receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving such services consistent with the standards set out in OAR chapter 411, Division 4.

(2) Scope. These rules apply to adult foster homes providing services to five or fewer adults with mental or emotional disorders, regardless of whether the provider receives public funds.

Stat. Auth.: ORS 413.042, 413.032, 413.085

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0000, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 11-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; MHS 4-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

**309-040-0301
Required Home-like Qualities**

This rule becomes effective July 1, 2016 and is enforceable as described in OAR 309-040-0315(7).

(1) Each AFH must have all of the following qualities:

(a) The home is integrated in and supports the same degree of access to the greater community as people not receiving HCBS, including opportunities for an individual to:

(A) Seek employment and work in competitive integrated employment settings;

(B) Engage in greater community life;

(C) Control personal resources; and

(D) Receive services in the greater community.

(b) The AFH is selected by the individual or, as applicable, the individual's representative, from among available setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options must be:

(A) Identified and documented in the individual's person-centered service plan;

(B) Based on the needs and preferences of the individual; and

(C) Based on the individual's available resources for room and board.

(c) The AFH ensures individual rights of privacy, dignity, respect, and freedom from coercion and restraint.

(d) The AFH optimizes, but does not regiment, individual initiative, autonomy, self-direction, and independence in making life

choices including, but not limited to, daily activities, physical environment, and with whom to interact.

(e) The AFH facilitates individual choice regarding services and supports, and who provides the services and supports.

(2) Additional Home-like Requirements. The provider must maintain the following qualities at the AFH:

(a) The home must be physically accessible to each individual;

(b) The provider must provide the individual with a unit of specific physical place that the individual may own, rent, or occupy under a legally enforceable residency agreement.

(c) The provider must provide and include in the residency agreement that the individual has, at a minimum, the same responsibilities and protections from an eviction that a tenant has under the landlord-tenant law of the state of Oregon and other applicable laws or rules of the county, city, or other designated entity. For a setting in which landlord-tenant laws do not apply, the residency agreement must provide substantially equivalent protections for the individual and address eviction and appeal processes. The eviction and appeal processes must be substantially equivalent to the processes provided under landlord-tenant laws.

(d) The provider must ensure that each individual has privacy in his or her own unit.

(e) The provider must maintain units with entrance doors lockable by the individual. The provider must ensure that only the individual, the individual's roommate (where applicable), and only appropriate staff, as described in the individual's person-centered service plan, have keys to access the unit.

(f) The provider must ensure that individuals sharing units have a choice of roommates.

(g) The provider must provide and include in the residency agreement that individuals have the freedom to decorate and furnish his or her own unit as agreed to within the Residency Agreement.

(h) The provider must permit each individual to have visitors of his or her choosing at any time.

(i) The provider must ensure each individual has the freedom and support to control his or her own schedule and activities.

(j) The provider must ensure each individual has the freedom and support to have access to food at any time.

(3) The provider must take reasonable steps to ensure that the program maintains the qualities identified in this rule. Failure to take reasonable steps may include, but is not limited to:

(a) Failure to maintain a copy of the person-centered service plan at the home;

(b) Failure to cooperate or provide necessary information to the person centered planning coordinator; or

(c) Failure to attend or schedule a person centered planning meeting where necessary.

(4) When a provider is unable to ensure a quality described under sections (2)(d) to (2)(j) of this rule due to threats to the health and safety of the individual or others, the provider may seek an individually-based limitation with the consent of the individual or, as applicable, the individual's legal representative, through the process described in OAR 411-004-0040 and incorporated by OAR 309-040-0391. The provider may not apply an individually based limitation until the limitation is approved and documented as required by OAR 309-040-0391.

Stat. Auth.: ORS 413.042, 413.032, 413.085
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0305

Definitions

As used in these rules the following definitions apply:

(1) "Abuse" includes but is not limited to:

(a) Any death caused by other than accidental or natural means or occurring in unusual circumstances;

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(c) Willful infliction of physical pain or injury;

(d) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of an AFH or community program, or provider, or other caregiver and the individual. For situations other than those involving an employee, provider, or other caregiver and an individual, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical conduct directed toward the individual;

(e) Neglect that leads to physical harm through withholding of services necessary to maintain health and well being;

(f) Abuse does not include spiritual treatments by a duly accredited practitioner of a recognized church or religious denomination when voluntarily consented to by the individual.

(2) "Abuse Investigation and Protective Services" means an investigation and any subsequent services or supports necessary to prevent further abuse as required by ORS 430.745 to 430.765 and OAR 943-045-0000, or any other rules established by the Division applicable to allegations of abuse of individuals residing at an AFH licensed by the Division.

(3) "Activities of Daily Living (ADL)" are those individual skills necessary for an individual's continued well-being including eating and nutrition, dressing, individual hygiene, mobility, and toileting.

(4) "Administration of Medication" means administration of medicine or a medical treatment to an individual as prescribed by a Licensed Medical Practitioner.

(5) "Adult Foster Home (AFH)" means any home licensed by the Health Systems Division of the OHA in which residential care is provided to five or fewer individuals who are not related to the provider by blood or marriage as described in ORS 443.705 through 443.825. For the purpose of these rules, if an adult family member of the provider receives care, he or she must be included as one of the individuals within the total license capacity of the AFH. An AFH or person that advertises, including word-of-mouth advertising, to provide room, board, and care and services for adults, is deemed to be an AFH. For the purpose of these rules, an AFH does not include facilities referenced in ORS 443.715(1)(2)(3)(4).

(6) "Aid to Physical Functioning" means any special equipment ordered for an individual by a Licensed Medical Professional (LMP) or other qualified health care professional which maintains or enhances the individual's physical functioning.

(7) "Applicant" means any person or entity that makes an application for a license that is also the owner of the business.

(8) "Assessment" means an evaluation of an individual and the individual's level of functioning completed by a qualified provider and provides the basis for the development of the individual's Personal Care Plan and Person Centered Service Plan.

(9) "Authority" means the Oregon Health Authority or its designee.

(10) "Division Staff" means an employee of the Division, the Division's designee, or the designee of the local Community Mental Health Program.

(11) "Behavioral Interventions" means those interventions that will modify the individual's behavior or the individual's environment.

(12) "Bill of Rights" means civil, legal or human rights afforded to those individuals residing in an AFH, which are in accord with those rights afforded to all other U.S. citizens, including but not limited to those rights delineated in the AFH Bill of Rights as described in OAR 309-040-0410.

(13) "Board of Nursing Rules" means the standards for Registered Nurse Teaching and Delegation and assignments to Unlicensed Persons according to the statutes and rule of the Oregon State Board of Nursing, chapter 851, division 47, ORS 678.010 to 678.445.

(14) "Care" means the provision of but is not limited to services of room, board, services and assistance with ADLs, such as assistance with bathing, dressing, grooming, eating, money management, recreational activities, and medication management.

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Care also means services that promote maximum individual independence and enhance quality of life.

(15) “Caregiver” includes the provider, resident managers, or substitute caregivers who provide services to an individual.

(16) “Case Manager” means a person employed by a local, regional, or state allied agency approved by the Division to provide case management services

(17) “CMS” means the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

(18) “Community Mental Health Program (CMHP)” means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(19) “Compensation” means payments made by or on behalf of an individual to a provider in exchange for room and board, care and services, including services described in the individual’s Personal Care Plan and Person Centered Service Plan (20) “Complaint Investigation” means an investigation of any allegation that a provider has taken action, or inaction, which is perceived as contrary to law, rule, or policy but does not meet the criteria for an abuse investigation.

(21) “Condition” means a provision attached to a new or existing license, which limits or restricts the scope of the license or imposes additional requirements on the licensee.

(22) “Contested Case Hearing” means a hearing resulting in a directed or recommended action. The hearing is held at the request of the provider or the Division in response to an action, sanction, or notice of finding issued by the Division that would result in the loss of license of the provider or other sanctions that would adversely affect the license of the provider. The hearing group is composed of:

(a) The provider and if the provider chooses, the provider’s attorney;

(b) The Division as represented by the Attorney General’s Office; and

(c) The Office of Administration Hearings Administrative Law Judge.

(23) “Contract” means a written agreement between a provider and the Division to provide room and board, care and services for compensation for individuals of a licensed AFH.

(24) “Controlled Substance” means any drug classified as schedules one through five under the Federal Controlled Substance Act.

(25) “Criminal History Check (CHC)” means the Oregon Criminal History Check and when required, a National Criminal History check and or a State-Specific Criminal History check, and the processes and procedures required by the rules OAR 943-007-0000 through 943-007-0500 Criminal History Check.

(26) “Day Care” means care and services in an AFH for a person who is not an individual of the AFH. Children under the age of five living in the AFH are included in the licensed capacity of the home.

(27) “Declaration for Mental Health Treatment” means a document that states the individual’s preferences or instructions regarding mental health treatment as defined by ORS 127.700 through 127.737.

(28) “Designated Representative” means:

(a) Any adult who is not the individual’s paid provider, who:

(A) The individual has authorized to serve as his or her representative; or

(B) The individual’s legal representative has authorized to serve as the individual’s representative.

(b) The power to act as a designated representative is valid until the individual or the individual’s legal representative modifies the authorization and notifies the Division of the modification, the individual or the individual’s representative notifies the provider that the designated representative is no longer authorized to act the individual’s behalf, or there is a change in the legal authority upon

which the designation was based. Notice must include the individual’s or the representative’s signature as appropriate.

(c) An individual, or the individual’s legal representative, is not required to appoint a designated representative.

(29) “Director” means the Director of the Oregon Health Authority or that person’s designee.

(30) “Discharge Summary” means a document that describes the conclusion of the planned course of services described in the individual’s individualized personal care plan and person centered service plan, regardless of outcome or attainment of goals described in the individual’s individualized personal care plan. In addition, the discharge summary addresses individual’s monies, financial assets and monies, medication and personal belongings at time of discharge.

(31) “Division” means the Health Systems Division of the Oregon Health Authority or its designee.

(32) “Employee” means a person who is employed by a licensed AFH (AFH), who receives wages, a salary, or is otherwise paid by the AFH for providing the service. The term also includes employees of other providers delivering direct services to an individual.

(33) “Exempt Area” means a county agency that provides similar programs for licensing and inspection of AFHs which the Director finds equal to or superior to the requirements of ORS 443.705 to 443.825 and which has entered into an agreement with the Division to license, inspect, and collect fees according to the provisions of 443.705 to 443.825.

(34) “Family Member” for the purposes of these rules, means a husband or wife, natural parent, child, sibling, adopted child, domestic partner, adopted parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild, aunt, uncle, niece, nephew, or first cousin.

(35) “HCB” Means: Home and Community Based.

(36) “Home” means the Adult Foster Home (AFH) and as indicated by the context of its use, may refer to the one or more buildings and adjacent grounds on contiguous properties used in the operation of the AFH.

(37) “Home and Community-Based Services” or “HCBS” means Home and Community-Based Services as defined in OAR chapter 411, division 4. HCBS are services provided in the home or community of an individual.

(38) “Home-like” means an environment that promotes the dignity, security, and comfort of individuals through the provision of personalized care and services, and encourages independence, choice, and decision-making by the individuals

(39) “House Rules” means those written standards governing house activities developed by the provider and approved by the Division. These standards must not conflict with the AFH Bill of Rights or other individual rights set out by these rules.

(40) “Incident Report” means a written description and account of any occurrence including but not limited to, any injury, accident, acts of physical aggression, use of physical restraints, medication error, any unusual incident involving an individual or the home and/or providers.

(41) “Individual” means any person being considered for placement or currently residing in a licensed home receiving residential, HCBS and other services regulated by these rules on a 24-hour basis except as excluded under ORS 443.400.

(42) “Individually-Based Limitation” means a limitation to a quality listed in OAR 411-004-0020(2)(c) to (2)(g) and as incorporated by OAR 309-040-0410(3) applied in accordance with the required process described in OAR 309-040-0391 An individually-based limitation is based on specific assessed need and only implemented with the informed consent of the individual or the individual’s legal representative, as described in OAR 411-004-0040 and these rules. These qualities include the individual’s right to:

(a) Live under a legally enforceable agreement with protections substantially equivalent to landlord-tenant laws;

(b) The freedom and support to access food at any time;

(c) Have visitors of the individual’s choosing at any time;

(d) Have a lockable door in the individual's unit, which may be locked by the individual;

(e) Choose a roommate when sharing a unit;

(f) Furnish and decorate the individual's unit according to the Residency Agreement;

(g) The freedom and support to control the individual's schedule and activities; and

(h) Privacy in the individual's unit.

(43) "Informed Consent" means:

(a) Options, risks, and benefits of the services outlined in these rules have been explained to an individual and, as applicable, the individual's legal representative in a manner that the individual and, as applicable, the legal representative comprehends; and

(b) The individual and, as applicable, the individual's legal representative consents to a person-centered service plan of action, including any individually-based limitations to the rules, prior to implementation of the initial or updated person-centered service plan or any individually-based limitation.

(44) "Initial Personal Care Plan (IPCP)" means a written document developed for an individual within 24 hours of admission to the home. The document must address the care and services to be provided for the individual during the first 30 days or less until the Personal Care Plan can be developed. At a minimum the IPCP must contain goals that address the following: Immediate health care support needs, medication management issues, safety and supervision needs, activities of daily living that the individual needs assistance with completing as well as any pertinent information as required by the case manager or their designee at the time of the admission. The provider must develop an Initial Personal Care Plan (IPCP) within 24 hours of admission to the AFH.

(45) "Legal Representative" means a person who has the legal authority to act for an individual and only within the scope and limits to his or her authority as designated by the court or other agreement. A legal representative may include:

(a) For an individual under the age of 18, the parent, unless a court appoints another person or agency to act as the guardian; or

(b) For an individual 18 years of age or older, a guardian appointed by a court order or an agent legally designated as the health care representative.

(46) "Level One AFH" means an AFH licensed by the Division to provide care and services to individuals with severe and persistent mental illness, who may also have limited medical conditions.

(47) "License" means a document issued by the Division to applicants who are determined by the Division to be in substantial compliance with these rules.

(48) "Licensed Medical Practitioner (LMP)" means any person who meets the following minimum qualifications as documented by the CMHP or designee and holds at least one of the following educational degrees and a valid license:

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

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

(49) "Licensee" means the person or entity to whom a license is issued and whose name(s) is on the license.

(50) "Local Mental Health Authority (LMHA)" means the county court or board of county commissioners of one or more counties who choose to operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation which directly contracts with the Division to operate a CMHP for that county.

(51) "Mandatory Reporter" means any public or private official who, while acting in an official capacity, comes in contact with and has reasonable cause to believe that the adult has suffered abuse, or that any person with whom the official contact while acting in an official capacity, has abused the adult. Pursuant to ORS 430.765(2) psychiatrists, psychologists, clergy, and attorneys are not mandatory reporters with regard to information received

through communications that are privileged under 40.225 to 40.295.

(52) "Medication" means any drug, chemical, compound, suspension or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any individual.

(53) "Mental or Emotional Disturbances (MED)" means a disorder of emotional reactions, thought processes, or behavior that results in substantial subjective distress or impaired perceptions of reality or impaired ability to control or appreciate the consequences of the person's behavior and constitutes a substantial impairment of the person's social, educational, or economic functioning. Medical diagnosis and classification must be consistent with the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-V). As used in these rules, this term is functionally equivalent to "serious and persistent mental illness."

(54) "Mistreatment" means the following behaviors, displayed by an employee, program staff, caregiver, provider or volunteer of an AFH when directed toward an individual:

(a) "Abandonment" means desertion or willful forsaking when the desertion or forsaking results in harm or places the individual at a risk of serious harm.

(b) "Financial Exploitation" means:

(A) Wrongfully taking the assets, funds, or property belonging to or intended for the use of an individual.

(B) Alarming an individual by conveying a threat to wrongfully take or appropriate money or property of the individual if the individual would reasonably believe that the threat conveyed would be carried out.

(C) Misappropriating, misusing, or transferring without authorization any money from any account held jointly or singly by an individual.

(D) Failing to use the income or assets of an individual effectively for the support and maintenance of the individual. "Effectively" means use of income or assets for the benefit of the individual.

(c) "Involuntary Restriction" means the involuntary restriction of an individual for the convenience of a caregiver or to discipline the individual. Involuntary restriction may include but is not limited to placing restrictions on an individual's freedom of movement by restriction to his or her room or a specific area, or restriction from access to ordinarily accessible areas of the facility, residence or program, unless agreed to by the treatment plan. Restriction may be permitted on an emergency or short term basis when an individual's presence would pose a risk to health or safety to the individual or others.

(d) "Neglect" means active or passive failure to provide the care, supervision, or services necessary to maintain the physical and mental health of an individual that creates a significant risk of harm to an individual or results in significant mental injury to an individual. Services include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of the individual.

(e) "Verbal Mistreatment" means threatening significant physical harm or emotional harm to an individual through the use of:

(A) Derogatory or inappropriate names, insults, verbal assaults, profanity, or ridicule.

(B) Harassment, coercion, punishment, deprivation, threats, implied threats, intimidation, humiliation, mental cruelty, or inappropriate sexual comments.

(C) A threat to withhold services or supports, including an implied or direct threat of termination of services. "Services" include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of an individual.

(D) For purposes of this definition, verbal conduct includes but is not limited to the use of oral, written, or gestured communication that is directed to an individual or within their hearing distance or sight, regardless of their ability to comprehend. In this

circumstance the assessment of the conduct is based on a reasonable person standard.

(E) The emotional harm that can result from verbal abuse may include but is not limited to anguish, distress, or fear.

(f) “Wrongful Restraint” means any use of a physical or chemical restraint except for:

(A) An act of restraint prescribed by a licensed physician pursuant to OAR 309-033-0730; or

(B) A physical emergency restraint to prevent immediate injury to an individual who is in danger of physically harming himself or herself or others, provided that only the degree of force reasonably necessary for protection is used for the least amount of time necessary.

(55) “National Criminal History Check” means obtaining and reviewing criminal history outside Oregon’s borders. This information may be obtained from the Federal Bureau of Investigation through the use of fingerprint cards and from other criminal information resources in accordance with OAR 943-007-0000 through 943-007-0500 Criminal History Check Rules.

(56) “Neglect” means an action or inaction that leads to physical harm through withholding of services necessary to maintain health and well-being. For purposes of this paragraph, “neglect” does not include a failure of the state or a community program to provide services due to a lack of funding available to provide the services.

(57) “Nurse Practitioner” means a registered nurse who has been certified by the board as qualified to practice in an expanded specialty role within the practice of nursing.

(58) “Nursing Care” means the practice of nursing by a licensed nurse, including tasks and functions relating to the provision of nursing care that are delegated under specified conditions by a registered nurse to persons other than licensed nursing personnel, which is governed by ORS chapter 678 and rules adopted by the Oregon State Board of Nursing in OAR Chapter 851.

(59) “Nursing Delegation” means that a registered nurse authorizes an unlicensed person to perform special tasks of individual/nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of an individual in a specific situation, evaluation of the ability of the unlicensed person, teaching the task and ensuring supervision.

(60) “Person-Centered Service Plan” means written documentation that includes the details of the supports, desired outcomes, activities, and resources required for an individual to achieve and maintain personal goals, health, and safety as described in OAR 411-004-0030.

(61) “Person-Centered Service Plan Coordinator” means the person, which may be a case manager, service coordinator, personal agent, and other person designated by the Division to provide case management services or person-centered service planning for and with individuals.

(62) “Personal Care Plan (PCP)” means a written plan outlining the care and services to be provided to an individual. The PCP is based upon the review of current assessment, referral, observations, individual preference, and input from members of the Personal Care Plan Team. The plan identifies the care, services, activities, and opportunities to be provided by the caregiver to promote the individual’s recovery and independence.

(63) “Personal Care Plan Team (PCP Team)” means a group composed of the individual, the case manager or other designated representative CMHP representative, the provider, resident manager, and others needed including the individual’s legal guardian, representatives of all current service providers, advocates or others determined appropriate by the individual receiving services. If the individual is unable or does not express a preference, other appropriate team membership must be determined by the PCP team members.

(64) “Personal Care Services” means services prescribed by a physician or other designated person in accordance with the individual’s plan of treatment. The services are provided by a caregiver that is qualified to provide the service and is not a member of the individual’s immediate family. For those AFH individuals who are Medicaid eligible, Personal Care services are funded under Medicaid.

(65) “Practice of Registered Nursing” means the application of knowledge drawn from broad in-depth education in the social and physical sciences in assessing, planning, ordering, giving, delegating, teaching and supervising care which promotes the person’s optimum health and independence.

(66) “Program Staff” includes an employee or person who, by contract with an AFH provides a service to an individual.

(67) “Provider” means a qualified person or an organizational entity operated by or contractually affiliated with a community mental health program, or contracted directly with the Division for the direct delivery of mental health services and supports to adults receiving residential and supportive services in an AFH.

(68) “Psychiatric Security Review Board (PSRB)” means the Board consisting of five members appointed by the Governor and subject to confirmation by the Senate under Section Four, Article 111 of the Oregon Constitution and described in ORS 161.295 through 161.400 and OAR 309-032-1540.

(69) “Registered Nurse” means a person licensed and registered to practice nursing by the State of Oregon Board of Nursing in accordance with ORS Chapter 678 and OAR Chapter 851.

(70) “Related” includes the following relationships: spouse, domestic partner, natural parent, child sibling, adopted child, adopted parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, aunt, uncle, niece, nephew or first cousin.

(71) “Relative” means any person identified as a family member.

(72) “Representative” refers to both “Designated Representative” and “Legal Representative” as defined in these rules unless otherwise stated.

(73) “Residency Agreement” means the written, legally enforceable agreement between a provider and an individual or the individual’s representative when the individual receives services from the provider. The Residency Agreement identifies the rights and responsibilities of the individual and the provider. The Residency Agreement must provide the individual protection from eviction substantially equivalent to landlord-tenant laws.

(74) “Resident Manager” means an employee of the provider who is approved by the Division to live in the AFH and is responsible for the care and services of individuals on a day-to-day basis.

(75) “Residential Care” means the provision of room, board, and services that assist the individual in activities of daily living, such as assistance with bathing, dressing, grooming, eating, medication management, money management or recreation. Residential care includes 24 hour supervision; being aware of the individual’s general whereabouts; monitoring the activities of the individual while on the premises of the AFH to ensure the individual’s health, safety, and welfare; providing social and recreational activities; and assistance with money management as requested.

(76) “Residents’ Bill of Rights” means residents of the AFH have the following rights as defined in ORS 443.739. Each individual has a right to:

- (a) Be treated as an adult, with respect and dignity;
- (b) Be informed of all individual rights and all house rules;
- (c) Be encouraged and assisted to exercise legal rights, including the right to vote;
- (d) Be informed of the individual’s medical condition and the right to consent to or refuse treatment;
- (e) Receive appropriate care and services, and prompt medical care as needed;
- (f) A safe and secure environment;
- (g) Be free from mental and physical abuse;

(h) Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner;

(i) Complete privacy when receiving treatment or personal care;

(j) Associate and communicate privately with any person the individual chooses;

(k) Send and receive personal mail unopened;

(l) Participate in activities of social, religious and community groups;

(m) Have medical and personal information kept confidential;

(n) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space;

(o) Manage the individual's own money and financial affairs unless legally restricted;

(p) Be free from financial exploitation. The provider must not charge or ask for application fees or nonrefundable deposits and must not solicit, accept or receive money or property from an individual other than the amount agreed to for services;

(q) A written agreement regarding the services to be provided and the rate schedule to be charged. The provider must give 30 days' written notice before any change in the rates or the ownership of the home;

(r) Not to be transferred or moved out of the AFH without 30 days' advance written notice and an opportunity for a hearing. A provider may transfer or discharge an individual only for medical reasons including a medical emergency described in ORS 443.738(1)(a), or for the welfare of the individual or other individuals, or for nonpayment;

(s) Be free of discrimination in regard to race, color, national origin, sexual orientation, disability, sex or religion;

(t) Make suggestions and complaints without fear of retaliation.

(77) "Respite Care" means the provision of room, board, care, and services in an AFH for a period of up to 14 days. Respite care individuals will be counted in the total licensed capacity of the home. Respite care is not crisis respite care.

(78) "Restraints" means any physical hold, device, or chemical substance, which restricts, or is meant to restrict, the movement or normal functioning of an individual.

(79) "Room and Board" means the provision of meals, a place to sleep, laundry and housekeeping.

(80) "Seclusion" means the involuntary confinement of an individual to a room or area where the individual is physically prevented from leaving.

(81) "Self-Administration of Medication" means the act of an individual placing a medication in or on the individual's own body. The individual identifies the medication and the times and manners of administration, and placed the medication internally or externally on the individual's own body without assistance.

(82) "Self Preservation" in relation to fire and life safety means the ability of individuals to respond to an alarm without additional cues and be able to reach a point of safety without assistance.

(83) "Services" means those activities which are intended to help the individuals develop appropriate skills to increase or maintain their level of functioning and independence. Services include coordination and consultation with other service providers or entities to assure residents access to necessary medical care, treatment, and/or services identified in the individual's personal care plan.

(84) "Substitute Caregiver" means any person meeting the qualifications of a caregiver who provides care and services in an AFH under the jurisdiction of the Division in the absence of the provider or resident manager. An individual may not be a substitute caregiver.

(85) "Unit" means the personal space and bedroom of an individual, as agreed to in the Residency Agreement.

(86) "Unusual Incident" means those incidents involving acts of physical aggression, serious illnesses or accidents, any injury or illness of an individual requiring a non-routine visit to a health care

practitioner, suicide attempts, death of an individual, a fire requiring the services of a fire Department, or any incident requiring an abuse investigation.

(87) "Variance" means an exception from a regulation or provision of these rules, granted in writing by the Division, upon written application from the provider.

(88) "Volunteer" means a person who provides a service or who takes part in a service provided to individuals receiving services in an AFH or other provider, and who is not a paid employee of the AFH or other provider. The services must be non-clinical unless the person has the required credentials to provide a clinical service.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042; 413.032

Stats. Implemented: ORS 426.072 & 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0005, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 6-2007(Temp), f. & cert. ef. 5-25-07 thru 11-21-07; MHS 13-2007, f. & cert. ef. 8-31-07; MHS 11-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; MHS 4-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0310

License Required

(1) License Required. In accordance with ORS 443.725, every provider of Adult Foster Care must be licensed by the Division before opening or operating an AFH.

(a) The provider must live in the home that is to be licensed or hire a resident manager to live in the home.

(b) There must be a provider, resident manager or substitute caregiver on duty 24 hours per day in an AFH under the jurisdiction of the Department.

(2) Placement. An AFH must not accept placement of an individual without first being licensed by the Division.

(3) Unlicensed AFH. No individual may be placed in an AFH that is not licensed.

(4) Criminal History Check Requirements. Providers, resident managers, substitute caregivers, volunteers and occupants over the age of 16, excluding individuals, must have documentation of an approved criminal history/background check in accordance with ORS 181.537, 443.735 and OAR 943-007.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0010, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0315

License Application and Fees

(1) Application. A completed, written application will be submitted by the applicant on forms supplied by the Division. The application is not complete until all information requested by the Department and on the forms supplied by the Division is submitted to the Department. Incomplete applications are void 60 days after initial receipt of by the Division.

(2) Additional Homes. An applicant must submit a separate application for each location operated as an AFH.

(3) Contents of Application. The application must include:

(a) The maximum capacity requested and a written statement describing family members needing care, individuals who receive respite care, individuals who receive day care and/or individuals who receive room and board;

(b) A written statement from a Licensed Medical Practitioner regarding the mental and physical ability of the applicant to provide care to individuals and to operate the AFH. If the applicant will employ a resident manager, the applicant must provide a written statement from a physician or a LMP regarding the mental and physical ability of the resident manager to operate the AFH and to provide care to individuals;

(c) A completed financial information form provided by the Division. The applicant must demonstrate to the Division the applicant's financial ability and the resources necessary to operate the

AFH. Financial ability will include but is not limited to, providing the Division with a list of unsatisfied judgments, pending litigation and unpaid taxes and notifying the Division regarding whether the applicant is in bankruptcy. If the applicant is unable to demonstrate the financial ability and resources required, the Division may require the applicant to furnish a financial guarantee as a condition of initial licensure in accordance with ORS 443.735(e) and 443.745;

(d) A completed Facility Provider Enrollment Application;

(e) A signed letter of support from the Local Mental Health Authority or designee for the applicant to be licensed to operate the AFH;

(f) A copy of the documentation of Criminal History Check approval in accordance with OAR943-007 for the provider(s), the resident manager, caregiver(s), volunteers and other occupants over the age of 16, excluding individuals, and other persons as defined in ORS 443.735(5)(a)(b), (6)(a)(b)(c);

(g) A floor plan of the AFH showing the location and size of rooms, exits, secondary emergency egress, smoke detectors and fire extinguishers and evidence of compliance with facility safety requirements as described in OAR 309-040-0370(1) through (13);

(h) A completed AFH Self-Inspection Guide; and

(i) Each application must be accompanied by a fee of \$20 per bed requested for license.

(4) Review of Application. The Division will determine compliance with these rules based on receipt of the completed application material and fees, a review of information submitted, an investigation of information submitted, an inspection of the AFH, and interviews with the provider determined by the Division and other persons as identified by the Division.

(5) Withdrawal of Application. The applicant may withdraw the application at any time during the application process by notifying the Division in writing.

(6) Revocation, Surrender, Non-Renewal, or Denial of Application. An applicant whose license has been revoked or voluntarily surrendered, following a receipt of Notice of Intent to Revoke or Notice of Intent of Non-Renewal from the Division, or whose application has been denied by the Division for reasons relating to but not limited to, criminal convictions, civil proceedings against the applicant, or substantiated allegations of abuse by the applicant will not be permitted to submit an application for one year from the date that the revocation, surrender or denial is made final. A longer period may be specified in the order revoking or denying the license.

(7) Enforcement of Home and Community Based Required Qualities.

(a) An AFH licensed on or after July 1, 2016 must be in full compliance with all regulatory requirements under these rules at the time of initial licensure;

(b) An AFH licensed prior to July 1, 2016 must come into compliance with applicable rules as follows:

(A) All AFHs must be in full compliance with all applicable rules no later than January 1, 2017.

(B) For those rules designated by the Division to become effective July 1, 2016, the provider must make measurable progress towards compliance with those rules. The Division will not issue sanctions or penalties for failure to meet those rules effective July 1, 2016 or those obligations imposed by OAR Chapter 411, Division 4, until January 1, 2017 if the provider demonstrates measurable progress towards compliance.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0015, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0320

Classification of AFHs

The Division licenses Level 1 AFHs. Level 1 AFHs provide care and services to individuals with severe and persistent mental illness, who may also have limited medical conditions.

(1) Level One. A Level 1 AFH license may be issued by the Division based upon a determination that an AFH is in substantial compliance with these rules and a review of the qualifications of the provider and the resident manager, if there is one, and compliance with the following requirements.

(2) Requirement for Issuance of License. A Level 1 AFH license will be issued by the Division if the applicant or resident manager completes the training requirements outlined in OAR 309-040-0335, and the home and provider are in compliance with 309-040-0300 through 309-040-0455.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0011, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0325

Capacity

(1) Number of Individuals. The Division will determine the number of individuals permitted to reside in an AFH based on the ability of the caregiver to meet the care needs of the individuals, the fire safety standards, and compliance with the physical structure standards of these rules. Determination of maximum licensed capacity will include consideration of total household composition including children.

(a) Sleeping arrangements for children in care must be safe and appropriate, based on the child's age, gender, special needs, behavior, and history of abuse and neglect.

(b) Each child in care must have a safe and adequate bed in which to sleep.

(2) Limiting Capacity. The following limits apply:

(a) The number of individuals is limited to five;

(b) Respite care individuals are included in the licensed capacity of five;

(c) Day care individuals are included in the licensed capacity of five;

(d) Adult family members of the provider or resident manager who need care are included in the licensed capacity of five; and,

(e) Child family members of the provider or resident manager who need care may be included in the licensed capacity of five.

(3) Ability to Provide Care. If the number of individuals who receive care exceeds the ability of the provider to meet the care, health, life, and safety needs of the individuals, the Division may reduce the licensed capacity of the AFH.

(4) Conditions on Capacity. The Division may place conditions, restrictions, or limitations on the AFH license as necessary to maintain the health, life, and safety of the individual.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0012, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0330

Zoning for Adult Foster Homes

An AFH is a residential use of property for zoning purposes. Under ORS 197.665, an AFH is a permitted use in any residential zone, including a residential zone, which allows a single family dwelling, and in any commercial zone which allows a single family dwelling. No city or county may impose any zoning requirement on the establishment and maintenance of an AFH in these zones that is more restrictive than that imposed on a single-family dwelling in the same zone.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0100, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0335

Training Requirements for Providers, Resident Managers, and Substitute Caregivers

(1) Training Requirements and Compliance. All providers, resident managers, and substitute caregivers must satisfactorily meet all educational requirements established by the Division. No person may provide care to any individual prior to acquiring education or supervised training designed to impart the basic knowledge and skills necessary to maintain the health, safety and welfare of the individual. Required course work and necessary skills may include, but are not limited to: physical caregiving; screening for care and service needs; appropriate behavior towards individuals with physical, cognitive and emotional disabilities; emergency procedures; medication management; personal care products; food preparation; home environment and safety procedures; residents' rights; issues related to architectural accessibility; and, mandatory abuse reporting.

(2) Ability to Communicate. The provider, resident manager, and substitutive caregivers must be able to understand and communicate in oral and written English in accordance with ORS 443.730.

(3) Testing Requirements. Training for all providers, resident managers and substitute caregivers must be in compliance with ORS 443.738. The provider must satisfactorily pass any testing requirements established by the Division before being licensed or becoming a resident manager or substitute caregiver. The test must be completed by the caregiver without the help of any other person. The provider, resident manager and substitute caregiver must have the ability to, but not limited to, understanding and responding appropriately to emergency situations, changes in medical conditions, physicians' orders and professional instructions, nutritional needs, individuals' preferences and conflicts.

(4) Exceptions to Training Requirements. The Division may make exceptions to the training requirements for persons who are appropriately licensed medical care professional in Oregon or who possess sufficient education, training, or experience to warrant an exception. The Division will not make any exceptions to the testing requirements.

(5) Unexpected and Urgent Staffing Need. In accordance with ORS 443.738, the Division may permit a person who has not completed the training or passed the required test to act as a resident manager until the training and testing are completed, or for 60 days, whichever is shorter, if the Division determines that an unexpected and urgent staffing need exists. The provider must notify the Division of the situation and demonstrate that the provider is unable to find a qualified resident manager, that the person has met the requirements for a substitute caregiver for the AFH, and that the provider will provide adequate supervision.

(6) Documentation of Current Training and Testing. The provider or resident manager must maintain current documentation of the training and testing of substitute caregivers including but not limited to:

(a) Documentation of criminal history check in compliance with OAR 410-007-0200 through 410-007-0380.

