Standards for Children's Intensive Mental Health Treatment Services

309-032-1100 Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for intensive mental health treatment services for children within a comprehensive system of care. The goal of these services is to maintain the child in the community in the least restrictive treatment setting appropriate to the acuity of the child's disorder. The system of care shall be child and family-centered and community-based with the needs of the child and family determining the types and mix of services provided. These services may be as intensive, frequent and individualized as is medically appropriate to sustain the child in treatment in the community.

(2) Statutory Authority. These rules are authorized by ORS 430.041, 430.640(1)(h), and 743.556 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 6-2000, f. & cert. ef. 2-15-00

309-032-1110 Definitions As used in these rules:

(1) "Accreditation" means official notification given a provider of compliance to standards established by an accrediting organization approved by the Health Care Financing Administration to accredit providers of Medicaid reimbursed "inpatient under 21."

(2) "Active treatment" means implementation of a professionally developed and supervised individual plan of care to improve a child's condition.

(3) "Acute care" means short term psychiatric treatment in a hospital or other equivalent level of care.

(4) "Admission criteria" means the behavioral and diagnostic requirements to be met for a child to be admitted to intensive mental health treatment services.

(5) "Assessment and Evaluation Program" means a service designed for children who need non-hospital level psychiatric assessment, evaluation and brief treatment in a staff or facility secure program.

(6) "Behavior management policy" means the written policies and procedures adopted by the provider that describe the behavioral interventions to be used by the provider to manage maladaptive or problem behavior of an admitted child.

(7) "Case management" means the service provided to children and families to link and coordinate segments of the service delivery system of a single provider or of several providers to ensure that the most effective

means of meeting the child's needs for care are used. Case management functions for children with intensive treatment needs include planning specific treatment goals and services needed to achieve goals; linking the child to appropriate services delineated in the care plan; monitoring and ongoing contact with the child to ensure that services are being delivered appropriately; and advocating for the child's clinical needs.

(8) "Certification" means official approval given by the Division to an appropriately licensed and/or accredited provider to deliver intensive treatment services.

(9) "Chemical restraint" means the administration of medication for the acute management of uncontrolled behavior. Chemical restraint is different from the use of medication for treatment of symptoms of severe emotional disturbances and/or disorders. Chemical restraint of children is prohibited.

(10) "Child" or "Children" means a person or persons under the age of 18, or for those with Medicaid eligibility under the age of 21, who receives ITS services.

(11) "CHIP" means the Child Health Insurance Program federal grant-in-aid program to states under Title XXI of the Social Security Act.

(12) "Client Process Monitoring System" or "CPMS" means the Division's client information system for community based services.

(13) "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 foundation for managing and tracking the provision and quality of services.

(14) "Clinical supervision" means the documented oversight by a Clinical Supervisor of mental health treatment services provided by Qualified Mental Health Professionals or Qualified Mental Health Associates.

(15) "Clinical supervisor" means a Qualified Mental Health Professional with two years post-graduate clinical experience in a mental health treatment setting. The clinical supervisor, as documented by the provider, operates within the scope of his or her practice or licensure, and demonstrates the competency to oversee and evaluate the mental health treatment services provided by other Qualified Mental Health Professionals or Qualified Mental Health Associates.

(16) "Comprehensive mental health assessment" means the written documentation by a QMHP of the child's presenting mental health problem(s) and mental status; and emotional, cognitive, family, substance use, behavioral, social, physical, nutritional, school or vocational, recreational and cultural functioning; and developmental, medical and

legal history. A comprehensive mental health assessment is collected through interview with the child, family and other relevant persons; review of previous treatment records; observation; and psychological and neuropsychological testing when indicated. The comprehensive mental health assessment concludes with a completed DSM five axis diagnosis, clinical formulation, prognosis for treatment, and treatment recommendations. The comprehensive mental health assessment is used to document the need for mental health services and to develop or update the child's individual plan of care.
(17) "Consent to treatment" means the informed, voluntary, written agreement as required in ORS 430.210(d) between the provider and the child's custodial parent or guardian, or the child if legally emancipated, for the child to receive prescribed treatment for a specific diagnosis.
(18) "Consultation" means professional advice or explanation given concerning a specific child to others involved in the treatment process, including family members, staff members of other human service agencies and care providers.
(19) "Contractor" means a CMHP, MHO or other entity approved by the Division for contracting or subcontracting to purchase intensive mental health treatment services for children. A contractor is responsible for assuring that the provider of contracted services meets the requirements established in this rule including applicable licensing, certification and accreditation standards and holds a valid Certificate of Approval issued by the Division.
(20) "Continued stay criteria" means the diagnostic, behavioral and functional indicators documented in the child's plan of care by the interdisciplinary team to provide the clinical rationale for a child to remain in an intensive mental health treatment service.
(21) "Crisis" means either an urgent or emergency situation that occurs when a child's mental status, emotional stability, or functioning evidences a rapid deterioration and there is an immediate need to address the situation to prevent further deterioration in the child's condition.
(22) "Custodial parent" means the parent(s) or guardians having legal custody of the child.
(23) "Custody" means the legal care and supervision of the child by the person, agency or institution having the authority to authorize ordinary, urgent or emergent medical, psychiatric, psychological and other remedial care and treatment for the child. The custodial parent(s) is not required to relinquish custody of the child to receive mental health treatment services.

