ALTERNATIVES TO STATE HOSPITALIZATION
Standards for Community Treatment Services for Children
309-032-0950
Purpose and Statutory Authority
(1) Purpose. These rules prescribe standards and procedures for community mental health treatment services for children within a comprehensive system of care. The system of care shall be child-centered and community-based with the needs of the child and family dictating the types and mix of services provided. These services may be as intensive, frequent and individualized as is medically necessary to sustain the child in treatment in the community. The provision of community mental health treatment services may require the treatment provider to work outside the clinic setting.
(2) Statutory Authority. These rules are authorized by ORS 430.041, ORS 743.556 and ORS 430.640(1)(h) to carry out the provisions of ORS 430.630.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96
309-032-0960
Definitions
As used in these rules:
(1) "Admission criteria" means the standards to be met for a child to be enrolled in and receive community treatment services.
(2) "Biopsychosocial" means the combination of biological, psychological and sociocultural factors that influence the child's development and/or functioning.
(3) "Case number" means the unique identification number assigned to each child. No more than one such number shall be assigned to the child and the number shall be identical for both the treatment record and Client Process Monitoring System enrollment. Once assigned, the case number must be retained for all subsequent admissions or periods of service for the child.
(4) "Child" or "Children" means a person or persons under the age of 18, or for those with Medicaid eligibility, under the age of 21.
(5) "Children's Global Assessment Scale" or "CGAS" means a scale used to measure and condense different aspects of a child's biopsychosocial functioning into a single clinically meaningful index of severity. The CGAS is an adaptation of the Diagnostic and Statistical Manual Global Assessment Scale for adults by the Department of Child Psychiatry, Columbia University, published in November 1982. The CGAS is recommended for use with children aged 4 through 16. The CGAS score is numerically quantified on Axis Five of the DSM multiaxial diagnosis.
(6) "Client Process Monitoring System" or "CPMS" means an automated data system maintained by the MHDDSD.
(7) "Clinical record" means the collection of all documentation regarding a child's mental health treatment. The record is a legal document. The clinical

record provides the basis by which the provider manages service delivery and quality assurance.
(8) "Clinical services coordination" means coordinating the access to, and provision of, services from multiple agencies according to the child's treatment plan; establishing crisis service linkages; advocating for the child's treatment needs; and providing assistance in obtaining entitlements based on a mental or emotional disability. To be eligible for Clinical Services Coordination, the enrolled child:
(a) Must have a severe and persistent mental disorder, which is not the result of conduct, substance abuse or mental retardation or other developmental disability, diagnosed on Axis I of a 5-Axes diagnosis;
(b) Must have documented mental or emotional symptoms that have been evident for one year or more, or are likely to continue for more than a year;
(c) Must have symptoms which have resulted in substantial functional limitations on two or more of the following areas of age appropriate development: role and task performance; cognition and communication; behavior toward self and others; and mood and emotions;
(d) Must have symptoms which result in a level of functioning of 49 or lower as scored on the CGAS or Global Assessment of Functioning Scale (GAF); and
(e) Must be at immediate risk of removal from home for mental health treatment or is returning home from a psychiatric inpatient or JCAHO accredited residential psychiatric treatment program.
(9) "Clinical supervision" means the documented oversight by a Qualified Mental Health Professional of mental health treatment services provided by a Qualified Mental Health Professional or Qualified Mental Health Associate. Clinical Supervision includes evaluating the effectiveness of the mental health treatment services provided. Clinical Supervision is performed on a regular, routine basis either individually or in a group setting at least once every three months.
(10) "Clinical supervisor" means a Qualified Mental Health Professional with two years post-graduate clinical experience in a mental health treatment setting who follows a professional code of ethics. The Clinical Supervisor, as documented by the Local Mental Health Authority, demonstrates the competency to oversee and evaluate the mental health treatment services provided by the Qualified Mental Health Professional or Qualified Mental Health Associate.
(11) "Community crisis services" means a system of urgent and emergency services of limited duration including screening, mental health assessment, and stabilization provided by every CMHP or its designated subcontractors 24 hours-a-day, seven days-a-week to respond to, and stabilize, children in mental health crisis.
(12) "Community Mental Health Program" or "CMHP" means the entity providing the services described in ORS 430.620 and ORS 430.630(3) for