(b) Documentation that substitute caregiver has successfully completed the training required by the Division.

(c) Documentation that provider has trained the caregiver to meet the routine and emergency needs of the individuals.

(d) Documentation that provider has oriented the caregiver to the individuals in the AFH, their care needs and skills training, personal care plan, and the physical characteristics of the AFH.

(7) Annual Training Hours. The Division will require a minimum of twelve hours of training annually directly related to the care and services for individuals with mental illness. The provider, resident manager, and substitute caregiver of an AFH must complete required training and document in the provider, resident manager, and substitute caregiver's training records. Such training is in addition to any orientation, which is attended by applicants prior to licensing and must include, but is not limited to:

(a) Understanding and Recognizing Severe and Persistent Mental Illness

(b) Mandatory Abuse Reporting

(c) Medication Management, Dispensing, and Documentation

(d) Incident Report Writing

(e) Individual Rights

(f) AFH Emergency Planning

(g) Fire Safety

(h) Complaints and Grievances

(i) Cardiopulmonary Resuscitation (CPR) and First Aid

(8) Additional Training Requirements. The Division may require the provider, resident manager or substitute caregiver to obtain additional training, whether or not the twelve hour annual training requirement has already been met as specified by the Division.

(9) Training for Delegated and/or Assigned Nursing Care Services. Providers, resident managers or substitute caregivers who perform delegated and/or assigned nursing care services as part of the Personal Care Plan must receive training and appropriate monitoring from a registered nurse on performance and delivery of those services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86;

MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-

24-99, cert. ef. 8-26-99; Renumbered from 309-040-0030, MHD 3-2005, f. &

cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0340

Issuance of a License

(1) Issuance of a License. Applicants must be in substantial compliance with these Administrative Rules and Oregon Revised Statutes (ORS) 443.705 through 443.825 before a license is issued. If cited deficiencies are not corrected within time frames specified by the Division, the application will be denied. The Division will issue a license to an applicant that is found to be in substantial compliance with these rules. The license must include, but is not limited to, the name of the applicant, name of the AFH, address of the home to which the license applies, the maximum number of individuals, resident manager (if applicable), conditions (if applicable), license number, payment received, effective date and expiration date, and the signature of the Assistant Administrator of the Division. The license must be visibly posted in the AFH and available for inspection at all times.

(2) Conditions on a License. The Division may attach conditions to the license, which limit, restrict, or specify other criteria for operation of the AFH. Conditions to a license may include, but are not limited to, care of a specifically identified individual. The conditions must be posted with the license in the AFH and be available for inspection at all times.

(3) Reporting Changes. Each provider must report promptly to the Division any significant changes to information supplied in the application or subsequent correspondence. Such changes include, but are not limited to, changes in the AFH name, owner entity, resident manager, telephone number, and/or mailing address. Such changes include, but are not limited to, changes in staffing when such changes are significant or impact the health, safety, or well-being of individuals.

(4) Change of Ownership of an AFH. When an AFH is sold, the prospective new owner must apply for a license in accordance with OAR 309-040-0315 if the new owner intends to operate an AFH.

(5) Transfer of License. An AFH license is not transferable or applicable to any location or persons other than those specified on the license.

(6) Effective Date of a License. A license is valid for one year from the effective date on the license unless sooner revoked or suspended.

(7) Substantial Compliance Requirements. Applicants must be in substantial compliance with these Administrative Rules before a license is issued. If cited deficiencies are not corrected within the time frames specified by the Division, the license will be denied.

(8) Issuing a License in Compliance. The Division may not issue an initial license unless:

(a) The applicant and the AFH are in compliance with ORS 443.705 to 443.825 and the rules of the Division;

(b) The Division has completed an inspection of the AFH. If cited deficiencies are not corrected within the time frames specified by the Division, the application will be denied;

(c) The Division has received an approved criminal history records check on the applicant, resident manager, substitute caregiver, and any occupant (other than an individual), 16 years of age or older or is identified in ORS 443.735(5)(a)(b), (6)(a)(b)(c) and who will be residing in or employed by the AFH, as identified in OAR 943-007, and any other rules established by the Division.

(9) Financial Ability and Resources. The applicant must demonstrate to the Division the financial ability and resources necessary to operate the AFH. The demonstration of financial ability must include, but need not be limited to, providing the Division with a list of any unsatisfied judgments, pending litigation and unpaid taxes and notifying the Division regarding whether the applicant is in bankruptcy. If the applicant is unable to demonstrate the financial ability and resources required by this paragraph, the Division may require the applicant to furnish a financial guarantee as a condition of initial licensure.

(10) Resident Manager Changes. If a resident manager changes during the period of the license, the provider must notify the Division immediately and identify a plan for providing care to

the individuals. The provider must submit a completed resident manager application on forms supplied by the Division that include, a copy of the documentation of criminal history background check and approval in accordance with OAR 943-007, a physician statement and payment of a \$10.00 fee. If the resident manager is to change during the license renewal process the \$10.00 is not applicable.

(11) Revised License. Upon receipt of the completed resident manager application and approval by the Division a revised license will be issued by the Division in accordance with ORS 443.738(1) through (4).

(12) 60-Day Provisional License. Notwithstanding any other provision of ORS 443.735 or 443.725 or 443.738, the Division may issue a 60-day provisional license to a qualified person if the Division determines that an emergency situation exists after being notified that the licensed provider of an AFH is no longer overseeing operation of the AFH.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99); Renumbered from 309-040-0020, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0345

Renewal

(1) Renewal Application and Fee. The provider must submit a completed the Division renewal application and the required fee at least 165 days prior to the expiration date of the license. If the renewal application is not received from the Division within the time period described, the provider must request the application from the Division or the County Mental Health partner. If the completed renewal application and fee are not submitted prior to the expiration date, the AFH will be treated as an unlicensed home, subject to civil penalties.

(2) Exceptions for Renewal Application. The renewal application must include the same information and fee as required for a new application, except that a physician's statement and financial information form are not required if the Division can reasonably assume this information has not changed.

(3) Additional Requirements for Renewal Application. The Division may require the applicant to submit a current (within six months) physician's statement and a current (within six months) criminal history check if investigation by the Division for license renewal indicates that it is necessary.

(4) Information Investigation and Site Inspection. The Division will investigate any information in the renewal application and must conduct an inspection of the AFH.

(5) Inspection Report. The provider will be given a formal written report from the inspection citing any deficiencies and a time frame for correction that does not exceed 30 days from the date of the inspection report unless otherwise noted in the inspection report.

(6) Correction of Deficiencies. The AFH provider must correct cited deficiencies prior to issuing a renewed license. If cited deficiencies are not corrected within the time frame specified by the Division, the renewal application will be denied and administrative sanctions may be imposed.

(7) Requirements for License Renewal. The Division may not renew a license unless:

(a) The applicant and the AFH are in compliance with ORS 443.705 to 443.825 and the rules of the Division;

(b) The Division has completed an inspection of the AFH;

(c) The Division has completed a criminal records check as required by ORS 181.536 through 181.537, 443.735 and OAR 943-007 on the applicant and any occupant, other than an individual, 16 years of age or older or is identified in ORS 443.735(5)(a)(b), (6)(a)(b)(c) and who will be residing in or employed by or otherwise acting as a provider, resident manager, substitute caregiver or volunteer for the AFH provider.

(8) National Criminal Record Check. The provider, resident manager, substitute caregiver or volunteer or person residing in the AFH may continue to work or reside in the home pending the

national criminal records check provided that the Oregon criminal record check was clear and no convictions were self-disclosed in accordance with OAR 943-007.

(9) Criminal Record Check. A criminal records check must be completed for the applicant and any occupant, other than an individual, 16 years of age or older who will be residing in or employed by or otherwise acting as a provider, resident manager, substitute caregiver or volunteer for the AFH provider if the Division believes there is reason to justify a new criminal history check in accordance with OAR 943-007 Criminal History Check Required.

(10) Burden of Proof — Less than 24 Months. An AFH provider seeking initial licensing or in operation for less than 24 months, carries the burden of proof to establish compliance with ORS 443.705 to 443.825 and the Division rules.

(11) Burden of Proof — More than 24 Months. The burden of proof will be upon the Division to establish compliance with ORS 443.705 to 443.825 and the Division rules if an AFH provider is seeking renewal of a license and has been in continuous operation for more than 24 months.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0025, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

**309-040-0350
Variance**

(1) A provider or applicant may apply to the Division for a variance from a provision of these rules. The provider must justify to the Division that such a variance does not jeopardize the health, life, or safety of the individuals, and the variance would not violate or compromise applicable ORS.

(2) The Division may not grant a variance from a regulation or provision of these rules pertaining to the license capacity of the AFH, inspections of the AFH, civil, legal and human rights, and inspection of the public files. No variance related to fire and life safety will be granted by the Division without prior consultation with the local fire authority or its designee.

(3) A provider or applicant may apply to the Division for a variance specific to each individual under ORS 443.725, subject to the following requirements:

(a) The variance is effective only for the specific individual who has been assessed and meets the safety requirements prescribed by the Division. This assessment shall become part of the individual's PCP;

(b) A variance allowing a specific individual to be in the AFH alone shall not exceed 4 hours in a 24 hour period;

(c) No variance allows a provider to leave an individual alone in the AFH between the hours of 11:00 pm to 6:00 am; and

(d) 24 hour per day care shall continue for any individual that does not qualify to be in the AFH alone.

(4) Variances must be granted or denied in writing. All variances granted must be reviewed with each license renewal under OAR 309-040-0345. A variance granted to one AFH provider, or a variance granted regarding a specific individual, does not constitute a precedent for any other AFH, provider, applicant, or individual.

(5) The AFH provider or applicant may appeal the denial of a variance request by submitting a request for reconsideration in writing to the Division. The Division will make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Division will be final.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0035, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 2-2007(Temp), f. & cert. ef. 5-4-07 thru 10-31-07; MHS 12-2007, f. & cert. ef. 8-31-07; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0355

Contracts

(1) Public Assistance Individuals. Providers who care for public assistance individuals must enter into a contract with the Division and comply with Division rules governing reimbursement for services and refunds.

(2) Private Pay Individuals. Providers who care for private paying individuals must enter into a signed contract with the individual or person paying for care. This contract must include, but is not limited to, a PCP, a schedule of rates, conditions under which the rates can be changed, and the AFH's policy on refunds at the time of hospitalization, death, discharge, or voluntary move.

(3) Notification of Increases, Additions, and Other Modifications of Rates. The provider must provide 30 days' prior written notification to private individuals or persons paying for care of increases, additions, and other modifications of the rates to be charged unless the change is due to a medical emergency resulting in a greater level of care, in which case the provider must give notice within ten days of the change.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0040, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0360

Qualifications for Adult Foster Home Providers, Resident Managers and Other Caregivers

(1) Qualifications for a Provider. An AFH provider must meet the following qualifications:

(a) Be at least 21 years of age;

(b) Live in the AFH to be licensed, unless an approved resident manager lives in the AFH;

(c) Provide evidence satisfactory to the Division regarding experience, training, knowledge, interest, and concern in providing care to persons with severe and persistent mental illness. Such evidence may include, but is not limited to:

(A) Certified nurse's aide training;

(B) Nursing home, hospital or institutional work experience;

(C) Licensed practical nurse or registered nurse training and experience;

(D) Training approved by the Division;

(E) Experience in caring for individuals with severe and persistent mental illness at home; and

(F) Home management skills.

(d) Possess the physical health and mental health determined necessary by the Division to provide 24-hour care for adults who are mentally ill. Applicants must have a statement from a physician, on a form provided by the Division, that they are physically and mentally capable of providing care;

(e) Undergo a criminal history check in accordance with OAR 943-007 and be deemed eligible for licensure by the Division. The Division will evaluate and verify information regarding criminal history;

(f) Provide evidence of sufficient financial resources to operate an AFH for at least two months, unless the application is for renewal of an AFH that is already in operation. A credit reference check may be required;

(g) Be literate and capable of understanding written and oral orders and communicating with individuals, physician, case manager, and appropriate others; and be able to respond appropriately to emergency situations at all times;

(h) If transporting individuals by motorized conveyance, must have a current driver's license in compliance with the Department of Motor Vehicles laws and vehicle insurance as required by the State of Oregon.

(2) Qualifications for a Resident Manager. The resident manager must meet the provider qualifications listed in subsection (1)(a) through (h) of this rule. A resident manager applicant may work in the home pending outcome of the national criminal history

check, if the Oregon criminal history check was clear and no convictions were self-disclosed on the criminal record authorization.

(3) Qualifications for a Substitute Caregiver. Substitute caregivers left in charge of an individual for any period of time must have access to individual records and meet the following qualifications:

- (a) Be at least 18 years of age;
- (b) Be subject to a criminal history check. A substitute caregiver may work in the home pending outcome of the national criminal history check providing the Oregon criminal history check was clear and no convictions were self-disclosed on the criminal record authorization;
- (c) Be able to communicate orally and in writing with individuals, physicians, case managers, and appropriate others;
- (d) Know fire safety and emergency procedures;
- (e) Have a clear understanding of job responsibilities, have knowledge of PCPs and be able to provide the care specified for each individual's needs;
- (f) Be able to meet the requirements of a resident manager when left in charge of an AFH for 30 days or longer;
- (g) Not be an individual; and
- (h) If transporting individual(s) by motorized conveyance, must have a current driver's license in compliance with Department of Motor Vehicles laws and vehicle insurance as required by the State of Oregon.

(4) Providers Responsibility for Standards. The provider must not hire or continue to employ a resident manager or substitute caregiver who does not meet the standards stated in this rule.

(5) Providers Responsibility for Supervision and Training. A provider is responsible for the supervision and training of resident managers and substitute caregivers and their general conduct when acting within the scope of their employment and/or duties.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0045, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0365

Facility Standards

In order to qualify for or maintain a license, an AFH must meet the following provisions.

(1) Compliance with Building and Fire Code. Demonstrate compliance with Oregon Structural Specialty Code (OSSC) and Oregon Fire Code: and

(a) Each AFH must maintain up-to-date documentation verifying they meet applicable local business license, zoning, and building and housing codes, and state and local fire and safety regulations. It is the duty of the provider to check with local government to be sure all applicable local codes have been met;

(b) Each AFH established on or after October 1, 2004 must meet all applicable State building, mechanical, and housing codes for fire and life safety. The AFH must be inspected for fire safety by an inspector designated by the Division using the recommended standards established by the State Fire Marshal for facilities housing one to five persons. Refer to Appendix I of the Oregon Fire Code, the Oregon Residential Specialty Code, and the Oregon Structural Specialty Code. When deemed necessary by the Division, a request for fire inspection must be made to the State Fire Marshal.

(c) The building and furnishings must be clean and in good repair and grounds must be maintained. Walls, ceilings, and floors must be of such character to permit frequent washing, cleaning, or painting. There must be no accumulation of garbage, debris, rubbish or offensive odors;

(d) Stairways must be provided with handrails. A functioning light must be provided in each room, stairway, and exit way; incandescent light bulbs must be protected with appropriate covers. Yard and exterior steps must be accessible to individuals;

(e) The heating system must be in working order. Areas of the AFH used by individuals must be maintained at no less than 68

degrees Fahrenheit during the day and 60 degrees Fahrenheit during sleeping hours. During times of extreme summer heat, the provider must make a reasonable effort to make the individuals comfortable using available ventilation or fans;

(f) There must be at least 150 square feet of common space, and sufficient comfortable furniture in the AFH to accommodate the recreational and socialization needs of the occupants at one time. Common space must not be located in the basement or garages unless such space was constructed for that purpose or has otherwise been legalized under permit. Additional space is required if wheelchairs are to be accommodated;

(g) Pools and hot tubs must be equipped with sufficient safety barriers or devices to prevent accidental injury in accordance with Section R116 of the Oregon Residential Specialty Code.

(2) Accessibility for Persons with Disabilities. Any accessibility improvements made to accommodate an identified individual must be in accordance with the specific needs of the individual and comply with Chapter 11 of the building code.

(3) Outdoor Areas. An accessible outdoor area is required and must be made available to individuals. A portion of the outdoor area must be covered and have an all-weather surface, such as a patio or deck.

(4) Storage Areas. Storage for a reasonable amount of individual individual belongings beyond that of the individual's unit must be made available.

(a) All yard maintenance equipment must be maintained in a locked storage if such equipment poses a safety threat.

(b) A locked storage area for individual medications separate from food, laundry and toxic or hazardous materials must be made accessible to all caregivers. For individuals who are self-medicating, the provider must make a secured locked box available to assure the safety of all occupants of the home.

(c) A locked storage area separate from food and medications must be designated when there are toxic or hazardous materials on the premises.

(5) Bathrooms. All equipment must be clean and in good repair and provide individual privacy and have: a finished interior; a mirror; an operable window or other means of ventilation; and a window covering.

(a) Must have tubs or showers, toilets and sinks, and hot and cold water. A sink must be located near each toilet. A toilet and sink must be provided on each floor where rooms of non-ambulatory individuals or individuals with limited mobility are located. There must be at least one toilet, one sink, and one tub or shower for each six household occupants, including the provider and family;

(b) Must have hot and cold water in sufficient supply to meet the needs of individuals for personal hygiene. Hot water temperature sources for bathing areas must not exceed 120 degrees Fahrenheit;

(c) Must have shower enclosures with nonporous surfaces; glass shower doors will be tempered safety glass. Shower curtains must be clean and in good condition. Non-slip floor surfaces will be provided in tubs and showers;

(d) Must have grab bars for toilets, tubs, and/or showers for individual's safety as required by individual's disabilities;

(e) The home must not be designed such that an individual or employee must walk through another individual's bedroom to get to a bathroom. Individuals must have barrier-free access to toilet and bathing facilities with appropriate fixtures.

(f) If there are non-ambulatory individual; alternative arrangements for non-ambulatory individuals must be appropriate to individual needs for maintaining good personal hygiene.

(g) Individuals must have appropriate racks or hooks for drying bath linens.

(6) Units. All furniture and furnishings must be clean and in good repair. Units for all household occupants must have been constructed as a bedroom when the home was built or remodeled under permit; be finished, with walls or partitions of standard construction which go from floor to ceiling, and a door which opens directly to a hallway or common use room without passage through another unit or common bathroom; be adequately ventilated, heated and

lighted with at least one operable window which meets fire egress regulations. (See Section R310 Emergency Escape and Rescue Openings in the Oregon Residential Specialty Code.) All units must include a minimum of 70 square feet of usable floor space for each individual or 120 square feet for two individuals and have no more than two persons per room and allow for a minimum of three feet between beds. In addition, the provider must ensure the following:

(a) Each unit has a lockable entrance door for the individual's privacy, as follows:

(A) The locking device must release with a single-action lever on the inside of the unit, open to a hall or common-use room;

(B) The provider must provide each individual with a personalized key that operates only the door to his or her unit door from the corridor side.

(D) The provider must maintain a master key to access all of the units that is quickly available to the provider or resident manager as appropriate and documented in the individual's person-centered service plan;

(E) The provider must not disable or remove a lock to a unit without first obtaining consent from the individual or the individual's legal representative through the individually based limitations process described in OAR 411-004-0040(2) and as incorporated by OAR 309-040-0391; and

(F) Section (6)(a) of these rules and its subsections are effective July 1, 2016 and enforceable as described in OAR 309-040-315(7).

(b) Providers, resident managers or their family members must not sleep in areas designated as living areas, nor share units with individuals;

(c) In determining maximum capacity, consideration must be given to whether children over the age of five have a bedroom separate from their parents.

(d) Units must be on ground level for individuals who are non-ambulatory or have impaired mobility;

(e) Individual units must be in close enough proximity to alert the provider or resident manager to night time needs or emergencies, or be equipped with a call bell or intercom.

(7) Housing Codes. Each AFH established on or after October 1, 2004 must meet all applicable State building, residential, fire, mechanical, and housing codes for fire and life safety. The AFH must be inspected for fire safety by an inspector designated by the Division using the recommended standards established by the State Fire Marshal for facilities housing one to five individuals. Refer to Appendix I of the Oregon Fire Code, the Oregon Residential Specialty Code, and the Oregon Structural Specialty Code. When deemed necessary by the Department, a request for fire inspection must be made to the State Fire Marshal.

(8) Special hazards.

(a) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers, or safety containers, and secured to prevent tampering by individuals or others. Firearms on the premises of an AFH must be stored in a locked cabinet. The firearms cabinet must be located in an area of the home that is not readily accessible to individuals and all ammunition must be stored in a separate, locked location;

(b) Smoking regulations will be adopted to allow smoking only in designated areas. Smoking will be prohibited in sleeping rooms and upon upholstered crevasse furniture. Ashtrays of non-combustible material and safe design will be provided in areas where smoking is permitted;

(c) Cleaning supplies, poisons and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, preparation and storage, dining areas, and medications.

(9) Common Use Rooms. All furniture and furnishings must be clean and in good repair. There must be at least 150 square feet of common space, and sufficient comfortable furniture in the AFH to accommodate the recreational and socialization needs of the occupants at one time. Common space must not be located in the basement or garages unless such space was constructed for that

purpose or has otherwise been legalized under permit. Additional space will be required if wheelchairs are to be accommodated;

(10) Laundry and Related Space. All equipment must be clean and in good repair. Laundry facilities must be separate from food preparation and other individual use areas. The provider must maintain the following:

(a) Locked storage area for chemicals that pose a safety threat to individuals or family members;

(b) Sufficient, separate storage and handling space to ensure that clean laundry is not contaminated by soiled laundry;

(c) Outlets, venting and water hookups according to State Building Code requirements; and

(d) Washers must have a minimum rinse temperature of 140 degrees Fahrenheit.

(11) Kitchen. All equipment must be clean and in good repair. The provider must maintain an area for dry storage, not subject to freezing, in cabinets or a separate pantry with a minimum of one week's supply of staple foods. The provider must maintain the following:

(a) Sufficient refrigeration space maintained at 45 degrees Fahrenheit or less and freezer space for a minimum of two days' supply of perishable foods;

(b) A dishwasher with a minimum final rinse of 140 degrees Fahrenheit;

(c) Smooth, nonabsorbent and cleanable counters for food preparation and serving;

(d) Appropriate storage for dishes and cooking utensils designed to be free from potential contamination;

(e) Stove and oven equipment for cooking and baking needs;

(f) Storage for a mop and other cleaning tools and supplies used for food preparation, dining and adjacent areas. Such cleaning tools must be maintained separately from those used to clean other parts of the home; and

(g) Dining Space where meals are served must be provided to seat all individuals at the same seating.

(12) Details and Finishes:

(a) The building and furnishings must be clean and in good repair and grounds will be maintained. Walls, ceilings, and floors will be of such character to permit frequent washing, cleaning, or painting

(b) Doors. Locks used on doors to individuals' units must be in good repair with an interactive lock to release with operation of the inside door handle and be master keyed from the corridor side and comply with the requirements established by OAR 309-040-0365(6)(a) and its subsections. Exit doors must not have locks that prevent evacuation except as permitted by Section 1008.1.8 of the building code. An exterior door alarm or other acceptable system may be provided for security purposes and alert the provider when individual(s) or others enter or exit the home.

(c) Handrails. Handrails must be secured on all stairways.

(13) Heating and Ventilation. The heating system must be in working order:

(a) Temperature Control. Areas of the AFH used by individuals must be maintained at no less than 68 degrees Fahrenheit during daytime hours and no less than 60 degrees Fahrenheit during sleeping hours. During times of extreme summer heat, the provider must make reasonable effort to make the residents comfortable using available ventilation or fans;

(b) Exhaust Systems. All toilets and shower rooms must be ventilated by a mechanical exhaust system or operable window.

(c) Fireplaces, Furnaces, Wood Stoves. Design and installation must meet standards of the Oregon Mechanical and Residential Specialty Code and have annual inspections to assure no safety hazard exists.

(d) Water Temperature in individual areas, hot water temperatures must be maintained within a range of 110¼ to 120 degrees Fahrenheit. Hot water temperatures for washing machines and dishwashers must be at least 140 degrees Fahrenheit.

(14) Electrical. All electrical systems must meet the standards of the Oregon Electrical Specialty Code in effect on the date of

installation, and all electrical devices must be properly wired and in good repair:

(a) When not fully grounded, GFI-type receptacles or circuit breakers as an acceptable alternative may protect circuits in individual areas.

(b) Circuit breakers or non-interchangeable circuit-breaker-type fuses in fuse boxes must be used to protect all electrical circuits.

(c) A sufficient supply of electrical outlets must be provided to meet individual and staff needs without the use of extension cords or outlet expander devices.

(d) A functioning light must be provided in each room, stairway, and exit way. Lighting Fixtures will be provided in each individual bedroom and bathroom, with a light switch near the entry door, and in other areas as required to meet task illumination needs.

(e) Incandescent light bulbs must be protected with appropriate covers.

(15) Plumbing. All plumbing must meet the Oregon Plumbing Specialty Code in effect on the date of installation, and all plumbing fixtures must be properly installed and in good repair.

(16) Pool, Hot Tubs and Ponds. Pools, hot tubs, and ponds must be equipped with sufficient safety barriers or devices to prevent accidental injury in accordance with Section R116 of the Oregon Residential Specialty Code.

(17) Telephones:

(a) A telephone must be available and accessible 24 hours a day for individuals' use for incoming and outgoing calls in the AFH;

(b) Emergency telephone numbers for the local CMHP, Police, Fire, Medical, Poison Control, provider and other emergencies must be posted by the individuals' telephone. The posting must include the name, address and telephone number of the AFH, telephone numbers for making complaints or a report of alleged abuse to the local CMHP, the Division, the Office of Investigations and Training, and the Oregon Advocacy Center.

(d) AFH telephone numbers must be listed in the local telephone directory.

(e) The provider may establish reasonable rules governing telephone use to ensure equal access by all individuals. Each individual or guardian (as applicable) will be responsible for payment of long distance phone bills where calls were initiated by the individual, unless otherwise mutually agreed arrangements have been made.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Sections (8)-(10) renumbered to 309-040-0052; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0050, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0370

Safety

(1) Training on Safety Procedures. The provider must train all program staff in staff safety procedures prior to beginning their first regular shift. All individuals must be trained in individual safety procedures as soon as possible during their first 72 hours of residency.

(2) Emergency Procedure.

(a) An emergency evacuation procedure must be developed, posted, and rehearsed with occupants. A record must be maintained of evacuation drills. Drills must be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes.

(A) Drills must be held at least once every 30 days.

(B) One drill practice must be held at least once every 90 days during individual's nighttime sleeping hours. Fire drill records must be maintained for three years and will include date, time for full evacuation, safety equipment checked (to include fire extinguishers, smoke detectors, secondary egress points, flashlights, and furnace filters), comments on the drill results, and names of individuals requiring assistance for evacuation;

(b) The Personal Care Plan must document that, within 24 hours of arrival, each new individual has received an orientation to basic safety and has been shown how to respond to a fire alarm, and how to exit from the AFH in an emergency;

(c) The provider must demonstrate the ability to evacuate all individuals from the facility within three minutes. If there are problems in demonstrating this evacuation time, the Division may apply conditions to the license which include, but may not be limited to, reduction of individuals under care, additional staffing, increased fire protection, or revocation of the license;

(d) The provider must provide to the Division, maintain as current, and post a floor plan on each floor containing room sizes, location of each individual's bed, fire exits, resident manager or provider's sleeping room, smoke detectors, fire extinguishers and escape routes. A copy of this drawing must be submitted with the application and updated to reflect any change;

(e) There will be at least one plug-in rechargeable flashlight available for emergency lighting in a readily accessible area on each floor including basement.

(3) Disaster Plan. A written disaster plan must be developed to cover such emergencies and disasters as fires, explosions, missing persons, accidents, earthquakes and floods. The plan will be posted by the phone and immediately available to the employees. The plan will specify temporary and long-range habitable shelter where staff and individuals will reside if the facility becomes uninhabitable.

(4) Poisonous and Other Toxic Materials. Non-toxic cleaning supplies must be used whenever available. Poisonous and other toxic materials must be properly labeled and stored in locked areas distinct and apart from all food and medications.

(5) Evacuation Capability. Evacuation capability categories are based upon the ability of the individuals and staff as a group to evacuate the facility or relocate from a point of occupancy to a point of safety.

(a) Documentation of an individual's ability to safely evacuate from the facility must be maintained in the individual's personal care plan.

(b) Individuals experiencing difficulty with evacuating in a timely manner must be provided assistance from staff and offered environmental and other accommodations, as practical. Under such circumstances, the provider must consider increasing staff levels, changing staff assignments, offering to change the individual's room assignment, arranging for special equipment, and taking other actions that may assist the individual.

(c) Individuals who still cannot evacuate the home safely in the allowable period of time (3 minutes) must be assisted with transferring to another program with an evacuation capability designation consistent with the individual's documented evacuation capability.

(d) Written evacuation records must be retained for at least three years. Records must include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.

(6) Unobstructed Egress. All stairways, halls, doorways, passageways, and exits from rooms and from the home must be unobstructed.

(7) Portable Firefighting Equipment. At least one 2A-10BC rated fire extinguisher must be in a visible and readily accessible location on each floor, including basements, and must be inspected at least once a year by a qualified worker that is well versed in fire extinguisher maintenance. All recharging and hydrostatic testing must be completed by a qualified agency properly trained and equipped for this purpose;

(8) Smoke Alarms. Approved smoke detector systems or smoke alarms must be installed according to Oregon Residential Specialty Code and Oregon Fire Code requirements. These alarms will be tested during each evacuation drill. The provider must provide approved signal devices for persons with disabilities who do not respond to the standard auditory alarms. All of these devices

must be inspected and maintained in accordance with the requirements of the State Fire Marshal or local agency having jurisdiction. Ceiling placement of smoke alarms or detectors is recommended. Alarms must be equipped with a device that warns of low battery when battery operated. All smoke detectors and alarms must be maintained in functional condition;

(9) Special hazards:

(a) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers or safety containers, and secured to prevent tampering by individuals and vandals. Firearms on the premises of an AFH must be stored in a locked cabinet. The firearms cabinet must be located in an area of the home that is not readily accessible to clients and all ammunition must be stored in a separate, locked location;

(b) Smoking regulations must be adopted to allow smoking only in designated areas. Smoking must be prohibited in sleeping rooms and upon upholstered crevasse furniture. Ashtrays of non-combustible material and safe design must be provided in areas where smoking is permitted;

(c) Cleaning supplies, poisons and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, preparation and storage, dining areas, and medications.

(10) Sprinkler Systems. Sprinkler systems, if used, must be installed in compliance with the Oregon Structural Specialty Code and Oregon Fire Code and maintained in accordance with rules adopted by the State Fire Marshal.

(11) First Aid Supplies. First aid supplies must be readily accessible to staff. All supplies will be properly labeled.

(12) Portable Heaters. Portable heaters are a recognized safety hazard and will not be used, except as approved by the State Fire Marshal, or authorized representative.

(13) Safety Program. A safety plan must be developed and implemented to identify and prevent the occurrence of hazards. Hazards may include, but are not limited to, dangerous substances, sharp objects, unprotected electrical outlets, use of extension cords or other special plug-in adapters, slippery floors or stairs, exposed heating devices, broken glass, inadequate water temperatures, overstuffed furniture in smoking areas, unsafe ashtrays and ash disposal, and other potential fire hazards.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0375

Sanitation

(1) Water Supply. The water supply in the home must meet the requirements of the current rules of the Authority governing domestic water supplies.

(a) A municipal water supply must be utilized if available.

(b) When the home is not served by an approved municipal water system, and the home qualifies as a public water system according to OAR 333-061-0020(94), Authority rules for public water systems, then the provider must comply with the OAR chapter 333 rules of the Authority pertaining to public water systems. These include requirements that the drinking water be tested for total coliform bacteria at least quarterly, and nitrate at least annually, and reported to the Division. For adverse test results, these rules require that repeat samples and corrective action be taken to assure compliance with water quality standards, that public notice be given whenever a violation of the water quality standards occurs, and that records of water testing be retained according to the Division requirements.

(2) Surfaces. All floors, walls, ceilings, windows, furniture, and equipment must be kept in good repair, clean, neat, and orderly.

(3) Plumbing Fixtures. Each bathtub, shower, lavatory, and toilet must be kept clean, in good repair and regularly sanitized.

(4) Disposal of Cleaning Waste Water. No kitchen sink will be used for the disposal of cleaning wastewater.

(5) Soiled Laundry. Soiled linens and clothing must be stored in an area or container separate from kitchens, dining areas, clean linens, clothing, and food.

(6) Pest Control. All necessary measures must be taken to prevent rodents and insects from entering the home. Should pests be found in the home, appropriate action must be taken to eliminate them.

(7) Grounds Maintenance. The grounds of the facility must be kept orderly and reasonably free of litter, unused articles, and refuse.

(8) Garbage Storage and Removal. Garbage and refuse receptacles must be clean, durable, watertight, insect and rodent proof, and will be kept covered with tight-fitting lids. All garbage and solid waste must be disposed of at least weekly and in compliance with the current rules of the Department of Environmental Quality.

(9) Sewage Disposal. All sewage and liquid wastes must be disposed of in accordance with the Plumbing Code to a municipal sewage system where such facilities are available. If a municipal sewage system is not available, sewage and liquid wastes must be collected, treated, and disposed of in compliance with the current rules of the Department of Environmental Quality. Sewage lines, and septic tanks or other non-municipal sewage disposal systems where applicable, must be maintained in good working order.

(10) Biohazard Waste. Biohazard waste must be disposed of in compliance with the rules of the Department of Environmental Quality.

(11) Infection Control. Precautions must be taken to prevent the spread of infectious and/or communicable diseases as defined by the Centers for Disease Control and to minimize or eliminate exposure to known health hazards.

(a) In accordance with OAR 437, division 2, subdivision Z, section 1910.1030 of the Oregon Occupational Safety and Health Code, program staff must employ universal precautions whereby all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

(b) Bathroom facilities must be equipped with an adequate supply of toilet paper, soap, and towels.

(12) Infection Control for Pets and Other Household Animals. If pets or other household animals exist at the home, sanitation practices must be implemented to prevent health hazards.

(a) Such animals must be vaccinated in accordance with the recommendations of a licensed veterinarian. Proof of such vaccinations must be maintained on the premises.