(24) "Diagnosis" means the primary mental disorder listed in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), that is the medically appropriate reason for clinical care and the main focus of treatment. The primary 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 primary diagnosis covered under these rules although these conditions or disorders may co-occur with the diagnosable mental disorder.

(25) "Direct supervision" means the oversight and coordination by a QMHP of interventions described in the individual plan of care performed by a Qualified Mental Health Associate (QMHA) and other direct care staff. Direct supervision also includes reviewing and evaluating the documentation of interventions directed by the individual plan of care performed by a QMHA or other direct care staff. Direct supervision is performed on a regular, routine basis in an individual or group setting.

(26) "Direction of the psychiatrist" means medical oversight of the clinical aspects of care required of accredited "inpatient under 21" providers by the Health Care Financing Administration (HCFA). Medical oversight includes participation on the interdisciplinary team, prescribing treatment on individual plans of care by signature, prescribing and/or monitoring medications and reviewing special treatment procedures.

(27) "Discharge criteria" means the diagnostic, behavioral and functional indicators the child and/or family will meet to move to the next level of service.

(28) "Discharge instructions" means a brief document which transmits information about the child's ongoing care and treatment needs. Discharge instructions include current medication and medical information, diagnosis and current treatment intervention strategies to manage the child prior to receiving a discharge summary. Discharge instructions shall be part of the information given to the parent or guardian upon or prior to discharge.

(29) "Discharge summary" means written documentation of the last service contact with the child; the diagnosis at admission; and 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.

(30) "Division" means the Department of Human Resources Agency responsible for the administration of mental health and developmental disabilities programs and laws of the state.
(31) "DSM" means the current edition of the "Diagnostic and Statistical Manual of Mental Disorders" published by the American Psychiatric Association.
(32) "Enrollment" means the assignment of Oregon Health Plan clients to Mental Health Organizations (MHOs), Oregon Health Plan Managed Care Enrollment Requirements.
(33) "Family" means the parent(s), legal guardian, siblings, grandparents, spouse and other primary relations of the child whether by blood, adoption, legal or social relationship.
(34) "Five-axis diagnosis" means the multiaxial system of evaluation in the DSM organized to provide a comprehensive approach to psychiatric assessment and to ascertain that all of the information necessary for planning treatment and predicting treatment outcomes for children is recorded on each of five axis.
(35) "Formal complaint" means the expression in a manner appropriate to the child or family/guardian of dissatisfaction or concern about the provision or denial of services that is the responsibility of the provider under these rules. The formal complaint can be expressed by a child or by the child's representative.
(36) "Fully Capitated Health Plan" or "FCHP" means a prepaid health plan under contract with the Office of Medical Assistance Programs to provide capitated physical health and chemical dependency services under the Oregon Health Plan. Some FCHPs also serve as Mental Health Organizations.
(37) "Goal" means an expected result or condition to be achieved, which 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.
(38) "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.
(39) "Indicators of progress" means the diagnostic, behavioral, or functional measures used by the provider to demonstrate the degree to which a child and family have made functional or behavioral improvement in the areas being measured.
(40) "Individual plan of care" means the written plan developed by a QMHP for active treatment for each child admitted to an intensive treatment service program. The individual plan of care specifies the DSM

diagnosis, goals, measurable objectives, and specific treatment modalities and is based on a completed mental health assessment or comprehensive mental health assessment of the child's functioning and the acuity and severity of psychiatric symptoms.

(41) "Individuals with Disabilities Education Act" or "IDEA" means the federal law requiring that a free and appropriate education be provided to all children with mental and physical handicapping conditions. The education provided must include all educational and related services necessary for the child to learn.

(42) "Initial plan of care" means the written plan developed by a QMHP for active treatment based on the mental health assessment completed at admission. The initial plan of care specifies assessment and treatment modalities before completing the individual plan of care.

(43) "Intensive treatment services" or "ITS" means the range of service components in the system of care inclusive of treatment foster care, therapeutic group homes, psychiatric day treatment, partial hospitalization, residential psychiatric treatment, sub-acute care or other services as determined by the Division that provides active psychiatric treatment for children with severe emotional disorders and their families.

(44) "Interdisciplinary team" means a team of qualified treatment and education professionals including a child and adolescent psychiatrist or LMP and the child's parent or guardian responsible for assessment and evaluation, the development and oversight of individual plans of care, and the provision of treatment for children admitted to an intensive treatment services program.

(45) "Isolation" means the staff-directed placement of a child in a room or other space in which the child is alone and without ongoing verbal or visual contact with others. Periodic visual or verbal contact by staff does not prevent the child from being considered to be in isolation. A child who is placed in his or her bedroom at the child's normal bedtime or otherwise has a routine separation unrelated to behavior or conduct is not considered to be isolation.

(46) "Level of care" means the relative amount and intensity of 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.

