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OREGON ADMINISTRATIVE RULES COMPILATION

CHAPTER 309

Oregon Health Authority

Health Systems Division: Mental Health Services

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DIVISION 12

ADMINISTRATIVE PRACTICE AND PROCEDURE

DIVISION 13

ACCOUNTING AND BUSINESS PRACTICES

DIVISION 8
CERTIFICATION OF BEHAVIORAL HEALTH TREATMENT SERVICES

309-008-0100
Purpose and Scope

(1) These rules establish procedures for the application, initial certification, certification renewal, 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 section (2) of this rule.
(2) These rules apply to providers seeking certification to provide behavioral health treatment services under the following service delivery rules:
(a) OAR 309-014-0000 to 0040 (Community Mental Health Programs);
(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 309-033-0200 to 0970 (Involuntary Commitment Proceedings);
(f) OAR 309-039-0500 to 0580 (Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services);
(g) OAR 415-020-0000 to 0090 (Standards for Outpatient Opioid Treatment Programs);
(h) OAR 415-054-0020 to 0580 (DUII Alcohol/Other Drug Information and DUII Alcohol/Other Drug Rehabilitation Programs);
(i) OAR 415-055-0000 to 0035 (Recommendations for Restricted License for Driving Under the Influence of Intoxicants and Other Related Suspensions and/or Revocations); and
(j) OAR 415-057-0020 to 0150 (Standards for Department of Corrections-Based Alcohol and Other Drugs Treatment Programs).
(3) These rules do not establish procedures for other health care services types or licenses not listed in section (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 provide 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.
Statutory/Other Authority: ORS 179.040, ORS 413.042, ORS 413.032-413.033, ORS 426.072, ORS 426.236, ORS 426.500, ORS 430.021, ORS 430.256, ORS 430.357, ORS 430.560, ORS 430.640, ORS 430.870, ORS 743A.168
Statutes/Other Implemented: ORS 413.520, ORS 426.060, ORS 426.140, ORS 430.010, ORS 430.254, ORS 430.335, ORS 430.590, ORS 430.620, ORS 430.637
History: MHS 17-2017, amend filed 12/28/2017, effective 01/01/2018; MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 12-2016(Temp), f. & cert. ef. 7-29-16 thru 12-27-16; MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0200
Definitions

(1) “ASAM Criteria” means the most current publication of the American Society of Addiction Medicine criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 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 issued by the Division that identifies and declares provider certification. A letter accompanying issuance of the certificate shall 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 individuals 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 designee.
(11) “Division” means the Health Systems Division of the Oregon Health Authority or 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.
(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 Division contractor , providing behavioral health treatment services under group health insurance coverage that 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 an individual , 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, individuals who provide services by contract with the provider, program administrators, directors, or others who manage the provision of services, and the provider itself when the provider is an individual or group of individuals.
(21) “Program Director” means an individual 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 OARs describing the specific regulatory standards for each of the types of behavioral health treatment services the Division certifies.
(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 promote 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 that even if one or more requirements is not met in the determination of the Division does not:
(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 that 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, and experiences and activities designed to remediate symptoms of a DSM diagnosis.
Statutory/Other Authority: 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
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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.
(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.
Statutory/Other Authority: 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
Statutes/Other 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
History: MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 12-2016(Temp), f. & cert. ef. 7-29-16 thru 12-27-16; MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0300
Terms of Certification

(1) Each applicant and provider shall:
(a) Permit Division staff to inspect the service delivery location 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 verify information contained in the application or ensure compliance with all applicable statutes, administrative rules, other applicable regulations, or contractual obligations; and
(B) Allow immediate entry and inspection, extending to any premises the Division has reason to believe a provider provides behavioral health treatment services.
(b) 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;
(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) Assure the provider is certified to provide only those services that are specified in the scope of services and conditions listed on the certificate;
(d) 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) Ascertain the certificate does not create an express or implied contract in the absence of a fully executed written contract; and
(f) Ensure that the certificate is not transferable to any other individual, provider, or service delivery location without Division approval.
(2) The Division may 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
(b) 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.
Statutory/Other Authority: 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
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0400
The Application Process

(1) 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 must submit a completed application to the Division.

(2) The Division shall 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 locations; 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 shall 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; and
(d) Complete and current copies of the following documents:
(A) A description of the applicant's service delivery locations 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 locations;
(D) Applicant's policies and procedures regarding seclusion and restraint practices; and
(E) Applicant's Code of Conduct.
(e) Identification of financial interest of any individual including stockholders who have an incident of ownership in the applicant representing an interest of five percent or more. For purposes of these rules, an individual with a five percent or more incident of ownership is presumed to have an effect on the operation of the provider, unless the individual establishes that the individual has no involvement in the operation of the provider.
(f) Background information on all licenses, certifications, and letters of approval held or previously held by the applicant or by any owner disclosed under subsection (e) of this rule to provide care or treatment or engage in a profession or trade. The list shall include every license, certification, and letter of approval regardless of whether it was issued by the Authority or another regulatory body:
(A) The type of license or certification;
(B) The name of the issuing regulatory body;
(C) The name of the individual or business to whom it was issued;
(D) The start and end date of the period of license or certification;
(E) A list of the dates of any suspensions, revocations, conditions, penalties, denials, nonrenewal, or other adverse actions initiated or taken on a license or certificate, including documentation of the final resolution of those actions;
(F) Disclosure of whether any of the licenses or certificates had expired or were relinquished while a suspension, revocation, condition, penalty, denial, nonrenewal, or other adverse action was pending or proposed; and
(G) Copies of all current licenses or certificates.
(g) Disclosure of any substantiated findings of abuse, neglect, or mistreatment by the applicant, owner, or program staff.
(5) Where applicable, the Division shall maintain copies of the documents listed in section (4)(d) of this rule within the Division's CCO document bank.
(6) Timeframe for application submission:
(a) 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) 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.
Statutory/Other Authority: 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
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History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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 shall conduct a comprehensive audit of the application materials:
(a) The Division shall notify the applicant that the application has been accepted as complete;
(b) The Division shall contact the applicant to schedule a certification review; and
(c) For incomplete applications, the Division shall provide written feedback describing any additional information necessary to complete the application.
(2) The Division shall issue a written notice of intent to deny completed applications in accordance with ORS 183.
(3) Completed applications for certification may be denied when:
(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 demonstrate readiness, willingness, and ability to meet and sustain compliance with all applicable statutes, rules, and regulations;
(d) The applicant's operation would threaten the health, welfare, or safety of one or more individuals or the public; or
(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 issue a notice of intent to deny a completed application when:
(a) The applicant has previously had any certification or license suspended or revoked by the Division, the Authority, the Department of Human Services, or any other similar state agency outside of Oregon;
(b) The applicant employs or contracts with any program staff for whom there is substantiated evidence of abuse, neglect, or mistreatment;
(c) The applicant is listed on any current Medicaid exclusion list under OAR 410-120-1380; or
(d) The applicant submits false or inaccurate information to the Division.
(5) 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.
Statutory/Other Authority: 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
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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) When the Division has denied an application, the Division shall notify the applicant in writing and provide the

applicant the opportunity to request a hearing under ORS Chapter 183.411 to 500. 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) When the Division has issued a notice of intent to deny 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 informal conference with the Division as set forth in OAR 309-008-1200.
Statutory/Other Authority: 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
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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:
(a) After receipt of a complete application, the Division shall complete a comprehensive audit of the required application documentation and the service delivery locations. The Division may not issue an initial certification without a completed Initial Certification Review;
(b) After receipt of a complete application, the Division shall complete a comprehensive audit of the required application documentation and the service delivery locations. For continued certification, Certification Renewal Reviews must occur prior to the expiration of the existing certificate and at least once every three years;
(c) The Division may conduct Discretionary Certification Reviews with reasonable notice to ensure compliance with applicable statute, administrative rules, other applicable regulations, and contractual obligations. Discretionary Certification Reviews may be conducted by the Division with or without notice for the following reasons:
(A) The Division has reasonable concern the provider may act to alter records or make them unavailable for inspections;
(B) The Division received a complaint or information that suggests or alleges conditions or practices that could threaten the health, safety, rights, or welfare of individuals; or
(C) 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.
(2) If the Division is not permitted access to records or service delivery locations for the purpose of conducting a certification review, the Division may take action on the certificate up to and including the application of conditions, suspension, or revocation.
(3) A provider or applicant must permit state or local fire inspectors and state or local health inspectors to enter and inspect the service delivery locations as required by administrative rule, state fire code, or local regulations.
(4) At the sole discretion of the Division, the Division may complete a certification review partially or fully via a desk review process. A desk review process is when the Division conducts a certification review based on the provider or applicant's submission of required documentation and telephonic interviews when the Division does not physically visit the service delivery locations:
(a) The Division shall 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 shall securely dispose of documentation containing protected health information submitted by the applicant or provider.

Statutory/Other Authority: 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
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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 shall 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;
(b) Document review; and
(c) Interviews with or a request for completion of a questionnaire by individuals knowledgeable about 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 the Division during a certification review.
(3) Within 30 days following the completion of each discretionary review, the Division may at its discretion issue a report and require a Plan of Correction (POC) congruent with section (4) of this rule.
(4) Within 30 days following the completion of each initial or renewal certification review, the Division shall issue a report that includes:
(a) A statement of any 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) Pursuant to a certification review when the Division determines a provider or applicant is not operating in substantial compliance with all applicable statutes, administrative rules, and other regulations, and the POC process is appropriate, the Division may require the provider or applicant to submit a POC. The Division shall provide written notice of the requirement to submit a POC, and the provider or applicant shall prepare and submit a POC according to the following terms:
(A) The provider or applicant shall 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 POC process;
(B) The POC shall address each finding of non-compliance and shall include:
(i) The planned action already taken or to be taken to correct each finding of non-compliance;
(ii) The anticipated or requested timeframe for the completion of each corrective action not yet complete at the time of POC submission to the Division;
(iii) A description of and plan for quality assurance activities intended to ensure ongoing compliance; and
(iv) The name of the individual responsible for ensuring the implementation of each corrective action within the POC.
(c) If the Division finds that clarification or supplementation to the POC is required prior to approval, the Division shall contact the provider or applicant to provide notice of requested clarification or supplementation, and the provider or applicant shall submit an amended POC within 14 calendars days of notification;
(d) The provider shall submit a sufficient POC approved by the Division prior to receiving a certificate. Upon the Division's approval of the POC, the Division shall issue the appropriate certification;
(e) The Division may deny or revoke an applicant or provider's certification if the provider fails to submit an adequate POC within the timeframes established in this rule.
Statutory/Other Authority: 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168

Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 4-2017, f. 5-23-17, cert. ef. 6-1-17; MHS 30-2016(Temp), f. 12-30-16, cert. ef. 1-1-17 thru 6-29-17; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0900

Issuing Certificates

(1) The Division shall issue an approved applicant a certificate to provide behavioral health treatment services. Every certificate shall:
(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.
(2) After conduct of the certification review, the Division shall issue initial certificates to new applicants that demonstrate substantial compliance with applicable administrative rules and statutes:
(a) For up to one calendar year from the date of initial certification; and
(b) Initial certifications may be issued with conditions pursuant to this rule.
(3) After conduct of the certification review and the plan of correction process where applicable, the Division shall renew the certificate of an applicant with a current certification that demonstrates substantial compliance with applicable administrative rules or statutes:
(a) For up to three calendar years from the date of renewal; and
(b) Renewal certifications may be issued with conditions pursuant to these rules.
Statutory/Other Authority: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168
Statutes/Other Implemented: ORS 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, 813.260
History: MHS 4-2017, f. 5-23-17, cert. ef. 6-1-17; MHS 30-2016(Temp), f. 12-30-16, cert. ef. 1-1-17 thru 6-29-17; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0905

Conditions

(1) The Division may elect at any time and at its discretion to place conditions on a certificate upon a finding that:
(a) The applicant or provider employs or contracts with any program staff for whom there is substantiated evidence of abuse, neglect, or mistreatment;
(b) The applicant or provider employs or contracts with any program staff that fails to meet relevant minimum qualifications described in these rules, service delivery rules, or other applicable law;
(c) There is substantiated evidence of abuse, neglect, 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 has substantially failed to comply with these rules, service delivery rules, or other applicable law;
(f) The applicant or provider fails to fully implement a POC or adequately maintain a corrective action;

(g) The Division has issued the applicant or provider through two or more consecutive certification reviews substantially similar findings 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; or
(i) The applicant or provider fails to comply with any reporting requirements relating to funding certification.
(2) The Division shall consider the sum of the circumstances including but not limited to the following criteria when deciding whether to impose 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 law;
(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 POC's.
(3) 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 concerns identified by the Division;
(b) Limiting the total number of individuals enrolled in services or on a waitlist for services;
(c) Limiting the population such as narrowing the age range of individuals who the applicant or provider may serve;
(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 law.
(4) The Division may issue a notice of intent to impose conditions as described in section (15) of this rule or may impose conditions on a certificate With Notice or Without Notice as described in sections (4) to (8). In imposing conditions With Notice or Without Notice, a provider or an applicant may request an informal conference:
(a) The Division may issue the conditions With Notice by issuing a Notice of Impending Imposition of Certificate Condition (Notice) at least 48 hours prior to issuing an Order Imposing Certificate Condition (Order) to a provider or an applicant. After the Order is issued, the Division shall revise the certificate to indicate the conditions that have been ordered;
(b) The Division may impose the conditions without Notice only if the Division determines that there is an imminent threat to individuals such that the Division determines it is not safe or practical to give an applicant or a provider advance notice. The Division may impose the conditions without notice by issuing an Order to a provider or an applicant. After the Order is issued, the Division shall revise the certificate to indicate the conditions that have been ordered.
(5) The Notice may be provided in writing or orally. When the Notice is provided in writing, it shall be sent by certified or registered mail or delivered in person to the applicant or provider. If the Notice is provided orally, it may be provided by telephone or in person to the applicant, provider, or person represented as being in charge of the program. When the Notice is delivered orally, the Division shall subsequently provide written notice to the applicant or provider by registered or certified mail. The Notice shall:
(a) Generally describe the acts or omissions of the applicant or provider and the circumstances that led to the finding that the imposition of a certificate condition is warranted;
(b) Generally describe why the acts or omissions and the circumstances create a situation for which the imposition of a condition is warranted;
(c) Provide a brief statement identifying the impending condition;
(d) Identify a person within the Division whom the applicant or provider may contact and who is authorized to enter the Order or to make recommendations regarding issuance of the Order;
(e) Specify the date and time the Order is scheduled to take effect; and

(f) Offer that the applicant or provider may request an informal conference prior to the issuance of the Order Imposing Certificate Condition, or if the provider has already requested an informal conference, specify the date and time that an informal conference shall be held.
(6) If an informal conference is requested regarding conditions, the conference shall be held at a location designated by the Division. If determined to be appropriate by the Division, the conference may be held by telephone. Following the informal conference, the Division may modify the conditions. The timing of the informal conference is described as follows:
(a) If a Notice is issued, the applicant or provider may request an informal conference to object to the Division's proposed action before the condition is scheduled to take effect. The request for an informal conference shall be made prior to the date the conditions are intended to be effective. If timely requested, the informal conference shall be held within seven days of the request. The Order Imposing Condition may be issued at any time after the informal conference;
(b) If an Order Imposing Condition is issued without a prior Notice, the applicant or provider may within 48 hours of the issuance of the Order request an informal conference. If timely requested, the informal conference shall be held within two business days of receipt of the request. Following the informal conference, the Division at its discretion may modify the conditions.
(7) When an Order is issued, the Division must serve the Order either personally or by registered or certified mail. The Order must include the following statements:
(a) The authority and jurisdiction under which the condition is being issued;
(b) A reference to the particular sections of the statute and administrative rules involved;
(c) The effective date of the condition;
(d) A short and plain statement of the nature of the matters asserted or charged;
(e) The specific terms of the certificate condition;
(f) Right to request a contested case hearing under ORS Chapter 183.411 to 500;
(g) A statement that if a request for hearing is not received by the Division within 21 days of the date of the Order, the applicant or provider shall have waived the right to a hearing under ORS Chapter 183.411 to 500;
(h) Findings of specific acts or omissions of the applicant or provider that are grounds for the condition and the reasons the acts or omissions create a situation for which the imposition of a certificate condition is warranted; and,
(i) A statement that the Division may combine the hearing on the Order with any other proceeding affecting the certificate. The procedures for the combined proceeding must be those applicable to the other proceedings affecting the certificate.
(8) Hearing:
(a) If the Division serves an Order Imposing Condition, the applicant or provider is entitled to a contested case hearing.;
(b) The Division must receive the request for a hearing within 21 days of the date of Order. If a request for hearing is not received by the Division within 21 days of the date of the Order, the applicant or provider shall have waived the right to a hearing;
(c) The applicant or provider may request a contested case hearing, regarding the imposition of the conditions in addition to or in lieu of an informal conference. Requesting a contested case hearing may not delay the effective date of the conditions.
(9) When a restriction of enrollment or intake is in effect pursuant to an Order, the Division in its sole discretion may authorize the provider to admit or serve new individuals for whom the Division determines that alternate placement or provider is not feasible.
(10) Conditions may be imposed for the duration of the certificate or limited to some other shorter period of time. If the condition corresponds to the certificate period, the reasons for the condition shall be considered at the time of renewal to determine if the conditions are still appropriate. The effective date and expiration date of the condition shall be indicated on the certificate.
(11) When the applicant or provider determines that the circumstances leading to imposition of the condition no longer exist and that effective systems are in place to ensure that similar deficiencies do not recur, the applicant or provider

may make written request to the Division for re-inspection.
(12) Re-inspection:
(a) If the Division finds that the situation for which the condition was imposed has been corrected and finds that systems are in place to ensure that similar deficiencies do not recur, the condition shall be withdrawn, and the Division must revise the certificate accordingly. Following re-inspection, the Division shall notify the facility by telephone of the decision to withdraw the condition. Telephone notification shall be followed by written notification;
(b) If the Division determines after a re-inspection that the situation for which the condition was imposed continues to exist or that there are not sufficient systems in place to prevent similar deficiencies, the certificate condition may not be withdrawn, and the Division is not obligated to re-inspect again for at least 45 days. A decision not to withdraw the Order shall be given to the applicant or provider in writing, and the applicant or provider shall be informed of the right to a contested case hearing. Nothing in this rule is intended to limit the Division's authority to conduct a certification review at any time.
(13) The Division may deny and refuse to renew or revoke the certificate when the provider or applicant fails to comply timely with the condition.
(14) When the Division orders a condition be placed on a certificate With Notice or Without Notice under the provisions of this rule, the applicant or provider is entitled to request a contested case hearing.
(15) In addition to or instead of imposing conditions With Notice or Without Notice as described in sections (4) to (8) and (14), the Division may issue a notice of intent to impose a condition with the opportunity for a contested case hearing prior to imposing the condition. Notices of intent to impose a condition shall be issued consistent with sections (1)-(3) and (9)-(13).
Statutory/Other Authority: 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 4-2017, f. 5-23-17, cert. ef. 6-1-17; MHS 30-2016(Temp), f. 12-30-16, cert. ef. 1-1-17 thru 6-29-17

309-008-1000
Modification to Certification

(1) A provider with a current certificate seeking to open new service delivery locations, relocate current service delivery locations, or 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 shall 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 shall 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 shall 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 shall 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 shall provide written notice of its determination.
Statutory/Other Authority: 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
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1100
Nonrenewal, Suspension, and Revocation of Certification

(1) Immediate suspension of a certificate may occur if there is a serious danger to the public health and safety as the Division sets forth specific reasons for its finding. The provider may request a contested case hearing to contest the immediate suspension order. Requests for a hearing must be received by the Division within 90 days from the date the immediate suspension order was served on the provider personally or was mailed by certified or registered mail. If the provider requests a hearing, the hearing shall be held as soon as practicable:
(a) The Division finds there is substantial failure to comply with applicable statutes, administrative rules, service delivery rules, or other applicable regulations;
(b) There is a threat to health or safety of individuals.
(2) The Division may revoke or refuse to renew a certificate of one or more service delivery locations listed on the certificate when the Division determines that there is substantiated evidence of abuse, neglect, or mistreatment or determines that a provider:
(a) Demonstrates substantial failure to comply with these administrative rules or with applicable state or federal law;
(b) There is a threat to the health or safety of individuals;
(c) Fails to maintain any State of Oregon license that is a prerequisite for providing services that were approved;
(d) Has a direct contract with the Division, and the Division terminates its agreement or contract with the provider;
(e) Fails to comply with the requirements of one or more conditions on the certificate;
(f) Fails to submit and or implement a POC sufficient to come into substantial compliance with these and other applicable rules or regulations;
(g) Submits falsified or incorrect information to the Division;
(h) Refuses 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;
(i) Fails to maintain sufficient staffing or fails to comply with staff qualification requirements;
(j) The provider fails to demonstrate readiness, willingness, and ability to meet and sustain compliance with all applicable statutes, rules, and regulations;
(3) When the Division determines the need to revoke or deny renewal of a certificate issued under these rules, a notice of intent to take action on the certificate shall be issued to the provider.
Statutory/Other Authority: 430.870, 743A.168, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 4-2017, f. 5-23-17, cert. ef. 6-1-17; MHS 30-2016(Temp), f. 12-30-16, cert. ef. 1-1-17 thru 6-29-17; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1200
Informal Conference

(1) When the Division issues an Order of Suspension, a notice of intent to revoke, notice of intent to deny an application, or notice of intent to nonrenew (refusal to renew the certificate to an applicant or provider pursuant to these rules, the Division shall offer the applicant or provider an opportunity for an informal conference. The applicant or provider shall make its request for an informal conference in writing within seven days of the issuance of the notice of intent and within 14 days of an Order of Suspension. Upon receipt of a timely written request, the Division shall select a location and time for such a conference.
(2) Following the conference, the Division may:
(a) Withdraw or amend the notice of intent or suspension order; or
(b) Choose not to withdraw the notice of intent or suspension order.
(3) The Division shall provide written notice of its decision under section (2) of this rule within 14 calendar days of the informal conference.
(4) Informal conferences regarding conditions are not described in this rule and instead are described in OAR 309-008-0905.
Statutory/Other Authority: 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 4-2017, f. 5-23-17, cert. ef. 6-1-17; MHS 30-2016(Temp), f. 12-30-16, cert. ef. 1-1-17 thru 6-29-17; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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 who issued a notice of intent to revoke, impose conditions, or refuse 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 imposition of a condition or orders immediate suspension of a certificate under the provisions of this rule, the provider shall be entitled to request a hearing in accordance with ORS Chapter 183.
Statutory/Other Authority: 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168
Statutes/Other Implemented: ORS 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 4-2017, f. 5-23-17, cert. ef. 6-1-17; MHS 30-2016(Temp), f. 12-30-16, cert. ef. 1-1-17 thru 6-29-17; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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.
Statutory/Other Authority: 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.
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, 813.260.
History: MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1500
Complaints

(1) Any individual 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) The Division shall only investigate a complaint concerning a provider falling within the Division's scope and regulatory authority:
(a) The Division shall investigate and respond to a complaint pursuant to Division policies and procedures;
(b) The Division shall 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 nonrenewal an applicant or provider's application or certificate.
Statutory/Other Authority: 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
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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 requests a variance to these rules, applicable service delivery rules, or other applicable regulations.
(2) 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) The Director, whose decision is final, shall 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) A variance granted by the Division becomes part of the certificate. Continuance of the variance will not be automatic and will be reconsidered at the expiration of the variance or when the certification is being considered for renewal, whichever comes first.
(5) Requesting renewal of a variance in advance of current variance expiration is the responsibility of each provider.
(6) 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.
Statutory/Other Authority: 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
Statutes/Other Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637
History: MHS 15-2017, temporary amend filed 12/01/2017, effective 12/01/2017 through 05/29/2018; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16; 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 & 413.042.
(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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 183.330
History: MHD 4-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 19-1983, f. & ef. 9-23-83; MHD 18-1980, f. & ef. 12-2-80; MHD 19, f. 5-31-74, ef. 6-25-74; MHD 6, f. 2-18-72, ef. 3-11-72

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 183.330
History: MHD 5-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 9-1986, f. & ef. 9-26-86; MHD 20, f. 5-31-74, ef. 6-25-74; MHD 6, f. 2-18-72, ef. 3-11-72

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.
Statutory/Other Authority: ORS 413.042, 430.078
Statutes/Other Implemented: ORS 430.078
History: Renumbered from 309-011-0140, MHS 17-2012, f. and cert. ef. 12-28-12; MHS 10-2010, f. & cert. ef. 7-22-10

309-011-0024
Purpose and Scope
The purpose of these rules is to implement ORS 430.073, related to the Oregon Health Authority's (OHA) 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 Oregon Health Authority .
Statutory/Other Authority: ORS 413.042, 430.073
Statutes/Other Implemented: ORS 430.073
History: MHS 25-2016, f. & cert. ef. 12-27-16; MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0026

Definitions

(1) “Administrative Support” means the tasks provided by the Oregon Health Authority, which are detailed in OAR 309-011-0230(b) below.
(2) “Advise” means to recommend, suggest or inform.
(3) “CAC” means the Consumer Advisory Council authorized by ORS 430.073 and comprised of consumers appointed by the Director.
(4) “Consumer” means a person who has received or is currently receiving mental health or addiction services.
(5) “Director” means the OHA manager assigned as liaison between the CAC and the OHA Director, or his or her designee.
(6) “Director’s Designee” means the Behavioral Health Director of the Office of Health Policy and Analytics
(7) “Majority Vote” means a decision agreed upon by the majority of the quorum present.
(8) “Oregon Health Authority Representative” means the individual(s) identified by Oregon Health Authority to provide administrative support to CAC.
(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.
Statutory/Other Authority: ORS 413.042, 430.073
Statutes/Other Implemented: ORS 430.073
History: MHS 25-2016, f. & cert. ef. 12-27-16; 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 adult and children’s behavioral health and addictions services from the Oregon Health Authority.
(2) CAC may provide evaluation and feedback on site reviews related to adult and children’s behavioral health and addictions services provided by the Oregon Health Authority.
(3) CAC shall work in cooperation with the Director’s Designee or other designated OHA representatives to promote, support and communicate OHA’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 OHA Representative, develop and adopt a work plan for the ensuing twelve months.
(7) CAC may establish committees to investigate and report to CAC regarding areas of interest to CAC.
(8) CAC shall not establish OHA policies, rules, internal directives or procedures.
Statutory/Other Authority: ORS 413.042, 430.073
Statutes/Other Implemented: ORS 430.073
History: MHS 25-2016, f. & cert. ef. 12-27-16; 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 OHA Representative may determine the procedures related to conducting CAC

business.
Statutory/Other Authority: ORS 413.042, 430.073
Statutes/Other Implemented: ORS 430.073
History: MHS 25-2016, f. & cert. ef. 12-27-16; 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 three-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), and 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) OHA may appointment any member for up to two additional three-year terms.
(4) No person shall be excluded from serving as a member of CAC due to affiliation with any organization or institution, or based on race, ethnic origin, religious affiliation, gender, age, disability or sexual orientation.
(5) Only the Director's Designee may remove a person from CAC.
(6) Members of CAC are entitled to compensation in an amount determined by the director and to actual and necessary travel expenses incurred by the member in the performance of the member's official duties. Claims for compensation and expenses shall be paid out in funds appropriated to the authority for purposes of the council under ORS 292.495. [2007 c.805 2; 2009 c.595 463]
Statutory/Other Authority: ORS 413.042, 430.073
Statutes/Other Implemented: ORS 430.073
History: MHS 25-2016, f. & cert. ef. 12-27-16; 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 OHA 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 OHA representative.
(h) With approval from the OHA 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.
Statutory/Other Authority: ORS 413.042, 430.073
Statutes/Other Implemented: ORS 430.073
History: MHS 25-2016, f. & cert. ef. 12-27-16; MHS 17-2012, f. & cert. ef. 12-28-12

309-011-0036

OHA Responsibilities

(1) OHA shall provide:

(a) Necessary training and orientation to CAC members in collaboration with CAC members, including but not limited to the following subject areas:

(A) OHA'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, OHA 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.

Statutory/Other Authority: ORS 413.042, 430.073

Statutes/Other Implemented: ORS 430.073

History: MHS 25-2016, f. & cert. ef. 12-27-16; 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.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 430.050

History: MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 6-1982, f. & ef. 3-23-82

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.
Statutory/Other Authority: ORS 413.042, 430.050
Statutes/Other Implemented: 430.050
History: MHD 4-1995, f. 5-31-95, cert. ef. 6-1-95; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 6-1982, f. & ef. 3-23-82

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.
Statutory/Other Authority: ORS 413.042, 430.050
Statutes/Other Implemented: 430.050
History: MHD 4-1995, f. 5-31-95, cert. ef. 6-1-95; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 6-1982, f. & ef. 3-23-82

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.
Statutory/Other Authority: ORS 413.042, 430.050
Statutes/Other Implemented: 430.050, 430.630
History: MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 6-1982, f. & ef. 3-23-82

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.
Statutory/Other Authority: ORS 430.210, 413.042, 443.450
Statutes/Other Implemented: ORS 443.400 - 443.460, 443.991
History: 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 intergovernmental 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.
Statutory/Other Authority: ORS 413.042, 443.450

Statutes/Other Implemented: ORS 430.210, 443.400 - 443.460, 443.991
History: 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.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 430.210, 443.400 - 443.460, 443.991
History: 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.
Statutory/Other Authority: ORS 413.042, 430.078
Statutes/Other Implemented: ORS 430.078
History: MHS 17-2012, f. & cert. ef. 12-28-12; MHS 10-2010, f. & cert. ef. 7-22-10

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.
Statutory/Other Authority: ORS 413.042, 430.078
Statutes/Other Implemented: ORS 430.078
History: MHS 17-2012, f. & cert. ef. 12-28-12; MHS 10-2010, f. & cert. ef. 7-22-10

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.
Statutory/Other Authority: ORS 413.042, 430.078
Statutes/Other Implemented: ORS 430.078
History: MHS 17-2012, f. & cert. ef. 12-28-12; MHS 10-2010, f. & cert. ef. 7-22-10

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 subpena, 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).
Statutory/Other Authority: ORS 179.770, 413.042, 430.021
Statutes/Other Implemented: 179.610 – 179.770
History: MHD 1-1980, f. & ef. 1-14-80; MHD 6-1979(Temp), f. & ef. 9-20-79

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.

Statutory/Other Authority: ORS 179.770, 413.042
Statutes/Other Implemented: ORS 179.610 – 179.770
History: MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91; MHD 14-1980, f. & ef. 6-24-80; MHD 5-1980(Temp), f. & ef. 4-18-80

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.
Statutory/Other Authority: ORS 179.770, 413.042
Statutes/Other Implemented: ORS 179.610 – 179.770
History: MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91; MHD 14-1980, f. & ef. 6-24-80; MHD 5-1980(Temp), f. & ef. 4-18-80

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.
Statutory/Other Authority: ORS 179.770, 413.042

Statutes/Other Implemented: ORS 179.610 – 179.770
History: MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91; MHD 14-1980, f. & ef. 6-24-80; MHD 5-1980(Temp), f. & ef. 4-18-80

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 obligations 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.
Statutory/Other Authority: ORS 179.770, 413.042
Statutes/Other Implemented: ORS 179.610 – 179.770
History: MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91; MHD 14-1980, f. & ef. 6-24-80; MHD 5-1980(Temp), f. & ef. 4-18-80

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.
Statutory/Other Authority: ORS 179.770, 413.042
Statutes/Other Implemented: ORS 179.610 – 179.770
History: 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.
Statutory/Other Authority: ORS 179.770, 413.042
Statutes/Other Implemented: ORS 179.610 – 179.770
History: MHD 15-1980, f. & ef. 6-24-80; MHD 8-1980(Temp), f. & ef. 4-18-80

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.
Statutory/Other Authority: ORS 179.770, 413.042, 431.120
Statutes/Other Implemented: ORS 179.610 – 179.770
History: MHS 4-2007, f. & cert. ef. 5-25-07; MHD 10-1983, f. & ef. 6-8-83; MHD 2-1983(Temp), f. & ef. 2-18-83

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.
Statutory/Other Authority: 413.042, ORS 179.770
Statutes/Other Implemented: ORS 179.610 – 179.770
History: 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.

Statutory/Other Authority: ORS 179.770, 413.042

Statutes/Other Implemented: ORS 179.610 – 179.770

History: 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.

Statutory/Other Authority: ORS 179.770, 413.042

Statutes/Other Implemented: ORS 179.610 – 179.770

History: 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.

Statutory/Other Authority: ORS 179.770, 413.042

Statutes/Other Implemented: ORS 179.610 – 179.770

History: MHD 11-1985, f. & ef. 6-19-85

309-012-0235

Termination of Relative Foster Care Funding

(1) This rule is adopted in coordination with the Oregon Health Authority’s (Authority) work with counties to transition participating individuals from relative adult foster care to Medicaid-funded services or other available programs.

(2) Effective December 31, 2017, the Authority shall no longer fund relative adult foster care directly or through Service Element 34A of its contracts with community mental health programs.

(3) Relative adult foster care does not include the services provided in licensed adult foster homes pursuant to OAR chapter 309, division 040.

Statutory/Other Authority: ORS 413.042, ORS 430.640

Statutes/Other Implemented: ORS 413.042, ORS 430.610-430.651

History: MHS 16-2017, adopt filed 12/26/2017, effective 12/31/2017; MHS 14-2017, temporary adopt filed 11/21/2017, effective 11/21/2017 through 05/19/2018

DIVISION 13

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 ORS 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.
(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 Administration 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.510 – 179.530
History: MHD 16-1980, f. & ef. 6-24-80; MHD 9-1980(Temp), f. & ef. 4-18-80; MHD 42(Temp), f. & ef. 9-9-76

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 resident'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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385, 179.440
History: MHD 2-1985, f. & ef. 2-7-85; MHD 2-1981, f. & ef. 6-25-81

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385, 179.440
History: MHD 2-1985, f. & ef. 2-7-85; MHD 2-1981, f. & ef. 6-25-81

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385, 179.440
History: MHD 2-1985, f. & ef. 2-7-85; MHD 2-1981, f. & ef. 6-25-81

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385, 179.440
History: MHD 2-1985, f. & ef. 2-7-85; MHD 2-1981, f. & ef. 6-25-81

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385, 179.440
History: MHD 2-1985, f. & ef. 2-7-85; MHD 2-1981, f. & ef. 6-25-81

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).
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 430.021
History: 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 intend 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 430.021
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 430.021
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 430.021
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 430.021
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 430.021

History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 430.021
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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.
(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 lessor 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.”
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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.
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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 noncompliance 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.
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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.
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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 consultation with Division program offices and/or the local mental health authority.
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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).
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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.
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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.
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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.
Statutory/Other Authority: ORS 179.040, 413.042, 430.640
Statutes/Other Implemented: ORS 414.018, 430.610–430.695
History: MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020; MHD 9-1978, f. & ef. 12-11-78

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 programs.
(2) Certificate Required: To receive a certificate for the provision of behavioral health treatment services a Community Mental Health Program must meet the criteria under OAR 309-008-0100 to 309-008-1600; in addition, the Opioid Treatment Program must:
(3) Renewal: The renewal of a Certificate shall be governed by OAR 309-008-0100 to 309-008-1600.
(4) Denial, Revocation, Nonrenewal, Suspension: The denial, revocation, nonrenewal, or suspension of a letter of approval or license for an opioid treatment program may be based on any of the grounds set forth in OAR 309-008-1100.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.695
History: MHS 23-2016, f. & cert. ef. 12-1-16; 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) “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.

(2) “Chief Officer” means the Chief Health Systems Officer of the Oregon Health Authority, or his or her designee.

(3) “CMHP” means "Community Mental Health Program": an entity that is responsible for planning and delivery of safety net services for persons with mental or emotional disturbances, drug abuse problems, 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.

(4) "CMHP Program Area" means the organization of all services for persons with either mental or emotional disturbances, drug abuse problems, or alcoholism and alcohol abuse problems, operated by, a local mental health authority, operated in a specific geographic area of the state under a contract with the Division.

(5) "CMHP Director" means the director of a CMHP who operates or contracts for all services for persons with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse problems under the omnibus contract with the Division.

(6) "Community Mental Health Advisory Committee" means the advisory committee to a local mental health authority.

(7) "Division" means the Health Systems Division of the Oregon Health Authority.

(8) "Individual" means a person receiving services under 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 or private corporation.

(9) "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 services and included in the approved community mental health 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 contractors shall be considered local revenues.

(10) "Omnibus Contract" means the Financial Assistance Grant Agreement or contract between the Health Systems Division and a local mental health authority for all services for persons with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse problems, operated in a specific geographic area.

(11) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services provided by the community mental health contractor.

(12) "Service Element" means a distinct service or group of services for person with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse problems, operated in the community under a contract with the Health Systems Division, or under contract with a local mental health authority.

(13) "Service Provider" means an entity or person that delivers services funded wholly or in part by the Division under a contract with the Division.

(14) "State Institution" means Oregon State Hospital in Junction City and Salem.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 430.610 – 430.640

History: MHS 23-2016, f. & cert. ef. 12-1-16; 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 Program

The purpose of a CMHP is to provide a system of appropriate, accessible, coordinated, effective, efficient safety net

services to meet the mental health needs of the citizens of the community.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16; 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 services and shall integrate such services with other mental health system components in the state by:
(1) Assessing needs for community mental health services in the state.
(2) Identifying priorities among needs and preparing state plans for community mental health 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, alcohol abuser, alcoholic, drug abuser and drug-dependent persons shall be effective, coordinated and integrated with other services within the Oregon Health Authority.
(4) Obtaining resources and contracting with local mental health authorities for the operation of community mental health safety net service.
(5) Subject to the availability of funds, providing public information, program consultation, technical assistance, and training concerning community mental health services.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16; 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
Program Director Qualifications
(1) The CMHP Director shall be a full time employee of the local mental health authority or the public or private corporation operating the community mental health program;
(2) The CMHP 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 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 program.
(3) When the position of community mental health program director becomes vacant, an interim director shall be appointed to serve until a permanent director is appointed.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16; 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

309-014-0021
Management Functions
(1) In addition to other duties as may be assigned in the area of developmental disability services, the CMHP 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) 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 individual abuse; and
(2) Management Plan. The CMHP shall maintain a plan assigning responsibility for the management functions and duties described in this section. The community mental health program shall assure that the functions and duties are assigned to people who have the knowledge and experience necessary to perform them.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0022
Contracts
(1) 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 CMHP 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.
(2) Limit on contract requirements. When a CMHP contracts with a public agency or private corporation for delivery of developmental disability services, the CMHP shall include in the contract only terms that are substantially similar to model contract terms established by the Division. The CMHP may not add contractual requirements, including qualifications for contractor selection, which are nonessential to the service element(s) being provided under the contract. The CMHP 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:
(a) "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 the CMHP, and any other requirements approved by the Division as local options under procedures established in these rules.
(b) "Substantially similar to model contract terms" means that the terms developed by the CMHP 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.
(c) "Nonessential to the service element(s) being provided" means requirements that are not substantially similar to model contract terms developed by the Division.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0023
The Appeal Process
(1) Notice of Appeal.
(a) If a service provider believes that the contract offered by the CMHP 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 Chief Officer within 30 calendar days after the effective date of the contract requirement. The notice of appeal shall include:
(A) A copy of the contract and any pertinent contract amendments;
(B) Identification of the specific term(s) that are in dispute; and
(C) A complete written explanation of the dissimilarity between terms.

(D) The service provider shall send a copy of its notice of appeal to the CMHP. Upon receipt of this notice, the CMHP shall suspend enforcement of compliance with any contract requirement under appeal by the contractor until the appeal process is concluded.
(2) The Chief Officer or designee, shall offer to meet with both to mediate a solution. If a solution cannot be mediated, the Chief Officer shall declare an impasse through written notification to all parties and immediately appoint a panel to consider arguments from both parties.
(3)(a) The Mediation Panel The panel shall include, at a minimum, a representative from the Division, a representative from another CMHP, and a representative from another service provider organization.
(b) The panel shall meet with the parties, consider their respective arguments, and send written recommendations to the Chief Officer 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.
(c) The Chief Officer 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 CMHP shall take immediate action to amend contracts as needed to comply with the Administrator's decision.
(3)(a) Expedited Appeal Process. The CMHP 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.
(b) The request shall be made in writing to the Division's Chief Officer. 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.
(c) If an expedited process is approved, the Chief Officer shall notify all parties of his/her decision concerning the dispute within three additional business days. The Chief Officer'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 Chief Officer's temporary decision until notified of a final decision.
(4) Exception to Facility Requirements. The CMHP may add contract requirements that the CMHP considers necessary to ensure the siting and maintenance of residential facilities in which individual 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 CMHP 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. The CMHP 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 CMHP 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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0025

Management of Community Mental Health Program Areas

Each CMHP contractor providing a community mental health program area under a contract with the Division is required to meet the following standards for management:
(1) Organizations:
(a) Each CMHP 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 CMHP area director and to each of the components of the

CMHP area contractor;
(b) For all components of the community mental health 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 subcontract 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 CMHP 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 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.
Statutory/Other Authority: 430.640, ORS 413.042
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16; 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
Management of All Service Elements
All contractors providing community mental health 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 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 CMHP 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 CMHP 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 CMHP 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 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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16; 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
Delivery of CMHP Service Elements

All community mental health contractors providing community mental health service elements under a contract with the Division are required to meet the following general standards for delivery of community mental health service elements:
(1) Eligibility for Service:
(a) In accordance with the Civil Rights Act of 1964, community mental health services shall not be denied any person on the basis of race, color, creed, sex, national origin or duration of residence. Community mental health 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 services based on ability to pay;
(d) Any person eligible for community mental health services provided by one agency shall also be eligible for other CMHP 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 services shall make pertinent clinical and financial eligibility information concerning a client of the agency readily available to other community mental health 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 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 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 contractor and state institutions. Each CMHP or community mental health 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 program or CMHP 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 CMHP 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 CMHP area contractor, who will have principal responsibility for liaison and implementation of the agreement; and
(D) Each agreement between the state institution and a CMHP, or program area contractor, shall be reviewed and renewed at least once a year.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16; 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

309-014-0036
Records

(1) 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.
(2) 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.
(3) 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.
(4) Client Rights. Each agency providing any community mental health 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 treatment to be undertaken;
(B) Alternative 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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0037
Dispute Resolution

(1) The CMHP 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 CMHP. 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 CMHP 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 Chief Officer, the CMHP 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 Chief Officer 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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00

309-014-0040
Variances

(1) Requirements and standards for requesting and granting variances or exceptions are found in OAR 309-008-1600.
(2) Division Review and Notification: 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.
(4) A variance granted by the Division shall be attached to, and become part, of the contract for that year.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.640
History: MHS 23-2016, f. & cert. ef. 12-1-16; 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: 2011 OL Ch. 418, Sec. 13-19
History: MHS 3-2012, f. & cert. ef. 2-23-12; MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: 2011 OL Ch. 418, Sec. 13-19
History: MHS 3-2012, f. & cert. ef. 2-23-12; MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: 2011 OL Ch. 418, Sec. 13-19
History: MHS 3-2012, f. & cert. ef. 2-23-12; MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: 2011 OL Ch. 418, Sec. 13-19
History: MHS 3-2012, f. & cert. ef. 2-23-12; MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: 2011 OL Ch. 418, Sec. 13-19
History: MHS 3-2012, f. & cert. ef. 2-23-12; MHS 6-2011(Temp), f. 8-26-11, cert. ef. 9-1-11 thru 2-28-12

DIVISION 15
MEDICAID PAYMENT FOR PSYCHIATRICHOSPITAL 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 7-1987, f. & ef. 12-30-87; Reverted to MHD 21-1983, f. & ef. 12-5-83; MHD 12-1985(Temp), f. & ef. 7-1-85; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 6-1989, f. & cert. ef. 11-17-89; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87, Renumbered from 309-015-0015; Reverted to MHD 21-1983, f. & ef. 12-5-83; MHD 12-1985(Temp), f. & ef. 7-1-85; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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 maximum 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
(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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 3-1985, f. & ef. 2-25-85; MHD 10-1984(Temp), f. & ef. 12-21-84; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89

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).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065
History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87; MHD 21-1983, f. & ef. 12-5-83; MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

History: MHD 2-1994, f. & cert. ef. 2-24-94; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 7-1987, f. & ef. 12-30-87

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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 109.675, 179.505, 413.520 - 413.522, 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
History: MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 ORS 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, shall 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, shall 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 Criteria" means the most current edition of the American Society of Addiction Medicine (ASAM) for the Treatment of Addictive, Substance-related, and Co-Occurring Conditions, which is a clinical guide to develop patient-centered service plans and make objective decisions about admission, continuing care, and transfer or discharge for individuals and is incorporated by reference in these rules.
(8) “Authority” means the Oregon Health Authority.
(9) “Behavioral Health Treatment” means treatment for mental health, substance use disorders, and problem gambling.
(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 an individual 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, shall 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 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 943-007-0010 through 943-007-0501.
(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 an individual 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 individual 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 an individual 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 an individual 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) “Medication Assisted Treatment (MAT)” means the use of medication in combination with counseling and behavioral therapies for the treatment of substance use disorders.
(47) “Oregon Health Authority” means the Oregon Health Authority of the State of Oregon.
(48) "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.
(49) “Peer” means any individual supporting an individual or the individual's family member 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.
(50) “Peer Delivered Services” means an array of agency or community-based services and supports provided by peer support specialists and peer wellness specialists to individuals or family members with similar lived experience that are designed to support the needs of individuals and families as applicable.
(51) "Peer Support Specialist" means an individual providing peer delivered services to an individual or family member with similar life experience under the supervision of a qualified clinical supervisor and a qualified peer delivered services supervisor, as practicable. A peer support specialist shall be certified by the Authority’s Office of Equity and Inclusion as required by OAR 410-180-0300 to 0380 and be:
(a) A self-identified individual currently or formerly receiving addictions or mental health services;
(b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;
(c) A self-identified individual in recovery from problem gambling; or
(d) A person who has experience parenting a child who:
(A) Is a current or former consumer of mental health or addiction treatment; or
(B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.
(52) “Peer Support and Peer Wellness Specialist Supervision" means supervision by a certified PSS or PWS with at least one year of experience as a PSS or PWS in behavioral health services or supervision by a qualified PSS/PWS supervisor and a qualified clinical supervisor. The supports provided include guidance in the unique discipline of peer delivered services and the roles of peer support specialists and peer wellness specialists.
(53) “Peer Delivered Services Supervisor" means an individual qualified to evaluate and guide PSS and PWS program staff in the delivery of peer delivered services and supports.
(54) “Peer Wellness Specialist” means an individual who supports an individual in identifying mental health service and support needs through community outreach, assisting individuals with access to available services and resources, addressing barriers to services, and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness. A peer wellness specialist shall be certified by the Authority’s Office of Equity and Inclusion as required by OAR 410-180-0300 to 0380 and be:
(a) A self-identified individual currently or formerly receiving mental health services; or
(b) A self-identified individual 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.
(55) “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.
(56) "Program" means a particular type or level of service that is organizationally distinct.
(57) "Program Administrator" or "Program Director" means a person with appropriate professional qualifications and experience, who is designated to manage the operation of a program.
(58) "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.
(59) "Provider" means an organizational entity, or qualified individual, 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.
(60) “Publicly Funded” means financial support, in part or in full, with revenue generated by a local, state or federal government.
(61) "Quality Assessment and Performance Improvement" means the structured, internal monitoring and evaluation of services to improve processes, service delivery and service outcomes.
(62) “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.
(63) "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.
(64) “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.
(65) “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.
(66) “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.
(67) "Screening" means the process to determine whether the individual needs further assessment to identify circumstances requiring referrals or additional services and supports.
(68) “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.
(69) "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.
(70) “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.
(71) “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.
(72) "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.
(73) “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.
(74) "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.
(75) "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.
(76) "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.
(77) “Substance Use Disorders Treatment and Recovery Services” means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.