(b) Animals not confined in enclosures must be under control and maintained in a manner that does not adversely impact individuals or others.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0380

Resident Furnishings

(1) Bedrooms/Units:

(a) Bedrooms for all household occupants and units for individuals must have been constructed as a bedroom when the home was built or remodeled under permit; be finished, with walls or partitions of standard construction which go from floor to ceiling, and a door which opens directly to a hallway or common use room without passage through another bedroom/unit or common bathroom; be adequately ventilated, heated and lighted with at least one operable window which meets the requirements of Section R310 of the Oregon Residential Specialty Code; have at least 70 square feet of usable floor space for each individual or 120 square feet for two individuals and have no more than two individuals per room;

(b) Providers, resident managers, or their family members must not sleep in areas designated as living areas, nor share bedrooms/units with individuals;

(c) There must be an individual bed for each individual consisting of a mattress in good condition and springs at least 36 inches wide. Cots, rollaway, bunks, trundles, couches, and folding beds may not be used for individuals. Each bed must have clean bedding in good condition consisting of a bedspread, mattress pad,

two sheets, a pillow, a pillowcase, and blankets adequate for the weather. Sheets and pillowcases must be laundered at least weekly, and more often if necessary. Waterproof mattress covers must be used for incontinent individuals. Day care individuals may not use individual beds;

(d) Each unit must have sufficient separate, private dresser and closet space for each individual's clothing and personal effects, including hygiene and grooming supplies. Individuals must be allowed to keep and use reasonable amounts of personal belongings, and to have private, secure storage space. Drapes or shades for windows must be in good condition and provide privacy for individuals;

(e) Units must be on ground level for individuals who are non-ambulatory or have impaired mobility;

(f) Units must be in close enough proximity to provider to alert provider to night time needs or emergencies, or be equipped with a call bell or intercom.

(2) Personal Hygiene Items. Each individual must be assisted in obtaining personal hygiene items in accordance with individual needs. Items must be stored in a clean and sanitary manner, and may be purchased with the individual's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, menstrual supplies (if needed), towels and washcloths.

(3) Supplies Provided by AFH. Sufficient supplies of soap, shampoo and toilet paper for all individuals must be provided.

(4) Common Area Furniture. An adequate supply of furniture for individual use in living room, dining room, and other common areas must be maintained in good condition.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0385

Food Services

(1) Well-balanced Diet. Three nutritious meals must be served daily at times consistent with those in the community. Meals must be planned and served in accordance with the recommended dietary allowances found in the United States Department of Agriculture Food Guide Pyramid or as directed by a prescriber. Consideration must be given to cultural and ethnic backgrounds of individuals in food preparation.

(2) Modified or Special Diets. An order from a Licensed Medical Professional must be obtained for each individual who, for health reasons, is on a modified or special diet. Such diets must be planned in consultation with the individual.

(3) Menus. Menus must be prepared at least one week in advance and provide a sufficient variety of foods served in adequate amounts for each individual at each meal and adjusted for seasonal changes. Records of menus, as served, must be filed and maintained in the AFH for three years. Individual preferences and requests must be considered in menu planning. Religious and vegetarian preferences must be reasonably accommodated.

(4) Meal Preparation. Meals must be prepared and served in the facility where the individuals live. Payment for meals eaten away from the facility for the convenience of the provider (e.g. restaurants, senior meal sites) is the responsibility of the provider. Meals and snacks as part of an individual recreational outing are the responsibility of the individual. Food preparation areas must be clean, free of obnoxious odors and in good repair.

(5) Supply of Food. Adequate supplies of staple foods, for a minimum of one week, and perishable foods, for a minimum of two days, must be maintained on the premises.

(6) Adequate Storage. Food must be stored, prepared, and served in accordance with the Authority Food Sanitation Rules.

(a) All working refrigerators and freezers must have a thermometer in working order.

(b) Food storage areas and equipment must be such that food is protected from dirt and contamination and maintained at proper temperatures to prevent spoilage.

(7) Food Service Equipment. Equipment must be maintained in a safe and sanitary manner. Utensils, dishes and glassware must

be maintained in a sufficient number to accommodate the licensed capacity of the AFHs. Utensils, dishes, and glassware must be washed in hot soapy water, rinsed, and stored to prevent contamination. A dishwasher with sanicycle is recommended.

(8) The provider must support the individual's right to access food at any time. The provider may only apply an individually based limitation where the circumstances meet, and the provider complies with, the standards and requirements of OAR 411-050-0655 as incorporated by OAR 309-040-0391. This subsection is effective July 1, 2016 and enforceable as described in OAR 309-040-0315(7).

(9) If an individual misses a meal at a scheduled time, an alternative meal must be made available.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0390

Standards and Practices for Care and Services

(1) Caregiver Requirements. There must be a provider, resident manager or substitute caregiver on duty 24 hours per day in an AFH in accordance with ORS 443.725(3).

(2) Medications and Prescriber's Orders:

(a) There must be a copy of a medication, treatment, or therapy order signed by a physician, nurse practitioner or other licensed prescriber in the individual's file for the use of any medications, including over the counter medications, treatments, and other therapies.

(b) A provider, resident manager or substitute caregiver must dispense medications, treatments, and therapies as prescribed by a physician, nurse practitioner or other licensed prescriber. Changes to orders for the dispensing and administration of medication or treatment must not be made without a written order from a physician, nurse practitioner or other licensed prescriber. A copy of the medication, treatment, or therapy order must be maintained in the individual's record. The provider, resident manager or substitute caregiver must promptly notify the individual's case manager of any request for a change in individual's orders for medications, treatments, or therapies.

(c) Each individual's medication must be clearly labeled with the pharmacist's label or the manufacturer's originally labeled container and kept in a locked location. The provider and/or provider's family medication must be stored in a separate locked location. All medication for pets or other animals must be stored in a separate locked location. Unused, outdated, or recalled medications must not be kept in the AFH and must be disposed in a manner to prevent diversion into the possession of people other than for whom it was prescribed. The provider must document disposal of all unused, outdated and/or recalled medication on individuals' individual drug disposal forms.

(d) Medications must not be mixed together in another container prior to administration except as packaged by the pharmacy or by physician order;

(e) A written medication administration record (MAR) for each individual must be kept of all medications administered by the program staff to that individual, including over the counter medications. The MAR must indicate name of medication, dosage and frequency of administration, route or method, dates and times given, and will be immediately initialed by the caregiver dispensing using only blue or black indelible ink. Treatments, therapies and special diets must be immediately documented on the medication administration record including times given, type of treatment or therapy, and initials of the caregiver giving it using only blue or black indelible ink. The medication administration record must have a legible signature for each set of initials using only blue or black indelible ink;

(f) The MAR must include documentation of any known allergy or adverse reactions to a medication, and documentation and an explanation of why a PRN medication was administered and the results of such administration;

(g) Self-administration of medication. For any individual who is self-administering medication the individual's individual record must include the following:

(A) Documentation that the individual has been trained for self-administering of prescribed medication or treatment or that the prescriber has provided documentation that training for the individual is unnecessary;

(B) Documentation that the individual is able to manage his or her own medication regimen and the provider must keep medications stored in an area that is inaccessible to others and locked;

(C) Documentation of retraining when there is a change in dosage, medication and time of delivery;

(D) Documentation of review of self-administration of medication as part of the Personal Care Plan process; and

(E) Documentation of a current prescriber order for self-administration of medication.

(h) Injections may be self-administered by the individual, or administered by a relative of the individual, a currently licensed registered nurse, a licensed practical nurse under registered nurse supervision, or providers who have been trained and are monitored by a physician or delegated by a registered nurse in accordance with administrative rules of the Board of Nursing chapter 851, division 047. Documentation regarding the training or delegation must be maintained in the individual's record;

(5) Delegation of Nursing Care Tasks. Nursing tasks may be delegated by a registered nurse to providers and other caregivers only in accordance with administrative rules of the Board of Nursing chapter 851, division 47. This includes but is not limited to the following conditions:

(a) The registered nurse has assessed the individual's condition to determine there is not a significant risk to the individual if the provider or other caregiver performs the task;

(b) The registered nurse has determined the provider or other caregiver is capable of performing the task;

(c) The registered nurse has taught the provider or caregiver how to do the task;

(d) The provider or caregiver has satisfactorily demonstrated to the registered nurse the ability to perform the task safely and accurately;

(e) The registered nurse provides written instructions for the provider or caregiver to use as a reference;

(f) The provider or caregiver has been instructed that the task is delegated for this specific person only and is not transferable to other individuals or taught to other care providers;

(g) The registered nurse has determined the frequency for monitoring the provider or caregiver's delivery of the delegated task; and

(h) The registered nurse has documented a Personal Care Plan for the individual including delegated procedures, frequency of registered nurse follow-up visits, and signature and license number of the registered nurse doing the delegating.

(6) Initial Personal Care Plan. The Initial Personal Care Plan must be developed within 24 hours of admission to the AFH.

(7) Personal Care Plan.

This section and its parts remain in effect until July 1, 2016. On that date, new rules governing PCPs and rules concerning person centered planning per OAR 309-040-0315(7) become effective and enforceable.

(a) In accordance with Standards for Adult Mental Health Services, OAR 309-032-0535 Definitions (3) Case management (22) Personal Care Plan and 309-032-0545 Adult Mental Health Services (1)(2) the provider will develop the PCP in collaboration with the individual and others as appropriate, including the individual's case manager, and guardian as applicable. The Personal Care Plan for an individual will be reviewed and updated by the personal care plan team every 180 days or more frequently as necessary in accordance with 309-032-0545 Adult Mental Health Services (2)(g);

(b) The individual's case manager or other designated person will review and update the individual's personal care services prescription and status as needed;

(c) If the team agrees that interim changes in the Personal Care Plan are required, the case manager will make the changes.

(8) Personal Care Plan.

This subsection and its subparts are effective July 1, 2016 and enforceable as described in OAR 309-040-0315(7).

(a) Timing Requirements. During the initial 30 calendar days following the individual's admission to the AFH, the provider must continue to assess and document the individual's preferences and care needs. The provider must complete and document the assessment and care plan in a PCP within 30 days after admission unless the individual is admitted to the AFH for crisis-respite services.

(b) Personal Care Plan Contents. A PCP is an individualized plan intended to implement and document the provider's delivery of services as well as any individualized limitations contained within the person centered service plan and identify the goals to be accomplished through those services. The PCP must describe the individual's needs, preferences, and capabilities, and what assistance the individual requires for various tasks.

(c) Development of Personal Care Plan. The provider must develop the PCP based upon the findings of the individual assessment, with participation of the individual and the individual's representative (as applicable), and through collaboration with the individual's primary mental health treatment provider and the person centered service plan coordinator. With consent of the individual or the individual's representative, family members, representatives from involved agencies, and others with an interest in the individual's circumstances may be invited to participate in the development of the PCP. The provider must have proper, prior authorization from the individual, or the individual's representative, prior to such contact.

(d) Addressing the Person-Centered Service Plan. The PCP must adequately consider and facilitate the implementation of the individual's Person-centered Service Plan by addressing the following:

(A) Address the implementation and provision of services by the provider consistent with the obligations imposed by the person-centered service plan;

(B) Identify the individual's service needs, desired outcomes and service strategies to advance all areas identified in the person centered service plan, the individual's physical and medical needs, medication regimen, self-care, social-emotional adjustment, behavioral concerns, independent living capability and community navigation, as well as any other area of concern or the other goals set by the individual;

(c) The PCP must be signed by the individual, the provider or the provider's designee, and others, as appropriate, to indicate mutual agreement with the course of services outlined in the plan;

(d) The provider must review and update each individual's PCP every six months and when an individual's condition changes. The review must be documented in the individual's record at the time of the review and include the date of the review and the provider's signature. If a PCP contains many changes and becomes less legible, the provider must write a new care plan;

(e) The PCP must be attached to the person-centered service plan as an addendum.

(9) Person-Centered Service Plan. A person-centered service plan is required as follows:

(a) A person centered service plan coordinator, under contract with the Division will complete a Person-Centered Service Plan with each individual, pursuant to OAR 411-004-0030. The provider must make a good faith effort to implement and complete all elements the provider is responsible for implementing as identified in the Person-Centered Service Plan.

(b) The person-centered service plan coordinator documents the person-centered service plan on behalf of the individual and provides the necessary information and supports to ensure the individual directs the person-centered service planning process to the maximum extent possible.

(c) The person-centered service plan must be developed by the individual and, as applicable, the legal or designated representative of the individual, and the person-centered service plan coordinator.

dinator. Others may be included only at the invitation of the individual and, as applicable, the individual's representative.

(d) To avoid conflict of interest, the person-centered service plan may not be developed by the provider for individuals receiving Medicaid. The Division may grant exceptions where it determines that the provider is the only willing and qualified entity to provide case management and develop the person-centered service plan in a specific geographic area.

(e) For private pay individuals, a person-centered service plan may be developed by the individual, or, as applicable, the legal or designated representative of the individual, and others chosen by the individual. Providers will assist private pay individuals in developing person-centered service plans when no alternative resources are available. Private pay individuals are not required to have a written person-centered service plan.

(10) Person-Centered Service Planning Process. A person-centered service plan must be developed through a person-centered service planning process. The person-centered service planning process:

- (a) Is driven by the individual;
- (b) Includes people chosen by the individual;
- (c) Provides necessary information and supports to ensure the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions;
- (d) Is timely, responsive to changing needs, occurs at times and locations convenient to the individual, and is reviewed at least annually;
- (e) Reflects the cultural considerations of the individual;
- (f) Uses language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual and, as applicable, the individual's representative;
- (g) Includes strategies for resolving disagreement within the process, including clear conflict of interest guidelines for all planning participants, such as:
 - (A) Discussing the concerns of the individual and determining acceptable solutions;
 - (B) Supporting the individual in arranging and conducting a person-centered service planning meeting;
 - (C) Utilizing any available greater community conflict resolution resources;
 - (D) Referring concerns to the Office of the Long-Term Care Ombudsman; or
 - (E) For Medicaid recipients, following existing, program-specific grievance processes.
- (h) Offers choices to the individual regarding the services and supports the individual receives, and from whom, and records the alternative HCB settings that were considered by the individual;
- (i) Provides a method for the individual or, as applicable, the individual's representative, to request updates to the person-centered service plan for the individual, as needed;
- (j) Is conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare;
- (k) Identifies the strengths and preferences, service and support needs, goals, and desired outcomes of the individual;
 - (l) Includes any services that are self-directed, if applicable;
 - (m) Includes, but is not limited to, individually identified goals and preferences related to relationships, greater community participation, employment, income and savings, healthcare and wellness, and education;
 - (n) Includes risk factors and plans to minimize any identified risk factors; and
- (o) Results in a person-centered service plan documented by the person-centered services plan coordinator, signed by the individual or, as applicable, the individual's representative, participants in the person-centered service planning process, and all persons responsible for the implementation of the person-centered service plan, including the provider, as described below in section (11)(a)(O) of this rule. The person-centered service plan is distributed to the individual, and, as applicable, the individual's

representative, and other people involved in the person-centered service plan as described below in section (11)(d) of this rule.

(11) Required Contents of Person-Centered Service Plan:

(a) Where the provider is responsible for developing the person-centered service plan, the provider must ensure that the plan includes the following:

(A) HCBS and setting options based on the needs and preferences of the individual, and for residential settings, the available resources of the individual for room and board;

(B) The HCBS and settings are chosen by the individual and are integrated in, and support full access to, the greater community;

(C) Opportunities to seek employment and work in competitive integrated employment settings for those individuals who desire to work. If the individual wishes to pursue employment, a non-disability specific setting option must be presented and documented in the person-centered service plan;

(D) Opportunities to engage in greater community life, control personal resources, and receive services in the greater community to the same degree of access as people not receiving HCBS;

(E) The strengths and preferences of the individual;

(F) The service and support needs of the individual;

(G) The goals and desired outcomes of the individual;

(H) The providers of services and supports, including unpaid supports provided voluntarily;

(I) Risk factors and measures in place to minimize risk;

(J) Individualized backup plans and strategies, when needed;

(K) People who are important in supporting the individual;

(L) The person responsible for monitoring the person-centered service plan;

(M) Language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual receiving services and, as applicable, the individual's representative;

(N) The written informed consent of the individual or, as applicable, the individual's representative;

(O) Signatures of the individual or, as applicable, the legal or designated representative of the individual, participants in the person-centered service planning process, and all people and providers responsible for the implementation of the person-centered service plan as described below in subsection (c) of this section;

(P) Self-directed supports; and

(Q) Provisions to prevent unnecessary or inappropriate services and supports.

(b) Where the provider is not responsible for the developing the person-centered service plan but provides or will provide services to the individual, the provider must provide relevant information and provide necessary support for the person-centered service plan coordinator or other person developing the plan to fulfill the characteristics described in part (a) of this subsection.

(c) The individual or, as applicable, the individual's representative, decides on the level of information in the person-centered service plan that is shared with providers. To effectively provide services, providers must have access to the portion of the person-centered service plan that the provider is responsible for implementing.

(d) The person-centered service plan is distributed to the individual and, as applicable, the individual's representative, and other people involved in the person-centered service plan as described above in subsection 9(c) of this section.

(e) The person-centered service plan must justify and document any individually-based limitation to be applied as described in OAR 309-040-0391 when conditions under OAR 309-040-0410(2) may not be met due to threats to the health and safety of the individual or others.

(f) The person-centered service plan must be reviewed and revised:

(A) At the request of the individual or, as applicable, the individual's representative;

(B) When the circumstances or needs of the individual change; or

(C) Upon reassessment of functional needs as required every 12 months.

(12) Crisis Respite Individuals. Because it may not be possible to assemble complete records and develop a person-centered service plan during the crisis-respite individual's short stay, the provider is not required to develop a person-centered service plan under these rules, but must, at a minimum, develop an initial care plan as required by subsection (7) of these rules to identify service needs, desired outcomes, and service strategies to resolve the crisis or address the individual's other needs that caused the need for crisis-respite services. In addition, the provider must provide relevant information and provide necessary support for the person-centered service plan coordinator as described in section (11)(b) of this rule.

(13) Individual Records. The provider must develop an individual record for each individual. The provider must keep the individual record current and available on the premises for each individual admitted to the AFH. The provider must maintain an individual record consistent with the following requirements:

(a) General Information: The record must include:

(A) The individual's name, previous address, date of entry into AFH, date of birth, sex, marital status, religious preference, preferred hospital, Medicaid and/or Medicare numbers where applicable, guardianship status, and;

(B) The name, address, and telephone number of:

(i) The individual's legal representative, designated representative, family, advocate or other significant person;

(ii) The individual's preferred primary health provider designated back up health care provider and/or clinic;

(iii) The individual's preferred dentist;

(iv) The individual's day program or employer, if any;

(v) The individual's case manager; and

(vi) Other agency representatives providing services to the individual.

(C) Individual records must be available to the Authority conducting inspections or investigations, as well as to the individual, or the individual's representative;

(D) Record Retention. Original individual records must be kept for a period of three years after discharge when an individual no longer resides in the AFH.

(E) In all other matters pertaining to confidential records and release of information, providers must comply with ORS 179.505.

(b) Medical Information:

(A) History of physical, emotional and medical problems, accidents, illnesses or mental status that may be pertinent to current care;

(B) Current orders for medications, treatments, therapies, use of restraints, special diets and any known food or medication allergies;

(C) Completed medication administration records from the license review period;

(D) Name and claim number of medical insurance, and any pertinent medical information such as hospitalizations, accidents, immunization records including Hepatitis B status and previous TB tests, incidents or injuries affecting the health, safety or emotional well-being of any individual.

(c) Individual Account Record:

(A) Individual's Income Sources.

(B) Refer to individual's personal care plan with supporting documentation from the income sources to be maintained in the individual's individual record.

(C) Individual's room and board and service costs. Individual or the individual's representative will agree to specific costs for room and board and services within the pre-set limits of the state contract. A copy must be given to the individual, the individual's representative, and the original in the individual's individual record.

(D) Individual's record of discretionary funds.

(d) If an individual maintains custody and control of his or her discretionary funds then no accounting record is required.

(e) If a designee of the AFH maintains custody and control of an individual's discretionary fund, a signed and dated account and

balance sheet must be maintained with supporting documentation for expenditures \$10 and greater. The AFH designee must have specific written permission to manage an individual's discretionary fund.

(f) House Rules: The provider must maintain a copy of the written house rules with documentation that the provider discussed the house rules with the individual.

(g) Unusual Incidents: A written incident report of any unusual incidents relating to the AFH including but not limited to individual care. The incident report must include how and when the incident occurred, who was involved, what action was taken by staff, and the outcome to the individual. In compliance with HIPAA rules, only the individual's name may be used in the incident report. Separate reports must be written for each individual involved in an incident. A copy of the incident report must be submitted to the CMHP within five working days of the incident. The original will be placed in the individual's individual record.

(h) General Information: Any other information or correspondence pertaining to the individual;

(i) Progress Notes. Progress notes must be maintained within each individual's record and document significant information relating to all aspects of the individual's functioning and progress toward desired outcomes as identified in the individual's personal care plan. A progress note must be entered in the individual's record at least once each month.

(14) Residents' Bill of Rights.

(a) The provider must guarantee the Residents' Bill of Rights as described in ORS 443.739. The provider must post a copy of the Individual's Bill of Rights in a location that is accessible to individuals, individuals' representatives, parents, guardians, and advocates. The provider must give a copy of the Residents' Bill of Rights to each individual, individual's representative, parent, guardian, and advocate along with a description of how to exercise these rights.

(b) The provider must explain and document in the individual's file that a copy of the Residents' Bill of Rights was given to each individual at admission, and is posted in a conspicuous place including the name and phone number of the office to call to report complaints.

(15) Physical Restraints. Physical Restraints are not allowed. Providers, resident managers, or substitute caregivers must not use physical restraints for individuals receiving personal care services authorized or funded through the Division.

(16) General Practices. The provider must:

(a) Conspicuously post the State license and Abuse and Complaint poster where it can be seen by individuals;

(b) Cooperate with Division personnel or designee in complaint investigation procedures, abuse investigations and protective services, planning for individual care, application procedures and other necessary activities, and allow access of Division personnel to the AFH, its individuals, and all records;

(c) Give care and services, as appropriate to the age and condition of the individual(s), and as identified on the PCP. The provider must ensure that physicians' orders and those of other medical professionals are followed, and that the individual's physicians and other medical professionals are informed of changes in health status and/or if the individual refuses care;

(d) House Rules.

(A) The provider must develop reasonable written house rules regarding hours, visitors, use of tobacco and alcohol, meal times, use of telephones and kitchen, monthly charges and services to be provided and policies on refunds in case of departure, hospitalization or death.

(B) The provider must discuss house rules with the individual and the individual's representative and families at the time of arrival and be posted in a conspicuous place in the facility. The provider must maintain written documentation in the individual record that the provider discussed the house rules with the individual along with a copy of the house rules.

(C) House rules are subject to review and approval by the Division and may not violate individual's rights as stated in ORS 430.210.

(D) House rules must not restrict or limit the home-like qualities identified in OAR 309-040-0410(2). This subsection is effective July 1, 2016 and enforceable according to 309-040-0315(7).

(e) In the provider's absence, the provider must have a resident manager or substitute caregiver on the premises to provide care and services to individuals. For absences greater than 72 consecutive hours, the CMHP must be notified of the name(s) of the substitute caregiver(s) for the provider or resident manager.

(f) A provider, resident manager, or substitute caregiver must be present in the home at all times.

(g) Allow and encourage individuals to exercise all civil and human rights accorded to other citizens;

(h) Not allow or tolerate physical, sexual, or emotional abuse or punishment, or exploitation, or neglect of individuals;

(i) Provide care and services as agreed to in the PCP;

(j) Keep information related to individual(s) confidential as required under ORS 179.050;

(k) Ensure that the number of individuals requiring nursing care does not exceed the provider's capability as determined by the CMHP and/or the Division;

(l) Not admit individuals who are clients of Aging and People with Disabilities without the express permission of the Division;

(m) Notify the Division prior to a closure and give individuals, the individuals' representative, families, and CMHP staff 30 days written notice of the planned change except in circumstances where undue delay might jeopardize the health, safety or well-being of individuals, providers or caregivers. If a provider has more than one AFH, individual cannot be shifted from one AFH to another without the same period of notice unless prior approval is given and agreement obtained from individuals, family members and CMHP;

(n) Exercise reasonable precautions against any conditions which could threaten the health, safety or welfare of individuals;

(o) Immediately notify the appropriate PCP Team members (in particular the CMHP representative and family/guardian) if: the individual has a significant change in medical status; the individual has an unexplained or unanticipated absence from the AFH; the provider becomes aware of alleged or actual abuse of the individual; the individual has a major behavioral incident, accident, illness, hospitalization; the individual contacts, or is contacted by, the police; or the individual dies and follow-up with an incident report.

(17) Incident Reports. The provider must write an incident report for any unusual incident and forward a copy of the incident report to the CMHP within five working days of the incident. Any incident that is the result of or suspect of abuse must be reported to the Office of Investigations and Training within 24 hours of occurrence.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Renumbered from 309-040-0050(8)-(10); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 7-2001(Temp) f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 4-2002, f. 2-26-02, cert. ef. 2-27-02; Renumbered from 309-040-0052, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0391

Individually-Based Limitations

This rule becomes effective on July 1, 2016 and enforceable according to OAR 309-040-0315(7).

(1) When the home-like qualities described below create a threat to the health and safety of an individual or others, a provider may seek to apply individually-based limitation through the process described in this rule. A provider may not otherwise limit the following home-like qualities without a valid individually-based limitation:

(a) The freedom and support to access food at any time;

(b) Have visitors of the individual's choosing at any time;

(c) Have a unit entrance door that is lockable by the individual with only appropriate program staff having access;

(d) Choose a roommate when sharing a unit;

(e) Furnish and decorate the individual's unit as agreed to in the Residency Agreement;

(f) The freedom and support to control the individual's schedule and activities; and

(g) Privacy in the individual's unit.

(2) Minimum Requirements for Applying Individually-Based Limitation: A provider may only apply an individually-based limitation if:

(a) The quality threatens the health or safety of the individual or others;

(b) The individually-based limitation is supported by a specific assessed need;

(d) The individual or the individual's legal representative consents;

(e) The limitation is directly proportionate to the specific assessed need; and

(f) The individually-based limitation will not cause harm to the individual.

(3) The provider must demonstrate and document that the individually-based limitation meets the requirements of subsection (2) of this rule and that the conditions described below exist in the person-centered service plan. The provider must submit and sign a provider-created form that includes the following:

(a) The specific and individualized assessed need justifying the individually-based limitation;

(b) The positive interventions and supports used prior to consideration of any individually-based limitation;

(c) Documentation that the provider or other entities have tried other less intrusive methods but did not work;

(d) A clear description of the limitation that is directly proportionate to the specific assessed need;

(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation;

(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary;

(g) The informed consent of the individual or, as applicable, the individual's legal representative, including any discrepancy between the wishes of the individual and the consent of the legal representative; and

(h) An assurance that the interventions and support do not cause harm to the individual.

(4) The provider must:

(a) Maintain a copy of the completed and signed form documenting the consent to the individually-based limitation described in subsection (3) of this rule. The form must be signed by the individual, or, if applicable, the individual's legal representative;

(b) Regularly collect and review the ongoing effectiveness of and the continued need for the individually-based limitation; and

(c) Request review of the individually-based limitation by the Person-Centered Service Plan Coordinator when a new individually-based limitation is indicated, or change or removal of an individually-based limitation is needed, but no less than annually.

(5) The qualities and obligations described in sections (1)(b)-(g) do not apply to an individual receiving crisis-respite services and a provider is not required to seek an individually based limitation for such an individual to comply with these rules.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0392

Residency Agreement

This rule becomes effective July 1, 2016 and is enforceable as described in OAR 309-040-0315(7).

(1) The provider must enter into a written residency agreement with each individual or the individual's representative residing at the AFH consistent with the following:

(a) The written residency agreement must be signed by the provider and the individual, or the individual's representative, prior to or at the time of admission;

(b) The provider must provide a copy of the signed agreement to the individual or the individual's representative and must retain

the original signed agreement within the individual's individual record;

(c) The provider must give written notice to an individual and the individual's representative at least 30 calendar days prior to any general rate increases, additions, or other modifications of the rates; and

(d) Updates to Residency Agreements: The provider must update residency agreements at least annually and also when social security rates change or an individual's finances change such that the amount paid for room and board changes.

(2) The residency agreement must include, but is not limited to, the following terms:

(a) Room and Board. The residency agreement must include the room and board agreement including the room and board rate describing the estimated public and private pay portions of the rate.

(A) Where an individual's social security or other funding is not active at the time of admission to the program, the program must prepare the room and board agreement based upon the estimated benefit to be received by the individual; and

(B) If, when funding is later activated, actual income of the individual varies from the estimated income noted on the residency agreement, the agreement must be updated and re-signed by all the applicable parties.

(b) Services and supports to be provided in exchange for payment of the room and board rate;

(c) Conditions under which the provider may change the rates;

(d) The provider's refund policy in instances of an individual's hospitalization, death, transfer to a nursing facility or other care facility, and voluntary or involuntary move from the home;

(e) A statement indicating that the individual is not liable for damages considered normal wear and tear;

(f) The provider's policies on voluntary moves and whether or not the provider requires written notification of a non-Medicaid individual's intent to not return;

(g) The potential reasons for involuntary termination of residency in compliance with this rule and individual's rights regarding the eviction and appeal process as described in OAR 309-040-0410;

(h) Any policies the provider may have on the use of alcohol, cannabis, and illegal drugs of abuse;

(i) Smoking policies in compliance with the Tobacco Freedom Policy established by the Division;

(j) Policy addressing pet and service animals. The provider must not restrict animals that provide assistance or perform tasks for the benefit of a individual with a disability. Such animals are often referred to as services animals, assistance animals, support animals, therapy animals, companion animals, or emotional support animals.

(k) Policy regarding the presence and use of legal medical and recreational marijuana at the home;

(l) Schedule of meal times. The provider must not schedule meals with more than a fourteen (14)-hour span between the evening meal and the following morning's meal consistent OAR 411-050-0645);

(m) Policy regarding refunds for individuals eligible for Medicaid services, including pro-rating partial months and if the room and board is refundable;

(n) Any house rules or social covenants required by the provider which may be included in the agreement or as an addendum;

(o) The provider must also include the following in the residency agreement:

(A) Statement informing the individual of the freedoms authorized by 42 CFR 441.301(c)(2)(xiii) & 42 CFR 441.530(a)(1)(vi)(F), which must not be limited without the informed, written consent of the individual or the individual's representative and include the right to:

(i) Live under a legally enforceable agreement with protections substantially equivalent to landlord/tenant laws;

(ii) The freedom and support to access food at any time;

(iii) To have visitors of the individual's choosing at any time;

(iv) Have a lockable door in the individual's unit, which may be locked by the individual;

(v) Choose a roommate when sharing a unit;

(vi) Furnish and decorate the individual's unit according to the Residency Agreement;

(vii) The freedom and support to control the individual's schedule and activities; and

(viii) Privacy in the individual's unit.

(3) The provider may not propose or enter into a residency agreement that:

(a) Charges or asks for application fees, refundable deposits, or non-refundable deposits;

(b) Includes any illegal or unenforceable provision or ask or require the individual to waive any of the individual's rights or licensee's liability for negligence; or

(c) Conflict with individual rights or these rules.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0395

Standards for Admission, Transfers, Respite, Discharges, and Closures

(1) Each individual referred for placement in an AFH has the right to pick and choose from available service settings.

(2) Admission. A provider may only admit an individual with a referral from, or the prior written approval of the CMHP or the Division. At the time of the referral, a provider will be given complete information about the case history of the individual as it relates to behavior, skill level, medical status, or other relevant information. The provider retains the right to deny admission of any individual if the provider believes the individual cannot be managed effectively in the AFH, or for any other reason not specifically prohibited by this rule. AFHs may not be used as a site for foster care for children, adults from other agencies, or any type of shelter or day care without the written approval of the CMHP or the Division.

(3) Transfers:

(a) An individual must not be transferred by a provider to another AFH or moved out of the AFH without 30 days advance written notice to the individual, the individual's representative, guardian or conservator, and the CMHP stating reasons for the transfer as provided in ORS 443.739(18) and OAR 411-088-0070, and the individual's right to a hearing as provided in ORS 443.738(11)(b), except where undue delay might jeopardize the health, safety or well-being of the individual or others, for a medical emergency, or to protect the welfare of the individual or other individuals. A provider may only transfer an individual for the following reasons:

(A) Behavior that poses a significant danger to the individual or others;

(B) Failure to make payment for care;

(C) The AFH has had its license revoked, not renewed, or voluntarily surrendered; or

(D) The individual's care needs exceed the ability of the provider.

(b) Individuals who object to the transfer will be given the opportunity for hearing as provided in ORS 443.738(11)(b) and OAR 411-088-0080. Participants may include the individual, and at the individual's request, the provider, a family member and CMHP staff member.

(4) Respite. Providers must not exceed the licensed capacity of the AFH. However, respite care of no longer than two weeks duration may be provided a individual if the addition of the respite individual does not cause the total number of residents to exceed five. Thus, a provider may exceed the licensed number of residents by one respite individual, for two weeks or less, if approved by the CMHP or the Division, and if the total number of residents does not exceed five.

(5) Discharge:

(a) A provider may only discharge an individual for the reasons stated in paragraphs (3)(a)(A) through (D) of this rule. The

provider must give at least 30 days written notice to an individual and the Division before termination of residency, except where undue delay might jeopardize the health, safety or well-being of the individual or others;

(b) The provider must promptly notify the CMHP or Division if an individual gives notice or plans to leave the AFH or if an individual abruptly leaves.

(6) Closing. Providers must notify the Division prior to a voluntary closure of an AFH, and give individuals, families, and the CMHP, 30 days' written notice, except in circumstances where undue delay might jeopardize the health, safety or well-being of an individual, provider or caregiver. If a provider has more than one AFH, an individual cannot be shifted from one house to another house without the same period of notice unless prior approval is given and agreement obtained from individuals, family members, and the CMHP.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Former sections (3)(a)-(c) renumbered to 309-040-0057; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 7-2001(Temp) f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 4-2002, f. 2-26-02, cert. ef. 2-27-02; Renumbered from 309-040-0055, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0400

Inspections

(1) Division or Designee Inspections. The Division will conduct an inspection of an AFH:

(a) Prior to issuance of a license;

(b) Upon receipt of an oral or written complaint of violations that threaten the health, safety, or welfare of individuals; or

(c) Anytime the Division has probable cause to believe that an AFH has violated a regulation or provision of these rules or is operating without a license.

(2) Division Inspections. The Division may conduct inspections of an AFH:

(a) Anytime such inspections are authorized by these rules and any other time the CMHP or Division considers it necessary to determine if an AFH is in compliance with these rules or with conditions placed upon the license;

(b) To determine if cited deficiencies have been corrected; and

(c) For the purpose of monitoring of the individuals' care.

(3) State or Local Fire Inspectors. State or local fire inspectors must be permitted access to enter and inspect the AFH regarding fire safety upon request of the CMHP or Division.

(4) Full Access by Division and/or CMHP. The Division and/or CMHP staff must have full access and division to examine, among other things, AFH and individual records and accounts, and the physical premises, including the buildings, grounds, equipment, and any vehicles.

(5) Interviews. The Division or CMHP staff must be permitted to interview the provider, resident manager, caregiver, and individuals. Interviews are confidential and conducted in private, and are confidential except as considered public record under ORS 430.763.

(6) Authorized Entrance to AFH. Providers must authorize resident managers and substitute caregivers to permit entrance by the Division or CMHP staff for the purpose of inspection and investigation.