(47) "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.
(48) "Licensed Medical Practitioner" or "LMP" means any person who meets the following minimum qualifications as documented by the provider:
(a) Holds at least one of the following educational degrees and valid licensure:
(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) A Licensed Medical Practitioner contracting or employed for the first time with a provider under these rules after July 1, 2000, shall be a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.
(49) "Manual restraint" means the act of involuntarily restricting a child's movement by holding the whole or a portion of a child's body in order to protect the child or others from injury. The momentary periods of physical restriction by direct contact with the child, without the aid of material or mechanical devices, accomplished with limited force, that prevent the child from completing an act that would result in potential physical harm to the child or others are not considered to be restraint.
(50) "Mechanical restraint" means the use of any physical device to involuntarily restrain the movement of all or a portion of a child's body as a means of controlling his or her physical activities in order to protect the child or other persons from injury. Mechanical restraint shall only be used by Sub-Acute providers specifically authorized in writing to use mechanical restraint by the Division. Mechanical restraint does not apply to movement restrictions stemming from physical medicine, dental, diagnostic or surgical procedures which are based on widely accepted, clinically appropriate methods of treatment by qualified professionals operating within the scope of their licensure.
(51) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to poor and indigent persons under Title XIX of the Social Security Act.
(52) "Medically appropriate" means services which are required for prevention (including preventing a relapse), diagnosis or treatment of

mental health conditions and which are appropriate and consistent with the diagnosis; consistent with treating the symptoms of a mental illness or treatment of a mental condition; appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective; not solely for the convenience of the provider of the services, child or family; and the most cost effective of the alternative levels of medically appropriate services which can be safely and effectively provided to the child and family in the LMP's judgement.

(53) "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/or medication administration records and placed in the client's record.

(54) "Mental health assessment" means the written documentation by a QMHP of the child's presenting mental health problem(s) and relevant child and family history, mental status examination and DSM 5-axis diagnosis or provisional diagnosis.

(55) "Mental Health Information System" means the information system of the Division that includes the Client Process Monitoring System for non-hospital services, the Medicaid Management Information System for the Medicaid eligible population and billable services delivered, and the Oregon Patient Resident Care System for inpatient and acute services. It provides a statewide client registry for tracking services utilization and contractor capacity.

(56) "Mental Health Organization" or "MHO" means a prepaid health plan under contract with the Division to provide covered services under the Oregon Health Plan.

(57) "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.

(58) "Milieu" means the daily environment of structure and therapy, education, recreation and socialization interactions with staff and peers for children in treatment.

(59) "Minor child" means an unmarried person under the age of 18.
(60) "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.
(61) "Objective" means a quantifiable statement of a desired future state or condition which is related to the attainment of a goal within a stated deadline for achievement.
(62) "Oregon Youth Authority (OYA)" means the department of state government created by the 1995 Legislative Assembly that is charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.
(63) "Partial hospitalization program" means a comprehensive interdisciplinary day treatment program certified under this rule to provide psychiatric services, therapy, education and therapeutic activities as an alternative to hospitalization which meets Health Care Financing Administration accreditation standards.
(64) "Plan of correction" means a written document which specifies actions that a provider will take to come into compliance with these rules.
(65) "Progress note" means the written documentation of the clinical course of treatment.
(66) "Provider" means an organization or agency certified by the Division to provide intensive mental health treatment services for children.
(67) "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.
(68) "Psychiatric Day Treatment" means the comprehensive, interdisciplinary, non-residential community based program certified under this rule consisting of psychiatric treatment, family treatment and therapeutic activities integrated with an accredited education program.
(69) "Psychiatric Residential Treatment Facility" or "PRTF" means the behavioral health care programs certified under this rule to provide 24-hour, seven days per week active mental health treatment under the direction of a psychiatrist for children under age 21. These services are associated with a Residential Psychiatric Treatment Program for children who can benefit from a less restrictive residential psychiatric environment.

(70) "Psychiatrist" means a Licensed Medical Practitioner who is board-eligible or board-certified in child and adolescent psychiatry and licensed to practice in the State of Oregon.
(71) "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 provider:
(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 competency 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 as assigned on an individual plan of care.
(72) "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 provider:
(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 demonstrate the competency 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 an individual plan of care; conduct a Comprehensive Mental Health Assessment and provide individual, family and/or group therapy within the scope of their training.

(73) "Quality Management" means a continuous process to simultaneously promote consistency of performance and to promote meaningful change in measurable objectives. The process is used to improve a provider's performance and adjust measurable objectives and benchmarks.

(74) "Quality of care" means the degree to which services are consistent with best practices and produce desired and satisfactory mental health outcomes for the child.

(75) "Reportable incident" means an event in which an admitted child while in the program is believed to have been abused, endangered or significantly harmed. This may include, but is not limited to, incidents as a result of staff action or inaction, incidents between children, incidents that occur on passes, or incidents of self-harm where medical attention is necessary.

(76) "Residential Psychiatric Treatment Program" means the behavioral health care programs certified under this rule to provide 24-hour, seven days per week active mental health treatment under the direction of a psychiatrist for children under age 21.

(77) "Seclusion" means the involuntary confinement of a child alone in a specifically designed room from which the child is physically prevented from leaving.

(78) "Severe emotional 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 continue for more than one year, or on the basis of a specific diagnosis is likely to continue for more than one year.

(79) "Special treatment procedures" means seclusion; manual restraint; staff directed isolation for more than five hours in five days or a single episode of two hours; and experimental practices and research projects that involve risk to a child.

(80) "Special Treatment Procedures Committee" means the committee established or designated by the provider to review special treatment procedures.

(81) "State Office for Services to Children and Families (SOSCF) or (SCF)" means the Division serving as Oregon's child welfare agency.

(82) "Sub-Acute Psychiatric Care" means mental health treatment under the clinical direction of a psychiatrist as an alternative to hospitalization certified under this rule for children who are not in the most acute phase of a mental condition but who require a level of care higher than that provided in a residential psychiatric treatment setting.