(78) “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.
(79) “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.
(80) “Transfer” means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.
(81) “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.
(82) "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.
(83) "Urinalysis Test" means an initial test and, if positive, a confirmatory test:
(a) An initial test shall 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 shall be by a different analytical method from that of the initial test to ensure reliability and accuracy;
(c) All urinalysis tests shall be performed by laboratories meeting the requirements of OAR 333-024-0305 to 333-024-0365.
(84) "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.
(85) "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.
(86) "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 shall be non-clinical unless the individual has the required credentials to provide a clinical service.
(87) “Wellness” means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.
Statutory/Other Authority: ORS 413.042, 430.256, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 109.675, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0107
Certification Required
Entities providing or seeking to provide residential treatment services under these rules shall also hold or successfully obtain from the Division a certificate to provide behavioral health treatment services under OAR 309-008-0100 to 309-008-1600 if they intend to provide an outpatient service regulated by the Division’s service delivery rules.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16;

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 shall develop and implement written policies and procedures, compliant with these rules.

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

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

(a) Personnel Qualifications, Credentialing and Training;

(b) Criminal Records Checks, compliant with ORS 181.533 through 181.575 and OAR 943-007-0001 - 0501; 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 Division's 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 shall establish written policies that:

(a) Prohibit physical or other forms of aversive action to discipline an individual;

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

(c) Prohibit withholding shelter, regular meals, clothing or aids to physical functioning;

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

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

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450

Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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, including medications used to treat opioid dependence;
(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 section (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 shall be specified in reasonable detail, and any restriction of the right to communicate shall be no broader than necessary to prevent this harm; and
(B) The individual and his or her guardian, if applicable, shall be given specific written notice of each restriction of the individual's right to private and uncensored communication. The provider shall 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) The provider shall 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 shall 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, shall be explained to the individual, and if appropriate, to her or his guardian; and
(c) Individual rights shall be posted in writing in a common area.
Statutory/Other Authority: ORS 413.042, 430.256, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055, 813.200 - 813.270
History: Suspended by MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0125
Specific Staff Qualifications and Competencies
Program staff shall meet the following qualifications, credentialing or licensing standards and competencies:
(1) Program Administrators or Program Directors shall 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 shall demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources,

group, family and individual therapy or counseling, documentation and rationale for services to promote intended outcomes and implementation of all provider policies.
(3) Clinical Supervisors in substance use disorders treatment and recovery programs shall be certified or licensed by a health or allied provider agency as follows:
(a) For supervisors holding a certification or license in addiction counseling, qualifications for the certificate or license shall have included at least:
(A) 4000 hours of supervised experience in substance use counseling;
(B) 300 contact hours of education and training in substance use related subjects; and
(C) Successful completion of a written objective examination or portfolio review by the certifying body.
(b) For supervisors holding a health or allied provider license, the license or registration shall have been issued by one of the following state bodies and the supervisor shall possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of substance use disorders:
(A) 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 shall have one of the following qualifications:
(A) Five years of paid full-time experience in the field of substance use disorders counseling; or
(B) A Bachelor's degree and four years of paid full-time experience in the social services field, with a minimum of two years of direct substance use disorders counseling experience; or
(C) A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct substance use disorders counseling experience;
(4) Clinical Supervisors in problem gambling treatment and recovery programs shall meet the requirements for clinical supervisors in either mental health or substance use disorders treatment and recovery programs, and have completed 10 hours of gambling specific training within two years of designation as a problem gambling services supervisor.
(5) Peer Delivered Services Supervisors shall be a certified Peer Support Specialist (PSS) or Peer Wellness Specialist (PWS) with at least one year experience.
(6) Substance use disorders treatment staff shall:
(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 shall 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 shall 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 shall have been issued by one of the following state bodies and the person shall 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 shall 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 shall 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 shall have been issued by one of the following state bodies and the person shall 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) Peer support specialists and Peer Wellness specialists, including family and youth support and wellness specialists, shall meet the requirements in OAR 410-180-0300 to 0380 for certification and continuing education. They shall also:
(a) Demonstrate the ability to support others in their recovery or resiliency; and
(b) Demonstrate personal life experience and tools of self-directed recovery and resiliency.
Statutory/Other Authority: ORS 413.042, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0130
Documentation, Training and Supervision
(1) Providers shall maintain personnel records for each program staff that contains all of the following documentation:
(a) Where required, verification of a criminal record check consistent with OAR 943-007-0001 through 943-007-0501;
(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 shall 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 943-007-0001 through 943-007-0501; and
(e) Results of a Tuberculosis screening as per OAR 333-071-0057(7)(b)(A).

(3) Providers shall ensure that program staff receives training applicable to the specific population for whom services are planned, delivered, or supervised. The program shall 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 shall 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; and
(g) Care Coordination.
(4) Persons providing direct services shall receive supervision by a qualified Clinical Supervisor, as defined in these rules, related to the development, implementation, and outcome of services. Clinical supervision shall be provided to assist program staff and volunteers to increase their skills, improve quality of services to individuals, and supervise program staff and volunteers' compliance with program policies and procedures, including:
(a) Documentation of two hours per month of supervision for each person supervised. The two hours shall 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
(b) 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;
(c) As practicable, for persons providing direct Peer Delivered Services, one hour of supervision shall be provided by a qualified Peer Delivered Services Supervisor.
Statutory/Other Authority: ORS 413.042, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0135
Entry

(1) Entry Process: The program shall utilize an entry procedure to ensure the following:
(a) Individuals shall be considered for entry without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, except when program eligibility is restricted to children, adults or older adults, familial status, marital status, source of income, and disability;
(b) Individuals shall receive services in the most timely manner feasible consistent with the presenting circumstances;
(c) The provider may not deny entry to individuals who are prescribed medication to treat opioid dependence; and
(d) For individuals receiving services funded by the SAPT Block Grant, entry of pregnant women to services shall 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 shall 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 shall 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) Individuals with dependent children.
(3) Written informed consent for services shall be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason shall be documented and further attempts to obtain

informed consent shall be made as appropriate.
(4) The provider shall develop and maintain service records and other documentation for each individual that demonstrates the specific services and supports..
(5) The provider shall 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 shall be obtained for any confidential information concerning the individual being considered for, or receiving, services.
(7) At the time of entry, the program shall offer to the individual and guardian if applicable, written program orientation information. The written information shall be in a language understood by the individual and shall include:
(a) A description of individual rights consistent with these rules;
(b) Policies concerning grievances and appeals consistent with these rules, including an example grievance form;
(c) Notice of privacy practices; and
(d) An opportunity to register to vote.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0140
Assessment
(1) At the time of entry, an assessment shall be completed.
(2) The assessment shall 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 shall 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 shall be assessed and individual service records shall contain follow-up actions and referrals when an individual reports symptoms indicating risk of suicide.
(4) Each assessment shall be consistent with the dimensions described in the ASAM PPC and shall 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 shall 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 shall periodically update assessments as applicable, when there are changes in clinical circumstances.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0145
Service Plan and Service Notes
(1) The Service Plan shall be a written, individualized plan to improve the individual's condition to the point where the

individual's continued participation in the program is no longer necessary. The Service Plan is included in the individual's service records and shall:
(a) Be completed prior to the start of services;
(b) Reflect the full 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 shall include:
(a) Treatment objectives that are:
(A) Individualized to meet the assessed needs of the individual; and
(B) Measurable for the purpose of evaluating, including a baseline evaluation.
(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) Providers shall document each service and support in a Service Note to include:
(a) The specific services rendered;
(b) The specific service plan objectives being addressed by the services provided;
(c) The date, time of service, and the actual amount of time the services were rendered;
(d) The personnel rendering the services, including name and credential;
(e) The setting in which the services were rendered;
(f) Periodic updates describing the individual's progress.
(4) Decisions to transfer individuals shall be documented, including:
(a) The reason for the transfer;
(b) Referrals to follow up services and other behavioral health providers; and
(c) Outreach efforts made, as indicated.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0150
Service Record

(1) Documentation Standards: Documentation shall be appropriate in quality and quantity to meet professional standards applicable to the provider and any additional standards for documentation in the provider's policies and any pertinent contracts.
(2) General Requirements for Individual Service Record: All providers shall develop and maintain a Service Record for each individual upon entry. The record shall, 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) Transfer documentation;
(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;
(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.
(3) When medical services are provided, the following documents shall 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.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0155
Transfer and Continuity of Care
(1) Planned Transfer: Providers shall meet the following requirements for planned transfer:
(a) Decisions to transfer individuals shall be documented in a transfer summary; and
(b) The documentation shall include the reason for transfer and shall be consistent with ASAM criteria established in the assessment.
(2) Transfer Process and Continuity of Care: Prior to transfer, providers shall:
(a) When applicable, coordinate and provide appropriate referrals for medical care and medication management. The transferring provider shall 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 shall document outreach efforts made to re-engage the individual, or document the reason why such efforts were not made; and
(e) The provider shall report all instances of Transfer on the mandated state data system.
(3) A Transfer Summary shall 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 shall 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 shall be sent to the receiving provider within 30 days of the transfer.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 shall provide concurrent service and support planning and delivery for substance use and mental health diagnosis, including integrated assessment, Service Plan and Service Record.
Statutory/Other Authority: ORS 413.042, 430.640, 443.450
Statutes/Other Implemented: 743A.168, ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0165
Residential Problem Gambling Treatment Services
These services include group, individual, and family treatment consistent with the following requirements:
(1) The first offered service appointment shall be five business days or less from the date of request for services.
(2) Service sessions shall address the challenges of the individual as they relate, directly or indirectly, to the problem gambling behavior.
(3) Providers may provide telephone counseling when person-to-person contact would involve an unwise delay, as follows:
(a) Individuals shall be currently enrolled in the problem gambling treatment program;
(b) Phone counseling shall be provided by a qualified program staff within their scope of practice;
(c) Service Notes for phone counseling shall 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 shall meet HIPAA and 42 CFR standards for privacy; and
(e) There shall 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 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 shall address the problems of the family member as they relate directly or indirectly to the problem gambling behavior; and
(b) Services to the family shall 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 shall be included in the entry process and documented in the assessment.
(7) The service plan shall include a financial component, consistent with the financial assessment.
Statutory/Other Authority: ORS 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055, 813.200 - 813.270
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0170

Residential Substance Use Disorders Treatment and Recovery Services

(1) Pregnant women or other individuals using substances intravenously, whose services are funded by the SAPT Block Grant, shall receive interim referrals and information prior to entry, to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services shall include:
(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) Programs approved and designated as culturally specific programs shall 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 shall be within close proximity to the culturally specific populations;
(B) Where available, public transportation shall be within close proximity to the program; and
(C) Hours of service, telephone contact, and other accessibility issues shall be appropriate for the population.
(m) The physical facility where the culturally specific services are delivered shall be psychologically comfortable for the group including:
(A) Materials displayed shall be culturally relevant; and
(B) Mass media programming (radio, television, etc.) shall be sensitive to cultural background.
(n) Other cultural differences shall 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.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 shall meet the following standards:
(1) Development of Service Plans and case management services shall include participation of parents, other family members, schools, children's services agencies, and juvenile corrections, as appropriate.
(2) Services, or appropriate referrals, shall include:
(a) Family counseling;
(b) Education services;
(c) Community and social skills training; and
(d) Smoking cessation service.
(3) Continuing care services shall be of appropriate duration and designed to maximize recovery opportunities. The services shall 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.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 shall meet the following standards:

(a) The Assessment shall 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 shall address all areas identified in the assessment and applicable service coordination details to address the identified needs;

(c) The program shall 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 shall 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 shall include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies.

(3) The program shall 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 shall be consistent with the ASAM PPC and shall include referrals to female dominated support groups where available.

(4) Programs that receive SAPT Block Grant funding shall 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 that 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 that 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.

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450

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

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0185

Medical Protocols in Residential Substance Use Disorders Treatment Programs

Medical protocols shall be approved by a medical director under contract with a program or written reciprocal agreement with a medical practitioner under managed care. The protocols shall:

(1) Require a medical history be included in the Assessment.

(2) Designate those medical symptoms and conditions that, when found, require further investigation, physical examinations, treatment, 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, shall 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.

(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.

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450

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

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0190

Administration of Medications

The following guidelines shall be followed in policies on administration of medications in residential programs:

(1) Medications prescribed for one individual may 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 shall be approved in writing by a physician and closely monitored by the residential program staff.

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

(4) A written record of all disposal of prescription drugs in a residential program shall be maintained in the program and shall 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) All prescription drugs stored in the residential program shall be kept in a locked stationary container. Medications requiring refrigeration shall be stored in a refrigerator using a locked container.

(6) Written documentation of medications prescribed for the individual by an LMP shall be maintained in the Individual Service Record. Documentation for each medication prescribed shall 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 and the signature and credentials of program staff administering or prescribing medications; and

(f) Medication records that contain:
(A) Observed side effects including laboratory findings; and
(B) Medication allergies and adverse reaction.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0195

Building Requirements

All substance use disorders treatment and recovery programs shall:
(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 shall be current and posted in a conspicuous area.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0200

Facility Standards for Substance Use Disorders Residential Treatment and Recovery Programs

(1) Residential programs shall 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 shall be submitted to the State Fire Marshal for approval;
(c) Plans shall 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 shall be prepared and bear the stamp of an Oregon licensed architect or engineer; and
(e) The water supply, sewage, and garbage disposal system shall be approved by the agency having jurisdiction.
(2) All rooms used by individuals shall 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 shall be provided for exclusive use of individuals, program staff, and invited guests, and shall:
(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 shall be provided for the exclusive use of individuals, program staff, and invited guests and shall:

(A) Provide a minimum of 15 square feet per occupant; and
(B) Be provided with adequate ventilation.
(c) Bedrooms shall be provided for all individuals and shall:
(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 shall be provided and conveniently located in each building containing a bedroom and shall:
(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, the Division, and Public Health Division shall be distributed to taps conveniently located throughout the residential program;
(f) All plumbing shall comply with applicable codes;
(g) Laundry facilities, when provided, shall 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 shall be provided appropriate to the size of the residential program. Separate storage areas shall 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 that shall be properly labeled, stored in the original container, and kept in a locked storage area.
(i) Furniture shall be provided for each individual and shall include:
(A) A bed with a frame and a clean mattress and pillow;
(B) A private dresser or similar storage area for personal belongings that is readily accessible to the individual; and
(C) Access to a closet or similar storage area for clothing.
(j) Linens shall be provided for each individual and shall 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) The residential program shall 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 shall 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 shall be filed and maintained in the residential program records for at least 30 days;
(c) All modified or special diets shall be ordered by a physician;

(d) At least three meals shall 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 shall be maintained on the premises;
(f) Food shall 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 shall be effectively washed, rinsed, sanitized, and stored after each individual use to prevent contamination in accordance with Division standards; and
(h) Raw milk and home-canned vegetables, meats, and fish may not be served or stored in a residential program.
(4) The residential program shall meet the following safety requirements:
(a) At no time shall the number of individuals served exceed the approved capacity;
(b) A written emergency plan shall be developed and posted next to the telephone used by program staff and shall 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 shall 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 shall be inspected as required by the State Fire Marshal;
(B) All flammable and combustible materials shall be properly labeled and stored in the original container in accordance with the rules of the State Fire Marshal; and
(C) The residential program shall conduct unannounced fire evacuation drills at least monthly. At least once every three months the monthly drill shall 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 shall be maintained.
(d) At least one program staff who is trained in First Aid and CPR shall be onsite at all times; and
(5) The residential program shall meet the following sanitation requirements:
(a) All floors, walls, ceilings, window, furniture, and equipment shall be kept in good repair, clean, neat, orderly, and free from odors;
(b) Each bathtub, shower, hand-washing sink, and toilet shall be kept clean and free from odors;
(c) The water supply in the residential program shall meet the requirements of the rules of the Public Health Division governing domestic water supplies;
(d) Soiled linens and clothing shall 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 shall be taken;
(f) All measures necessary to control rodents shall be taken;
(g) The grounds of the program shall be kept orderly and free of litter, unused articles, and refuse;
(h) Garbage and refuse receptacles shall be clean, durable, water-tight, insect- and rodent proof and kept covered with a tight-fitting lid;
(i) All garbage solid waste shall be disposed of at least weekly and in compliance with the rules of the Department of Environmental Quality; and
(j) Sewage and liquid waste shall be collected, treated, and disposed of in compliance with the rules of the Department of Environmental Quality.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0205

Quality Assessment

Providers shall 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.

Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450

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

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 shall be followed.

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

(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) The provider shall have a Grievance Process Notice that shall be posted in a conspicuous place stating the telephone number of:

(a) The Division complaints representative;

(b) Disability Rights Oregon; and

(c) The applicable Coordinated Care Organization; and

(d) The Governor's Advocacy Office.

(5) 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 shall review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response shall include information about the appeal process.

(6) A grievant, witness, or staff member of a provider may 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) 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) Individuals and their legal guardians, as applicable, shall 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 shall 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 shall be available to assist the individual;
(c) The CMHP director or Division shall 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.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-018-0215
Variances
(1) 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 shall submit a written application to the Division; and
(c) Variance requests shall 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) The Division shall approve or deny the request for a variance and shall 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 shall include the specific alternative practice, service, method, concept, or procedure that is approved and the duration of the approval.
(4) Appeal of the denial of a variance request shall be made in writing to the Chief Officer of the Division, whose decision will be final and shall be provided in writing within 30 days of receipt of the appeal.
(5) The LMHA, CMHP, or provider may implement a variance only after written approval from the Division.
(6) The provider shall submit a request to extend a variance in writing prior to a variance expiring. Extensions shall be approved in writing by the Division.
(7) Granting a variance for one request does not set a precedent that shall be followed by the Division when evaluating subsequent requests for variance.
Statutory/Other Authority: ORS 413.042, 428.205 - 428.270, 430.640, 443.450
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

DIVISION 19

OUTPATIENT ADDICTIONS AND MENTAL HEALTH SERVICES

309-019-0100

Purpose and Scope

(1) These rules prescribe minimum service delivery standards for services and supports provided by providers certified by the Health Systems Division (Division) of the Oregon Health Authority (Authority).
(2) 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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 461.549, 743A.168
History: MHS 6-2017, f. & cert. ef. 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0105

Definitions

(1) "Abuse of an Adult" means the circumstances defined in OAR 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) “Acute Care Psychiatric Hospital” means a hospital or facility that provides 24 hours-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care, and treatment.
(4) “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.
(5) “Adolescent” means an individual from 12 through 17 years of age or those individuals determined to be developmentally appropriate for youth services.
(6) "Adult" means an individual 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 shall 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 shall have all rights afforded to adults as specified in these rules.
(7) “Assertive Community Treatment (ACT)” means an evidence-based practice designed to provide comprehensive treatment and support services to individuals with serious and persistent mental illness. ACT is intended to serve individuals who have severe functional impairments and who have not responded to traditional psychiatric outpatient treatment. ACT services are provided by a single multi-disciplinary team that typically includes a psychiatrist, a nurse, and at least two case managers and are designed to meet the needs of each individual and to help keep the individual in the community and out of a structured service setting, such as residential and hospital care. ACT is characterized by the following:
(a) Low client to staff ratios;
(b) Providing services in the community rather than in the office;
(c) Shared caseloads among team members;
(d) Twenty-four hour staff availability;
(e) Direct provision of all services by the team (rather than referring individuals to other agencies); and
(f) Time-unlimited services.

(8) “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.
(9) "ASAM Criteria" means the most current edition of the American Society of Addiction Medicine (ASAM) for the Treatment of Addictive, Substance-related, and Co-Occurring Conditions, which is a clinical guide to develop patient-centered service plans and make objective decisions about admission, continuing care, and transfer or discharge for individuals and is incorporated by reference in these rules.
(10) “Authority” means the Oregon Health Authority.
(11) “Behavioral Health Treatment” means treatment for mental health, substance use disorders, and problem gambling.
(12) "Behavior Support Plan" means the individualized proactive support strategies used to support positive behavior.
(13) “Behavior Support Strategies” means proactive supports designed to replace challenging behavior with functional, positive behavior. The strategies address environmental, social, neuro-developmental, and physical factors that affect behavior.
(14) “Best Practice Risk Assessment” has the meaning given that term in OAR 309-023-0110.
(15) “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.
(16) "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.
(17) “Certificate of Approval” means the document issued by the Authority that identifies and declares certification of a provider pursuant to OAR 309-008-0000 through 309-008-1300.
(18) “Chief Officer” means the Chief Health Systems Officer of the Division or designee.
(19) "Child" means an individual 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 shall be considered a child until age 21 for purposes of these rules.
(20) "Clinical Supervision" means oversight by a qualified clinical supervisor of addictions and mental health services and supports provided according to these rules, including ongoing evaluation and improvement of the effectiveness of those services and supports.
(21) "Clinical Supervisor" means an individual qualified to oversee and evaluate addictions or mental health services and supports.
(22) “Co-occurring Substance Use and Mental Health Disorders (COD)” means the existence of a diagnosis of both a substance use disorder and a mental health disorder.
(23) "Community Mental Health Program (CMHP)" means the organization of various services for individuals 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 chapter 309, division 014.
(24) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.
(25) "Conditional Release" means placement by a court or the Psychiatric Security Review Board (PSRB) of an individual who has been found eligible under ORS 161.327 or 161.336 for supervision and treatment in a community setting.
(26) "Court" means the last convicting or ruling court unless specifically noted.
(27) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 943-007-0001 through 0501.
(28) "Crisis" means 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 or death.
(29) "Crisis Intervention" has the meaning given that term in OAR 309-023-0110.
(30) "Crisis Line Services" means phone-based services that establish immediate communication links and provide supportive interventions and information for individuals in an urgent or emergent situation.
(31) "Crisis Plan" means an individualized document designed to help anticipate and prevent future crisis episodes and direct interventions in the instance of a crisis.
(32) "Cultural Awareness" means the process by which individuals and systems respond respectfully and effectively to individuals of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, gender identity, gender expression, 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.
(33) "Culturally Specific Program" means a program designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture.
(34) "Declaration for Mental Health Treatment" means a written statement of an individual's preferences concerning their 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.
(35) "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.
(36) "Division" means the Health Systems Division.
(37) "DSM" means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
(38) "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 participating in a diversion agreement under ORS 813.200.
(39) "Emergent" means the onset of symptoms requiring attention within 24 hours to prevent serious deterioration in mental or physical health or threat to safety.
(40) "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.
(41) "Entry" means the act or process of acceptance and enrollment into services regulated by this rule.
(42) "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, or legal or social relationships. Family also means any natural, formal, or informal support persons identified as important by the individual.
(43) "Family Support" means the provision of peer delivered services to people 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.
(44) "Gender Identity" means an individual's self-identification of gender without regard to legal or biological identification including but not limited to individuals identifying themselves as male, female, transgender, transsexual, non-binary, and gender diverse.
(45) "Gender Expression" means the external characteristics and behaviors that are socially defined as masculine, feminine, or androgynous such as dress, mannerisms, speech patterns, and social interactions.
(46) "Geographic Service Area" means the geographic area within the county boundaries in which the CMHP operates.

(47) "Grievance" means a formal complaint submitted to a provider verbally or in writing by an individual or the individual's representative pertaining to the denial or delivery of services and supports.
(48) "Guardian" means an individual appointed by a court of law to act as guardian of a minor or a legally incapacitated individual.
(49) "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).
(50) "Individual" means any individual 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 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 outpatient services may include but are not limited to day treatment, correctional day treatment, evening treatment, and partial hospitalization.
(53) "Intensive Outpatient Services and Supports (IOSS)" means a specialized set of comprehensive in-home and community-based supports and mental health treatment services for children that are developed by the child and family team and delivered in the most integrated setting in the community.
(54) "Interdisciplinary Team (IDT)" means a group of professional and direct care staff that have primary responsibility for the development of a Service Plan for an individual receiving services.
(55) "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.
(56) "Intern" or "Student" means an individual providing paid or unpaid program services to complete a credentialed or accredited educational program recognized by the State of Oregon.
(57) "Juvenile Psychiatric Security Review Board (JPSRB)" means the entity described in ORS 161.385.
(58) "Lethal Means Counseling" means best practice research-based counseling strategies to help patients at risk for suicide and their families reduce access to lethal means, including but not limited to firearms.
(59) "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.
(60) "Licensed Health Care Professional" means a practitioner of the healing arts acting within the scope of their practice under state law who is licensed by a recognized governing board in Oregon.
(61) "Licensed Medical Practitioner (LMP)" means an individual 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 IOSS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.
(62) "Linkage agreement" has the meaning given that term in OAR 309-032-0860
(63) "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 composed of two or more boards of county commissioners.

(64) "Mandatory Reporter" means any public or private official, as defined in ORS 419B.005, who comes in contact with or has reasonable cause to believe that an individual has suffered abuse or that any individual with whom the official comes in contact with has abused the individual. Pursuant to ORS 430.765, psychiatrists, psychologists, clergy, and attorneys are not mandatory reporters with regard to information received through communications that are privileged under ORS 40.225 to 40.295.
(65) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to eligible individuals under Title XIX of the Social Security Act.
(66) "Medical Director" means a physician licensed to practice medicine in the State of Oregon and 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.
(67) "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.
(68) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis, or treatment of a physical or behavioral health condition or injuries that 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.
(69) “Medication Assisted Treatment (MAT)” means the use of medication in combination with counseling and behavioral therapies for the treatment of substance use disorders.
(70) “Mental Health Intern” means an individual 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 individual shall:
(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 practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by the provider; and
(d) Receive, at a minimum, weekly supervision by a qualified clinical supervisor employed by the provider of services.
(71) "Mobile Crisis Services" means mental health services for individuals in crisis provided by mental health practitioners who respond to behavioral health crises onsite at the location in the community where the crisis arises and who provide a face-to-face therapeutic response. The goal of mobile crisis services is to help an individual resolve a psychiatric crisis in the most integrated setting possible and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration.
(72) "Mobile Crisis Response Time" means the time from the point when a professional decision is made that a face-to-face intervention is required to the time the actual face-to-face intervention takes place in the community.
(73) “Nursing Services” means services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) within the scope of practice as defined in OAR 851-045-0060.
(74) “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.
(75) “Outpatient Community Mental Health Services and Supports” means all outpatient mental health services and supports provided to children, youth, and adults.
(76) “Outpatient Problem Gambling Treatment Services” means all outpatient treatment services and supports provided

to individuals with gambling related problems and their families.
(77) "Outreach" means the delivery of behavioral health services, referral services, and case management services in non-traditional settings including 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 means attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.
(78) “Peer” means any individual supporting an individual or the individual's family member 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.
(78) “Peer Delivered Services” means an array of agency or community-based services and supports provided by peer support specialists and peer wellness specialists to individuals or family members with similar lived experience that are designed to support the needs of individuals and families as applicable.
(80) "Peer Support Specialist" means an individual providing peer delivered services to an individual or family member with similar life experience under the supervision of a qualified clinical supervisor and a qualified peer delivered services supervisor, as practicable. A peer support specialist shall be certified by the Authority’s Office of Equity and Inclusion as required by OAR 410-180-0300 to 0380 and be:
(a) A self-identified individual currently or formerly receiving addictions or mental health services;
(b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;
(c) A self-identified individual in recovery from problem gambling; or
(d) A person who has experience parenting a child who:
(A) Is a current or former consumer of mental health or addiction treatment; or
(B) Is facing or has faced difficulties in accessing education and health and wellness services due to a mental health or behavioral health barrier.
(81) “Peer Support and Peer Wellness Specialist Supervision" means supervision by a certified PSS or PWS with at least one year of experience as a PSS or PWS in behavioral health services or supervision by a qualified PSS/PWS supervisor and a qualified clinical supervisor. The supports provided include guidance in the unique discipline of peer delivered services and the roles of peer support specialists and peer wellness specialists.
(82) “Peer Delivered Services Supervisor" means an individual qualified to evaluate and guide PSS and PWS program staff in the delivery of peer delivered services and supports.
(83)“Peer Wellness Specialist” means an individual who supports an individual in identifying mental health service and support needs through community outreach, assisting individuals with access to available services and resources, addressing barriers to services, and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness. A peer wellness specialist shall be certified by the Authority’s Office of Equity and Inclusion as required by OAR 410-180-0300 to 0380 and be:
(a) A self-identified individual currently or formerly receiving mental health services; or
(b) A self-identified individual 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.
(84) “Problem Gambling Treatment Staff” means an individual certified or licensed by a health or allied provider agency to provide problem gambling treatment services that include assessment, development of a service plan, and group and family counseling.
(85) "Program" means a particular type or level of service that is organizationally distinct.
(86) "Program Administrator" or "Program Director" means an individual with appropriate professional qualifications and experience who is designated to manage the operation of a program.
(87) "Program Staff" means an employee or individual who by contract with the program provides a service and has the applicable competencies, qualifications, or certification required to provide the service.

(88) “Provider” means an individual, organizational provider, or Community Mental Health Program as designated under ORS 430.637(1)(b) that holds a current certificate to provide outpatient behavioral health treatment or prevention services pursuant to these and other applicable service delivery rules.
(89) "Psychiatric Security Review Board (PSRB)" means the entity described in ORS 161.295 through 161.400.
(90) "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.
(91) "Psychologist" means a psychologist licensed by the Oregon Board of Psychologist Examiners.
(92) “Publicly Funded” means financial support in part or in full with revenue generated by a local, state, or federal government.
(93) "Qualified Mental Health Associate (QMHA)” means an individual delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-019-0125.
(94) "Qualified Mental Health Professional (QMHP)" means a LMP or any other individual meeting the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-019-0125.
(95) "Qualified Person" means an individual who is a QMHP or a QMHA and is identified by the PSRB and JPSRB in its Conditional Release Order. This individual is designated by the provider to deliver or arrange and monitor the provision of the reports and services required by the Conditional Release Order.
(96) "Quality Assessment and Performance Improvement" means the structured, internal monitoring and evaluation of services to improve processes, service delivery, and service outcomes.
(97) “Recovery” means a process of healing and transformation for an individual to achieve full human potential and personhood in leading a meaningful life in communities of their choice.
(98) "Representative" means an individual 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, Division employee, attorney, or legal guardian.
(99) “Resilience” means the universal capacity that an individual uses to prevent, minimize, or overcome the effects of adversity. Resilience reflects an individual’s strengths as protective factors and assets for positive development.
(100) "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 may be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the service plan.
(101) “Safety Plan” means a best practice research-based individual directed document developed through a collaborative process in which the provider assists the individual in listing strategies to use when suicide ideation is elevated or after a suicide attempt.
(102) "Screening" means the process to determine whether the individual needs further assessment to identify circumstances requiring referrals or additional services and supports.
(103) “Screening Specialist” means an individual who possesses valid certification issued by the Division to conduct DUII evaluations.
(104) "Service Plan" means a comprehensive plan for services and supports provided to or coordinated for an individual and their family, as applicable, that is reflective of the assessment and the intended outcomes of service.
(105) “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.
(106) “Service Record” means the written or electronic documentation regarding an individual and resulting from entry, assessment, orientation, services and supports planning, services and supports provided, and transfer.
(107) "Services" means 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.
(108) “Signature” means any written or electronic means of entering the name, date of authentication, and credentials of the individual providing a specific service or the individual authorizing services and supports. Signature also means any

written or electronic means of entering the name and date of authentication of the individual, guardian, or any authorized representative of the individual receiving services.
(109) "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.
(110) "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.
(111) "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, and includes but is not limited to substance induced psychotic disorder, mood disorder, as defined in DSM criteria.
(112) “Substance Use Disorders Treatment and Recovery Services” means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.
(113) “Substance Use Disorders Treatment Staff” means an individual 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.
(114) “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.
(115) “Suicide Risk Assessment” means a best practice assessment supported by research to determine an individual’s risk for suicide.
(116) “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.
(117) “Transfer” means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.
(118) “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.
(119) "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.
(120) “Triage” means a classification process to determine priority needs.
(121) "Urinalysis Test" means an initial test and, if positive, a confirmatory test:
(a) An initial test shall 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 shall be by a different analytical method from that of the initial test to ensure reliability and accuracy;
(c) All urinalysis tests shall be performed by laboratories meeting the requirements of OAR 333-024-0305 through 0365.
(122) "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.
(123) "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.
(124) "Volunteer" means an individual who provides a program service or takes part in a program service and is not a program employee and is not paid for services. The services shall be non-clinical unless the individual has the required credentials to provide a clinical service.
(125) “Warm Handoff” has the meaning given that term in OAR 309-032-0860
(126) “Wellness” means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.
(127) “Wraparound” means a high fidelity model of team-based intensive care coordination for children and their families based on National Wraparound Initiative values and principles.
(128) “Young Adult in Transition” means an individual who is developmentally transitioning into independence, sometime between the ages of 14 and 25.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0110
Provider Policies
(1) All providers shall develop and implement written personnel policies and specific 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 943-007-0001 through 0501; and
(d) Fraud, waste, and abuse in federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510.
(2) All providers shall develop and implement written service delivery policies and specific procedures compliant with these rules:
(a) Service delivery policies shall be available to individuals and family members upon request; and
(b) Service delivery policies and procedures shall 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 Division Trauma Informed Services Policy;
(H) Provision of culturally and linguistically appropriate services;
(I) Crisis prevention and response, including suicide risk assessment, safety planning, and lethal means counseling;
(J) Incident reporting; and
(K) Peer delivered services.

(3) Providers of ECS services shall develop behavior support policies consistent with OAR 309-019-0155(3).
(4) Community Mental Health Programs shall develop policies for linkage agreements compliant with OAR 309-032-0870.
(5) The provider's policies and procedures shall:
(a) Prohibit titration of medications prescribed for the treatment of opioid dependence as a condition of receiving treatment;
(b) Allow continued use of medications prescribed for opioid dependence based on individual choice and physician recommendation; and
(c) Prohibit transfer of individuals who are prescribed medication for the treatment of opioid dependence based solely on the individual's initial or continued use of the medication.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 413.520 - 413.522, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 services and supports that are consistent with the assessment and 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 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, including medications used to treat opioid dependence;
(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) Be informed of suicide risk;
(q) Have family and guardian involvement in service planning and delivery;
(r) Make a Declaration for Mental Health Treatment when legally an adult;
(s) File grievances, including appealing decisions resulting from the grievance;
(t) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
(u) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
(v) Exercise all rights described in this rule without any form of reprisal or punishment.
(2) The provider shall 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 shall 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 shall be explained to the individual, and if applicable the guardian; and
(c) Individual rights shall be posted in writing in a common area.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.495, 430.640, 443.450
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380- 426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0120
Licensing and Credentialing
Program staff in the following positions must meet applicable credentialing or licensing standards, including those set forth in these rules:
(1) Substance Use Disorders Treatment Staff.
(2) Clinical Supervisors.
(3) LMPs.
(4) Medical Directors.
(5) Peer Support Specialists.
(6) Peer Wellness Specialists.
(7) Peer Delivered Services Supervisor;
(8) Problem Gambling Treatment Staff.
(9) QMHAs.
(10) QMHPs.
Statutory/Other Authority: ORS 430.256, 430.640
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 428.205 - 428.270, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: Suspended by MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0125
Specific Staff Qualifications and Competencies
Program staff shall meet the following qualifications, credentialing or licensing standards and competencies:
(1) Program administrators or program directors shall 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 shall demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources; group, family, and individual therapy or counseling; best practices for suicide risk assessment, lethal means counseling, and safety planning; documentation and rationale for services to promote intended outcomes; and implementation of all provider policies.
(3) Clinical supervisors in mental health programs shall 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 shall 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 shall have included at least:
(A) 4000 hours of supervised experience in substance use counseling;
(B) 300 contact hours of education and training in substance use related subjects; and
(C) Successful completion of a written objective examination or portfolio review by the certifying body.
(b) For supervisors holding a health or allied provider license, the license or registration shall have been issued by one of the following state bodies, and the supervisor shall possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of substance use disorders:
(A) 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 shall have one of the following qualifications:
(A) Five years of paid full-time experience in the field of substance use disorders counseling; or
(B) A Bachelor's degree and four years of paid full-time experience in the social services field with a minimum of two years of direct substance use disorders counseling experience; or
(C) A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct substance use disorders counseling experience.
(5) Clinical supervisors in problem gambling treatment programs shall meet the requirements for clinical supervisors in either mental health or substance use disorders treatment programs and have completed ten hours of gambling specific training within two years of designation as a problem gambling services supervisor.
(6) Peer Delivered Services Supervisors shall be a certified Peer Support Specialist (PSS) or Peer Wellness Specialist (PWS) with at least one year experience.
(7) Substance use disorders treatment staff shall:
(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, suicide risk associated with problem gambling, 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 shall make application for certification no later than six months following that date. The two years is not renewable if the individual 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 shall 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 shall have been issued by one of the following state bodies, and the individual shall 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.
(8) Problem Gambling treatment staff shall:
(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 shall make application for certification no later than six months following that date. The two years is not renewable if the individual 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 shall include 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 shall be issued by one of the following state bodies, and the individual shall 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.
(9) QMHAs shall demonstrate the ability to communicate effectively; understand mental health assessment, treatment, and service terminology as well as suicide risk assessment, lethal means counseling, and safety planning; 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 shall a 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 OAR 309-019-0105.
(10) QMHPs shall 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; conducting a mental status examination; completing a DSM diagnosis; conducting best practice suicide risk assessments, lethal means counseling, and safety planning; writing and supervising the implementation of a service plan; and providing individual, family, or group therapy within the scope of their training. In addition, QMHPs shall 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; or
(g) A qualified Mental Health Intern, as defined in 309-019-0105.
(11) Peer support specialists and peer wellness specialists, including family and youth support and wellness specialists, shall meet the requirements in OARs 410-180-0310, 410-180-0312, and 410-180-0320 for certification and continuing education. They shall also:
(a) Demonstrate the ability to support others in their recovery or resiliency; and
(b) Demonstrate personal life experience and tools of self-directed recovery and resiliency.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: 430.254 - 430.640, 430.850 - 430.955, 743A.168, ORS 428.205 - 428.270, 430.010, 430.205 - 430.210
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 3-2015, f. & cert. ef. 5-28-15; MHS 1-2015(Temp), f. & cert. ef. 3-25-15 thru 9-20-15; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0130

Personnel Documentation, Training and Supervision

(1) Providers shall maintain personnel records for each program staff that contains all of the following documentation:
(a) When required, verification of a criminal record check consistent with OAR 943-007-0001 through 0501;
(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. Documentation shall include the date supervision took place, the amount of supervision time, and a brief description of relevant topics discussed.
(2) Providers utilizing contractors, interns, or volunteers shall 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 943-007-0001 through 0501.
(3) Providers shall ensure that program staff receives training applicable to the specific population for whom services are planned, delivered, or supervised. The program shall document appropriate orientation for each program staff or individual providing services within 30 days of the hire date. At a minimum, training and orientation for all program staff shall 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) Care Coordination;
(h) For Enhanced Care Services, positive behavior support training; and

(i) Declaration for Mental Health Treatment.
(4) Program staff providing direct services shall receive clinical supervision by a qualified clinical supervisor related to the development, implementation, and outcome of services:
(a) Supervision shall be provided to assist program staff to increase their skills within their scope of practice, improve quality of services to individuals, and supervise program staff and volunteers' compliance with program policies and procedures;
(b) Documentation of two hours per month of supervision for each individual supervised. The two hours shall include one hour of individual face-to-face contact 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. The two hours shall include at least one hour of individual face-to-face contact for each individual supervised. Individual face-to-face contact may include real time, two-way audio visual conferencing;
(d) Documentation of weekly supervision for program staff meeting the definition of mental health intern; or
(e) As practicable, for persons providing direct Peer Delivered Services, one hour of supervision shall be provided by a qualified Peer Delivered Services Supervisor, as practicable.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 109.675, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0135

Entry and Assessment

(1) The program shall utilize an entry procedure that at a minimum shall ensure the provision and documentation of the following:
(a) Individuals shall be considered for entry without regard to race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when program eligibility is restricted to children, adults, or older adults), familial status, marital status, source of income, and disability;
(b) The provider may not deny entry to individuals who are prescribed medication to treat opioid dependence;
(c) Individuals shall receive services in the most timely manner feasible consistent with the presenting circumstances;
(d) Written voluntary informed consent for services shall be obtained from the individual or guardian prior to the start of services. If consent is not obtained, the reason shall be documented and further attempts to obtain informed consent shall be made as appropriate;
(e) The provider shall develop and maintain service records and other documentation for each individual that demonstrates the specific services and supports for which payment has been requested;
(f) The provider shall report the entry of all individuals on the mandated state data system;
(g) In accordance with ORS 179.505 and HIPAA, an authorization for the release of information shall be obtained for any confidential information concerning the individual being considered for or receiving services;
(h) At the time of entry, the program shall offer to the individual and guardian, if applicable, written program orientation information. The written information shall be in a language understood by the individual and shall 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) Policy concerning grievances and appeals consistent with these rules including an example grievance form;
(D) Notice of privacy practices; and

(E) An opportunity to register to vote.
(2) Entry of individuals whose services are funded by the Substance Abuse Prevention Treatment (SAPT) Block Grant shall 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) Pregnant women or other individuals using substances intravenously, whose services are funded by the SAPT Block Grant, shall receive interim referrals and information prior to entry to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services shall include:
(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;
(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; and
(e) Peer Delivered Services that address parenting and youth in transition support.
(4) Assessment:
(a) At the time of entry, an assessment shall be completed;
(b) The assessment shall 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 shall 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 shall be consistent with the dimensions described in the ASAM and shall document a diagnosis and level of care determination consistent with the DSM and ASAM;
(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 shall document referral for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider;
(f) Providers shall periodically update assessments, including suicide risk assessments, as applicable, when there are changes in clinical circumstances or risk factors for suicide; and
(g) Any individual continuing to receive mental health services for one or more continuous years shall receive an annual assessment, including a suicide risk assessment by a QMHP.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0140
Service Plan and Service Notes
(1) In addition to any program specific service delivery requirements, the service plan shall be an individualized plan

designed 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 shall:
(a) Reflect the full assessment and the level of care to be provided;
(b) Include the participation of the individual and family members, as applicable;
(c) Be completed and signed by qualified program staff as follows:
(A) A QMHP in mental health programs;
(B) Supervisory or treatment staff in substance use disorders treatment programs; and
(C) Supervisory or treatment staff in problem gambling treatment programs.
(d) For mental health services, a QMHP who is also a licensed health care professional shall recommend the services and supports by signing the service plan within ten business days of the start of services; and
(e) An LMP shall 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 shall include:
(a) Treatment objectives that are:
(A) Individualized to meet the assessed needs of the individual;
(B) Measurable for the purpose of evaluating individual progress, including a baseline evaluation.
(b) The specific services and supports indicated by the assessment that shall be used to meet the treatment objectives;
(c) A projected schedule for service and support delivery, including the expected frequency and duration of each type of planned therapeutic encounter and peer support services;
(d) The credentials of the personnel that will be providing each service and support; and
(e) A projected schedule for re-evaluating the service plan.
(3) Providers shall document each service and support in a Service Note to include:
(a) The specific services rendered;
(b) The specific service plan objectives being addressed by the services provided;
(c) The date, time of service, and the actual amount of time the services were rendered;
(d) The relationship of the services provided to the treatment objective described in the service plan;
(e) The personnel rendering the services, including their signature and credential;
(f) The setting in which the services were rendered.
(4) Decisions to transfer individuals shall be documented including:
(a) The reason for the transfer;
(b) Referrals to follow up services and other behavioral health providers; and
(c) Outreach efforts made as indicated.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 shall provide concurrent service and support planning and delivery for substance use disorders, gambling disorder, and mental health diagnosis, including integrated assessment addressing co-occurring behavioral health diagnoses, service plan, and service record.

Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0150

Community Mental Health Programs: Outpatient Mental Health Services to Children and Adults

(1) Crisis services shall be provided directly or through linkage to a local crisis services provider and shall include the following:
(a) Twenty-four hours, seven days per week telephone or face-to-face screening within one hour of notification of the crisis event to determine an individual's need for immediate community mental health services; and
(b) Twenty-four hours, seven days per week capability to conduct, by or under the supervision of a QMHP, an assessment, including suicide risk 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 shall be provided including the following:
(a) Program staff shall 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 shall 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;
(c) Assistance with a warm handoff process, as indicated, compliant with OAR 309-032-0870;
(d) Assistance with a follow-up visit within seven days of discharge from an acute care psychiatric hospital, as indicated, compliant with OAR 309-032-0870; and
(e) Referral and coordination to help individuals at risk of suicide and their families.
(3) When significant health and safety concerns are identified, program staff shall ensure that necessary services or actions occur to address the identified health and safety needs for the individual, including services to individuals at imminent risk of suicide as determined by the suicide risk assessment.
(4) Peer Delivered Services shall be made available.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0151

Community Mental Health Programs: Mobile Crisis Services

(1) By July 1, 2018, or when the CMHP is contracted to provide the service, CMHP or their designee shall provide mobile crisis services as a component of crisis services according to OAR 309-019-0150 for individuals experiencing mental health crisis within their respective geographic service area to meet the following objectives:
(a) Reduce acute psychiatric hospitalization of individuals experiencing mental health crisis; and
(b) Reduce the number of individuals with mental health diagnoses who are incarcerated as a result of mental health crisis events involving law enforcement.
(2) Mobile crisis services include, at a minimum but is not limited to:
(a) Twenty-four hours a day, seven days a week screening to determine the need for immediate services for any individual requesting assistance or for whom assistance is requested;
(b) Within appropriate safety considerations, a face-to-face therapeutic response delivered in a public setting at locations in the community where the crisis arises including but not limited to an individual’s home, schools, residential

programs, nursing homes, group home settings, and hospitals to enhance community integration;
(c) Mental health crisis assessment;
(d) Crisis intervention;
(e) Assistance with placement in crisis respite, peer respite, or residential services as defined in OAR 309-035-0100;
(f) Assistance to families and families of choice in managing suicide risk until the individual is engaged in outpatient services or when the individual is to receive services on an outpatient basis;
(g) Initiation of involuntary services if applicable;
(h) Assistance with hospital placement; and,
(i) Connecting individuals with ongoing supports and services.
(3) Counties shall track and report response time. Counties shall respond to crisis events in their respective geographic service area with the following maximum response times:
(a) Counties defined as "urban" shall respond within one hour;
(b) Counties defined as "rural" shall respond within two hours;
(c) Counties defined as "frontier" shall respond within three hours;
(d) Counties defined as "rural" and "frontier" shall contact an individual experiencing a crisis event via telephone by a staff member who is trained in crisis management within one hour of being notified of the crisis event.
(4) By July 1, 2018, each CMHP shall develop and implement policies and procedures to monitor the number of instances that mobile crisis response times exceed the maximum response times established in OAR 309-019-0151.
(5) The CMHP shall submit electronically a written quarterly report using forms and procedures prescribed by the Authority to the Division contract administrator no later than 45 calendar days following the end of each reporting quarter.
(6) The CMHP shall track and report the number of individuals receiving a mobile crisis services contact to include the following information:
(a) Location of mobile crisis service;
(b) Disposition of the mobile crisis contact;
(c) Whether the crisis contact resulted in admission to acute care; or
(d) If the mobile crisis contact resulted in referral in mental health treatment and stabilization in a community setting.
(7) Counties shall track and report response time consistent with required response time.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 109.675, 161.390 – 161.400, 413.520 – 413.520 – 413.522, 430.010, 430.205 – 430.210, 430.254 – 430.640, 430.850 – 430.955, 461.549, 743A.168, 813.010 – 813.052, 813.200 – 813.270
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0152
Mobile Crisis Response Reporting Requirements
(1) The CMHP shall submit electronically a written quarterly report using forms and procedures prescribed by the Authority to the Division contract administrator no later than 45 calendar days following the end of each reporting quarter:
(2) The CMHP shall track and report the number of individuals receiving a mobile crisis services contact to include the following information:
(a) Location of mobile crisis service;
(b) Disposition of the mobile crisis contact;
(c) Whether the crisis contact resulted in admission to acute care; or
(d) If the mobile crisis contact resulted in referral in mental health treatment and stabilization in a community setting.
(3) Counties shall track and report response time:

(a) Counties classified as “urban” shall respond within one hour;
(b) Counties classified as “rural” shall respond within two hours;
(c) Counties classified as “frontier” shall respond within three hours.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630, 430.634
History: Suspended by MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0155

Enhanced Care Services (ECS) and Enhanced Care Outreach Services (ECOS)

(1) To be eligible for ECS/ECOS, an individual shall:
(a) Be APD service eligible;
(b) Meet the diagnostic criteria of severe mental illness with complex behaviors 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 complex behaviors; and
(e) Be currently or have been a patient at the Oregon State Hospital or have received inpatient 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 complex behaviors and be currently exhibiting two or more of the following: self-endangering behavior, aggressive behavior, intrusive behavior, intractable psychiatric symptoms, complex medication needs, sexually inappropriate behavior, and elopement behavior.
(2) ECS/ECOS providers shall:
(a) For ECS, provide a minimum of four hours per day or additional hours as required to support the needs of the enhanced care facility, seven days per week of mental health staffing provided or arranged for by the contracted mental health provider;
(b) Coordinate interdisciplinary team meetings (IDT) to develop the service plan, review the behavior support plan, and to coordinate care planning with the Department of Human Services (Department) licensed provider staff, APD case manager, QMHP, prescriber and related professionals such as the Department licensed facility or program direct care staff, the Department licensed facility RN, and facility administrator. IDTs in ECS programs shall be held weekly and at least quarterly for ECOS;
(c) Coordinate quarterly behavioral health trainings for Department-licensed providers and related program staff providing services to ECS and ECOS recipients; and
(d) Ensure the availability of consultation and crisis services staffed by a QMHP or the local CMHP available to the ECS and ECOS provider and the Department licensed facility direct care staff 24-hours per day.
(3) Behavior support services shall be designed to facilitate positive alternatives to challenging behavior and to assist the individual in developing adaptive and functional living skills. Providers shall:
(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 that ensures 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.
(4) Providers shall develop a transition plan for each individual as part of the initial assessment process. Each individual's mental health service plan shall reflect their transition goal and the supports necessary to achieve transition.
(5) Staffing requirements include:
(a) Each ECS and ECOS program shall have a minimum of one 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 coordinating services and trainings with facility staff;
(b) Each ECS and ECOS program shall have psychiatric consultation available. For ECS programs serving more than ten individuals, the psychiatrist shall participate.
(6) In ECS programs, the CMHP and the Department licensed provider shall develop a written collaborative agreement that addresses at a 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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.640, 443.450
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0160

Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board

(1) Services and supports shall include all appropriate services, including peer delivered services, determined necessary to assist the individual in maintaining community placement and that are consistent with Conditional Release Orders and the Agreement to Conditional Release.
(2) Providers of PSRB and JPSRB services acting through the designated qualified individual shall submit reports to the PSRB or JPSRB as follows:
(a) For individuals under the jurisdiction of the PSRB or the JPSRB, providers shall 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 individual designated to serve as the individual's qualified person who shall 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 that 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 shall 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 shall 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.
Statutory/Other Authority: 430.640, 443.450, ORS 161.390, 413.042, 430.256, 426.490 - 426.500
Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 426.380 - 426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0165

Intensive Outpatient Services and Supports (IOSS) for Children

(1) IOSS 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, IOSS services shall include:
(a) Provider participation on the child and family team or wraparound team;
(b) A documented proactive safety and crisis plan developed by the child and family team. The proactive safety and crisis plan shall at minimum include:
(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) IOSS providers shall include the following additional documentation in the service record:
(a) Identified care coordinator and care coordination provider as well as documentation of provider participation on child and family team or wraparound team;
(b) Documented identification of strengths and needs;
(c) A summary and review of service coordination planning by the provider or by the child and family team or wraparound team when applicable; and
(d) A documented proactive safety and crisis plan.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254-430.640, 430.850 - 430.955
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0170

Outpatient Problem Gambling Treatment and Recovery Services

Outpatient problem gambling treatment services include group, individual, and family treatment consistent with the following requirements:

(1) The first offered service appointment shall be five or fewer business days from the date of request for services.

(2) Service sessions shall address the challenges of the individual as they relate, directly or indirectly, to the problem gambling behavior.

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

(a) The individual shall be currently enrolled in the problem gambling treatment program;

(b) Phone counseling shall be provided by a qualified program staff within their scope of practice;

(c) Service notes for phone counseling shall 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 shall meet HIPAA and 42 CFR standards for privacy; and

(e) There shall 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 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 shall address the problems of the family member as they relate directly or indirectly to the problem gambling behavior; and

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

(5) Twenty-four hour crisis response shall be accomplished through agreement with other crisis services, on-call program staff, or other arrangement acceptable to the Division.

(6) A financial assessment shall be included in the entry process and documented in the assessment.

(7) The service plan shall include a financial component consistent with the financial assessment.

(8) A risk assessment for suicide ideation shall be included in the entry process and documented in the assessment as well as appropriate referrals made.

(9) The service plan shall address suicidal risks if determined within the assessment process.

Statutory/Other Authority: ORS 161.390, 430.640, 461.549

Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380- 426.395, 426.490 - 426.500, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 3-2015, f. & cert. ef. 5-28-15; MHS 1-2015(Temp), f. & cert. ef. 3-25-15 thru 9-20-15; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0175

Culturally Specific Substance Use Disorders Treatment and Recovery Services

(1) Programs approved and designated as culturally specific programs shall 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 awareness policies;
(j) Ensure that data on an 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 shall be within close proximity to the culturally specific populations;
(B) Where available, public transportation shall be within close proximity to the program; and
(C) Hours of service, telephone contact, and other accessibility issues shall be appropriate for the population.
(m) The physical facility where the culturally specific services are delivered shall be psychologically comfortable for the group including:
(A) Materials displayed shall be culturally relevant; and
(B) Mass media programming shall be sensitive to cultural background.
(n) Other cultural differences shall 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.
Statutory/Other Authority: ORS 413.042, 430.640, 443.450
Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 shall meet the following standards:
(1) Development of service plans and case management services shall include participation of parents, other family members, schools, children's services agencies, and juvenile corrections, as appropriate.
(2) Services or appropriate referrals shall include:
(a) Family counseling;
(b) Community and social skills training; and
(c) Smoking cessation service.
(3) Continuing care services shall be of appropriate duration and designed to maximize recovery opportunities. The services shall include:
(a) Reintegration services and coordination with family and schools;
(b) Youth dominated self-help groups where available;
(c) Referral to emancipation services when appropriate;

(d) Referral to physical or sexual abuse counseling and support services when appropriate; and
(e) Referral for peer delivered services.
Statutory/Other Authority: ORS 161.390, 413.042, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 430.010, 428.205 - 428.270, 430.205 - 430.210, 430.254-430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 shall meet the following standards:
(a) The assessment shall 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 shall address all areas identified in the assessment and applicable service coordination details to address the identified needs;
(c) The program shall 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 shall 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 services;
(E) Smoking cessation;
(F) Housing; and
(G) Transportation.
(2) Services shall include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies.
(3) The program shall coordinate referral 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;
(b) Parenting training;
(c) Continuing care treatment services shall be consistent with the ASAM and shall include referrals to female dominated support groups where available.
Statutory/Other Authority: ORS 161.390, 413.042, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254-430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0187

Substance Abuse Prevention Treatment (SAPT) Block Grant

Programs that receive SAPT Block Grant funding shall provide or coordinate the following services for individuals:
(1) Primary medical care, including referral for prenatal care if applicable, and child care and transportation where needed;

(2) Primary pediatric care, including immunizations for their children;
(3) Gender specific substance use disorders treatment and other therapeutic interventions that may include but are not limited to:
(a) Relationship issues;
(b) Sexual and physical abuse;
(c) Parenting;
(d) Access to child care and transportation while receiving these services; and
(e) Therapeutic interventions for children in the custody of women or men in treatment that may include but are not limited to:
(A) Their developmental needs;
(B) Any issues concerning sexual and physical abuse and neglect; and
(C) Sufficient case management and transportation to ensure that women and their children have access to services.
Statutory/Other Authority: ORS 161.390, 413.042, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254-430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18

309-019-0190

Community-Based Substance Use Treatment Programs for Individuals in the Criminal Justice System

(1) For individuals in the criminal justice system, community-based substance use treatment 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 shall 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 shall demonstrate coordination of services with criminal justice partners through written protocols, program staff activities, and individual record documentation.
(4) Program directors or clinical supervisors shall 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 shall:
(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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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;
(b) Placement, continued stay, and transfer of individuals must be based on the criteria described in the ASAM PPC, subject to the following:
(A) Individuals must demonstrate continuous abstinence for a minimum of 90 days prior to completion as documented by urinalysis tests and other evidence;
(B) Only DUII rehabilitation programs may certify treatment completion;
(C) Using the criteria from the ASAM, 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) 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 outlined in these rules, the samples must be tested for at least five controlled drugs, including alcohol;
(b) At least one of the samples must be collected and tested in the first two weeks of the program, and at least one must 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) The program must report:
(a) To the Division on Division prescribed forms;
(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 ten 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) 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 may not be issued until the individual:
(a) Meets the completion criteria approved by the Division;
(b) Meets the terms of the fee agreement between the provider and the individual; and
(c) Demonstrates 90 days of continuous abstinence prior to completion.
(5) 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) Without the approval of the chief officer, no agency or individual may provide DUII rehabilitation to an individual who has also been referred by a judge to the same agency or individual for a DUII screening. Failure to comply with this rule shall 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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.640, 443.450
Statutes/Other Implemented: ORS 161.390 - 161.400, 430.010, 428.205 - 428.270, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 743A.168
History: MHS 6-2017, f. & cert. ef. 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0200

Medical Protocols in Outpatient Substance Use Disorders Treatment and Recovery Programs

Medical protocols shall be approved by a medical director under contract with a program or written reciprocal agreement with a medical practitioner under coordinated care. The protocols shall:

(1) Require a medical history be included in the assessment.

(2) Designate those medical symptoms and conditions that, when found, require further investigation, physical examinations, treatment, 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 shall 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.

(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.

Statutory/Other Authority: ORS 430.640, 443.450

Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 assure 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 individuals 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.

(6) Outpatient programs may not allow tobacco use in program facilities and on program grounds.

Statutory/Other Authority: ORS 413.042, 430.640, 443.450

Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.524 - 430.640, 430.850 - 430.955, 443.400 - 443.460

History: Suspended by MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0210

Quality Assessment and Performance Improvement

Providers shall 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.
Statutory/Other Authority: ORS 430.640
Statutes/Other Implemented: ORS 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955
History: MHS 6-2017, f. & cert. ef. 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0215

Grievances and Appeals

(1) Any individual or parent or guardian receiving services may file a grievance with the provider, the individual's coordinated care plan, or the Division.
(2) For individuals whose services are funded by Medicaid, grievance and appeal procedures are set forth in OAR 410-141-0260 through 410-141-0266.
(3) For individuals whose services are not funded by Medicaid, providers shall:
(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 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 individual 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) The provider shall have a Grievance Process Notice that shall be posted in a conspicuous place stating the telephone number of:
(a) The Division complaints representative;
(b) Disability Rights Oregon;
(c) Any applicable Coordinated Care Organization; and
(d) The Governor's Advocacy Office.
(5) In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures are completed, the individual or guardian of the individual may request an expedited review. The program administrator shall review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response shall include information about the appeal process.
(6) A grievant, witness, or staff member of a provider may 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) 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) Individuals and their legal guardians may appeal entry, transfer, and grievance decisions as follows:
(a) If the individual or guardian 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. The appeal shall be submitted to the Division;
(b) If requested, program staff shall be available to assist the individual;
(c) The Division shall provide a written response within ten working days of the receipt of the appeal; and
(d) If the individual or guardian is not satisfied with the appeal decision, they may file a second appeal in writing within ten working days of the date of the written response to the chief officer.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640

Statutes/Other Implemented: 430.254 - 430.640, 430.850 - 430.955, 743A.168, ORS 161.390 - 161.400, 179.505, 428.205 - 428.270, 430.010, 430.205 - 430.210
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0220

Variances

(1) Requirements and standards for requesting and granting variances or exceptions are found in OAR 309-008-1600.
(2) The Division's chief officer or designee shall approve or deny the request for a variance to these rules. The request shall be made in writing using the Division approved variance request form and following the variance request procedure pursuant to OAR 309-008-1600.
(3) Granting a variance for one request does not set a precedent that shall be followed by the Division when evaluating subsequent requests for variance.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-019-0225

Assertive Community Treatment (ACT) Definitions

(1) In addition to the definitions in OAR 309-019-0105, the definitions below apply to this and subsequent rule sections.
(2) "Collateral Contacts" means members of the individual's family or household or significant others (e.g., landlord, employer) who regularly interact with the individual and are directly affected by or have the capability of affecting their condition and are identified in the treatment plan as having a role in the individual's recovery. For the purpose of the Assertive Community Treatment (ACT) program, a collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g., meeting with a shelter staff who is assisting an ACT recipient in locating housing).
(3) "Community-Based" means services and supports that shall be provided in a participant's home and surrounding community and not solely based in a traditional office-setting. ACT services may not be provided to individuals residing in an RTF or RTH licensed by the Division unless:
(a) The individual is not being provided rehabilitative services; or
(b) The individual has been identified for transition to a less intensive level of care. When identified for transition to a less intensive level of care, the individual may receive ACT services for up to six months prior to discharge from the RTH or RTF.
(4) "Competency" means one year of experience or training in the specialty area and demonstration of the specific skills or knowledge.
(5) "Competitive Integrated Employment" means full-time or part time work:
(a) At minimum wage or higher;
(b) At a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees 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;
(c) With eligibility for the level of benefits provided to other employees;
(d) At a location where the employee interacts with other individuals 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 individuals; and
(e) That present opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.
(6) “Comprehensive Assessment” means the organized process of gathering and analyzing current and past information with each individual and the family and support system and other significant individuals 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 or professional roles, talents, personal traits) that may act as resources to the individual and the recovery planning team in pursuing goals. 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 family and natural support network in the community.
(7) “Co-Occurring Disorders (COD) Services” means integrated assessment and treatment for individuals who have co-occurring mental health and substance use condition.
(8) “Division Approved Reviewer” means the Division’s contracted entity that is responsible for conducting ACT fidelity reviews, training, and technical assistance to support new and existing ACT programs statewide.
(9) “Fidelity” for the purposes of the ACT program means the provider is providing services that are faithful to the evidence-based practice model and obtains a satisfactory score from the Oregon Center of Excellence for ACT as part of the their regular reviews.
(10) “Fixed Point of Responsibility” means the ACT team provides virtually all needed services, rather than sending clients to different providers. If the team cannot provide a service, the team ensures that the service is provided.
(11) “Full-Time Equivalent” (FTE) means a way to measure how many full-time employees are required to provide the appropriate level of services to fulfill minimum fidelity requirements.
(12) “Hospital Discharge Planning” means a process that begins upon admission to the Oregon State Hospital (OSH) or an acute care psychiatric 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. For OSH, discharge planning teams include a representative of a community mental health provider from the county where the individual is likely to transition.
(13) “Individual Placement and Support (IPS) Supported Employment Services” means individualized services that assist individuals to obtain and maintain integrated, paid, competitive employment. Supported employment services are provided in a manner that seeks to allow individuals to work the maximum number of hours consistent with their preferences, interests, and abilities and are individually planned, based on person-centered planning principles and evidence-based practices.
(14) “Individual Treatment Team (ITT)” means a group or combination of three to five ACT team staff members who together have a range of clinical and rehabilitation skills and expertise. The core members are the case manager, the psychiatrist or psychiatric nurse practitioner, one clinical or rehabilitation staff individual who backs up and shares case coordination tasks and substitutes for the service coordinator when they are not working, and a peer support and wellness specialist.
(15) “Initial Assessment and Individualized Treatment Plan” means the initial evaluation of:
(a) The individual’s mental and functional status;
(b) The effectiveness of past treatment; and
(c) The current treatment, rehabilitation, and support service needs. The results of the information gathering and

analysis are used to establish the initial treatment plan to support recovery and help the individual achieve their goals.
(16) “Large ACT Team” means an ACT team serving 80 to 120 individuals.
(17) “Life Skills Training” means training that helps individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.
(18) “Medication Management” means the prescribing and administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. For the purposes of ACT, medication management is a collaborative effort between the individual receiving services and the prescribing psychiatrist or psychiatric nurse practitioner with the ACT treatment team.
(19) “Mid-Size Act Team” means an ACT team serving between 41 and 79 individuals.
(20) “Natural Supports” means personal associations and relationships typically developed in the community that enhance the quality and security of life for individuals, including but not limited to family relationships, friendships reflecting the diversity of the neighborhood and the community, association with fellow students or employees in regular classrooms and work places, and associations developed though participation in clubs, organizations, and other civic activities.
(21) “Psychiatry Services” means the prescribing and administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. Psychiatry services shall be provided by a psychiatrist or a psychiatric nurse practitioner licensed by the Oregon Medical Board.
(22) “Single Point of Contact” (SPOC) means a designated individual in a service region that is responsible for coordinating and tracking referrals to ACT programs within their geographic service area.
(23) “Small ACT Team” means an ACT team serving between ten to 40 individuals.
(24) “Symptom Management” means to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment.
(25) “Telepsychiatry” means the application of telemedicine to the specialty field of psychiatry. The term describes the delivery of psychiatric assessment and care through telecommunications technology, usually videoconferencing.
(26) “Time-unlimited Services” means services that are provided not on the basis of predetermined timelines but if they are medically appropriate.
(27) “Vocational Services” 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0226
Assertive Community Treatment (ACT) Overview
(1) The Substance Abuse and Mental Health Services Administration (SAMHSA) characterizes ACT as an evidence-based practice for individuals with a serious and persistent mental illness. ACT is characterized by:
(a) A team approach;
(b) Community based;
(c) A small client to staff caseload, typically 10:1, to consistently provide necessary staffing diversity and coverage;
(d) Time-unlimited services;
(e) Flexible service delivery;
(f) A fixed point of responsibility; and
(g) 24/7 availability for response to psychiatric crisis.
(2) ACT services shall include but are not limited to:

(a) Hospital discharge planning, including OSH and acute care psychiatric hospitals;
(b) Case management;
(c) Symptom management;
(d) Psychiatry services;
(e) Nursing services;
(f) Co-occurring substance use and mental health disorders treatment services;
(g) Individual Placement and Support (IPS) supported employment services;
(h) Life skills training; and
(i) Peer delivered services.
(3) SAMHSA characterizes a high fidelity ACT program as one that includes the following staff members:
(a) Psychiatrist or Psychiatric Nurse Practitioner;
(b) Psychiatric Nurse;
(c) Qualified Mental Health Professional (QMHP) ACT Team Supervisor;
(d) Qualified Mental Health Professional (QMHP) Mental Health Clinician;
(e) Substance Abuse Treatment Specialist;
(f) Employment Specialist;
(g) Mental Health Case Manager; and
(h) Certified Peer Support Specialist.
(4) SAMHSA characterizes high fidelity ACT programs as those that adhere to the following:
(a) Providing explicit admission criteria with an identified mission to serve a particular population using quantitative and operationally defined criteria;
(b) Managing intake rates. ACT eligible individuals are admitted to the program at a low rate to maintain a stable service environment;
(c) Maintaining full responsibility for treatment services that includes, at a minimum, the services required under OAR 309-019-0230(2)(a)–(i);
(d) Twenty-four hour responsibility for covering psychiatric crises;
(e) Involvement in hospital admissions, including OSH and acute care psychiatric hospitals;
(f) Involvement in planning for hospital discharges, including OSH and acute care psychiatric hospitals; and
(g) As long as medically appropriate, time-unlimited services.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

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 shall hold and maintain a certificate issued under the authority established in OAR chapter 309, division 008 issued by the Division for the purpose of providing outpatient behavioral health treatment services; and
(b) The provider shall hold and maintain a certificate issued by the Division under OAR 309-019-0225 through 025 for the purpose of providing ACT; and
(c) A provider certified to provide ACT services shall be reviewed annually for fidelity adherence by the Division approved reviewer and achieve a minimum score of 114 on the fidelity scale. Providers may not bill Medicaid or use General Funds for the provision of ACT services unless they complete 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 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 chapter 309, division 008 may request the addition of ACT services be added to their certificate of approval using the procedure outlined in OAR 309-008-0400 and 309-008-1000(1), in addition to application materials required in OAR chapter 309, division 008 and this rule. The provider shall also submit to the Division a letter of support that indicates receipt of technical assistance and training from the Division approved ACT reviewer.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 109.675, 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0235

ACT Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0230 to maintain an ACT provider designation on the Division issued certificate, a provider shall submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 114. Extension of a certification period has no bearing on the frequency or scope of fidelity reviews or re-certification reviews required under OAR chapter 309, division 008.
(2) Fidelity reviews shall be conducted utilizing the Substance Abuse and Mental Health Services ACT Toolkit Fidelity Scale, which the Division shall make available to providers electronically.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: 430.254 - 430.640, 430.850 - 430.955, 743A.168, ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0240

ACT Failure to Meet Fidelity Standards

(1) In addition to any plan of correction requirements issued by the Division under OAR 309-008-0800(4)(c), if a certified ACT provider does not receive a minimum score of 114 on any fidelity review, the following shall occur:
(a) Technical assistance shall be made available by the Division approved reviewer to address problem areas identified in the fidelity review;
(b) Technical assistance shall be available for a period of 90 days from the date of the fidelity review where the provider scored below the minimum established in section one of this rule;
(c) At the end of the 90 day period, a follow-up review shall be conducted by the Division approved reviewer;
(d) The provider shall forward a copy of the amended fidelity review report to the provider's CCO; and
(e) 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 who is 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.
Statutory/Other Authority: ORS 413.042, 430.256, 430.640

Statutes/Other Implemented: ORS 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0241

Waiver of Minimum Fidelity Requirements

(1) The Division may grant a waiver of minimum ACT fidelity requirements and extend an ACT program's certification period if the waiver to the requirement would not diminish the effectiveness of the ACT model, violate the purposes of the program, or adversely affect the program participants' health and welfare:
(a) Waivers may not be granted that are inconsistent with the individual participant's rights or federal, state, or local laws and regulations;
(b) The Division shall review waivers to minimum fidelity requirements on a case-by-case basis.
(2) Waivers granted to ACT minimum fidelity requirements shall result in an extension to the ACT program's certification period. An ACT program that is a Division approved waiver period is eligible to receive Medicaid and State General Fund reimbursement for ACT services if the ACT program meets the following criteria:
(a) The ACT program shall receive technical assistance from the Division approved reviewer and develop a plan to meet the minimum fidelity requirements; and
(b) The ACT program shall notify the appropriate CCO that the program is operating under the Division approved waiver of minimum fidelity requirements.
(3) The Division shall grant waivers of minimum fidelity requirements for a period that may not exceed 180 days.
(4) A waiver of minimum fidelity requirements may only be granted to ACT programs that have received a fidelity review within 12 months prior to the request.
(5) Requests for a waiver of minimum fidelity requirements shall be submitted to the Division's ACT program coordinator for approval.
Statutory/Other Authority: ORS 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0242

ACT Program Operational Standards

(1) All ACT teams shall be available seven days a week, 24 hours a day by direct phone link and regularly accessible to individuals who work or are involved in other scheduled vocational or rehabilitative services during the daytime hours. ACT teams may utilize split staff assignment schedules to achieve coverage.
(2) ACT teams are primarily responsible for crisis response and for after-hour calls related to individuals they serve. The ACT team shall operate continuous and direct after-hours on-call system with staff experienced in the program and skilled in crisis intervention procedures. The ACT team shall have the capacity to respond rapidly to emergencies, both in person and by telephone. To ensure direct access to the ACT team, individuals shall be given a phone list with the responsible ACT staff to contact after hours.
(3) Service Intensity:
(a) The ACT team shall have the capacity to provide the frequency and duration of staff-to-individual contact required by each individual's service plan and their immediate needs;
(b) The ACT team shall provide a minimum of 40 percent of all services in-community as demonstrated by the average in-community encounters reviewed in case record reviews;
(c) The ACT team shall have the capacity to increase and decrease contacts based upon daily assessment of the individual's clinical need with a goal of maximizing independence;

(d) The team shall have the capacity to provide multiple contacts to individuals in high need and a rapid response to early signs of relapse;
(e) The team shall have the capacity to provide support and skills development services to individuals' natural supports and collateral contacts;
(f) Natural supports and collateral contacts may include family, friends, landlords, or employers, consistent with the service plan. Natural supports and collateral contacts are typically not supports that are paid for services;
(g) The ACT team Psychiatrist and the Psychiatric Nurse Practitioner (PNP) shall have scheduling flexibility to accommodate individual needs. If the individual will not come to meet the Psychiatrist or the PNP at the ACT office, the Psychiatrist or PNP shall provide services as clinically indicated for that individual in the community. Secure telepsychiatry may be used when clinically indicated;
(h) The ACT team shall have the capacity to provide services via group modalities as clinically appropriate, including but not limited to individuals with substance abuse disorders and for family psychoeducation and wellness self-management services.
(4) An ACT team shall have sufficient staffing to meet the varying needs of individuals. As an all-inclusive treatment program, a variety of expertise shall be represented on the team. Staffing shall be clearly defined and dedicated to the operation of the team.
(5) Staffing Guidelines for ACT teams:
(a) A single ACT team may not serve more than 120 individuals unless:
(A) It is expanding for the expressed purpose of splitting into two ACT teams within a 12-month period; and
(B) It hires the appropriate staff to meet the required 1:10 staff ratio to individuals served.
(b) ACT team individual to clinical staff ratio may not exceed 10:1;
(c) ACT team staff shall be composed of individual staff members in which a portion or all of their job responsibilities are defined as providing ACT services;
(d) Other than for coverage when a staff member has a leave of absence, ACT teams may not rotate staff members into the ACT team that are not specifically assigned to the team as part of their position's job responsibilities.
(6) No individual ACT staff member shall be assigned less than .20 FTE for their role on the team unless filling the role of psychiatrist or PNP. The ACT team psychiatrist or PNP may not be assigned less than .10 FTE.
(7) Maximum ACT team staffing requirements: ACT teams may not exceed the following upper staffing limits:
(a) No more than eight individual staff members per small ACT team;
(b) No more than 12 individual staff members per mid-size ACT team;
(c) No more than 18 individual staff members per large ACT team.
(8) ACT team staffing is multi-disciplinary. The core minimum staffing for an ACT team includes:
(a) A team leader position that shall be occupied by only one individual. The team leader is a QMHP level clinician qualified to provide direct supervision to all ACT staff except the psychiatric care provider and nurse. Pursuant to the table in OAR 309-019-0242(13), the Team Leader FTE is dictated by the number of individuals served by the ACT team;
(b) Pursuant to the table in OAR 309-019-0242(11), Psychiatric Care Provider (Psychiatrist or PNP) FTE is dictated by the number of individuals served by the ACT team;
(c) Pursuant to the table in OAR 309-019-0242(11), the Nurse FTE is dictated by the number of individuals served by the ACT team;
(d) The Program Administrative Assistant FTE is not counted in the clinical staff ratio.
(9) ACT team minimum staffing shall include clinical staff with the following FTE and specialized competencies:
(a) Pursuant to the table in OAR 309-019-0242(11), the Substance Abuse Specialist FTE is dictated by the number of individuals served by the ACT team. A Substance Abuse Specialist specialized competencies shall include:
(A) Substance abuse assessment and substance abuse diagnosis;
(B) Principles and practices of harm reduction;
(C) Knowledge and application of motivational interviewing strategies.
(b) Pursuant to the table in OAR 309-019-0242(11), the Employment Specialist FTE is dictated by the number of

individuals served by the ACT team. An Employment Specialist specialized competencies shall include:
(A) Competence in the IPS Supported Employment fidelity model;
(B) Vocational assessment;
(C) Job exploration and matching to individual's interest and strengths;
(D) Skills development related to choosing, securing, and maintaining employment.
(c) Pursuant to the table in OAR 309-019-0242(11), the Peer Support and Wellness Specialist FTE is dictated by the number of individuals served by the ACT team.
(d) See a Certified Peer Support Specialist or Peer Wellness Specialist as described in OAR 410-180-0300 and 410-180-0380. A registry of certified Peer Support Specialist Specialists and Peer Wellness Specialists may be found at the Office of Equity and Inclusion's Traditional Health Worker's website.
(10) ACT Team Staffing Core Competencies:
(a) Upon hiring, all clinical staff on an ACT team shall have experience in providing direct services related to the treatment and recovery of individuals with a serious and persistent mental illness. Staff shall be selected consistent with the ACT core operating principles and values. Clinical staff shall have demonstrated competencies in clinical documentation and motivational interviewing;
(b) All staff shall demonstrate basic core competencies in designated areas of practice, including the Assertive Community Treatment core principles, integrated mental health and substance abuse treatment, supported employment, psycho-education, and wellness self-management;
(c) All staff shall receive ACT 101 training from the Division approved reviewer prior to receiving the Division provisional certification; and
(d) All professional ACT team staff shall obtain the appropriate licensure to provide services in Oregon for their respective area of specialization.
(11) ACT Team Size Staff (FTE) to Individual Ratio Table: [Table not included. See ED. NOTE.]
(12) The ACT team shall conduct daily organizational staff meetings at least four days per week and regularly scheduled times per a schedule established by the team leader. These meetings shall be conducted in accordance with the following procedures:
(a) The ACT team shall maintain in writing:
(A) A roster of the individuals served in the program; and
(B) For each individual, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the individual's status that day.
(b) The daily organizational staff meeting includes a review of the treatment contacts that occurred the day before and provides a systematic means for the team to assess the day-to-day progress and status of all clients;
(c) During the daily organizational staff meeting, the ACT team shall also revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.
(13) The ACT team shall conduct treatment planning meetings under the supervision of the team leader and the Psychiatrist or PNP. These treatment planning meetings shall:
(a) Convene at regularly scheduled times per a written schedule set by the team leader;
(b) Occur and be scheduled when the majority of the team members can attend, including the psychiatrist or psychiatric nurse practitioner, team leader, and all members of the treatment team;
(c) Require individual staff members to present and systematically review and integrate an individual's information into a holistic analysis and prioritize problems; and
(d) Occur with sufficient frequency and duration to make it possible for all staff to:
(A) Be familiar with each individual and their goals and aspirations;
(B) Participate in the ongoing assessment and reformulation of problems;
(C) Problem-solve treatment strategies and rehabilitation options;
(D) Participate with the individual and the treatment team in the development and the revision of the treatment plan;

and
(E) Fully understand the treatment plan rationale in order to carry out each individual's plan.
(14) ACT Assessment and Individualized Treatment Planning:
(a) An initial assessment and treatment plan is completed upon each individual's admission to the ACT program; and
(b) Individualized treatment plans for ACT team-served individuals shall be updated at least every six months.
(15) Service Note Content:
(a) More than one intervention, activity, or goal may be reported in one service note, if applicable;
(b) ACT team staff shall complete a service note for each contact or intervention provided to an individual. Each service note shall include all of the following:
(A) Individual's name;
(B) Medicaid identification number or client identification number;
(C) Date of service provision;
(D) Name of service provided;
(E) Type of contact;
(F) Place of service;
(G) Purpose of the contact as it relates to the goals on the individual's treatment plan;
(H) Description of the intervention provided. Documentation of the intervention shall accurately reflect substance abuse related treatment for the duration of time indicated;
(I) Amount of time spent performing the intervention;
(J) Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goal;
(K) Signature and credentials or job title of the staff member who provided the service; and
(L) Each service note page shall be identified with the beneficiary's name and client identification number.
(c) Documentation of discharge or transition to lower levels of care shall include all of the following:
(A) The reasons for discharge or transition as stated by both the individual and the ACT team;
(B) The individual's biopsychosocial status at discharge or transition;
(C) A written final evaluation summary of the individual's progress toward the goals set forth in the person-centered treatment plan;
(D) A plan for follow-up treatment, developed in conjunction with the individual; and
(E) The signatures of the individual, the team leader, and the psychiatrist or PNP.
[Ed Note: Tables referenced are available from the Agency.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0245
ACT Admission Criteria
(1) Participants shall meet the medically appropriate standard as designated in OAR 309-019-0105. Participants who are medically appropriate shall 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) Individuals with a primary diagnosis of a substance use disorder or intellectual developmental disabilities or borderline personality disorder or traumatic brain injury or an autism spectrum disorder are not the intended recipients of ACT and may not be referred to ACT if they do not have a co-occurring, qualifying psychiatric disorder;

(c) Participants with other psychiatric illnesses are eligible dependent on the level of the long-term disability;
(d) 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).
(e) Participants with one or more of the following problems, which are indicators of continuous high service needs (e.g., greater than eight hours per month):
(A) High use of acute care psychiatric hospitals or emergency departments for psychiatric reasons, including psychiatric emergency services as defined in OAR 309-023-0110(e.g., two or more readmissions in a six month period);
(B) Intractable (e.g., persistent or very recurrent) severe major symptoms, affective, psychotic, suicidal);
(C) Coexisting substance abuse disorder of significant duration (e.g., greater than six 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.
(2) The ACT program provides community-based, long-term or time-unlimited services and is not intended to be in and of itself a transitional program.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205 - 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0248
ACT Admission Process
(1) A comprehensive assessment as described in OAR 309-019-0105(6) that demonstrates medical appropriateness shall 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) or the 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 and the referral for services when an approximate, reasonable date of admission to the ACT program is anticipated;
(b) The Authority shall work with the CCOs and the CMHPs to identify regional SPOCs;
(c) The Authority shall 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 shall be completed and reported to the Division within seven business days of receiving the referral. To accomplish this, the SPOC shall 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 shall be submitted through the designated regional SPOC, regardless of the origin of the referral when an approximate, reasonable date of admission to the ACT program is anticipated. The designated regional SPOC shall accept and evaluate referrals from mental health outpatient programs, residential treatment facilities or homes, families or individuals, and other referring sources.
(5) Given the severity of mental illness and functional impairment of individuals who qualify for ACT services, the final decision to admit a referral rests with the provider. Any referral to a provider shall therefore present a full picture of the individual by means of the supporting medical documentation attached to the Universal ACT Referral and Tracking Form and include an approximate date the referred individual will be able to enroll in an ACT program. A tentative admission decision and an agreement to screen by the ACT services provider shall be completed within five 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 shall provide the individual with the option of being added to a waiting list until such time as the ACT eligible individual may be admitted to a certified ACT program:
(A) The ACT eligible individual who is not accepted into an ACT program due to capacity shall be offered alternative community-based rehabilitative services as described in the Oregon Medicaid State Plan that includes evidence-based practices to the extent possible;
(B) Alternative rehabilitative services shall be made available to the individual:
(i) Until the individual is admitted into an ACT program;
(ii) Alternative rehabilitative services are medically appropriate and meet the individual's treatment goals; or
(iii) The individual refuses alternative medically appropriate rehabilitative services.
(6) Upon the decision to admit an individual to the ACT program, the Authority's Universal ACT Referral and Tracking Form shall be updated to include:
(a) A tentative admission is indicated;
(b) When an admission is not indicated, notation shall be made of the following:
(A) The reasons 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. The Authority shall 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 309-019-0245, 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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 430.640
Statutes/Other Implemented: ORS 161.390 - 161.400, 428.205 - 428.270, 430.010, 430.205- 430.210, 430.254 - 430.640, 430.850 - 430.955, 743A.168
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0250

ACT Transition to Less Intensive Services and Discharge

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

(2) This transition 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 including but not limited to work, social, and self-care without ongoing assistance from the ACT provider;

(c) Requests discharge or declines or refuses services;

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

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

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

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0255

ACT Reporting Requirements

(1) Providers certified by the Division to provide ACT shall submit quarterly outcome reports using forms and procedures prescribed by the Division.

(2) Providers shall submit quarterly outcome reports within 45 days following the end of each subject quarter to the Division or the Division reviewer. Each quarterly report shall provide the following information:

(a) Individuals served:

(A) Individuals who are homeless at any point during a quarter;

(B) Individuals with safe stable housing for six 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;

(I) Individuals receiving ACT services that are not enrolled in Medicaid.

(b) 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.

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

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

History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0270

Definitions

(1) Competitive Integrated Employment" means full-time or part time work:
(a) At minimum wage or higher 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;
(b) At a location where the employee interacts with other individuals 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 individuals;
(c) As appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.
(2) "Division Approved Reviewer" means the Oregon Supported Employment Center for Excellence (OSECE). OSECE is the Division's contracted entity responsible for conducting IPS Supported Employment fidelity reviews, training, and technical assistance to support new and existing IPS Supported Employment programs statewide.
(3) "Fidelity" for the purposes of the IPS Supported Employment program means the provider is providing services that are faithful to the evidence-based practice model and obtains a satisfactory score from the Oregon Supported Employment Center for Excellence for IPS Supported Employment as part of the their regular reviews.
(4) "Vocational Services" for the purposes of the ACT program in Oregon means employment support services that will lead to competitive integrated employment. The Division specifies the use of fidelity IPS Supported Employment for providing vocational services within the ACT program, as described in OAR 309-019-0225 – 309-019-0255.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History: MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0275
Individual Placement and Support (IPS) Supported Employment Overview
(1) Supported employment is an evidence-based practice for individuals with serious mental illness.
(2) Supported employment is characterized by:
(a) Emphasis on competitive employment;
(b) Every individual interested in work is eligible for services regardless of symptoms, substance use disorders, treatment decisions, or any other issue;
(c) Employment services are integrated with mental health treatment;
(d) Individuals have access to personalized benefits planning;
(e) Job search begins soon after an individual expresses interest in working; and
(f) Client preferences for jobs and preferences for service delivery are honored;
(g) Employment specialists systematically visit employers who are selected based on job seeker preferences to learn about their business needs and hiring preferences;
(h) Job supports are individualized and continue for as long as each worker wants and needs the support.
(3) Supported employment services include but are not limited to:
(a) Job development;
(b) Supervision and job training;
(c) On-the-job visitation;
(d) Consultation with the employer;
(e) Job coaching;
(f) Counseling;
(g) Skills training; and
(h) Transportation.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History: MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0280

Supported Employment Providers

(1) To be eligible for Medicaid or State General Fund reimbursement, supported employment services shall be provided only by those providers meeting the following minimum qualifications:
(a) The provider shall hold and maintain a current certificate under OAR chapter 309, division 008 issued by the Division for the purpose of providing behavioral health treatment services; and
(b) A provider certified to provide supported employment services shall be reviewed annually for fidelity adherence by the Division approved reviewer and achieve a minimum score of 100 on the fidelity scale. Providers may 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 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) To be eligible for Medicaid reimbursement, supported employment services shall be provided by a certified supported employment provider.
(3) A provider holding a certificate of approval under OAR chapter 309, division 008 may request the addition of IPS supported employment services to their certificate of approval via the procedure outlined in OAR 309-008-0400 and 309-008-1000(1):
(a) In addition to application materials required in OAR chapter 309, division 008, and this rule, the provider shall also submit to the Division a letter of support that indicates receipt of technical assistance and training from the Division approved supported employment reviewer;
(b) New providers of IPS supported employment services shall submit a letter to the Division that indicates the intention to implement a high-fidelity IPS supported employment program.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0285

Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0275 to maintain an IPS supported employment provider designation on the Division issued certificate, a provider shall submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 100 of 125.
(2) Providers certified to provide IPS supported employment services that achieve a fidelity score of 100 or better when reviewed by the Division approved supported employment reviewer are certified for 12 months.
(3) Fidelity reviews shall be conducted utilizing the Substance Abuse and Mental Health Services Supported Employment Fidelity Scale, which shall be made available to providers electronically.
(4) Providers shall cooperate with the Division approved supported employment reviewer for the purpose of improving supported employment services.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 430.630
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-

309-019-0290

Failure to Meet Fidelity Standards

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

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

(b) At the end of the 90-day period, a follow-up review shall 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 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 supported employment services may also have their certificate of approval suspended or revoked if the 90-day re-review results in a fidelity score of less than 100.

(3) A provider who is issued a notice of intent to apply a condition, revoke, suspend, or refusal to renew its certificate may request a hearing in accordance with ORS Chapter 183 and OAR 309-008-1300.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 430.630

History: MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0295

Reporting Requirements

(1) Providers of supported employment services shall submit quarterly outcome 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.

(2) Each quarterly report shall provide the following information:

(a) All individuals who received supported employment in the reporting quarter;

(b) Individuals who received supported employment services who are employed in competitive integrated employment; and

(c) Individuals who discontinued receiving supported employment services and are employed in competitive integrated employment; and

(d) Individuals who received supported employment services as a part of the Assertive Community Treatment program.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 430.630

History: MHS 6-2017, f. & cert. ef. 6-23-17; MHS 1-2017(Temp), f. 1-17-17, cert. ef. 1-18-17 thru 7-16-17; MHS 26-2016(Temp), f. 12-27-16, cert. ef. 12-28-16 thru 6-23-17

309-019-0300

Service Requirements

(1) Crisis line services shall be provided directly or through linkages to a crisis line services provider 24/7.