(7) Division to Conduct Inspections With or Without Advance Notice. The Division and/or CMHP staff has authority to conduct inspections with or without advance notice to the provider, staff, or individual of the AFH. The Division and/or CMHP will not give advance notice of any inspection if notice might obstruct or seriously diminish the effectiveness of the inspection or enforcement of these rules.

(8) Search Warrant. If the Division and/or CMHP staff is not permitted access or inspection, a search warrant may be obtained.

(9) Respect Private Possessions. The inspector will respect the private possessions and living area of individuals, providers, and caregiver while conducting an inspection.

(10) Confidential Information. Completed reports on inspections, except for confidential information, will be available to the

public, upon written request to the Division and/or CMHP, during business hours.

(11) Investigate Allegations of Abuse. For individuals receiving services authorized and/or funded by HSD, the Division will investigate allegations of abuse as defined in ORS 430.735 to 430.765.

(12) Alleged Abuse. When abuse is alleged or death of an individual has occurred and a law enforcement agency, or the Division and/or its designee, has determined to initiate an investigation, the provider must not conduct an internal investigation without prior authorization from the Division. For the purposes of this section, an internal investigation is defined as conducting interviews of the alleged victim, witness, the alleged perpetrator or any other persons who may have knowledge of the facts of the abuse allegation or related circumstances; reviewing evidence relevant to the abuse allegation, other than the initial report; or any other actions beyond the initial actions of determining:

(a) If there is reasonable cause to believe that abuse has occurred; or

(b) If the alleged victim is in danger or in need of immediate protective services; or

(c) If there is reason to believe that a crime has been committed; or

(d) What, if any, immediate personnel actions will be taken.

(13) Completion of Abuse Investigation. The Division or its designee will complete an Abuse Investigation and Protective Services Report according to OAR 404-045-0300. The report will include the findings based upon the abuse investigation as defined in OAR 943-045-0260(12) Inconclusive, (16) Not Substantiated, (22) Substantiated.

(14) Provider Notified of Completion of Investigation. When the provider has been notified of the completion of the abuse investigation, a provider may conduct an investigation without Division approval to determine if any other personnel actions are necessary.

(15) Abuse Investigation and Protective Services Report. Upon completion of the investigation report according to OAR 943-045-0320, the sections of the report which are public records and not exempt from disclosure under the public records law will be provided to the appropriate provider. The provider must implement the actions necessary within the deadlines listed to prevent further abuse as stated in the report.

(16) Prohibition of Retaliation. A provider must not retaliate against any person who reports in good faith suspected abuse, or against the individual with respect to the report.

(17) Retaliatory Liability. In accordance with ORS 430.755 any provider who retaliates against any person because of a report of suspected abuse or neglect may be liable according to 430.755, in a private action to that person for actual damages and, in addition, a penalty in accordance with 443.775(10) notwithstanding any other remedy provided by law. The authority of the Director to impose civil penalties and the factors to be considered will be in accordance with 443.790.

(18) Adverse Action Creates a Presumption of Retaliation. In accordance with OAR 943-045-0340 Adverse Action, any adverse action creates a presumption of retaliation if taken within 90 days of a report of abuse. For purposes of this subsection, "adverse action" means any action taken by a community facility, community program or person involved in a report against the person making the report or against the adult because of the report and includes but is not limited to:

(a) Discharge or transfer from the AFH, except for clinical reasons;

(b) Discharge from or termination of employment;

(c) Demotion or reduction in remuneration for services; or

(d) Restriction or prohibition of access to the community facility or its residents.

(19) Adverse Action Limits. Adverse action may also be evidence of retaliation after 90 days even though the presumption no longer applies.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-

24-99, cert. ef. 8-26-99; Renumbered from 309-040-0060, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0405

Procedures for Correction of Violations

(1) Conference Request. At any time after receipt of a notice of violations or an inspection report, the licensee or the Division may request a conference, in writing. The conference will be scheduled within ten days of a request by either party. The purpose of the conference is to discuss the violations stated in the notice of violation and to provide information to the licensee to assist the licensee in complying with the requirements of the rules. The written request by a licensee or the Division for a conference will not extend any previously established time limit for correction.

(2) Notification of Correction. The licensee will notify the Division of correction of violations, in writing, no later than the date specified in the notice of violation.

(3) No Report of Compliance. If, after inspection of the AFH, the violations have not been corrected by the date specified in the notice of violation or if the Division has not received a report of compliance, the Division may institute one or more of the following actions:

(a) Imposition of an administrative sanction that may include revocation, suspension, placement of conditions on the license or non-renewal of a license as deemed appropriate by the Division.

(b) Filing of a criminal complaint.

(4) Serious and Immediate Danger. If an individual is in serious and immediate danger, the license may be immediately suspended or revoked and arrangements made to move the individuals.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0070, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0410

Residents' Rights, Complaints, and Grievances

(1) Residents' Bill of Rights.

(a) The Provider must guarantee the Individuals' Bill of Rights as described in ORS 443.739. The provider must post them in a location that is accessible to individuals, individual's representatives, parents/guardian/advocates. A copy of the Residents' Bill of Rights must be given to each individual and representative/parent/guardian/advocate along with a description of how to exercise these rights.

(b) The provider must explain and document in the individual's file that a copy of the Individual's Bill of Rights is given to each individual at admission, and is posted in a conspicuous place including the name and phone number of the office to call in order to report complaints. The Bill of Rights states each individual has the right to:

(A) Be treated as an adult, with respect and dignity;

(B) Be encouraged and assisted to exercise constitutional and legal rights as a citizen including the right to vote and be informed of all house rules;

(C) Receive appropriate care and services and prompt medical care as needed. Be informed of the individual's medical condition and the right to consent to or refuse treatment;

(D) Adequate personal privacy and privacy to associate and communicate privately with any person of choice, such as family members, friends, advocates, and legal, social service and medical professionals, send and receive personal mail unopened, and engage in telephone conversations as explained in 309-040-0410; have medical and personal information kept confidential;

(E) Have access to and participate in activities of social, religious, and community groups;

(F) Be able to keep and use a reasonable amount of personal clothing and belongings and to have a reasonable amount of private, secure storage space.

(G) Be free of discrimination in regard to race, color, national origin, sex, religion, sexual orientation, or disability;

(H) Manage his/her financial affairs unless legally restricted. Be free from financial exploitation. The provider will not charge or ask for application fees or nonrefundable deposits and will not solicit, accept or receive money or property from an individual other than the amount agreed to for services;

(I) A safe and secure environment;

(J) Written notices prior to rate increases and evictions;

(K) A written agreement regarding services to be provided and agreed upon rates;

(L) Voice suggestions, complaints, or grievances without fear of retaliation;

(M) Freedom from training, treatment, chemical or physical restraints except as agreed to, in writing, in an individual's PCP. Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner;

(N) Be allowed and encouraged to learn new skills, to act on their own behalf to their maximum ability, and to relate to residents in an age appropriate manner;

(O) An opportunity to exercise choices including such areas as food selection, personal spending, friends, personal schedule, leisure activities, and place of residence;

(P) Freedom from punishment. Behavior intervention programs must be approved in writing on the individual's PCP;

(Q) Freedom from abuse and neglect;

(R) The opportunity to contribute to the maintenance and normal activities of the household;

(S) Access and opportunity to interact with persons with/without disabilities;

(T) The right not to be transferred or moved out of the AFH without 30 days' advance written notice and an opportunity for a hearing as described in ORS 443.738(11)(b) and OAR 411-088-0080. A provider may transfer or discharge a individual only for medical reasons including a medical emergency described in ORS 443.738(11)(a), or for the welfare of the individual or other residents, or for nonpayment; and

(U) Utilize advance directives. Advance directives will be explained to each individual upon admission. If the individual does not already have any advance directive or directives, he or she will be given an opportunity to complete them. If any advance directives are completed by the individual the provider shall document these directives in the individual's record; if the individual declines to file any advance directives, this declination will be documented in the individual's record.

(i) As used in this section, the term "advance directive" has the meaning given under ORS 127.505, and includes the "Declaration for Mental Health Treatment" under ORS 127.700 through 127.737.

(2) Additional Rights for Individuals:

(a) Live under a legally enforceable residency agreement in compliance with protections substantially equivalent to landlord/tenant laws as described in this rule;

(b) Have visitors of the individual's choosing at any time and the freedom to visit with guests within the common areas of the program and the individual's sleeping room;

(c) The freedom and support to control one's own schedule and activities including but not limited to: Accessing the community without restriction;

(d) Access to community resources including recreation, religious services, agency services, employment and day programs, unless such access is legally restricted;

(e) Have a lockable door in the individual's bedroom, which may be locked by the individual;

(f) Choose a roommate when sharing a bedroom;

(g) Furnish and decorate the individual's bedroom according to the residency agreement;

(h) The freedom and support to control the individual's schedule and activities;

(i) Privacy in the individual's bedroom;

(j) Section (2) of these rules and its subsections are effective July 1, 2016 and enforceable as described in OAR 309-040-0315(7).

(3) The qualities and obligations described in section 2 (b), (c), (d), (e) and (h) of this rule do not apply to an individual receiving crisis-respite services and a provider need not seek an individually based limitation for such an individual to comply with these rules.

(4) The provider must actively work to support and ensure each individual's rights described in this rule are not limited or infringed upon by the provider or an AFH caregiver, except where expressly allowed under these rules.

(5) Complaints and Grievances. Any person who believes these rules have been violated may file a complaint with the Division and/or CMHP. The Division and/or CMHP will investigate any complaint or grievance regarding the AFH.

(6) Complaint and Grievance Notice. The Division and/or CMHP will furnish each AFH with a Complaint and Grievance Notice, which the provider must post in a conspicuous place stating the telephone number of the Division and the CMHP and the procedure for making complaints or grievances.

(7) Complaint and Grievance Actions. A copy of all AFH complaints or grievances will be maintained by the Division. All complaints or grievances and actions taken on the complaint or grievance, indexed by the name of the provider, will:

(a) Be placed into the public file at the Division. Information regarding the investigation of the complaint or grievance will not be filed in the public file until the investigation has been completed;

(b) Protect the privacy of the complainant or grievant and the individual; and

(c) Treat the names of the witnesses as confidential information.

(8) Substantiated Complaints or Grievances. Providers who acquire substantiated complaints or grievances pertaining to the health, safety or welfare of individuals may have their licenses suspended, revoked or not renewed, or may have conditions placed on the license.

(9) Retaliation Against an Individual. The AFH provider, resident manager, or caregiver must not retaliate in any way against any individual after a complaint or grievance has been filed with the Division. Retaliation may include, but is not limited to:

(a) Increasing charges or threatening to increase charges;

(b) Decreasing or threatening to decrease services, rights or privileges;

(c) Threatening to increase charges or decrease services, rights or privileges;

(d) Taking or threatening to take any action to coerce or compel the individual to leave the AFH; or

(e) Abusing, harassing, or threatening to abuse or harass an individual in any manner.

(10) Retaliation Against Others. A complainant, grievant, witness or caregiver of an AFH must not be subject to retaliation by a provider, or resident manager, or substitute caregiver for making a report or being interviewed about a complaint or being a witness. Retaliation may include, but is not limited to, caregiver dismissal or harassment, or restriction of access to either the AFH or an individual.

(11) Immunity. The complainant has immunity from any civil or criminal liability with respect to the making or content of a complaint or grievance made in good faith.

(12) Public Complaint Files. Any person has the right to inspect and receive a photocopy of the public complaint files, including protective services files, maintained by the Division upon written request subject to the Division's procedures, ORS 192.410 through 192.505, and photocopy charges for public record requests.

Stat. Auth.: ORS 443.735

Stats. Implemented: ORS 127.700 - 127.737 & 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0065, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 4-2009(Temp), f. & cert. ef. 8-6-09 thru 2-2-10; MHS 1-2010, f. & cert. ef. 1-29-10; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0415

Administrative Sanctions and Conditions

(1) Administrative Sanctions. An administrative sanction may be imposed for non-compliance with these rules. An administrative sanction includes one or more of the following actions:

(a) Attachment of conditions to a license;

(b) Civil penalties;

(c) Denial, suspension, revocation, or non-renewal of license.

(2) Notice of Intent. If the Division imposes an administrative sanction, it will serve a Notice of Intent of the administrative sanction upon the licensee personally or by certified mail.

(3) Notice of Administrative Sanction. The notice of administrative sanction will state:

(a) Each sanction imposed;

(b) A short and plain statement of each condition or act that constitutes a violation;

(c) Each statute or rule allegedly violated;

(d) A statement of the licensee's right to a contested case hearing;

(e) A statement of the authority and jurisdiction under which the hearing is to be held;

(f) A statement that the Division files on the subject of the contested case automatically become part of the contested case record upon default for the purpose of proving a prima facie case; and

(g) A statement that the notice becomes a final order upon default if the licensee fails to request a hearing within the specified time.

(4) Hearing. If an administrative sanction is imposed for reason other than abuse, neglect, or exploitation, a hearing will precede it if the licensee requests the hearing in writing within 60 days after receipt of the notice per ORS Chapter 183.

(5) Failure to Request a Hearing. If a licensee fails to request in writing a hearing within 60 days, the Notice of Administrative Sanction will become a Final Order of the Division by default.

(6) Immediate Action. The Division may immediately suspend, revoke, or not renew a license for a substantiated finding of abuse, neglect, or exploitation of an individual. The licensee may submit a request, in writing, for a contested case hearing within 60 days of the notice of intent of suspension, revocation or non-renewal.

(7) Individual Removal. When a license is denied, suspended, revoked, or not renewed, the Division will work with the CMHP to arrange for individuals to move for their protection.

(8) Conditions on License. Conditions may be attached to a license upon a finding that:

(a) Information on the application or initial inspection requires a condition to protect the health and safety of individuals, pending further action by the Division;

(b) There exists a threat to the health, safety, and welfare of an individual, pending further action by the Division or Division designee;

(c) There is reliable evidence of abuse of an adult, pending further action by the Division;

(d) The AFH is not being operated in compliance with these rules, pending further action by the Division; or

(e) The provider is licensed to care for a specific individual only and further placements may not be made to the AFH.

(9) Conditions on Licensee. Conditions which may be imposed on a licensee include but are not limited to:

(a) Restricting the maximum capacity of the AFH;

(b) Restricting the number and impairment level of individuals allowed based upon the capacity of the caregivers to meet the health and safety needs of all residents;

(c) Requiring an additional caregiver or caregiver qualifications;

(d) Requiring additional training of caregivers;

(e) Requiring additional documentation as deemed necessary by the Division;

(f) Restricting a provider from opening an addition AFH; and/or

(g) Suspending admissions to the AFH.

(10) Notification of Conditions. The provider must be notified, in writing, of any conditions imposed, the reason for the conditions, and be given an opportunity to request a hearing under ORS Chapter 183.

(11) Review by the Division. In addition to, or in lieu of, a contested case hearing, a provider may request, in writing, a review by the Division administrator or designee of conditions imposed by the CMHP or Division. The review does not diminish the provider's right to a hearing or extend the time period to request a hearing.

(12) Length of Conditions. Conditions may be imposed for the extent of the license period (one year), extended to the next license period, or limited to some other shorter period of time as deemed necessary by the Division. If the conditions correspond to the licensing period, the reasons for the conditions will be considered at the time of renewal to determine if the conditions are still appropriate. The effective date and expiration date of the conditions will be indicated on the attachment to the license.

(13) Hearing Rights. Hearing rights are in accordance with ORS 183.310 to 183.550.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0075, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0420

Denial, Suspension, Revocation or Non-renewal of License

(1) Causative Action. The Division will deny, suspend, revoke, or refuse to renew a license where it finds:

(a) There has been substantial failure to comply with these rules or where there is substantial non-compliance with local codes and ordinances, or any other state or federal law or rule applicable to the health and safety of individuals in an AFH; or

(b) The applicant or provider has been convicted of one or more crimes described in the Criminal Record Check:

(A) The applicant or provider has had a certificate or license to operate a foster home or residential care facility denied, suspended, revoked or refused to be renewed in this or any other state/county within three years preceding the present action if the denial, suspension, revocation or refusal to renew was due in any part to abuse of an adult, creating a threat to the residents or failure to possess physical health, mental health or good personal character;

(B) If the denial, suspension, revocation or refusal to renew occurred more than three years from the present action, the applicant or provider is required to establish to the Division by clear and convincing evidence his/her ability and fitness to operate an AFH. If the applicant or provider does not meet this burden, then the Division will deny, suspend, revoke or refuse to renew the license;

(C) The applicant or provider is associated with a person whose license for a foster home or residential care facility was denied, suspended, revoked or refused to be renewed due to abuse of an adult, or failure to possess physical health, mental health or good personal character within three years preceding the present action, unless the applicant or provider can demonstrate to the Division by clear and convincing evidence that the person does not pose a threat to the individuals;

(D) For purposes of this subsection, an applicant or provider is "associated with" a person as described above, if the applicant or provider:

(i) Resides with the person;

(ii) Employs the person in the AFH;

(iii) Receives financial backing from the person for the benefit of the AFH;

(iv) Receives managerial assistance from the person for the benefit of the AFH; or

(v) Allows the person to have access to the AFH.

(E) For purposes of this section only, "present action" means the date of the notice of denial, suspension, revocation or refusal to renew.

(2) Causative Action by Provider. The Division may deny, suspend, revoke, or refuse to renew an AFH license if the applicant or provider:

(a) Submits fraudulent or untrue information to the Division;

(b) Has a history of, or demonstrates financial insolvency, such as filing for bankruptcy, foreclosure, eviction due to failure to pay rent, or termination of utility services due to failure to pay bill(s);

(c) Has a prior denial, suspension, revocation or refusal to renew a certificate or license to operate a foster home or residential care facility in this or any other state/county;

(d) Has threatened the health, safety, or welfare of any individual;

(e) Has a substantiated finding of abuse of an adult;

(f) Has a medical or psychiatric problem, which interferes with the ability to provide care;

(g) Refuses to allow access and inspection;

(h) Fails to comply with a final order of the Division to correct a violation of the rules for which an administrative sanction has been imposed; or

(i) Fails to comply with a final order of the Division imposing an administrative sanction.

(j) Fails to report knowledge of the illegal actions of or disclose the known criminal history of a provider, resident manager, substitute caregiver, or volunteer of the AFH.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0090, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0425

Removal of Residents

(1) Order to Move. The Division may order the removal of individuals from an AFH to an alternative placement on the following grounds:

(a) When a violation of these rules is not corrected after time limit specified in notice;

(b) There is a violation of an individual's rights;

(c) The number of individuals currently in the AFH exceeds the maximum licensed capacity of the AFH;

(d) The AFH is operating without a license; or

(e) There is evidence of abuse of an adult that presents a serious and immediate danger to individuals.

(2) Individual Assistance. The CMHP must provide the individual assistance in locating and visiting alternative placements, if needed, and has the right to contest the move as provided in ORS 443.738(11)(b) and OAR 411-088-0080.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Renumbered from 309-040-0085; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 7-2001(Temp) f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 4-2002, f. 2-26-02, cert. ef. 2-27-02; Renumbered from 309-040-0092, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0430

Conditions

(1) Attachment to License. Conditions may be attached to a license upon a finding that:

(a) Information on the application or initial inspection requires a condition to protect the health and safety of individuals;

(b) There exists a threat to the health, safety, and welfare of a individual;

(c) There is reliable evidence of abuse of an adult;

(d) The AFH is not being operated in compliance with these rules; or

(e) The provider is licensed to care for a specific individual(s) only and further placements may not be made to the AFH.

(2) Notification of Conditions. The provider must be notified, in writing, of any conditions imposed, the reason for the conditions, and be given an opportunity to request a hearing under ORS Chapter 183.

(3) Hearing Rights. In addition to, or in lieu of, a contested case hearing, a provider may request in writing a review by the Division administrator or designee of conditions imposed by the CMHP or the Division. The review does not diminish the provider's right to a hearing or extend the time period to request a hearing.

(4) Length of Conditions. Conditions will be imposed for the extent of the license period (one year), extended to the next license period or limited to some other shorter period of time as deemed necessary by the Division. If the conditions correspond to the licensing period, the reasons for the conditions will be considered at the time of renewal to determine if the conditions are still appropriate. The effective date and expiration date of the conditions will be indicated on the attachment to the license.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0093, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0435

Criminal Penalties

(1) Unlicensed. Operating an AFH without a license is punishable as a Class C misdemeanor.

(2) Refusal to Comply. Refusing to allow any of the following is punishable as a Class B misdemeanor:

(a) Division access to the AFH for inspection or investigation;

(b) Division access to individuals in order to interview individuals privately or to review records; or

(c) State and local fire inspector access to the AFH regarding fire safety.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0095, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0440

Civil Penalties

(1) Penalties for Other than Abuse. Civil penalties, for other than substantiated allegations of abuse, will not exceed \$100 per violation with a maximum of \$250 may be assessed for violation of these rules, with the exception of substantiated abuse findings.

(2) Penalties for Abuse. Civil penalties of a maximum of \$1000 per occurrence may be assessed for each substantiated abuse finding.

(3) Other Penalties. In addition to any other liability or penalty, the Division may impose a penalty for any of the following:

(a) Operating an AFH without a license;

(b) Exceeding the number of residents identified on the license;

(c) The Provider fails to achieve satisfactory compliance with the requirements of these rules within the time specified, or fails to maintain such compliance;

(d) The AFH is unable to provide an adequate level of care to individuals;

(e) There is retaliation or discrimination against an individual, the individual's representative, family, employee, or any other person for making a complaint against the AFH;

(f) The provider fails to cooperate with the Division, physician, registered nurse, or other health care professional in carrying out an individual's care plan; or

(g) Other violations are found on two consecutive inspections of an AFH after a reasonable amount of time has been allowed for the elimination of the violations.

(4) Penalty Due. Any civil penalty imposed under this section will become due and payable when the provider incurring the penalty receives a notice in writing from the Division. The notice will be sent by registered or certified mail and will include:

(a) A reference to the particular sections of the statute, rule, standard, or order involved;

(b) A short and plain statement of the matter asserted or charged;

(c) A statement of the amount of the penalty or penalties imposed; and

(d) A statement of the right to request a hearing.

(5) Application for Hearing. The provider to whom the notice is addressed will have 60 days from the date of the notice of intent in which to make written application for a hearing.

(6) Hearings. All hearings will be conducted according to the applicable provisions of ORS Chapter 183.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0097, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0445

Public Information

(1) Current Information. The Division will maintain current information on all licensed AFHs and make that information available to prospective individuals, individuals' representatives, their families, and other interested members of the public.

(2) Current Information Content. The information will include:

(a) The location of the AFH;

(b) A brief description of the physical characteristics of the home;

(c) The name and mailing address of the provider;

(d) The license classification of the home and the date the provider was first licensed to operate that home;

(e) The date of the last inspection, the name and telephone number of the office that performed the inspection and a summary of the findings;

(f) Copies of all complaint investigations involving the home, together with the findings of and actions taken by the Division;

(g) Any license conditions, suspensions, denials, revocations, civil penalties, exceptions or other actions taken by the department involving the home; and

(h) Whether care is provided primarily by the licensed provider, a resident manager, or other arrangement.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0098, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0450

Adjustment, Suspension or Termination of Payment

(1) Causative Actions. The CMHP or Division may adjust, suspend, or terminate payment(s) to a provider when any of the following conditions occur:

(a) The provider's AFH license is revoked, suspended, or terminated;

(b) Upon a finding that the provider is failing to deliver any service as agreed to in the PCP; or

(c) When funding, laws, regulations, or the CMHP or Division priorities change such that funding is no longer available, redirected to other purposes, or reduced;

(d) The individual's service needs change;

(e) The individual is absent without providing notice to the provider for five or more consecutive days;

(f) The individual is determined to be ineligible for services;

(g) The individual moves, with or without notice, from the AFH; the provider will be paid only through the last day of the individual's occupancy.

(2) Division Obligation. The CMHP or Division is under no obligation to maintain the AFH at its licensed capacity or to provide payments to potential providers.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0055(3)(a)-(c); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0057, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

309-040-0455

Enjoinment of Adult Foster Home (AFH) Operation

The Division may commence an action to enjoin (ban) the operation of an AFH pursuant to ORS 443.775(5):

(1) Unlicensed. When an AFH is operated without a valid license; or

(2) Unresolved Placement. After notice of revocation, non-renewal, or suspension has been given, a reasonable time for placement of individuals in other facilities has been allowed, and such placement has not been accomplished.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 443.705 - 443.825

Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0099, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17

DIVISION 48

INTERMEDIATE AND SKILLED NURSING FACILITIES

309-048-0050

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe Division standards and procedures regarding the screening, evaluation and provision of specialized services to persons with mental illness who apply for or reside in Medicaid certified nursing facilities. They implement Public Law 100-203 of the Omnibus Budget Reconciliation Act of 1987 that added Section 1919 to the Social Security Act.

(2) Statutory authority and procedure. These rules are authorized by ORS 413.042 and to carry out the provisions of ORS 410.535, 414.065 & 426.490 to 426.500 and Public Law 100-203.

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0060

Definitions

As used in these rules:

(1) “Annual resident review” means the review of referrals from the annual resident screening process by designees of the Addictions and Mental Health Division. The purpose of the review is to determine the need for a Level II psychiatric evaluation.

(2) “Annual resident screening” means the annual screening by nursing facility staff of all residents for acute symptoms or indicators of mental illness.

(3) “Categorical determination” means a decision made by a contractor of the Aging and People with Disabilities Division (APD) based on a functional assessment. This determination identifies a person who, despite the presence of mental illness, can be admitted to a nursing facility. The categories are:

(a) Individuals requiring nursing facility care for 30 days or less for convalescent care following an acute care hospitalization for illness or surgery;

(b) Persons with terminal illness with a prognosis of six months or less; and

(c) Persons with severe medical condition that precludes participation in or benefit from specialized services.

(4) “Client Process Monitoring System (CPMS)” means the automated client data system maintained by the Division.

(5) “Community Mental Health Program (CMHP)” means the organization of all services for persons experiencing problems related to mental illness, drug and alcohol abuse, and mental retardation or other developmental disabilities, operated by, or contractually affiliated with, a local mental health authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(6) “Determination” means the decision/recommendation made by a designee of the Division regarding an individual’s eligibility for Level II evaluation, i.e., presence of a serious mental illness and need for “specialized services” as required by Public Law 100-203. Determinations regarding an individual’s need for nursing facility services are the responsibility of the APD.

(7) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority.

(8) “Indicators of mental illness — applicants.” Applicants to nursing facilities with a diagnosis of a major mental disorder and a history of treatment related to his diagnosis in the past two years are considered to have indicators of mental illness. Alzheimer’s and/or a diagnoses of dementia are excluded from this definition of major mental disorder.

(9) “Indicators of mental illness — residents.” Residents of nursing facilities with psychiatric or behavioral symptoms that indicate a need for “specialized services” are considered to have indicators of mental illness regardless of diagnosis or history of treatment.

(10) “Level I” means the federally required screening for indicators of mental illness process implemented by APD under OAR 411-070-0043. All applicants to nursing facilities are screened for indicators of mental illness and a determination made whether the applicant requires nursing facility care based on a functional assessment.

(11) “Level II” means the evaluation process conducted by designees of the Division to determine whether an individual with mental illness requires specialized services. The determination is based on a current functional assessment, history and physical, psychosocial evaluation, a mental health assessment and a medication review.

(12) “Level II summary” means the form approved by OMHS which identifies data to be collected by Division designees in the Level II evaluation.

(13) “Licensed medical professional” means a medically trained person who is licensed to practice in the State of Oregon and has one of the following degrees: MD (Medical Doctor); DO (Doctor of Osteopathy); NP (Nurse Practitioner); PA (Physician’s Assistant); or RN (Registered Nurse).

(14) “Nursing facility (NF)” means a facility that contains Medicaid certified inpatient beds and provides medical services but excludes hospital/surgical procedures. The facility must be licensed and certified by APD.

(15) “Office of Mental Health Services (OMHS)” means that portion of the Division responsible for mental health services.

(16) “Pre-admission screening (PAS)” is the state required process used by APD to screen all Medicaid eligible persons seeking admission to nursing facilities. This screening covers functional, medical, economic and psychosocial variables and is the basis for making a determination regarding the individual’s categorical status and his/her need for nursing facility services.

(17) “Pre-Admission Screening and Annual Resident Review (PASARR)” is the assessment process conducted by agencies within the Oregon Health Authority that implements the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), Subsection 1919(e)(7), which prohibits a Medicaid certified nursing facility from admitting any individual until a screening is completed to determine mental illness or mental retardation (or related conditions), and whether the individual requires nursing facility services or specialized services for mental illness.

(18) “Private admission assessment” is the process that APD uses to screen for indicators of mental illness and categorical status in non-Medicaid applicants to nursing facilities.

(19) “Qualified mental health professional (QMHP)” means a mental health practitioner with qualifications defined in OAR 309-032-1505.

(20) “Senior and Disabled Services Division (SDSD)” means the Oregon Health Authority agency responsible for the provision of nursing facility services as specified in OAR chapter 411.

(21) “Specialized psychiatric rehabilitative services” means services of a lesser intensity than required under specialized services for mental illness. The nursing facility may provide these services directly or make arrangements for their provision with private sector practitioners or community mental health programs.

(22) “Specialized services for mental illness” means the implementation of an individualized plan of care developed, provided and supervised by a physician and qualified mental health

professionals in an inpatient psychiatric hospital. This plan of care shall prescribe specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness. A nursing facility resident requiring specialized services shall be considered to be eligible for the level of services provided in an inpatient psychiatric hospital. Residents requiring this level of care will require relocation to an inpatient facility until the "acute" nature of their symptoms are stabilized.

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0070

Procedures for Level I, Pre-Admission Screening (PAS)

(1) Nursing facility placement. A person identified with mental illness indicators who requests placement in a nursing facility must meet APD-PAS criteria demonstrating a need for nursing facility care. The person may be placed in a nursing facility without a Level II evaluation if the person:

(a) Meets criteria of categorical determinations OAR 309-048-0060; or

(b) Has a primary diagnosis of dementia; and

(c) Does not require specialized services OAR 309-048-0060(22).

(2) Level II referrals. Persons shall be referred to the Division for a Level II evaluation prior to placement in a nursing facility if:

(a) A Level I pre-admission screen or a private admission assessment has identified the individual as having indicators of mental illness; and

(b) The individual is *not* eligible for a categorical determination.

(3) Level II waiver. The Division may waive the Level II evaluation requirement if:

(a) The individual does not need specialized services or has received maximum benefit from specialized services; and

(b) The individual has been determined to be in need of nursing facility services by an APD designee or contractor; and

(c) A facility has been identified that can meet the individual's mental health needs.

(4) Level II eligibility. Individuals may be required by the Division to have a Level II evaluation to determine the need for specialized services prior to placement in a nursing facility if any of the above conditions (subsections (3)(a), (b) and (c) of this rule) are not met.

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0080

Procedures for Annual Resident Reviews (ARR)

A resident screened and referred by a nursing facility as having indicators of mental illness shall be reviewed by a Division designee using a format approved by the Division.

(1) Timelines. The review shall be completed by a QMHP within 7 working days of receipt of the referral from the nursing facility.

(2) Screening and consultation. The review shall consist of up to two hours of screening and consultation to determine if the indicators of mental illness require a comprehensive evaluation (Level II).

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0090

Level II Evaluations

(1) Content. A Level II evaluation shall:

(a) Be completed by a QMHP within 30 calendar days of the annual resident review referral or within seven working days of the pre-admission screening referral;

(b) Include a mental health assessment, a psychosocial evaluation, relevant testing and a review of the medication regime and physical examination by a licensed medical professional;

(c) Establish a diagnosis and determine the need for specialized services.

(2) Specialized psychiatric rehabilitation. If the need for specialized services is not established, the evaluation shall include treatment recommendations for specialized psychiatric rehabilitation services whenever indicated.

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0100

Documentation

(1) Level II waivers. The Division shall send a copy of any waiver from the pre-admission requirement for a Level II, to the APD Level I screener who has determined that the individual needs nursing facility care pursuant to OAR 309-048-0060.

(2) Nursing facility. CMHP evaluators shall send copies of the annual resident review and Level II evaluation to the nursing facility within 7 and 30 days respectively.

(3) Division. CMHP evaluators shall send copies of the annual resident review, Level II evaluation and the Level II summary sheet to the OMHS within 30 days of receipt of the nursing facility referral.

(4) Client Process Monitoring System. CMHP designees shall enter information on all persons receiving a Level II evaluation into CPMS.

(5) Standards. Level II evaluations shall follow documentation standards set forth in OAR 309-032-1535.

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0110

Specialized Services for Individuals Residing in Nursing Facilities

(1) Location. Specialized services for persons with mental illness are provided only in inpatient psychiatric settings that provide 24 hour coverage by trained mental health professionals who can deliver mental health services designed by an interdisciplinary team which includes a psychiatrist.

(2) Readmission to nursing facilities. A person identified by a Level II evaluation as in need of specialized services shall not enter or remain in a nursing facility. When a client has received maximum benefit from specialized services, the client can be reconsidered for admission subject to Level I requirements or return to a nursing facility placement subject to APD OAR 411-088-0000 to 411-088-0080, Licensing Requirements for Nursing Facilities, Transfer Rules.

(3) Procurement of specialized services. When a client is identified to be in need of specialized services, the Level II evaluator shall:

(a) Assist the nursing facility or Level I screener in locating an appropriate treatment resource;

(b) Insure that the client in need of specialized services is informed of his/her treatment options including the right to refuse treatment;

(c) Inform all parties involved, of procedures related to pre-commitment investigation, if the client refuses specialized services and presents a danger to self or others;

(d) Notify the Division within 72 hours if a client is determined to be in need of specialized services and these services are not being provided.

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0120

Relocation of Persons with Mental Illness From Nursing Facilities to Other Residential Settings

(1) Coordination of Plans. CMHP, NF and APD staff shall coordinate relocation plans for residents of nursing facilities with mental illness found to be ineligible for nursing facility care.

(2) Right of return. All relocations of residents must comply with nursing facility transfer rules, division 88, OAR 411.

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0130

Appeals

In accordance with ORS 413.042, adults with mental illness, and court approved legal guardians for individuals with mental illness, shall have the right to appeal decisions made by the Division based on screenings, admission waiver request, discharge and relocation plans.

(1) Appeals. Appeals shall be submitted to the Children, Adult and Families Division (CAF) Hearings Office and arrive there within 30 calendar days after receipt of the contested determination/decision.

(2) Negotiations. The CAF Division Hearings Office shall, when it deems appropriate, refer appealed decisions back to the Division for efforts to negotiate an agreement. If the Division is unable to negotiate an agreement within 10 working days, the Division will remand the appeal back to the CAF Hearings Office for final disposition.

(3) Hearings. The CAF Hearings Office shall convene a hearing in accordance with OAR 461-025-0300 through 461-025-0375, and reach a final determination on the appeal within ninety (90) days of the final day of the hearing.

(4) Determinations. All decisions of the CAF Hearing Office shall be final.