(83) "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 severe emotional disorders and their families.

(84) "Therapeutic group home" means mental health treatment settings certified under this rule for children in group care homes of eight or fewer children in SCF-licensed homes where the home parents are employed or contracted by the supervising agency to provide in-home psychosocial skills development for each child.

(85) "Treatment foster care" means mental health treatment settings certified under this rule for children residing in SCF certified homes where the home parents are employed or contracted by the supervising agency to provide in-home psychosocial skills development for each child.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1120 General Conditions of Participation for Children's Intensive Mental Health Treatment Services Providers
Providers delivering children's intensive mental health services shall:
(1)(a) Hold, and/or assure that subcontractors hold, a valid Certificate of Approval issued by the Division and, if applicable, accreditation approved by the Division and the Health Care Financing Administration and appropriate license or certification from the State Office for Services to Children and Families;
(b) Providers that are not required to have accreditation approved by the Health Care Financing Administration may use alternative standards for the organization of their services;
(A) Alternative standards include the Day and Residential Treatment Services (DARTS) Standards or others approved by the Division;

(B) In the event of a conflict between this rule and voluntary standards, the standards and procedures outlined in this rule will supercede all alternative standards.

(2) 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 admitted child specific to the child's diagnosis, level of functioning and the acuity and severity of the child's psychiatric symptoms;

(3) Maintain 24 hour, seven days per week treatment responsibility for admitted children. Non-residential programs shall maintain on-call capability at all times to respond directly or by referral to the treatment needs of admitted children including crises 24 hours per day, seven days per week;

(4) Deliver active psychiatric treatment in the least restrictive, least intensive setting appropriate to each admitted child's treatment history, diagnosis, development, level of functioning and degree of impairment, current symptoms and the extent of family and other supports;

(5) Use treatment methods appropriate for children with severe emotional disorders that are based on sound clinical theory and professional standards of care and widely accepted by qualified professionals in the mental health field;

(6) Demonstrate family involvement and participation in all phases of assessment, treatment planning and the child's treatment by documentation in the clinical record;

(7) Report suspected child abuse as required in ORS 419B.010;

(8) Maintain reportable incident files including:

(a) Child abuse reports made by the provider to law enforcement or the State Office for Services to Children and Families child protective services documenting the dates of the incident the persons involved and, if known, the outcome of such reports; and

(b) Reportable incident information documenting the date of the incident, the persons involved, the quality and performance actions taken to initiate investigation of the incident, and correct any identified deficiencies.

(9) Inform the Division and the legal guardian within one working day of reportable incidents.

(10) Enroll children in the Mental Health Information System when the child's mental health services are funded all or in part by Division funds, unless the Division contract does not require enrollment;

(11) Maintain policies and practices prohibiting on- or off-site non-professional relationships and activities between employees and admitted

children and their families unless the activities are approved by the provider and interdisciplinary team and identified as clinically appropriate services in the child's individual plan of care;
(12) Provide services for children in a smoke free environment in accordance with Public Law 103.277, the Pro-Child Act;
(13) Establish systematic and objective methods to accomplish the following:
(a) Periodically monitor and evaluate access to, and provision of, children's intensive mental health treatment services;
(b) Identify and seek to resolve problems in access to, or provision of, services; and
(c) Improve access and services using reliable and valid performance measures; and to periodically report pertinent data and information as directed by the Division.
(14) Demonstrate education service integration in all phases of assessment, treatment planning, active treatment, and discharge planning by documentation in the clinical record; and
(15) Maintain policies and procedures to ensure the safety and emergency needs of children, families, staff and visitors including:
(a) First aid and cardiopulmonary resuscitation training for staff who are assigned to provide direct service to children;
(b) Off campus activities;
(c) Medical and/or dental emergencies; and
(d) Facility and environmental emergencies.
(16) Demonstrate cultural competency, gender responsiveness and language appropriateness in the delivery of services to clients.
(17) Demonstrate operation by a governing body whose membership reflects diverse community interests and whose organization and operation shall be set out in writing.
(18) Develop and publish a comprehensive document which describes the mission statement, treatment philosophy, programmatic descriptions, admission criteria, and the policies and procedures for operation of the program.
(19) Develop policies and procedures for orientation of the incoming child and family that consider pre-admission orientation times convenient for the family and that facilitate adequate staff program and child and family preparation prior to admission.
(20) Develop policies and procedures prohibiting firearms and outlining the management of other potentially dangerous objects.

Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1130 General Treatment Requirements

(1) Admission. Providers shall plan admissions, help the child and family understand the reason for admission, give admission consideration to children that realistically allows the child's family to participate in treatment, and advise the family on transportation arrangements when needed.

(2) Prior to admission for planned admissions or within 14 days following an emergency admission, providers shall determine that a child is eligible for intensive treatment services. Admissions shall be based on the provider's clinical review of the child's functioning, of the severity and acuity of the child's psychiatric symptoms, and of documentation of the following:

(a) A completed five-axis diagnosis current within 60 days of the admission date;

(b) Pertinent biological, psychological and sociocultural factors influencing the child's development and functioning;

(c) The acuity and severity of the child's psychiatric symptoms as scored on measures established by the Division;

(d) The child's functioning as scored on measures established by the Division; and

(e) Attempts to effectively treat the child in a less restrictive level of care.