(2) Crisis line services shall include but is not limited to:

(a) 24/7 accessibility to a QMHP;

(b) 24/7 bi-lingual or interpreter availability;

(c) 24/7 telephone screening to determine the need for immediate intervention;

(d) 24/7 linkage to emergency service providers, including first responders and mobile crisis services;

(e) Best practice risk assessment, including suicide risk assessment;

(f) Suicide intervention and prevention;
(g) Lethal means counseling and safety planning for individuals at risk for suicide;
(h) Crisis intervention;
(i) Crisis plan development;
(j) Triage;
(k) Providing information regarding services and resources in the community; and
(L) Procedures for de-escalation for calls from suicidal individuals.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.630, 430.640, 430.644 - 430.646
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0305

Provider Standards

(1) Crisis line services providers shall develop and implement written policies and procedures to address provider standards.
(2) Provider standards shall include but is not limited to:
(a) Training curriculum and ongoing education programs to meet training requirements;
(b) Coordination with other treatment providers including mobile crisis services and other crisis line services providers to support seamless transitions of care;
(c) Linkages to emergency services providers including first responders to address imminent risks and to support seamless transitions of care;
(d) De-escalation procedures;
(e) Follow-up procedures when indicated and appropriate;
(f) Documentation;
(g) Code of ethics; and
(h) Security of information protocols.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.630, 430.640, 430.644 - 430.646
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0310

Minimum Staffing Requirements

(1) At least one QMHP shall be available by phone or face-to-face 24/7 for consultation.
(2) At least one QMHP shall provide regular clinical supervision to staff.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.630, 430.640, 430.644 - 430.646
History: MHS 10-2017(Temp), f. 9-15-17, cert. ef. 9-15-17 thru 3-13-18; MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0315

Training Requirements

(1) Staff training curriculum shall include but is not limited to:
(a) Triage protocol;
(b) Referral resources;
(c) Crisis plan development;
(d) Screening for a Declaration for Mental Health Treatment.
(2) Staff training curriculum shall include best practices for the following:
(a) Risk assessment, including suicide risk assessment;
(b) Suicide intervention and prevention;

(c) Safety planning;
(d) Lethal means counseling;
(e) De-escalation methods;
(f) Crisis intervention;
(g) Recovery support, including peer delivered services;
(h) Trauma informed care; and
(i) Cultural awareness.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.630, 430.640, 430.644 - 430.646
History: MHS 6-2017, f. & cert. ef. 6-23-17

309-019-0320
Documentation Requirements
(1) Documentation of calls shall include but is not limited to:
(a) Summary of presenting concern, assessment of risk factors, interventions, evaluation of interventions, the plan for the management and resolution of the crisis or emergency situation reported, referrals to other services, and collaboration that occurred with emergency services providers or other treatment providers, when appropriate;
(b) If a suicide risk assessment was completed;
(c) Summary of safety planning and lethal means counseling, as appropriate.
(2) A log or report of all contacts with the provider, including the name of each caller, when available, the crisis line worker, and the time and duration of the call shall be maintained for quality assurance review and ongoing staff supervision.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.630, 430.640, 430.644 - 430.646
History: MHS 6-2017, f. & cert. ef. 6-23-17

DIVISION 22
INTENSIVE TREATMENT SERVICES FOR CHILDREN AND ADOLESCENTS AND CHILDREN'S EMERGENCY SAFETY INTERVENTION SPECIALIST

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 System 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: Intensive Treatment Services (ITS) for Children and Adolescents.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 21-2016, f. & cert. ef. 12-1-16; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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, neuro-developmental, 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 that identify and declare 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 designee.
(13) “Child” means an individual 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 shall be considered a child until age 21 for purposes of these rules.
(14) “Children’s Emergency Safety Intervention Specialist (CESIS)” means a Qualified Mental Health Professional (QMHP) 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.
(15) “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.
(16) “Clinical Supervisor” means an individual qualified to oversee and evaluate addictions or mental health services and supports.
(17) “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 Division.
(18) “Co-occurring Disorder” means the existence of both a substance use disorder and a mental health disorder.
(19) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.
(20) “Community Mental Health Program (CMHP)” means the organization of various services for individuals 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.

(21) “Criminal Records Check” means the Oregon Criminal Records Check and the processes and procedures required by OAR 943-007-0001 through 943-007-0501.
(22) “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.
(23) “Cultural Competence” means the process by which people and systems respond respectfully and effectively to individuals 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.
(24) “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.
(25) “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.
(26) “Division” means the Health Systems Division.
(27) “DSM” means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
(28) “Emergency Safety Intervention” means the use of seclusion or personal restraint under OAR 309-022-0175 as an immediate response to an unanticipated threat of violence or injury to an individual or others.
(29) “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.
(30) “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 above.
(31) “Emergent” means the onset of symptoms requiring attention within 24 hours to prevent serious deterioration in mental or physical health or threat to safety.
(32) “Entry” means the act or process of acceptance and enrollment into services regulated by this rule.
(33) “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, or legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.
(34) “Family Support” means the provision of peer delivered services to individuals 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.
(35) “Family Support Specialist” means an individual who meets qualification criteria under OAR chapter 410 division 180 and provides peer delivered services to a family member who has experience parenting a child who is a current or former consumer of mental health or addiction treatment or is facing or has faced difficulties in accessing education, health, and wellness services due to a mental health or behavioral health barrier.
(36) “Gender Identity” means an individual’s self-identification of gender without regard to legal or biological identification, including but not limited to individuals 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 an individual appointed by a court of law to act as guardian of a minor or a legally incapacitated individual.
(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 have consented to the services on or prior to the first date of service.
(43) “Intensive Outpatient Services and Supports (IOSS)” means a specialized set of comprehensive in-home and community-based supports and mental health treatment services 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 shall 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) “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.
(50) “Licensed Medical Practitioner (LMP)” means an individual 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 IOSS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.
(51) “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.
(52) “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 ORS 40.225 to 40.295.
(53) "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.
(54) "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.
(55) "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 an individual who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work, or a behavioral science field to meet the educational requirement of QMHP. The individual shall:
(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 their practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by the provider; and
(d) Receive, at minimum, weekly supervision by a qualified clinical supervisor employed by the provider of services.
(58) "Outreach" means the delivery of behavioral health services, referral services, and case management services in non-traditional settings including 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.
(59) "Peer" means any individual supporting an individual or a family member 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.
(60) "Peer Delivered Services" means an array of agency or community-based services and supports provided by peer wellness specialists 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.
(61) "Peer Support Specialist" means an individual 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 shall complete a Division approved training program as required in OAR 410-180-0300 to 0380 and be:
(a) A self-identified individual currently or formerly receiving mental health services; or
(b) A self-identified individual 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.
(62) "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 may be used only in approved

ITS programs as an emergency safety intervention under OAR 309-022-0175.
(63) “Program” means a particular type or level of service that is organizationally distinct.
(64) “Program Administrator” or “Program Director” means an individual with appropriate professional qualifications and experience who is designated to manage the operation of a program.
(65) “Program Staff” means an employee or individual who by contract with the program provides a service and has the applicable competencies, qualifications, or certification required in these rules to provide the service.
(66) “Provider” means an individual , 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.
(67) “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.
(68) “Psychiatric Day Treatment Services (PDTS)” means the comprehensive, interdisciplinary, non-residential, community-based program certified under these rules consisting of psychiatric treatment, family treatment, and therapeutic activities integrated with an accredited education program.
(69) “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.
(70) “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.
(71) “Psychologist” means a psychologist licensed by the Oregon Board of Psychologist Examiners.
(72) “Publicly Funded” means financial support, in part or in full, with revenue generated by a local, state, or federal government.
(73) “Qualified Mental Health Associate (QMHA)” means an individual delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-022-0125.
(74) “Qualified Mental Health Professional (QMHP)” means a LMP or any other individual meeting the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-022-0125.
(75) “Quality Assessment and Performance Improvement” means the structured, internal monitoring and evaluation of services to improve processes, service delivery, and service outcomes.
(76) “Recovery” means a process of healing and transformation for an individual to achieve full human potential and personhood in leading a meaningful life in communities of his or her choice.
(77) “Reportable Incident” means a serious incident involving an individual in an ITS program that shall 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.
(78) “Representative” means an individual 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.
(79) “Resilience” means the universal capacity that an individual uses to prevent, minimize, or overcome the effects of adversity. Resilience reflects an individual’s strengths as protective factors and assets for positive development.
(80) “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 may be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the service plan.
(81) “Screening” means the process to determine whether the individual needs further assessment to identify

circumstances requiring referrals or additional services and supports.
(82) “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 may be used only in approved ITS programs as an emergency safety intervention specified in OAR 309-022-0175.
(83) “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.
(84) “Service Plan” means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family that is reflective of the assessment and the intended outcomes of service.
(85) “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.
(86) “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.
(87) “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.
(88) “Signature” means any written or electronic means of entering the name, date of authentication, and credentials of the individual providing a specific service or the individual 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.
(89) “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.
(90) “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.
(91) “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.
(92) “Transfer” means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.
(93) “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.
(94) “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.
(95) “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.
(96) “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.
(97) “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.
(98) “Wellness” means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.

(99) “Wraparound” means a high fidelity process of team based intensive care coordination for children and their families based on National Wraparound Initiative values and principles.
(100) “Young Adult in Transition” means an individual who is developmentally transitioning into independence, sometime between the ages of 14 and 25.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 21-2016, f. & cert. ef. 12-1-16; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0110

Provider Policies

(1) All providers shall 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 943-007-0001 through 0501; and
(d) Fraud, waste, and abuse in federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510.
(2) All providers shall develop and implement written policies and procedures consistent with these rules:
(a) Policies shall be available to individuals and family members upon request; and
(b) Service delivery policies and procedures shall 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 and suicide prevention and response;
(H) Incident reporting;
(I) Family involvement;
(J) Trauma-informed service delivery consistent with the AMH Trauma Informed Services Policy;
(K) Provision of culturally and linguistically appropriate services; and
(L) Peer delivered services
(3) In addition to the personnel and service delivery policies required of all providers, residential program providers shall 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, suicide risk assessment, and emergency procedures;
(d) Emergency safety interventions in ITS programs; and
(e) Behavior support policies consistent with OAR 309-022-0165.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; 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) Have access to peer delivered services;
(d) 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 receive a copy of the written service plan;
(e) Have all services explained, including expected outcomes and possible risks;
(f) Confidentiality and the right to consent 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;
(g) 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 legally 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.
(h) Inspect their service record in accordance with ORS 179.505;
(i) Refuse participation in experimentation;
(j) Receive medication specific to the individual's diagnosed clinical needs;
(k) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
(L) Be free from abuse or neglect and be able to report any incident of abuse or neglect without being subject to retaliation;
(m) Have religious freedom;
(n) Be free from seclusion and restraint, except as set forth in OAR 309-021-0175;
(o) Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;
(p) 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;
(q) Have family and guardian involvement in service planning and delivery;
(r) Make a declaration for mental health treatment when legally an adult;
(s) File grievances, including appealing decisions resulting from the grievance;
(t) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
(u) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
(v) Exercise all rights described in this rule without any form of reprisal or punishment.
(2) In addition to the rights set forth in section (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 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 shall be specified in reasonable detail, and any restriction of the right to communicate shall be no broader than necessary to prevent this harm; and
(B) The individual and his or her guardian, if applicable, shall be given specific written notice of each restriction of the individual's right to private and uncensored communication. The provider shall 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) The provider shall 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 shall 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 shall be explained to the individual and if appropriate to her or his guardian; and
(c) Individual rights shall be posted in writing in a common area.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 161.390, 413.042, 426.490 - 426.500, 428.205 - 428.270, 430.256, 430.640, 443.450

Statutes/Other 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
History: MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0125
Specific Staff Qualifications and Competencies

(1) Program administrators or program directors shall 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 shall demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, and utilization of community resources; group, family and individual therapy or counseling; and documentation and rationale for services to promote intended outcomes and implementation of all provider policies.
(3) Clinical supervisors in mental health programs shall meet QMHP requirements and have completed two years of post-graduate clinical experience in a mental health treatment setting.
(4) QMHAs shall 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. QMHAs shall 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 OAR 309-022-0105.
(5) QMHPs shall 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, completing a DSM diagnosis, writing and supervising the implementation of a service plan; and providing individual, family, or group therapy within the scope of their training. QMHPs shall 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 OAR 309-022-0105.
(6) Peer support specialists shall be qualified as defined in OAR 410-0180-0312 and demonstrate knowledge of approaches to support others in recovery and resiliency and demonstrate efforts at self-directed recovery.
Statutory/Other Authority: ORS 161.390, 413.042, 426.490 - 426.500, 428.205 - 428.270, 430.256, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0130
Documentation, Training and Supervision

(1) Providers shall 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 943-007-0001 through 0501;
(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 shall 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 943-007-0001 through 0501.
(3) Providers shall 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 OAR 309-022-0165.
(4) Individuals providing services to individuals in accordance with these rules shall receive supervision related to the development, implementation, and outcome of services by a qualified clinical supervisor:
(a) Clinical supervision shall be provided to assist program staff and volunteers to increase their skills, improve quality of services to individuals, and supervise program staff and volunteers' compliance with program policies and procedures, including:
(A) Documentation of clinical supervision for QMHP staff of no less than two hours per month. The two hours shall include one hour of face-to-face contact for each individual 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
(B) 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 individual supervised.
(b) Documentation of clinical supervision for each QMHA staff supervised of no less than two hours per month. The two hours shall include one hour of face-to-face contact for each individual 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 may be conducted by a lead QMHA staff;
(c) Documentation of weekly supervision for program staff meeting the definition of mental health intern. Documentation shall include:
(A) The date supervision took place;
(B) The amount of supervision time;
(C) A brief description of relevant topics discussed.
Statutory/Other Authority: ORS 161.390, 413.042, 426.490 - 426.500, 428.205 - 428.270, 430.256, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450

Statutes/Other 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
History: MHS 21-2016, f. & cert. ef. 12-1-16; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0140

Service Planning and Coordination

(1) The provider shall 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 shall facilitate a planning process, resulting in a service plan that reflects the assessment;
(b) A service plan shall be completed prior to the start of services;
(c) A licensed health care professional shall recommend the services and supports by signing the service plan;
(d) Individuals and family members shall be invited to participate in the development of the service plan;
(e) Providers shall 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, offer peer delivered services, and give the individual and guardian a written copy of the service plan;
(f) Providers shall collaborate with community partners to coordinate or deliver services and supports identified in the service plan;
(g) Providers shall collaborate to exchange information with any applicable physical health care providers for the individual to promote regular and adequate health care.
(2) The service plan shall be a written, individualized plan to improve the individual's condition to the point where the individual's continued participation in the program is no longer necessary. The service plan is included in the individual's service records and shall:
(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 shall recommend the services and supports by signing the Service plan within ten business days of the start of services; and
(f) An LMP shall 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 shall include:
(a) Individualized treatment objectives;
(b) The specific services and supports that will be used to meet the treatment objectives;
(c) Measurable and observable outcomes;
(d) A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter;
(e) The type of personnel that will be furnishing the services; and
(f) Proactive safety and crisis planning;
(g) A behavior support plan consistent with OAR 309-022-0165; and
(h) The interdisciplinary team shall conduct a review of progress and transfer criteria at least every 30 days from the date of entry and shall document the member's present, progress, and changes made. For Psychiatric Day Treatment Services, the review shall be conducted every 30 days, and the LMP shall participate in the review at least every 90 days.
(4) Providers shall document each service and support using service notes. A service note, at minimum, shall 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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0155

General Staffing Requirements

(1) ITS providers shall 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 shall establish policies, procedures, and contracts to assure:
(a) Availability of psychiatric services to meet the following requirements:
(A) 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
(B) 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.
(b) There shall be at least one program staff who has completed First Aid and CPR training on duty at all times.
(2) Residential ITS providers shall ensure overnight program staff will visually monitor clients at specified intervals as per agency policy during sleeping hours for signs of life. This includes monitoring for breathing and movement.
(3) ITS providers shall 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 shall 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 shall be at least one family therapist for each 12 children;
(d) Psychiatric services;
(e) Individual, group, and family therapies provided by a QMHP. There shall 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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 requirements for facilities and programs shall 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) PRTFs shall maintain one or more linkages with acute care hospitals or CCOs to coordinate necessary inpatient care;
(c) Psychiatric residential clinical care and treatment shall 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 shall be available to the unit 24-hours per day, seven days per week; and
(d) PRTFs shall be staffed at a clinical staffing ratio of not less than one program staff for three children during the day and evening shifts at all times. At least one program staff for every three program staff members during the day and evening shifts shall be a QMHP or QMHA. For overnight program staff there shall be a staffing ratio of at least one program staff for six children at all times for each program unit. At least one of the overnight program staff shall be a QMHA. For units that by this ratio have only one overnight program staff, there shall be additional program staff immediately available within the facility or on the premises. At least one QMHP shall be on site or on call at all times. At least one program staff with designated clinical leadership responsibilities shall be on site at all times.
(2) Programs providing PRTS shall meet the requirements for PRTF's listed in section (1)(a).
(3) Programs providing SCIP and SAIP services shall meet the requirements for PRTFs listed in section (1). They shall also establish policies and practices to meet the following:
(a) The staffing model shall allow for the child's frequent contact with the child psychiatrist a minimum of one hour per week;
(b) Psychiatric nursing staff shall 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 shall be available 24 hours per day as appropriate; and
(d) Program staff with specialized training in SCIP or SAIP shall be available 24 hours per day;
(e) The program shall provide all medically appropriate psychiatric services necessary to meet the child's psychiatric care needs;
(f) The program shall 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 may not rely on external entities such as law enforcement or acute hospital care to assist in the management of the SCIP or SAIP setting.
(4) In addition to the services provided as indicated by the assessment and specified in the service plan, Sub-Acute Psychiatric Care providers shall:
(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 multi-disciplinary community partners to plan for the long-term emotional, behavioral, physical, and social needs of the child to be met in the most integrated setting in the community.
(5) Psychiatric Day Treatment Services (PDTS):
(a) PDTS shall 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 shall 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 shall be staffed at a clinical staffing ratio of at least one QMHP or QMHA for three children.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.

Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450

Statutes/Other 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

History: MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0175
Restraint and Seclusion

(1) Providers shall meet the following general conditions of personal restraint and seclusion:
(a) Personal restraint and seclusion shall only be used in an emergency safety situation to prevent immediate injury to an individual who is in danger of physically harming himself 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 shall be directly related to the immediate risk related to the behavior of the individual and may not be used as punishment, discipline, or for the convenience of staff;
(d) Personal restraint or seclusion shall 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 shall under no circumstances exceed four hours for individuals ages 18 to 21, two hours for individuals ages 9 to 17, or one hour for individuals under age 9;
(e) An order for personal restraint or seclusion may not be written as a standing order or on an as needed basis;
(f) Personal restraint and seclusion may not be used simultaneously;
(g) Providers shall 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 shall 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 shall require an immediate documented order by a physician, licensed practitioner, or a licensed CESIS;
(b) The order shall include:
(A) Name of the individual 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 shall 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 shall 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 shall 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 shall 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 shall review all personal restraint documentation prior to the end of the shift in which the intervention occurred; and
(g) Each incident of personal restraint shall be documented in the service record. The documentation shall 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) Providers shall be certified by the Division for the use of seclusion:
(a) Authorization for seclusion shall be obtained by a psychiatrist, licensed practitioner, or CESIS prior to or immediately after the initiation of seclusion. Written orders for seclusion shall be completed for each instance of seclusion and shall 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 shall 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 shall 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 shall conduct a face-to-face assessment of the physical and psychological well-being of the individual;
(e) The individual shall have regular meals, bathing, and use of the bathroom during seclusion, and the provision of these shall be documented in the service record; and
(f) Each incident of seclusion shall be documented in the service record. The documentation shall 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 shall be approved by the Division: If the use of seclusion occurs in a room with a locking door, the program shall be authorized by the Division for this purpose and shall meet the following requirements:
(a) A facility or program seeking authorization for the use of seclusion shall submit a written application to the Division;
(b) The application shall include a comprehensive plan for the need 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 shall review the application and, after a determination that the written application is complete and satisfies all applicable requirements, shall provide for a review of the facility by authorized Division staff;
(d) The Division shall 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 shall have the opportunity to fully observe the treatment and seclusion practices employed by the facility;
(e) After the review, the chief officer shall approve or disapprove the facility's application and upon approval shall 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 shall be provided with specific recommendations and have the right of appeal to the Division; and
(g) Certification of a facility shall be effective for a maximum of three years and may be renewed thereafter upon approval of a renewal application.
(5) An ITS provider seeking certification shall have available at least one room that meets the following specifications and structural and physical requirements for seclusion:
(a) The room shall be of adequate size to permit three adults to move freely and allow for one adult to lie down. Any newly constructed room shall be no less than 64 square feet;
(b) The room may not be isolated from regular program staff of the facility and shall be equipped with adequate locking devices on all doors and windows;
(c) The door shall open outward and contain a port of shatterproof glass or plastic through which the entire room may be viewed from outside;
(d) The room shall contain no protruding, exposed, or sharp objects;
(e) The room shall contain no furniture. A fireproof mattress or mat shall be available for comfort;
(f) Any windows shall be made of unbreakable or shatterproof glass or plastic. Non-shatterproof glass shall be protected by adequate climb-proof screening;
(g) There may be no exposed pipes or electrical wiring in the room. Electrical outlets shall be permanently capped or covered with a metal shield secured by tamper-proof screws. Ceiling and wall lights shall be recessed and covered with safety glass or unbreakable plastic. Any cover, cap, or shield shall be secured by tamper-proof screws;
(h) The room shall meet State Fire Marshal fire, safety, and health standards. If sprinklers are installed, they shall be recessed and covered with fine mesh screening. If pop-down type, sprinklers shall have breakaway strength of under 80 pounds. In lieu of sprinklers, combined smoke and heat detectors shall be used with similar protective design or installation;
(i) The room shall be ventilated, kept at a temperature no less than 64°F and no more than 85°F. Heating and cooling vents shall be secure and out of reach;
(j) The room shall be designed and equipped in a manner that would not allow a child to climb off the floor;
(k) Walls, floor, and ceiling shall be solidly and smoothly constructed to be cleaned easily and have no rough or jagged portions; and
(L) Adequate and safe bathrooms shall be available.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 28.270, 430.640, 443.450
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 21-2016, f. & cert. ef. 12-1-16; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0180

Transfer and Continuity of Care

(1) Providers shall meet the following requirements for planned transfer:

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

(b) Planned transfers shall be consistent with the transfer criteria established by the interdisciplinary team and documented in the service plan.

(c) Providers may 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 may 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.

(2) Prior to transfer, providers shall:

(a) Coordinate and provide appropriate referrals for medical care and medication management. The transferring provider shall assist the individual to identify the medical provider who will provide continuing care and 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 shall 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 shall notify the PSRB or JPSRB immediately and provide a copy of the transfer summary within 30 days;

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

(g) At a minimum, the provider's interdisciplinary team shall:

(A) Integrate transfer planning into ongoing treatment planning and documentation from the time of entry and specify the transfer criteria that shall 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 shall 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 peer support when requested by the parent or guardian and provider to which the child shall 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 shall be provided to individuals who leave through a planned transfer. The last service provider’s interdisciplinary team shall identify the medical personnel who will provide continuing care and shall 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) A Transfer summary shall include the following:

(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 safety and suicide prevention planning; and

(d) Identification of resources to assist the individual and family including peer delivered services, if applicable, in accessing recovery and resiliency services and supports;
(e) If the transfer is to services with another provider, all documentation contained in the service record requested by the receiving provider shall be furnished, compliant with applicable confidentiality policies and procedures within 14 days of receipt of a written request for the documentation;
(f) A complete transfer summary shall be sent to the receiving provider within 30 days of the transfer.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.45
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640, 443.450
Statutes/Other 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
History: MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0192

Variance

(1) Requirements and standards for requesting and granting variances or exceptions are found in OAR 309-008-1600.
(2) The chief officer of the Division shall approve or deny the request for a variance. The variance shall be made in writing

using the Division approved variance request form and following the variance request procedure set forth in 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.
Statutory/Other Authority: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Statutes/Other 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
History: MHS 7-2017, f. & cert. ef. 6-23-17; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17

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.
Statutory/Other Authority: ORS 413.042, 426.415
Statutes/Other Implemented: ORS 426.415
History: Reverted to MHS 5-2014, f. & cert. ef. 2-3-14; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 413.042, 426.415
Statutes/Other Implemented: ORS 426.415
History: Reverted to MHS 5-2014, f. & cert. ef. 2-3-14; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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 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.
Statutory/Other Authority: ORS 413.042, 426.415
Statutes/Other Implemented: ORS 426.415
History: Reverted to MHS 21-2016, f. & cert. ef. 12-1-16; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 21-2016, f. & cert. ef. 12-1-16; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 413.042, 426.415
Statutes/Other Implemented: ORS 426.415
History: Reverted to MHS 5-2014, f. & cert. ef. 2-3-14; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 413.042, 426.415
Statutes/Other Implemented: ORS 426.415
History: Reverted to MHS 5-2014, f. & cert. ef. 2-3-14; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

309-022-0220
Complaints
(1) Any person who believes these rules have been violated may file a compliant 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.
Statutory/Other Authority: ORS 413.042, 426.415
Statutes/Other Implemented: ORS 426.415
History: Reverted to MHS 5-2014, f. & cert. ef. 2-3-14; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 413.042, 426.415
Statutes/Other Implemented: ORS 426.415
History: Reverted to MHS 5-2014, f. & cert. ef. 2-3-14; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 413.042, 426.415
Statutes/Other Implemented: ORS 426.415
History: Reverted to MHS 5-2014, f. & cert. ef. 2-3-14; MHS 27-2016(Temp), f. & cert. ef. 12-29-16 thru 6-26-17; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; 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 proposed 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) "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).
(12) "Living Room Setting" means a care setting that reflects the relaxed, warm, welcoming and non-clinical qualities of a typical living room.
(13) "Medically Appropriate Treatment" has the meaning given that term in OAR 410-172-0630.
(14) "Mental Status Examination" means an overall assessment of an individual's mental functioning.
(15) "Peer" has the meaning given that term in OAR 410-180-0305.
(16) "Peer Delivered Services" has the meaning given that term in OAR 309-019-0100.
(17) "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.
(18) "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.
(19) "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.
(20) "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.
(21) "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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; 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 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; 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.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042
History: MHS 29-2016, f. & cert. ef. 12-29-16; MHS 15-2016(Temp), f. & cert. ef. 10-6-16 thru 4-3-17

DIVISION 27
YOUTH SUICIDE COMMUNICATIONAND POST-INTERVENTION PLAN

309-027-0010
Purpose and Scope
(1) These rules implement Senate Bill (SB) 561 from Oregon's 2015 Regular Session. The rules identify Local Mental Health Authorities (LMHAs) as the entities responsible for initiating and coordinating the community response to each case of suicide which meets the criteria established in SB 561. There are three purposes for the rules:
(a) The rules establish minimum standards for the communication protocol and post-intervention protocol to address suspected youth suicide.
(b) The rules aim to reduce the risk of contagion among individuals 24 years of age or younger after a suspected youth suicide by establishing overall guidelines for communication and post-intervention response protocols for effective communication and response by local agencies, groups, or individuals .
(c) The rules establish the process for LMHAs to report suspected youth suicides to the Oregon Health Authority within seven (7) days of the death.
(2) The Oregon Health Authority shall provide technical assistance to LMHAs in developing and implementing the

protocols and reporting of suspected youth suicides.
Statutory/Other Authority: ORS 413.042, 430.630, 430.634, 430.640
Statutes/Other Implemented: ORS 418.735
History: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0020
Definitions

(1) “Authority” means the Oregon Health Authority (OHA).
(2) “Communication Protocol” means the plan identifying information-sharing pathways to improve notifications and information-sharing regarding a suspected youth suicide between the LMHA and community partners, and the individuals within those entities to communicate or receive communications.
(3) “Community partners” includes local individuals, entities, and organizations including medical examiners, public school districts, public universities, private post-secondary institutions of education, or any facility or organization that provides services or resources to runaway or homeless youth.
(4) “Coordinator” means the Authority’s Suicide Intervention and Prevention Coordinator or his or her designee.
(5) “LMHA” means a Local Mental Health Authority as defined in ORS 430.630.
(6) “Medical examiner” has the same meaning given that term in ORS 146.003(10) or a physician appointed as provided by ORS 146.003 to 146.189 to investigate and certify the cause and manner of deaths requiring investigation, including the State Medical Examiner.
(7) “Authority’s Plan” means the Authority’s Youth Suicide Communication and Post-Intervention Plan developed to implement SB 561 codified as ORS 418.735.
(8) “Post-Intervention” or “Postvention” means the activities implemented after a suspected youth suicide, including support for the bereaved family, friends, professionals, peers and those with geographic, social or social media ties to the deceased. “Post-intervention and “postvention” are used interchangeably. In order to meet the needs of those bereaved by a suicide, and to reduce the risk of contagion “post-intervention” includes:
(a) Immediate postvention response implemented in the immediate days and weeks after a suspected youth suicide;
(b) Intermediate postvention response implemented in the several months after a suspected youth suicide; and
(c) Long-term postvention response implemented up to a year after the suspected youth suicide.
(9) “Primary LMHA” means the LMHA serving the county where the suspected youth suicide occurred.
(10) “Response Protocol” means the plan identifying the roles, responsibilities and actions of the LMHA and community partners that are activated in response to a suspected youth suicide.
(11) “Suicide Contagion” means the exposure to the suicide or suicidal behavior of one or more persons that influences others to engage in suicidal behavior, including to attempt or complete suicide.
(12) “Suspected Youth Suicide” means a death of an individual 24 years of age or younger reported by a medical examiner or designee that is believed to have been caused by self-directed injurious behavior with an intent to die as a result of the behavior.
(13) “Traumatic Death” means a death that is sudden, unanticipated, violent, mutilating or destructive, random and/or preventable, involves multiple deaths, or one in which the mourner has a personal encounter with death. It may be caused by an accident, homicide, suicide or death in war.
Statutory/Other Authority: ORS 413.042, 430.630, 430.634, 430.640
Statutes/Other Implemented: ORS 418.735
History: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0030
Communication Protocol

(1) Each LMHA, in collaboration with community partners, shall identify local pathways for information-sharing and shall establish a Communication Protocol to communicate across and within the LMHA and community partners to inform and mobilize post-intervention response.

(2) Communication Protocols shall, at the minimum:
(a) Identify the community partners involved in developing and implementing the protocol;
(b) Identify the specific roles and responsibilities of the LMHA and community partners for implementing the protocol;
(c) Identify how a Lead Communication Person will be identified for responding to each suspected youth suicide. The Lead Communication Person may vary among incidents, depending on the nature of the death, location of the death, age of the decedent, or other factors. The Lead Communication person may be an individual designated by a school district or university, the LMHA, another facility, or another community partner. The Lead Communication Person is responsible for centralizing information-sharing activities in the event of a suspected youth suicide;
(d) Detail the communication-sharing process among community partners; and
(e) Identify the specific information and data that will be communicated between and across the community partners. This may vary, depending on the role or responsibilities of each partner and applicable law.
(3) The LMHA shall document the completed Communication Protocol in writing and submit to the Coordinator within 120 days of the effective date of these rules.
(4) At least annually each LMHA, in collaboration with community partners, shall review the Communication Protocol and evaluate the protocol's effectiveness over the past year, and provide a rationale for all revisions to the Coordinator.
(5) The Coordinator shall:
(a) Review the communication protocols submitted by the LMHAs;
(b) Review any revisions to the communication protocols as submitted annually; and
(c) Provide feedback to the LMHA, including information on best practices, and offer technical assistance for preparation and implementation of the protocols.
Statutory/Other Authority: ORS 413.042, 430.630, 430.634, 430.640
Statutes/Other Implemented: ORS 418.735
History: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0040
Response Protocol

(1) Each LMHA, in collaboration with community partners, shall develop a Response Protocol identifying community partners, programs, individuals and others within the community that may be mobilized to provide post-intervention response to a suspected youth suicide.
(2) At minimum, the Response Protocol shall:
(a) Identify the community partners involved in developing and implementing the Response Protocol;
(b) Identify the roles, responsibilities, services, and available resources of each community partner involved in implementing the Response Protocol including the immediate, intermediate and long-term postvention response.
(c) Identify how a Lead Response Person shall be identified for responding to each suspected youth suicide. The Lead Response Person may vary, depending on the circumstances and may be an individual designated by a school district or university, the LMHA, or another community partner. The Lead Response Person is responsible for coordinating post-intervention response in the event of a suspected youth suicide. The Lead Response Person for the Response Protocol also may be the Lead Communication Person.
(d) Establish and detail the post-intervention response process among community partners, including outreach to families and families of choice; and
(e) Identify the evaluation process used by community partners to debrief and assess the effectiveness of each suspected youth suicide response and the mechanism to adjust processes, as indicated, in the future. The evaluation process shall include an assessment of the effectiveness of meeting the needs of grieving families and families of choice; friends or others with relationships with the deceased; and the wider network of community members impacted by the suspected youth suicide.
(f) Identify how the Primary LMHA will notify other LMHAs linked to the deceased through residency, employment, school attendance, or significant family or social ties.

(3) The LMHA shall document the completed Response Protocol in writing and submit to the Coordinator.
(4) At least annually each LMHA in collaboration with community partners shall review the Response Protocol to debrief and evaluate the protocol's effectiveness in the past year, and provide a rationale for all revisions to the Coordinator.
(5) For the purposes of Response Protocols, the Coordinator shall:
(a) Review the response protocols submitted by the LMHAs;
(b) Review any revisions to the response protocols submitted annually; and
(c) Provide feedback to the LMHA and offer technical assistance on best practices for development and implementation of the protocols.
Statutory/Other Authority: ORS 413.042, 430.630, 430.634, 430.640
Statutes/Other Implemented: ORS 418.735
History: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0050
Technical Assistance
As part of the Authority's plan for communication and response coordination among LMHAs and community partners, the Authority shall provide technical assistance for developing and updating protocols, including Coordinator assistance through:
(1) Providing comments regarding best practices to LMHAs on the content of communication and response protocols;
(2) Providing technical assistance regarding best practices in preparing the protocols;
(3) Providing technical assistance on best practices in implementing the protocols; and
(4) Providing technical assistance on best practices in responding to suspected youth suicides. This may include telephone assistance on a case by case basis, general information in the form of publications, web content, presentations or webinars.
Statutory/Other Authority: ORS 413.042, 430.630, 430.634, 430.640
Statutes/Other Implemented: ORS 418.735
History: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0060
Reporting To Coordinator
(1) Each LMHA shall designate a Designated Reporter assigned to timely report suspected youth suicides and postvention activities to the Coordinator. Each LMHA shall provide the name and all contact information (including email address and phone number) for the Designated Reporter. The LMHA shall also designate a backup Designated Reporter to assume those responsibilities in the event of the Youth Suicide Reporter's absence. The LMHA shall maintain updated contact information of the Designated Reporter and backup with the Coordinator.
(2) Within seven (7) days of a suspected or confirmed youth suicide the primary LMHA shall report to the Coordinator as follows or to the extent allowed by law.
(3) The LMHA in the county where the death occurred shall report the death to the Coordinator. The Primary LMHA and each impacted LMHA shall report their respective postvention activities. At a minimum, the reports to OHA shall include:
(a) Date of report;
(b) The author's name, affiliated LMHA, email address and phone number;
(c) The date of the suspected youth suicide and the city and county in which the suspected youth suicide occurred;
(d) Age of the decedent;
(e) If a student, the name of the school, public or private university or college, or private post-secondary institution of education attended by the deceased.
(f) A narrative discussing the postvention activities completed or to be completed by the Primary LMHA, other impacted LMHAs, if available, and community partners. The narrative must include activities completed or planned for:
(A) The immediate postvention response;

(B) The intermediate postvention response; and
(C) The long-term postvention response, including how the interventions may change due to the end of a school year, at graduation, and at the anniversary of the death.
(g) If the LMHA has not determined intermediate or long-term postvention response activities at the time of the seven-day report, the LMHA shall provide the narrative described in subsection (f) to the Coordinator within 45 days of the date of the initial report.
(h) A request or decline of technical assistance from OHA.
(i) If assistance is requested, the LMHA shall make the request by phone or secure email and include as much of the following as is possible:
(A) The decedent's age; race and/or ethnicity; gender; gender identify; and sexual orientation;
(B) Identify the agency with custody of the decedent, if applicable;
(C) Identify organizations or individuals that provided services or resources to the decedent if the decedent was a runaway or homeless youth at the time of death;
(D) Location of the suspected youth suicide (such as a public place or private residence);
(E) Any evidence of bullying (cyber or in person);
(F) The manner in which, if at all, social media were involved;
(G) Whether, within the previous year, the decedent's family experienced another suicide;
(H) A description of all other traumatic deaths within the community, if known within the previous year; and
(I) Whether the decedent was receiving mental or behavioral health services at or close to the time of death.
(4) LMHAs shall notify the Coordinator if a death reported as a suspected youth suicide is later determined by the medical examiner or designee to not be a suicide.
(5) OHA shall provide LMHAs with a form for reporting the required information via e-mail to the Coordinator.
(6) Each LMHA shall annually report to the Coordinator an assessment of the effectiveness of the: communication and response protocols; post-intervention services provided, and procedures for reporting deaths to OHA. The LMHA may also include an estimate of the costs to the LMHA in implementing these rules that year.
(7) As part of the Authority's Plan to improve communication and response to suspected youth suicides, the Coordinator shall use the information compiled from the LMHA annual reports to aid its efforts to serve as a resource to the LMHAs.
Statutory/Other Authority: ORS 413.042, 430.630, 430.634, 430.640
Statutes/Other Implemented: ORS 418.735
History: MHS 24-2016, f. & cert. ef. 12-5-16

DIVISION 31
PROGRAMS FOR MENTAL OREMOTIONAL 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 a 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 Department, 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.
Statutory/Other Authority: ORS 161. 390, 179.360, 179.040, 413.042
Statutes/Other Implemented: ORS 161, 426.005 – 426.680
History: MHS 4-2015, f. & cert. ef. 5-28-15; 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

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.695
History: MHS 2-2012, f. & cert. ef. 2-9-12; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 7-2011, f. & cert. ef. 9-26-11

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 Health Systems Division (Division).
(3) “Division” means the Health Systems Division (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) Has or is reasonably assumed to have a serious mental illness;
(c) 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) “Person with serious mental illness” has the meaning given that term in OAR 309-036-0105.
(15) “Projects for Assistance in Transition from Homelessness” (PATH) means the Formula Grants, 42 U.S.C. 290cc-21 to 290-cc-35.
(16) “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.
(17) "Secretary" means the Secretary of the U.S. Department of Health and Human Services.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430
History: MHS 8-2017, f. & cert. ef. 6-23-17; MHS 2-2012, f. & cert. ef. 2-9-12; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 7-2011, f. & cert. ef. 9-26-11

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.695
History: MHS 2-2012, f. & cert. ef. 2-9-12; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 7-2011, f. & cert. ef. 9-26-11

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.695
History: MHS 2-2012, f. & cert. ef. 2-9-12; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 7-2011, f. & cert. ef. 9-26-11

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.695
History: MHS 2-2012, f. & cert. ef. 2-9-12; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 7-2011, f. & cert. ef. 9-26-11

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.610 – 430.695
History: MHS 2-2012, f. & cert. ef. 2-9-12; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 7-2011, f. & cert. ef. 9-26-11

309-032-0850

Purpose

These rules prescribe standards and procedures for regional acute care psychiatric services for adults.

Statutory/Other Authority: ORS 413.042, 430.640

Statutes/Other Implemented: ORS 430.630, 430.640

History: MHS 8-2017, f. & cert. ef. 6-23-17; MHS 22-2016, f. & cert. ef. 12-1-16; MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0860

Definitions

As used in these rules:

(1) “Adult” means an individual age 18 years or older.

(2) “Certificate” means the document issued by the Division that identifies and declares certification of a provider pursuant to OAR 309-008-0100 to 309-008-1600. A letter accompanying issuance of the certificate shall detail the certificate’s scope and approved service delivery locations.

(3) “Clinical Record” means a separate file established and maintained under these rules for each patient.

(4) “Community Mental Health Program” or “CMHP” means the organization of all services for individuals with mental or emotional disturbances, substance use problems, and developmental disabilities, 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.

(5) “Council” means an organization of individuals 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.

(6) “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.

(7) “Division” means the Health Systems Division of the Oregon Health Authority.

(8) “DSM” means the current edition of the “Diagnostic and Statistical Manual of Mental Disorders” published by the American Psychiatric Association.

(9) “Goal” means the broad aspirations or outcomes toward which the patient is striving and toward which all services are intended to assist the patient.

(10) “Guardian” means an individual appointed by a court of law to act as a guardian of a legally incapacitated person.

(11) “Independent Medical Practitioner” means a medically trained individual 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).

(12) “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.

(13) “Linkage Agreement” means a written agreement between regional acute care psychiatric facilities and other entities involved in patient care that includes, but is not limited to, CCOs, CMHPs, and state hospitals that describes the roles and responsibilities each entity assumes in order to assure that the goals of the regional acute care psychiatric services are achieved.

(14) “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.

(15) “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.

(16) “Mental Health Assessment” means a process in which the individual’s need for mental health services is determined through evaluation of the individual’s strengths, goals, needs, and current level of functioning.

(17) “Mental Status Examination” means an overall assessment of an individual’s mental functioning that includes descriptions of appearance, behavior, speech, and mood, and affect suicidal or 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.
(18) “Objective” means an interim level of progress or a component step the specification of which is necessary or helpful in moving toward a goal.
(19) “OPRCS” means the Oregon Patient/Resident Care System. OPRCS is a Division operated, on-line computerized information system that accepts, stores, and returns information about patients from state operated institutions and other designated inpatient services.
(20) “Patient” means an individual 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) “Person with Serious and Persistent Mental Illness (SPMI)” means, for the purposes of a warm handoff, an individual age 18 or older who meets the current DSM diagnostic criteria for at least one of the following conditions as a primary diagnosis:
(a) Schizophrenia and other psychotic disorders;
(b) Major depressive disorder;
(c) Bipolar disorder;
(d) Anxiety disorders, limited to OCD and PTSD;
(e) Schizotypal personality disorder;
(f) Borderline personality disorder.
(g) The applicable ICD 9 & 10 codes for SPMI diagnoses can be found at https://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Oregon-Performance-Plan.aspx.
(23) “Program Administrator” means an individual with appropriate professional qualifications and experience appointed by the governing body to manage the operation of the regional acute care psychiatric services.
(24) “Psychiatrist” means a physician licensed 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.
(25) “Qualified Mental Health Professional” or “QMHP” means an individual 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 individual 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, or group therapy.
(26) “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.
(27) “Supervisor” means an individual with two years of experience as a qualified mental health professional and who, in accordance with OAR 309-032-0870, reviews the services provided to patients by qualified individuals.
(28) “Telehealth” means a technological solution that provides two-way, video-like communication on a secure line.
(29) “Treatment Plan” means an individualized, written plan defining specific rehabilitation objectives and proposed service interventions derived from the patient’s mental health assessment.
(30) “Warm Handoff” means the process of transferring a patient from one provider to another prior to discharge from an acute care psychiatric hospital that involves face-to-face meetings with the patient, either in person or through the use of telehealth, and that coordinates the transfer of responsibility for the patient’s ongoing care and continuing treatment and services. A warm handoff shall be offered to individuals with SPMI, defined in OAR 309-032-0860(22), as

part of the discharge planning process.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.630, 430.640
History: MHS 8-2017, f. & cert. ef. 6-23-17; MHS 22-2016, f. & cert. ef. 12-1-16; MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0870
Standards for Approval of Regional Acute Care Psychiatric Service

(1) The facility in which a regional acute care psychiatric service is provided shall maintain state certificates and licenses as required by Oregon law for the health, safety, and welfare of the individuals served. Non-hospital facilities shall be licensed by the Division as required by ORS 443.410. Non-hospital facilities shall be certified by the Division as required by OAR 309-008-0100 to 1600. The facility shall 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) A regional acute care psychiatric service shall include 24-hours 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 amelioration of acute dysfunctional symptoms or behaviors that result in the earliest possible return of the individual to a less restrictive environment.
(3) A regional acute care psychiatric service shall maintain clinical records as follows:
(a) Except as otherwise applicable, clinical records are confidential as set forth in ORS 179.505 and 192.502 and any other applicable state or federal 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 apply;
(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 shall be signed by the staff providing the service and making the entry. Each signature shall include the individual’s academic degree or professional status and the date signed.
(4) The clinical record shall contain:
(a) Identifying demographic information including, if available, who to contact in an emergency and the names of individuals 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 patient is unable or unwilling to do so;
(c) 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, a mental status examination, an initial DSM diagnosis, and an assessment of the resources currently available to the individual. 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 individual 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) 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 shall include the following elements:
(A) A description of events precipitating admission and any goals of the patient in seeking or entering services;
(B) When relevant to the patient's service needs, historical information including: a current Declaration for Mental Health Treatment; mental health history; medical history; substance use history; developmental history; social history including family and interpersonal history; sexual and other abuse history; educational, vocational, and 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) A copy of the patient's Declaration for Mental Health Treatment if the patient elected to complete or provided one.
(e) 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 they have 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;
(H) The patient's anticipated continuing care needs, including need for housing, and for individuals with SPMI, the coordination needs for a warm handoff process.
(f) Progress notes shall document observations, treatment rendered, response to treatment, 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 patient 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) The discharge planning process shall begin at the time of admission with the participation of the patient and, when indicated, the family, guardian, or family of choice, and shall include, but is not limited to:
(A) An assessment of continuing care needs, including prescribed medications, behavioral and primary health care needs, and housing needs;
(B) Consultation with the individual's CCO to address continuing care needs upon discharge, when applicable, and;
(C) Planning a follow-up visit with a community mental health provider within seven days of the anticipated discharge date.