Stat. Auth.: ORS 413.042 & 426.500

Stats. Implemented: ORS 410.535, 414.065 & 426.490 to 426.500

Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

DIVISION 90

FORENSIC MENTAL HEALTH EVALUATORS AND EVALUATIONS

309-090-0000

Purpose and Scope

These rules establish minimum standards for the certification of psychiatrists, licensed psychologists, and regulated social workers, who are Licensed Clinical Social Workers (LCSW), related to performing forensic examinations and evaluations as described in ORS 161.309–161.370, 419C.150, 419C.378–419C.398 and 419C.524. The rules are intended to ensure that forensic evaluations meet consistent quality standards and are conducted by qualified and trained evaluators. The Oregon Health Authority shall provide training, certify qualified applicants and maintain a list of certified forensic evaluators for statewide use.

Stat. Auth.: ORS 413.042, 161.309-370, 161.392, 419C.378 - 384

Stats. Implemented: ORS 161.309-370, 161.392, 419C.378 -384

Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0005

Definitions

(1) “Authority” means the Oregon Health Authority.

(2) “Competence” means the same as “fitness to proceed” and is defined according to ORS 161.360.

(3) “Conditional Certification” means a psychologist, psychiatrist, or regulated social worker who is a Licensed Clinical Social Worker is temporarily Court-designated as a certified evaluator as defined in OAR 309-090-0010(3).

(4) “Criminal Responsibility” is defined according to ORS 161.295.

(5) “Division” means the Health Systems Division of the Authority.

(6) “Evaluator” means a psychiatrist, licensed psychologist or a Licensed Clinical Social Worker certified by the Authority to perform forensic evaluations.

(7) “Forensic Psychiatric or Psychological Evaluation” means the assessment of a defendant or juvenile in which the certified forensic evaluator opines on a specific psycho-legal referral question related to ORS 161.360 or 161.295, or 419C.378-419C.398 and is ordered by the Court or requested by associated attorneys.

(8) “Full Certification” means a psychiatrist or licensed psychologist in the state of Oregon satisfying the requirements of this chapter as defined in OAR 309-090-0010(1).

(9) “Juvenile” means an individual under the age of 18.

(10) “Juvenile Certification” means an evaluator in the state of Oregon satisfies the requirements of this chapter as defined in OAR 309-090-0010(1) and has also completed the specialized juvenile segment of the Oregon Forensic Evaluator Training and has successfully passed the examination for juvenile certification.

(11) “Licensed Clinical Social Worker” means a regulated social worker licensed with the Oregon board of Licensed Social Workers pursuant to ORS 675.530.

(12) “Licensed Psychologist” means a psychologist licensed pursuant to ORS 675.010 through 675.150 by the Oregon Board of Psychologist Examiners.

(13) “Mental Defect” means intellectual disability, brain damage or other biological dysfunction that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual’s functioning, as defined in the current Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5); of the American Psychiatric Association.

(14) “Mental Disease” means any diagnosis of mental disorder which is a significant behavioral or psychological syndrome or pattern that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual’s functioning, as defined in the current Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5); of the American Psychiatric Association.

(a) The term “mental disease or defect” as defined in these rules does not include an abnormality manifested solely by repeated criminal or otherwise antisocial conduct, abnormalities manifested solely by substance induced disorders, or an abnormality consisting solely of paraphilias;

(b) For offenses committed on or after January 1, 1984, the term “mental disease or defect” does not include any abnormality constituting solely a personality disorder.

(15) “Oregon Forensic Evaluator Training Program” means a training program approved by the Authority to review with psychiatrists licensed psychologists, and Licensed Clinical Social Workers best practices for forensic evaluations and the standards required in these rules to perform forensic evaluations for courts in the state of Oregon.

(16) “Psychiatrist” means a physician licensed by the Oregon Medical Board pursuant to ORS 677.010 through 677.450 and who has completed an approved residency training program in psychiatry.

(17) “Redacted Forensic Evaluation” means a forensic evaluation report for which all identifying information of the client and evaluator has been removed. Specific information that should be redacted includes any information which may specifically identify the defendant or juvenile, name and discipline of the evaluator, address, phone, fax or logos that may identify the evaluator, qualifications of the evaluator that may identify the evaluator.

(18) “Regulated Social Worker” means a social worker registered pursuant to ORS 675.510.

(19) “Substantial Danger to Self or to Others” means the individual requires a hospital level of care due to a mental disease or defect.

(20) “Successful completion of training” means:

(a) Attendance at the entire training; and

(b) Passing the examination given at the conclusion of the training.

(21) “Temporary Certification” means the certification granted by the Authority under these rules after an applicant has satisfied the requirements of OAR 309-090-0010(2).

(22) "Youth" means an individual under 18 years of age who is alleged to have committed an act that is a violation, or, if done by an adult would constitute a violation, of a law or ordinance of the United States or a state, county, or city, pursuant to ORS 419A.004. Stat. Auth.: ORS 161.398, 419C.524; 419C.382, 161.309 -370, 419C.378 -384 Stats. Implemented: ORS 161.309-370, 419C.378-398 Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 16-2012, f. & cert. ef. 12-26-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0010

Forensic Certification Types and Requirements

Psychiatrists licensed psychologists, and Licensed Clinical Social Workers must be certified by the Authority to submit evaluation reports to the court for the purpose of criminal responsibility or competency when ordered by the court as required in ORS 161.309, 161.365, 419C.524 through 419C.527 and 419C.378 through 419C.398.

(1) Applicants must meet the following requirements for full certification:

(a) A psychiatrist must submit a completed application form, psychiatrist supplement, and nonrefundable \$250 application fee and;

(A) Have a current license to practice in Oregon;

(B) Participate in and successfully complete the Oregon Forensic Evaluator Training; and

(C) Submit to the Authority for review three redacted forensic evaluation reports completed by the applicant within the previous 24 months.

(i) If an applicant desires to perform criminal responsibility evaluations, if available, at least one redacted forensic evaluation report should be an evaluation of criminal responsibility.

(ii) If an applicant desires to perform juvenile evaluations, the applicant shall participate in and successfully complete the specialized juvenile segment of the Oregon Forensic Evaluator Training, and, if available, at least one redacted forensic evaluation report should be an evaluation of a juvenile.

(b) A licensed psychologist must submit a completed application form, psychologist supplement and nonrefundable \$250 application fee and:

(A) Have a current license to practice in Oregon;

(B) Participate in and successfully complete the Oregon Forensic Evaluator Training; and

(C) Submit to the Authority for review three redacted forensic evaluation reports completed by the applicant within the previous 24 months.

(i) If an applicant desires to perform criminal responsibility evaluations, if available, at least one redacted forensic evaluation report should be an evaluation of criminal responsibility,

(ii) If an applicant desires to perform juvenile evaluations, the applicant shall participate in and successfully complete the specialized juvenile segment of the Oregon Forensic Evaluator training and, if available, at least one redacted forensic evaluation report should be an evaluation of a juvenile.

(c) A Licensed Clinical Social Worker must submit a completed application form, social worker supplement, and nonrefundable \$250 application fee and;

(A) Have a current Oregon license as a clinical social worker as defined in ORS 675.530;

(B) Participate in and successfully complete the Oregon Forensic Evaluator Training including the specialized juvenile segment; and

(C) Submit to the Authority for review three redacted forensic evaluation reports completed by the applicant specifically addressing juvenile competency completed within the previous 24 months.

(d) A Licensed Clinical Social Worker is restricted from providing forensic evaluations except for evaluations specifically addressing a youth's fitness to proceed in a proceeding initiated by a petition alleging jurisdiction under ORS 119C.005.

(e) Full Certification has a maximum duration of 24 months from certification date.

(2) Temporary Certification:

(a) Applicants who submit applications for Forensic Evaluator Certification shall be granted a Temporary Certification until participation in and successful completion of the Oregon Forensic Evaluator Training and submission of three redacted forensic evaluation reports. If the applicant desires to perform criminal responsibility evaluations, at least one redacted forensic evaluation report must be an evaluation of criminal responsibility. Applicants must attend the next regularly scheduled training date or request an extension which may be granted by the Authority.

(b) Evaluators with temporary certification who submit forensic evaluation reports for panel review are certified to perform forensic evaluations for individuals charged with crimes including:

(A) Aggravated murder;

(B) Murder; or

(C) Ballot Measure 11 Offenses.

(c) If no redacted forensic evaluation reports are available, evaluators may perform evaluations of those charged with crimes other than aggravated murder, murder or Ballot Measure 11 offenses for the purpose of generating evaluation reports to the Authority for review.

(d) For Certification purposes, psychiatrists enrolled in an ACGME-Accredited residency training program may participate in evaluations where certification is required under ORS 161.309, 161.365 and 419C.524 only under the direct supervision and review of a psychiatrist or psychologist that has been granted full certification under the provisions of OAR 309-090-0010.

(e) Temporary certification has a maximum duration of 12 months. An extension of an additional three months may be granted by the Authority for extenuating circumstances.

(3) Conditional Certification. An evaluator, who has not been certified by the Authority, may be granted conditional certification by the court, if exigent circumstances exist such as an out of state expert evaluation being sought, or an unusual expertise is required. The court will notify the Authority of the granting of a conditional certification. Conditional Certification ends at the disposition of the particular case for which the conditional certification was granted.

Stat. Auth.: ORS 161.392-.413.042 419C.524, 161.309 -370, 419C.382

Stats. Implemented: ORS 161.309 -370, 161.392, 419C.382, 419C.380

Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0015

Application Requirements and Process

(1) Applications must be submitted to the Authority using a form and in a manner prescribed by the Authority.

(2) The application must be accompanied by:

(a) Proof of the applicable license by the State of Oregon, as a Psychiatrist Psychologist, or Licensed Clinical Social Worker.

(b) A copy of a current resume or curriculum vitae providing documentation of forensic training and experience.

(c) Three redacted forensic evaluation reports of competency or criminal responsibility. If no redacted forensic evaluation reports are available, an applicant may be temporarily certified and may perform evaluations of those charged with crimes other than aggravated murder, murder, or Ballot Measure 11 offenses for the purpose of generating reports to the Authority for review; and;

(d) A non-refundable application fee of \$250.00.

(3) After a complete application packet is received the Authority shall:

(a) Evaluate the materials to determine whether the applicant is qualified for Full or Temporary Certification;

(b) Grant, deny or place conditions on a certification; and

(c) Issue a written statement to the applicant of its determination.

Stat. Auth.: ORS 161.392- 419C.524, 419C.392, 161.309 -370, 419C.378-384.

Stats. Implemented: ORS 161.309 -370, 161.392 419C.378-384

Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0020

Recertification Requirements

(1) An evaluator must request recertification using a form, and in a manner prescribed by the Authority.

(2) The minimum requirements for recertification are:

(a) Proof of the applicable license by the State of Oregon;

(b) Within six months of expiration of certification, participation in recertification updates to the Oregon Forensic Evaluator Training Program approved by the Authority;

(c) Review and approval by the Division of a minimum of two redacted forensic evaluation reports completed by the applicant during the past 24 months. If the psychiatrist or licensed psychologist applicant desires to perform criminal responsibility evaluations, at least one redacted sample should be an evaluation of criminal responsibility. If performing Juvenile evaluations one of these should be a juvenile competency or criminal responsibility evaluation. Licensed Clinical Social Workers cannot perform any forensic evaluations other than fitness to proceed evaluations for youth in a proceeding initiated by a petition alleging jurisdiction under ORS 419C.005. All redacted evaluation reports submitted by Licensed Clinical Social Workers for panel review must specifically address the topic of juvenile competency for youth in a proceeding initiated by a petition alleging jurisdiction under 419C.005. These reports shall be subject to review and must meet or exceed standards identified by the Authority as listed in OAR 309-090-0025. The review panel may request to review an additional evaluation report if necessary to make a determination that the reports meet or exceed standards as listed in 309-090-0025; and

(d) A non-refundable application fee of \$250.00.

(e) Continued compliance with all applicable laws and requirements.

(3) Failure to satisfy the factors listed in section (2) above shall result in a non-recertification order from the Authority.

(4) Failure to reapply, attend recertification updates to the Oregon Forensic Evaluator Training or submit redacted evaluation reports for review and approval shall constitute a forfeiture of full certification which may be restored only upon written application approved by the Authority. Individuals who fail to reapply may receive a temporary certification for up to twelve months. Evaluators are responsible for monitoring their own expiration date and reapplying at the appropriate time.

(5) Individuals who receive non-recertification orders may reapply for certification and will be certified after they meet all of the requirements for certification. The Authority shall also provide notice of the applicant's right to a hearing pursuant to the provisions of ORS Chapter 183.

Stat. Auth.: ORS 161.309-161.370, 161.392, 413.042, 419C.524; 161.309 -370, 419C.378-384

Stats. Implemented: 161.309 -370, 419C.378-384

Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0025

Content of Written Evaluations Assessing Competency and Criminal Responsibility

(1) At minimum each forensic evaluation report shall include the following:

(a) Identifying information of the defendant, a description of the forensic examination, criminal charges, the referral source and the referral question;

(b) The evaluative procedure, techniques and tests used in the examination and the purpose for each, informed consent and limits of confidentiality;

(c) Background information, relevant history of mental and physical illnesses, substance use and treatment histories, medications, hospital or jail course, and current setting.

(d) Summary of a mental status examination;

(e) A substantiated diagnosis in the terminology of the American Psychiatric Association's current edition of the Diagnostic and Statistical Manual of Mental Disorders;

(f) A consideration of malingering must be present in every evaluation report; and

(g) A summary of relevant records reviewed for the evaluation.

(2) In addition to OAR 309-090-0025(1), when the defendant or juvenile's competency is in question, the evaluation report shall also include, at a minimum, opinions and explanations related to the defendant or juvenile:

(a) Understanding of his or her charges, the possible verdicts and the possible penalties;

(b) Understanding of the trial participants and the trial process;

(c) Ability to assist counsel in preparing and implementing a defense;

(d) Ability to make relevant decisions autonomously; and

(e) If determined incapacitated: A recommendation of treatment and other services necessary for the defendant to gain or restore capacity, including an opinion and explanation as to whether the person requires a hospital level of care.

(f) The evaluator may not provide the defendant or juvenile's statements about the alleged criminal conduct unless necessary to support the evaluator's finding of competence or incompetence.

(3) In addition to OAR 309-090-0025(1), related to the question of criminal responsibility, the evaluation report shall also include, at a minimum, opinions and explanations addressing:

(a) The defendant or juvenile's account of the alleged offense including thoughts, feelings and behavior;

(b) Summary of relevant records; including police reports,

(c) An expert opinion regarding the role of substance use in the alleged offense;

(d) The defendant or juvenile's mental state at the time of the alleged offense and

(e) An expert opinion regarding whether the defendant, as a result of mental disease or defect at the time of engaging in the alleged criminal conduct, lacked substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.

(f) An expert opinion regarding; if the individual is determined guilty except for insanity of a misdemeanor is the individual a substantial danger to others as defined in these rules.

Stat. Auth.: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382; 161.309 -370

Stats. Implemented: ORS 161.309 -370

Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 16-2012, f. & cert. ef. 12-26-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0030

Forensic Evaluation Review Panel

(1) A multi-disciplinary review panel shall be appointed by the director of the Division and serve at the discretion of the Director to review forensic evaluation reports submitted in support of applications for certification.

(2) An individual interested in participating in the Forensic Evaluation Review Panel shall submit a letter of interest and resume to the Director of the Division.

(3) Members shall be experienced in the criminal justice system and have familiarity with the issues of competency and criminal responsibility.

(4) Members shall serve a two year term and are eligible for reappointment at the discretion of the Director. Vacancies occurring during a member's term shall be filled immediately for the remainder of the unexpired term.

(5) Members shall be reimbursed on a per diem basis for each day during which the member is engaged in the performance of official duties.

Stat. Auth.: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 161.309 -370, 419C.378-384

Stats. Implemented: ORS 161.309 -370, 419C.378-384, 161.392, 419C.382

Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0035

Forensic Evaluation Review Panel Process

(1) Members of the Forensic Evaluation Review Panel shall meet at the discretion of the Authority to review all submitted redacted forensic evaluation reports as the need arises.

(2) Redacted forensic evaluation reports shall be reviewed by panel members with different professional backgrounds to determine whether the reports have met the requirements of form and content.

(3) Panel members shall issue a report to the Division with feedback for the certified forensic evaluator.

(4) The Review Panel shall participate in the process for reviewing complaints and remediation plans under OAR 309-090-0060 through 309-090-0062 and make recommendations to the Authority if requested.

Stat. Auth.: ORS 161.309-161.370, 161.392, 419C.524; 161.309 -370, 419C.378-384

Stats. Implemented: ORS 161.392, 161.309 -370, 413.042, 419C.378-384

Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0040

Forensic Evaluator Training Program

(1) The Authority will establish a course of training for persons desiring the issuance of a certificate. At a minimum the training will include a review of:

(a) The Oregon statutes and case law applicable to the issues of competency and criminal responsibility;

(b) Testing and techniques related to assessing competency and criminal responsibility;

(c) The required contents of a report;

(d) The ethical standards and considerations relevant to an evaluation of competency and criminal responsibility;

(e) Assessment of risk to others and recommendations for treatment and services.

(2) Additional specialized training shall be required for evaluators desiring to perform evaluations on children younger than age 15 and other specialized populations.

(3) An examination will be administered at the completion of the initial training.

(4) Updates to this training shall be provided every two years and consist of information regarding relevant changes to the law, rules, process for Forensic Evaluator Certification, and relevant advanced topics.

Stat. Auth.: ORS 161.309-161.370, 161.392, 419C.524, 419C.382; OL 2011, HB 3100, HB 2836, 419C.382

Stats. Implemented: OL 2011, HB 3100, HB 2836, ORS 419C.382

Hist.: MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 14-2014, f. & cert. ef. 10-29-14

309-090-0050

Confidentiality

Except for the names of certified evaluators, all records provided to the Authority or the Division under these rules are confidential and privileged and may not be released or utilized for any purpose outside these rules. Any practitioner who in good faith complies with these rules, including providing sample evaluations for review in order to maintain certification, is not responsible for any failure by another individual or agency to maintain confidentiality, in regard to these rules.

Stat. Auth.: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382; 161.309 -370, 419C.378-384

Stats. Implemented: ORS 161.309 -370, 419C.378-384

Hist.: MHS 13-2012, f. & cert. ef. 6-25-12; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0055

Certification Denial, Suspension, Revocation, Non-Recertification and Complaints Regarding Content of Written Evaluation Reports

(1) An applicant may be denied certification, or an evaluator may be denied recertification for reasons including but not limited to:

(a) The applicant for initial or recertification attempted to procure a certification through fraud, misrepresentation or deceit;

(b) The applicant for initial or recertification submits to the Authority any notice, statement or other document required for certification which is false or untrue, or contains any material misstatement or omission of fact;

(c) The applicant for initial or recertification has been convicted of a felony; or

(d) The applicant for initial or recertification fails to meet the requirements for receiving certification or recertification.

(2) An applicant's certification may be revoked for any of the following reasons:

(a) The evaluator fails to meet any of the applicable requirements of these rules;

(b) The applicant loses his or her professional license for any reason;

(c) The Authority accepts one or more complaints regarding the content of written reports; the forensic review panel reviews the complaints and determines that the deficiencies in the reports represent a substantial departure from the standards of practice established by these rules. Complaints regarding content are limited to standards set forth in OAR 309-090-0025.

(3) The Authority may immediately suspend an evaluator's certification in the event of a situation in which the Authority determines that immediate action is necessary, such as receipt of a serious complaint which has not yet been fully reviewed by the Authority.

Stat. Auth.: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382; 161.309 -370, 419C.378-384

Stats. Implemented: ORS 161.309 -370, 419C.378 - 384

Hist.: MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0060

Complaints on Which the Authority Can Act

(1) Any complaint regarding the content of forensic evaluation reports must be submitted in a form and manner prescribed by the Authority and provide sufficient detail as to why the evaluation report is cause for a complaint.

(2) Complaints considered by the Authority must be limited to standards for content of written forensic evaluation reports as set forth in OAR 309-090-0025.

Stat. Auth.: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382; , 161.309 -370, 419C.378-384

Stats. Implemented: ORS 161.309 -370, 419C.378 - 384

Hist.: MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0065

Complaint Processing and Investigation

(1) If a complaint is accepted, reviewed by the Authority, and found to warrant consideration by the forensic evaluation review panel, the evaluation report shall be forwarded to the panel for consideration and determination as to whether or not the deficiencies represent a substantial departure from the standards of practice established by these rules.

(2) If the Authority determines that there is substantial departure from the standards set forth in OAR 309-090-0025, the Authority in consultation with the forensic evaluation review panel shall provide written notice to the evaluator which may include recommended remediation steps provided by the review panel, denial of certification, or revocation of certification.

(3) If a remediation plan is recommended by the review panel, an evaluator shall have 30 days from the date of notice to respond with a written plan for remediation. If the Authority approves the plan, the evaluator shall maintain temporary certification status for up to six months at which time the Authority shall determine whether the issues raised have been adequately addressed.

(a) If the issues raised have been adequately addressed, the Authority shall withdraw its notice and grant or restore full certification.

(b) If the issues have not been adequately addressed, the Authority may proceed with denial or revocation of certification and shall provide notice of the applicant's right to appeal, pursuant to the provisions of ORS Chapter 183.

(4) If certification is denied or revoked and evaluator may request reconsideration by the Director of the Authority by submitting a written request within 15 business days of receiving notice.

(5) Individuals making complaints on issues determined to be not covered by these rules may be referred to the appropriate licensing boards.

Stat. Auth.: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382; 161.309 -370, 419C.378-384

Stats. Implemented: ORS 161.309 -370, 419C.378 - 384

Hist.: MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

309-090-0070

Contested Case Hearing

If the Authority denies, revokes, non-renews, suspends, or imposes a condition on certification, the Authority shall provide notice of the applicant's right to a hearing pursuant to the provisions of ORS Chapter 183.

Stat. Auth.: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382; 419C.378-384

Stats. Implemented: ORS 161.309 -370, 419C.378 - 384

Hist.: MHS 14-2014, f. & cert. ef. 10-29-14; MHS 4-2016, f. & cert. ef. 5-3-16

DIVISION 91

STATE HOSPITAL ADMISSIONS AND DISCHARGES

309-091-0000

Purpose and Scope

(1) These rules establish and define the criteria which support the proper management and utilization of services provided by the Oregon state hospital system, by limiting admissions to those most severely symptomatic individuals whose treatment and recovery needs cannot be met in a community treatment setting.

(2) These rules apply to all individuals admitted into any state hospital setting, and address differences which occur due to each individual's legal status.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0005

Definitions

(1) "AMH" means the Addictions and Mental Health Division of the Oregon Health Authority.

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

(3) "Chief Medical Officer" (CMO) means the physician designated by the superintendent of each state institution who is responsible for the administration of medical treatment, or his or her designee.

(4) "Civil Commitment" means the individual has been committed to the Authority for emergency psychiatric care and treatment pursuant to ORS 426.070, 426.228 to 426.235 or 426.237.

(5) "Clinical Reviewer" means the Division employee designated to the role of determining eligibility for state hospital admissions.

(6) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(7) "DSM" means the most recent edition of the Diagnostic and Statistical Manual of Psychiatric Disorders, published by the American Psychiatric Association.

(8) "Forensic" means related to the law, and references individuals committed to treatment and supervision by the courts pursuant to Oregon Revised Statutes (ORS) 161.290 – 161.400.

(9) "Legal Guardian" in this rule means an individual appointed by a court of law to act as guardian of an adult having been determined to be legally incapacitated.

(10) "Licensed Residential Facility or Licensed Residential Home" means those residences defined in OAR 309, Chapter 035.

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

(a) The Board of County Commissioners of one or more counties that establishes or operates a CMHP;

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

(c) A regional LMHA comprised of two or more boards of county commissioners.

(12) "Primary Diagnosis" means the diagnosis which identified the condition considered the most severe for which the individual receives treatment.

(13) "Psychiatric Security Review Board" (PSRB) means board appointed by the Governor and authorized in ORS 161.385.

(14) "Responsible Party" means the LMHA, community mental health program, the Medicaid managed care organization, when applicable the individual's legal guardian, and other parties identified by AMH.

(15) "Severe Mental Illness" (SMI) means an individual's symptoms meet the criteria in OAR 309-091-0010.

(16) "State Hospital" means any campus of the Oregon State Hospital (OSH) system, and the Blue Mountain Recovery Center (BMRC).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0010

Civily Committed and Guardian Authorized Admission Criteria

Each non-forensic individual admitted to a state hospital must meet the following criteria:

(1) The individual must be age 18 or older;

(2) The individual must be named in a current civil commitment order, or the individual's legal guardian must have signed consent for admission;

(3) There must be recent documentation by a qualified professional that the individual is experiencing an Axis I diagnosis of a mental disorder with severe psychotic symptoms, such as schizophrenia, delusional disorder, affective disorder, mood disorder or other disorders which manifest psychotic symptoms as defined in the most recent version of the DSM; and

(4) The current symptoms must be of such severity that the resulting symptoms require extended placement in a 24-hour medically supervised psychiatric hospital. Severity is established by a determination of:

(a) The degree of dangerousness to self;

(b) The degree of dangerousness to others; and

(c) The degree of the individual's inability to meet his or her basic health and safety needs.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0015

Determining Need for State Hospital Care

(1) State hospital level of care is determined appropriate when the individual's condition or symptoms have not improved in an acute care setting despite having received comprehensive psychiatric and medical assessment, treatment and/or community services typical for a psychiatric illness or psychiatric emergency.

(2) Prior to referral for admission to a state hospital, the individual should have received:

(a) A comprehensive medical assessment to identify conditions that may be causing, contributing to, or exacerbating the mental illness;

(b) Services from an appropriate medical professional for the treatment and stabilization of any medical or surgical conditions that may be contributing to or exacerbating the mental illness and

(c) Treatment in an acute setting within the parameters of the most recent version of the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders.

(d) In addition there must be evidence of additional treatment and services having been attempted, including:

(A) Use of evidence-based or promising psychosocial interventions which were delivered in relevant culturally-competent, strength-based, person-centered and trauma-informed manners and which adequately treated the assessed and/or expressed needs of the individual. When requested by the individual, treatments should include members of the individual's family, support network and /or peers;

(B) Documentation of ongoing review and discussion of options for discharge to non-hospital levels of care; and

(C) Documentation of services and supports attempted by the responsible party to divert admission and establish treatment and recovery in a non-hospital setting.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0020

Neuropsychiatric and Geropsychiatric Admissions

Admissions due primarily to symptoms resulting from a traumatic or acquired brain injury, dementia or other cognitive disorders, or an organic brain syndrome due to a medical condition may occur on a case-by-case basis when, as determined by the designated clinical reviewer, the individual's condition or symptoms would likely improve if treated in a state hospital, and at least one of the following:

(1) Denial of admission will result in a serious health or safety issue for the individual; or

(2) Denial of admission will cause a specifically described community safety issue; or

(3) Denial of admission will result in the significant worsening of the individual's condition.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0025

Exclusion Criteria and Exceptions

(1) State hospitals are intended to provide recovery-oriented intervention for individuals experiencing symptoms related to a severe, persistent and disabling mental illness.

(2) Admissions must not be based upon a primary diagnosis of the following related conditions:

(a) An acute or existing medical or surgical condition which requires primary placement in a medical setting and which cannot be safely or adequately treated within a state hospital facility;

(b) Delirium;

(c) Pervasive Developmental Disorder;

(d) Intellectual Developmental Disorder;

(e) Substance Use or Substance Abuse Disorder or

(f) Personality Disorder.

(3) Administrative transfers from the Oregon Department of Correction of individuals for the purpose of treatment may occur in accordance with OAR 291-047-0021. Individuals civilly committed upon discharge from the Oregon Department of Correction must meet the admission criteria and the process defined in this rule.

(4) Administrative transfers from the Oregon Youth Authority of individuals over the age of 18 for the purpose of stabilization and evaluation not exceeding 30 days may occur in accordance with OAR 416-425-020.

(a) Individuals transferred for the purpose of stabilization and evaluation for a period of time exceeding 30 days may occur in accordance with OAR 416-425-020.

(b) Individuals over the age of 18 who are civilly committed upon discharge from the Oregon Youth Authority must meet the admission criteria and the process defined in this rule.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0030

Discharge Planning

(1) The state hospital will notify the responsible parties of each admission, unit or campus transfer, and each hospital treatment team determination related to assessing discharge readiness.

(2) The responsible party must arrange housing, treatment and other services assessed as needed to support the continuity of care necessary to maintain the individual's stability in the community.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0035

Discharge Criteria and Procedures for Civil Commit or Guardian

(1) The state hospital will periodically assess the individual's continued need for state hospital level of care based upon the admission criteria established in these rules.

(2) The state hospital retains the authority to solely determine when someone no longer needs state hospital level of care based on standardized criteria adopted by the hospital. Whenever possible, the decision should be made in collaboration with the responsible party and legal guardian, when applicable.

(3) An individual determined ready for discharge may later be determined not ready for discharge and removed from the discharge ready list.

(4) Individuals with an active discharge and community placement plan who no longer meet the state hospital criteria as defined in these rules shall not remain in an Oregon state hospital.

(5) Prior to an individual no longer needing state hospital level of care, the hospital will collaborate with the responsible party and with the patient's legal guardian if assigned by the courts, to identify appropriate services and supports for the patient.

(6) When an individual no longer needs state hospital level of care, and an appropriate community transition plan and additional necessary supports are in place, the patient will be discharged.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0040

Forensic Admission Criteria and Procedures

Forensic admissions will occur as prescribed ORS 161.327, 161.328, 161.365, 161.370.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072

Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0045

Discharge Criteria and Procedures

(1) Individuals admitted by court order after a finding of guilty except for insanity of a felony will be discharged when approved by the PSRB and in accordance with the state hospital policies and procedures.

(2) Individuals whose jurisdiction under the PSRB has ended as identified by the state hospital Legal Department shall be allowed to discharge on midnight of the final day of PSRB jurisdiction unless the hospital determines the need for civil commitment or some other legal hold.

(3) The responsible party will assess individuals ending jurisdiction and when determined appropriate, arrange housing, treatment and other services assessed as needed to support the continuity of

care necessary to maintain the individual's stability in the community.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 179.321, 426.010, 426.020, 426.072
Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12

309-091-0050

Other Forensic Discharges

(1) For the purposes of this rule, discharge occurs when the state hospital moves the individual from the state hospital's psychiatric care to either a community setting or other institutional setting – including but not limited to discharge to a jail.

(2) Individuals committed to the state hospital pursuant to ORS 161.370 shall be discharged from the state hospital upon the any of the following:

(a) The court has ordered that the individual be discharged from the state hospital or that the underlying criminal charges be dismissed;

(b) The state hospital both:

(A) Has sent notice to the court pursuant to ORS 161.370 subsection (5)(a), (5)(b)(A), (5)(b)(B), or subsection (8); and

(B) Has transported the individual to a jail;

(c) A period of time has passed which is equal to the maximum sentence the court could have imposed if the individual had been convicted; or

(d) A period of time has passed which is equal to 1,095 days from the individual's initial custody date at the hospital under ORS 161.370.

(3) In counting the maximum period of time under (2)(c) through (d) of this section, the state hospital shall count the days in which the defendant was admitted to the state hospital pursuant to ORS 161.370 on any charge alleged in the accusatory instrument and shall not count any days in which the individual had been discharged from the state hospital.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 179.321, 426.010, 426.020, 161.370, 179.360 & 2011 SB 432
Hist.: MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12; MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 7-2015(Temp), f. & cert. ef. 10-28-15 thru 4-22-16; MHS 3-2016, f. & cert. ef. 4-28-16

DIVISION 92

OREGON STATE HOSPITAL REVIEW PANEL

309-092-0000

Purpose and Scope

Oregon Laws 2011, chapter 708, Senate Bill 420 (SB 420) went into effect on January 1, 2012. The law created two tiers of offenders who are found guilty except for insanity and are affected by a mental disease or defect presenting a substantial danger to others. Under SB 420, tier one offenders (i.e., Measure 11 offenders) remain exclusively under the jurisdiction of the Psychiatric Security Review Board (PSRB), but the Oregon Health Authority (OHA) acquires jurisdiction over tier two offenders (i.e., non-Measure 11 offenders) while they are in the Oregon State Hospital. OHA is responsible for determining when tier two offenders may be conditionally released or discharged into the community. As with the PSRB, OHA must have as its primary concern the protection of society. In order to implement SB 420, via these rules OHA establishes the Oregon State Hospital Review Panel (SHRP) and the processes applicable to the SHRP.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.
Stats. Implemented: ORS 161.295 - 161.400, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0005

Definitions

(1) "Administrative Hearing" means a meeting of the SHRP where a quorum is present and a conditional release plan is reviewed or reviewed and modified.

(2) "Administrative Meeting" means any meeting of the SHRP where a quorum is present for the purpose of considering matters relating to SHRP policy and administration.

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

(4) "Conditional Release" means a grant by the court, PSRB or SHRP for an individual to reside outside a state hospital in the community under conditions for monitoring and treatment of mental and physical health.

(5) "Director" means the Director of the Authority.

(6) "Division" means the Addictions and Mental Health (AMH) Division of the Authority.

(7) "Hospital Pass" means any time an individual will be off hospital grounds for any length of time not accompanied by hospital staff.

(8) "Individual" means any person under the jurisdiction of the SHRP.

(9) "Insanity Defense" means the following: For offenses committed on or after January 1, 1984, an individual is guilty except for insanity if, as a result of a mental disease or defect at the time of engaging in criminal conduct, the individual lacked substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law. The name of the insanity defense from January 1, 1978, through December 31, 1983, was "not responsible due to mental disease or defect." From January 1, 1971, through December 31, 1977, the insanity defense was known as "not guilty by reason of mental disease or defect." The name of the insanity defense prior to 1971 was "not guilty by reason of insanity."

(10) "Mental Disease" means any diagnosis of mental disorder which is a significant behavioral or psychological syndrome or pattern that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

(11) "Mental Defect" is defined as mental retardation, brain damage or other biological dysfunction that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. "Mental disease or defect" does not include an abnormality manifested solely by repeated or criminal or otherwise antisocial conduct. For offenses committed on or after January 1, 1984, the term "mental disease or defect" does not include any abnormality constituting solely a personality disorder.

(12) "Proof of Dangerousness" means any evidence regarding whether the individual's mental disease or defect may, with reasonable medical probability, occasionally become active, and when active, render the individual a substantial danger to others.

(13) "PSRB" refers to the Psychiatric Security Review Board.

(14) "Quorum" is the presence of at least three members of the SHRP.

(15) "Review Panel" or "SHRP" refers to the Oregon State Hospital Review Panel established by the Authority.

(16) "Review Panel's Office" and "Review Panel Staff" means the office and staff of the Legal Affairs office at a state hospital.

(17) "SB 420" means OR Laws 2011, chapter 708, Senate Bill 420 that takes effect on January 1, 2012.