(3) Assessment.

(a) On admission the child shall have an initial plan of care based on a mental health assessment completed by a QMHP.

(b) A comprehensive mental health assessment shall be conducted by the provider's interdisciplinary team and be completed within 30 treatment days after admission.

(c) The comprehensive assessment shall be revised and updated annually.

(4) Active Treatment and Individual Plans of Care.

(a) Providers shall fully inform the child in developmentally appropriate language and obtain informed consent from the child's parent(s) or guardian about the proposed care and shall document in the child's clinical record that the following information has been reviewed, discussed, and agreed to by the participants:

(A) Active treatment and other interventions to be undertaken;

(B) Alternative treatments or interventions available, if any;

(C) Projected time to complete the treatment process;

(D) Indicators by which progress will be measured;
(E) Benefits which can reasonably be expected;
(F) Risks of treatment, if any;
(G) Prognosis for treatment; and
(H) Discharge plan.
(b) The individual plan of care shall clinically support the level of care to be provided and shall:
(A) Be developed and implemented no later than 14 treatment days after admission by an interdisciplinary team in consultation with the child, the parent(s) or guardian and the provider to which the child will be discharged;
(B) Be based on a mental health assessment of the child's functioning, the acuity and severity of the child's psychiatric symptoms, diagnosis, and the biological, medical, psychological and sociocultural factors that influence the child's development and functioning;
(C) State treatment goals and measurable and observable objectives;
(D) Prescribe an integrated program of therapies, activities, interventions and experiences designed to meet the goals;
(E) Include a discharge plan to ensure continuity of care with the child's family, school, and community upon discharge; and
(F) Be signed and dated by the psychiatrist and other members of the interdisciplinary team including the child's guardian, and when appropriate the child.
(5) Individual Plan of Care Review. A written summary of each individual plan of care review shall be filed in the child's clinical record. Revisions shall be implemented as necessary based on each child's individualized response to the treatment interventions.
(a) The review in nationally accredited sub-acute, assessment and evaluation programs and residential psychiatric treatment programs shall be conducted every 30 days by the interdisciplinary team.
(b) In other programs, the review shall be conducted every 30 days by the child's interdisciplinary team. The psychiatrist shall participate in the review at least every 90 days.
(6) Discharge Planning and Coordination.
(a) Providers shall establish written policies and practices for identifying, planning and coordinating discharge to after-care resources. At a minimum, the provider's interdisciplinary team shall:
(A) Integrate discharge planning into ongoing treatment planning and documentation from the time of admission, and specify the discharge

criteria that will indicate resolution of the symptoms and behaviors that justified the admission;
(B) Review and, if needed, modify the discharge plan every 30 days;
(C) Include the parent, guardian and provider to which the child will be discharged in discharge planning and reflect their needs and desires to the extent clinically indicated;
(D) Finalize the discharge plan prior to discharge 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; and
(E) Assure that appropriate medical care and medication management will be provided to clients who leave through a planned discharge. The discharging provider's interdisciplinary team shall identify the medical personnel who will provide continuing care and shall also arrange an initial appointment with that provider.
(b) Providers shall give written discharge instructions to the child's parent(s) or guardian, or the provider of the next level of care on the date of discharge.
(c) Providers shall notify the child's parent(s) or guardian and the provider to which the child will be discharged of the anticipated discharge dates at the time of admission and when the discharge plan is changed.
(d) Providers shall not discharge a child from an intensive treatment service unless the interdisciplinary team, in consultation with the child's parent(s) or guardian or the provider of the next level of care, determines that the child requires a more or less, restrictive level of care. If the determination is to admit the child to acute care, the provider shall not discharge the child from the program during the acute care stay unless the interdisciplinary team, in consultation with the child's parent(s) or guardian or the provider of the next level of care determines that the child requires a more or less restrictive level of care.
(e) A discharge summary reflecting the active course of treatment shall be completed and placed in the chart within 15 treatment days following discharge.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1140

General Staffing and Personnel Requirements

(1) Providers of children's intensive mental health treatment services shall have the clinical leadership and sufficient QMHP, QMHA and other staff

to meet the 24-hour, seven days per week treatment needs of admitted children and shall establish policies, contracts and practices to assure:
(a) Availability of psychiatric services to meet the following requirements:
(A) Provide medical oversight of the clinical aspects of care in nationally accredited sub-acute, assessment and evaluation programs and residential psychiatric treatment programs and provide 24-hour, seven days per week psychiatric on-call coverage; or consult on clinical care and treatment in psychiatric day treatment, partial hospitalization, therapeutic group homes and treatment foster care programs;
(B) Assess 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 individual plan of care goals; and
(C) Participate in the provider's interdisciplinary team and Quality Management process.
(b) An executive director or clinical director who meets the following minimum qualifications:
(A) Masters degree in a human service-related field from an accredited school;
(B) Five years experience in a human services program;
(C) Documented professional references, training and academics; and
(D) Subscribes to a professional code of ethics.
(2) Providers of children's intensive mental health services shall have adequate numbers of QMHP, QMHA and other staff whose care specialization is consistent with the duties and requirements of the specific level of care. Professional staff shall operate within the scope of their training and licensure.
(3) Providers shall assure through documentation in personnel files that all supervisory and clinical staff meet all applicable professional licensing and/or certification, and QMHP or QMHA competencies.
(4) Providers shall maintain a personnel file for each employee, that contains:
(a) The employment application;
(b) Verification of a criminal history check as required by ORS 181.536 - 181.537;
(c) A written job description;
(d) Documentation and copies of relevant licensure and/or certification that the employee meets applicable professional standards;
(e) Annual performance appraisals;
(f) Annual staff development and training activities;