(m) A warm handoff shall be offered to individuals with SPMI as part of the discharge planning process that involves a face-to-face meeting, either in person or through the use of telehealth, and includes either:
(A) A community provider, the patient, and if possible hospital staff, or;
(B) A transitional team, the patient, and if possible hospital staff to support the patient, to serve as a bridge between hospital staff and a community provider, and to ensure the patient connects with a community provider.
(n) The discharge plan shall be based on the patient's treatment goals, clinical needs, and informed choice and 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 individual's condition, a summary of continuing care needs including prescribed medications, behavioral and primary health care needs, and housing needs. Documentation to support linkages to timely and appropriate community services upon discharge shall be detailed in the discharge plan including, but not limited to:
(A) The plan to address the patient's need for immediate housing upon discharge, when applicable, including notifying the patient's community provider regarding the need for housing; and
(B) The plan to address the patient's need for a follow-up visit with a community mental health provider within seven days of the anticipated discharge date;
(C) For individuals with SPMI, the discharge plan shall also include:
(i) Whether a warm handoff occurred and the community provider or transitional team involved in the warm handoff process, when applicable; or
(ii) Whether the patient declined a warm handoff.
(5) The regional acute care psychiatric service shall supply the Division, using the Division's on-line OPRCS via computer and modem, information about individuals admitted to and discharged from the service. The information shall include the patient's name, DSM diagnosis, admission date, discharge date, legal status, Medicaid eligibility, Medicaid Prime Number, and various patient demographics. The information shall be entered on the day of admission and updated on the day of discharge.
(6) 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 individuals 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 that 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 that 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 skill training received;
(k) A physician shall be available, at least on-call, at all times.
(7) The regional acute care psychiatric service shall have a policy and procedure manual. The policy and procedure manual must be made available to any individual 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 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 procedures. 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 shall 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 individuals. Programs shall provide written copies of the rights and grievance procedures 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 individuals 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 individuals with physical disabilities, including designation of a county or regional geropsychiatric liaison staff member;
(E) Linkage agreements with entities involved in patient care; (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 payers.
(8) 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 individuals alleged to be mentally ill under OAR 309-033-0500 through 0560, (Approval of Hospital and Nonhospital Facilities that Provide Services to Committed Persons or to Persons in Custody or on Diversion).
(9) The facility in which a service is operated shall comply with all applicable federal rules and regulations.
(10) 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 that shall be renewed every two years.
(11) 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 describe 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;
(G) An annual needs assessment survey of individuals that have received services.
(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.
(12) 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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.630, 430.640
History: MHS 8-2017, f. & cert. ef. 6-23-17; MHS 22-2016, f. & cert. ef. 12-1-16; MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0890
Variances
(1) The Division may grant variances to a regional acute care psychiatric service 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) Application for a variance to these or other applicable rules shall be obtained pursuant to the process governed by OAR 309-008-1600.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 430.630, 430.640
History: MHS 8-2017, f. & cert. ef. 6-23-17; MHS 22-2016, f. & cert. ef. 12-1-16; 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 though 309-033-0170, which were in effect from September 2, 1992 through August 31, 1994.
Statutory/Other Authority: ORS 413.042, 426.005 - 426.395
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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) Community Mental Health Program (CMHP) means the entity responsible for 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.
(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 location 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.
Statutory/Other Authority: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; MHD 9-2000, f. & cert. ef. 7-21-00; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0010

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.
Statutory/Other Authority: ORS 413.042, 426.060
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.228, 426.231, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHD 9-2000, f. & cert. ef. 7-21-00; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0040

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.
Statutory/Other Authority: ORS 413.042, 426.228, 426.231, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHD 9-2000, f. & cert. ef. 7-21-00; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0050

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.
Statutory/Other Authority: ORS 413.042, 426.070, 426.231, 426.232, 426.233, 426.234
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHD 9-2000, f. & cert. ef. 7-21-00; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0060

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, Procedures 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.
Statutory/Other Authority: ORS 413.042, 426.236, 426.237
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.060, 426.385, 430.205 - 430.210
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 5-2009, f. & cert. ef. 12-17-09; MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0080

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.
Statutory/Other Authority: ORS 413.042, 426.127, 426.273, 426.278
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.060
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.060, 426.223, 426.233, 426.273, 426.275, 426.278
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.301, 426.307
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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 noncompliance 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.
Statutory/Other Authority: ORS 413.042, 426.275
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.300
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0140

309-033-0340
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 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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 is 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 Non-Hospital 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.
Statutory/Other Authority: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; MHD 10-2000, f. & cert. ef. 7-21-00; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0010

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.
Statutory/Other Authority: ORS 413.042, 426.060, 426.235
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.150
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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) 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) A secure transport provider shall submit a letter of application to the Division. If approved, the Division shall issue a certificate of approval to provide transportation 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 in 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 secure transport provider's vehicles 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 non-breakable 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 items or instruments in the secured area that may be used by the client to inflict harm to self, attendant or person accompanying the client;
(H) Have an operating cellular phone or other communication device for use in transit;
(I) Have adequate ventilation and heating appropriate to the secured seating; or
(J) Be licensed as an ambulance service in accordance with OAR 333-250-0040, if providing transportation to a Psychiatric Emergency Services (PES) facility.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; MHD 10-2000, f. & cert. ef. 7-21-00; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 5-2007, f. & cert. ef. 5-25-07; MHD 10-2000, f. & cert. ef. 7-21-00; MHD 3-2000(Temp), f. 1-25-00, cert. ef.

1-25-00 thru 7-22-00

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.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 426.005 - 426.395

History: MHD 10-2000, f. & cert. ef. 7-21-00; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00

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.

Statutory/Other Authority: ORS 413.042, 426.060, 426.235

Statutes/Other Implemented: ORS 426.005 - 426.395

History: Reverted to 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; MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0050

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.
Statutory/Other Authority: ORS 413.042, 426.060 - 426.500
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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) “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.
(4) “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.
(5) “Community Mental Health Program” (CMHP) the entity responsible for 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.
(6) “Community hospital” means any hospital that is not a state hospital.
(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;
(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.
(9) “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.
(10) “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.
(11) “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.
(12) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority.
(13) “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.
Statutory/Other Authority: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; 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.
Statutory/Other Authority: ORS 413.042, 426.238
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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 pursuant to OAR 309-008-0100 to 309-008-1600. If approved, a Certificate pursuant to OAR 309-008-0100 to 309.008-1600 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.
Statutory/Other Authority: ORS 413.042, 426.228, 426.232, 426.233, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; 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.
Statutory/Other Authority: ORS 413.042, 426.123, 426.232, 426.233, 426.234, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.231
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.385
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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) “Community Mental Health Program” (CMHP) the entity responsible for 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
(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.
Statutory/Other Authority: ORS 413.042, 426.385
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; 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.
Statutory/Other Authority: ORS 413.042, 426.385
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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 consent. When administering 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.
Statutory/Other Authority: ORS 413.042, 426.072, 426.231, 426.236
Statutes/Other Implemented: ORS 426.005 – 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.385
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.385
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.236, 426.385, 430.021
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 13-2014, f. & cert. ef. 9-29-14; MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0000

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) “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.
(4) "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.
(5) “Community Mental Health Program” (CMHP) the entity responsible for 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
(6) "Community Hospital" means any hospital that is not a state hospital.
(7) “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.
(8) "Court" means the circuit court acting pursuant to ORS Chapter 426.
(9) "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.
(10) "Director" means the community mental health program director who has been authorized by the local mental health authority to direct the CMHP.
(11) "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).
(12) "Division" means the Health Systems Division of the Oregon Health Authority (OHA).
(13) “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 or ORS 426.072, 426.232 or 426.233 must not be the sole justification that an emergency exists.
(14) “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.
(15) "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.
(16) “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.
(17) "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.
(18) “P.R.N.” (pro re nata) means that a medication or medical treatment has been ordered to be given as needed.
(19) “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.
(20) "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.
(21) “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.
(22) “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.
(23) "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.
(24) “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.
(25) "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.
(26) “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.
(27) "State Hospital" means each campus of the Oregon State Hospital.
Statutory/Other Authority: ORS 413.042, 426.005, 426.060, 426.110, 426.232, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; MHS 13-2014, f. & cert. ef. 9-29-14; MHS 5-2008, f. & cert. ef. 6-27-08; MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0010

309-033-0720
Application, Training and Minimum Staffing Requirements

(1) Only the following facilities shall be certified pursuant to this rule and the procedures found OAR 309-008-0100 to 309-008-1600 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 309-008-0100 to 309-008-1600. 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.
Statutory/Other Authority: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; MHS 13-2014, f. & cert. ef. 9-29-14; MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0030

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.
Statutory/Other Authority: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236, 430.041
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 426.236, 426.385, 430.041
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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
Statutory/Other Authority: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 13-2014, f. & cert. ef. 9-29-14; MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0040

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.
Statutory/Other Authority: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236, 430.041
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 426.236, 426.385, 430.021
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 426.236, 426.385, 430.021
Statutes/Other Implemented: ORS 426.005 - 426.309
History: MHS 13-2014, f. & cert. ef. 9-29-14; MHS 5-2008, f. & cert. ef. 6-27-08; MHS 17-2007(Temp), f. 12-28-07, cert. ef. 1-1-08 thru 6-29-08

309-033-0740
Variances
(1) 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) The HSD 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 HSD 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.
Statutory/Other Authority: ORS 426.236, 426.385
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; MHS 13-2014, f. & cert. ef. 9-29-14; MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0050

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.
Statutory/Other Authority: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.241
History: MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0000; MHD 6-1994, f. & cert. ef. 8-24-94

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.
Statutory/Other Authority: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.241
History: MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0010; MHD 6-1994, f. & cert. ef. 8-24-94

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.
Statutory/Other Authority: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.241
History: MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0030; MHD 6-1994, f. & cert. ef. 8-24-94

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.
Statutory/Other Authority: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236
Statutes/Other Implemented: ORS 426.241

History: MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0040; MHD 6-1994, f. & cert. ef. 8-24-94

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.

Statutory/Other Authority: ORS 413.042, 426.060 - 426.500

Statutes/Other Implemented: ORS 426.005 - 426.395

History: 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) “Community Mental Health Program” (CMHP) the entity responsible for 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

(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.
Statutory/Other Authority: ORS 413.042, 426.060 - 426.500
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHS 28-2016, f. & cert. ef. 12-29-16; 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, homocidality 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.
Statutory/Other Authority: ORS 413.042, 426.060 - 426.500
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.060 - 426.500
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.060 - 426.500
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.060 - 426.500
Statutes/Other Implemented: ORS 426.005 - 426.395
History: 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.
Statutory/Other Authority: ORS 413.042, 426.060 - 426.500
Statutes/Other Implemented: ORS 426.005 - 426.395
History: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0070

309-033-0970
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. Applications for variances to this rule are to be completed pursuant to OAR 309-008-0100 to 309-008-1600.
Statutory/Other Authority: ORS 426.060 - 426.500
Statutes/Other Implemented: ORS 426.005 - 426.309
History: MHS 28-2016, f. & cert. ef. 12-29-16; MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0080

DIVISION 35
RESIDENTIAL TREATMENT FACILITIES AND RESIDENTIAL TREATMENT HOMES FOR ADULTS WITH MENTAL HEALTH DISORDERS

309-035-0100
Purpose and Scope
(1) These rules prescribe standards by which the Health Systems Division (Division) of the Oregon Health Authority (Authority) licenses community based residential treatment facilities and community based residential treatment homes for adults with mental health disorders. The standards promote optimum health, mental and social well-being, and recovery for adults with mental health 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 individuals not receiving HCBS, consistent with the standards set out in OAR chapter 411, division 4.
(2) These rules apply to all Residential Treatment Homes (RTH) and Residential Treatment Facilities (RTF) providing services to adults with mental health disorders regardless of whether the program receives public funds. These rules

prescribe distinct standards in some areas for Secure Residential Treatment Facilities (SRTF) or are based on the number of individuals receiving services in the program.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 5-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 10-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

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 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) "Program Administrator" means the individual designated by the provider as responsible for the daily operation and maintenance of the RTH or RTF or the program administrator's designee.
(3) "Adult" means an individual 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 that maintains or enhances the individual's physical functioning.
(5) "Applicant" means the individual or entity, including the Division, who owns, seeks to own or operate, or maintains and operates a program and is applying for a license.
(6) "Approved" means authorized or allowed by the Authority or designee.
(7) "Authority" means the Oregon Health Authority or 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 including but not limited to 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 individuals with mental health disorders, operated by, or contractually affiliated with, a local mental health authority. CMHP's operate in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.
(12) "Competitive Integrated Employment" means work in a competitive labor market that is performed on a full-time or part-time basis and includes self-employment. Competitive Integrated Employment also means individuals are

compensated as rates set forth by federal, state or local minimum wage law and eligible for benefits and opportunities for advancement.
(13) "Contract" means a formal written agreement between the CMHP, CCO, Oregon Health Plan contractor, or the Division and a provider.
(14) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the CCO's members.
(15) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 943-007-0001 through 943-007-0501.
(16) "Crisis-Respite Services" means providing services to individuals who are RTF residents for up to 30 days.
(17) "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.
(18) “Designated Representative” means:
(a) Any adult who is not the individual’s paid provider who the individual or the individual's representative has authorized to serve as the individual's representative;
(b) The power to act as a designated representative is valid until modified or rescinded. The individual or representative must notify the Division or provider of any change in designation. The notice shall 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.
(19) "DSM" means the "Diagnostic and Statistical Manual of Mental Disorders (DSM-V)" published by the American Psychiatric Association.
(20) “Deputy Director” means the deputy director of the Health Systems Division of the Oregon Health Authority or designee.
(21) "Division" means the Health Systems Division of the Oregon Health Authority or designee.
(22) “Division Staff” means individuals employed by the Division or individuals delegated by the Division to conduct licensing activities under these rules.
(23) "Direct Care Staff" means program staff responsible for providing services for an individual.
(24) "Emergency Admission" means an admission to a program made on an urgent basis due to the pressing service needs of the individual.
(25) “Employee” means an individual employed by a provider who receives wages, a salary, or is otherwise paid by the provider for providing the service.
(26) "Evacuation Capability" means the ability of occupants, including individuals and program staff as a group, to 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, who 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 shall 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.
(27) "Fire Code" means the Oregon Fire Code as adopted by the State of Oregon Fire Marshal.

(28) “HCB” means Home and Community-Based.
(29) “HCBS” means Home and Community-Based Services; services provided in the individual's home or community.
(30) “Home and Community-Based Settings” or “HCB Settings” means a physical location meeting the requirements of OAR 411-004-0020 where an individual receives Home and Community-Based Services.
(31) "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.
(32) “Individual” means any individual being considered for placement or is 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.
(33) “Individual Service Record” means an individual’s records maintained by the program pursuant to OAR 309-035-0130(4).
(34) "Individually-Based Limitation" means any limitation to the qualities outlined in OAR 309-035-0195, due to health and safety risks. An individually-based limitation is based on a specific assessed need and only implemented with the individual's or individual's representative's informed consent as described in OAR 309-035-0195.
(35) "Informed Consent" means:
(a) That options, risks, and benefits of the services outlined in these rules have been explained to an individual or the individual’s legal representative in a manner that the individual comprehends; and
(b) That the individual or 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.
(36) "Legal Representative" means an individual with the legal authority to act for an individual and only within the scope and limits to the authority 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 individual 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.
(37) "Licensed Medical Professional (LMP)" means an individual 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.
(b) Whose training, experience, and competence demonstrate the ability to conduct a comprehensive mental health assessment and provide medication management.
(38) "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 that contracts with the Division to operate a CMHP or MHO for that county.
(39) "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 individual.
(40) "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.
(41) "Mental Health Assessment" means a determination by a Qualified Mental Health Professional (QMHP) of an individual's need for mental health services. It involves collection and assessment of data pertinent to the individual'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.
(42) “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 individual's income or assets 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 service plan.
(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 individual's well-being;
(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 service essential to the individual's well-being;
(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 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 the 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.
(43) "Nursing Care" means the practice of nursing by a licensed nurse, including tasks and functions that are delegated by a registered nurse to an individual 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.
(44) 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.
(45) "Person-Centered Service Plan Coordinator" means the individual, which may be a case manager, service coordinator, personal agents or other individual, designated by the Division to provide case management services or person-centered service planning for and with an individual.
(46) "P.R.N. (pro re nata) Medications and Treatments" means those medications and treatments that have been ordered to be given as needed.

(47) "Program" means the Residential Treatment Facility or Residential Treatment Home licensed by the Division and may refer to the setting grounds, caregiver, staff, or services as applicable to the context.
(48) “Program Staff” means an employee, volunteer, direct care staff, or individual who, by contract with a program, provides a service to an individual.
(49) "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.
(50) "Protection" means the necessary actions taken by the program to prevent abuse, mistreatment, or exploitation of the individual to prevent self-destructive acts and to safeguard the individual’s property and funds when used in the relevant context.
(51) “Provider” means the program administrator, individual, or organizational entity licensed by the Division which operates the program and provides services to individuals.
(52) “Representative” refers to both “Designated Representative” and “Legal Representative” as defined in these rules, unless otherwise stated.
(53) "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.
(54) "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 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.
(55) "Residential Treatment Facility (RTF)" means a program licensed by the Division to provide services on a 24-hour basis for six to 16 individuals as described in ORS 443.400(9). An RTF does not include the entities set out in ORS 443.405.
(56) “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.
(57) "Restraints" means any chemical or physical methods or devices that are intended to restrict or inhibit the movement, functioning, or behavior of an individual.
(58) "Room and Board" means compensation for the provision of meals, a place to sleep, and tasks such as housekeeping and laundry.
(59) "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.
(60) "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.
(61) “Services and Supports” means those services defined as habilitation services and psychosocial rehabilitation services under OAR 410-172-0700(1), (2) & 410-172-0710(1), (2).
(62) "Setting" means one or more buildings and adjacent grounds on contiguous properties that are used in the operation of a program.
(63) "Supervision" means a program staff’s observation and monitoring of an individual or oversight of a program staff by the program administrator applicable to the context.
(64) "Termination of Residency" means the time at which the individual ceases to reside 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.
(65) "Treatment" means a planned, individualized program of medical, psychological or rehabilitative procedures, experiences and activities designed to relieve or minimize mental, emotional, physical or other symptoms or social,

educational or vocational disabilities resulting from or related to the mental or emotional disturbance, physical disability or alcohol or drug problem.
(66) "Unit" means the bedroom and other space of an individual receiving services from a program, as agreed to in the Residency Agreement. Unit includes private single occupancy spaces and shared units with roommates.
(67) “Volunteer” means an individual who provides a service or 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.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 5-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 10-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; MHS 4-2008, f. & cert. ef. 6-12-08; MHS 13-2007, f. & cert. ef. 8-31-07; MHS 6-2007(Temp), f. & cert. ef. 5-25-07 thru 11-21-07; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0110

Required Home-like Qualities

This rule becomes effective July 1, 2016, and enforceable pursuant to OAR 309-035-0115 (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 individuals’ not receiving HCBS including opportunities for an individual to:
(A) Seek employment and work in competitive integrated employment settings:
(i) For which an individual 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;
(II) 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
(III) 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.
(ii) For which an individual is eligible for the level of benefits provided to other employees;
(iii) At a location where the individual interacts with other individuals who are not individuals with disabilities. This does not include supervisory personnel or individuals providing services to the individual to the same extent as individuals without disabilities and who are in comparable positions who interact with others; and
(iv) That present opportunities for advancement similar to those for other employees who are not individuals with disabilities and who have similar positions.
(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 legal or designated representative from among available setting options for which the individual meets medical necessity criteria including non-disability specific settings and an option for a private unit in a residential setting. The setting options shall be:
(A) Identified and documented in the individuals' person-centered service plan;
(B) Based on the individual's needs and preference; and
(C) Based on the individual’s available resources 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 shall 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 shall be:
(a) Identified and documented in the person-centered service plan for the individual;
(b) Based on the individual's needs and preferences; and
(c) Based on the individual's available resources for room and board.
(3) The provider shall take reasonable steps to ensure that the program maintains the qualities identified in sections (2) and (3) of 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 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) A program shall maintain the following:
(a) The setting shall be physically accessible to an individual;
(b) The provider shall 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 shall 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 shall provide substantially equivalent protections for the individual and address eviction and appeal processes. The eviction and appeal processes shall be substantially equivalent to the processes provided under landlord-tenant laws;
(d) The provider shall provide each individual with privacy in their own unit;
(e) The provider shall maintain units with entrance doors lockable by the individual. The program shall 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 shall ensure that individuals sharing units have a choice of roommates;
(g) The provider shall provide and include in the Residency Agreement that individuals have the freedom to decorate and furnish their own unit;
(h) The provider shall allow each individual to have visitors of their choosing at any time;
(i) The provider shall ensure each individual has the freedom and support to control their own schedule and activities;
(j) The provider shall ensure each individual has the freedom and support to have access to food at any time.
(5) A SRTF is not required to maintain the qualities or meet the obligations identified in section (4)(d)(e)(f)(h)(i) 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 section (4) (b) or (c) 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 qualities outlined under section (4)(e) through (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 the individual's legal representative. The provider may not apply an individually-based limitation until the limitation is approved, consented and documented as outlined in OAR 309-035-0195.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0115
Licensing

(1) The Division shall 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 shall 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 health disorder, the directors of the Authority and the Department shall determine the department responsible for licensure.
(3) 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 individual, 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) Physical 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 individuals involved in the operation of the program who will have contact with the individuals including but not limited to caregivers;
(g) Written background information pertaining to any current or previous licensure or certification by a state agency, including those licenses or certificates granted to a business or person affiliated with the business, including:
(A) Copies of all current licenses or certificates;
(B) Documentation showing the final disposition of any suspension, denial, revocation, or other disciplinary actions initiated on any current or previous license or certificate, including settlement agreements, where applicable; and
(C) Documentation of any substantiated allegations of abuse or neglect pertaining to the applicant or anyone employed by or contracted with the applicant.
(h) A complete set of policies and procedures;
(i) Setting plans and specifications; and
(j) Other information the Division may reasonably require.
(4) 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 shall meet the following criteria:
(a) Plans shall be prepared in accordance with the Building Code and as outlined in OAR 309-035-0140;
(b) Plans shall be to scale and sufficiently complete to allow full review for compliance with these rules; and
(c) Plans shall bear the stamp of an Oregon licensed architect or engineer when required by the Building Code.
(5) Prior to approval of a license for a new or renovated setting, the applicant shall 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) The following fees shall 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) 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 section (6), except that no fee shall 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 shall 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) Upon receipt of an application and fee, the Division shall conduct an application review. Initial action by the Division on the application shall begin within 30 days of receipt of all application materials. The review shall:
(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) The Division may elect to deny an application prior to review when the applicant has previously had any action taken on a certificate or license, including denial, suspension, conditions, intent to revoke, or revocation by the Division, Oregon Health Authority, the Oregon Department of Human Services, or any other state agency.
(10) The provider shall submit and complete a plan of correction for each finding of noncompliance:
(a) If the findings of noncompliance substantially impact the welfare, health, and safety of individuals, the provider shall submit a plan of correction that shall be approved by the Division prior to issuance of a license. In the case of a currently operating program, the findings may result in suspension or revocation of a license;
(b) If it is determined that the findings 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 the plan of correction submitted and completed as a condition of licensing;
(c) The Division shall specify required documentation and set the time lines for the submission and completion of plans of correction in accordance with the severity of the findings;
(d) The Division shall review and evaluate each plan of correction. If the plan of correction does not adequately remedy the findings of noncompliance, the Division shall require a revised plan of correction and may 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 shall make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Division shall be final.
(11) 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) The provider seeking a variance shall submit in writing an application to the Division that 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) The director or designee shall review and approve or deny the request for a variance;
(c) The Division shall notify the provider of the decision in writing within 30 days after receipt of the request. A variance may be implemented only after receipt of written approval from the Division;

(d) The provider may appeal the denial of a variance request by submitting a request for reconsideration in writing to the Division's Director. The Director shall make a decision within 30 days of receipt of the appeal. The decision of the Director shall be final; and
(e) A variance shall 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.
(12) Upon finding that the applicant is in substantial compliance with these rules, the Division shall issue a license:
(a) The license issued shall 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 shall be effective for two years from the date issued unless sooner revoked or suspended; and
(c) A program license is not transferable or applicable to any setting, location, or management other than that indicated on the application and license.
(13) The license shall be valid only under the following conditions:
(a) The provider may 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 shall have sleeping, dining, and living areas for use only by its own individual's caregivers and invited guests;
(b) The provider shall maintain the license posted in the setting and available for inspection at all times; and
(c) A license becomes 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.
(14) Division staff shall visit and inspect every setting at least once every two years to determine whether it is maintained and operated in accordance with these rules. The provider or applicant shall allow Division staff entry and access to the setting and individuals for the purpose of conducting the inspections:
(a) Division staff shall 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, shall be available to the Division for review; and
(c) The State Fire Marshal or authorized representatives shall, 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.
(15) Incidents of alleged abuse covered by ORS 430.735 through 430.765 and reported complaints shall be investigated in accordance with OAR 943-045-0250 through 0370. The Division may delegate the investigation to a CMHP or other appropriate entity.
(16) The Division may 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 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; and
(b) The revocation, suspension, or denial shall be done in accordance with ORS 443.440
(17) The provider shall report promptly to the Division any significant changes to information supplied in the application or subsequent correspondence. Changes include but are not limited to changes in the setting or program name, provider, program administrator, telephone number, and mailing address. Changes also include but are not limited to changes in the physical nature of the setting, policies and procedures, or staffing pattern when the changes are significant or impact the individual's health, safety, or well-being.
(18) Enforcement of Home and Community-Based Services and Settings Requirements:
(a) All programs licensed on or after July 1, 2016, shall 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, shall come into compliance with rules as follows:
(A) All programs shall be in full compliance with these rules no later than January 1, 2017; and

(B) For the rules designated by the Division to become effective July 1, 2016, the provider shall make measureable progress towards compliance with those rules. The Division may not issue sanctions and penalties for failure to meet the 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.
Statutory/Other Authority: ORS 413.042, ORS 443.450, ORS 443.420
Statutes/Other Implemented: ORS 413.032, ORS 443.400 - 443.465, ORS 443.991
History: MHS 11-2017, temporary amend filed 10/03/2017, effective 10/03/2017 through 03/30/2018; MHS 5-2017, f. & cert. ef. 6-8-17; 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; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0120
Contracts and Rates
(1) A provider receiving service payments shall 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 shall be referred to or maintained in the program.
(2) The provider shall specify in a fee policy and procedure rates for all services and the procedures for collecting payments from individuals and payees. The fee policy and procedures shall 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 shall be made according to the rate schedule outlined in the contract. Room and board payments for individuals receiving Social Security benefits or public assistance shall be in accordance with rates determined by the Division;
(b) For private paying individuals, the program shall enter into a signed agreement with the individual, and, if applicable, the individual's designated representative. This agreement shall include but is not 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; and
(c) Before increasing rates or modifying payment procedures, the program shall provide a 30-day advance notice of the change to all individuals, representatives, payees, guardians, or conservators.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0125
Administrative Management
(1) The provider shall 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) The provider shall 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 record checks processed in compliance with the procedures required by OAR 943-007-0001 through 0501 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 shall 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) The provider shall 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 shall be consistent with requirements of these rules and shall address at a minimum the following:
(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) The provider shall 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 shall be consistent with individual rights as set forth in OAR 309-035-0175;
(b) House rules shall be posted in an area readily accessible to individuals;
(c) House rules shall be reviewed and updated as necessary;
(d) Individuals shall be provided an opportunity to review and provide input into any proposed changes to house rules before the revisions become effective; and
(e) Effective July 1, 2016, house rules may not restrict or limit the program qualities identified in OAR 309-035-0110.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.460, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; 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; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0130
Records

(1) Records shall be maintained to document the legal operation of the program, personnel practices, and individual services and supports. All records shall be properly obtained, accurately prepared, safely stored, and readily available or electronically accessible within the setting. All entries in records required by these rules shall 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) Records documenting the legal operation of the program shall include but not 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 shall document and 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, documentation that Hepatitis B inoculations have been given or made available, performance appraisals, and documentation of pre-service orientation and other training.
(4) Individual service records shall be maintained for each individual and include:
(a) An easily accessible summary sheet that includes, but is not limited to, the individual's name, previous address, date of admission to the program, gender, biological sex, date of birth, marital status, legal status, religious preference, health provider information, evacuation capability, DSM diagnosis, physical health diagnosis, medication allergies, food allergies, information indicating whether advance mental health and health directives and burial plan have been executed, and the name of individuals to contact in case of emergency;
(b) The names, addresses, and telephone numbers of the individual's representative, legal guardian or conservator, parents, next of kin, or other significant persons; physicians or other medical practitioners; dentist; case manager or therapist; day program, school, or employer; and any governmental or other agency representatives 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 medical health directives, burial plans, or location of these;
(e) A residential service plan and copy of plans from other service providers;
(f) Effective July 1, 2016, and pursuant to OAR 309-035-0115(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.
(5) The program shall retain all referral packets, screening materials, and screening responses-placement determinations for a minimum of three years from the date of the referral.
(6) For an individual receiving crisis-respite services, the provider shall obtain and maintain records as outlined in these rules. Because it may not be possible to obtain and maintain complete records during a crisis-respite stay, the program shall, at a minimum, maintain records that are deemed reasonable to provide services in the program.
(7) All individual service records shall be stored in a weatherproof and secure location. Access to records shall be limited to the program administrator and direct care staff unless otherwise allowed in these rules.
(8) All individual service records shall be kept confidential as required by law. A signed release of information shall be obtained for any disclosure from an individual service record in accordance with all applicable laws and rules.

(9) An individual or the representative shall be allowed to review and obtain a copy of the individual service record as required by ORS 179.505(9).
(10) Pertinent information from records of an individual being transferred to another facility shall be transferred with the individual. A signed release of information shall first be obtained in accordance with applicable laws and rules.
(11) The program shall keep all records, except those transferred with an individual, for a period of three years.
(12) If a program changes ownership or program administrator, all individual and personnel records shall remain at the setting. Prior to the dissolution of any program, the program administrator shall notify the Division in writing as to the location and storage of individual service records or those records shall be transferred with the individual.
(13) If an individual or representative disagrees with the content of the individual service record, or otherwise desires to provide documentation for the record, the individual or representative may provide material in writing that then shall become part of the individual service record.
(14) The program shall 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 shall 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 shall include the materials reviewed in screening the individual, the summary sheet, and any other available information. The program shall make every effort to complete the individual service record in a timely manner. The assessment and residential service plan shall be completed in accordance with OAR 309-035-0185. Records on prescribed medications and health needs shall be completed as outlined in OAR 309-035-0215.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; 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; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0135

Staffing

(1) The provider shall maintain a written job description for each staff position that specifies the position's qualifications and job duties:
(a) A direct care staff person shall 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) All program staff having 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) Program staff who will have contact with individual's must be tested for tuberculosis within two weeks of first employment; additional testing shall take place as deemed necessary; and the employment of program staff who test positive for tuberculosis shall be restricted if necessary; and
(d) All program staff shall meet other qualifications when required by a contract or financing arrangement approved by the Division.
(2) Personnel policies shall be made available to all program staff and shall describe hiring, leave, promotion, and disciplinary practices.
(3) The program administrator shall provide or arrange a minimum of 16 hours pre-service orientation and eight hours in-service training annually for each program staff including:
(a) Pre-service training for direct care staff shall include but not limited to a comprehensive tour of the setting; a review of emergency procedures developed in accordance with OAR 309-035-0145; 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 shifts; and
(b) In-service training shall 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) The provider and program administrator shall ensure that an adequate number of program and direct care staff are available at all times to meet the treatment, health, and safety needs of individuals. Program staff must be scheduled to meet the changing needs and ensure safety of individuals. Minimum staffing requirements are as follows:
(a) In RTHs serving one to five individuals, there shall be at least one direct care staff on duty at all times;
(b) In RTFs serving six to 16 individuals, there shall be at least one 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 shall be implemented;
(d) Class I and Class II SRTFs shall ensure staffing levels meet the requirements set forth in chapter 309, divisions 32 and 33; and
(e) Program and direct care staff on night duty shall be awake and dressed at all times. In settings where individuals are housed in two or more detached buildings, program staff shall monitor each building at least once an hour during the night shift. An approved method for alerting program staff to problems shall be in place and implemented. This method shall be accessible to and usable by the individuals.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0140
Setting Requirements
(1) The provider shall 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 shall 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) Programs shall 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 shall 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; and
(c) Any accessibility improvements made to accommodate an identified individual shall be in accordance with the specific needs of the individual.
(3) An accessible outdoor area is required and shall be made available to all individuals. For programs or portions thereof licensed on or after June 1, 1998, a portion of the accessible outdoor area shall be covered and have an all-weather surface such as a patio or deck.
(4) The setting shall have sufficient and safe storage areas that include but not limited to:
(a) Storage for a reasonable amount of individual belongings beyond that available in the individual's unit shall be

provided appropriate to the size of the setting;
(b) All maintenance equipment including yard maintenance tools shall be maintained in adequate storage space. Equipment and tools that pose a danger to individuals shall be kept in locked storage; and
(c) Storage areas necessary to ensure a functional, safe, and sanitary environment consistent with OAR 309-035-0140 through 0155 and 309-035-0210 through 0215.
(5) For programs initially licensed on or after June 1, 1998, all individual use areas and individual units shall be accessible through temperature controlled common areas or hallways with a minimum width of 36 inches except that a minimum width of 48 inches shall be provided along the route to accessible bedrooms and bathrooms and between common areas and required exits.
(6) The setting shall have sufficient space 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 shall be installed in an area readily accessible to staff in accordance with the Fire Code.
(7) The provider shall 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 shall 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 shall maintain units as follows:
(a) For programs licensed prior to June 1, 1998, units shall 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 shall be limited to one or two individuals. At least ten percent of units, but no less than one unit, shall be accessible for individuals with mobility disabilities. All units shall 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 shall provide a lockable entrance door to each unit for the individual's privacy as follows:
(A) The locking device shall release with a single-action lever on the inside of the room and open to a hall or common-use room;
(B) The provider shall provide each individual with a personalized key that operates only the door to his or her unit from the corridor side;
(D) The provider shall 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 obtaining consent from the individual or the individual's representative through the individually-based limitations process outlined in OAR 309-035-0195; and
(F) Section (7) of these rules are effective July 1, 2016 and enforceable as described in OAR 309-035-0115(17).
(d) A clothes closet with adequate clothes hanging rods shall 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 shall be provided totaling a minimum of 64 cubic feet for each individual. In an accessible unit, the clothes hanging rod height shall be adjustable or no more than 54 inches in height to ensure accessibility for an individual using a wheelchair; and
(e) Each unit shall have exterior windows with a combined area at least one-tenth of the floor area of the room. Unit windows shall be equipped with curtains or blinds for privacy and light control. For programs or portions of programs initially licensed on or after June 1, 1998, an escape window shall be provided consistent with building code requirements.
(8) Bathing and toilet facilities shall 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 shall be available for each eight individuals, and one bathtub or shower shall be available for each ten individuals; and

(b) In programs or portions of programs initially licensed on or after June 1, 1998, a minimum of one toilet and one lavatory shall be available for each six individuals, and a minimum of one bathtub or shower shall be available for each ten individuals, when these fixtures are not available in units. At least one centralized bathroom along an accessible route shall be designed for disabled access in accordance with Chapter 11 of the Oregon Structural Specialty Code.
(9) The setting shall include lounge and activity areas for social and recreational use by individuals, program staff and invited guests totaling no less than 15 square feet per individual.
(10) Laundry facilities shall 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 shall 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 shall be included in the primary laundry facilities:
(a) Countertops or spaces for folding tables 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 must have a minimum rinse temperature of 155 degrees Fahrenheit (160 degrees Fahrenheit recommended) unless a chemical disinfectant is used; and
(d) Sufficient storage and handling space to ensure that clean laundry is not contaminated by soiled laundry.
(11) 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 shall have the following:
(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 for a minimum of two days' supply of perishable foods. The space shall be maintained at 45 degrees Fahrenheit or less and freezer space maintained at 0 degrees Fahrenheit or less;
(c) A dishwasher 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;
(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 for dining and adjacent areas. Cleaning tools shall be maintained separately from those used to clean other parts of the setting.
(12) The setting shall have a separate dining room or an area where meals are served for use by individuals, employees, and guests:
(a) In programs licensed prior to June 1, 1998, the setting's dining area shall seat at least half of the individuals at one time with a minimum area of 15 square feet per individual; and
(b) In programs or portions of programs initially licensed on or after June 1, 1998, the setting's dining space shall seat all residents with a minimum area of 15 square feet per individual exclusive of serving facilities and required exit pathways.
(13) All details and finishes shall meet the finish requirements of applicable sections of the Building Code and the Fire Code as follows:
(a) Surfaces of all walls, ceilings, windows, and equipment shall be nonabsorbent and readily cleanable;
(b) The setting's, flooring, thresholds, and floor junctures shall 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 shall be free from cracks and breaks, and bathing areas shall have non-slip surfaces;
(c) In programs or portions of programs initially licensed on or after June 1, 1998, all doors to units, bathrooms, and common use areas shall provide a minimum clear opening of 32 inches;
(d) In all programs:
(A) Lever type door hardware shall be provided on all doors used by individuals;

(B) Locks used on doors to individual units must be interactive to release with operation of the inside door handle and comply with the requirements established by OAR 309-035-0140(7)(c)(A)(B)(D)(E);
(C) Exit doors may not include locks that prevent evacuation except in accordance with building code and fire code requirements and with written approval of the Division; and
(D) An exterior door alarm or other acceptable system may be provided for security purposes and to alert staff when individuals or others enter or exit the setting.
(e) Handrails shall be provided on all stairways as specified in the Building Code.
(14) All areas of the setting shall be adequately ventilated and temperature controlled in accordance with the Mechanical and Building Code requirements:
(a) Each setting shall 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 shall be made available when air conditioning is not provided;
(b) All toilet and shower rooms shall be adequately ventilated with a mechanical exhaust fan, window mounted exhaust fan, or central exhaust system that discharges to the outside;
(c) Where used, the design and installation of fireplaces, furnaces, wood stoves and boilers shall meet standards of the Oregon Mechanical Specialty Code and the Boiler Specialty Code, as applicable. Documentation of annual inspection noting safe and proper operation shall be maintained at the setting; and
(d) In individual-use areas, hot water temperatures shall be maintained within a range of 110 to 120 degrees Fahrenheit. Hot water temperatures in laundry and kitchen areas shall be at least 155 degrees Fahrenheit.
(15) All wiring systems and electrical circuits shall meet the standards of Oregon Electrical Specialty Code in effect on the date of installation, and all electrical devices shall be properly wired and in good repair. The provider shall ensure the following:
(a) When not fully grounded, circuits in individual use areas shall be protected by GFCI type receptacles or circuit breakers as an acceptable alternative;
(b) A sufficient supply of electrical outlets shall be provided to meet individual and staff needs;
(c) No 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 shall be provided in each individual unit and bathroom, switchable near the entry door and in other areas as required to meet task illumination; and
(g) Lighting fixtures that illuminate evacuation pathways shall be operable within ten seconds during a failure of the normal power supply and provide illumination for a period of at least two hours.
(16) All plumbing shall meet the Oregon Plumbing Specialty Code in effect on the date of installation, and all plumbing fixtures shall be properly installed and in good repair.
(17) The program shall provide adequate access to telephones for private use by individuals. The program shall 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 shall 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 is not allowed within the setting including within buildings or on the grounds.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0145
Safety

(1) The provider shall train all program staff in safety procedures prior to beginning their first regular shift. Every individual must be trained in individual safety procedures as soon as possible within the first 72 hours of residency.
(2) The program shall develop and implement a written procedure and disaster plan authorized by the State Fire Marshal or authorized representative. The plan shall cover such emergencies and disasters as fires, explosions, missing persons, accidents, earthquakes, and floods. The program shall post the plan by the phone and be immediately available to the program administrator and program staff. The plan shall include diagrams of evacuation routes, and these must be posted. The plan shall specify where staff and individuals will reside if the setting becomes uninhabitable. The program shall update the plan and shall 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) Noncombustible and nonhazardous materials shall be used whenever possible. When necessary to the operation of the facility, flammable and combustible liquids and other hazardous materials shall 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 shall be the minimum necessary.
(4) Non-toxic cleaning supplies shall be used whenever available. Poisonous and other toxic materials shall be properly labeled and stored in locked areas distinct and apart from all food and medications.
(5) 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 shall 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 shall 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 shall be admitted to the program; and
(b) Individuals experiencing difficulty with evacuating in a timely manner shall be provided assistance from staff and offered environmental and other accommodations, as practical. Under such circumstances, the program shall 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. The program shall assist individuals who still cannot evacuate the building safely in the allowable period of time and shall assist with transferring to another facility with an evacuation capability designation consistent with the individual's documented evacuation capability.
(6) The program shall ensure that every individual shall participate in an unannounced evacuation drill each month:
(a) At least once every three months, the program shall conduct a drill during individual sleeping hours between 10 p.m. and 6 a.m.;
(b) Drills shall 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 shall be provided with special assistance and a notation made in the individual service record; and
(d) Written evacuation records shall be maintained for at least three years. They shall 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) All stairways, halls, doorways, passageways, and exits from rooms and from the building shall be unobstructed.
(8) The program shall provide and maintain one or more 2A10BC fire extinguishers on each floor in accordance with the Fire Code.
(9) Approved fire alarms and smoke detectors shall be installed according to Building Code and Fire Code requirements. These alarms shall be set off during each evacuation drill. The program shall provide appropriate signal devices for

persons with disabilities who do not respond to the standard auditory alarms. All of these devices shall be inspected and maintained in accordance with the requirements of the State Fire Marshal or local agency having jurisdiction.
(10) The program shall install and maintain sprinkler systems compliant with the Building Code and maintained in accordance with rules adopted by the State Fire Marshal. The program shall maintain an automated sprinkler system as follows:
(a) Programs initially licensed prior to July 1, 2016, are not required to install or maintain a sprinkler system if one were not present at the time of initial licensure;
(b) The Division recommends that all programs licensed prior to July 1, 2016, install and maintain sprinkler systems;
(c) Any program initially licensed on or after July 1, 2016, shall have and maintain a sprinkler system.
(11) The Division may not issue any variances addressing sprinkler systems in programs licensed on or after July 1, 2016.
(12) First aid supplies shall be readily accessible to staff. All supplies shall be properly labeled.
(13) Portable heaters are a recognized safety hazard and may not be used.
(14) The provider shall develop and implement a safety program 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.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0150
Sanitation
(1) The water supply in the facility shall meet the requirements of the current rules of Oregon Health Services governing domestic water supplies and:
(a) A municipal water supply shall be utilized if available; and
(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 shall 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 Oregon Health Services. For adverse test results, these rules require that repeat samples and corrective action be taken to assure compliance with water quality standards, public notice be given whenever a violation of the water quality standards occurs, and records of water testing be retained according to the Oregon Health Services requirements.
(2) All floors, walls, ceilings, windows, furniture, and equipment shall be kept in good repair, clean, sanitary, neat, and orderly.
(3) Each bathtub, shower, lavatory, and toilet shall be kept clean, in good repair, and regularly sanitized.
(4) No kitchen sink, lavatory, bathtub, or shower shall be used for the disposal of cleaning waste water.
(5) Soiled linens and clothing shall be stored in an area or container separate from kitchens, dining areas, clean linens, clothing, and food.
(6) All necessary measures shall be taken to prevent rodents and insects from entering the setting. The provider shall take appropriate action to eliminate rodents or insects.
(7) The grounds of the setting shall be kept orderly and reasonably free of litter, unused articles, and refuse.
(8) Garbage and refuse receptacles shall be clean, durable, watertight, insect and rodent proof, and shall be kept covered with tight-fitting lids. All garbage and solid waste shall be disposed of at least weekly and in compliance with the current

rules of the Department of Environmental Quality (DEQ).
(9) All sewage and liquid wastes shall 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 shall be collected, treated, and disposed of in compliance with the current rules of the DEQ. Sewage lines and septic tanks or other non-municipal sewage disposal systems shall be maintained in good working order.
(10) Biohazardous waste shall be disposed of in compliance with the rules of the DEQ.
(11) Precautions shall be taken to prevent the spread of infectious or communicable diseases as defined by the Centers for Disease Control and to minimize or eliminate exposure to known health hazards:
(a) Program staff shall employ universal precautions whereby all human blood and certain body fluids are treated if known to be infectious for HIV, HBV, and other blood borne pathogens.
(12) If pets or other household animals reside at the setting, sanitation practices shall be implemented to prevent health hazards:
(a) Animals shall be vaccinated in accordance with the recommendations of a licensed veterinarian. Documentation of vaccinations shall be maintained on the premises;
(b) Animals not confined in enclosures shall be under control and maintained in a manner that does not adversely impact individuals or others; and
(c) No live animal shall be kept or allowed in any portion of the setting where food is stored or prepared, except that aquariums and aviaries shall be allowed if enclosed so as not to create a public health problem.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0155
Individual Furnishings
(1) The program shall permit an individual to use the individual's own furniture within space limitations of the individual's unit. Otherwise, furniture shall be provided or arranged for each individual, maintained in good repair, and include the following:
(a) A bed including a frame and a clean mattress and pillow;
(b) A private dresser or similar storage area for personal belongings that 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 shall provide the individual with a key or other method to gain access to her locked storage space.
(2) The program shall provide linens for each individual and shall include the following:
(a) Sheets, pillowcase, other bedding appropriate to the season and the individual's comfort;
(b) Availability of a waterproof mattress or waterproof mattress cover; and
(c) Towels and washcloths.
(3) The provider shall assist each individual in obtaining personal hygiene items in accordance with individual needs. These shall 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 hairbrush, a toothbrush, toothpaste, and menstrual supplies (if needed).
(4) The provider shall provide sufficient supplies of soap, shampoo, and toilet paper for all individuals.
(5) An adequate supply of furniture for individual use in living room, dining room, and other common areas shall be maintained in good condition.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 443.400 - 443.465, 443.991

History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 5-2009, f. & cert. ef. 12-17-09; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0163

Admission to Program

(1) The provider shall ensure the admission process includes the following:

(a) The provider shall specify in its admission policy and procedures the program staff responsible for each component of the admission information-gathering and decision-making process. The program shall allocate responsibilities to promote effective processing of referrals and admissions;

(b) The provider shall develop and implement admission policies and procedures that support a prospective individual's right to select and choose from available service settings when the individual meets medical necessity criteria;

(c) The provider shall 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; and

(d) The provider may close admissions to the program when accepting an additional prospective individual may 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) Unless limited by contractual agreement with the Division or other Division-approved party, the program may accept referrals from a variety of sources.

(3) In accordance with ORS 179.505 and the 42 CFR, Part 2, the program shall obtain an authorization for the release of information for disclosure for any confidential information concerning a prospective individual.

(4) The provider shall consider an individual 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 health disorder.

(5) Prior to accepting an individual for admission to the program, the program administrator shall determine that the individual meets admission criteria including the following:

(a) The provider shall 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 agencies currently providing services to the individual sufficient to determine eligibility for admission and service needs; and

(b) The provider shall receive screening packets for each individual referred for placement. At a minimum, screening packets shall include:

(A) Written documentation that the prospective individual has or is suspected of having a mental health 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;

(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.