(18) "State Hospital" means a state institution as defined in ORS 179.010 and operated by the Authority.

(19) "Statutory Hearing" is a meeting of the SHRP where a quorum is present and an application is made for discharge, conditional release, commitment or modification filed pursuant to ORS 161.336, 161.341 or 161.351 or as otherwise required by ORS 161.337 to 161.351.

(20) "Substantial Danger to Others" means an individual is a substantial danger to others if the individual is demonstrating or previously has demonstrated intentional, knowing, reckless or

criminally negligent behavior which places others at risk of physical injury.

(21) "Superintendent" means the superintendent of a state hospital.

(22) "Tier One Offender" means an individual who has been found guilty except for insanity of a tier one offense as defined in ORS 161.332 as amended by SB 420.

(23) "Tier Two Offender" means an individual who has been found guilty except for insanity only of offenses that are not tier one offenses.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0010

Membership and Terms

(1) The SHRP shall consist of five members appointed by the Director of the Authority. The SHRP shall be composed of a psychiatrist, a psychologist, a member with substantial experience in probation and parole, a member of the general public and a lawyer. If the Director of the Authority determines that it is necessary, the psychiatrist position of the SHRP may be filled by a psychologist.

(2) Members shall initially serve one year terms, but after January 2013 they shall serve overlapping four-year terms commencing on the date of their appointment. Vacancies occurring during a member's term shall be filled immediately by appointment of the Director.

(3) Review Panel Members serve at the discretion of the Director.

(4) Review Panel Members are eligible for reappointment.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0015

Chair; Powers and Duties

(1) In January of each year, the SHRP shall elect — by a majority of Review Panel Members votes — one of its members as chairperson to serve for a one-year term with the possibility of reelection.

(2) The chairperson shall have the powers and duties necessary for the performance of the office. These shall include, but not be limited to:

(a) Presiding at hearings and meetings;

(b) Assigning members to panels and designating an acting chairperson when appropriate; and

(c) Making rulings on procedural matters.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0020

Responsibilities, Function and Purpose of Review Panel

(1) The SHRP shall monitor the mental and physical health and treatment of any individual placed under its jurisdiction as a result of a finding by a court of guilty except for insanity. The SHRP shall have as its primary concern the protection of society. In addition, the SHRP's responsibilities shall include, but not be limited to:

(a) Holding hearings as required by law to determine the appropriate status of individuals under its jurisdiction;

(b) Modifying or terminating conditional release plans while individuals under its jurisdiction are in the hospital;

(c) Maintaining and keeping current medical, social and criminal histories of all individuals under the SHRP's jurisdiction; and

(d) Observing the confidentiality of records as required by law.

(2) The SHRP shall be supported by and the SHRP process and procedures shall be administered by the Legal Affairs Director and Legal Affairs Staff at the state hospital.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0025

Jurisdiction of Individuals Under The SHRP

The SHRP shall have jurisdiction as set forth in ORS Chapter 161 over tier two offenders — while they are in the state hospital — who are adjudged by a court to be guilty except for insanity and presenting a substantial danger to others:

(1) The court must find that the individual would have been guilty of a tier two offense during a criminal episode in the course of which the individual caused physical injury or risk of physical injury to another.

(2) The period of jurisdiction of the SHRP, in addition to time spent under jurisdiction of the PRSB while on conditional release, shall be equal to the maximum sentence the court finds the individual could have received had the person been found guilty.

(3) The SHRP and the PSRB do not consider time spent on unauthorized leave from the custody of the Authority as part of the jurisdictional time.

(4) The SHRP has jurisdiction over all tier two individuals who used the insanity defense successfully and were placed on conditional release or committed to a state mental hospital by the court prior to January 1, 1978. The period of jurisdiction in these cases shall be equal to the maximum sentence the person could have received if found guilty and shall be measured from the date of judgment.

(5) The SHRP shall maintain jurisdiction over individuals who are legally placed under its jurisdiction by any court of the State of Oregon and who are housed in a state hospital.

(6) The Juvenile Psychiatric Security Review Board will have jurisdiction over juveniles found guilty except for insanity.

(7) Upon receipt of verified information of time spent in custody, individuals placed under the SHRP's jurisdiction shall receive credit for:

(a) Time spent in any correctional facility for the offense for which the individual was placed under the SHRP's jurisdiction; and

(b) Time spent in custody of the Authority at a state hospital for determination of the defendant's fitness to proceed or under a detainer for the criminal charges for which the individual ultimately was placed under the SHRP's jurisdiction.

Stat. Auth.: ORS 413.042, 161.327, 161.332, 161.336, 161.346, 161.351, 161.385, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0030

Scheduling Review Panel Hearings and Meetings

(1) The SHRP shall meet at least twice every two months unless the chairperson determines that there is not sufficient business before the SHRP to warrant a meeting at the scheduled time.

(2) The SHRP shall hold administrative meetings as necessary to consider matters relating to SHRP policy and administration.

(3) Public notice shall be given in accordance with the Public Meetings Law.

(4) The SHRP may hold administrative hearings to expedite such matters as approving modifications of conditional release orders, reviewing plans for conditional release and approving or disapproving them.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0035

Quorum and Decisions

(1) The presence of at least three members of the SHRP constitutes a quorum.

(2) Three concurring votes (affirmative or negative) are required to make a SHRP decision.

(3) When three members cannot agree on a decision, the hearing may be continued, for no longer than 60 days. The tape of the hearing and the exhibits shall be reviewed by the remaining member(s) and a decision by the majority of the members shall be the finding and order of the SHRP.

(4) If the attorney for an individual or a pro se individual objects to the remaining member's or members' review as set forth in section (2) of this rule, the SHRP may reschedule the matter for a hearing before the entire SHRP.

(5) If an objection for good cause is made to a specific member of the SHRP sitting on the panel considering a specific case, that member shall withdraw and, if necessary, the hearing shall be postponed and rescheduled.

(6) If an objection for good cause is made to a specific staff member of the SHRP being present during the panel's deliberations in a specific case, and if the SHRP determines that good cause exists, that staff member shall not be present during deliberations in that case.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0040

Public Meetings Law

(1) All meetings of the SHRP are open to the public in accordance with the Public Meetings Law.

(2) Deliberations of the SHRP are not open to the public.

(3) For the purposes of this rule, the term "public" does not include staff of the SHRP.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0045

Records

(1) A record shall be kept of SHRP action taken at an administrative meeting and any decision made at an administrative hearing of the SHRP.

(2) All SHRP hearings, except SHRP deliberations, shall be recorded by manual or electronic means which can be transcribed. No other record of SHRP hearings shall be made. All documents considered at hearings shall be included as exhibits and kept as part of the record.

(a) Audio recordings capable of being transcribed shall be kept by the SHRP for a minimum period of two years from the hearing date.

(b) SHRP hearings may be transcribed from the recording for appeal purposes. If transcribed, the transcript may be substituted for the original record. ORS 161.348(2) authorizes the SHRP to submit to the appellate court the record of the proceeding or, if the person agrees, a shortened record. The record may include a certified true copy of a tape recording of the proceedings at a hearing.

(c) Any material to which an objection is sustained shall be removed from the record; the objection and ruling of the SHRP shall be noted on the record.

(d) The audio tape or transcript of the proceedings shall be made available at cost to a party to the proceedings upon request.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0050

Public Records Law; Confidentiality

The attorneys for an individual or a pro se individual shall have the right to review any records to be considered at the hearing. Applicable federal and state confidentiality laws, such as the Health Insurance Portability and Accountability Act (HIPAA) and ORS 179.505 shall be observed with respect to other requests to inspect an individual's records.

Stat. Auth.: ORS 413.042, 161.385, 161.387, 192.450, 192.500, 192.525; & 192.690, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0055

Hearing Notices

The SHRP shall provide written notice of SHRP hearings to the following persons or agencies within a reasonable time:

(1) The individual;

(2) The attorney representing the individual;

(3) The District Attorney;

(4) The community supervisor or case monitor;

(5) The Court or department of the county from which the individual was committed;

(6) The victim, if the court finds that the victim requests notification;

(7) The victim, if subsequent to the disposition of the criminal case, the victim asks either the PSRB or SHRP for notification.

(8) Any other interested person requesting notification ; (9) A state hospital unit in which the individual resides; and (10) The PSRB in the case of conditional release hearings.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0060

Information Contained in Notice

Written notice shall contain the following:

(1) Time, place and location of the hearing;

(2) The issues to be considered, reference to statutes and rules involved, authority and jurisdiction;

(3) A statement of individual's rights, including the following:

(4) The right to appear at all proceedings, except SHRP deliberations;

(5) The right to cross-examine all witnesses appearing to testify at the hearing;

(6) The right to subpoena witness and documents as provided in ORS 161.395;

(7) The right to legal counsel and, if indigent as defined by the indigency standard set forth by the State Court Administrator's office, to have counsel provided without cost; and

(8) The Right to examine all information, documents and reports under consideration.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.

Stats. Implemented: ORS 161.295 - 161.400, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0065

Time Frame of Hearings

Hearings shall be held within the following time frames:

(1) The initial hearing under ORS 161.341(6)(a) shall occur within 90 days following the individual's placement under the SHRP's jurisdiction and commitment to a state hospital.

(2) The revocation hearing under ORS 161.336(4)(c) shall occur within 20 days following the individual's return to OSH for violation of the individual's conditional release requirements.

(3) An individual's request for conditional release or discharge under ORS 161.341(3) shall be heard within 60 days of receipt of the request, except for initial requests for conditional release under ORS 161.341(5).

(4) An individual is eligible to request a hearing six months after last hearing, and the hearing must be held within 60 days after filing the request pursuant to ORS 161.341(4).

(5) A request for conditional release by the state hospital, under ORS 161.341(1) may be made at any time and shall be heard within 60 days of receipt of the request.

(6) A request by the outpatient supervisor under ORS 161.336(7)(b) for conditional release, modification of conditional release or discharge may be made at any time and shall be heard within 60 days of receipt of request.

(7) Two-year hearings under ORS 161.341(6)(b) are mandatory for individuals committed to a state hospital when no other hearing has been held within two years.

Stat. Auth.: ORS 413.042 & 161.341, SB 420.
Stats. Implemented: ORS 161.336, 161.341, 161.351, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0070

Chairperson Conducting Hearing

The chairperson or acting chairperson shall preside over hearings and shall have the authority to:

- (1) Designate the order of presentation and questioning;
- (2) Determine the scope of questioning; and
- (3) Set time limits and cut off irrelevant questions and irrelevant or unresponsive answers.

Stat. Auth.: ORS 413.042 & 161, SB 420 .
Stats. Implemented: ORS 161.385, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0075

Patient’s Right to Review Record; Exceptions

(1) Individuals shall receive directly, or through their attorney, written notice of the hearing and a statement of their rights in accordance with ORS 161.346.

(2) All exhibits to be considered by the SHRP shall be disclosed to the individual’s attorney or the individual if proceeding pro se, as soon as they are available.

(3) Exhibits not available prior to the hearing shall be made available to the individual’s attorney or the patient, if not represented, at the hearing.

(4) All material relevant and pertinent to the individual and issues before the SHRP shall be made a part of the record.

(5) Any material not made part of the record shall be separated and a statement to that effect shall be placed in the record.

Stat. Auth.: ORS 413.042 & 161.327, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0080

Evidence Considered; Admissibility

The SHRP shall consider all evidence available to it which is material, relevant and reliable. All evidence of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs shall be admissible, including but not limited to the following:

- (1) The record of trial;
- (2) Information supplied by the state’s attorney or any interested party including the individual;
- (3) Information concerning the individual’s mental condition;
- (4) The entire psychiatric and criminal history of the individual including motor vehicle records;
- (5) Psychiatric or psychological reports ordered by the SHRP under ORS 161.346(3);
- (6) Psychiatric and psychological reports under ORS 161.341(2) written by a person chosen by the state or the individual to examine the individual; and
- (7) Testimony of witnesses.

Stat. Auth.: ORS 413.042 & 161, SB 420
Stats. Implemented: ORS 161.336, 161.341 & 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0085

Motion Practice

Any party bringing a motion before the SHRP shall submit the motion and memorandum of law to the SHRP and the opposing party one week prior to the hearing date in which the motion will be heard.

Stat. Auth.: ORS 413.042 & 161.327, SB 420
Stats. Implemented: ORS 161.346, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0090

Objections to Evidence

The chairperson or acting chairperson shall rule on questions of evidence. Hearsay evidence shall not be excluded unless the chairperson or acting chairperson determines the evidence is not material, relevant or reliable.

(1) In determining whether the evidence is material, relevant or reliable, the SHRP shall consider the following:

- (a) The age and source of the documents;
- (b) The ability of the witness to have observed and had personal knowledge of the incidents; and
- (c) The credibility of the witness and whether the witness has bias or interest in the matter.

(2) The individual, the individual’s attorney or attorney representing the state may object to any evidence. The SHRP may decide the following:

(a) To sustain the objection and deny the admission and consideration of the evidence on the grounds that it is not material, relevant or reliable;

(b) To overrule the objection and admit the evidence;

(c) In considering the weight given to that evidence, consider the reason for the objection; or

(d) To grant a continuance for a period of time, not to exceed 60 days, to allow a witness to appear or be subpoenaed to testify about the evidence under consideration.

Stat. Auth.: ORS 413.042 & 161.327, SB 420.
Stats. Implemented: ORS 161.346 & 161.385, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0095

Witnesses and Documents; Subpoena

(1) Witnesses or documents may be subpoenaed as provided in ORS 161.395 upon request of any party to the hearing or on the Review Panel’s own motion, upon a proper showing of the general relevance and reasonable scope of the documentary of physical evidence sought.

(2) Witnesses with a subpoena other than parties or state officers or employees shall receive fees and mileage as prescribed by law.

(3) A judge of the Circuit Court of the county in which the hearing is held may compel obedience by proceeding for contempt for failure of any person to comply with the subpoena issued.

Stat. Auth.: ORS 413.042 & 161.387; SB 420
Stats. Implemented: ORS 161.346 & ORS 161.395; SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0100

Testimony Given on Oath

The SHRP shall take testimony of a witness upon oath or affirmation of the witness administered by the chairperson or acting chairperson at the hearing.

Stat. Auth.: ORS 413.042 & 161.327, SB 420.
Stats. Implemented: ORS 161.346 & 161.385, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0105

Standards and Burdens of Proof

(1) The standard of proof on all issues at hearings of the SHRP shall be the preponderance of the evidence. The burden of proof shall depend on the type of hearing:

(a) In an initial 90-day hearing under ORS 161.341(6)(a), the state has the burden to show the individual continues to be affected by a mental disease or defect and continues to be a substantial danger to others.

(b) In a revocation hearing under ORS 161.336(4)(c), the state has the burden to show the individual’s unfitness for conditional release and that jurisdiction of the SHRP should continue.

(c) In an individual's request for conditional release or discharge under ORS 161.341(3), the individual has the burden of proving his or her fitness for conditional release or discharge, unless it has been more than two years since the State had the burden of proof. In that case, the burden is on the State.

(d) In a request for conditional release or discharge of the individual by the Authority under ORS 161.341(1), the state must prove the individual is not appropriate for conditional release or discharge.

(e) In a status review hearing under ORS 161.346, the state has the burden of proving that the commitment, proposed conditional release plan or other current status of the patient is appropriate.

(f) In all other cases (such as two, five, and ten-year hearings), the state bears the burden of proof.

(2) If at any hearing state hospital staff agrees with the individual on the issue of mental disease or defect, dangerousness or fitness for conditional release, but no advance notice is given to the SHRP that the hospital requests discharge or conditional release, the burden of proof remains with the individual. The testimony of state hospital staff will be considered as evidence to assist the SHRP in deciding whether the individual has met his/her burden.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.336, 161.341 & 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0110 Burden of Going Forward

The party that has the burden of proof shall also have the burden of going forward with the evidence (calling and examining witnesses, proposing conditions of release, etc.).

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0115 Continuance of Hearing

Upon the request of any party or on its own motion, the SHRP may for good cause continue a hearing for a reasonable period of time not to exceed 60 days to obtain additional information or testimony.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0120 Cancellation of Hearing

Unless an individual asks for cancellation of a hearing for good cause, in writing, and with four weeks' advance notice, the individual shall not be eligible to request a hearing for six months from the date of the scheduled hearing.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0125 Use of Restraints

(1) The SHRP prefers to have individuals appear at hearings without physical restraints. If, in the judgment of the individual's physician, the individual might need restraining, the SHRP prefers to have staff attending the hearing with the individual rather than use of physical restraints. However, the final decision on use of restraints lies with the physician.

(2) Any attorney objecting to the individual appearing with restraints at the hearing may raise the issue and ask for testimony from the physician.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0130 Decisions of The SHRP

(1) Within 15 days following the conclusion of a hearing, the SHRP shall provide the individual, the attorney representing the individual, the district attorney representing the state, the committing court and, where applicable, the Authority and local mental health agency or supervisor written notice of the SHRP's decision.

(2) The order of the SHRP shall be signed by a member present at the hearing.

(3) The SHRP may issue its decision orally on the record at the hearing.

(4) The formal order of the SHRP shall contain the findings of facts, conclusions of law, reasons for the decision and notice of the right to appeal under ORS 161.348.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0135 Notification of Right to Appeal

At the conclusion of a Review Panel hearing, the chair or acting chair shall provide the individual and attorney with written notification advising of the right to appeal on an adverse decision. Within 60 days from the date an order is signed and the right to an attorney if indigent.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0140 Patient Appearing Pro Se

When an individual waives the right to be represented by an attorney, the SHRP shall take written or oral testimony and decide whether the individual is capable of understanding the proceedings.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0145 Issues Before The SHRP

At any hearing before the SHRP, issues considered shall be limited to those relevant to the purposes of the hearing. Notice of intent to raise new issues shall be given to the SHRP in writing prior to the hearing. If new issues are raised, the SHRP may continue the hearing to consider the issues and give the parties an opportunity to submit additional evidence.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0150 Primary Concern: Protection of Society

In determining whether an individual should be conditionally released or discharged, the SHRP shall have as its primary concern the protection of society. The SHRP shall not discharge an individual whose mental disease or defect may, with reasonable medical probability occasionally become active, and when active, render the individual a danger to others.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.336, 161.341, 161.346, 161.351, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0155 Initial Hearing

After being placed under the jurisdiction of the SHRP and committed to a state hospital, the individual shall have an initial hearing before the SHRP to determine whether the individual should be committed, conditionally released or discharged:

(1) At an initial hearing, the SHRP shall make a finding on the issue of presence of mental disease or defect and dangerousness

and may base it on the court’s findings and any additional information received.

(2) If the SHRP finds at its initial hearing that the individual is affected by a mental disease or defect, presents a substantial danger to others and is not a proper subject for conditional release, the SHRP shall order the individual committed to a state hospital designated by the Authority.

(3) If the SHRP finds the individual is still affected by a mental disease or defect and is a substantial danger to others but can be adequately controlled with treatment and supervision if conditionally released, the SHRP shall find the individual appropriate for conditional release and shall follow procedures set forth in 309-092-0190.

(4) If the SHRP makes a finding the individual is no longer affected by a mental disease or defect or is no longer a substantial danger to others, the SHRP shall order the discharge of the individual from jurisdiction.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.336, ORS 161.341 & ORS 161.346; SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

**309-092-0160
Revocation Hearing**

(1) Within 20 days following the return of a tier two individual to a state hospital the SHRP shall hold a hearing and consider whether the revocation was appropriate and whether the individual can be continued on conditional release or should be committed to a state hospital.

(2) The SHRP may consider a request for discharge at a revocation hearing or make that finding after considering the evidence before the SHRP.

(3) If the SHRP finds the individual is affected by a mental disease or defect and presents a substantial danger to others and cannot be safely controlled in the community while on conditional release, the individual shall be committed to a state hospital.

(4) If the SHRP finds the individual could be controlled in the community but no conditional release plan has been approved by the SHRP, the SHRP shall order the individual committed to a state hospital but find the individual appropriate for conditional release, and shall order a conditional release plan be created.

(a) The SHRP shall specify what conditions the plan should include.

(b) The SHRP may approve the conditional release plan submitted by the staff of the hospital, by the individual or someone on the individual’s behalf, at an administrative hearing.

(c) If the PSRB submits conditions of release, the SHRP must order that those conditions be followed.

(5) If the SHRP finds the individual can be controlled in the community and a verified conditional release plan is approved by the SHRP, the SHRP shall order the individual placed on conditional release.

(6) If the individual has been charged with a new crime or is serving time in the corrections system, the SHRP shall not hold a revocation hearing until such time as jurisdiction of the individual is returned to the Authority or upon an appropriate request to hold a hearing.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.336, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

**309-092-0165
Patient Request for Conditional Release**

In a hearing before the SHRP on an individual request for conditional release, the SHRP shall consider whether, although still affected by mental disease or defect, the individual can be adequately controlled in the community with treatment and supervision, and shall determine whether the individual is a proper subject for conditional release in accordance with procedures set forth in Division 070.

Stat. Auth.: ORS 413.042 & 161.327, SB 420
Stats. Implemented: ORS 161.341, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

**309-092-0170
Patient Request for Discharge**

In a hearing before the SHRP on an individual’s request for discharge, the SHRP shall determine whether the individual continues to be affected by a mental disease or defect and is a substantial danger to others:

(1) If the SHRP finds the individual is no longer affected by mental disease or defect or if so affected, no longer presents a substantial danger to others, the individual shall be discharged.

(2) If the SHRP finds the individual is not appropriate for discharge, the SHRP may consider whether the individual is appropriate for conditional release even if not requested previously by the individual.

Stat. Auth.: ORS 413.042 & 161.327, SB 420
Stats. Implemented: ORS 161.341, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

**309-092-0175
Hospital Request for Conditional Release**

(1) At any time while an individual is committed to a state hospital the superintendent of the state hospital shall apply to the SHRP for conditional release if it is the opinion of the treating physician that the individual continues to be affected by mental disease or defect and continues to be a danger to others but can be controlled in the community with proper care, medication, supervision and treatment.

(2) The application shall be accompanied by an updated report setting forth facts supporting the state hospital staff’s opinion and a plan for treatment and supervision in the community which includes observations and facts which support staff recommendations.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.341, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

**309-092-0178
SHRP’s Procedure for Conditional Release of Tier Two Offenders**

The SHRP has jurisdiction of Tier Two offenders while the individuals are in the Oregon State Hospital. The PSRB has jurisdiction of and supervision over Tier Two offenders conditionally released from the State Hospital. The SHRP is responsible for conducting the hearings for the Authority. To efficiently facilitate the issuance of conditional release orders with conditions provided by the PSRB, the following process will be utilized:

(1) When a Tier Two Offender (“the individual”) is committed to the jurisdiction of SHRP, SHRP will send a copy of the commitment order to the PSRB upon receipt.

(2) Throughout the course of the conditional release planning process for Tier Two offenders in the State Hospital, SHRP shall continue to conduct the statutorily required hearings for the individual.

(3) Upon receipt of all of the following documents, SHRP shall forward all of the documents to the PSRB with notice that SHRP intends to conduct a conditional release hearing in order to allow the PSRB to conduct an administrative review as provided in OAR 859-070-0040:

(a) SHRP’s order for evaluation of possible conditional release of a Tier Two offender;

(b) The Tier Two offender’s current updated SHRP exhibit file;

(c) The evaluation by the proposed community provider;

(d) A summary of conditional release plan form which outlines the proposed conditions; and

(e) A Progress Note Update authored by the treating psychiatrist dated within 30 days of the signed summary of the conditional release plan form.

(4) The SHRP shall set the matter for either a full or administrative hearing for consideration of conditional release no sooner than 30 days after the PSRB has been provided the required documents. This will allow the time necessary for the SHRP to provide the statutorily-required notice to the victims and other interested parties as well as for the PSRB to conduct its review of the proposed conditions of release.

(5) No less than 7 days prior to that hearing date, the SHRP shall provide a copy of the proposed conditions of release to the individual's attorney and the State's attorney at the Department of Justice for review and opportunity to request a full hearing regarding the proposed conditions before issuance of a final order by the SHRP.

(6) If either attorney submits a written request by fax or email for a full hearing, it must be received no less than 48 hours prior to the scheduled hearing date. If no request is received, the SHRP may proceed with an administrative hearing if it chooses.

(7) The SHRP must review the PSRB's report and recommended conditions of release. The SHRP may order the conditional release of the individual, including any applicable conditions, and the transfer of jurisdiction to the PSRB. The SHRP shall issue a final order within 15 days of its hearing.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.341, SB 420
Hist.: MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0180

Hospital or Outpatient Supervisor Request for Discharge

At any time while an individual is committed to a state hospital the superintendent of the state hospital or designee shall apply to the SHRP for discharge if, in the opinion of the hospital physician or outpatient supervisor, the individual is no longer affected by mental disease or defect or, if so affected, the person no longer presents a substantial danger to others. The application shall be accompanied by a report setting forth the facts supporting the opinion.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.341, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0185

Mandatory Two-Year, Five-Year Hearings

(1) The SHRP shall have periodic mandatory hearings for all individuals.

(2) In no case shall an individual be committed and held in a state hospital under the SHRP's jurisdiction for a period of time exceeding two years without a hearing before the SHRP to determine whether the individual should be conditionally released or discharged.

(3) At mandatory two-year hearings, the SHRP shall consider:

(a) Whether the individual continues to be affected by mental disease or defect and whether the individual presents a substantial danger to others; and

(b) If the individual is affected by mental disease or defect and is a substantial danger to others, whether the individual could be adequately controlled if conditionally released.

Stat. Auth.: ORS 413.042 & 161.387; SB 420
Stats. Implemented: ORS 161.341 & ORS 161.351; SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0190

Status Hearing

The SHRP may hold a hearing at any time to review the status of the individual to determine whether a conditional release or discharge order is appropriate.

Stat. Auth.: ORS 413.042 & 161.327, SB 420
Stats. Implemented: ORS 161.336, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0195

Review Panel Order of Conditional Release

(1) In determining whether an order of conditional release is appropriate, the SHRP shall have as its goals the protection of the public, the best interests of justice and the welfare of the individual. The SHRP may consider the testimony and exhibits at the hearing regarding the individual's behavior in the hospital including the individual's progress, insight and responsibility taken for his or her own behavior.

(2) If the SHRP finds the individual may be controlled in the community and a verified conditional release plan is approved by the SHRP, the SHRP may order the individual placed on conditional release.

(3) If the SHRP finds the individual could be controlled in the community but no conditional release plan has been approved by the SHRP, the SHRP may order the individual to remain in a state hospital but find the individual appropriate for conditional release pending submission of a conditional release plan approved by the SHRP.

(a) The SHRP shall specify what conditions the plan should include and may approve the conditional release plan submitted by the staff of the state hospital, by the individual or someone on the individual's behalf at an administrative hearing.

(b) Following the procedures set forth in OAR 309-092-0178, the PSRB may provide the SHRP with conditions of release that the PSRB determines are advisable. If the SHRP orders the individual conditionally released, the SHRP shall include the conditions of release in the order.

(4) If a verified conditional release plan has not been approved and the conditions need further examination and approval by the SHRP, the SHRP may commit the individual, find the individual appropriate for conditional release or continue the hearing.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.336, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0200

Elements of Conditional Release Order

(1) The SHRP may consider any or all of the following elements of a conditional release plan and determine which are appropriate and necessary to insure the safety of the public. Following the procedures set forth in OAR 309-092-0178, the PSRB may provide the SHRP with conditions of release that the PSRB determines are advisable. If the SHRP orders the individual conditionally released, the SHRP shall include the conditions of release in the order

(a) Housing must be available for the individual. The SHRP may require 24-hour supervised housing, a supervised group home, foster care, housing with relatives or independent housing.

(b) Mental health treatment must be available in the community. The SHRP-approved provider of the treatment must have had an opportunity to evaluate the patient and the proposed conditional release plan and to be heard before the SHRP.

(A) The provider must have agreed to provide the necessary mental health treatment to the individual.

(B) The treatment may include individual counseling, group counseling, home visits, prescription of medication or any other treatment recommended by the provider(s) and approved by the SHRP.

(C) Reporting responsibility: An individual must be available to be designated by the PSRB as having primary reporting responsibility.

(2) Special conditions may be imposed, including but not limited to, the following: no consumption of alcohol, taking of antabuse, observation by designated individual of each ingestion of medication; submitting to drug screen tests; no driving; vocational activities; day treatment; attending school; working; or sex offender assessment and treatment.

(3) Parole and probation supervision may be ordered.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.336, SB 420

Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0205

The Authority’s Responsibility to Prepare Plan

(1) When a state hospital determines an individual may be ready for conditional release, the state hospital staff may request that the SHRP order an evaluation for community placement.

(2) The Division is responsible for and shall prepare the conditional release plan. In order to carry out the conditional release plan, the Division may contract with a community mental health program, other public agency, or Private Corporation or an individual to provide evaluations for community placement, supervision and treatment.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.336, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0210

Out-of-State Conditional Release Order

The SHRP may consider and approve a conditional release plan to have the individual reside out of state.

Stat. Auth.: ORS 413.042 & 161, SB 420 .
Stats. Implemented: ORS 161.336, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0215

Reconsideration

(1) A party to the hearing may request reconsideration of a Review Panel finding in writing. Also, on its own motion, the SHRP may reconsider the finding.

(2) If an issue is appropriately raised, the matter shall be remanded to the SHRP for hearing on that issue. Reconsideration may be upheld if:

(a) The written findings are found to be inaccurate or do not support the action taken by the SHRP;

(b) Substantial information material to the issues which was not known or which could not have been known at the time of the hearing is received;

(c) A material misrepresentation of facts or concealment of facts occurred; or

(d) The SHRP decision is contrary to the rules or statutes governing the SHRP.

(3) If the issues are not appropriately raised, the individual shall receive written notification of the reasons for denial of reconsideration.

(4) If good cause exists, a party to the hearing may request reconsideration by the Director. Subject to the Director’s discretion and determination of good cause, the Director may reconsider the SHRP’s findings by listening to the audio of the hearing and reviewing the exhibits from the hearing. The Director may overrule or sustain the SHRP’s findings. The Director may also remand the matter to the SHRP for further consideration.

Stat. Auth.: ORS 413.042 & 161.327, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0220

Judicial Review

(1) The Legislature has provided that a final Review Panel order shall be subject to review by the Court of Appeals upon petition to the court within 60 days of the issuance of the order in accordance with ORS 161.385(8).

(2) The SHRP shall provide the attorney for the individual and the court with the record of proceedings.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.385, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0225

Enforcement of Review Panel Orders

The SHRP may apply to the circuit court of the appropriate county for contempt proceedings under ORS 161.395 when its directive to an agency or person is not followed.

Stat. Auth.: ORS 413.042 & 161.327, SB 420
Stats. Implemented: ORS 161.395, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0230

Compliance

State or local community mental health programs shall comply with any order of the SHRP.

Stat. Auth.: ORS 413.042, 137.540, 161.327, 192.620, 430.630, SB 420
Stats. Implemented: ORS 161.336, 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0235

Custody of An Individual Who is a Substantial Danger to Others

The Legislature has provided that the community mental health program director, the director of the facility providing treatment to an individual on conditional release, any peace officer or any individual responsible for the supervision of the individual on conditional release may take or request that an individual on conditional release be taken into custody if there is reasonable cause to believe the individual is a substantial danger to others because of mental disease or defect and the person is in need of immediate care, custody or treatment. The individual shall be transferred to a state hospital designated by the Authority.

Stat. Auth.: ORS 413.042 & 161.387, SB 420
Stats. Implemented: ORS 161.346, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

309-092-0240

Leaves and Passes

(1) Any overnight or out-of-town leave of absence or pass request for SHRP individuals in a state hospital shall be signed by a physician and submitted to the hospital Risk Review Committee for initial consideration. A leave of absence or pass may be requested when the physician is of the opinion that a leave of absence or pass from the hospital would pose no substantial danger to others and would be therapeutic for the individual.

(2) If the hospital’s Risk Review Committee approves the request, the request and recommendation of the Risk Review Committee shall be presented to the SHRP for the purposes of ORS 161.326 (Notice to victim).

Stat. Auth.: ORS 413.042, 137.540, 161.315, 161.327, 161.332, 161.341, 161.346, 161.351, 161.365, 161.370, 161.390, 161.400, 192.690, 428.210, SB 420
Stats. Implemented: ORS 161.400, SB 420
Hist.: MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12; MHS 9-2012, f. & cert. ef. 6-19-12

DIVISION 102

HANDLING PATIENT MAIL IN STATE INSTITUTIONS

309-102-0100

Purpose and Scope

(1) Purpose. These rules prescribe the standards for handling mail belonging to patients in state institutions, including mail arriving for patients and mail patients are sending from the state institution.

(2) Scope. These rules apply to all individuals residing in a state institution as defined in OAR 309-102- 0005.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 179.360 & 426.385
Hist.: MHS 5-2011, f. & cert. ef. 8-3-11; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 1-2012, f. & cert. ef. 2-9-12

309-102-0110

Definitions

(1) "Contraband" means any controlled substance, drug paraphernalia, unauthorized currency or any other article which by statute, rule, order or the state institution's policies, is prohibited from being in a patient's possession, and the use of which could endanger the safety or security of the institution.

(2) "Controlled Substance" means a drug or its immediate precursor classified under the federal Controlled Substances Act and as modified under ORS 475.035.

(3) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(4) "Drug Paraphernalia" means all equipment, products and materials of any kind which are marketed for use or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, storing, containing, concealing, injecting, ingesting, inhaling or otherwise introducing into the human body a controlled substance in violation of ORS 475.840 to 475.980 ORS 475.525(2).

(5) "Electronic Mail" means digital messages transmitted electronically.

(6) "Journalist Mail" means any mail sent to news media organizations such as, but not limited to newspapers, magazines and television station news departments.

(7) "Legal Mail" means any mail received from or addressed to, any attorney, court, tribal official, elected official, disability rights organizations or advocacy group that is part of the system outlined in ORS 192.517.

(8) "Limited Item" means any food, non-prescribed medicine, vitamins, supplements or other article which is allowed for patient use, but which must be held or kept in a specific area for reasons of maintaining public health standards to ensure proper dosage or to limit its ingestion, viewing or other use to the owner of the item.

(9) "Mail" means any letter, post card, periodical or any other type of envelope or package, except for legal mail and journalist mail.

(10) "Patient" means a person who is residing in a state institution.

(11) "Prohibited Item" means:

(a) Alcohol, controlled substances or drug paraphernalia;

(b) Any item that reasonably could be used as or turned into a weapon or instrument of escape;

(c) Any item the possession of which is considered detrimental to the treatment of a specific patient and which is recorded as prohibited with the rationale in the patient's chart by the treating physician; or

(d) Any item the possession of which is disallowed to a clearly defined portion of the patient population or to the entire patient population pursuant to the institution's policies.

(12) "Reasonable Cause" means a person has knowledge or notice of facts or circumstances which would lead a person of ordinary care and prudence to have a strong suspicion that a specific piece of mail contains a prohibited or limited item.