(g) Employee incident reports;
(h) Disciplinary actions;
(i) Commendations; and
(j) Reference checks.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1150 System of Care

(1) General Requirements. All ITS providers described in this section shall meet the following general requirements:
(a) Active psychiatric treatment and education services shall be functionally integrated in a therapeutic milieu designed to promote achievement of goals and treatment objectives developed in each child's individual plan of care.
(b) ITS facilities shall meet all applicable licensing, certification and accreditation/or standards for plant technology, safety management, professional staffing, therapeutic environment, performance measurement, quality management and utilization review.
(c) ITS providers shall maintain linkages with primary care physicians, CMHPs and MHOs and the child's parent(s) or guardian to plan for necessary continuing care resources for the child.
(d) ITS providers shall maintain linkages with the applicable education service district or school district to coordinate and provide the necessary educational services for the children.
(e) When treatment services interrupt the child's day to day educational environment, the program provides or makes arrangements for the continuity of the child's education.
(f) ITS providers shall ensure that the following services be available and accessible through direct service, contract or by referral:
(A) Psychiatric and psychological assessment and treatment;
(B) Individual, group and family therapies;
(C) Medication evaluation, management and/or monitoring;
(D) Pre-vocational/vocational rehabilitation;
(E) Therapies supporting speech, language and hearing rehabilitation;
(F) Individual and group psychosocial skills development;
(G) Behavior management;
(H) Activity and recreational therapies;
(I) Nutrition;
(J) Physical health care services or coordination; and

(K) Case management, treatment planning and coordination, and consultation.
(g) Family therapy shall be provided by a Qualified Mental Health Professional. The family therapist to child ratio shall be at least one family therapist for each 12 children.
(h) There shall be a clinical supervisory ratio of at least one QMHP clinical supervisor for each nine staff.
(i) Providers of ITS shall measure individual active treatment outcomes for children in treatment with the provider. Measurement of active treatment outcomes shall include, but are not limited to:
(A) Stabilization of the acuity and severity of symptoms;
(B) Reduction of danger to self or others;
(C) Improvement in the level of function;
(D) Stabilization of behavior and conduct; and
(E) Development of new adaptive coping skills.
(2) In addition to the general requirements for all ITS providers listed in 309-032-1150(1), the following service specific requirements shall be met.
(3) Psychiatric Residential Treatment Services. These services are structured treatment environments with daily 24-hour supervision and active psychiatric treatment. It includes Sub-Acute Psychiatric Care, Assessment and Evaluation Programs, Residential Psychiatric Treatment Programs, and Psychiatric Residential Treatment Facilities. Psychiatric Residential Treatment Services are provided by nationally accredited providers certified under these rules for children who require active treatment for a diagnosed mental disorder in a 24-hour residential setting. An education program provided and admitted children shall have, or have been screened for, an Individual Education Plan, Personal Education Plan, and/or an Individual Family Service Plan.
(a) Providers of Psychiatric Residential Treatment Services shall maintain one or more linkages with acute care hospitals and/or MHOs to coordinate necessary inpatient care.
(b) Psychiatric residential clinical care and treatment shall be under the direction of a medical director who is a psychiatrist as defined in these rules 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.
(c) Psychiatric Residential Treatment Services shall be staffed to the acuity and severity of admitted children at a staffing ratio of not less than

one staff for three children during the day and evening shifts. At least one staff for every three staff members during the day and evening shifts shall be a Qualified Mental Health Professional or Qualified Mental Health Associate. For overnight staff there shall be a staffing ratio of at least one staff for six children with one being a Qualified Mental Health Associate. For units that by this ratio have one overnight staff, there shall be additional staff immediately available within the facility or on the premises. At least one Qualified Mental Health Professional shall be on site or on call at all times. At least one staff with designated clinical leadership responsibilities shall be on site at all times.

(4) Sub-Acute Psychiatric Care. These are services provided by nationally accredited providers certified under these rules for children who need 24-hour intensive mental health treatment in a secure setting to assess, evaluate and stabilize or resolve the symptoms of an acute episode that occurred as the result of the diagnosed mental disorder. In addition to the requirements provided in 309-032-1150(1)–(3) Sub-Acute Psychiatric Care providers shall:

(a) Provide psychiatric nursing staffing at least 16 hours per day;

(b) Establish policies and practices to meet the following admission and continued stay criteria:

(A) Admission:

(i) The child is admitted by physician order for a period up to 14 days to determine through assessment and evaluation the existence of a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis that shall be the basis for the development of a plan to guide the child's treatment; or

(ii) The child has a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis; and

(iii) The child needs treatment 24-hours each day in a secure setting under the direction of a psychiatrist to stabilize or resolve symptoms or behaviors which were identified as the reason for admission and which are consistent with the DSM diagnosis;

(iv) The admitting and referring physicians have consulted and agree on the admission;

(v) Proposed treatments for the DSM diagnosis require close nursing supervision and monitoring and psychiatric supervision at least one to three times per week; and

(vi) Less restrictive or less intensive services cannot be expected to improve the child's condition or prevent further regression so that Sub-Acute services will no longer be needed.