(c) The provider shall ensure that screenings be conducted at the prospective program setting unless:

(A) Travel arrangements cannot be made due to inclement weather; or
(B) The individual or representative requests a phone screening or screening at the individual's current location.
(d) The provider shall make contact with the referring agency for the purpose of scheduling a screening appointment within 48 hours of receipt of the referral packet;
(e) The provider shall 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;
(f) The provider shall provide the following to each individual referred for placement:
(A) Materials explaining conditions of residency;
(B) Services available to individuals residing in the program; and
(C) An opportunity to meet with a prospective roommate if the program uses a shared room model.
(g) The screening meeting shall include the program administrator, the prospective individual, and the individual's representative. With the prospective individual's consent, the meeting may also include family members, other representatives as appropriate, representatives of relevant service-providing agencies, and others with an interest in the individual's admission.
(6) If an individual is referred for emergency or crisis-respite admission, an amended or abbreviated screening process may be used to more quickly meet the needs of individuals seeking placement. Screening and admission information obtained may be less comprehensive than for regular admissions but shall 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 shall document the reasons for incomplete information.
(7) Prior to admission, the provider shall evaluate and determine whether a prospective individual is eligible for admission based on the following criteria. The individual shall:
(a) Be assessed to have a mental health disorder or a suspected mental health disorder;
(b) Be at least 18 years of age;
(c) Not require continuous nursing care unless a reasonable plan to provide the care exists, the need for residential treatment supersedes the need for nursing care, and the Division approves the placement;
(d) Have evacuation capability consistent with the setting's SR occupancy classification; and
(e) Meet additional criteria required or approved by the Division through contractual agreement or condition of licensing.
(8) 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 well-being of the individual or another individual, if the individual is 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;
(9) The provider 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.
(10) The provider's admission decision shall be made as follows:
(a) The program's decision shall be based on review of screening materials, information gathered during the face-to-face screening meeting, and evaluation of the admission criteria;
(b)The program shall inform the prospective individual and the individual's representative of the admission decisions within 72 hours of the screening meeting;
(c) When the program denies admission, the program shall inform the applicant, the individual's representative, and the referring entity in writing of the basis for the decision and the individual's right to appeal the decision;
(d) When the program approves admission, the program shall inform the applicant, the individual's representative, and

the referring entity through an acceptance notification that shall include:
(A) When not waitlisted or first on the waitlist, an estimated date of admission;
(B) When waitlisted, the number on the waitlist.
(11) Management of waitlists includes the following:
(a) The program shall establish admissions waitlists of reasonable length;
(b) The program shall document actions taken in the management of the waitlist;
(c) The program shall contact a waitlisted individual, the individual's representative, and the referring entity monthly to determine if the individual has been placed elsewhere;
(d) The program shall prioritize admissions on a waitlist as follows:
(A) The program shall give first priority to those individuals under current civil commitment or under the jurisdiction of the Psychiatric Security Review Board and seeking to transition from the Oregon State Hospital or other hospital level of care into the community;
(B) The program shall give second priority for admission to individuals seeking admission to programs as an alternative to or to prevent civil commitment or placement at the Oregon State Hospital or for the purpose of transitioning from a program or a secure residential treatment facility;
(e) The program shall determine priority for admission based on the priorities described above and on a first-come first-served basis. The program may not take into account the individual's county of origin, responsibility, or residency;
(f) Within 72 hours of a provider learning of a pending opening, the program shall notify the first individual on the waitlist, the individual's representative, and the referring entity of the expected opening. The individual shall 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:
(A) The program receives no response from the individual, the individual's representative, or the referring entity within three business days;
(B) The individual will not be ready to transition into the program within one week; or
(C) The individual no longer desires placement at the program.
(12) The program shall obtain informed consent for services from the individual or representative prior to admission to the program unless the individual's ability to consent is legally restricted.
(13) Upon admission, the program administrator shall provide and document an orientation to each new individual that includes, but is not limited to, the following:
(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 the individual's rights;
(f) Review of grievance procedures;
(g) Completion of a residency agreement;
(h) Discussion of the conditions under which residency would be terminated;
(i) General description of available services and activities;
(j) Review and explanation of advance directives. If the individual does not already have any advance directives, the program shall provide an opportunity to complete advanced directives;
(k) Emergency procedures in accordance with OAR 309-035-0145(2);
(L) Review of the person-centered planning process; and
(m) Review of the process for imposing individually-based limitations on certain program obligations to the individual.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0165

Residency Agreement

This rule becomes effective July 1, 2016, and enforceable as described in OAR 309-035-0115(17).

(1) The provider shall enter into a written residency agreement with each individual or representative and be admitted to the program consistent with the following procedures:

(a) The written residency agreement shall be signed by the program administrator and the individual or representative prior to or at the time of admission;

(b) The provider shall provide a copy of the signed agreement to the individual or representative, and the provider shall retain the original signed agreement in the individual's service record;

(c) The provider shall give written notice to an individual or representative at least 30 calendar days prior to any general rate increases, additions, or other modifications of the rates; and

(d) The provider shall 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 shall include, but is not limited to, the following:

(a) The room and board rate describing the estimated public and private pay portions of the rate:

(A) When an individual's social security or other funding is not active at the time of admission to the program, the program shall 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 shall be updated and resigned by all the applicable parties.

(b) Services and supports 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 309-035-0183(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. These 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) The provider may not schedule meals with more than a 14-hour span between the evening meal and the following morning's meal (see, 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 that 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) that may not be limited without the informed, written consent of the individual or the legal representative and include the right to the following:

(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 that 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 asks 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 the provider's liability for negligence; or
(c) Conflicts with individual rights or these rules.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0170

Termination of Residency

(1) Each provider's termination policy and procedure shall designate the program staff responsible for each step of the process for terminating residency. The provider shall designate responsibilities 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 shall be responsible for initiating and coordinating termination proceedings. The provider shall make reasonable efforts to prevent unnecessary terminations by making reasonable accommodations within the program and setting.
(2) A resident or guardian may terminate residency in a facility upon providing at least 30-days' notice. Upon mutual agreement between the administrator and the resident or guardian, less than 30 days' notice may be provided.
(3) 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 to the individual or representative specifying the causes may immediately terminate the residency. The notice shall specify the individual's right to appeal the emergency termination decision in accordance with OAR 309-035-0183(3).
(4) When other circumstances arise providing grounds for termination of residency under this section, the program administrator shall discuss these grounds with the individual, or representative, and with the individual's permission other individuals with an interest in the individual's circumstances. If a decision is made to terminate residency, the program administrator shall provide at least 30 days' written notice specifying the causes to the individual or representative. This notice shall also specify the individual's right to appeal the termination decision in accordance with OAR 309-035-0183(3). Upon mutual agreement between the program administrator and the individual's representative, termination may occur with less than 30 days' notice. The program shall make reasonable efforts 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 the following:
(a) The individual no longer needs or desires services provided by the program and expresses a desire to move to an alternative setting;
(b) The 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) The 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 setting;

(d) The individual cannot safely evacuate the setting in accordance with the setting's SR Occupancy Classification after efforts described in OAR 309-035-0145(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) Except in the case of emergency terminations or crisis-respite services, a pre-termination meeting shall be held with the individual, the individual's representative, 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 shall 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 shall be documented in the individual service record.
(6) Documentation of discussions and meetings held concerning termination of residency and copies of notices shall be maintained in the individual service record.
(7) At the time of termination of residency the individual shall 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 as in the following:
(a) In the event of pending charges, the program may withhold 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 shall provide the individual with a final financial statement along with any funds due to the individual; and
(b) In the case of an individual's property being left at the setting for longer than seven days after termination of residency, the program shall make a reasonable attempt to contact the individual or representative. The program shall allow the individual or representative 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 shall be forwarded to the individual or representative.
(8) Because crisis-respite services are time-limited, the planned end of services may not be considered a termination of residency and subject to requirements in OAR 309-035-0170(2)(4)(5). Upon admission to crisis-respite services the individual or individual's representative shall 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 representative. A program providing crisis-respite services shall implement policies and procedures that specify reasonable time frames and the grounds for discontinuing crisis-respite services earlier than the date planned.
(9) 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 shall make an attempt to contact the individual or representative and others interested in the individual's circumstances to confirm the individual's intent to discontinue residency.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0175
Individual Rights

(1) Each individual shall be assured the same civil and human rights accorded to other citizens. These rights shall be assured unless expressly limited by a court in the case of an individual 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 that 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 shall 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) The provider shall ensure that individuals receiving mental health services have the rights set forth in ORS 430.210:
(4) An individual also has a right to the following:
(a) Adequate food, shelter, and clothing;
(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 309-035-0205.
(g) To review the program's policies and procedures; and
(h) Not participate in research without informed voluntary written consent.
(5) An individual also has the following HCBS 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 that 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;
(g) The freedom and support to have access to food at any time;
(h) Privacy in the individual’s unit; and
(i) Section (5) of this rule are effective July 1, 2016, and OAR 309-035-0115(17).
(6) An SRTF is not required to maintain the qualities or obligations identified in section (5) (b), (c), (d), (e) and (h). 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) For the purpose of this section, 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 circumstances and condition indicate an unreasonable risk of harm to the individual or others that 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 prevent 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 individuals are treated to include changes to the physical setting or location that allows access to fresh air and the outdoors, so long as such changes do not add an unreasonable amount to the cost of the renovation.
(9) The program shall have and implement written policies and procedures that protect individuals' rights and encourage and assist individuals to understand and exercise their rights. The program shall post a listing of individual rights under these rules in a place readily accessible to all individual s and visitors.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0183

Individual Grievances and Appeals

(1) The provider shall develop and implement written policies and procedures concerning the grievance and appeal process. A copy of the grievance and appeal process shall be posted in a place readily accessible to individuals. A copy of the grievance and appeal process shall be provided to each individual at the time of admission to the program.
(2) A provider's process for grievances shall, at a minimum, include the following:
(a) Individuals shall be encouraged to informally resolve complaints through discussion with program staff; and
(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 shall be available to assist the individual;
(B) The written complaint shall 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 shall include the reasons for the grievance and the proposed resolutions. No complaint shall be disregarded because it is incomplete;
(D) Within five days of receipt of the complaint, the program administrator shall meet with the individual to discuss the complaint. The individual may have an advocate or other person of their choosing present for this discussion;
(E) Within five days of meeting with the individual, the program administrator shall provide a written decision to the individual. As part of the written decision, the program administrator shall provide information about the appeal process; and
(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 309-035-0183 are completed, the individual may request an expedited review. The program administrator shall review and respond in writing to the grievance within 48 hours. The written decision shall include information about the appeal process.
(3) An individual, an individual's legal representative, the Division or other Division-approved party, and an applicant shall 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; and
(b) If program services are delivered by a person or entity other than the Division, the appeal shall 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 shall be available to assist the individual;
(B) The CMHP director or designee shall provide a written decision within ten days of receiving the appeal; and
(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 shall be final.
(c) If program services are delivered by the Division, the appeal shall 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 shall be available to assist the individual;
(B) The deputy director or designee shall review and approve or deny the appeal;
(C) The Division shall notify the individual of the decision in writing within ten days after receipt of the appeal; and
(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 shall be final.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0185

Individual Assessment and Residential Service Plan

(1) The program shall complete an assessment for each individual within 14 days after admission to the program unless admitted for crisis-respite services:
(a) The assessment shall 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 shall be made with proper authorization for the release of information;
(b) Assessment findings shall be summarized in writing and included in the individual service record. Assessment findings shall 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; and
(c) The provider shall provide assessment findings to the person-centered service plan coordinator to assist in the development of the person-centered service plan.
(2) 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 shall schedule and conduct an assessment of the individual for the purpose of developing a person-centered service plan. The provider shall support the person-centered service plan coordinator efforts to develop the plan and provide information as necessary.
(3) The provider shall develop and implement an individualized plan for the purpose of implementing and documenting the provision of services and supports as well as any individually-based limitations contained within the person-centered service plan. Identification of the goals to be accomplished through the services provided shall be prepared for each individual within 30 days after admission, unless admitted to the facility for crisis-respite services:
(a) If the person-centered service plan is unavailable for use in developing the residential service plan, providers shall still develop an initial residential service plan based on the information available within 30 days of admission. Upon the person-centered service plan becoming available, the providers shall amend the residential service plan as necessary to comply with this rule;
(b) The residential service plan shall be based upon the findings of the individual assessment, be developed with participation of the individual and representative, and be developed through collaboration with the individual's primary

mental health treatment provider. With consent of the individual or representative, family members, representatives from involved agencies, and others with an interest in the individual's circumstances shall be invited to participate. All contacts with others shall be made with proper, prior authorization from the individual;
(c) The residential service plan shall include the following:
(A) The 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.
(d) The residential service plan shall be signed by the individual, the individual's representative, 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; and
(e) The provider shall attach the residential service plan to the person-centered service plan.
(4) 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 shall be developed within 48 hours of admission that 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) The provider shall maintain progress notes within each individual's service record and document significant information relating to all aspects of the individual's functioning and progress toward desired outcomes identified in the residential service plan. The provider shall enter a progress note in the individual's record at least once each month.
(6) The provider shall review and update the assessment and residential service plan at least annually. On an ongoing basis, the provider shall update the residential service plan as necessary based upon changing circumstances or upon the individual's request for reconsideration.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0190
Person-Centered Service Plan
This rule becomes effective July 1, 2016, and enforceable as described in OAR 309-035-0115(17).
(1) When developed as described in sections (2) and (3), a person-centered service plan shall 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 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 representative to request updates to the person-centered service plan;
(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 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 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 when 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) When the provider is responsible for developing the person-centered service plan, the provider shall ensure that the plan includes the following:
(A) HCBS and setting options based on the individual's needs and preferences, and for residential settings, the individual's available resources 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 shall 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 the individual's representative;
(N) The written informed consent of the individual or the individual's representative;
(O) Signatures of the individual or 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;
(P) Self-directed supports; and

(Q) Provisions to prevent unnecessary or inappropriate services and supports.
(c) When the provider is not responsible for developing the person-centered service plan but provides or shall provide services to the individual, the provider shall provide relevant information and provide necessary support for the person-centered service plan coordinator or other individuals developing the plan to fulfill the characteristics described in subsection (b) of this section;
(d) The individual or representative decides on the level of information in the person-centered service plan that is shared with providers. To effectively provide services, providers shall have access to the portion of the person-centered service plan that the provider is responsible for implementing;
(e) The person-centered service plan shall be distributed to the individual, individual's representatives and others involved in the person-centered service plan;
(f) The person-centered service plan shall justify and document any individually-based limitation to be applied as outlined in OAR 309-035-0195 when the qualities under 309-035-0195(1) create a threat to the health and safety of the individual or others; and
(g) The person-centered service plan shall be reviewed and revised:
(A) At the request of the individual or representative;
(B) When the circumstances or needs of the individual change; or
(C) Upon reassessment of functional needs as required every 12 months.
(3) 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 shall, at a minimum, develop an assessment and residential service plan as deemed appropriate 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 shall provide relevant information and provide necessary support for the person-centered service plan coordinator as described in this rule.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 13-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2008, f. & cert. ef. 6-12-08; MHD 4-2005, f. & cert. ef. 4-1-05; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 9-1985, f. & ef. 6-7-85; MHD 9-1984(Temp), f. & ef. 12-10-84

309-035-0195
Individually-Based Limitations

This rule becomes effective on July 1, 2016, and enforceable as described in OAR 309-035-0115(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) A provider may apply an individually-based limitation only 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;
(c) The individual or representative consents;
(d) The limitation is directly proportionate to the specific assessed need; and

(e) The individually-based limitation will not cause harm to the individual.
(3) The provider shall demonstrate and document that the individually-based limitation meets the requirements of section (2) of this rule and the measures described below in the person-centered service plan. The provider shall 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 those methods 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 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 shall:
(a) Maintain a copy of the completed and signed form documenting the consent to the individually-based limitation described in section (4) of this rule. The form shall be signed by the individual or 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 section (2)(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 does not need to seek an individually-based limitation to comply with these rules.
(6) The qualities described in sections (2)(d) and (g) do not apply to an individual receiving crisis-respite services, and a provider does not need to seek an individually-based limitation to comply with these rules.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0200
Individual Services and Activities
(1) The provider shall make services and activities available at the program including 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 309-035-0185. The provider shall encourage individuals to care for their own needs to the extent possible. The provider shall ensure all services and activities be provided in a manner that respects individuals' rights, promotes recovery, and protects personal dignity.
(2) Services and activities to be available shall include but not limited to:
(a) Provision of adequate shelter;
(b) Provision of at least three meals per day, seven days per week, provided pursuant to OAR 309-035-0210;
(c) Assistance and support, as necessary, to enable individuals to meet personal hygiene and clothing needs;
(d) Laundry services that may include access to washers and dryers 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 309-035-0215;

(h) Assistance with community navigation and transportation arrangements;
(i) Assistance with money management when 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 to the Division.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0205
Use of Seclusion or Restraints

(1) The use of seclusion or restraints is prohibited except in SRTFs with the Division's approval.
(2) 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 shall 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 0740 and 309-033-0500 through 0560. These rules include special requirements for staffing, training, reporting, policies and procedures, and the setting's physical environment.
(3) Seclusion or restraints may only be used in an approved SRTF when an emergency occurs in accordance with OAR 309-033-0700 through 0740 and 309-033-0500 through 0560. In such emergency situations, seclusion and restraint shall 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 shall 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 shall be reported to the Division. To use seclusion or restraints with an individual who is not in state custody under civil commitment proceedings, the individual shall be placed on a hold.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0210
Food Services

(1) The provider shall plan and serve meals in accordance with the recommended dietary allowances found in the United States Department of Agriculture Food Guide Pyramid.
(2) The provider shall obtain an order from an LMP for each individual who, for health reasons, is on a modified or special diet. The provider shall plan such diets in consultation with the individual.
(3) The provider shall support the individual's right to access food at any time. The provider may only apply an individually-based limitation when the circumstances meet and the provider complies with the standards and requirements of OAR 309-035-0195. This section is effective July 1, 2016, and enforceable as described in OAR 309-035-0115(17).
(4) If an individual misses a meal at a scheduled time, the provider shall make an alternative meal available.
(5) The provider shall prepare menus at least one week in advance and shall provide a sufficient variety of foods served in adequate amounts for each individual at each meal and adjusted for seasonal changes. The provider shall file and maintain records of menus in the facility for at least 30 days. The provider shall consider individual preferences and

requests in menu planning. The provider shall reasonably accommodate religious and vegetarian preferences.
(6) The provider shall maintain adequate supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days at the setting. An emergency supply of potable water shall be available such that the provider maintains seven gallons of water per individual.
(7) The provider shall store, prepare, and serve food in accordance with Health Services Food Sanitation Rules.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0215

Health Services

(1) The program administrator shall ensure that all individuals are offered medical attention when needed. The provider shall arrange for health services with the informed consent of the individual or the individual's representative. The program shall arrange for physicians to be available in the event the individual's regular physician is unavailable. The provider shall identify a hospital emergency room that may be used in case of emergency.
(2) The provider shall ensure that each individual admitted to the program shall be screened by an LMP or other qualified health care professional to identify health problems and to screen for communicable disease. The provider shall maintain documentation of the initial health screening in the individual service record:
(a) The health screening shall 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 shall be obtained prior to the individual's admission and include the results of testing for tuberculosis;
(c) For emergency admissions including crisis-respite admissions, the health screening shall be obtained as follows:
(A) For individuals experiencing psychiatric or medical distress, a health screening shall be completed by an LMP prior to the individual's admission or within 24 hours of the emergency placement. The health screening shall 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 shall 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 shall 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 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 shall be provided in writing and be signed and dated by the attending health care professional within 24 hours of the individual's admission.
(3) Except for crisis-respite individuals, the program shall ensure that each individual has a primary physician who is responsible for monitoring their health care. Regular health examinations shall be done in accordance with the recommendations of this primary health care professional but not less than once every three years. Newly admitted individuals shall have a health examination completed within one year prior to admission or within three months after admission. Documentation of findings from each examination shall be placed in the individual's service record.
(4) A written order signed by a physician is required for any medical treatment, special diet for health reasons, aid to physical functioning, or limitation of activity.
(5) A written order signed by a physician is required for all medications administered or supervised by program staff. This written order is required before any medication is provided to an individual. Medications may not be used for the convenience of staff or as a substitute for programming. Medications may not be withheld or used as reinforcement or punishment or in quantities that are excessive in relation to the amount needed to attain the client's best possible functioning:
(a) Medications shall 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 shall document that medications shall 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 shall enter information in the individual's record consistent with section (5) (h) below;
(b) Program staff who assist with administration of medication shall be trained by a Licensed Medical Professional on the use and effects of commonly used medications;
(c) Medications prescribed for one individual may 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 shall develop and implement a policy and procedure that ensures all orders for prescription drugs are reviewed by an LMP, as specified by a physician, at least every six months. When this review identifies a contra-indication or other concern, the individual's primary physician or LMP shall be immediately notified. Each individual receiving psychotropic medications shall be evaluated at least every three months by the LMP prescribing the medication, who shall 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 shall dispose of all unused, discontinued, outdated, or recalled medications and any medication containers with worn, illegible or missing labels. The provider shall dispose of 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 shall maintain a written record of all disposals 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 disposing of the medication. For any medication classified as a controlled substance in schedules 1 through 5 of the Federal Controlled Substance Act, the disposal shall be witnessed by a second staff person who documents their observation by signing the disposal record;
(g) The provider shall 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 shall be labeled. Medications requiring refrigeration shall be stored in an enclosed, locked container within the refrigerator. The provider shall ensure that individuals have access to a locked, secure storage space for their self-administered medications. The program shall 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 shall record in the medical record each type, date, time, and dose of medication provided. All effects, adverse reactions, and medication errors shall be documented in the individual's service record. All errors, adverse reactions, or refusals of medication shall be reported to the prescribing LMP within 48 hours;
(i) P.R.N. medications and treatments shall only be administered in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.
(6) 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.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0220
Civil Penalties

(1) For purposes of imposing civil penalties, programs licensed under ORS 443.400 to 443.455 are considered to be long-term care facilities subject to ORS 441.705 to 441.745.
(2) Violations of any requirement within any part of the following sections of the rule may result in a civil penalty:
(a) 309-035-0115;
(b) 309-035-0120;
(c) 309-035-0125;
(d) 309-035-0130;
(e) 309-035-0135;
(f) 309-035-0140;
(g) 309-035-0145;
(h) 309-035-0150;
(i) 309-035-0155;
(j) 309-035-0163;
(k) 309-035-0170;
(l) 309-035-0175;
(m) 309-035-0183;
(n) 309-035-0185;
(o) 309-035-0200;
(p) 309-035-0205;
(q) 309-035-0210; and
(r) 309-035-0215.
(3) Civil penalties shall 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 shall be assessed after the procedures outlined in OAR 309-035-0110(8) have been implemented;
(b) A mandatory penalty up to $500 shall be assessed for falsifying individual service records or program records or causing another to do so;
(c) A mandatory penalty of $250 per occurrence shall 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 shall 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) Any civil penalty imposed under this section shall become due and payable ten days after notice is received unless a request for a hearing is filed. The notice shall be delivered in person or sent by registered or certified mail and shall 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) The person to whom the notice is addressed shall have 20 days from the date of receipt of the notice to request a hearing. This request shall be in writing and submitted to the Division. If the written request for a hearing is not received, the Division shall issue a final order.
(6) All hearings shall be conducted pursuant to the applicable provisions of ORS Chapter 183.
(7) 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 that 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) Civil penalties are subject to judicial review under ORS 183.480.
(9) All penalties recovered under ORS 443.790 to 443.815 shall be paid into the State Treasury and credited to the General Fund.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-035-0225
Criminal Penalties
(1) Violation of any provision of ORS 443.400 through 443.455 is a Class B misdemeanor.
(2) 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 received and a reasonable time has been allowed for placement of individuals in other programs.
Statutory/Other Authority: ORS 413.042, 443.450
Statutes/Other Implemented: ORS 413.032, 443.400 - 443.465, 443.991
History: MHS 5-2017, f. & cert. ef. 6-8-17; MHS 2-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 426.502–426.508
History: MHS 7-2010, f. & cert. ef. 6-7-10; MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 426.502–426.508
History: MHS 7-2010, f. & cert. ef. 6-7-10; MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 426.502–426.508
History: MHS 7-2010, f. & cert. ef. 6-7-10; MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 426.502–426.508
History: MHS 7-2010, f. & cert. ef. 6-7-10; MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 426.502–426.508
History: MHS 7-2010, f. & cert. ef. 6-7-10; MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 426.502–426.508
History: 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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 426.502–426.508
History: 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.
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 426.502–426.508
History: 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.
Statutory/Other Authority: ORS 413.042, 743A.168
Statutes/Other Implemented: ORS 743A.160, 743.168
History: MHS 19-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89

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 l 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-habitating 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.
Statutory/Other Authority: ORS 413.042, 743A.168
Statutes/Other Implemented: ORS 743A.160, 743.168
History: MHS 19-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89

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.
Statutory/Other Authority: ORS 413.042, 743A.168

Statutes/Other Implemented: ORS 743A.160, 743.168
History: MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89

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.
Statutory/Other Authority: ORS 413.042, 743A.168
Statutes/Other Implemented: ORS 743A.160, 743.168
History: MHS 19-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89

309-039-0540

General Standards

Each provider is required to meet all applicable standards from the following standards:
(1) Specific Staff Qualifications and Compentencies, detailed in OAR 309-019-0125; and
(2) Personnel Documentation, Training and Supervision, detailed in OAR 309-019-0130.
Statutory/Other Authority: ORS 413.042, 743A.168
Statutes/Other Implemented: ORS 743A.160, 743.168
History: MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89

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.

Statutory/Other Authority: ORS 413.042, 743A.168
Statutes/Other Implemented: ORS 743A.160, 743.168
History: MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89

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.
Statutory/Other Authority: ORS 413.042, 743A.168
Statutes/Other Implemented: ORS 743A.160, 743.168
History: MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89

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.
Statutory/Other Authority: ORS 413.042, 743A.168
Statutes/Other Implemented: ORS 743A.160, 743.168
History: MHS 19-2016, f. 11-28-16, cert. ef. 11-30-16; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89

DIVISION 40
ADULT FOSTER HOMES

309-040-0300
Purpose and Scope

(1) These rules prescribe care and service standards by which the Health Systems Division (Division) of the Oregon Health Authority (Authority) 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 shall 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 these services consistent with the standards set out in OAR chapter 411, division 4.
(2) 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.
Statutory/Other Authority: ORS 413.042, 413.032, 413.085
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHS 4-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 11-2011(Temp), f. & cert. ef. 12-5-11 thru 5-31-12; Renumbered from 309-040-0000, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0305
Definitions

As used in these rules, the following definitions apply:
(1) "Abuse" includes but is not limited to the following:
(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 all other situations, 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)" means those individual skills necessary for an individual's continued well-being including eating and nutrition, dressing, personal 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 Authority 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. If an adult family member of the provider receives care, they shall be included as one of the individuals within the total license capacity of the AFH. An AFH or individual that advertises,

including word-of-mouth advertising, to provide room, board, and care and services for adults is considered an AFH. For the purpose of these rules, an AFH does not include facilities referenced in 443.715.
(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 that maintains or enhances the individual's physical functioning.
(7) "Applicant" means any individual 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 residential care plan and person-centered service plan.
(9) “Authority” means the Oregon Health Authority or designee.
(10) "Behavioral Interventions" means interventions that modify the individual's behavior or the individual's environment.
(11) "Bill of Rights" means civil, legal, or human rights afforded to those individuals residing in an AFH that 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 outlined in OAR 309-040-0410.
(12) "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 and ORS 678.010 to 678.445.
(13) "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. Care also means services that promote maximum individual independence and enhance quality of life.
(14) “Caregiver” means the provider, resident managers, or substitute caregivers who provide services to an individual.
(15) "Case Manager" means an individual employed by a local, regional, or state allied agency approved by the Division to provide case management services and assist in the development of the personal care plan. Case manager’s evaluate the appropriateness of services in relation to the consumer’s assessed need and review the residential care plan every 180 days.
(16) "CMS" means the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.
(17) "Community Mental Health Program (CMHP)" means the organization of all services for individuals 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.
(18) "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 residential care plan and person-centered service plan
(19) "Complaint Investigation" means an investigation of any allegation that a provider has taken action, or inaction, that is perceived as contrary to law, rule, or policy but does not meet the criteria for an abuse investigation.
(20) "Condition" means a provision attached to a new or existing license that limits or restricts the scope of the license or imposes additional requirements on the licensee.
(21) "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.
(22) "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.
(23) "Controlled Substance" means any drug classified as schedules one through five under the Federal Controlled Substance Act.
(24) "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 943-007-0001 through 943-007-0501 (Criminal History Checks).
(25) "Day Care" means care and services in an AFH for an individual 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.
(26) "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.
(27) "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 is 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 shall 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; and
(d) For the purposes of these rules, the term individual shall be considered to include the individual's designated representative.
(28) "Director" means the Director of the Oregon Health Authority or designee.
(29) "Discharge Summary" means a document that describes the conclusion of the planned course of services described in the individual's residential 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.
(30) "Division" means the Health Systems Division of the Oregon Health Authority or designee.
(31) "Division Staff" means an employee of the Division, the Division's designee, or the designee of the local Community Mental Health Program.
(32) "Employee" means an individual employed by a licensed AFH and 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 AFH's that the Director finds equal to or superior to the requirements of ORS 443.705 to 443.825 and that 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" 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 individual's home or community.
(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 the written standards governing house activities developed by the provider and approved by the Division. These standards may 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, or any unusual incident involving an individual, the home, or provider.
(41) “Individual” means any individual 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) "Individual Care Services" means services prescribed by a physician or other designated individual 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.
(43) "Individually-Based Limitation" means a limitation to the qualities outlined in OAR 309-040-0393(1)(a) through (g), due to health and safety risks. An individually-based limitation is based on a specific assessed need and implemented only with the informed consent of the individual or the individual’s legal representative as outlined in 309-040-0393.
(44) "Informed Consent" means:
(a) Options, risks, and benefits of the services outlined in these rules have been explained to an individual and, in a manner that the individual comprehends; and
(b) The individual 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.
(45) "Initial Residential Care Plan (IRCP)" means a written document developed for an individual, within 24 hours of admission to the home, the addressed the care and services to be provided for the individual during the first 30 days or less until the residential care plan can be developed.
(46) "Legal Representative" means an individual who has the legal authority to act for an individual and only within the scope and limits to the authority as designated by the court or other agreement. A legal representative may include the following:
(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.
(c) For purposes of these rules, the term individual shall be considered to include the individual's legal representative.
(47) "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.
(48) "License" means a document issued by the Division to applicants who are determined by the Division to be in substantial compliance with these rules.
(49) "Licensed Medical Practitioner (LMP)" means any individual 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.
(50) "Licensee" means the individual or entity to whom a license is issued and whose name is on the license.
(51) "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 that directly contracts with the Division to operate a CMHP for that county.
(52) "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 individual 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.
(53) "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.
(54) "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 individual's social, educational, or economic functioning. Medical diagnosis and classification shall 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."
(55) “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 their 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 themselves 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 individual's well-being;
(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 the following:
(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 themselves or others, provided that only the degree of force reasonably necessary for protection is used for the least amount of time necessary.
(56) "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 943-007-0001 through 943-007-0501 (Criminal History Checks).
(57) "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.
(58) "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.
(59) "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 individuals 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.
(60) "Nursing Delegation" means that a registered nurse authorizes an unlicensed individual to perform special tasks for individuals in select 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.
(61) 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.
(62) "Person-Centered Service Plan Coordinator" means the individual, which may be a case manager, service coordinator, personal agent, and other individual designated by the Division to provide person-centered service planning for and with individuals.
(63) "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 that promotes the person's optimum health and independence.
(64) “Program Staff” means an employee or individual who by contract with an AFH provides a service to an individual.
(65) "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 AFH.
(66) "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.
(67) "Registered Nurse" means an individual licensed and registered to practice nursing by the State of Oregon Board of Nursing in accordance with ORS Chapter 678 and OAR Chapter 851.
(68) "Related" means 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.
(69) "Relative" means any individual identified as a family member.
(70) “Representative” means both “Designated Representative” and “Legal Representative” as defined in these rules unless otherwise stated.
(71) "Residency Agreement" means the written, legally enforceable agreement between a provider and an individual when the individual receives services from the provider.
(72) "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.
(73) "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.
(74) "Residential Care Plan (RCP)" means a written plan outlining the care and services to be provided to an individual. The RCP is based upon the review of current assessment, referral, observations, individual preference, and input from members of the residential 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.
(75) "Residential Care Plan Team (RCP 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 shall be determined by the RCP team members.
(76) "Residents' Bill of Rights" means the AFH residents have the rights set forth in ORS 443.739.
(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 for individuals shall 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 that 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" means in relation to fire and life safety 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 that are intended to help the individual 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 the individual's access to necessary medical care, treatment, or services identified in the individual's personal care plan.
(84) "Substitute Caregiver" means any individual meeting the qualifications of a caregiver who provides care and services in an AFH under the Division's jurisdiction in the absence of the provider or resident manager. An individual may not be a substitute caregiver.
(85) "Unit" means the bedroom and other space of an individual residing in an AFH as agreed to in the residency agreement. Unit includes the following:
(a) Private single occupancy spaces; and
(b) Shared units with roommates as allowed by these rules.
(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 shall be

non-clinical unless the person has the required credentials to provide a clinical service.
[Publications: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042; 413.032
Statutes/Other Implemented: ORS 426.072, 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0307

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 shall have all of the following:
(a) The home shall be 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 individual selects the AFH 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 individual's needs and preferences; and
(C) Based on the individual's available resources for room and board.
(c) The AFH shall ensure individual rights of privacy, dignity, respect, and freedom from coercion and restraint;
(d) The AFH shall optimize, but 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 shall facilitate individual choice regarding services and supports and who provides the services and supports.
(2) The provider shall maintain the AFH as follows:
(a) The home shall be physically accessible to each individual;
(b) The provider shall 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 shall 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 shall provide substantially equivalent protections for the individual and address eviction and appeal processes. The eviction and appeal processes shall be substantially equivalent to the processes provided under landlord-tenant laws;
(d) The provider shall ensure that each individual has privacy in their own unit;
(e) The provider shall maintain units with entrance doors lockable by the individual and ensure that only the individual, the individual's roommate, and only appropriate staff, as described in the individual's person-centered service plan, have keys to access the unit;
(f) The provider shall ensure that individuals sharing units have a choice of roommates;
(g) The provider shall provide that individuals have the freedom to decorate and furnish their unit as agreed to within the

Residency Agreement;
(h) The provider shall permit each individual to have visitors of their choosing at any time;
(i) The provider shall ensure each individual has the freedom and support to control their own schedule and activities;
(j) The provider shall ensure each individual has the freedom and support to have access to food at any time.
(3) The provider shall 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, failure to:
(a) Maintain a copy of the person-centered service plan at the home;
(b) Cooperate or provide necessary information to the person-centered service plan coordinator; or
(c) Attend or schedule a person-centered planning meeting when necessary.
(4) When a provider is unable to ensure the qualities as outlined in section (2)(d) through (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 individual's consent through the process outlined in OAR 309-040-0393. The provider may not apply an individually-based limitation until the limitation is approved and documented as required by OAR 309-040-0393.
Statutory/Other Authority: ORS 413.042, 413.032
Statutes/Other Implemented: ORS 413.085, 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0310
License Required

(1) License Required. In accordance with ORS 443.725, every provider of Adult Foster Care shall be licensed by the Division before opening or operating an AFH.
(a) The provider shall 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 Division.
(2) Placement. An AFH may not accept placement of an individual without first being licensed by the Division.
(3) Unlicensed AFH. No individual shall 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, shall have documentation of an approved criminal history background check in accordance with ORS 181A.200, 443.735 and OAR 943-007-0001 through 0501.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0010, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0315
License Application and Fees

(1) A completed, written application shall be submitted by the applicant on forms supplied by the Division. The application is not complete until all information is received by the Division. Incomplete applications are void 60 days after initial receipt by the Division.
(2) An applicant shall submit a separate application for each location operated as an AFH.
(3) The application shall include the following:
(a) The maximum capacity requested and a written statement describing family members needing care, individuals who receive respite care, individuals who receive day care, or individuals who receive room and board;
(b) A written statement from an LMP regarding the mental and physical ability of the applicant to provide care to individuals and to operate the AFH. If the applicant employs a resident manager, the applicant shall 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 shall demonstrate to the Division the applicant's financial ability and the resources necessary to operate the AFH. Financial ability shall 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(3)(e);
(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) Documentation of a Criminal History Check approval in accordance with OAR 943-007-0001 through 0501 for the provider, the resident manager, caregivers, volunteers and other occupants over the age of 16, excluding individuals, and other persons as defined in ORS 443.735;
(g) Written background information pertaining to any current or previous licensure or certification by a state agency, including those licenses or certificates granted to a business or person affiliated with the business, including:
(A) Copies of all current licenses or certificates;
(B) Documentation showing the final disposition of any suspension, denial, revocation, or other disciplinary actions initiated on any current or previous license or certificate, including settlement agreements, where applicable; and
(C) Documentation of any substantiated allegations of abuse or neglect pertaining to the applicant or anyone employed by, or contracted with, the applicant.
(h) 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 outlined in OAR 309-040-0370;
(i) A completed AFH Self-Inspection Guide; and
(j) Each application must be accompanied by a fee of $20 per bed requested for license.
(4) The Division shall 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 individuals as identified by the Division.
(5) The applicant may withdraw the application at any time during the application process by notifying the Division in writing.
(6) The Division may elect to deny an application prior to review when the applicant has previously had any action taken on a certificate or license, including denial, suspension, conditions, intent to revoke or revocation by the Division, Oregon Health Authority, the Oregon Department of Human Services, or any other state agency.
(7) An applicant whose license has been revoked or voluntarily surrendered, following a receipt of Notice of Intent to Revoke or Notice of Intent to Not Renew 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, may 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.
(8) Enforcement of Home and Community-Based Required Qualities:
(a) An AFH licensed on or after July 1, 2016, shall be in full compliance with all requirements under these rules at the time of initial licensure;
(b) An AFH licensed prior to July 1, 2016, shall come into compliance with applicable rules as follows:
(A) All AFH's shall 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 may 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.
Statutory/Other Authority: ORS 413.042, ORS 443.420
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 12-2017, temporary amend filed 10/03/2017, effective 10/03/2017 through 03/30/2018; MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0015, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92)

309-040-0320

Classification of AFHs

(1) 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.
(2) 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 applicable, and is in compliance with the OAR 309-040-0300 through 0455 and has met the training requirements set forth in OAR 309-040-0335.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0011, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99

309-040-0325

Capacity

(1) The Division shall 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 shall include consideration of total household composition including children. Sleeping requirements for children are:
(a) Sleeping arrangements for children in care shall 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 shall 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) 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 AFH licensed capacity.
(4) The Division may place conditions, restrictions, or limitations on the AFH license as necessary to maintain the health, life, and safety of the individual.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0012, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92)

309-040-0330

Zoning for Adult Foster Homes

(1) 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 that allows a single family dwelling and in any commercial zone that allows a single family dwelling.
(2) No city or county may impose any zoning requirement on the establishment and maintenance of an AFH in residential or commercial zones that is more restrictive than that imposed on a single-family dwelling in the same zone.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0100, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86

309-040-0335

Training Requirements for Providers, Resident Managers, and Substitute Caregivers

(1) All providers, resident managers, and substitute caregivers shall satisfactorily meet all educational requirements established by the Division. Providers and staff may not 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) The provider, resident manager, and substitutive caregivers shall be able to understand and communicate in oral and written English in accordance with ORS 443.730.
(3) Training for all providers, resident managers, and substitute caregivers shall comply with ORS 443.738. The provider shall satisfactorily pass any testing requirements established by the Division before being licensed or becoming a resident manager or substitute caregiver. The test shall be completed by the caregiver without the help of any other individual. The provider, resident manager, and substitute caregiver shall have the ability to, but not be limited to, understand and respond appropriately to emergency situations, changes in medical conditions, physicians' orders and professional instructions, nutritional needs, and individuals' preferences and conflicts.
(4) The Division may make exceptions to the training requirements for individuals appropriately licensed medical care professionals in Oregon or who possess sufficient education, training, or experience to warrant an exception. The Division may not make any exceptions to the testing requirements.
(5) 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 shall notify the Division of the situation and demonstrate that the provider is unable to find a qualified resident manager, that the individual meets the requirements for a substitute caregiver for the AFH, and that the provider shall provide adequate supervision.
(6) The provider or resident manager shall 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 943-007-0001 through 0501;
(b) Documentation that a substitute caregiver has successfully completed the training required by the Division;
(c) Documentation that the provider has trained the caregiver to meet the routine and emergency needs of the individuals;
(d) Documentation that the 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) The Division shall 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 the training in the provider, resident manager, and substitute caregiver's training records. The training is in addition to any orientation that is attended by applicants prior to licensing and shall 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; and
(i) Cardiopulmonary Resuscitation (CPR) and First Aid.
(8) 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.
(9) Providers, resident managers, or substitute caregivers who perform delegated or assigned nursing care services as part of the residential care plan shall receive training and appropriate monitoring from a registered nurse on performance and delivery of those services.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0030, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0340

Issuance of a License

(1) Applicants shall be in substantial compliance with these rules ORS 443.705 through 443.825 before the Division shall issue a license if cited deficiencies are not corrected within time frames specified by the Division, the application may be denied. The license shall 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 shall be visibly posted in the AFH and available for inspection at all times.
(2) The Division may attach conditions to the license that 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 shall be posted with the license in the AFH and be available for inspection at all times.
(3) Each provider shall report promptly to the Division any significant changes to information supplied in the application or subsequent correspondence. Changes include but are not limited to changes in the AFH name, owner entity, resident manager, telephone number, or mailing address, and staffing changes if those changes are significant or impact the health, safety, or well-being of individuals.
(4) When an AFH is sold, the prospective new owner shall apply for a license in accordance with OAR 309-040-0315 if the new owner intends to operate an AFH.
(5) An AFH license is not transferable or applicable to any location or individuals other than those specified on the license.
(6) A license is valid for one year from the effective date on the license unless sooner revoked or suspended.