(13) "Safety" means the institution and all patients and others persons within and around it are free from injury, threats, harassment, identity theft or other dangers.

(14) "Security" means prevention of any patient's potential escape from a state institution or the prevention of damage to institutional or personal property within the grounds of the state institution.

(15) "State Institution" means all Oregon State Hospital campuses including the Blue Mountain Recovery Center.

(16) "Superintendent" means the executive head of any state institution or that person's designee.

(17) "Treatment Care Plan" means an individualized and comprehensive written plan of therapeutic interventions designed, in collaboration between the patient and his or her treatment team, to facilitate rehabilitation of psychiatric symptoms and eventual independence.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.360 & 426.385

Hist.: MHS 5-2011, f. & cert. ef. 8-3-11; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 1-2012, f. & cert. ef. 2-9-12

309-102-0120

Patient Rights Related to Mail

(1) Except as outlined in OAR 309-102-0130 through 309-102-0140, all patients in state institutions shall have the right to communicate freely by sending and receiving sealed mail.

(2) All journalist, legal or other mail may be sent or delivered by hand or via any parcel delivery service.

(3) Except as provided in ORS 309-102-0130 through 309-102-0140, no employee or any person acting through or on behalf of the Division shall:

(a) Open, read, censor, inspect or otherwise examine any patient's incoming or outgoing mail without the expressed permission of the patient who is the sender or the receiver of the mail;

(b) Prevent, obstruct or delay any patient's outgoing mail from being promptly mailed; or

(c) Prevent, obstruct or delay any patient's incoming mail from being promptly delivered to the patient.

(4) Except as required for treatment reasons, employees having read or examined a patient's mail shall protect the patient's confidentiality by refraining from discussions related to the mail.

(5) A patient shall be promptly informed, verbally and in writing, of:

(a) Any limitation to the right to send or receive sealed mail;

(b) Any item having been opened by staff; and

(c) Any item being held pursuant to these rules.

(6) At the request of a patient with a need, an employee may assist in reading or sending mail. Need for this assistance shall first be documented in the patient's Treatment Care Plan by the physician.

(7) Patients shall be provided a reasonable amount of writing material by the state institution, as defined in policy. Stamps shall be available for purchase by patients with funds. Patients without funds will be provided a reasonable number of stamps by the state institution, as defined in policy.

(8) The exchange of electronic mail is an earned privilege and is related to the patient's recent behaviors, current level of care and other privileges.

(9) The application of these rules may be contested by way of the state institution's grievance procedures.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.360 & 426.385

Hist.: MHS 5-2011, f. & cert. ef. 8-3-11; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 1-2012, f. & cert. ef. 2-9-12

309-102-0130

Mail Suspected To Contain Contraband, Limited Items or Evidence of a Crime

(1) The superintendent may designate in writing, certain areas of the state institution as locked high security areas that require additional precautions to protect the safety and security of the facility.

(2) In designated areas, employees of the state institutions may open all except legal mail in the presence of the patient as prescribed in this rule, even though there may not be reasonable cause to believe that a specific piece of mail contains a prohibited or limited item.

(3) In order to ensure the health or safety of individuals or the safety or security of the institution, the superintendent may additionally order:

(a) Incoming and outgoing mail be scanned with non-invasive technology including but not limited to x-rays or metal detectors;

(b) Mailed electronic equipment or other items which may have had contraband placed within, be given additional scrutiny such as, but not limited to turning the item on to ensure its basic functionality or opening up the item to look inside.

(4) When there is reasonable cause to suspect mail contains a limited item, the superintendent may order the item be opened by staff in the presence of the patient.

(a) If a limited item is found within the mail, the item will be stored and made available to the patient pursuant to the state institution's related policies and procedures.

(b) If there is no limited or prohibited item within, the patient may retain possession of the limited item.

(5) When there is reasonable cause to suspect mail contains evidence of a real or potential crime, the following steps shall occur:

(a) If the real or potential crime may immediately threaten the health or safety of individuals or the safety or security of the institution or the health or safety of any affiliated person, the superintendent may hold, open or otherwise inspect the mail.

(b) If the real or potential crime does not appear to immediately threaten the health or safety of individuals or the safety or security of the institution, the superintendent is authorized to:

(A) Contact a law enforcement agency and request a judicial warrant to open the mail and

(B) Hold the mail until either the judicial warrant is denied or the warrant is received and the item is confiscated by the law enforcement agency.

(c) If the judicial warrant is denied the item must promptly be delivered to the patient.

(d) If the item is confiscated, opened and examined and found to be permissible the item must promptly be delivered to the patient.

(e) If the item is found to contain evidence of a real or potential crime, it will remain in possession of the law enforcement agency for further action.

(6) The intended recipient of any mail withheld pursuant to this rule will be promptly informed of the action unless there is reasonable cause to believe that doing so may:

(a) Increase the potential threat to the health or safety of individuals or the safety or security of the institution or

(b) Destroy or adversely alter the suspected evidence of a real or potential crime.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.360 & 426.385

Hist.: MHS 5-2011, f. & cert. ef. 8-3-11; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 1-2012, f. & cert. ef. 2-9-12

309-102-0140

Disposition of Mail Retained or Delivered To Patient

(1) Once opened under staff supervision for inspection, permissible items shall not be read or otherwise further inspected and shall be delivered without undue delay to the patient.

(2) Any item retained from a patient's mail shall be clearly marked to identify, at minimum the date of the inspection and retention, the patient's name, the name and address of the sender, a description of the held items and both the printed name and the signature of the employee conducting the process. The item shall then be handled as provided in the Division's rules related to the handling of personal property of patients in state institutions.

(3) When any item is confiscated by a law enforcement agency, each part of the process shall be documented in the patient's chart with, at minimum, the date of inspection and confiscation, the patient's name, the name and address of the sender, a description of the confiscated item or items and both the printed name and the signature of the employee who witnessed the law enforcement's confiscation.

(4) All documentation related to any held item shall be in writing and kept in the patient's chart. The patient shall receive a legible copy of each document.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.360 & 426.385

Hist.: MHS 5-2011, f. & cert. ef. 8-3-11; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 1-2012, f. & cert. ef. 2-9-12

309-102-0150

Notice to Patients and Employees

(1) Upon admission to the state institution, patients shall be informed of these rules and the institution's related policies and procedures, all their legal rights as detailed in ORS 426.385 and instructions on how to obtain a copy of these rules.

(2) The superintendent of the state institution shall ensure these rules and any related policies and procedures are thoroughly explained to each employee upon the commencement of their employment and annually thereafter.

(3) Violation of these rules and any related institutional policies or procedures by an employee of the Division shall constitute cause for disciplinary action.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.360 & 426.385

Hist.: MHS 5-2011, f. & cert. ef. 8-3-11; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 1-2012, f. & cert. ef. 2-9-12

DIVISION 104

TELEPHONE USE BY PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-104-0000

Purpose and Statutory Authority

(1) Purpose. These rules prescribe policy and procedures for the use of telephones by patients and residents in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 179.040 and 413.042 and carry out the provisions of 426.385 and 427.031.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.040 & 413.042

Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

309-104-0005

Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(3) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(4) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by 42 CFR 442.401 or as amended.

(5) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(6) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(7) "Superintendent" means the executive head of a state institution listed in section (6) of this rule.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.040 & 413.042

Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

309-104-0010

Policy

(1) All patients and residents have the right to make and receive telephone calls except as provided in section (4) of this rule.

(2) State institutions shall make available to patients and residents telephones which are accessible and ensure privacy.

(3) Except as stated in section (4) of this rule, no employee or any person acting through, or on behalf of, the Division shall monitor telephone conversations, or prevent or obstruct a patient or resident from making or receiving telephone calls.

(4) State institutions shall have the right to restrict use of telephones under the following circumstances:

(a) State institutions may set reasonable hours for telephone use by patients and residents for both incoming and outgoing calls. Exceptions to this provision are a patient's or resident's lawyer, clergy or personal physician, or in emergency situations;

(b) Unless the patient or resident objects, an employee may provide assistance in making or receiving telephone calls for those residents or patients who have physical or mental handicapping conditions which prevent them from performing these activities. Need for this assistance must be documented in the patient's or resident's chart by a physician or qualified mental retardation professional;

(c) State institutions have the right to reasonably restrict telephone usage if a patient or resident misuses or abuses access to telephones.

(5) Access to telephones shall not be denied in connection with any behavioral contingencies or earned privileges.

(6) State institutions may install public telephones on living units for patients and residents as long as the institution ensures that telephones are private, available, and accessible. Calls to a patient's or resident's attorney, private physician, or clergyman will not be restricted solely on account of funds.

(7) A patient or resident has the right to contest any restriction on access to telephones or other application of these rules as provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

(8) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division constitutes cause for disciplinary action.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.040 & 413.042

Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

309-104-0015

Procedures

(1) State institutions shall make known telephone availability and any restrictions to patients and residents on each living area.

(2)(a) Any restrictions in telephone usage for individual patients or residents must be by order of the treating physician or qualified mental retardation professional;

(b) Decisions by the physician or qualified mental retardation professional to restrict telephone usage must be documented in the patient's or resident's record by that professional. Specific reasons for the restriction must be clearly stated with supporting documentation as needed.

(3) State institutions must notify, in writing, the affected patient or resident of restrictions within 24 hours after imposing a restriction. The notification must state the reasons and duration of the restriction. There must be at least an oral explanation of the

patient's or resident's right to appeal the restriction through the Division's grievance procedures.

(4) Decisions to restrict telephone usage must be reviewed and, if necessary, renewed at least monthly by the physician or qualified mental retardation professional. Restrictions will expire unless renewed.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.040 & 413.042

Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

309-104-0020

Notice To Patients, Residents, and Employees

(1) Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.040 & 413.042

Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

DIVISION 106

VISITATION OF PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-106-0000

Purpose and Statutory Authority

(1) Purpose. These rules prescribe policy and procedures concerning visitation of patients and residents in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 179.040 and 413.042 and carry out the provisions of 426.385.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

309-106-0005

Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Addictions and Mental Health.

(2) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(3) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(4) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by 42 CFR 442.401 or as amended.

(5) "Reasonable Cause" means that the person must have knowledge or notice of facts and circumstances which would lead a person of ordinary care and prudence to have a strong suspicion.

(6) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(7) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(8) "Superintendent" means the executive head of the state institution as listed in section (7) of this rule.

(9) "Visitor" means any person who is not a patient or resident of a particular ward or cottage and is not a Division employee or volunteer regularly assigned to the state institution.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

309-106-0010

Policy

(1) The Division recognizes the needs of patients and residents to have access to and maintain contact with family members and the community of which they are a part as well as the needs of family and community members to have access to patients and residents. Except as provided in section (6) of this rule, patients and residents have the right to receive visits from anyone they wish.

(2) State institutions shall provide designated places for visitations to occur in as much comfort and privacy as possible.

(3) State institutions may set reasonable limitations on visitation hours.

(4) State institutions shall post visitation rules and restrictions on every living unit and in the administration area.

(5) A patient's or resident's lawyer, physician or clergy shall not be restricted to the time and place limitations established by the institution under sections (2) and (3) of this rule.

(6) State institutions shall have the right to restrict visitation under the following circumstances:

(a) The patient or resident refuses to see the visitor;

(b) Reasonable cause exists to believe that the visitor would be harmful to the patient's or resident's physical or mental health;

(c) The visitor's behavior is unreasonably disruptive to the institution or any part thereof;

(d) Reasonable cause exists to believe that the visitor would endanger the safety of patients, residents or staff by introducing contraband or assisting in planning or executing escape from the institution;

(e) The visit would constitute an unreasonable intrusion into the privacy of one or more residents or patients;

(f) Alcohol and drug programs in state institutions may impose a programmatic restriction on visitation of up to two weeks for newly admitted patients. Exceptions to this restriction are the patient's lawyer, clergy, and private physician;

(g)(A) The patient or resident has been adjudicated incompetent and has a legal guardian, or the patient or resident is an unemancipated minor;

(B) The legal guardian or custodial parent of the patient or resident has requested a restriction and has demonstrated good cause therefor; and

(C) The treating physician or qualified mental retardation professional has ordered the restriction pursuant to the request of the legal guardian or custodial parent.

(7) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division constitutes cause for disciplinary action.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

309-106-0015

Procedures

(1) Each institution shall designate a central location to initially receive visitors and shall make available information on visitation procedures and restrictions.

(2) Decisions by the physician or qualified mental retardation professional to restrict a visitor must be documented in the patient's or resident's record by that professional. Specific reasons for the restriction must be clearly stated with supporting documentation, as needed.

(3) State institutions must notify the affected patient or resident of a restriction in writing and within 24 hours of imposing the restriction. The notification must state the reasons and duration of restriction and explain to the patient or resident the right to appeal imposition of the restriction.

(4) Decisions to restrict a visitor must be reviewed and, if necessary, renewed at least monthly for a patient and at least quarterly for a resident by the physician or qualified mental retardation professional. Restrictions will expire unless renewed.

(5) A patient, resident, parent, guardian, or other persons significantly involved with a patient or resident has the right to contest any restriction on visitors or other application of these rules as pro-

vided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

309-106-0020

Notice to Patients, Residents, and Employees

(1) Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

DIVISION 108

HANDLING OF PERSONAL PROPERTY OF PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-108-0000

Purpose and Statutory Authority

(1) Purpose. These rules prescribe procedures for the handling of personal property of patients and residents in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 179.040 and 413.042 and carry out the provisions of 426.385 and 427.031.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83; MHD 7-1986, f. & ef. 9-4-86

309-108-0005

Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(3) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(4) "Prohibited Item" means:

(a) Alcoholic beverages, controlled substances, and prescription and non-prescription drugs or medications;

(b) Any item that reasonably can be used as a weapon or instrument of escape;

(c) Any item the possession of which is detrimental to the treatment and training or health and safety of the patients or residents in a particular ward or cottage and which is prohibited in writing and posted on the affected ward or cottage; and

(d) Any item the possession of which is detrimental to the treatment and training of an individual patient or resident and which is recorded in the treatment and training orders section of the patient's or resident's chart by the treating physician or qualified mental retardation professional.

(5) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by 42 CFR 442.401 or as amended.

(6) "Reasonable Cause" means that the person has knowledge or notice of facts and circumstances which would lead a person of ordinary care and prudence to have a strong suspicion.

(7) "Search" means a close inspection of a patient/resident's person, and a patient/resident's room or living area and personal property whenever there is a reasonable cause that said patient/resident may be in possession of a prohibited item.

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(8) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(9) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

(10) "Superintendent" means the executive head of the state institution as listed in section (9) of this rule.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83; MHD 7-1986, f. & ef. 9-4-86

309-108-0010

Policy

(1) All patients and residents shall have the right to retain and use on each ward or cottage reasonable amounts of personal property, other than prohibited items. State institutions shall provide on each ward or cottage private, adequate, and accessible storage for reasonable amounts of personal property:

(a) Patients and residents needing specific assistance in exercising the right to retain and use personal property shall receive such assistance. This shall be documented in the treatment or training plan;

(b) Each state institution shall develop procedures to protect the personal property of patients and residents against theft by other patients and residents.

(2) State institutions shall designate one or more locations for storage of reasonable amounts of excess personal property. Excess personal property is property which cannot be stored on the patient's or resident's ward or cottage due to size or amount.

(3) State institutions shall provide a secure location for storage of patients' and residents' valuables. Valuables include, but are not limited to, stocks, bonds, jewelry, cash above the amount permitted on the ward or cottage, heirlooms, credit cards, driver's license and any other small item, excluding prohibited items and excess property, which a patient or resident wants retained in a secure location.

(4) Excess property and valuables shall be returned to the patient or resident upon release or discharge of the patient or resident, or upon request of the patient or resident if there is space available on the ward or cottage to accommodate it.

(5) Prohibited items shall be handled as provided in OAR 309-108-0015(6).

(6) State institutions may restrict the amount of cash allowed to be retained by patients or residents on the living unit.

(7) A patient/resident may be searched by Division personnel whenever said personnel have reasonable cause to believe that a patient/resident may be in possession of a prohibited item.

(8) No employee or any person acting through, or on behalf of the Division shall censor a patient's or resident's personal property unless there is reasonable cause to believe that such item is contrary to the treatment and training goals of the individual. Such censorship must be documented in the patient's or resident's record by the treating physician or qualified mental retardation professional with supporting documentation, as necessary and communicated to the patient or resident in writing.

(9) Patients and residents shall have the right to appeal the application of any portion of these rules as provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

(10) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division constitutes cause for disciplinary action.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83; MHD 7-1986, f. & ef. 9-4-86

309-108-0015

Procedures

(1) All personal property that a patient or resident brings into the institution at the time of admission must be itemized in writing with an accompanying description, regardless of where the item is stored.

(2) Staff shall encourage and assist patients and residents to mark all personal property in such a way which identifies it as an individual patient's or resident's possession.

(3) Any medications brought by the patient or resident at the time of admission should be sent home with a legal guardian or family member if possible. If this is not possible, the medication must be marked with the patient's or resident's name and case number and sent to the pharmacy of the state institution until the patient or resident is discharged.

(4) Patients and residents may bring, or have brought or sent in, nutritional supplements (e.g., vitamins and minerals), and may use them provided that the patient's or resident's treating physician inspects, tests, or otherwise checks the substance claimed to be a nutritional supplement and determines that:

(a) The substance is a nutritional supplement;

(b) The substance is safe for human consumption or use; and

(c) Use or consumption of the nutritional supplement will not interfere with the testing, diagnosis, treatment, or training of the patient or resident; and

(d) The nutritional supplements are kept by the ward or cottage staff in a secure place and dispensed upon request.

(5) Any items sent through the mail or given by a visitor to a patient or resident become the personal property of that patient or resident and shall be handled in accordance with the procedures set forth in these rules.

(6) Prohibited items shall be handled as follows:

(a) The rules regarding the possession of prohibited items shall be discussed with the patient or resident and if the patient or resident is an unemancipated minor or legally incapacitated, the patient's or resident's parent or legal guardian, and such items shall be disposed of as follows:

(A) Given to the patient's or resident's parent, guardian, spouse, friend, attorney, or other person designated by the patient or resident;

(B) In the case of gifts, returned to the sender or giver;

(C) Kept in a secure location on the ward or cottage or central location of the institution for delivery to the patient or resident upon release or discharge from the institution; or

(D) Destroyed in the presence of at least two employees of the state institution.

(b) If agreement cannot be reached over the disposition of such items, the patient or resident may appeal the proposed disposition of prohibited items pursuant to the Division's grievance procedures in OAR 309-118-0000 through 309-118-0050. The state institution must retain the prohibited item in a secure location until a decision is made;

(c) The possession of items prohibited by law shall be turned over to the appropriate law enforcement authorities.

(7) Searches shall adhere to the following restrictions:

(a) Except for visual inspection of nose, mouth or ears without digital intrusion, all internal examinations must be conducted by either a physician or a nurse and only upon authorization of the superintendent or designee;

(b) Except for physicians and nurses, only same sex personnel shall carry out searches of a patient/resident's person except in emergencies;

(c) Upon completion of searches of a patient/resident's living area and personal property staff shall return the area to a neat and orderly condition and ensure that authorized property is in no way damaged or dispossessed.

(8) State institutions shall develop written procedures for handling missing personal property. These procedures may include the involvement of law enforcement authorities.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.385

Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83; MHD 7-1986, f. & ef. 9-4-86

309-108-0020

Notice to Patients, Residents, and Employees

(1) Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple

statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 179.321, 426.385
Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83

DIVISION 112

USE OF RESTRAINT FOR PATIENTS IN STATE INSTITUTIONS

309-112-0000

Purpose and Statutory Authority

(1) Purpose. These rules prescribe policies and procedures concerning the use of restraint in the treatment, and behavior management of patients in state institutions operated by the Division. In addition to these general rules, other more specific requirements established by federal regulations must be followed where applicable.

(2) Statutory Authority. These rules are authorized by ORS 179.040 and 413.042 and carry out the provisions of 426.385.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 426.385
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

309-112-0005

Definitions

As used in these rules:

(1) "Chief Medical Officer" means the physician designated by the superintendent of each state institution pursuant to ORS 179.360(1)(f) who is responsible for the administration of medical treatment at each state institution, or his or her designee.

(2) "Division" means the Division of State Hospitals of the Oregon Health Authority.

(3) "Interdisciplinary Team (IDT)" means a group of professional and direct care staff which has primary responsibility for the development of a plan for the care and treatment of an individual patient.

(4) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(5) "Restraint" means one or more of the following procedures:

(a) "Personal Restraint" means a procedure in which a patient or resident is placed in a prone or supine position or held in a chair by another person in order to restrict the physical movement of the patient or resident;

(b) "Physical Restraint" means a device which restricts the physical movement of a patient and which cannot be removed by the person and is not a normal article of clothing, a therapy device, or a simple safety device; or

(c) "Seclusion" means the placement of a patient alone in a locked room.

(6) "Restraint Review Committee" means the committee appointed by the superintendent of each state institution as provided in OAR 309-112-0030.

(7) "Security Area" means a cottage or unit in which a program is conducted for dangerous patients, including those judged guilty except for insanity, those court ordered into a secure program prior to trial, and those court committed patients not manageable in less secure programs.

(8) "Security Transportation" means using physical restraint while a patient is being transported outside a security area.

(9) "State Institution" means Oregon State Hospital in Salem and Junction City.

(10) "Superintendent" means the executive head of the state institution as listed in section (11) of this rule, or his or her designee.

Stat. Auth.: ORS 179.040 & 413.042
Stats. Implemented: ORS 426.385
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 11-1982(Temp), f. & ef. 6-10-82; MHD 21-1982, f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 2-1986, f. & ef. 3-31-86; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

309-112-0010

General Policies Concerning Use of Restraint

(1) State institutions shall not use restraint except in emergencies, as provided in OAR 309-112-0015, or as part of planned treatment programs as provided in 309-112-0017, and only then subject to the conditions and limitations of these rules. An order for physical restraint may not be in effect longer than 12 hours. No form of restraint shall be used as punishment, for the convenience of staff, or as a substitute for activities, treatment, or training.

(2) State institutions shall provide training in the appropriate use of restraint to all employees having direct care responsibilities.

(3) Medication will not be used as a restraint, but will be prescribed and administered according to acceptable medical, nursing, and pharmaceutical practices.

(4) Patients shall not be permitted to use restraint on other patients.

(5) Physical restraint must be used in accordance with sound medical practice to assure the least risk of physical injury and discomfort. Any patient placed in physical restraint shall be protected from self-injury and from injury by others.

(7) Checking a patient in restraint:

(a) A patient in restraint must be checked at least every 15 minutes;

(b) Attention shall be paid to the patient's basic personal needs (such as regular meals, personal hygiene, and sleep) as well as the patient's need for good body alignment and circulation;

(c) Staff shall document that the patient was checked and appropriate attention paid to the person's needs.

(8) During waking hours the patient must be exercised for a period not less than 10 minutes during each two hours of physical restraint. Partial release of physical restraint shall be employed as necessary to permit motion and exercise without endangering other staff and patients.

(9) Unless the order authorizing use of restraint specifically provides otherwise, the patient shall be released as soon as it is reasonable to assume that the behavior causing use of restraint will not immediately resume if the patient is released.

(10) OAR 309-112-0015 and 309-112-0017 require staff of state institutions to apply the most appropriate form of restraint consistent with the patient's behavior requiring intervention, the need to protect the staff and other patients, the patient's treatment or training needs and preservation of the patient's sense of personal dignity and self-esteem. The determination of the most appropriate intervention requires consideration of the following factors:

(a) The individual patient involved; e.g., the present physical ability to engage in violent or destructive behavior, any preference the individual patient has for one method of behavior management versus another, and the patient's reaction to various methods of intervention;

(b) The risk or degree of physical or psychological harm and discomfort that accompany the various methods of intervention;

(c) The risk or degree of interference with the individual's ongoing treatment or training and other activities.

(11) A summary of all uses of restraint, other than personal restraint for 15 minutes or less, shall be sent to the chief medical officer at least monthly.

(12) The following types of procedures are part of ordinary and customary medical care for physical illnesses or conditions and are not subject to the provisions of these rules:

(a) Holding or restraining a patient during an examination, blood drawing, performance of a diagnostic test or during treatment for an acute medical condition;

(b) Restricting movement with orthopedic devices such as casts, wheel chairs, braces, and positioning devices;

(c) Isolating a patient with a known or suspected infectious disease;

(d) Protecting seizure-prone and self-abusive patients by the use of protective gear.

(13) A patient, guardian, or a duly authorized representative of the patient, or guardian has the right to contest any application of these rules as provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

(14) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division constitutes cause for disciplinary action.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385

Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 11-1982(Temp), f. & ef. 6-10-82; MHD 21-1982, f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 16-1985(Temp), f. & ef. 10-9-85; MHD 2-1986, f. & ef. 3-31-86; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

309-112-0015

Use of Restraint in Emergencies

(1) Subject to the provisions of these rules, restraint may be used to manage the behavior of a patient in emergencies. An emergency exists, as determined by the chief medical officer or designee if, because of the behavior of a patient:

(a) There is a substantial likelihood of immediate physical harm to the patient or others in the institution; and

(b) There is a substantial likelihood of significant property damage; or

(c) The patient's behavior seriously disrupts the activities of other patients on the unit or cottage; and

(d) Measures other than the use of restraint are deemed ineffective to manage the behavior.

(2)(a) When an emergency exists, the staff of a state institution shall select the most appropriate intervention consistent with OAR 309-112-0010(9);

(b) Whenever the interdisciplinary team (IDT) has reason to believe that in the course of a patient's care, custody, or treatment at a state institution it may become necessary to use restraint in an emergency, a member of the IDT shall, if practicable, ask the patient for an expression of preference or aversion to the various forms of intervention. A member of the IDT shall also ask the parent or guardian for an expression of preference regarding forms of intervention. The patient's expression, if any, as well as that of the parent or guardian shall be relayed to the other IDT members and recorded in the patient's chart;

(c) The patient's wishes for or against particular forms of intervention shall be respected by the person authorizing the use of restraint, provided that primary consideration shall be given to the need to protect the patient and others in the institution.

(3) Authorization:

(a) Except as provided in subsections (3)(d) and (e) of this rule, restraint shall be administered only pursuant to the order of the chief medical officer or the chief medical officer's designee;

(b) For the purposes of this section, the chief medical officer may designate one or more of the following persons: A physician licensed to practice medicine in the State of Oregon, a psychologist, or a psychiatric/mental health nurse practitioner;

(c) The chief medical officer or designee shall order the use of restraint only after adequately assessing the patient's condition and the environmental situation;

(d) If the chief medical officer or designee is not available immediately to assess the need for intervention, and an emergency exists as defined in section (1) of this rule:

(A) The person in charge of the unit or cottage at the time:

(i) May authorize temporary use of restraint for a period of time not to exceed 30 minutes; and

(ii) Shall immediately contact the chief medical officer or his or her designee.

(B) The chief medical officer or designee shall personally observe the patient as soon as practicable to assess the patient and assess the appropriateness of the temporary use of restraint. The observation shall be documented in the person's chart.

(e) Every incident of personal restraint must be ordered by the chief medical officer or his or her designee, or as provided in subsection (3)(d) of this rule. The order may be oral or written but shall be documented as provided in section (4) of this rule.

(4) Documentation:

(a) No later than the end of their work shifts, the persons who authorized and carried out the use of restraint shall document in the patient's chart including but not necessarily limited to:

(A) The specific behavior which required intervention;

(B) The method of intervention used and the patient's response to the intervention; and

(C) The reason this specific intervention was used.

(b) Within 24 hours after the incident resulting in the use of restraint, the chief medical officer or designee who ordered the intervention shall review and sign the documentation. In the case of patients detained in a psychiatric hospital pursuant to an emergency hold under ORS 426.180 through 426.225, the treating physician shall sign the documentation, if the treating physician is not the chief medical officer or designee who ordered the intervention.

(5) Time Limits: All orders authorizing use of restraint shall contain an expiration time, not to exceed 12 hours and consistent with OAR 309-112-0010(8). Upon personal re-examination of the patient, the chief medical officer or designee may extend the order for up to 12 hours at each review, provided that the behavior of the patient justifies extended intervention. After each 24 hours of continuous restraint, a second opinion from another designee of the chief medical officer shall be required for further extension of the restraint.

(6) Reporting: Under this rule all emergency uses of restraint in excess of 15 minutes shall be reported daily to the chief medical officer or designee.

(7) After the second use of emergency restraint on a particular patient during a one-month period, a treatment program designed to reduce the need for restraint must be developed.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385

Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 2-1986, f. & ef. 3-31-86; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

309-112-0017

Use of Restraint as Part of Planned Treatment or Training Programs

Subject to the provisions of these rules, restraint may be used as part of planned treatment program provided the informed consent of the patient is obtained or, if informed consent cannot be obtained, authorization to proceed with necessary treatment is obtained as provided in OAR 309-114-0000 through 309-114-0025.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385

Hist.: MHD 11-1982(Temp), f. & ef. 6-10-82; MHD 21-1982, f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

309-112-0020**Use of Security Transportation**

The chief medical officer or designee may authorize the use of secure transportation for patients of a secure program when outside the security area.

Stat. Auth.: ORS 179.040 & 413.042
 Stats. Implemented: ORS 426.385 & 427.031
 Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

309-112-0025**Use of Restraint for Acute Medical Conditions**

(1) During medical treatment for acute physical conditions, personal and physical restraint may be used to prevent a patient from injuring himself or herself.

(2) Use of a restraint in the presence of a physician may be authorized verbally; ongoing or continuing use of personal or physical restraint must be ordered in writing by a physician.

(3) Treatment staff shall:

(a) Attend to the patient's basic personal needs and exercise needs in accordance with general medical practice; and

(b) To the extent practicable, accommodate the patient's mental disabilities treatment and training regimen.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385
 Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

309-112-0030**Restraint Review Committee**

(1) Each state institution shall have a Restraint Review Committee. The members of the committee shall be appointed by the superintendent of each institution and shall consist of five members; two from institution staff and three community persons who are knowledgeable in the field of mental health. A quorum shall consist of three members. The committee may be one formed specifically for the purposes set forth in this rule, or the duties prescribed in this rule may be assigned to an existing committee.

(2) The purpose and duty of the Restraint Review Committee is to review and evaluate at least quarterly the appropriateness of all such interventions and report its findings to the superintendent.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385
 Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 12-1982, f. & ef. 6-10-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

309-112-0035**Notice to Patients and Employees**

(1) Upon admission, state institutions shall inform patients orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385
 Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; Administrative correction, 8-21-13; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; MHS 2-2016, f. & cert. ef. 4-21-16

DIVISION 114**INFORMED CONSENT TO TREATMENT AND TRAINING BY PATIENTS IN STATE INSTITUTIONS****309-114-0000****Purpose**

Purpose. These rules prescribe standards and procedures to be observed by personnel of state institutions operated by Division in obtaining informed consent to significant procedures, as defined by these rules, from patients of such state institutions. These rules do not apply to routine medical procedures. Administration of significant procedures without informed consent is permitted as described in OAR 309-114-0010(1)(b). The purpose of these rules is to assure that the rights of patients are protected with respect to significant procedures.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.070 & 426.385
 Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08; MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 12-2013(Temp), f. & cert. ef. 10-29-13 thru 4-27-14; MHS 9-2014, f. & cert. ef. 4-24-14; MHS 5-2015, f. & cert. ef. 8-28-15; MHS 5-2016, f. & cert. ef. 5-25-16

309-114-0005**Definitions**

As used in these rules:

(1) "Authorized Representative" or "representative" means an individual who represents a party in a contested case hearing; the representative must be supervised by an attorney that is licensed by the Oregon State Bar.

(2) "Chief Medical Officer" means the physician designated by the superintendent of each state institution pursuant to ORS 179.360(1)(f) who is responsible for the administration of medical treatment at each state institution.

(3) "Committed" or "Commitment" means an individual is admitted under ORS 161.327, 161.328, 161.370, 426.701, 426.130, 427.215 or 426.220 when the individual's guardian or health care representative is unavailable or unable to consent

(4) "Dangerousness" means either:

(a) A substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats, including verbal threats or attempts to commit suicide or inflict physical harm on him or herself. Evidence of substantial risk may include information about historical patterns of behavior that resulted in serious harm being inflicted by an individual upon him or herself as those patterns relate to the current risk of harm;

(b) A substantial risk that physical harm will be inflicted by an individual upon another individual, as evidenced by recent acts, behavior or threats, including verbal threats, which have caused such harm or which would place a reasonable person in reasonable fear of sustaining such harm. Evidence of substantial risk may include information about historical patterns of behavior

(5) "Division" means the State Hospitals Division of the Oregon Health Authority.

(6) "Guardian" means a legal guardian who is an individual appointed by a court of law to act as guardian of a minor or a legally incapacitated person.

(7) "Health Care Representative" means a person who has authority to make health care decisions for a patient.

(8) "Legally Incapacitated" means having been found by a court of law under ORS 426.295 to be unable, without assistance, to properly manage or take care of one's personal affairs, or who is a person under guardianship.

(9) "Material Risk." A risk is material if it may have a substantial adverse effect on the patient's psychological or physical health, or both. Tardive dyskinesia is a material risk of neuroleptic medication. Other risks include, but are not limited to raised blood pressure, onset of diabetes and metabolic changes.

(10) "Medication Educator" means a Qualified Mental Health Professional (QMHP) who provides information about the proposed significant procedures to patients.

(11) "Patient" means an individual who is receiving care and treatment in a state institution for the mentally ill.

(12) Patient with a "grave disability" means a patient who:

(a) Is in danger of serious physical harm to his or her health or safety absent the proposed significant procedures; or

(b) Manifests severe deterioration in routine functioning evidenced by loss of cognitive or volitional control over his or her actions which is likely to result in serious harm absent the proposed significant procedures.

(13) "Person Committed to the Division" or "Person" means an individual committed under ORS 161.327, 161.328, 426.701, 426.220, 161.370, 426.130, or 427.215.

(14) "Psychiatric Nurse Practitioner," means a registered nurse with prescription authority who independently provides health care to clients with mental and emotional needs or disorders.

(15) "Qualified Mental Health Professional" (QMHP) means any individual meeting the following minimum qualifications as documented by the state institution:

(a) Graduate degree in psychology;

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

(c) Graduate degree in social work or counseling;

(d) Graduate degree in a behavioral science field;

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

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

(g) Bachelor's or graduate degree in a relevant area.

(16) "Routine Medical Procedure" means a procedure customarily administered by facility medical staff under circumstances involving little or no risk of causing injury to a patient including, but not limited to physical examinations, blood draws, influenza vaccinations, tuberculosis (TB) testing, human immunodeficiency virus (HIV) testing and hygiene.

(17) "Significant Procedure" means a diagnostic or treatment modality and all significant procedures of a similar class that pose a material risk of substantial pain or harm to the patient such as, but not limited to psychotropic medication and electro-convulsive therapy. Significant procedures do not include routine medical procedures.