(B) Continued Stay:

(i) Children shall remain in Sub-Acute Psychiatric Care only as long as necessary to provide brief treatment to stabilize the child. Continued stays of more than 30 days shall be approved at 30-day intervals up to 90 days by the Division or its designated external review organization.
(ii) Children may continue to receive Sub-Acute Psychiatric Care services for more than 90 days only by authorization of the attending psychiatrist or the interdisciplinary team and approval by the Division or its designated external review organization.
(c) Mechanical restraint shall be used only by Sub-Acute providers specifically authorized by the Division in writing to use mechanical restraint.
(5) Assessment and Evaluation Programs. Assessment and Evaluation Programs shall provide services for children who need up to 90 days of 24-hour comprehensive mental health assessment to diagnose a mental disorder and to stabilize assessed symptoms and behavior that affect the child's functioning. In addition to the requirements provided in 309-032-1150(1) and (2) providers of assessment and evaluation program services shall establish policies and practices to meet the following admission and continued stay criteria:
(a) Admission:
(A) The child is admitted by physician order for a period up to 30 days to assess, evaluate and make written recommendations for continuing services. If the child is determined to have a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis that shall be the basis to guide the child's treatment; or
(B) The child has a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis; and
(C) The child needs additional assessment and brief active treatment 24 hours each day under the direction of a psychiatrist to stabilize or resolve symptoms or behaviors which were identified as reason for admission and which are consistent with the DSM diagnosis; and
(D) Less restrictive or less intensive services cannot be expected to improve the child's condition or prevent further regression so that residential assessment and evaluation services will no longer be needed.
(b) Continued Stay:
(A) Children shall remain in an Assessment and Evaluation program only for the period of time needed to complete the necessary battery of assessments and provide brief treatment to stabilize the child.

(B) Continued stays of more than 30 days shall be approved at 30-day intervals up to 90 days by the Division or its designated external review organization.
(C) Children may continue to receive Assessment and Evaluation services for more than 90 days only by authorization of the attending psychiatrist or the interdisciplinary team and approval by the Division or its designated external review organization.
(c) Assessment and Evaluation programs shall provide the referring source with written discharge instructions, a comprehensive written assessment and recommendations for continuing care at the conclusion of the assessment period.
(6) Residential Psychiatric Treatment Program. Services shall include 24-hour supervision for children who have a serious psychiatric, emotional and/or acute behavioral health issues which require intensive therapeutic counseling and activity, intensive staff supervision, support and assistance. In addition to the requirements provided in 309-032-1150(1)–(3) a Residential Psychiatric Treatment Program shall establish policies and practices to meet the following admission and continued stay criteria:
(a) Admission:
(A) A psychiatric or psychological evaluation including a completed 5-axis diagnosis current within 60 days of the application date. The child shall have a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis. The referral information shall have been reviewed by an independent psychiatric review process established by the Division to certify the need for services based on the following criteria:
(B) Ambulatory resources available in the community do not meet the child's treatment needs;
(C) Proper treatment of the child's psychiatric condition requires services on a 24-hour intensive treatment basis under the direction of a psychiatrist;
(D) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary;
(E) Providers shall accept an emergency admission only under unusual and extreme circumstances. Emergency admissions shall be retrospectively reviewed by the Division or its designated external review organization.
(b) Continued Stay:
(A) Children shall remain in a 24-hour Residential Psychiatric Treatment Program only for the period of time determined to be medically

appropriate to treat the psychiatric condition(s) identified on the child's individual plan of care.
(B) Continued stays shall be approved by the Division or its designated external review organization at 90-day intervals.
(C) Continued stays that exceed one year and at an annual basis thereafter shall be approved by the Division or a designated external psychiatric review process.
(7) Psychiatric Residential Treatment Facility. Services shall include 24-hour supervision for children who have a serious psychiatric, emotional and/or behavioral health issues which require intensive therapeutic counseling and activity, staff supervision, support and assistance. These services are associated with a Psychiatric Residential Treatment Program for children who can benefit from a less restrictive residential environment. In addition to the requirements provided in 309-032-1150(1)–(3) a Psychiatric Residential Treatment Facility shall:
(a) Be staffed to the acuity and severity of admitted children and have sufficient QMHP staff to ensure delivery of the appropriate mix and frequency of sound clinical treatment services. There shall be no less than one QMHP for the first five children enrolled. For each additional group of five, or any part thereof, a QMHP or QMHA will be added to the treatment staff ratio. At least one staff per every five staff members shall be a QMHP. For overnight staff there shall be a staffing ratio of at least one staff for six children with one being a QMHA. For units that by this ratio have one overnight staff, there shall be additional 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 staff with designated clinical leadership responsibilities shall be on site at all times.
(b) Admission criteria:
(A) The admission decision shall be the responsibility of the interdisciplinary team based on referral information current within the last 60 days;
(B) The referral information shall have been reviewed by an independent psychiatric review process established by the Division to certify the need for services based on the following criteria:
(i) Ambulatory resources available in the community do not meet the child's treatment needs;
(ii) Proper treatment of the child's psychiatric condition requires services on a 24-hour intensive treatment basis under the direction of a psychiatrist but is less severe than the need for Residential Psychiatric Treatment Program level of care;