persons with mental or emotional disorders, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the MHDDSD.
(13) "Community treatment services" means the full range of children's mental health services, except inpatient care, defined in ORS 430.630(3) and ORS 743.556.
(14) "Comprehensive mental health assessment" means a mental status exam and a biopsychosocial evaluation of a child's functioning in the following domains: emotional, cognitive, family, developmental, behavioral, social, physical, nutritional, school or vocational, substance abuse, cultural and legal, completed by a Qualified Mental Health Professional. The Comprehensive Mental Health Assessment concludes with a completed DSM five axes diagnosis followed by a clinical formulation and a comprehensive treatment plan. The Comprehensive Mental Health Assessment is revised and updated annually.
(15) "Consent to treatment" means the written agreement between the child's custodial parent or guardian, or by the child if age 14 or older, and the provider of mental health services, for the child to receive community mental health treatment services.
(16) "Consultation" is the planned professional advice about an enrolled child given by the Qualified Mental Health Professional to another professional involved in the child's treatment. Consultation is specific to goals and objectives in the child's treatment plan and is documented in the progress notes.
(17) "Continued stay criteria" means the standards to be met for a child to remain in community mental health treatment.
(18) "Crisis" means either an urgent or emergency situation that occurs when a child's mental or emotional stability or functioning is disturbed by a critical event in the child's environment and there is an immediate need to resolve the situation to prevent a serious deterioration in the child's condition.
(19) "Crisis stabilization" means the provision of appropriate child and family, psychological, and psychiatric and other medical interventions in the most normative setting possible for the child, and any placements necessary to protect and stabilize the child as quickly as possible.
(20) "Critical incident" means an incident as a result of staff action or inaction that punishes, endangers or otherwise harms a child enrolled in a community mental health program service.
(21) "Custodial parent" means the parent or parents having legal custody of the child.
(22) "Custody" means the legal care and supervision of the child by the person, agency or institution having the authority to authorize ordinary medical, psychiatric, psychological and other remedial care and treatment

for the child. Under ORS 418.312, custodial parents are not required to transfer legal custody of a child to the State Office for Services to Children and Families (SCF) in order to have the child placed in an SCF-contracted foster home, group home, residential or other institutional child care setting when the sole reason for the placement is the need to obtain services for the child's emotional, behavioral or mental disorder.
(23) "Diagnosis" means the principal mental disorder listed in the DSM, that is the medically necessary reason for clinical care and the main focus of treatment. The principal diagnosis is determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment. A DSM "V" code condition, substance use disorder or mental retardation is not considered the principal diagnosis although these conditions or disorders may co-occur with the diagnosable mental disorder.
(24) "Direct supervision" means the directing and coordinating by the QMHP of interventions performed by the Qualified Mental Health Associate (QMHA). Direct supervision also means reviewing and evaluating the documentation of all interventions performed by the QMHA. Direct supervision is performed on a regular, routine basis either individually or in a group setting.
(25) "Discharge criteria" means the standards to be met to complete service provision.
(26) "Discharge summary" means written documentation of the last service contact with the child, the diagnosis at enrollment, a summary statement that describes the effectiveness of treatment modalities and progress, or lack of progress, toward treatment objectives while in service. The discharge summary also includes the reason for discharge, changes in diagnosis during treatment, current level of functioning and prognosis and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.
(27) "DSM" means the fourth edition of the "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association.
(28) "Early and Periodic Screening, Diagnosis and Treatment" or "EPSDT" means the preventive and remedial medical care program for eligible persons under 21 years of age who are enrolled in the state's Medicaid program.
(29) "Emergency" means the sudden onset of acute psychiatric symptoms requiring attention within 24 hours to prevent a serious deterioration in a child's mental condition.
(30) "Enrollment" means, for a CMHP or CMHP subcontractor, the act of opening a clinical record for a child who is not currently receiving services. The date of enrollment is the first face to face treatment session with the

child or the child's family. Enrollment documentation includes the completed CPMS enrollment form. For children eligible to receive services from a Fully Capitated Health Plan or Mental Health Organization, enrollment means signing on with a fully capitated health plan or mental health organization under contract with the MHDDSD.
(31) "Five axes diagnosis" means the multiaxial system of evaluation in the DSM organized to provide a biopsychosocial approach to assessment and to ascertain that all of the information necessary for planning treatment and predicting outcomes for the child is recorded on each of five axes. The principal diagnosis is recorded on Axis I, any description of mental retardation or personality features on Axis II, physical disorders or conditions on Axis III, severity of psychosocial stressors on Axis IV, and the global assessment of functioning on Axis V.
(32) "Fully Capitated Health Plan" or "FCHP" means a prepaid health plan under contract with the MHDDSD and Office of Medical Assistance Programs to provide capitated physical and mental health services.
(33) "Global Assessment of Functioning Scale" or "GAF" means a scale in the DSM used to measure and condense different aspects of biopsychosocial functioning in adolescents 17 and older and adults into a single clinically meaningful index of severity of disorder. The GAF score is numerically quantified on Axis Five of the DSM multiaxial diagnosis.
(34) "Goal" means an expected result or condition to be achieved, is specified in a statement of relatively broad scope, provides a guideline for the direction of care and is related to an identified clinical problem.
(35) "Guardian" means a parent, other person or agency legally in charge of the affairs of a minor child and having the authority to make decisions of substantial legal significance concerning the child.
(36) "Informed consent to treatment" means that the information about a specific diagnosis and the risks or benefits of treatment options and the consequences of not receiving a specific treatment are understood by the child, if able, and the parent or guardian, if involved. The person consenting to treatment voluntarily agrees in writing, as required in ORS 430.210(d), to a prescribed treatment for the specific diagnosis.
(37) "Level of care" means the range of available mental health services provided from the least restrictive and least intensive in a community-based setting to the most restrictive and most intensive in an inpatient setting. As required in ORS 430.210(a), children are to be served in the most normative, least restrictive, least intrusive level of care appropriate to their treatment history, degree of impairment, current symptoms and the extent of family or other supports.
(38) "Level of functioning" means the description and numeric quantification on Axis V of a DSM diagnosis of the effectiveness of a child's ability to achieve or maintain developmentally appropriate behavior in one or more of the following areas: role and task performance, cognition and