(7) Applicants shall be in substantial compliance with these rules before a license is issued. If cited deficiencies are not corrected within the time frames specified by the Division, the license shall be denied.
(8) 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 shall 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 and who will be residing in or employed by the AFH, as identified in OAR chapter 943 division 007 and any other rules established by the Division.
(9) The applicant shall demonstrate to the Division the financial ability and resources necessary to operate the AFH. The demonstration of financial ability shall include, but is 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 in this section, the Division may require the applicant to furnish a financial guarantee as a condition of initial licensure.
(10) If a resident manager leaves during the period of the license, the provider shall notify the Division immediately and identify a plan for providing care to the individuals. The provider shall 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 chapter 943, division 007, a physician statement, and payment of a $10 fee. If the original plan includes changing the resident manager during the license renewal process, the $10 is not applicable.
(11) Upon receipt of the completed resident manager application and Division approval, a revised license may be issued in accordance with ORS 443.738(1) through (4).
(12) Notwithstanding any other provision of ORS 443.735, 443.725, or 443.738, the Division may issue a 60-day provisional license to a qualified individual 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0345
Renewal

(1) The provider shall submit a completed 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 by the Division within the time period described, the provider shall 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 shall be treated as an unlicensed home subject to civil penalties.
(2) 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) 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) The Division shall investigate any information in the renewal application and shall conduct an inspection of the AFH.
(5) The provider shall 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) The AFH provider shall 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 shall be denied and administrative sanctions may be imposed.
(7) 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 these rules;
(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 chapter 943, division 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 shall be residing in or employed by or otherwise acting as a provider, resident manager, substitute caregiver, or volunteer for the AFH provider.
(8) The provider, resident manager, substitute caregiver, or volunteer or individual 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 chapter 943, division 007.
(9) A criminal records check shall be completed for the applicant and any occupant, other than an individual, 16 years of age or older who shall 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 chapter 943, division 007.
(10) An AFH provider seeking initial licensing or that has been in operation for less than 24 months has the burden of proof to establish compliance with ORS 443.705 to 443.825 and the Division rules.
(11) The burden of proof shall 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0025, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

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 shall provide justification that a variance does not jeopardize the health, life, or safety of the individuals and would not violate or compromise an 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. The Division may not grant a variance related to fire and life safety without prior consultation with the local fire authority or 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 RCP;
(b) A variance allowing a specific individual to be in the AFH alone may not exceed four 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 p.m. to 6 a.m.; and
(d) Twenty-four hour per day care shall continue for any individual that does not qualify to be in the AFH alone.
(4) Variances shall be granted or denied in writing. All variances granted shall 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 shall make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Division shall be final.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0355

Contracts

(1) 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) Providers who care for private paying individuals must enter into a signed contract with the individual or person paying for care. This contract shall include, but is not limited to, an RCP, a schedule of rates, conditions under which the rates may be changed, and the AFH's policy on refunds at the time of hospitalization, death, discharge, or voluntary move.
(3) The provider shall provide a 30-day prior written notification to private pay individuals of increases, additions, and other modifications to the rates. Unless the change is due to a medical emergency resulting in a greater level of care, in which case the provider shall give notice within ten days of the change.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0040, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0360

Qualifications for AFH Providers, Resident Managers, and Other Caregivers

(1) 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. Evidence may include, but is not limited to the following:
(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) Division approved training;
(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 shall have a statement from a physician on a Division approved form that they are physically and mentally capable of providing care;
(e) Undergo a criminal history check in accordance with OAR chapter 943 division 007 and be found eligible for licensure by the Division. The Division shall 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, physicians, case managers, and appropriate others and be able to respond appropriately to emergency situations at all times;
(h) If transporting individuals by motorized conveyance, shall 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) The resident manager shall meet the provider qualifications listed in section (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) Substitute caregivers left in charge of an individual for any period of time shall 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 RCPs, and be able to provide the care specified for each individual;
(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 individuals by motorized conveyance, shall 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) The provider may not hire or continue to employ a resident manager or substitute caregiver who does not meet the requirements of this rule.
(5) A provider shall supervise and train resident managers and substitute caregivers and monitor their general conduct when acting within the scope of their employment or duties.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0045, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0365
Facility Standards
(1) In order to qualify for or maintain a license, an AFH shall meet the following provisions:
(a) Demonstrate compliance with Oregon Structural Specialty Code (OSSC) and Oregon Fire Code: and
(b) 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;
(c) For AFH's established on or after October 1, 2004, meet all applicable state building, mechanical, and housing codes for fire and life safety. The AFH shall 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 shall be made to the State Fire Marshal;
(d) The building and furnishings shall be clean and in good repair and grounds shall be maintained. Walls, ceilings, and floors shall be of such character to permit frequent washing, cleaning, or painting. There shall be no accumulation of

garbage, debris, rubbish, or offensive odors;
(e) Stairways shall be provided with handrails. A functioning light shall be provided in each room, stairway, and exit way; incandescent light bulbs shall be protected with appropriate covers. Yard and exterior steps shall be accessible to individuals;
(f) The heating system shall be in working order. Areas of the AFH used by individuals shall 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 shall make a reasonable effort to make the individuals comfortable using available ventilation or fans;
(g) There shall 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 shall 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;
(h) Pools and hot tubs shall be equipped with sufficient safety barriers or devices to prevent accidental injury in accordance with Section R116 of the Oregon Residential Specialty Code.
(2) Any accessibility improvements made to accommodate an identified individual shall be in accordance with the specific needs of the individual and comply with Chapter 11 of the building code.
(3) An AFH shall have an accessible outdoor area that shall be made available to individuals.
(4) Storage of a reasonable size for an individual's belongings beyond that of the individual's unit shall be made available:
(a) All yard maintenance equipment shall 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 shall be made accessible to all caregivers. For individuals who are self-medicating, the provider shall 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 shall be designated when there are toxic or hazardous materials on the premises.
(5) All equipment shall be clean and in good repair, provide individual privacy, and shall have but is not limited to, the following:
(a) A finished interior, a mirror, an operable window or other means of ventilation, and a window covering;
(b) Tubs or showers, toilets and sinks. A sink shall be located near each toilet. A toilet and sink shall be provided on each floor where rooms of non-ambulatory individuals or individuals with limited mobility are located. There shall be at least one toilet, one sink, and one tub or shower for each six household occupants, including the provider and family;
(c) Hot and cold water in sufficient supply to meet the needs of individuals for personal hygiene. Hot water temperature sources for bathing areas shall not exceed 120 degrees Fahrenheit;
(d) Shower enclosures with nonporous surfaces. Glass shower doors shall be tempered safety glass. Shower curtains shall be clean and in good condition. Non-slip floor surfaces shall be provided in tubs and showers;
(e) Grab bars for toilets, tubs, or showers for safety as required by an individual's disability;
(f) The AFH may not be designed to allow an individual or employee to walk through another individual's bedroom to get to a bathroom. Individuals shall have barrier-free access to toilet and bathing facilities with appropriate fixtures.
(g) If there are non-ambulatory individuals, alternative arrangements shall be appropriate to meet the non-ambulatory individual's needs for maintaining good personal hygiene.
(h) Individuals shall have appropriate racks or hooks for drying bath linens.
(6) All furniture and furnishings shall be clean and in good repair. Units for all household occupants shall have been constructed as a bedroom when the home was built or remodeled under permit; be finished, with walls or partitions of standard construction that 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 that meets fire egress regulations. (See Section R310 Emergency Escape and Rescue Openings in the Oregon Residential Specialty Code.) All units shall include a minimum of 70 square feet of usable floor space for each individual or 120 square feet for two individuals, have no more than two persons per room, and allow for a minimum of

three feet between beds. In addition, the provider shall ensure that:
(a) Each unit has a lockable entrance door for the individual's privacy:
(A) The locking device shall release with a single-action lever on the inside of the unit and open to a hall or common-use room;
(B) The provider shall provide each individual with a personalized key that operates only the door to his or her unit door from the corridor side;
(C) The provider shall maintain a master key to access all of the units that is quickly available to the provider or resident manager and documented in the individual's person-centered service plan;
(D) The provider may not disable or remove a lock to a unit without first obtaining consent from the individual through the individually-based limitations process outlined in OAR 309-040-0393; and
(E) Section (6) is effective July 1, 2016, and enforceable as described in OAR 309-040-0315(7).
(b) Providers, resident managers, or their family members may not sleep in areas designated as living areas or share units with individuals;
(c) In determining maximum capacity, consideration shall be given to whether children over the age of five have a bedroom separate from their parents;
(d) Units shall be on ground level for individuals who are non-ambulatory or have impaired mobility;
(e) Individual units shall 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) AFH's established on or after October 1, 2004, shall meet all applicable state building, residential, fire, mechanical, and housing codes for fire and life safety. The AFH shall 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 Division, a request for fire inspection shall be made to the State Fire Marshal.
(8) Special hazards such as the following:
(a) Flammable and combustible liquids and hazardous materials shall 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 shall be stored in a locked cabinet. The firearms cabinet shall be located in an area of the home that is not readily accessible to individuals, and all ammunition shall be stored in a separate, locked location;
(b) Smoking regulations shall be adopted to allow smoking only in designated areas. Smoking shall be prohibited in sleeping rooms and upon upholstered crevasse furniture. Ashtrays of noncombustible material and safe design shall be provided in areas where smoking is permitted;
(c) Cleaning supplies, poisons, and insecticides shall be properly stored in original, properly labeled containers in a safe area away from food, preparation and storage of food, dining areas, and medications.
(9) All furniture and furnishings shall be clean and in good repair. There shall 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 may 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 shall be required if wheelchairs are to be accommodated.
(10) All equipment shall be clean and in good repair. Laundry facilities shall be separate from food preparation and other individual use areas. The provider shall 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) Washing machines shall have a minimum rinse temperature of 140 degrees Fahrenheit.
(11) All equipment shall be clean and in good repair. The provider shall 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 shall

maintain the following:
(a) Sufficient refrigeration space maintained at 45 degrees Fahrenheit or less and freezer space maintained at 0 degree Fahrenheit or less 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 shall be maintained separately from those used to clean other parts of the home; and
(g) Dining Space where meals are served shall be provided to seat all individuals at the same seating.
(12) Details and Finishes:
(a) The building and furnishings shall be clean and in good repair, and grounds shall be maintained. Walls, ceilings, and floors shall be of such character to permit frequent washing, cleaning, or painting;
(b) Locks used on doors to individuals' units shall 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 may 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 individuals or others enter or exit the home.
(c) Handrails. Handrails shall be secured on all stairways.
(13) The heating system shall be in working order:
(a) Areas of the AFH used by individuals shall 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 shall make reasonable effort to make the residents comfortable using available ventilation or fans;
(b) All toilets and shower rooms shall be ventilated by a mechanical exhaust system or operable window;
(c) Design and installation of fireplaces, furnaces and wood stoves shall meet standards of the Oregon Mechanical and Residential Specialty Code and have annual inspections to assure no safety hazard exists;
(d) Hot water temperatures shall be maintained within a range of 110¼ to 120 degrees Fahrenheit. Hot water temperatures for washing machines and dishwashers shall be at least 140 degrees Fahrenheit.
(14) All electrical systems shall meet the standards of the Oregon Electrical Specialty Code in effect on the date of installation, and all electrical devices shall 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 shall be used to protect all electrical circuits;
(c) A sufficient supply of electrical outlets shall be provided to meet individual and staff needs without the use of extension cords or outlet expander devices;
(d) A functioning light shall be provided in each room, stairway, and exit way. Lighting Fixtures shall 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 shall be protected with appropriate covers.
(15) All plumbing shall meet the Oregon Plumbing Specialty Code in effect on the date of installation, and all plumbing fixtures shall be properly installed and in good repair.
(16) Pools, hot tubs, and ponds shall 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 shall 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 shall be posted by the individuals' telephone. The posting shall 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 Adult Abuse Prevention and Investigations and the Oregon Advocacy Center;
(c) AFH telephone numbers shall be listed in the local telephone directory;
(d) The provider may establish reasonable rules governing telephone use to ensure equal access by all individuals. Each individual or guardian (as applicable) shall be responsible for payment of long distance phone bills where calls were initiated by the individual, unless otherwise mutually agreed arrangements have been made.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0370

Safety

(1) The provider shall train all program staff in staff safety procedures prior to beginning their first regular shift. All individuals shall be trained in individual safety procedures as soon as possible during their first 72 hours of residency.
(2) Emergency Procedures:
(a) An emergency evacuation procedure shall be developed, posted, and rehearsed with occupants. A record shall be maintained of evacuation drills. Drills shall 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 shall be held at least once every 30 days;
(B) One drill practice shall be held at least once every 90 days during individual's nighttime sleeping hours between 10 p.m. and6a.m.Fire drill records shall be maintained for three years and 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 residential 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 shall 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 that 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 shall 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 shall be submitted with the application and updated to reflect any change;
(e) There shall be at least one plug-in rechargeable flashlight available for emergency lighting in a readily accessible area on each floor including a basement.
(3) A written disaster plan shall be developed to cover such emergencies and disasters as fires, explosions, missing persons, accidents, earthquakes, and floods. The plan shall be posted by the phone and immediately available to the employees. The plan shall specify temporary and long-range habitable shelter where staff and individuals shall reside if the AFH becomes uninhabitable.
(4) Non-toxic cleaning supplies shall be used whenever available. Poisonous and other toxic materials shall be properly labeled and stored in locked areas distinct and apart from all food and medications.

(5) 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 shall be maintained in the individual's personal care plan;
(b) Individuals experiencing difficulty with evacuating in a timely manner shall be provided assistance from staff and offered environmental and other accommodations, as practical. Under these circumstances, the provider shall 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 of three 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 shall be retained for at least three years. Records shall 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) All stairways, halls, doorways, passageways, and exits from rooms and from the home shall be unobstructed.
(7) At least one 2A-10BC rated fire extinguisher shall be in a visible and readily accessible location on each floor, including basements, and shall be inspected at least once a year by a qualified worker that is well versed in fire extinguisher maintenance. All recharging and hydrostatic testing shall be completed by a qualified agency properly trained and equipped for this purpose;
(8) Approved smoke detector systems or smoke alarms shall be installed according to Oregon Residential Specialty Code and Oregon Fire Code requirements. These alarms shall be tested during each evacuation drill. The provider shall provide approved signal devices for individuals with disabilities who do not respond to the standard auditory alarms. All of these devices shall 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 shall be equipped with a device that warns of low battery when battery operated. All smoke detectors and alarms shall be maintained in functional condition;
(9) Special hazards:
(a) Flammable and combustible liquids and hazardous materials shall 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 shall 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 shall be adopted to allow smoking only in designated areas. Smoking shall be prohibited in sleeping rooms and upon upholstered crevasse furniture. Ashtrays of noncombustible material and safe design shall be provided in areas where smoking is permitted;
(c) Cleaning supplies, poisons, and insecticides shall be properly stored in original, properly labeled containers in a safe area away from food, preparation and storage of food, dining areas, and medications.
(10) Sprinkler systems, if used, shall 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 shall be readily accessible to staff. All supplies shall be properly labeled.
(12) Portable heaters are a recognized safety hazard and may not be used, except as approved by the State Fire Marshal, or authorized representative.
(13) A safety plan shall 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.
Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0375

Sanitation

(1) The water supply in the home shall meet the requirements of the current Authority rules governing domestic water supplies:
(a) A municipal water supply shall 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 shall comply with the OAR chapter 333. 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. Public notice shall be given whenever a violation of the water quality standards occurs, and records of water testing shall be retained according to Division requirements.
(2) All floors, walls, ceilings, windows, furniture, and equipment shall be kept in good repair, clean, neat, and orderly.
(3) Each bathtub, shower, lavatory, and toilet shall be kept clean, in good repair, and regularly sanitized.
(4) Kitchen sinks may not be used for the disposal of cleaning wastewater.
(5) Soiled linens and clothing shall be stored in an area or container separate from kitchens, dining areas, clean linens, clothing, and food.
(6) All necessary measures shall be taken to prevent rodents and insects from entering the home. Should pests be found in the home, appropriate action shall be taken to eliminate them.
(7) The grounds of the facility shall be kept orderly and reasonably free of litter, unused articles, and refuse.
(8) Garbage and refuse receptacles shall be clean, durable, watertight, insect and rodent proof, and shall be kept covered with tight-fitting lids. All garbage and solid waste shall be disposed of at least weekly and in compliance with the current rules of the Department of Environmental Quality.
(9) All sewage and liquid wastes shall 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 shall 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, shall be maintained in good working order.
(10) Biohazard waste shall be disposed of in compliance with the rules of the Department of Environmental Quality.
(11) Precautions shall be taken to prevent the spread of infectious 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 2226of the Oregon Occupational Safety and Health Code, program staff shall 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 shall be equipped with an adequate supply of toilet paper, soap, and towels.
(12) If pets or other household animals exist at the home, sanitation practices shall be implemented to prevent health hazards:
(a) These animals shall be vaccinated in accordance with the recommendations of a licensed veterinarian. Proof of such vaccinations shall be maintained on the premises;
(b) Animals not confined in enclosures shall be under control and maintained in a manner that does not adversely impact individuals or others.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825

History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0380

Individual Furnishings

(1) Bedrooms and Units:

(a) Bedrooms for all household occupants and units for individuals shall have been constructed as a bedroom when the home was built or remodeled under permit; be finished with walls or partitions of standard construction that go from floor to ceiling and a door that opens directly to a hallway or common use room without passage through another bedroom or unit or common bathroom; be adequately ventilated, heated and lighted with at least one operable window that 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 may not sleep in areas designated as living areas, or share bedrooms or units with individuals;

(c) There shall 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 shall 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 shall be laundered at least weekly, and more often if necessary. Waterproof mattress covers shall be used for incontinent individuals. Day care individuals may not use individual beds;

(d) Each unit shall have sufficient separate, private dresser and closet space for each individual's clothing and personal effects, including hygiene and grooming supplies. Individuals shall be allowed to keep and use reasonable amounts of personal belongings and to have private, secure storage space. Drapes or shades for windows shall be in good condition and provider privacy for individuals;

(e) Units shall be on ground level for individuals who are non-ambulatory or have impaired mobility;

(f) Units shall be in close enough proximity to the provider to alert the provider to night time needs or emergencies or be equipped with a call bell or intercom.

(2) Each individual shall be assisted in obtaining personal hygiene items in accordance with individual needs. Items shall 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 or hairbrush, a toothbrush, toothpaste, menstrual supplies (if needed), towels, and washcloths.

(3) Sufficient supplies of soap, shampoo, and toilet paper for all individuals shall be provided.

(4) An adequate supply of furniture for individual use in the living room, dining room, and other common areas shall be maintained in good condition.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 443.705 - 443.825

History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0385

Food Services

(1) Three nutritious meals shall be served daily at times consistent with those in the community. Meals shall 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 shall be given to cultural and ethnic backgrounds of individuals in food preparation.

(2) An order from an LMP must be obtained for each individual who for health reasons is on a modified or special diet. These diets shall be planned in consultation with the individual.

(3) Menus shall 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 shall be filed and maintained in the AFH for three years. Individual preferences and requests shall be considered in menu planning. Religious and vegetarian preferences must be reasonably accommodated.
(4) Meals shall be prepared and served in the facility where the individuals live. Payment for meals eaten away from the AFH for the convenience of the provider (e.g. restaurants, senior meal sites) shall be paid for by the provider. Meals and snacks as part of an individual recreational outing shall be paid for by the individual. Food preparation areas shall be clean, free of obnoxious odors, and in good repair.
(5) The provider shall maintain adequate supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days at the setting. An emergency supply of potable water shall be available such that the provider maintains seven gallons of water per individual.
(6) Food shall be stored, prepared, and served in accordance with the Authority's Food Sanitation Rules:
(a) All working refrigerators and freezers shall have a thermometer in working order;
(b) Food storage areas and equipment shall be such that food is protected from dirt and contamination and maintained at proper temperatures to prevent spoilage.
(7) Equipment shall be maintained in a safe and sanitary manner. Utensils, dishes, and glassware shall be maintained in a sufficient number to accommodate the licensed capacity of the AFHs. Utensils, dishes, and glassware shall be washed in hot soapy water, rinsed, and stored to prevent contamination. A dishwasher with sanitation cycle is recommended.
(8) The provider shall support the individual’s right to access food at any time. The provider may only apply an individually-based limitation when there is a threat to the health and safety of an individual or others, and the provider complies with the requirements outlined in OAR 309-040-0393. This section 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 shall be made available.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0390

Standards and Practices for Care and Services

(1) There shall 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 shall 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 shall 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 may 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 shall be maintained in the individual's record. The provider, resident manager, or substitute caregiver shall 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 medications shall be clearly labeled with the pharmacist's label or the manufacturer's originally labeled container and kept in a locked location. The provider or provider's family medication shall be stored in a separate locked location. All medication for pets or other animals shall be stored in a separate locked location. Unused, outdated, or recalled medications may not be kept in the AFH and shall be disposed in a manner to prevent diversion into the possession of people other than for whom it was prescribed. The provider shall document disposal of all unused,

outdated, and or recalled medication on individuals' drug disposal forms;
(d) Medications may 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 shall be kept of all medications administered by the program staff to that individual, including over the counter medications. The MAR shall indicate name of medication, dosage and frequency of administration, route or method, dates and times given, and be immediately initialed by the caregiver dispensing using only blue or black indelible ink. Treatments, therapies, and special diets shall 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 shall have a legible signature for each set of initials using only blue or black indelible ink;
(f) The MAR shall 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) For any individual who is self-administering medication, the individual's record shall include the following documentation:
(A) 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) That the individual is able to manage his or her own medication regimen, and the provider shall keep medications stored in an area that is inaccessible to others and locked;
(C) Of retraining when there is a change in dosage, medication, and time of delivery;
(D) Of review of self-administration of medication as part of the residential care plan process; and
(E) 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 shall be maintained in the individual's record;
(3) 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 residential 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.
(4) The initial residential care plan shall be developed within 24 hours of admission to the AFH.
(5) This section and its subsections are effective July 1, 2016 and enforceable as described in OAR 309-040-0315(7):
(a) During the initial 30 calendar days following the individual's admission to the AFH, the provider shall continue to assess and document the individual's preferences and care needs. The provider shall complete and document the

assessment and care plan in an RCP within 30 days after admission unless the individual is admitted to the AFH for crisis-respite services;
(b) An RCP 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 identifies the goals to be accomplished through those services. The RCP shall describe the individual's needs, preferences, capabilities, and what assistance the individual requires for various tasks;
(c) The provider shall develop the RCP based upon the findings of the individual assessment with participation of the individual and through collaboration with the individual's primary mental health treatment provider and the person-centered service plan coordinator. With consent of the individual, 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 RCP. The provider shall have proper, prior authorization from the individual or the individual's representative prior to such contact;
(d) The RCP shall 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;
(e) The RCP shall 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;
(f) The provider shall review and update each individual's RCP every six months and when an individual's condition changes. The review shall 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 an RCP contains many changes and becomes less legible, the provider shall write a new care plan;
(g) The provider shall attach the RCP to the person-centered service plan.
(6) A person-centered service plan shall be completed in the following circumstances:
(a) A person-centered service plan coordinator under contract with the Division shall complete a person-centered service plan with each individual pursuant to OAR 411-004-0030. The provider shall 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 shall be developed by the individual and, as applicable, the legal or designated representative of the individual, and the person-centered service plan coordinator. 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 when 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 shall 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.
(7) A person-centered service plan shall be developed through a person-centered service planning process. The person-centered service planning process includes the following:

(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 to request updates to the person-centered service plan for the individual;
(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, participants in the person-centered service planning process, and all individuals responsible for the implementation of the person-centered service plan, including the provider, as described below in section (8)(a)(O) of this rule. The person-centered service plan is distributed to the individual, and other people involved in the person-centered service plan as described below in section (8)(d) of this rule.
(8) Required Contents of person-centered service plan:
(a) When the provider is required to develop the person-centered service plan, the provider shall 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 shall 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;
(N) The written informed consent of the individual:
(O) Signatures 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) When the provider is not required to develop the person-centered service plan but provides services to the individual, the provider shall provide relevant information and provide necessary support for the person-centered service plan coordinator or other persons developing the plan to fulfill the characteristics described in part (a) of this section;
(c) The individual decides on the level of information in the person-centered service plan that is shared with providers. To effectively provide services, providers shall 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 other people involved in the person-centered service plan as described above in subsection (c) of this section;
(e) The person-centered service plan shall justify and document any individually-based limitation to be applied as outlined in OAR 309-040-0393 when an individual's rights under OAR 309-040-0410(2)(b) through (i) may not be met due to threats to the health and safety of the individual or others;
(f) The person-centered service plan shall be reviewed and revised:
(A) At the request of the individual:
(B) When the circumstances or needs of the individual change; or
(C) Upon reassessment of functional needs as required every 12 months.
(9) 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 shall, at a minimum, develop an initial care plan as required by section (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 shall provide relevant information and provide necessary support for the person-centered service plan coordinator as described in section (11)(b) of this rule.
(10) The provider shall develop an individual record for each individual. The provider shall keep the individual record current and available on the premises for each individual admitted to the AFH. The provider shall maintain an individual record consistent with the following requirements:
(a) The record shall include:
(A) The individual's name, previous address, date of entry into AFH, date of birth, sex, marital status, religious preference, preferred hospital, Medicaid 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 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 shall be available to the Authority conducting inspections or investigations as well as to the individual or the individual's representative;
(D) Original individual records shall 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 shall 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 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 residential care plan with supporting documentation from the income sources to be maintained in the individual's individual record;
(C) The individual or the individual's representative shall agree to specific costs for room and board and services within the pre-set limits of the state contract. A copy shall 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 shall be maintained with supporting documentation for expenditures $10 and greater. The AFH designee shall have specific written permission to manage an individual's discretionary fund;
(f) The provider shall maintain a copy of the written house rules with documentation that the provider discussed the house rules with the individual;
(g) A written incident report of any unusual incidents relating to the AFH including but not limited to individual care. The incident report shall 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 shall be written for each individual involved in an incident. A copy of the incident report shall be submitted to the CMHP within five working days of the incident. The original shall be placed in the individual's individual record.
(h) Any other information or correspondence pertaining to the individual;
(i) Progress notes shall 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 shall be entered in the individual's record at least once each month.
(11) Residents' Bill of Rights:
(a) The provider shall guarantee the Residents' Bill of Rights as described in ORS 443.739. The provider shall post a copy of the Residents' Bill of Rights in a location that is accessible to individuals, individuals' representatives, parents, guardians, and advocates. The provider shall give a copy of the Residents' Bill of Rights to each individual, individuals' representative, parent, guardian, and advocate along with a description of how to exercise these rights;
(b) The provider shall 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.

(12) Providers, resident managers, or substitute caregivers may not use physical restraints for individuals receiving personal care services authorized or funded through the Division.
(13) The provider shall:
(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 and as identified on the RCP. The provider shall 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 or if the individual refuses care;
(d) House Rules:
(A) The provider shall 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 shall discuss house rules with the individual and families at the time of arrival and be posted in a conspicuous place in the facility. The provider shall 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 may not restrict or limit the individual rights under 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 shall 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 shall be notified of the name of the substitute caregiver for the provider or resident manager;
(f) A provider, resident manager, or substitute caregiver shall 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 RCP;
(j) Keep information related to individuals 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 Division or CMHP;
(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, an individual may not 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 that could threaten the health, safety, or welfare of individuals;
(o) Immediately notify the appropriate RCP Team members (in particular the CMHP representative and family or 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.
(14) The provider shall 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 suspected of being abuse shall be reported to the Office of Investigations and Training within 24 hours of occurrence.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0393

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 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 shall demonstrate and document that the individually-based limitation meets the requirements of section (2) of this rule and that the conditions described below exist in the person-centered service plan. The provider shall 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, 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 shall:
(a) Maintain a copy of the completed and signed form documenting the consent to the individually-based limitation described in section (3) of this rule. The form shall be signed by the individual.
(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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0394

Residency Agreement

This rule become effective July 1, 2016, and is enforceable as described in OAR 309-040-0315(7).
(1) The provider shall 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 shall be signed by the provider and the individual or the individual's representative prior to or at the time of admission;
(b) The provider shall provide a copy of the signed agreement to the individual or the individual's representative and shall retain the original signed agreement within the individual's individual record;
(c) The provider shall 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) The provider shall 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 shall include, but is not limited to, the following:
(a) 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 shall 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 shall 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 outlined 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 may not restrict animals that provide assistance or perform tasks for the benefit of an individual with a disability. Such animals are often referred to as service 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 may not schedule meals with more than a 14-hour span between the evening

meal and the following morning's meal consistent with OAR 411-050-0645);
(m) Policy regarding refunds for individuals eligible for Medicaid services, including prorating partial months, and if the room and board is refundable;
(n) Any house rules or social covenants required by the provider that may be included in the agreement 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 may not be limited without the informed, written consent of the individual 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 that 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 asks for application fees, refundable deposits, or non-refundable deposits;
(b) Includes any illegal or unenforceable provision or asks or requires the individual to waive any of the individual's rights or the licensee's liability for negligence; or
(c) Conflicts with individual rights or these rules.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0395

Standards for Admission, Transfers, Respite, Discharges, and Closures

(1) Each individual referred for placement in an AFH may select and choose from available service settings.
(2) 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 shall 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 may 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 may 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;
(b) The written notice shall state the 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);
(c) Except where undue delay might jeopardize the health, safety, or well-being of the individual or other individuals, a provider shall 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.
(d) Individuals who object to the transfer shall be given the opportunity for a 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 a CMHP staff member.
(4) Providers may not exceed the licensed capacity of the AFH. However, respite care of no longer than two weeks duration may be provided an 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 section (3) of this rule. The provider shall 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 shall promptly notify the CMHP or Division if an individual gives notice or plans to leave the AFH or if an individual abruptly leaves.
(6) Providers shall 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0400
Inspections
(1) The Division shall 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) The Division or CMHP may conduct inspections of an AFH:
(a) Anytime such inspections are authorized by these rules and any other time the Division or CMHP 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 shall be permitted access to enter and inspect the AFH regarding fire safety upon request of the Division or CMHP.
(4) The Division and CMHP shall have full access to examine AFH records and accounts, including individual records and accounts, and to inspect the physical premises, including the buildings, grounds, equipment, and any vehicles.
(5) The Division or CMHP staff shall be permitted to interview the provider, resident manager, caregiver, and individuals. Interviews are confidential conducted in private and are confidential except as considered public record under ORS 430.763.
(6) Providers shall authorize resident managers and substitute caregivers to permit entrance by the Division or CMHP staff for the purpose of inspection and investigation.
(7) The Division or CMHP staff shall conduct inspections with or without advance notice to the provider, staff, or an individual of the AFH. The Division or CMHP may 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) If the Division or CMHP staff is not permitted access or inspection, a search warrant may be obtained.
(9) The inspector shall respect the private possessions and living area of individuals, providers, and caregivers while conducting an inspection.
(10) Completed reports on inspections, except for confidential information, shall be available to the public upon written request to the Division or CMHP during business hours.
(11) For individuals receiving services authorized or funded by the Division, the Division shall investigate allegations of abuse as defined in ORS 430.735 to 430.765.
(12) When abuse is alleged or death of an individual has occurred and a law enforcement agency or the Division or its designee has determined to initiate an investigation, the provider may 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 must be taken.
(13) The Division or its designee shall complete an abuse investigation and protective services report in accordance with OAR 943-045-0250 through 0370.
(14) 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) Upon completion of the investigation report according to OAR 943-045-0320, the sections of the report that are public records and not exempt from disclosure under the public records law shall be provided to the appropriate provider. The provider shall implement the actions necessary within the deadlines listed to prevent further abuse as stated in the report.
(16) A provider may not retaliate against any person who reports in good faith suspected abuse or against the individual with respect to the report.
(17) 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) not withstanding any other remedy provided by law. The authority of the director to impose civil penalties and the factors to be considered shall be in accordance with 443.790.
(18) 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 section, "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 the following:
(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 may also be evidence of retaliation after 90 days even though the presumption no longer applies.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0060, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0405
Procedures for Correction of Violations

(1) 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 shall 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 shall not extend any previously established time limit for correction.
(2) The licensee shall notify the Division of correction of violations in writing no later than the date specified in the notice of violation.
(3) 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, or refusal to renew a license as deemed appropriate by the Division;
(b) Placement of conditions on the license as deemed appropriate by the Division; or
(c) Filing of a criminal complaint.
(4) If an individual is in serious and immediate danger, the Division may institute one or more of the following actions:
(a) If there is reliable evidence of abuse, neglect, or exploitation, the license may be immediately suspended or revoked and arrangements made to move the individual pursuant to OAR 309-040-0425;
(b) The Division may order the removal of the individual pursuant to OAR 309-040-0425; or
(c) Placement of conditions on the license as deemed appropriate by the Division.
Statutory/Other Authority: ORS 413.042, ORS 443.745
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 12-2017, temporary amend filed 10/03/2017, effective 10/03/2017 through 03/30/2018; MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0070, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0410
Residents' Bill of Rights, Complaints, and Grievances

(1) Residents' Bill of Rights:
(a) The provider shall guarantee Residents' Bill of Rights as described in ORS 443.739 and help residents exercise them;
(b) The provider shall post the Residents' Bill of Rights in a location that is prominent and accessible to individuals, individuals' representatives, parents, guardians, and advocates. The posted rights shall include the telephone number of the office to call to report complaints;
(c) The provider shall give a copy of the Residents' Bill of Rights to each individual, individuals' representatives, parents, guardians, and advocates along with a description of how to exercise these rights;
(d) Upon admission to the AFH:
(A) The provider shall explain the Residents' Bill of Rights to each individual and to individuals' representatives, parents, guardians, and advocates; and
(B) The provider shall document in the individual's file that a copy of the Residents' Bill of Rights is given to each individual and to individuals' representatives, parents, guardians, and advocates.
(e) The Residents' Bill of Rights state that each resident 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 individual of choice, such as family members, friends, advocates, and legal, social service, and medical professionals; send and receive personal mail unopened; engage in telephone conversations; and 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 financial affairs unless legally restricted. Be free from financial exploitation. The provider may not charge or ask for application fees or nonrefundable deposits and may 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 RCP. 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 shall be approved in writing on the individual's RCP;
(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 or 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 and OAR 411-088-0080. A provider may transfer or discharge an individual only for medical reasons including a medical emergency described in ORS 443.738, or for the welfare of the individual or other residents, or for nonpayment; and
(U) Utilize advance directives. Advance directives shall be explained to each individual upon admission. If the individual does not already have any advance directive or directives, he or she shall 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 shall be documented in the individual's record;
(V) 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 that 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 3(b)(c)(d)(e)(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 shall 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) Any person who believes these rules have been violated may file a complaint with the Division or CMHP. The Division or CMHP may investigate any complaint or grievance regarding the AFH.
(6) The Division or CMHP shall furnish each AFH with a Complaint and Grievance Notice that the provider shall post in a conspicuous place stating the telephone number of the Division and the CMHP and the procedure for making complaints or grievances.
(7) A copy of all AFH complaints or grievances shall be maintained by the Division. All complaints or grievances and actions taken on the complaint or grievance, indexed by the name of the provider, shall:
(a) Be placed into the public file at the Division. Information regarding the investigation of the complaint or grievance may 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) The Division may suspend, revoke, refuse to renew, or impose conditions against the license of a provider who acquires substantiated complaints or grievances pertaining to the health, safety, or welfare of individuals.
(9) The AFH provider, resident manager, or caregiver may 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 the following:
(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) A complainant, grievant, witness, or caregiver of an AFH may 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) 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) Any individual may 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.
Statutory/Other Authority: ORS 443.735
Statutes/Other Implemented: ORS 127.700 - 127.737, ORS 443.705 - 443.825
History: MHS 12-2017, temporary amend filed 10/03/2017, effective 10/03/2017 through 03/30/2018; MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0415

Administrative Sanctions

(1) The Division may attach conditions to a license in addition to or instead of imposing an administrative sanction. Conditions are described in OAR 309-040-0430.

(2) An administrative sanction includes one or more of the following actions:

(a) Civil penalties;

(b) Refusal to renew, denial, suspension or revocation of a license as set forth in OAR 309-040-0420.

(3) If the Division imposes an administrative sanction, it shall serve a Notice of Intent of the administrative sanction upon the licensee personally or by certified mail.

(4) The notice of administrative sanction shall state the following:

(a) Each sanction imposed;

(b) A short and plain statement of each circumstance, act, or omission that constitutes substantial non-compliance with the applicable rules;

(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.

(5) If an administrative sanction is imposed for reason other than abuse, neglect, or exploitation, a contested case hearing shall precede imposition if the licensee requests the hearing in writing within 60 days of service of the notice of intent to impose the administrative sanction pursuant to ORS Chapter 183.

(6) If a licensee fails to request in writing a hearing within 60 days of service of the notice, then the Notice of Administrative Sanction shall become a Final Order of the Division by default.

(7) 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 written request for a contested case hearing within 60 days of the notice of immediate suspension, revocation, or refusal to renew.

(8) When a license is denied, suspended, revoked, or not renewed, the Division and the CMHP shall work together to arrange for individuals to move for their protection as permitted by Resident Rights.

(9) Hearing rights are in accordance with ORS 183.411 to 183.550.

Statutory/Other Authority: ORS 413.042, ORS 443.745

Statutes/Other Implemented: ORS 443.705 - 443.825

History: MHS 12-2017, temporary amend filed 10/03/2017, effective 10/03/2017 through 03/30/2018; MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0075, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0420

Denial, Suspension, Revocation or Refusal to Renew

(1) The Division may deny, suspend, revoke, or refuse to renew a license where it finds any of the following:

(a) There has been substantial failure non-compliance with these rules;

(b) 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

(c) 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 or 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 individuals, 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 of the ability and fitness to operate an AFH. If the applicant or provider does not meet this burden, then the Division may 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) 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 bills;
(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 or 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.
Statutory/Other Authority: ORS 413.042, ORS 443.745
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 12-2017, temporary amend filed 10/03/2017, effective 10/03/2017 through 03/30/2018; MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0090, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0425

Removal of Residents

(1) 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) The CMHP shall provide the individual assistance in locating and visiting alternative placements, if needed, and explain the individual's right to contest the move as provided in ORS 443.738(11)(b) and OAR 411-088-0080.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 12-2017, temporary amend filed 10/03/2017, effective 10/03/2017 through 03/30/2018; MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0430
Conditions

(1) 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 an individual;
(c) There is reliable evidence of abuse or neglect of an individual;
(d) The AFH is substantially non-compliant with these rules; or
(e) The provider is licensed to care for a specific individual only and further placements may not be made to the AFH.
(2) The provider shall be notified in writing of any conditions imposed, the reason for the conditions, and be given an opportunity to request a contested case hearing under ORS Chapter 183.
(3) 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 or neglect of an adult, pending further action by the Division;
(d) The AFH is substantially non-compliant with these rules, pending further action by the Division.
(4) Conditions that may be imposed on a licensee include but are not limited to the following:
(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 additional AFH; or
(g) Suspending admissions to the AFH.
(5) The provider shall be notified in writing of any conditions imposed, the reason for the conditions, and be given an opportunity to request a contested case hearing under ORS Chapter 183.

(6) 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 Division or CMHP. The review does not diminish the provider's right to a hearing or extend the time period to request a hearing.
(7) 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 may be considered at the time of renewal to determine if the conditions are still appropriate. The effective date and expiration date of the conditions shall be indicated on the attachment to the license.
(8) Conditions attached to a license shall be effective upon order of the director of the licensing agency.
(9) Hearing rights are in accordance with ORS 183.411 to 183.550.
Statutory/Other Authority: ORS 413.042, ORS 443.745
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 12-2017, temporary amend filed 10/03/2017, effective 10/03/2017 through 03/30/2018; MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0093, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92)

309-040-0435

Criminal Penalties

(1) Operating an AFH without a license is punishable as a Class C misdemeanor.
(2) 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0095, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1986, f. & ef. 7-2-86; MHD 19-1985(Temp), f. & ef. 12-27-85

309-040-0440

Civil Penalties

(1) Civil penalties for other than substantiated allegations of abuse shall not exceed $100 per violation with a maximum of $250 and may be assessed for violation of these rules with the exception of substantiated abuse findings.
(2) Civil penalties of a maximum of $1000 per occurrence may be assessed for each substantiated abuse finding.
(3) 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) Any civil penalty imposed under this section shall become due and payable when the provider incurring the penalty receives a notice in writing from the Division. The notice shall be sent by registered or certified mail and includes the following:
(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) The provider to whom the notice is addressed shall have 60 days from the date of the notice of intent in which to make written application for a hearing.
(6) All hearings shall be conducted according to the applicable provisions of ORS Chapter 183.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0097, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92)

309-040-0445
Public Information
(1) The Division shall 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) The information shall include the following:
(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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0098, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99

309-040-0450
Adjustment, Suspension or Termination of Payment
(1) The Division or CMHP may adjust, suspend, or terminate payment 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 RCP; or
(c) When funding, laws, regulations, or the Division or CMHP 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 shall be paid only through the last day of the individual's occupancy.
(2) The Division or CMHP is under no obligation to maintain the AFH at its licensed capacity or to provide payments to potential providers.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; 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; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17

309-040-0455
Enjoinment of AFH Operation
The Division may commence an action to enjoin the operation of an AFH pursuant to ORS 443.775(5):
(1) When an AFH is operated without a valid license; or
(2) 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 443.705 - 443.825
History: MHS 9-2017, f. 6-29-17, cert. ef. 7-1-17; MHS 3-2017(Temp), f. 3-3-17, cert. ef. 3-4-17 thru 8-30-17; MHS 14-2016(Temp), f. 9-6-16, cert. ef. 9-7-16 thru 3-3-17; Renumbered from 309-040-0099, MHD 3-2005, f. & cert. ef. 4-1-05; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92)

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.
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: 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.
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: 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 he 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.
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: 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).
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: 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.
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: 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.
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: 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 precommitment 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.
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: 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.
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: 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.
Statutory/Other Authority: ORS 413.042, 426.500
Statutes/Other Implemented: ORS 410.535, 414.065, 426.490 to 426.500
History: MHD 2-1995, f. & cert. ef. 4-6-95

DIVISION 88
PLACEMENT OF DEFENDANTS WHO LACK FITNESS TO PROCEED

309-088-0105
Purpose and Scope
Oregon Revised Statutes (ORS) 161.365 and ORS 161.370 recognize that not all criminal defendants who lack fitness to proceed (commonly known as Aid and Assist defendants) need to be committed to the State Hospital or remain in jail. ORS 161.365 and ORS 161.370 require that "when the court has reason to doubt the defendant's fitness to proceed by reason of incapacity as described in ORS 161.360, the court may call any witness to its assistance in reaching it decision and shall order that a community mental health program director or the director's designee consult with the defendant to determine whether services and supervision necessary to safely restore the defendant's fitness to proceed are available in the community." These rules establish the standards for that to occur and encourage collaboration between the Court, State Hospital, Community Mental Health Program (CMHP), and parties to the case to the extent permitted by law.

Statutory/Other Authority: ORS 413.042, ORS 161.365, ORS 430.630, ORS 430.640
Statutes/Other Implemented: ORS 161.365, ORS 430.630, ORS 430.640, ORS 161.360, ORS 161.370
History: MHS 13-2017, temporary adopt filed 10/23/2017, effective 10/23/2017 through 04/20/2018

309-088-0115

Definitions

(1) “Authority” means the Oregon Health Authority (OHA).
(2) “Capacity” means – pursuant to ORS 161.360 – defendant is able:
(a) To understand the nature of the proceedings against himself or herself;
(b) To assist and cooperate with his or her counsel; and
(c) To participate in his or her own defense.
(3) “Community Mental Health Program (CMHP) Director” means the individual identified by the local mental health authority as the director of that particular local CMHP, or his or her designee.
(4) “Consultation” means a meeting between the CMHP and the defendant under the least restrictive conditions appropriate to assist the Court in determining whether the services and supervision necessary to safely restore the defendant’s fitness to proceed are available in the community. This consultation is not an examination regarding fitness to proceed, and therefore does not need to be completed by a Certified Forensic Evaluator pursuant to ORS 161.365 and OAR 309-090.
(5) “Court” means the Court with jurisdiction regarding defendant’s fitness to proceed under ORS 161.365 and ORS 161.370.
(6) “Fitness to Proceed” means the same as having capacity.
(7) “Incapacitated” means - pursuant to ORS 161.360 – that as a result of mental disease or defect, the defendant is unable:
(a) To understand the nature of the proceedings against himself or herself;
(b) To assist and cooperate with his or her counsel; or
(c) To participate in his or her own defense.
(8) “Legal skills training” means training on courtroom procedures, roles, language, and potential outcomes of the court process.
(9) “Services” may include, but are not limited to:
(a) Legal skills training
(b) Medication management;
(c) Case management;
(d) Behavioral intervention;
(e) Peer services;
(f) Psychiatric and medical treatment;
(g) Incidental support such as purchase of food, clothing, or transportation; and
(h) Linkages to benefits and community resources such as SNAP, housing/shelter, Medicaid enrollment, and cash assistance.
(9) “State Hospital” means the Oregon State Hospital system, including all campuses.
(10) “Supervision” may include, but is not limited to, a range of monitoring options based upon the defendant’s risk factors, such as recognizance release, release to family members or other third parties, drug and alcohol testing, appointments with providers, random home visits, court ordered participation with services, reports to the Court, or other conditions determined by the Court.
(11) “Unable to Aid and Assist” means the same as “incapacitated”, as defined in ORS 161.360(2).
Statutory/Other Authority: ORS 413.042, ORS 430.630, ORS 430.640, ORS 161.365
Statutes/Other Implemented: ORS 161.365, ORS 161.360, ORS 161.370
History: MHS 13-2017, temporary adopt filed 10/23/2017, effective 10/23/2017 through 04/20/2018

309-088-0125

CMHP Responsibilities

(1) When the Court has reason to doubt a defendant's fitness to proceed by reason of incapacity, ORS 161.365 and 161.370 require that the Court shall order a CMHP Director, or designee, to consult with the defendant in order to determine whether services and supervision necessary to safely restore the defendant's fitness to proceed are available in the community.

(2) Within two judicial days after receipt, the CMHP Director, or designee, shall send acknowledgement to the Court of having received the order for consultation.

(3) Initial consultation shall occur through a face-to-face meeting, and any follow-up (supplemental) consultations may occur through teleconference or video conference.

(4) The CMHP Director, or designee, shall ensure that the following steps are completed within seven judicial days of the order if the defendant is in custody, and within ten judicial days of the order if the defendant is out of custody:

(a) A review of available records related to defendant's medical or service needs;

(b) A consultation with the defendant to assess whether services and supervision necessary to safely restore the defendant's fitness to proceed are available in the community;

(c) Submit to the Court a findings report describing the outcome of the consultation regarding whether services and supervision necessary to safely restore the defendant's fitness to proceed are available in the community. The findings report shall be completed using the "Consultation Report Template" available at http://www.oregon.gov/oha/OSH/LEGAL/Pages/information-mental-health-providers.aspx

(d) Submission to the Court the packet of sample forms of court orders developed by the Authority to facilitate this process.

(5) The CMHP Director, or designee, shall make individual assessments of whether each defendant needs a particular service to gain or regain capacity as that term is defined in these rules. The fact that a defendant is incapacitated does not automatically mean that legal skills training is necessary to gain or regain capacity.

(6) The consultation shall occur and the findings report shall be submitted to the Court before the issuance of an order under ORS 161.370.

(7) If the Court orders the defendant to participate in services or supervision in the community under ORS 161.370(3), and the defendant's mental health later deteriorates or there are concerns about whether the defendant may continue to be safely restored in the community:

(a) Nothing in this rule prevents the Court from authorizing the CMHP to conduct additional consultation(s) and to submit new findings report(s) to the Court; and

(b) Nothing in this rule prevents the Court from later ordering that the defendant be committed to the State Hospital for treatment under ORS 161.370(2)(a) if the circumstances which led to the community services and supervision change.

(8) If, after receipt of the findings report, the Court commits the defendant to the custody of the superintendent of the State Hospital under ORS 161.370(2)(a), nothing in these rules prevents the CMHP from conducting new (supplemental) consultations and completing new findings reports to facilitate appropriate services and supervision for the defendant if circumstances change.