(18) "Significant Procedures of a Similar Class" means a diagnostic or treatment modality that presents substantially similar material risks as the significant procedure listed on the treating physician's or psychiatric nurse practitioner's informed consent form and is generally considered in current clinical practice to be a substitute treatment or belong to the same class of medications as the listed significant procedure.

(a) For purposes of these rules, medications listed in subsections 14(a)(A) through 14(a)(F) of this rule will be considered the same or similar class of medication as other medications in the same subsection:

(A) All medications used under current clinical practice as antipsychotic medications including typical and atypical antipsychotic medications;

(B) All medications used under current clinical practice as mood stabilizing medications;

(C) All medications used under current clinical practice as antidepressants;

(D) All medications used under current clinical practice as anxiolytics;

(E) All medications used under current clinical practice as psychostimulants; and

(F) All medications used under current clinical practice as dementia cognitive enhancers.

(b) Significant procedures of the same or similar class do not need to be specifically listed on the treating physician's or psychiatric nurse practitioner's form.

(19) "State Institution" or "Institution" means all Oregon State Hospital campuses and the Blue Mountain Recovery Center.

(20) "Superintendent" means the executive head of the state institution listed in section (18) of this rule, or the superintendent's designee.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 183.458, 426.070 & 426.385

Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-88), cert. ef. 6-1-88; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08; MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 1-2009(Temp), f. & cert. ef. 1-23-09 thru 7-22-09; MHS 2-2009(Temp), f. & cert. ef. 4-2-09 thru 7-22-09; MHS 3-2009, f. & cert. ef. 6-26-09; MHS 6-2009, f. & cert. ef. 12-28-09; MHS 5-2010(Temp), f. & cert. ef. 3-12-10 thru 9-8-10; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 13-2010(Temp), f. & cert. ef. 11-19-10 thru 5-18-11; MHS 4-2011, f. & cert. ef. 5-19-11; MHS 15-2014(Temp), f. & cert. ef. 12-1-14 thru 5-29-15; MHS 2-2015(Temp), f. & cert. ef. 4-24-15 thru 10-20-15; MHS 5-2015, f. & cert. ef. 8-28-15; MHS 8-2015(Temp), f. & cert. ef. 11-24-15 thru 5-20-16; MHS 5-2016, f. & cert. ef. 5-25-16

309-114-0010

General Policy on Obtaining Informed Consent to Treatment and Training

(1)(a) Basic Rule. Patients, or parents or guardians of minors, or guardians on behalf of legally incapacitated patients, may refuse any significant procedure and may withdraw at any time consent previously given to a significant procedure. Any refusal or withdrawal or withholding of consent shall be documented in the patient's record.

(b) Personnel of a state institution shall not administer a significant procedure to a patient unless written informed consent is obtained from or on behalf of the patient in the manner prescribed in these rules, except as follows:

(A) Administration of significant procedures to legally incapacitated patients as provided in section (6) of this rule;

(B) Administration of significant procedures without informed consent in emergencies under OAR 309-114-0015;

(C) Involuntary administration of significant procedures with good cause to persons committed to the Division under OAR 309-114-0020; or

(D) Involuntary administration of significant procedures pursuant to a valid court order.

(2) Capacity of the patient: In order to consent to, or refuse, withhold, or withdraw consent to significant procedures, the patient must have the capacity to make a decision concerning acceptance or rejection of a significant procedure, as follows:

(a) Unless adjudicated legally incapacitated for all purposes or for the specific purpose of making treatment decisions, a patient shall be presumed competent to consent to, or refuse, withhold, or withdraw consent to significant procedures. A person committed to the Division may be deemed unable to consent to or refuse, withhold, or withdraw consent to a significant procedure only if the person currently demonstrates an inability to reasonably comprehend and weigh the risks and benefits of the proposed procedure, alternative procedures, or no treatment at all including, but not limited to, all applicable factors listed in (3)(a) of this rule. The patient's current inability to provide informed consent is to be documented in the patient's record and supported by the patient's statements or behavior; and may be evidenced in the treating physician's or psychiatric nurse practitioner's informed consent form, the evaluation form by the independent examining physician and forms approving or disapproving the procedure by the superintendent or chief medical officer;

(b) A person committed to the Division shall not be deemed unable to consent to or refuse, withhold, or withdraw consent to a significant procedure merely by reason of one or more of the following facts:

(A) The person has been involuntarily committed to the Division;

(B) The person has been diagnosed as mentally ill;

(C) The person has disagreed or now disagrees with the treating physician's or psychiatric nurse practitioner's diagnosis; or

(D) The person has disagreed or now disagrees with the treating physician's or psychiatric nurse practitioner's recommendation regarding treatment.

(c) If a court has determined that a patient is legally incapacitated, then consent shall be sought from the legal guardian.

(3) Procedures for Obtaining Informed Consent and Information to be Given: The person from whom informed consent to a significant procedure is sought shall be given information, orally and in

writing, the substance of which is to be found on the treating physician's or psychiatric nurse practitioner's informed consent form. In the case of medication, there shall be attached a preprinted information sheet on the risks and benefits of the medication listed on the treating physician's or psychiatric nurse practitioner's form. All written materials under this rule will be provided in English. However, if the institution has reason to believe a patient has limited English language proficiency or the patient requests it, then the institution will make reasonable accommodations to provide the patient with meaningful access to the information, such as providing the patient with copies of the materials in the patient's native language if the materials are readily available in that language or providing the opportunity to have an interpreter orally translate written materials into the patient's native language. Specific information about significant procedures of a similar class will not be provided to or discussed with the patient.

(a) The information shall describe:

(A) The nature and seriousness of the patient's mental illness or condition;

(B) The purpose of the significant procedures listed on the treating physician's or psychiatric nurse practitioner's form, the intended outcome and the risks and benefits of the procedures;

(C) Any alternatives, particularly alternatives offering less material risks to the proposed significant procedure that are reasonably available and reasonably comparable in effectiveness;

(D) If the proposed significant procedure is medication, facility medical staff shall give the name, dosage range, and frequency of administration of the medication listed on the treating physician's or psychiatric nurse practitioner's form, and shall explain the material risks of the medication at that dosage range.

(E) The side effects of the intended medication or electro-convulsive therapy;

(F) The predicted medical, psychiatric, social, or legal consequences of not accepting the significant procedure or any comparable procedure, including any potential risk the patient represents to the health and safety of the patient, or others, which may include, but is not limited to, a consideration of the patient's history of violence and its relationship to mental health treatment if he or she does not receive the significant procedure;

(G) That consent may be refused, withheld or withdrawn at any time; and

(H) Any additional information concerning the proposed significant procedure requested by the patient.

(b) A medication educator shall assist by providing information to the patient that explains the proposed significant procedure, as described in subsection (3)(a)(B) and (E) of this rule;

(c) The treating physician or psychiatric nurse practitioner intending to administer a significant procedure shall document in the patient's chart that the information required in subsection (3)(a) of this rule was explained and that the patient, parent or guardian of a minor or guardian of a legally incapacitated patient explicitly consented, refused, withheld or withdrew consent. The treating physician or psychiatric nurse practitioner may document this by completing the informed consent form and make it part of the patient's record.

(4) When discussing the significant procedure with the treating physician or psychiatric nurse practitioner and the medication educator, the patient may request additional information about the significant procedure pursuant to OAR 309-114-0010(3)(a)(H) and present additional information relevant to making his or her decision.

(5) Voluntary Consent: Consent to a proposed significant procedure must be given voluntarily, free of any duress or coercion. Subject to the provisions of OAR 309-114-0020, the decision to refuse, withhold or withdraw consent previously given shall not result in the denial of any other benefit, privilege, or service solely on the basis of refusing, withholding or withdrawing consent. A voluntary patient may be discharged from the institution if offered procedures are refused.

(6) Obtaining Consent with Respect to Legally Incapacitated Patients: A state institution may not administer a significant procedure

to a legally incapacitated patient without the consent of the guardian, or, in the case of a minor, the parent or guardian, except in the case of an emergency under OAR 309-114-0015, where the institution has good cause to involuntarily administer a significant procedure under 309-114-0020, or pursuant to a valid court order. In order to prove good cause, the institution must prove 309-114-0020(1)(a) and (1)(d) in reference to the guardian and 309-114-0020(1)(b) and (1)(c) in reference to the patient.

(7) Reports of Progress: A patient, the parents or guardian of a minor patient, or the guardian of a legally incapacitated patient shall, upon request, be informed of the progress of the patient during administration of the significant procedure.

(8) These rules will be effective as of December 1, 2007 on all new orders for administration of significant procedures without informed consent. This includes new orders written after expiration of the previous order. This rule will be effective for existing, unexpired orders as of January 1, 2008, on a phased-in schedule that will accommodate as many new hearings as is practicable to schedule each week.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.070 & 426.385

Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-88), cert. ef. 6-1-88; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08; MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 1-2009(Temp), f. & cert. ef. 1-23-09 thru 7-22-09; MHS 3-2009, f. & cert. ef. 6-26-09; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 12-2013(Temp), f. & cert. ef. 10-29-13 thru 4-27-14; MHS 9-2014, f. & cert. ef. 4-24-14; MHS 2-2015(Temp), f. & cert. ef. 4-24-15 thru 10-20-15; MHS 5-2015, f. & cert. ef. 8-28-15

309-114-0015

Administration of Significant Procedures Without Informed Consent in Emergencies

(1) An emergency exists if in the opinion of the chief medical officer or designee:

(a) Immediate action is required to preserve the life or physical health of the patient and it is impracticable to obtain informed consent as provided in OAR 309-114-0010; or

(b) Immediate action is required because the behavior of the patient creates a substantial likelihood of immediate physical harm to the patient or others in the institution and it is impracticable to obtain informed consent as provided in OAR 309-114-0010.

(2) If an emergency exists, the chief medical officer or designee may administer a significant procedure to a patient without obtaining prior informed consent in the manner otherwise required by these rules provided:

(a) The specific nature of each emergency and the procedure which was used to deal with the emergency are adequately documented in the patient's record and a form provided for emergency procedure is completed and placed in the patient's record;

(b) Reasonable effort shall be made to contact the parent or legal guardian prior to the administration of the significant procedure. If contact is not possible, notice shall be given to the parent or legal guardian as soon as possible;

(c) Within a reasonable period of time after an emergency procedure is administered, the treatment team shall review the treatment or training program and, if practicable, implement a treatment or training program designed to correct the behavior creating the emergency; and

(d) The administration of a significant procedure in an emergency situation does not allow the institution to administer these procedures, once the emergency has subsided, without obtaining informed consent.

Stat. Auth.: ORS 179.040, 413.042

Stats. Implemented: ORS 179.321, 426.070 & 426.385

Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-88), cert. ef. 6-1-88; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08; MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 2-2015(Temp), f. & cert. ef. 4-24-15 thru 10-20-15; MHS 5-2015, f. & cert. ef. 8-28-15

309-114-0020

Involuntary Administration of Significant Procedures to Persons Committed to the Division with Good Cause

(1) Good cause: Good cause exists to administer a significant procedure to a person committed to the Division without informed consent if in the opinion of the treating physician or psychiatric nurse practitioner after consultation with the treatment team, the following factors are satisfied:

(a) Pursuant to OAR 309-114-0010(2), the person is deemed unable to consent to, refuse, withhold or withdraw consent to the significant procedure. This determination must be documented on the treating physician's or psychiatric nurse practitioner's informed consent form and the independent examining physician's evaluation form. It must include the specific questions asked and answers given regarding the patient's ability to weigh the risks and benefits of the proposed treatment, alternative treatment and no treatment including, but not limited to all relevant factors listed in 309-114-0010(3)(a).

(b) The proposed significant procedure will likely restore or prevent deterioration of the person's mental or physical health, alleviate extreme suffering or save or extend the person's life. This factor is established conclusively for purposes of a hearing under OAR 309-114-0025 by introducing into evidence the treating physician's or psychiatric nurse practitioner's informed consent form and the independent examining physician's evaluation form, unless this factor is affirmatively raised as an issue by the patient or his or her representative at the hearing.

(c) The proposed significant procedure is the most appropriate treatment for the person's condition according to current clinical practice all other less intrusive procedures have been considered and all criteria and information set forth in OAR 309-114-0010(3)(a) were considered. This factor is established conclusively for purposes of a hearing under 309-114-0025 by introducing into evidence the treating physician's or psychiatric nurse practitioner's informed consent form and the independent examining physician's evaluation form, unless this factor is affirmatively raised as an issue by the patient or his or her representative at the hearing.

(d) The institution made a conscientious effort to obtain informed consent from the patient. This factor is established conclusively for purposes of a hearing under OAR 309-114-0025 by introducing into evidence the treating physician's or psychiatric nurse practitioner's informed consent form and the medication educator's form or progress note, unless this factor is affirmatively raised as an issue by the patient or his or her representative at the hearing. If the institution has reason to believe a patient has limited English language proficiency or the patient requests it, the institution will make reasonable accommodations to provide the patient with meaningful access to the informed consent process, such as providing the patient with the opportunity to have an interpreter orally translate written materials into the patient's native language and provide translation during the treating physician's or psychiatric nurse practitioner's attempts to obtain informed consent and the medication educator's attempt to provide information about the significant procedure. A "conscientious effort" to obtain informed consent means the following:

(A) The patient's treating physician or psychiatric nurse practitioner made at least two good faith attempts to obtain informed consent by attempting to explain the procedure to the patient and documenting those efforts in the patient's record; and

(B) The medication educator made at least one good faith attempt to provide the information required in OAR 309-114-0010(3)(a)(B) and (E) and explain and discuss the proposed procedure with the patient.

(e) Because of the preliminary nature of their commitment, the following additional findings must be made for patients under ORS 161.370 jurisdiction in order to show good cause under this rule:

(A) Medication is not requested for the sole purpose of restoring trial competency; and

(B) The patient is being medicated because of the patient's dangerousness or to treat the patient's grave disability.

(2) Independent Review: Prior to granting approval for the administration of a significant procedure for good cause to a person committed to the Division, the superintendent or chief medical officer of a state institution for the mentally ill shall obtain consultation and approval from an independent examining physician, or if a patient refuses to be examined, the superintendent or chief medical officer shall document that an independent examining physician made at least two good faith attempts to examine the patient. The superintendent or chief medical officer shall maintain a list of independent examining physicians and shall seek consultation and approval from independent examining physicians selected on a rotating basis from the list. The independent examining physician shall not be an employee of the Division, shall be a board-eligible psychiatrist, shall have been subjected to review by the medical staff executive committee as to qualifications to make such an examination, shall have been provided with a copy of administration rules OAR 309-114-0000 through 309-114-0030 and shall have participated in a training program regarding these rules, their meaning and application.

(3) The superintendent or chief medical officer shall provide to a patient to whom a significant procedure is proposed to be administered written advance notice of the intent to seek consultation and approval of an independent examining physician for the purpose of administering the procedure without the patient's consent.

(4) The physician selected to conduct the independent consultation shall:

(a) Review the person's medical chart including the records of efforts made to obtain the person's informed consent and

(A) Personally examine the person at least one time; or

(B) If the patient refuses to be examined, the physician shall make two good faith attempts to examine the patient. If the patient refuses to be examined during these two good faith attempts, the independent consultation and approval requirement outlined in subsection (4)(a)(A) and (4)(b) of this rule shall be deemed to be fulfilled.

(b) Discuss the matter with the person to determine the extent of the need for the procedure and the nature of the person's refusal, withholding or withdrawal or inability to consent to the significant procedure. This determination as well as the supporting evidence in the form of the specific questions asked and answers given regarding the patient's ability to weigh the risks and benefits of the proposed treatment, alternative treatment and no treatment must be documented in the patient's record;

(c) Consider additional information, if any, presented prior to or at the time of examination or interview as may be requested by the person or anyone on behalf of the person; and

(d) Make a determination whether the factors required under these rules exist for the particular person or that one or more factors are not present and complete a report of his or her findings which provides their approval or disapproval of the proposed significant procedure. The written report must be provided to:

(A) The superintendent or chief medical officer; and

(B) The person to whom a significant procedure is proposed to be administered with a copy being made part of the person's record.

(5) Superintendent's Determination:

(a) The superintendent or chief medical officer shall approve or disapprove of the administration of the significant procedure to a person committed to the Division based on good cause provided that if the examining physician or psychiatric nurse practitioner found that one or more of the factors required by section (1) of this rule were not present or otherwise disapproved of the procedure; the superintendent or chief medical officer shall not approve the significant procedure and it shall not be performed;

(b) Approval of the significant procedure shall be only for as long as no substantial increase in risk is encountered in administering the significant procedure or significant procedure of a similar class during the term of a person's commitment, but in no case longer than 180 days. Disapproval shall be only for as long as no

substantial change occurs in the person's condition during the term of commitment, but in no case longer than 180 days;

(c) Written notice of the superintendent's or chief medical officer's determination shall be provided to the patient and made part of the individual's record. This notice must be delivered to the patient and fully explained by facility medical staff. This notice must include a clear statement of the decision to treat without informed consent, specific basis for the decision, what evidence was relied on to make the decision and include a clear notice of the opportunity to ask for a contested case hearing with an administrative law judge if the patient disagrees with the decision. Attached must be a form with a simple procedure to request a hearing. The patient indicating in writing or verbally to any staff member a desire to challenge the institution's decision will be sufficient to request a contested case hearing pursuant to OAR 309 114 0025. The patient shall have 48 hours to request a contested case hearing after receiving this notice. If the patient does not request a hearing within the 48 hour period or the patient subsequently withdraws his initial hearing request and is not already receiving the significant procedure, the institution may involuntarily administer the significant procedure. A patient retains the right to request an initial hearing on the decision to administer a significant procedure without informed consent at any time.

(d) If the patient withdraws his or her initial request for hearing or refuses to attend the initial hearing without good cause, the administrative law judge will issue a dismissal order pursuant to OAR 137-003-0672(3). A dismissal order will allow the institution to immediately administer the significant procedure without informed consent as if the patient had never requested a hearing. If a dismissal order is issued, the patient may request a second hearing. If the patient withdraws his second request for hearing or refuses to attend the second hearing without good cause, the hearing will occur as scheduled with the institution presenting a prima facie case pursuant to ORS 183.417(4) and the administrative law judge will issue a proposed order by default. The institution will then issue a final order by default.

(e) Records of all reports by independent examining physicians of the determinations of the superintendent or chief medical officer under this rule shall be maintained by the superintendent or chief medical officer in a separate file and shall be summarized each year. Such summaries shall show:

(A) Each type of proposed significant procedure for which consultation with an independent examining physician was sought;

(B) The number of times consultation was sought from a particular independent examining physician for each type of proposed significant procedure;

(C) The number of times each independent examining physician approved and disapproved each type of proposed significant procedure; and

(D) The number of times the superintendent or chief medical officer approved and disapproved each type of proposed significant procedure.

(f) The summaries referred to in subsection (5)(e) of this rule shall be public records and shall be made available to the public during reasonable business hours in accordance with ORS Chapter 192.

(6) When treatment is being administered without informed consent, the ward physician or psychiatric nurse practitioner will write a progress note addressing any changes in patient's capacity to give informed consent every 60 days.

(7) At any time that a patient's condition changes so that there appears to his or her treating physician or psychiatric nurse practitioner to be a substantial improvement in the patient's capacity to consent to or refuse treatment, a formal re assessment of the patient's capacity to consent shall occur as described in OAR 309-114-0010 and 309-114-0020. No order to administer treatment without informed consent in non-emergency situations shall be valid for longer than 180 days or the duration of the commitment, whichever is shorter, without re establishing the need for the order by following the procedures described in 309-114-0010 and 309-114-0020.

(8) When an individual is transferred to a state institution from a community hospital or another state institution where he or she was already being treated with a significant procedure without informed consent, the receiving institution must apply OAR 309-114-0000 through 309-114-0030 no later than 7 days after the date of admission to the new institution. A state institution can honor an existing order for involuntary administration of a significant procedure without informed consent if procedures such as those outlined in 309-114-0010 through 309-114-0030 have already been applied and all necessary documentation is in the patient's file.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 179.321, 426.070 & 426.385

Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-880, cert. ef. 6-1-88; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08; MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 1-2009(Temp), f. & cert. ef. 1-23-09 thru 7-22-09; MHS 3-2009, f. & cert. ef. 6-26-09; MHS 6-2010(Temp), f. & cert. ef. 3-24-10 thru 9-20-10; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 13-2010(Temp), f. & cert. ef. 11-19-10 thru 5-18-11; MHS 4-2011, f. & cert. ef. 5-19-11; MHS 12-2013(Temp), f. & cert. ef. 10-29-13 thru 4-27-14; MHS 9-2014, f. & cert. ef. 4-24-14; MHS 2-2015(Temp), f. & cert. ef. 4-24-15 thru 10-20-15; MHS 5-2015, f. & cert. ef. 8-28-15

309-114-0025

Contested Case Hearing

(1) Patient's Rights: A patient has the right to contest the hospital's determination that it has good cause to involuntarily administer a significant procedure without informed consent pursuant to OAR 309-114-0020(5)(c). If the patient is a minor or legally incapacitated, the parents or guardian has the right to contest the hospital's determination that it has good cause to involuntarily administer a significant procedure without informed consent pursuant to 309-114-0020(5)(c).

(a) Instructions and a simple method of requesting such a hearing shall be provided to every patient when he or she receives notice that the institution intends to administer a significant procedure without informed consent. The patient indicating in writing or verbally to any staff member a desire to challenge the institution's decision will be sufficient to request a contested case hearing.

(b) A patient's verbal or written request for a hearing implies consent to the release of his or her records and protected health information to his or her representative, the institution's representative, and the Office of Administrative Hearings for the purpose of preparing for and conducting the contested case hearing.

(c) After filing a request for an administrative hearing, an attorney or certified law student will be appointed by the Division to represent any patient who requests one. The patient has the right to be represented at the hearing by a representative appointed and paid by the state. The patient also has the right to be represented at the hearing by an attorney or certified law student of his or her choice and at his or her own expense.

(d) If a patient requests a contested case hearing and is not already receiving the significant procedure pursuant to a valid physician's or psychiatric nurse practitioner's order the patient has the right to not receive the significant procedure prior to and during the hearing. If the patient is already receiving the significant procedure pursuant to a valid physician's or psychiatric nurse practitioner's order, the institution may continue to administer the significant procedure to the patient until the final order is issued.

(2) Contested Case Hearing: The administrative hearing will conform to the requirements set forth in ORS 183.413 through 183.500, and the Attorney General's Model Rules at OAR 137-003-0501 and the following:

(a) The hearing must be held within 14 days of the date of the patient's request, unless the patient or his or her representative or the state institution's representative requests a delay for good cause or the patient or his or her representative and the state institution's representative agree to a postponement. Good cause includes, but is not limited to, the following circumstances: the patient's ward is quarantined at the time of the hearing, additional time is required to access necessary and relevant records not in the possession of the state institution, or titration of the patient's medication is necessary

to allow minimally adequate communication by the patient with his or her representative for purposes of the hearing.

(b) These hearings are closed to all non-participants, except personnel from the institution or the Attorney General's Office, personnel from Disability Rights Oregon, personnel from the Office of Administrative Hearings, or members of the patient's family. Any exceptions to this policy must be agreed to in advance by the institution's representative and the patient or their representative. The institution may exclude non-participants, otherwise allowed to attend these hearings, who are disruptive or represent a safety concern.

(c) In lieu of discovery, the patient or his or her representative will be provided with the treating physician's or psychiatric nurse practitioner's form, independent examining physician's evaluation form, the superintendent's or chief medical officer's form approving or disapproving of the administration of the significant procedure, and the preprinted information regarding the risks and benefits of the proposed significant procedures. The patient or his or her representative may also review the patient's chart and consult with the patient's treating physician or psychiatric nurse practitioner.

(d) The following procedures are not available in these contested case hearings: summary determination procedures as defined in OAR 137-003-580, pre-hearing motions as defined in 137-003-0630, and pre-determination review procedures in 137-003-0640.

(e) A final order must be issued by the administrative law judge within two days, excluding weekends and holidays, after the hearing, except when the administrative law judge determines that there is good cause to delay the final order. All final orders must be issued within 3 days of the close of the hearing or the record, whichever is later, excluding weekends and holidays. A final order is effective immediately upon being signed or as otherwise provided in the order.

(f) If after the hearing, the administrative law judge determines that there is an issue not raised by a party or the agency that impacts the outcome of the case, the administrative law judge must grant a continuance for good cause and inform the institution's representative and the patient or his or her representative so that they may present additional arguments and evidence on that issue.

(g) The administrative law judge must determine whether to affirm or reverse the state institution's decision that it has good cause to involuntarily administer a significant procedure without informed consent from the patient as defined by the factors in OAR 309-114-0020(1) with regards to the significant procedures listed on the treating physician's or psychiatric nurse practitioner's informed consent form.

(h) A final order affirming or reversing the institution's decision to involuntarily administer a significant procedure to the patient without informed consent includes all significant procedures listed on the treating physician's or psychiatric nurse practitioner's informed consent form and all unlisted significant procedures of a similar class.

(i) A final order approving the involuntary administration of the significant procedure without informed consent shall be reexamined if the treating physician or psychiatric nurse practitioner determines that there is a substantial increase in the risk to the patient in administering the significant procedure during the term of a person's commitment, but in no case longer than 180 days. Approval of the significant procedure may also be reexamined pursuant to OAR 309-114-0020(8) if the treating physician or psychiatric nurse practitioner determines that there is substantial improvement in the patient's capacity.

(j) A final order disapproving the involuntary administration of the significant procedure without informed consent lasts for no longer than 180 days. If a substantial change in the patient's condition occurs during this time, the institution may re-evaluate the patient using the entire OAR 309-114-0020 process, and must additionally document and explain what substantial change in the person's capacity has occurred since the administrative law judge decision was issued.

(k) If the final order reverses the institution's decision to involuntarily administer a significant procedure and the patient is

already receiving the significant procedure, then the hospital may continue to administer the significant procedure to the extent it is necessary to develop and implement a titration plan to safely discontinue the significant procedure according to current clinical practice.

(l) If the patient withdraws his initial request for hearing or refuses to attend the initial hearing without good cause, the administrative law judge will issue a dismissal order pursuant to OAR 137-003-0672(3). A dismissal order will allow the institution to immediately administer the significant procedure without informed consent as if the patient had never requested a hearing. If a dismissal order is issued, the patient may request a second hearing. If the patient withdraws his second request for hearing or refuses to attend the second hearing without good cause, the hearing will occur as scheduled with the institution presenting a prima facie case pursuant to ORS 183.417(4) and the administrative law judge will issue a final order by default. The final order by default will be issued in a manner consistent with the time frames and process outlined in OAR 309-114-0025(2).

(m) Any administrative law judge who will preside over a hearing regarding involuntary administration of a significant procedure without informed consent must complete agency approved training unique to administration of psychiatric treatment without consent. This training shall be developed by the Division in consultation with Disability Rights Oregon.

(n) Subject to the approval of the Attorney General, an agency officer or employee is authorized to appear, but not make legal argument, on behalf of the agency in contested case hearings involving the involuntary administration of a significant procedure to a patient.

(A) For purposes of this rule, the term "legal argument" is used as defined in ORS 183.452 and OAR 137-003-0545.

(B) When an agency officer or employee represents the agency, the presiding officer shall advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer shall provide reasonable opportunity for the agency officer or employee to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after the conclusion of the hearing.

Stat. Auth.: ORS 179.040

Stats. Implemented: ORS 179.321, 426.070 & 426.385

Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-88), cert ef. 6-1-88; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08; MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 3-2009, f. & cert. ef. 6-26-09; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 15-2014(Temp), f. & cert. ef. 12-1-14 thru 5-29-15; Administrative correction, 6-23-15

309-114-0030

Notice to Patients and Employees

(1) Upon a patient's admission, the state institutions shall inform the patient, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple summary of the contents, including the title, number, and purpose of these rules, and instructions on how to obtain a copy of the rules and advice about their content shall be prominently displayed in areas frequented by patients in all state institutions.

(2) All employees of state institutions involved in patient care shall be notified in writing at the commencement of his or her employment, or, for present employees, within a reasonable time after the effective date of these rules, of the rights, policies, and procedures set forth in these rules. These employees shall participate in a training program regarding the rules, their meaning and application.

Stat. Auth.: ORS 179.040

Stats. Implemented: ORS 179.321, 426.070 & 426.385

Hist.: MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 13-2010(Temp), f. & cert. ef. 11-19-10 thru 5-18-11; Administrative correction, 6-28-11

DIVISION 118

GRIEVANCE PROCEDURES FOR USE
IN STATE INSTITUTIONS

309-118-0000

Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for establishing grievance procedures, other than contested cases, for use by patients and residents of state institutions operated by the Division.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 426.385 and 427.031. These rules were adopted and filed with the Secretary of State on July 9, 1982.

(3) Effective Date. These rules are effective July 23, 1982.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385

Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0005

Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(3) "Emergency Grievance" means a grievance that:

(a) Is likely to cause irreparable harm to a substantial right of a patient or resident before completion of the grievance procedures set forth in OAR 309-118-0020; and

(b) Appears likely to be resolved in favor of the patient or resident.

(4) "Grievance" means a complaint about:

(a) The substance or application of any rule or written or unwritten policy of the Division or any of its state institutions affecting a patient or resident;

(b) The lack of a rule or policy concerning a matter affecting a patient or resident; or

(c) Any decision or action directed toward a patient or resident by the Division or any of the Division's employees or agents. (See also OAR 309-118-0015.)

(5) "Interdisciplinary Team (IDT)" means a group of professional and direct care staff which has primary responsibility for the development of a plan for the care, treatment, and training of an individual patient or resident.

(6) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(7) "Representative" means a person who acts on behalf of a patient or resident with respect to a grievance, including, but not limited to a relative, friend, employee of the Division, attorney or legal guardian. (See also OAR 309-118-0030.) In no case, may another patient or resident act as the representative of a grieving patient or resident.

(8) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(9) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(10) "Superintendent" means the executive head of the state institution as listed in section (9) of this rule.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385

Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0010

Policy Statement

(1) It is the policy of the Division that care, training, and treatment of patients and residents in state institutions should be administered in a manner that preserves the human, civil, and legal rights of patients and residents. It is in the interests of patients, residents, state institutions, and the Division that each state institution should

develop and maintain a system for patients, residents, and their representatives to identify and resolve within the Division grievances concerning care, treatment, training, and patient and resident rights.

(2) The Division recognizes the responsibility and authority of other state and federal agencies to receive and review complaints from patients, residents, and their representatives. No patient or resident shall be subjected to reprisal for contacting or seeking review of a grievance outside the Division, or pursuant to the state institution's grievance procedures.

(3) Patients and residents have varying abilities to verbalize grievances and comply with procedures for presenting a formal grievance, therefore:

(a) Staff of the state institutions have a responsibility to assist patients, residents, and their representatives to articulate grievances and use the grievance procedures to resolve them;

(b) Persons charged with the responsibility for administering the grievance procedures set forth in these rules shall do so with flexibility to the end that a fair resolution of each grievance is accomplished within the Division.;

(c) Representatives and staff of state institutions who assist patients, residents and representatives in using the grievance procedures shall not be disciplined or otherwise subjected to reprisal, provided that such persons act in good faith and for the purpose of protecting the rights of patients and residents.

(4) The grievance procedures shall be administered in such a manner as to protect any right of a patient or resident to maintain the confidentiality of records and communications.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385

Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0015

Non-Grievable Issues

Notwithstanding the definition of a grievance in OAR 309-118-0005(4), an issue may not be processed through the grievance procedures set forth in these rules if there is a contested case hearing or other separate process recognized by statute or administrative rule that affords notice and opportunity to be heard before an impartial decision-maker concerning that issue; e.g., institutional reimbursement orders and judicial certifications of continuing mental illness or mental retardation.

Stat. Auth.: ORS 179.040 & 413.042

Stats. Implemented: ORS 426.385

Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08; Administrative correction 6-19-08

309-118-0020

Grievance Procedures

(1) Informal Resolution. Whenever possible, a patient, resident, or representative should attempt to present and resolve grievances informally with the person or persons causing or involved in the area of complaint.

(2) Level 1 — Resolution by the interdisciplinary team. If a patient, resident, or representative cannot resolve a grievance through informal means, such person may submit a formal grievance statement to the patient's or resident's interdisciplinary team, as follows:

(a) A formal grievance must be in writing and may be on a form provided by the Division MHD-ADMS-0307. A formal grievance statement shall include at least the nature of the grievance and the proposed resolution;

(b) Copies of the grievance statement shall be forwarded to the superintendent of the state institution and to the grievance committee (described in OAR 309-118-0045) by the interdisciplinary team. In the event that the patient, resident, or representative fails or is unable to do so, the interdisciplinary team shall forward copies of the grievance statement to the superintendent and the grievance committee;

(c) Within 20 days after receiving the grievance statement, the interdisciplinary team shall:

(A) Discuss the matter personally with the person who filed the grievance, and if the grievance was filed by a representative,

with the patient or resident; and may contact other persons alleged or appearing to be involved in the grievance;

(B) Consider any information furnished by the patient, resident, or representative and such other information as may be relevant and material to the grievance;

(C) Prepare a written response to the grievance containing at least findings of fact and the interdisciplinary team's resolution of the grievance;

(D) Provide a copy of the report to the patient or resident, and representative, if any, and to the superintendent and the grievance committee.

(3) Level 2 — Grievance committee hearing. The patient, resident, or representative may request the grievance committee to review the grievance for any of the following reasons: failure of the treatment team to dispose of the grievance within 20 days after submission of the grievance; dissatisfaction with the interdisciplinary team's decision; or dissatisfaction with implementation of the decision. The procedure shall be as follows:

(a) A request for review must be in writing and may be on a form provided by the Division MHD-ADMS-0308. A request for review shall state the person's reason for seeking review, and should have attached to it a copy of the original grievance statement and, if available, the IDT report;

(b) Copies of the request will be given to the interdisciplinary team and superintendent. In the event that the patient, resident, or representative fails or is unable to do so, the interdisciplinary team shall forward copies as required in this paragraph;

(c) As a general rule, a request for review shall be filed within 14 days after the interdisciplinary team files its report. However, a patient, resident, or representative shall be permitted to file a formal grievance beyond the 14 days for good cause;

(d) The grievance committee shall send a written acknowledgement to the patient, resident, or representative that the request for review has been received. The grievance committee shall hold a hearing within 21 days after receipt of a request for review;

(e) With respect to the grievance committee hearing, the patient or resident has the right:

(A) To three days' written notice of the date, time, and place of the hearing;

(B) To be represented by the person of the patient's or resident's choice, including legal counsel, at the expense of the patient or resident;

(C) To call witnesses and question witnesses called by the grievance committee or state institution; and

(D) To offer written information as evidence.

(f) Grievance committee hearings shall be conducted as informally as possible consistent with the need for an orderly and complete presentation of the grievance. The rules of evidence for judicial proceedings are not applicable to grievance committee hearings. However, in resolving a grievance, the grievance committee shall consider only information of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs;

(g) The grievance committee shall have 21 days after completion of the hearing to decide the matter and make the decision