communication, behavior toward self and others, and mood and emotions as measured against age appropriate norms.
(39) "Licensed Medical Practitioner" means any person who meets the following minimum qualifications as documented by the Local Mental Health Authority 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;
(C) Physician's Assistant licensed to practice in the State of Oregon; and
(b) Whose training, experience and competence demonstrates the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.
(c) When the LMP is not a psychiatrist, the LMP shall have access to consultation services provided by a psychiatrist, preferably a child psychiatrist, either through direct employment by the provider or through written contract between the provider and the consulting psychiatrist.
(40) "Local Mental Health Authority" or "LMHA" means the county court or board of county commissioners of one or more counties who choose to operate a county mental health program or choose to operate an MHO; or, in the case of a Native American reservation, the tribal council; or, if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation which contracts with the MHDDSD to operate a CMHP or MHO for that county.
(41) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to poor and indigent persons. Medical assistance programs cover both health and mental health care for children and adults. Some services, such as EPSDT, are required to be provided by the state. Other services, such as case management, are optional.
(42) "Medicaid Authorization Specialist" or "MAS" means the Qualified Mental Health Professional designated at the county or regional level to determine the mental health needs of children requesting services, or for whom services are requested, and to authorize the provision of mental health services identified in the Service Authorization Form for Medicaid-eligible children.
(43) "Medical necessity" means the determination by a Licensed Medical Practitioner operating within the scope of his or her license, training and experience, that a service is reasonably necessary to diagnose, correct, cure, alleviate, rehabilitate or prevent the worsening of a disabling mental disorder. Medically necessary services must be consistent with standards of good practice, generally recognized by the professional community as effective, and there must also be no other equally effective, more

conservative, or less costly course of treatment available or suitable for the person requesting the service.
(44) "Medication service record" means the documentation of written or verbal orders for medication, laboratory, and other medical procedures issued by a Licensed Medical Practitioner employed by, or under contract with, the provider and acting within the scope of his or her license. The provision of medication services is documented in written progress notes and placed in the client's record.
(45) "Mental Health and Developmental Disability Services Division" or "MHDDSD" means the Department of Human Resources Agency responsible for the administration of state mental health and developmental disabilities programs and the mental health and developmental disabilities laws of the state.
(46) "Mental health assessment" means the documentation by a QMHP of the child's presenting mental health problem(s) and relevant child and family history, mental status examination and DSM five axis diagnosis or provisional diagnosis.
(47) "Mental Health Organization" or "MHO" means an entity under a risk bearing contract with the MHDDSD to provide mental health services on a prepaid, capitated basis.
(48) "Mental status examination" means the face-to-face assessment by a QMHP of a child's mental functioning within a developmental and cultural context that includes descriptions of appearance, behavior, speech, language, 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, concentration, general knowledge, intellectual ability, abstraction abilities, judgment, and insight appropriate to the age of the child.
(49) "Minor child" means an unmarried person under the age of 18.
(50) "Non-custodial parent" means a parent whose custodial responsibilities have been removed by the court by divorce decree. Under ORS 107.154, and unless otherwise ordered by the court, non-custodial parents have the same rights to consult with any person who may provide care and treatment for the child and to inspect and receive the child's medical and psychological records to the same extent as the custodial parent. The non-custodial parent may also authorize emergency medical, psychological and psychiatric or other health care if the custodial parent is unavailable.
(51) "Nurse Practitioner" means a Registered Nurse who has a graduate degree in nursing and is certified by the Oregon State Board of Nursing as qualified to practice as a Psychiatric/Mental Health Nurse Practitioner.
(52) "Objective" means the written statement of an expected result or condition that is related to the attainment of a goal. The objective is stated in measurable terms, has a specified time for accomplishment, and describes what services or activities are needed, how frequently they are needed and