(9) Each CMHP Director, or designee, shall provide the Authority a quarterly report with the following information for each consultation:

(a) Defendant's Name;

(b) Gender;

(c) Date of Birth;

(d) Electronic Health Record identification number or MOTS identification number;

(e) SID Number;

(f) Consultation Referral Date;

(g) Consultation Face-to-Face Date;

(h) Date findings report was provided to the Court;

(i) Recommendation from the findings report provided to the Court; and
(j) Court's determination on defendant's placement.
Statutory/Other Authority: ORS 161.365, ORS 413.042, ORS 430.640, ORS 430.630
Statutes/Other Implemented: ORS 161.365, ORS 161.370
History: MHS 13-2017, temporary adopt filed 10/23/2017, effective 10/23/2017 through 04/20/2018

309-088-0135
Discharge from the State Hospital for Community Restoration
(1) This rule applies when a defendant has been committed to the custody of the superintendent of the State Hospital under ORS 161.370(2)(a).
(2) As required in ORS 161.370(6)(b), the superintendent or designee shall file notice with the Court if it is determined that a defendant committed under 161.370 is no longer a danger to self or others as a result of mental illness or defect, or that the services and supervision necessary to restore the defendant's fitness to proceed become available in the community. The superintendent or designee:
(a) Shall consider the safety of the defendant and the public; and
(b) Shall, to the extent permitted or required by law or by court order, discuss with the CMHP the availability of services, supports, and supervision in the community.
(3) The CMHP may complete a supplemental consultation to facilitate discussions with the Court regarding the appropriateness and safety of community restoration services for the defendant.
(4) Nothing in this section prevents the committing Court from vacating the order of commitment under ORS 161.370(2)(a) and using the process described in ORS 161.370(6)(b) and ORS 161.370(3) to order that the defendant be released on supervision to the community for further restoration subject to conditions that the Court determines are appropriate.
Statutory/Other Authority: ORS 413.042, ORS 430.630, ORS 430.640
Statutes/Other Implemented: ORS 161.365, ORS 161.370
History: MHS 13-2017, temporary adopt filed 10/23/2017, effective 10/23/2017 through 04/20/2018

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.
Statutory/Other Authority: ORS 413.042, 161.309-370, 161.392, 419C.378 - 384
Statutes/Other Implemented: ORS 161.309-370, 161.392, 419C.378 -384
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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 applicants 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.
Statutory/Other Authority: ORS 161.398, 419C.524, 419C.382, 161.309 -370, 419C.378 -384
Statutes/Other Implemented: ORS 161.309-370, 419C.378-398
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 16-2012, f. & cert. ef. 12-26-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 161.392-413.042, 419C.524, 161.309 -370, 419C.382
Statutes/Other Implemented: ORS 161.309 -370, 161.392, 419C.382, 419C.380
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 161.392- 419C.524, 419C.392, 161.309 -370, 419C.378-384
Statutes/Other Implemented: ORS 161.309 -370, 161.392, 419C.378-384

History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 161.309 -370, 419C.378-384
Statutes/Other Implemented: 161.309 -370, 419C.378-384
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382, 161.309 -370
Statutes/Other Implemented: ORS 161.309 -370
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 16-2012, f. & cert. ef. 12-26-12; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 161.309 -370, 419C.378-384
Statutes/Other Implemented: ORS 161.309 -370, 419C.378-384, 161.392, 419C.382
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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 l 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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 419C.524, 161.309 -370, 419C.378-384
Statutes/Other Implemented: ORS 161.392, 161.309 -370, 413.042, 419C.378-384
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 419C.524, 419C.382, HB 2836, 419C.382
Statutes/Other Implemented: HB 2836, ORS 161.309, 161.325 - 329, 419C.382
History: MHS 14-2014, f. & cert. ef. 10-29-14; MHS 13-2012, f. & cert. ef. 6-25-12; MHS 12-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382 161.309 -370, 419C.378-384
Statutes/Other Implemented: ORS 161.309 -370, 419C.378-384
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14; MHS 13-2012, f. & cert. ef. 6-25-12

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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382 161.309 -370, 419C.378-384
Statutes/Other Implemented: ORS 161.309 -370, 419C.378 - 384
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14

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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382, 161.309 -370, 419C.378-384
Statutes/Other Implemented: ORS 161.309 -370, 419C.378 - 384
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14

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 y, the evaluator shall maintain temporary certification status for up to six months at which time the Authority shall l 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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382, 161.309 -370, 419C.378-384
Statutes/Other Implemented: 419C.378 - 384, ORS 161.309 -370
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14

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.
Statutory/Other Authority: ORS 161.309-161.370, 161.392, 413.042, 419C.524, 419C.382 419C.378-384
Statutes/Other Implemented: ORS 161.309 -370, 419C.378 - 384
History: MHS 4-2016, f. & cert. ef. 5-3-16; MHS 14-2014, f. & cert. ef. 10-29-14

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-091-0010
Civilly 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-091-0040

Forensic Admission Criteria and Procedures

Forensic admissions will occur as prescribed ORS 161.327, 161.328, 161.365, 161.370.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 426.072
History: MHS 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 179.321, 426.010, 426.020, 161.370, 179.360, 2011 SB 432
History: MHS 3-2016, f. & cert. ef. 4-28-16; Reverted to 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 6-2012, f. 5-3-12, cert. ef. 5-4-12; MHS 16-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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 or insanity only of offenses that are not tier one offenses.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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) TheSHRP 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.
Statutory/Other Authority: ORS 413.042, 161.327, 161.332, 161.336, 161.346, 161.351, 161.385, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042, 161.385, 161.387, 192.450, 192.500, 192.525; & 192.690, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.295 - 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.341, SB 420.
Statutes/Other Implemented: ORS 161.336, 161.341, 161.351, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161, SB 420 .
Statutes/Other Implemented: ORS 161.385, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.327, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161, SB 420
Statutes/Other Implemented: ORS 161.336, 161.341 & 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.327, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.327, SB 420.
Statutes/Other Implemented: ORS 161.346 & 161.385, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042, 161.387; SB 420
Statutes/Other Implemented: ORS 161.346, ORS 161.395, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.

Statutory/Other Authority: ORS 413.042 & 161.327, SB 420.

Statutes/Other Implemented: ORS 161.346 & 161.385, SB 420

History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.

Statutory/Other Authority: ORS 413.042 & 161.387, SB 420

Statutes/Other Implemented: ORS 161.336, 161.341 & 161.346, SB 420

History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.).

Statutory/Other Authority: ORS 413.042 & 161.387, SB 420

Statutes/Other Implemented: ORS 161.346, SB 420

History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.

Statutory/Other Authority: ORS 413.042 & 161.387, SB 420

Statutes/Other Implemented: ORS 161.346, SB 420

History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.336, 161.341, 161.346, 161.351, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.336, ORS 161.341, ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.336, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.327, SB 420
Statutes/Other Implemented: ORS 161.341, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.327, SB 420
Statutes/Other Implemented: ORS 161.341, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.341, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.

Statutory/Other Authority: ORS 413.042 & 161.387, SB 420

Statutes/Other Implemented: ORS 161.341, SB 420

History: 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.

Statutory/Other Authority: ORS 413.042 & 161.387, SB 420

Statutes/Other Implemented: ORS 161.341, SB 420

History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042, 161.387; SB 420
Statutes/Other Implemented: ORS 161.341, ORS 161.351, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.327, SB 420
Statutes/Other Implemented: ORS 161.336, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.336, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.

Statutory/Other Authority: ORS 413.042 & 161.387, SB 420

Statutes/Other Implemented: ORS 161.336, SB 420

History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.

Statutory/Other Authority: ORS 413.042 & 161.387, SB 420

Statutes/Other Implemented: ORS 161.336, SB 420

History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.

Statutory/Other Authority: ORS 413.042 & 161, SB 420 .

Statutes/Other Implemented: ORS 161.336, SB 420

History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.327, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.385, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.327, SB 420
Statutes/Other Implemented: ORS 161.395, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

309-092-0230
Compliance
State or local community mental health programs shall comply with any order of the SHRP.
Statutory/Other Authority: ORS 413.042, 137.540, 161, 327, 192.620, 430.630, SB 420
Statutes/Other Implemented: ORS 161.336, 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 413.042 & 161.387, SB 420
Statutes/Other Implemented: ORS 161.346, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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 forthe purposes of ORS 161.326 (Notice to victim).
Statutory/Other Authority: 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
Statutes/Other Implemented: ORS 161.400, SB 420
History: MHS 9-2012, f. & cert. ef. 6-19-12; MHS 13-2011(Temp), f. 12-21-11, cert. ef. 1-1-12 thru 6-27-12

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.360, 426.385
History: MHS 1-2012, f. & cert. ef. 2-9-12; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 5-2011, f. & cert. ef. 8-3-11

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 it's 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 it's 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.360, 426.385
History: MHS 1-2012, f. & cert. ef. 2-9-12; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 5-2011, f. & cert. ef. 8-3-11

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.360, 426.385
History: MHS 1-2012, f. & cert. ef. 2-9-12; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 5-2011, f. & cert. ef. 8-3-11

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 it's 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.360, 426.385

History: MHS 1-2012, f. & cert. ef. 2-9-12; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 5-2011, f. & cert. ef. 8-3-11

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.360, 426.385
History: MHS 1-2012, f. & cert. ef. 2-9-12; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 5-2011, f. & cert. ef. 8-3-11

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.360, 426.385
History: MHS 1-2012, f. & cert. ef. 2-9-12; MHS 8-2011(Temp), f. & cert. ef. 10-27-11 thru 4-20-12; MHS 5-2011, f. & cert. ef. 8-3-11

DIVISION 104
TELEPHONE USE BY PATIENTS ANDRESIDENTS 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.040, 413.042
History: 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.

Statutory/Other Authority: ORS 179.040, 413.042

Statutes/Other Implemented: ORS 179.040, 413.042

History: 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.

Statutory/Other Authority: ORS 179.040, 413.042

Statutes/Other Implemented: ORS 179.040, 413.042

History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.040, 413.042
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.040, 413.042
History: MHD 28-1982, f. 12-28-82, ef. 1-28-83

DIVISION 106
VISITATION OF PATIENTS ANDRESIDENTS 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: 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 provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: MHD 29-1982, f. 12-28-82, ef. 1-28-83

DIVISION 108

HANDLING OF PERSONAL PROPERTY OF PATIENTSAND 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 ORS 426.385.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: MHD 7-1986, f. & ef. 9-4-86; MHD 30-1982, f. 12-28-82, ef. 1-28-83

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.
(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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: MHD 7-1986, f. & ef. 9-4-86; MHD 30-1982, f. 12-28-82, ef. 1-28-83

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: MHD 7-1986, f. & ef. 9-4-86; MHD 30-1982, f. 12-28-82, ef. 1-28-83

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: MHD 7-1986, f. & ef. 9-4-86; MHD 30-1982, f. 12-28-82, ef. 1-28-83

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.385
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to 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; MHD 1-1984, f. 1-20-84, ef. 2-1-84; Reverted to MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1982(Temp), f. & ef. 1-14-82

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 2-1986, f. & ef. 3-31-86; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to MHD 2-1986, f. & ef. 3-31-86; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; MHD 2-1986, f. & ef. 3-31-86; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 21-1982, f. & ef. 9-24-82; MHD 11-1982(Temp), f. & ef. 6-10-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1982(Temp), f. & ef. 1-14-82

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 2-1986, f. & ef. 3-31-86; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to MHD 2-1986, f. & ef. 3-31-86; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; MHD 2-1986, f. & ef. 3-31-86; MHD 16-1985(Temp), f. & ef. 10-9-85; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 21-1982, f. & ef. 9-24-82; MHD 11-1982(Temp), f. & ef. 6-10-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1982(Temp), f. & ef. 1-14-82

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.
Statutory/Other Authority: ORS 179.040, 413.042

Statutes/Other Implemented: ORS 426.385
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 2-1986, f. & ef. 3-31-86; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to MHD 2-1986, f. & ef. 3-31-86; MHS 2-2013(Temp), f. & cert. ef. 1-23-13 thru 7-19-13; MHD 2-1986, f. & ef. 3-31-86; MHD 1-1984, f. 1-20-84, ef. 2-1-84; Reverted to MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1982(Temp), f. & ef. 1-14-82

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to 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; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 21-1982, f. & ef. 9-24-82; MHD 11-1982(Temp), f. & ef. 6-10-82

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385, 427.031
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to 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; MHD 1-1984, f. 1-20-84, ef. 2-1-84; Reverted to MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1982(Temp), f. & ef. 1-14-82

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to 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; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1982(Temp), f. & ef. 1-14-82

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to 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; MHD 1-1984, f. 1-20-84, ef. 2-1-84; Reverted to MHD 12-1982, f. & ef. 6-10-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 12-1982, f. & ef. 6-10-82; MHD 1-1982(Temp), f. & ef. 1-14-82

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHS 2-2016, f. & cert. ef. 4-21-16; Reverted to MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHS 6-2015(Temp), f. 10-20-15, cert. ef. 10-21-15 thru 4-15-16; Reverted to 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; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1982(Temp), f. & ef. 1-14-82

DIVISION 114
INFORMED CONSENT TO TREATMENT ANDTRAINING 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.070, 426.385
History: MHS 5-2016, f. & cert. ef. 5-25-16; MHS 5-2015, f. & cert. ef. 8-28-15; MHS 9-2014, f. & cert. ef. 4-24-14; MHS 12-2013(Temp), f. & cert. ef. 10-29-13 thru 4-27-14; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08; MHD 3-1983, f. 2-24-83, ef. 3-26-83

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;
(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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 183.458, 426.070, 426.385
History: MHS 5-2016, f. & cert. ef. 5-25-16; 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

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.070, 426.385
History: MHS 5-2015, f. & cert. ef. 8-28-15; 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

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.070, 426.385
History: MHS 5-2015, f. & cert. ef. 8-28-15; 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

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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 179.321, 426.070, 426.385
History: MHS 5-2015, f. & cert. ef. 8-28-15; 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

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 OAR 137-003-0630, and pre-determination review procedures in OAR 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.
Statutory/Other Authority: ORS 179.040
Statutes/Other Implemented: ORS 179.321, ORS 426.070, ORS 426.385
History: MHS 15-2014(Temp), f. & cert. ef. 12-1-14 thru 5-29-15; 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

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.
Statutory/Other Authority: ORS 179.040
Statutes/Other Implemented: ORS 179.321, 426.070, 426.385
History: Reverted to MHS 12-2010, f. & cert. ef. 9-9-10; MHS 13-2010(Temp), f. & cert. ef. 11-19-10 thru 5-18-11; MHS 12-2010, f. & cert. ef. 9-9-10; MHS 6-2008, f. & cert. ef. 7-25-08; MHS 2-2008(Temp), f. & cert. ef. 4-7-08 thru 10-4-08

DIVISION 118
GRIEVANCE PROCEDURES FOR USEIN 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: 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.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: Reverted to 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; MHD 15-1982, f. 7-9-82, ef. 7-23-82

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 known to the patient, resident, or representative. A written report containing at least findings of fact and the committee's resolution of the grievance shall be prepared and signed by the presiding member of the grievance committee within 21 days after completion of the hearing;
(h) The written report of the grievance committee's decision shall be given to the patient, resident, or representative, if any, and the superintendent.
(4) Level 3 — Review by the superintendent:
(a) The patient, resident, or representative may request the superintendent to review the grievance for: Failure of the grievance committee to make a decision within 21 days after completion of the hearing; dissatisfaction with the grievance committee's decision; or dissatisfaction with implementation of the decision. The following procedures shall be observed:
(A) A request for review must be in writing and must indicate the reasons for requesting review by the superintendent;
(B) The superintendent shall send a written acknowledgment to the patient, resident, or representative that the request for review has been received;
(C) The superintendent shall review the report of the grievance committee and may take such other action to investigate the matter as the superintendent deems appropriate;
(D) The superintendent shall prepare a written report affirming or modifying the grievance committee's decision concerning the grievance, and shall give copies of the report to the patient, resident or the representative, if any, and to the grievance committee.
(b) The superintendent, as executive head of the state institution, has the right, with good cause, to veto the implementation of any proposed resolution of a grievance. Good cause includes, but is not limited to, where the

resolution proposed exceeds the authority of the institution to implement.
(5) Level 4 — Review by the Administrator. If the patient, resident, or representative is dissatisfied with the superintendent's disposition of the grievance, the person may request the Administrator of the Division to review the matter. The following procedures shall be observed:
(a) A request for review must be in writing and must indicate the reasons for the person's dissatisfaction with the superintendent's action;
(b) The Administrator shall send a written acknowledgment to the patient, resident, or representative that the request for review has been received;
(c) The Administrator shall review the superintendent's report and may take such other action to investigate the matter as the Administrator deems appropriate; and
(d) The Administrator shall prepare a written report of the decision in response to the request for review of the grievance, and shall give copies of the report to the patient, resident, or representative, if any, and to the superintendent and grievance committee;
(e) Review by the Administrator is final. The Administrator's decision is not subject to appeal.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0025
Emergency Grievances
(1) If a patient, resident, or representative believes that the grievance is an emergency grievance, the patient, resident or representative may submit the formal grievance statement directly to the grievance committee.
(2) The grievance committee shall make a preliminary assessment of whether the grievance appears to be an emergency grievance and shall:
(a) Hear or investigate the matter and make a decision;
(b) If it appears that the grievance is not an emergency grievance, send the matter to the interdisciplinary team for attempted resolution; or
(c) Devise such other means to respond to the grievance as may be acceptable to the aggrieved party and the state institution.
(3) If the grievance is alleged patient or resident abuse as defined in administrative rules on patient or resident abuse, then the patient, resident, representative, interdisciplinary team, or grievance committee shall submit the matter to the superintendent of the institution. If a patient, resident, or representative is dissatisfied with the superintendent's response to an allegation of patient or resident abuse, the patient or resident may appeal to the Administrator of the Division.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0030
Representatives
(1) A patient or resident shall have the right not to be represented at all or to select the person who will act as the person's representative. The selected representative shall be respected at all levels of the grievance procedures.
(2) Staff members and other interested persons are encouraged to speak up on behalf of patients and residents who are limited in their ability to speak or act for themselves. However, the Division recognizes that a person claiming to be a representative may be acting without authority from, or against the wishes of, such patients and residents.
(3) At any level of the grievance procedures, the issue can be raised whether the claimed representative has the authority to act on behalf of the patient or resident involved. There may be an inquiry into whether the patient or resident understands that the claimed representative is acting on their behalf with respect to the subject matter of the

grievance and whether the patient or resident objects to the representative:
(a) If it is found that the patient or resident understands the situation and does not object, the representative shall be deemed to be acting on the person's behalf;
(b) If it is found that the patient or resident understands the situation and objects to the representative, the claimed representative shall be deemed not to have the authority to act on behalf of the person;
(c) If it is found that the patient or resident does not understand the situation or is unable to indicate objection or lack of objection, the interdisciplinary team, grievance committee, superintendent or designee, or Administrator or designee shall:
(A) Make a judgment whether the claimed representative is acting in the best interest of the patient or resident and either allow or disallow the claimed representative to proceed on behalf of the patient or resident involved; and
(B) If the claimed representative is not allowed to proceed, assist the patient or resident in obtaining a representative or appoint a representative.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0035

Staff Role in Grievance Procedures

(1) The superintendent shall ensure that there is at least one staff person on each ward or cottage who has the responsibility for assisting, on an "as requested basis," the patient, resident, or representative to move through the grievance procedures. At the conclusion of each level of the grievance procedures, the designated staff person should make the patient, resident or representative aware of the next level in the procedures.
(2) The superintendent and other employees of the Division at a state institution shall cooperate with the grievance committee in the resolution of grievances.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0040

Review by Courts

Nothing in these rules is intended to affect the right of a patient or resident to seek independent redress of grievances by access to state or federal courts. These rules do not create a contested case subject to judicial review.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385
History: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0045

Grievance Committee

(1) Each state institution shall have a grievance committee appointed by the superintendent.
(2) Each grievance committee shall have a minimum of five members, each with one or more alternates, designated by the superintendent, three of whom shall not be employees of the Division.
(3) Each grievance committee shall have the following duties:
(a) Serve as the second level in the state institution's grievance procedures;
(b) Receive and dispose of all emergency grievances submitted to the committee; and
(c) Review all formal grievances and resolutions, for the purpose of advising the superintendent regarding poorly resolved grievances and patterns of grievances.
Statutory/Other Authority: ORS 179.040, 413.042
Statutes/Other Implemented: ORS 426.385

History: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0050
Posting of Grievance Procedures

Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. A clear and simple statement of the grievance procedures shall be prominently posted in areas frequented by patients and residents, including each ward and cottage of the state institutions. Copies of the Grievance Statement and Request of a Grievance forms shall be accessible and available to patients and residents and their representatives.

Statutory/Other Authority: ORS 179.040, 413.042

Statutes/Other Implemented: ORS 426.385

History: MHD 15-1982, f. 7-9-82, ef. 7-23-82

DIVISION 120
PATIENT TRANSFERS

309-120-0070
Purpose

These rules prescribe procedures by which offenders in Oregon Youth Authority (OYA) close custody facilities may be transferred to a state mental hospital or a facility designated by the Addictions and Mental Health Division for evaluation and treatment.

Statutory/Other Authority: ORS 179.040, 179.473, 420.500, 420.505

Statutes/Other Implemented: ORS 179.040, 179.473, 420.500, 420.505

History: MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06; MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06

309-120-0075
Definitions

As used in these rules:

(l) “Close custody facility” means any of the secure facilities operated by the OYA, including, but not limited to, youth correctional facilities, work/study camps, and transition camps.

(2) “Facility designated by the Oregon Health Authority (Authority)” means a hospital or secure non-hospital facility designated by the Authority to provide evaluation and treatment services for offenders under the age of 18.

(3) “Hearing Officer” means an independent decision maker designated to conduct an administrative commitment hearing for an offender.

(4) “Mentally ill offender” means an offender who, because of a mental disorder or a severe emotional disorder, is one or more of the following:

(a) Dangerous to self or others;

(b) Is unable to provide for basic personal needs and is not receiving such psychiatric care as is necessary for health or safety; or

(c) An offender, who unless treated, will continue, with a reasonable medical probability, to physically or mentally deteriorate so that the offender will become a person described under either or both subparagraph (4)(a) or (4)(b) of this rule.

(5) “Offender” means a person placed in OYA close custody facility, including inmates in the legal custody of the Department of Corrections (DOC).

(6) “State Mental Hospital” as defined in ORS 426.010. Except as otherwise ordered by the Authority pursuant to ORS 179.325, the Oregon State Hospitals in Salem, Marion County, and Portland, Multnomah County, and the Blue Mountain Recovery Center in Pendleton, Umatilla County, will be used as state hospitals for the care and treatment of mentally ill offenders age 18 and over who are transferred by the OYA pursuant to these rules.

Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042

Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508, 420.500-420.525
History: MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06; MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06

309-120-0080

Procedures for Transfer

(l) The OYA close custody facility Superintendent, the Director of the OYA, or the Director's designee may request that the Superintendent of a state mental hospital or a facility designated by the Authority for evaluation and treatment accept a transfer of a mentally ill offender to a state mental hospital or facility designated by the Authority.
(2) If the Superintendent of the state mental hospital or facility designated by the Authority approves a transfer request made under paragraph (1) of this rule, the offender will be transferred.
(3) An offender may be transferred to a state mental hospital or a facility designated by the Authority for stabilization and evaluation for mental health treatment for a period not to exceed 30 days unless the transfer is extended with offender consent or following an administrative commitment hearing pursuant to paragraph (4) of this rule.
(4) Administrative commitments for offenders in the legal custody of the DOC and in the physical custody of the OYA will be accomplished through a hearing conducted by an OYA hearing officer in accordance with these rules. DOC offenders in OYA physical custody requiring mental health evaluation and treatment will be transferred directly from an OYA facility to a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Authority and returned directly to the OYA facility.
(5) The Authority will provide for an administrative commitment hearing conducted by a hearing officer employed or under contract with the OYA for administrative commitment or extension of the transfer of the offender if:
(a) The Authority determines that administrative commitment for treatment for a mental illness is necessary or advisable or that the Authority needs more than 30 days to stabilize or evaluate the offender; and
(b) The offender does not consent to the administrative commitment or an extension of the transfer.
(6) The administrative commitment hearing process will, at a minimum, include the following procedures:
(a) Not less than 24 hours before the administrative commitment hearing is scheduled to occur, the hearing officer will provide written notice of the hearing to the offender and the offender's parent/guardian if the offender is less than 18 years of age.
(b) The notice will include the following information:
(A) A statement that an administrative commitment to a state mental hospital listed in ORS 426.010 or a facility designated by the Authority, or an extension of the transfer, is being considered.
(B) A concise statement of the reason for administrative commitment or extension of the transfer.
(C) The offender's right to a hearing.
(D) The time and place of the hearing.
(E) Notice that the purpose of the administrative commitment hearing is to determine whether there is clear and convincing evidence that the offender is a mentally ill person as defined in ORS 426.005 such that administrative commitment or an extension of the transfer is warranted.
(F) The names of persons who have given information relevant to of the administrative commitment or extension of the transfer, and the offender's right to have these persons present at the administrative commitment hearing for the purposes of confrontation and cross-examination.
(G) The offender's right to admit or deny the allegations and present letters, documents, affidavits, or persons with relevant information at the administrative hearing in support of his/her defense or contentions, subject to the exclusions and restrictions provided in these rules.
(H) The offender's right to be represented by an attorney at his/her own expense. Assistance by a qualified and independent person approved by the hearing officer will be ordered upon a finding that assistance is necessary based upon the offender's financial inability to provide an assistant, language barriers, or competence and capacity of an offender to prepare a defense, to understand the proceedings, or to understand the rights available to him or her. An offender subject to an administrative commitment hearing may not receive assistance from another offender.

(I) A copy of this rule.
(c) The administrative commitment hearing will be held no more than five (5) days from the date of the written notice of the hearing.
(A) Prior to the commencement of the administrative commitment hearing, the hearing officer will furnish the offender a written explanation of the proceedings.
(B) The administrative commitment hearing will be conducted by a hearing officer employed or under contract with the OYA. The hearing officer will not have participated in any previous way in the assessment process.
(C) At the administrative commitment hearing, the offender will have an opportunity to be heard in person and through his/her attorney or independent assistant, if any.
(d) The administrative commitment hearing will be conducted in the following manner.
(A) Statement and evidence of the Authority in support of the action.
(B) Statement and evidence of the offender.
(C) Questioning, examination, or cross-examination of witnesses, unless in the opinion of the hearing officer an informant or witness would be subjected to risk of harm if his/her identity is disclosed.
(i) The offender's attorney or assistant, if any, may cross-examine witnesses, unless the hearing officer determines that it is necessary to deny cross-examination to preserve the anonymity of the witness.
(ii) If the offender has no attorney, the OYA Superintendent or designee will, if he/she has not already done so, appoint a qualified and independent person not directly involved with the offender, to cross-examine the witness for the offender. The hearing may be recessed if necessary for this purpose.
(D) The administrative commitment hearing may be continued with recesses as determined by the hearing officer.
(E) The hearing officer may set reasonable time limits for oral presentation and may exclude or limit cumulative, repetitious or immaterial evidence.
(F) The burden of presenting evidence to support a fact or position rests on the proponent of that fact or position. An offender may be administratively committed or the transfer extended only if the hearing officer finds by clear and convincing evidence that the offender is a mentally ill person as defined in ORS 426.005.
(G) Exhibits will be marked and the markings will identify the person offering the exhibit. The exhibits will be preserved by the OYA as part of the record of the proceedings.
(H) Evidentiary rules are as follows.
(i) Evidence of a type commonly relied upon by reasonably prudent persons in conduct of their serious affairs is admissible.
(ii) Irrelevant, immaterial, or unduly repetitious evidence will be excluded.
(iii) All offered evidence, not objected to, will be received by the hearing officer subject to his/her power to exclude irrelevant, immaterial, or unduly repetitious evidence.
(iv) Evidence objected to may be received by the hearing officer with rulings on its admissibility or exclusion to be made at the hearing or at the time a final order is issued.
(I) All testimony will be given under oath.
(J) The hearing officer may discontinue the commitment proceedings at any time and may return the offender to the OYA facility.
(7) The hearing officer will make a written summary of what occurs at the hearing, including the response of the offender and the substance of the documents or evidence given in support of administrative commitment.
(a) A mechanical recording of all oral testimony and presentations will be made. This tape may be reviewed by the hearing officer before any findings are determined, or in the event of a judicial review.
(b) Tapes will be kept at least 120 days after the final order is issued.
(8) The hearing officer will issue a written proposed order that contains:
(a) Rulings on admissibility of offered evidence and other matters;
(b) Findings of fact (each ultimate fact as determined by the hearing officer based on the evidence before it); and
(c) Conclusions and recommendations for action by the hearing officer.

(A) No Justification: The hearing officer may find that the evidence does not support placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Authority, in which case the hearing officer will recommend that the offender return to his or her former status with all rights and privileges of that status. The hearing record will be processed with final action subject to review by the Director of the Authority or designee. The findings must be on the merits. Technical or clerical errors in the writing or processing of the transfer request, or both, will not be grounds for a no justification finding, unless there is substantial prejudice to the offender.
(B) Justification: The hearing officer may find the evidence supports the offender's placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Authority, in which case the hearing officer will so inform the offender and recommend that the offender's administrative commitment exceed 30 days. The hearing record will be processed with final action subject to review by the Director of the Authority or designee. An offender's administrative commitment to a state mental hospital will not exceed 180 days unless the commitment is renewed in a subsequent administrative hearing in accordance with these rules.
(9) Hearing Record:
(a) Upon completion of a hearing, the hearing officer will prepare and cause to be delivered to the Director of the Authority or designee a hearing record within three (3) days from the date of the hearing.
(b) The hearing record will include:
(A) Examination reports
(B) Notice of hearing and rights;
(C) Recording of hearing;
(D) Supporting material(s); and
(E) Findings of Fact, Conclusions, and Recommendation of the hearing officer.
(10) The results of any hearing held to place an offender in a state mental hospital for administrative commitment will be reviewed and approved by the Director of the Authority or designee. The Director of the Authority or designee will review the Findings-of-Fact, Conclusions, and Recommendation of the hearing officer, in terms of the following factors:
(a) Was there substantial compliance with this rule;
(b) Was the decision based on substantial information; and
(c) Was the decision proportionate to the information and consistent with the provisions of this rule.
(11) Within three (3) days of the receipt of the hearing officer's report, the Director of the Authority or designee will enter an order, which may:
(a) Affirm the recommendation;
(b) Modify the recommendation;
(c) Reverse the recommendation; or
(d) Reopen the hearing for the introduction and consideration of additional evidence.
(12) When the Director of the Authority or designee takes action to modify or reverse, he or she must state the reason(s) in writing and immediately notify the offender, hearing officer, and the Superintendent of the sending OYA facility.
(13) When the Director of the Authority or designee reopens the hearing under this rule, the hearing officer will, pursuant to these rules, conduct the reopened hearing and prepare an amended hearing record within three (3) days of the reopened hearing. The Director of the Authority or designee will review the hearing officer's recommendation and enter an amended order, which may affirm, modify, or reverse the hearing officer's recommendation.
(14) Extension of Transfer: If the Authority determines that the administrative commitment must exceed 180 days in order to stabilize the offender; the administrative commitment must be renewed in a subsequent administrative commitment hearing held in accordance with these rules.
(15) Notwithstanding this rule, an administrative commitment may not continue beyond the term of legal custody to which the offender was sentenced.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508, 420.500-420.525
History: MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06; MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06

309-120-0200

Purpose

Purpose. These rules prescribe procedures by which inmates of Department of Corrections facilities may be transferred to a state mental hospital listed in ORS 426.010.

Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042

Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508

History: Renumbered from 309-120-0000, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06; MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(1) and (2); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; MHD 7-2005(Temp), f. & cert. ef. 7-7-05 thru 1-3-06

309-120-0205

Definitions

As used in these rules:

(1) "Department of Corrections Facility" means any institution, facility or staff office, including the grounds, operated by the Department of Corrections.

(2) "Inmate" means any person under the supervision of the Department of Corrections who is not on parole, probation, or post-prison supervision status.

(3) "Mentally Ill Inmate" means an inmate who, because of a mental disorder, is one or more of the following:

(a) Dangerous to self or others.

(b) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

(c) An inmate who:

(A) Is chronically mentally ill, as defined in ORS 426.495;

(B) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the Oregon Health Authority under ORS 426.060;

(C) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements referred to in subparagraph (3)(c)(B) of this rule; and

(D) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the inmate will become a person described under either or both subparagraph (3)(c)(A) or (3)(c)(B) of this rule.

(4) “State Mental Hospital” as defined in ORS 426.010. Except as otherwise ordered by the Oregon Health Authority pursuant to 179.325, the Oregon State Hospital in Salem, Marion County, and the Blue Mountain Recovery Center in Pendleton, Umatilla County, shall be used as state hospitals for the care and treatment of mentally ill persons who are assigned to the care of such institutions by the Authority or who have previously been committed to such institutions.

Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042

Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508

History: Renumbered from 309-120-0005, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06; MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(3); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; MHD 7-2005(Temp), f. & cert. ef. 7-7-05 thru 1-3-06

309-120-0210

Administrative Transfers (Mentally Ill Inmates)

(l) The Administrator of the Department of Corrections Counseling and Treatment Services Unit/designee may request the Superintendent/designee of a state mental hospital listed in ORS 426.010 to accept a transfer of a mentally ill inmate to a state mental hospital pursuant to these rules.

(2) An inmate may be transferred to a state mental hospital for stabilization and evaluation for mental health treatment for a period not to exceed 30 days unless the transfer is extended pursuant to a hearing conducted in accordance with these rules.

(3) If space is available and the Superintendent/designee of the state mental hospital approves, the inmate shall be transferred.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0215
Hearings Process
(1) The Oregon Health Authority shall provide for an administrative commitment hearing conducted by a hearings officer employed or under contract with the Department of Corrections for administrative commitment or extension of the transfer of the inmate if:
(a) The Oregon Health Authority determines that administrative commitment for treatment for a mental illness is necessary or advisable or that the Authority needs more than 30 days to stabilize or evaluate the inmate; and
(b) The inmate does not consent to the administrative commitment or an extension of the transfer.
(c) Inmates in the legal custody of the Department of Corrections and in the physical custody of the Oregon Youth Authority (OYA) will be administratively committed through an OYA hearing, pursuant to OAR 416-425-0020. Inmates in OYA physical custody will be transferred directly from an OYA facility to a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Authority and returned directly to the OYA facility.
(2) It is the responsibility of the Superintendent/designee of the Oregon State Hospital to notify the hearings officer of the need for a hearing and to provide him or her with a transfer request containing the evidence justifying such action.
(3) The hearing shall be conducted by an independent hearing officer.
(4) The hearings officer shall not have participated in any previous way in the assessment process.
(5) The hearings officer may pose questions during the hearing.
(6) The evidence considered by the hearings officer will be of such reliability as would be considered by reasonable persons in the conduct of their serious affairs.
(7) When confidential informant testimony is submitted to the hearings officer, the identity of the informant and the verbatim statement of the informant shall be revealed to the hearings officer in writing, but shall remain confidential.
(8) In order for the hearings officer to rely on the testimony of a confidential informant, information must be submitted to the hearings officer from which the hearings officer can find that the informant is a person who can be believed or that the information provided in the case at issue is truthful.
(9) At the conclusion of the hearing, the hearings officer will deliberate and determine whether by clear and convincing evidence that the inmate is a mentally ill person as defined in ORS 426.005 and will be administratively committed involuntarily to a state mental hospital. The hearings officer may postpone the rendering of a decision for a reasonable period of time, not to exceed three (3) working days from the date of the hearing, for the purpose of reviewing the evidence.
(10) An inmate subject to an administrative commitment to a state mental hospital has the rights to which persons are entitled under ORS 179.485.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0220
Representation
(1) In all cases, the inmate is entitled to:
(a) Speak in his or her own behalf; and
(b) Be present at all stages of the hearings process, except when the hearings officer finds that to have the inmate present would present an immediate threat to facility security or safety of its staff or others. The reason(s) for the finding shall be part of the record.

(2) Assistance by a qualified and independent person approved by the hearings officer will be ordered upon a finding that assistance is necessary based upon the inmate's financial inability to provide an assistant, language barriers, or competence and capacity of the inmate to prepare a defense, to understand the proceedings, or to understand the rights available to him or her. An inmate subject to an administrative commitment hearing may not receive assistance from another inmate.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0225
Notice of Hearing
(1) The inmate shall be given written notice that an administrative commitment to a state mental hospital listed in ORS 426.010, a hospital or facility designated by the Oregon Health Authority, or an extension of the transfer is being considered by the Department of Corrections and the Authority.
(2) The notice will be provided by the hearings officer. Such notice must be provided far enough in advance of the hearing to permit the inmate to prepare for the hearing, but in no case shall notice be provided less than 24 hours prior to the hearing. The hearing shall take place no later than five (5) days from the date of service of the notice.
(3) The notice shall include a copy of this rule.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0230
Investigation
(1) The inmate may request that an investigation be conducted. If an investigation is ordered, a designee of the hearings officer shall conduct the investigation. No person shall serve as an investigator who has participated in any previous way in the process.
(2) An investigation shall be conducted upon the inmate's request, if an investigation will assist in the resolution of the proceedings and the information sought is within the ability of the facility to procure or the inmate to provide with his or her own resources.
(3) The hearings officer may order an investigation on his or her own motion.
(4) The hearings officer shall allow the inmate access to the results of the investigation unless disclosure of the investigative results would constitute a threat to the safety and security of the facility, its staff or others, or to the orderly operation of the facility.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0235
Documents/Reports
(1) An inmate may present documents or reports during the hearing, subject to the exclusion and restrictions provided in these rules.
(2) The reporting employee or other agents of the Department of Corrections or Oregon Health Authority who are knowledgeable may submit to the hearings officer documents or reports in advance of the hearing that are being relied upon for the administrative commitment or extension of the transfer. Such evidence must be disclosed to the inmate during the hearing.
(3) The hearings officer may exclude documents or other evidence upon finding that such evidence would not assist in the resolution of the proceeding, or that such evidence would present an undue risk to the safety, security, and orderly

operation of the facility. The reason(s) for exclusion shall be made part of the record.
(4) Notwithstanding subsection (2) of this rule, the hearings officer may classify documents or other evidence as confidential, and not disclose such evidence to the inmate, upon finding that disclosure of psychiatric or psychological information would constitute a danger to another individual, compromise the privacy of a confidential source, or would constitute an immediate and grave detriment to the treatment of the individual, if medically contraindicated by the treating physician or a licensed health care professional in the written account of the inmate. The reason(s) for classifying documents or other evidence as confidential shall be made part of the record.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0240
Witnesses
(1) The hearings officer shall direct the scheduling and taking of testimony of witnesses at the hearing. Witnesses may include inmates, employees, or other persons. Testimony may be taken in person, by telephone, or by written report or statement.
(2) Except as provided in this subsection, a hearings officer must provide an inmate or his or her representative with the opportunity to call witnesses to testify before the hearings officer and to confront and cross-examine witnesses called by the state. The hearings officer may deny the opportunity provided in this rule upon a finding of good cause. Good cause includes, but is not limited to, an undue risk to the safety, security, or orderly operation of the facility or an immediate and grave detriment to the treatment of the individual due to disclosure of psychiatric or psychological information, if medically contraindicated by the treating physician or a licensed health care professional. The reason(s) for any denial of the opportunity to call witnesses or confront and cross-examine witnesses shall be made part of the record.
(3) If the inmate intends to call witnesses, the inmate must request that the hearings officer schedule witnesses to present testimony at the hearing. The request must be submitted to the hearings officer in writing in advance of the hearing, and include a list of the person(s) the inmate requests to be called to testify and direct examination questions to be posed to each person. The hearings officer shall arrange for the taking of testimony from such witnesses as properly requested by the inmate, subject to the exclusions and restrictions provided in these rules. The hearings officer, rather than the inmate, shall pose questions submitted by the inmate, including questions on cross-examination, if any. The hearings officer may briefly recess the hearing to allow the inmate, the inmate's assistant, or both, an opportunity to prepare cross-examination questions.
(4) The hearings officer may limit testimony when it is cumulative or irrelevant.
(5) All questions which may assist in the resolution of the proceedings, as determined by the hearings officer, shall be posed. The reason(s) for not posing a question will be made part of the record.
(6) The hearings officer may, on his or her own motion, call witnesses to testify.
(7) The hearings officer may exclude a specific inmate or staff witness upon finding that the witness' testimony would not assist in the resolution of the proceeding or presents an immediate undue hazard to facility security. If a witness is excluded, the reason(s) shall be made part of the record.
(8) The hearings officer may exclude other persons as witnesses, after giving reasonable consideration to alternatives available for obtaining witness testimony, upon finding that the witness' testimony would not assist the hearings officer in the resolution of the proceeding, the witness' appearance at the hearing would present an undue risk to the safety, security, or orderly operation of the facility or the safety of the witness or others, or that the witness is not reasonably available. The reason(s) for exclusion shall be made part of the record.
(9) Persons other than staff requested as witnesses may refuse to appear or testify.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0245

Postponement

(1) A hearing may be postponed by the hearings officer for good cause and for reasonable periods of time.
(2) Good cause includes, but is not limited to:
(a) Illness or unavailability of the inmate;
(b) Gathering of additional evidence; or
(c) Gathering of additional documentation.
(3) The reason(s) for the postponement shall be made part of the record.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0250

Findings

(1) No Justification: The hearings officer may find that the evidence does not support placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Oregon Health Authority, in which case the hearings officer will recommend that the inmate return to his or her former status with all rights and privileges of that status. The hearing record shall be processed with final action subject to review by the Superintendent/designee of the Oregon State Hospital. The findings must be on the merits. Technical or clerical errors in the writing or processing of the transfer request, or both, shall not be grounds for a no justification finding, unless there is substantial prejudice to the inmate.
(2) Justification: The hearings officer may find the evidence supports the inmate's placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Oregon Health Authority, in which case the hearings officer will so inform the inmate and recommend that the inmate's administrative commitment exceed 30 days. The hearing record shall be processed with final action subject to review by the Superintendent/designee of the Oregon State Hospital. An inmate's administrative commitment to a state mental hospital shall not exceed 180 days unless the commitment is renewed in a subsequent administrative hearing in accordance with these rules.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0255

Hearing Record

(1) Upon completion of a hearing, the hearings officer shall prepare and cause to be delivered to the Superintendent/designee of the Oregon State Hospital a hearing record within three (3) days from the date of the hearing.
(2) The record of the formal hearing shall include:
(a) Examination reports;
(b) Notice of hearing and rights;
(c) Recording of hearing;
(d) Supporting material(s); and
(e) "Findings-of-Facts, Conclusions, and Recommendation" of the hearings officer.
(3) The hearings officer will retain the recording and forward to the Superintendent/designee of the Oregon State Hospital items (2)(a), (2)(b), (2)(d), and (2)(e) of this rule.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0260

Superintendent's Review

(1) The results of any hearing held to place an inmate in a state mental hospital for administrative commitment will be reviewed and approved by the Superintendent/designee of the Oregon State Hospital.
(2) The Superintendent/designee of the Oregon State Hospital shall review the "Findings-of-Fact, Conclusions, and Recommendation" of the hearings officer, in terms of the following factors:
(a) Was there substantial compliance with this rule;
(b) Was the decision based on substantial information; and
(c) Was the decision proportionate to the information and consistent with the provisions of this rule.
(3) Within three (3) days of the receipt of the hearings officer's report, the Superintendent/designee of the Oregon State Hospital shall enter an "order," which may:
(a) Affirm the recommendation;
(b) Modify the recommendation;
(c) Reverse the recommendation; or
(d) Reopen the hearing for the introduction and consideration of additional evidence.
(4) When the Superintendent/designee of the Oregon State Hospital takes action to modify or reverse, he or she must state the reason(s) in writing and immediately notify the inmate, hearings officer, and Administrator for Counseling and Treatment Services.
(5) When the Superintendent/designee of the Oregon State Hospital reopens the hearing under this rule, the hearings officer shall, pursuant to these rules, conduct the reopened hearing and prepare an amended hearing record within three (3) days of the reopened hearing. The Superintendent/designee of the Oregon State Hospital shall review the hearing officer's recommendation and enter an amended "order," which may affirm, modify, or reverse the hearing officer's recommendation.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0265

Extension of Transfer

(1) If the Oregon Health Authority determines that the administrative commitment must exceed 180 days in order to stabilize the inmate, the administrative commitment must be renewed in a subsequent administrative commitment hearing held in accordance with these rules.
(2) Notwithstanding this rule, an administrative commitment may not continue beyond the term of incarceration to which the inmate was sentenced.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0270

Handling of Inmate Money and Personal Property

(1) When an inmate is transferred to a state mental hospital, the Department of Corrections shall send a check for the balance of the inmate's account to the business office of the state mental hospital.
(2) The inmate's personal property will be transferred from the Department of Corrections facility in accordance with standards and limitations set by the state mental hospital to which the inmate is transferred.
(3) When the inmate is returned to a Department of Corrections facility, the inmate's money and personal property, as allowed by the Department of Corrections Rules for Personal Property (Inmate) (OAR 291-117) and Trust Accounts (Inmate) (OAR 291-158), will be returned with the inmate. All property not allowed under the Department of Corrections rules for Personal Property (Inmate) shall be handled, controlled and disposed of in accordance with Oregon

Health Authority rules (309-108-0000 through 309-108-0020).
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: Renumbered from 309-120-0030, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06; MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(5); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00

309-120-0275

Visiting Privileges

(1) When an inmate is transferred to a state mental hospital, the Department of Corrections facility shall provide a copy of the inmate's approved list of visitors.
(2) All visitors shall be approved according to the state mental hospital's procedure.
(3) When an inmate is returned to a Department of Corrections facility, any new names added to the list will be subject to review and approval according to the Department of Corrections Rule on Visiting (Inmate) (OAR 291-127) before admission of new visitors will be allowed.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: Renumbered from 309-120-0035, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06; MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(5); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00

309-120-0280

Short-Term Transitional Leaves, Emergency Leaves and Supervised Trips

When an inmate is administratively transferred to a state mental hospital, no short-term transitional leaves, emergency leaves, or supervised trips shall be approved by the state mental hospital without approval of the functional unit manager of the Department of Corrections facility.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: Renumbered from 309-120-0040, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06; MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(6); MHD 1-2000, f. & cert. ef. 1-24-00

309-120-0285

Releases from a State Mental Hospital

An inmate who is transferred to a state mental hospital may be discharged and transferred back to a Department of Corrections facility for one of the following reasons:
(1) Completion of treatment;
(2) He/she could receive mental health services within the Department of Corrections, and there was a mutually agreed upon continuity of care plan developed by the state mental hospital and the Administrator of the Department of Corrections Counseling and Treatment Services Unit/designee; or
(3) He/she does not meet the requirements to continue treatment at a state mental hospital.
Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042
Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508
History: Renumbered from 309-120-0045, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06; MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-

81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(7); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00

309-120-0290

Reporting of Unusual Incidents

Reporting of unusual incidents involving inmates administratively transferred to a state mental hospital shall be handled in accordance with the Department of Corrections policy on Unusual Incident Reporting Process.

Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042

Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508

History: Renumbered from 309-120-0050, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06; MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(8); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00

309-120-0295

Confidentiality and Sharing of Information

(1) Department of Corrections records and other inmate information shall not be available to inmates or persons not employed by, nor under contract to, the Oregon Health Authority.

(2) Authority records and information will be handled in accordance with ORS 179.495, 179.505, 192.515, 192.517, and 42 CFR Part 2 relating to confidentiality of medical treatment records.

Statutory/Other Authority: ORS 179.040, 179.473, 179.479, 413.042

Statutes/Other Implemented: ORS 179.471-179.486, 179.495-179.508

History: Renumbered from 309-120-0055, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06; MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(9); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00