the primary Qualified Mental Health Professional who will be coordinating them.
(53) "Physician" means a Medical Doctor or a Doctor of Osteopathy licensed to practice in Oregon. For these rules, a physician is preferably a Board-Certified Child Psychiatrist.
(54) "Plan of correction" means a written document which specifies actions that a provider will take to come into compliance with these rules.
(55) "Progress note" means the written documentation of the clinical course of treatment. Progress notes become the basis for review and revision of the treatment plan and the treatment provided. Progress notes shall document the specific treatment service rendered, the child's response to the specific treatment service, the date the service was provided, the setting, who performed the service, who was present, and the amount of time taken to provide the service. A progress note concludes with the signature, educational credentials of the person providing the service, and the date the note was signed.
(56) "Provider" means a CMHP, CMHP subcontractor, FCHP or MHO which is contractually affiliated with the MHDDSD and is responsible for the direct delivery of children's mental health services, or an agency providing services under ORS 743.556.
(57) "Provisional diagnosis" means a statement on Axis I of a DSM diagnosis when there is a strong presumption that the full criteria for the diagnosis will ultimately be met.
(58) "Psychiatrist" means a physician who is Board-Eligible or Board-Certified in psychiatry and licensed in the State of Oregon.
(59) "Qualified Mental Health Associate" or "QMHA" means a person who delivers services under the direct supervision of a Qualified Mental Health Professional and who meets the following minimum qualifications as documented by the Local Mental Health Authority or designee:
(a) Has a bachelor's degree in a behavioral sciences field, or a combination of at least three years work, education, training or experience; and
(b) Has the competencies necessary to:
(A) Communicate effectively;
(B) Understand mental health assessment, treatment and service terminology and to apply the concepts;
(C) Provide psychosocial skills development; and
(D) Implement interventions prescribed on a treatment plan.
(60) "Qualified Mental Health Professional" or "QMHP" means a Licensed Medical Practitioner or any other person who meets the following minimum qualifications as documented by the Local Mental Health Authority or designee:
(a) Holds any of the following educational degrees:
(A) Graduate degree in psychology;
(B) Bachelor's degree in nursing and licensed by the State of Oregon;

(C) Graduate degree in social work;
(D) Graduate degree in a behavioral science field;
(E) Graduate degree in recreational, music, or art therapy;
(F) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and
(b) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise a treatment plan; conduct a Comprehensive Mental Health Assessment and provide individual, family and/or group therapy within the scope of their training.
(61) "Quality assurance" means the structured, internal monitoring and evaluation process to:
(a) Identify aspects of quality care;
(b) Use indicators and clinical criteria to continually and systematically monitor these aspects of care;
(c) Establish markers which indicate problems or opportunities to improve care;
(d) Take action to correct problems and improve substandard care;
(e) Assess the effectiveness of the actions; and
(f) Document the improvements in care.
(62) "Service coordination plan" means the written record of the services provided for children with a severe and persistent mental disorder by the social service agencies serving the child.
(63) "Severe and persistent disorder" means an emotional, mental, and/or neurobiological impairment which is manifested by emotional or behavioral symptoms that are not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism and which continues for more than one year, or on the basis of a specific diagnosis is likely to continue for more than one year.
(64) "Setting" means the location at which community-based mental health treatment services are provided and includes the CMHP office, the child's residence or other identified location.
(65) "Substantial compliance" means a level of adherence to MHDDSD rules applicable to the operation of a service that warrants certification by the MHDDSD as set forth in OAR 309-012-0000 through 309-012-0220.
(66) "System of care" means the comprehensive array of mental health and other necessary services which are organized to meet the multiple and changing needs of children with mental disorders.
(67) "Treatment" means the planned, medically necessary, individualized program of medical, psychological, and/or rehabilitative procedures, experiences and activities for a child designed to remediate symptoms of a

principal mental or emotional disorder diagnosed on Axis I of a five-axes DSM diagnosis. The principal disorder and the child's level of functioning are the reasons for treatment and the focus of the clinical interventions provided. The need for treatment is determined by a mental health assessment. Treatment is provided by a QMHP or QMHA.
(68) "Treatment plan" means the written documentation of the child's individualized treatment goal(s), measurable objectives and treatment services to be provided. The treatment plan is developed jointly by the QMHP and the child with his or her parent(s) or guardian, if appropriate. The treatment plan also includes the frequency and duration of the services and the QMHP who is coordinating the services.
(69) "Urgent" means the onset of psychiatric symptoms requiring attention within 72 hours to prevent a serious deterioration in a child's mental condition.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
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309-032-0970

General Provisions of the System of Care for Children's Community Mental Health Services

The Local Mental Health Authority or designee shall have in place a system of care for children's community mental health services. The Local Mental Health Authority or designee shall:
(1) Establish and maintain comprehensive mental health services for children as defined in ORS 430.630(3);
(2) Assure that mental health services are provided under clinical supervision;
(3) Hold a valid Certificate of Approval issued by the MHDDSD to provide Community Mental Health Treatment Services for Children;
(4) Demonstrate fiscally responsible practices;
(5) Manage the costs of mental health services as required by the MHDDSD;
(6) Assure each subcontractor is in compliance with standards and procedures prescribed in these rules;
(7) Monitor quality assurance and utilization review findings;
(8) Inform the MHDDSD by telephone and in writing within one working day of any critical incident affecting a child and propose the course of action to be taken by the CMHP to investigate or otherwise resolve the incident;
(9) Report suspected child abuse per ORS 419B.010;
(10) Assist children in obtaining and retaining benefits to which they are entitled, including Medicaid and Supplemental Security Income (SSI);
(11) Enroll children in the Client Process Monitoring System when the child's mental health services are funded all or in part by MHDDSD funds, unless the specific service the child receives is provided by an FCHP or MHO whose contract with the MHDDSD does not require enrollment;

(12) Operate programs that value diversity, cultural competence, and have the capacity for cultural self-assessment;
(13) Encourage family involvement in the child's treatment and advocacy on the child's behalf; and
(14) Provide community treatment services for children in a smoke free environment.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
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309-032-0980

Community Treatment Services

Community treatment services are rehabilitative in nature and may be provided to children outside the clinic setting. Treatment services must be based on sound clinical theory and recognized and widely accepted as clinically appropriate methods of treatment by qualified professionals in the mental health field. At a minimum, the LMHA or designee shall make the following services available in accordance with ORS 430.630:
(1) Community Crisis Services. At a minimum, children's community crisis services shall consist of:
(a) 24 hour, seven days per week face-to-face or telephone screening to determine the need for immediate services for any child requesting assistance or for whom assistance is requested;
(b) 24 hour, seven days per week capability to conduct, by or under the supervision of a QMHP, a mental health status examination to determine the child's condition and the interventions necessary to stabilize the child;
(c) A mental health assessment concluding with written recommendations by the QMHP regarding the need for further treatment;
(d) Provision of appropriate child and family, psychological, and psychiatric services necessary to stabilize the child as quickly as possible;
(e) Referral to the appropriate level of care and linkage to other medical interventions necessary to protect and stabilize the child as quickly as possible; and
(f) Linkage to appropriate social services.
(2) Mental health assessment.
(3) Individual, family and group therapies.
(4) Individual and group psychosocial skill development.
(5) Consultation with professionals involved with the child's treatment.
(6) Psychiatric services as needed for each child.
(7) Medication management and monitoring.
(8) Service planning and coordination.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-0990

Children's Community Treatment Services Admission Criteria
Admission to community treatment services shall be prioritized as follows:
(1) For mental health crisis services:
(a) Any child whose level of functioning indicates an emergency psychiatric condition;
(b) Any child whose level of functioning indicates an urgent psychiatric condition.
(2) For community based mental health treatment services:
(a) Children who, in accordance with the assessment of professionals in the mental health field:
(A) Are at immediate risk of psychiatric hospitalization or removal from home due to a mental or emotional disorder;
(B) Exhibit behavior which indicates high risk of developing disorders of a severe or persistent nature; or
(C) Have a severe mental or emotional disorder.
(b) Any other child who is experiencing mental or emotional disorders which significantly affect the child's ability to function in everyday life, but not requiring hospitalization or removal from home in the near future.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96
309-032-1000
Levels of Care Criteria
Children shall be served in the least restrictive, least intensive setting appropriate to their treatment history, degree of impairment, current symptoms and the extent of family and other supports. The QMHP must recommend the appropriate level of care to the child and parent or guardian when a more restrictive or less restrictive level of care is determined to be medically necessary. The following criteria are to be used to determine the appropriate level of care:
(1) Community based outpatient services. These services may be provided in clinic, home, school, or other settings familiar to and comfortable for the child.
(a) Admission.
(A) Child has a principal diagnosis on Axis I of a completed five-Axes DSM diagnosis; and
(B) Child does not immediately require more restrictive or intensive services.
(b) Continued Stay. At least one of the following is met:
(A) Child is making observed progress toward identified treatment goals as documented in the treatment plan, but treatment goals have not been reached.

(B) Child made no documented progress toward treatment goals, but the treatment plan has been modified based on a clarification of the nature of the identified problems and a re-evaluation of the child's treatment needs.
(C) Child exhibits new symptoms which can be safely and effectively treated at an outpatient level of care. The treatment plan has been revised accordingly.
(c) Discharge.
(A) Child's targeted symptoms have abated as documented by the attainment of goals in the treatment plan; or
(B) Child exhibits new symptoms which may not be safely or effectively treated at an outpatient level of care; and
(C) Child meets admission criteria for a more intensive or restrictive level of care; or
(D) Child is not benefitting from treatment and made no progress toward treatment goals in the last three months, even though appropriate treatment plan reviews and revisions were conducted.
(2) Community based treatment in residential settings. These services may be provided in settings such as Oregon Youth Authority or State Office for Services to Children and Families (SCF) contracted proctor care, therapeutic group homes, treatment foster care and residential facilities co-managed by MHDDSD.
(a) Admission.
(A) Child has a principal diagnosis on Axis I of a completed 5-Axes DSM diagnosis; and
(B) Child's condition is not manageable in the child's current living situation; or
(C) Child cannot reside at home due to the family's level of functioning; and
(D) Child needs treatment provided in a structured, supervised setting; and
(E) Less restrictive or less intensive services are not adequate to meet the child's treatment needs based on:
(i) Documented lack of response to prior treatment; or
(ii) The clinical judgment of the Medicaid Authorization Specialist (MAS) or the CMHP-designated QMHP and the treatment team working with the child.
(b) Continued Stay. At least one of the following is met:
(A) Child is making observed progress toward identified treatment goals as documented in the treatment plan, but treatment goals have not been reached.
(B) Child made no documented progress toward treatment goals, but the treatment plan has been reviewed and modified in order to reevaluate the child's treatment needs, clarify the nature of the identified problems, and/or to initiate new therapeutic interventions; or

(C) Child exhibits new symptoms or maladaptive behaviors that justify continuation and can be safely and effectively treated at an outpatient level of care. The treatment plan has been revised accordingly; and
(D) Child's continued stay has been reviewed and approved by the MAS or designated QMHP every three months.
(c) Discharge.
(A) Child's targeted symptoms and maladaptive behaviors have abated to the baseline level as documented by the attainment of goals in the treatment plan; or
(B) Child exhibits new symptoms and maladaptive behaviors which may not be treated safely or effectively at a community based residential level of care; or
(C) Child is not benefitting from treatment and made no progress toward treatment goals in the last six months even though appropriate treatment plan reviews and revisions were conducted.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
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309-032-1010

Medical Involvement

(1) A comprehensive mental health assessment shall be provided for:
(a) Children with a severe and persistent mental disorder for whom Service Coordination Plans have been developed and who receive Clinical Services Coordination; and
(b) Children who remain in service for at least one year.
(2) The comprehensive mental health assessment shall be maintained in the child's clinical record and shall be updated annually.
(3) A Licensed Medical Practitioner who is either a nurse practitioner or a physician will review and approve each comprehensive mental health assessment and treatment plan required by OAR 309-032-1010(1). The Licensed Medical Practitioner's approval indicates the Medical Necessity of the services.
(4) Children with a severe and persistent mental disorder for whom Service Coordination Plans have been developed and who receive Clinical Services Coordination shall have additional consultation with a Licensed Medical Practitioner who is either a nurse practitioner or a physician within six months of the comprehensive mental health assessment. The consultation documentation shall indicate the Medical Necessity of the continuing services and include one of the following:
(a) A written summary of a consultation between a Licensed Medical Practitioner who is either a nurse practitioner or a physician and the QMHP covering the following criteria:

(A) Symptoms or behaviors persist at a level of severity documented upon admission and the projected time frame for attainment of treatment goals has not been reached as documented in the treatment plan; or
(B) The child's and/or family's progress toward identified treatment goals for this level of care has been documented but not all treatment goals have been reached; or
(C) No progress toward treatment goals has been documented and the treatment plan has been modified to introduce further evaluation in order to clarify the nature of the identified problems and/or new therapeutic interventions have been initiated; or
(D) New symptoms or maladaptive behaviors have appeared while the child is in treatment. Treatment of these symptoms and behaviors has been incorporated into a revised treatment plan. The new symptoms and/or maladaptive behaviors justify continuation of treatment and may be treated safely and effectively with this level of care; or
(b) A written summary of a face-to-face psychiatric or clinical mental health assessment performed by a Licensed Medical Practitioner who is either a nurse practitioner or a physician.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1020

Service Coordination Plan

A Service Coordination Plan shall be developed by the provider for any child with a severe and persistent mental disorder who receives Clinical Services Coordination. The Service Coordination Plan shall include:
(1) A listing of any other providers of the child's mental health services along with the amount, duration, and scope of each provider's services; and
(2) A brief description of the child's service planning in the following domains: legal, education, family, physical health, and social.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1030

Children's Rights

Children and their families receiving mental health care under these rules are entitled to all rights in applicable Oregon Revised Statutes and Oregon Administrative Rules. The rights listed below shall be visibly posted and shall be explained, both verbally and in writing, by the provider to the person legally giving consent to treatment of the child at the time of enrollment.
(1) Consent to treatment. A custodial parent or legal guardian, or a minor child under conditions described below, must give written informed consent to diagnosis and treatment.

(a) Minor children can give informed consent in the following circumstances:
(A) Under age 18 and lawfully married.
(B) Age 16 or older and legally emancipated by the court.
(C) Age 14 or older for outpatient diagnosis and treatment for a mental or emotional disorder. For purposes of informed consent, outpatient treatment does not include treatment provided in residential facilities or in day or partial hospitalization programs.
(b) If the child is initially served in a crisis situation, these rights shall be explained as soon as clinically practical, but not more than five working days from the initiation of services if the child who received the crisis service remains in service.
(2) The custodial parent or legal guardian of any minor, age 14 or older who has consented to outpatient treatment or diagnosis, shall be involved before the end of treatment unless:
(a) The parents refuse;
(b) There are clear clinical indications to the contrary;
(c) The child has been sexually abused by the parent; or
(d) The child has been legally emancipated by the court or has been self sustaining for 90 days prior to obtaining treatment. As required in ORS 109.675, such refusal or the reasons for exclusion must be documented in the child's clinical record.
(3) Services refusal. The person giving consent to treatment has the right to refuse service, including any specific treatment procedure. If serious consequences may result from refusing a service, the consequences must be explained verbally and in writing by the provider to the custodial parent, guardian or child who is refusing service. Service refusal shall be documented in the clinical record.
(4) Grievances. The child or the person consenting to the child's treatment has the right to lodge an oral or written complaint or file a grievance with the entity providing treatment services. All service providers will:
(a) Have written procedures for accepting, processing and responding to oral or written complaints and grievances. The procedures must include:
(A) The process for registering an oral or written complaint or grievance;
(B) The time lines for processing an oral or written complaint or grievance; and
(C) Notification of the appeals process, including time lines for an oral or written complaint or grievance and the provision of the appropriate appeal forms.
(b) Designate a staff person to receive complaint or grievance information and enter the information into a log. The log will identify, at a minimum, the person lodging the complaint or grievance, the date of the complaint or grievance, the nature of the complaint or grievance, the resolution and the date of the resolution.

(c) Have written procedures for informing children and their legal guardian(s) orally and in writing about the provider's complaint or grievance procedures.
(d) Have written procedures for processing an expedited complaint request if it is believed that the child's health is at risk. A request for expedited complaint must be filed by the child or the person consenting to the child's treatment and must include the following:
(A) A statement that this is a request for an expedited complaint;
(B) An explanation of the urgency of resolving the issue; and
(C) A description of the consequences of following the regular complaint process.
(5) Service denial. The child or the person consenting to treatment on behalf of the child, has the right to appeal when a service has been denied. All providers must have written procedures as described in OAR 309-032-1030(4) for accepting, processing and responding to service denial complaints. In addition to the procedures described in OAR 309-032-1030(4), providers must respond in writing to the complaint within five working days of the complaint. The written response must include:
(a) The service requested;
(b) A statement of service denial;
(c) The basis for the denial; and
(d) Notification of the appeals process including the required time frame to file an appeal and provision of the appropriate appeal forms.
(6) Hearing request. All providers must include in their written appeals process the right of the Medicaid-eligible child, or the person consenting to treatment for the child, to file a request for hearing as a result of a denial of service or an adverse finding against a complainant in accordance with OAR 309-016-0140 through 309-016-0210.
(7) Access to clinical records. The person consenting to treatment, usually the custodial parent or guardian, has the right of access to the child's clinical record. A copy of the record is to be provided within five working days of requesting it. The person requesting the record is responsible for payment for the cost of duplication.
(8) Informed participation in treatment planning. The child, if appropriate, and the custodial parent or legal guardian and others of their choosing, shall have the opportunity to participate in an informed way in the treatment planning process for the child, and in the review, at least every three months, of the child's progress toward treatment goals and objectives. At a minimum, the following information should be discussed:
(a) Treatment and other interventions to be undertaken;
(b) Alternative treatments or interventions available, if any;
(c) Projected time to complete the treatment process;
(d) Benefits which can reasonably be expected; and
(e) Risks that may be involved in treatment, if any.

(9) Confidentiality. No records or information regarding the child which are made confidential by ORS 179.505, 45 CFR 205.50, 42 CFR Part 2 or any other applicable confidentiality law shall be disclosed except as permitted by the applicable law.
(10) Informed consent to fees for services. The amount and payment schedule of any fees to be charged must be disclosed in writing and agreed to by the person consenting to treatment.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1040

Establishment and Maintenance of Clinical Records

(1) Individuality and maintenance of clinical records. A separate, individualized clinical record shall be opened and maintained for each child served by a provider.
(2) Organization of clinical records. Each clinical record shall be uniform in organization, readily identifiable and accessible, and contain all of the components required by these rules in a current and complete manner.
(3) Signature of authors. All documentation required in this rule must be signed by the staff providing the service and making the entry. Signature must include the person's academic degree or professional credential and the date signed.
(4) Documentation of informed consent. All procedures in these rules requiring consent and the provision of such information to the consenting custodial parent or guardian or where appropriate, the child, shall be documented in the clinical record on forms describing what the child or adult giving consent has been informed of, and asked to consent to, and signed and dated by the consenting person. If the provider does not obtain the required documentation, the reasons must be specified in the clinical record and signed by the qualified supervisor of the person responsible for provision of treatment services to the child.
(5) Error corrections. Errors in the clinical record shall be corrected by lining out the incorrect data with a single line in ink, and then adding the correct information, the date corrected, and the initials of the person making the correction. Errors may not be corrected by removal or obliteration.
(6) Confidentiality of other clients. References to other persons being treated by the CMHP, CMHP subcontractors, FCHP or MHO when included in the child's clinical record shall preserve the confidentiality of the other clients.
(7) Security. Clinical records shall be secured, safeguarded, stored, and retained in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.
(8) Confidentiality of records. All clinical records are confidential to the extent provided for in 309-032-1030(9).

Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1050

Clinical Record Documentation Requirements

The child's clinical record shall contain adequate written information which is readily accessible and uniformly placed in the clinical record to document the diagnosed mental disorder and the child's need for treatment for the diagnosis. The documentation shall include:
(1) CPMS enrollment data if required by OAR 309-032-0960(30);
(2) Identifying data including child's name, date of birth, sex, address, phone number, and name of parent(s) or legal guardian including an address and phone number if different.
(3) A mental health assessment;
(4) An individualized treatment plan;
(5) Written discharge criteria;
(6) A comprehensive mental health assessment as required in OAR 309-032-1010.
(7) A Service Coordination Plan as required by OAR 309-032-1020.
(8) Written progress notes for each service provided;
(9) A written discharge summary; and
(10) A medication service record if medication is prescribed on the treatment plan.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1060

Quality Assurance Requirements

Providers will have a planned, systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to children and families. Providers will implement a Quality Assurance system which will assure compliance with the provisions of OAR 309-032-0950 through 309-032-1080. The Quality Assurance system shall include a Quality Assurance Committee and a Quality Assurance Plan which together implement a continuous cycle of measurement, assessment and improvement of clinical outcomes based on input from service providers and representatives of the children and families served.
(1) The Quality Assurance Committee shall carry out the Quality Assurance Plan and shall be the catalyst for improvement in the organization's clinical outcomes. The Quality Assurance Committee shall be composed of:
(a) One or more QMHPs, including an LMP who is preferably a child psychiatrist, who are representative of the scope of services delivered;
(b) A representative or representatives of the children and families served;

(c) Other persons who have the ability to identify, design, measure, assess and implement clinical and organizational changes.
(2) The Quality Assurance Committee duties shall:
(a) Identify indicators of quality;
(b) Identify measurable and time-specific performance objectives;
(c) Identify data sources to measure performance;
(d) Develop a process to systematically collect outcome data and identify staff who will collect and analyze data;
(e) Oversee the data collection process;
(f) Analyze the information collected and measure progress toward performance objectives;
(g) Identify clinical and operational changes necessary to achieve performance objectives;
(h) Implement clinical or operational changes that are indicated by the achievement or non-achievement of performance objectives; and
(i) Reassess and, if necessary, revise objectives and methods to measure performance on an ongoing basis.
(3) The Quality Assurance Committee shall meet at least quarterly.
(4) The written Quality Assurance Plan shall describe the implementation and ongoing operation of the functions performed by the Quality Assurance Committee. The Quality Assurance Plan shall include:
(a) A description of the Quality Assurance Committee's authority to identify and implement clinical and organizational changes;
(b) The composition and tenure of the Quality Assurance Committee;
(c) The schedule of Quality Assurance Committee meetings;
(d) The policies and procedures for identifying and using objective and measurable performance objectives.
(e) The policy and procedures for identifying and using data sources;
(f) The indicators of quality in the following domains:
(A) Access to services;
(B) Quality of care;
(C) Integration and coordination; and
(D) Outreach and prevention.
(g) The policies and procedures for reporting, tracking, investigating, and analyzing reports of critical incidents;
(h) The policies and procedures for both reviewing documentation and determining that the staff have the required competencies and credentials to perform assigned duties and meet the provider's performance objectives;
(i) The policies and procedures to manage utilization of services;
(j) The policies and procedures for reviewing complaint and grievance information; and
(k) The policies and procedures for clinical record reviews.

(5) A written summary of the pertinent facts and conclusions of each Quality Assurance Committee meeting will be maintained and be available for review by the MHDDSD, CMHP, MHO or FCHP.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1070

Certificate of Approval to Provide Community Based Mental Health Treatment Services

Providers of community mental health outpatient children's mental health services and providers operating under ORS 743.556 must be in compliance with OAR 309-032-0950 through 309-032-1080 and must hold a valid Certificate of Approval to provide Community Mental Health Treatment Services for Children from the MHD DSD as described in OAR 309-012-0130 through 309-012-0220. The Certificates will be issued as follows:
(1) A provider who is determined by the MHDDSD to be in substantial compliance with applicable rules will receive a three year Certificate of Approval.
(2) A provider who is determined by the MHDDSD to not be in substantial compliance with applicable rules may, at the discretion of the MHD DSD, have conditions placed on the Certificate of Approval.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1080

Sanctions for Non-Compliance

(1) Programs or services not in substantial compliance. When the MHDDSD determines, pursuant to this rule that a provider is not in substantial compliance with these rules, the MHDDSD may, at its discretion, require the provider to file a Plan of Correction within a period of time specified by the MHDDSD.
(2) MHDDSD authority. The MHDDSD may accept, reject, or modify the Plan of Correction or require the provider to comply with a Plan of Correction as directed and approved by the MHDDSD.
(3) Sanctions. Sanctions may include, at the discretion of the MHDDSD, elimination of the service or program, termination of the Certificate of Approval to provide Community Mental Health Treatment Services for Children, merger with an approved CMHP, or if applicable, withholding of funds. Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96