(iii) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary.
(c) Continued Stay:
(A) Children shall remain in a 24-hour Psychiatric Residential Treatment Facility only for the period of time determined to be medically appropriate to treat the psychiatric condition(s) identified on the child's individual plan of care.
(B) Continued stays shall be approved by the Division or its designated external review organization at 90-day intervals.
(C) Continued stays that exceed one year and at an annual basis thereafter shall be approved by the Division or a designated external psychiatric review process.
(8) Partial Hospitalization Programs. Partial Hospitalization services shall be delivered by nationally accredited providers certified under these rules to provide day hospital services. Partial Hospitalization services shall be provided to children who can be maintained at home by a parent, guardian or foster parent by qualified mental health professionals and qualified mental health associates under the direction of a psychiatrist.
(a) Partial Hospitalization services providers shall maintain one or more contracts with acute care hospitals and/or MHOs to coordinate necessary inpatient care with the MHOs and their contracted hospitals. Partial Hospitalization providers shall maintain linkages with primary care physicians, CMHPs and MHOs, and the child's parent(s) or guardian to plan for necessary continuing care resources for the child.
(b) Partial Hospitalization programs shall be staffed to the acuity and severity of admitted children at a clinical staffing ratio of at least one Qualified Mental Health Professional or Qualified Mental Health Associate for up to three children. And have the 24-hour on-call availability of at least one Qualified Mental Health Professional during hours the program is not open.
(c) Providers of Partial Hospitalization services shall establish policies and practices to meet the following admission, continued stay and discharge criteria:
(A) Admission:
(i) The admission decision shall be the responsibility of the interdisciplinary team. The admission shall be based on referral information current within the last 60 days.
(ii) The child shall have a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis and the referral information shall have been reviewed

by a psychiatric review process established by the Division to certify the need for services based on the following criteria:

(I) Partial Hospitalization level of care is appropriate to meet the child's treatment needs;

(II) Proper treatment of the child's psychiatric condition requires intensive treatment services under the direction of a psychiatrist; and

(III) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary.

(B) Continued Stay:

(i) Children shall remain in a Partial Hospitalization program only for the period of time determined to be medically appropriate to treat the psychiatric conditions identified on the child's individual plan of care.

(ii) Continued stays shall be reviewed by the interdisciplinary team and approved every 30 days by a Division approved process.

(9) Psychiatric Day Treatment. Psychiatric Day Treatment services are delivered by providers certified by the Division under these rules to provide Psychiatric Day Treatment services. Psychiatric Day Treatment services shall be provided to children who can be maintained at home by a parent, guardian or foster parent by qualified mental health professionals and qualified mental health associates in consultation with the psychiatrist. An education program is provided and admitted children shall have, or have been screened for, an Individual Education Plan, Personal Education Plan or Individual Family Service Plan.

(a) Psychiatric Day Treatment programs shall be staffed to the acuity and severity of admitted children at a clinical staffing ratio of at least one Qualified Mental Health Professional or Qualified Mental Health Associate for three children.

(b) Providers of Psychiatric Day Treatment services shall establish policies and practices to meet the following admission, and continued stay criteria:

(A) Admission:

(i) The admission decision shall be the responsibility of the interdisciplinary team. The admission shall be based on referral information current within the last 60 days.

(ii) The child shall have a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis and the referral information shall have been reviewed by a review process approved by the Division to certify the need for services based on the following criteria:

(I) Psychiatric Day Treatment level of care is appropriate to meet the child's treatment needs;
(II) Proper treatment of the child's psychiatric condition requires intensive treatment services in consultation with a psychiatrist; and
(III) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary.
(B) Continued Stay:
(i) Children shall remain in a psychiatric day treatment program only for the period of time determined to be medically appropriate to treat the psychiatric conditions identified on the child's individual plan of care.
(ii) Continued stay shall be reviewed by the interdisciplinary team and approved every 90 days by a review process approved by the Division.
(10) Substitute Care Settings. Providers of community-based intensive mental health treatment services in substitute care settings shall be certified under these rules. These services include therapeutic group homes and treatment foster care homes. The provider delivers active mental health treatment focused on the behavior, feelings and perceptions the child presents in the treatment/living milieu through regularly scheduled group and individual skills training. Active treatment is based on a mental health assessment of the child's developmental level, behavior, functioning and the severity and acuity of psychiatric symptoms.
(a) Treatment services provided in therapeutic group home and treatment foster care settings shall be delivered by QMHPs and QMHAs with experience and training in psychosocial skills development and milieu therapy under the direction of a qualified mental health professional in consultation with an psychiatrist. The treatment staffing ratio shall be one staff for every eight children.
(b) Providers of therapeutic group home and treatment foster care services shall maintain linkages with primary care physicians, applicable education agencies, CMHPs and MHOs, SCF or OYA representatives, and the child's parent(s) or guardian to coordinate related services and aftercare resources for the child.
(c) Therapeutic group home and treatment foster care and other individualized intensive treatment services provided in substitute care settings shall be staffed to the acuity and severity of admitted children according to the treatment prescribed in each child's individual plan of care. The provision of these services shall be supervised by a Qualified Mental Health Professional.

(d) Providers shall establish policies and practices to meet the following admission and continued stay criteria:
(A) Admission shall be based on referral information current within the last 60 days and include a written assessment by a Qualified Mental Health Professional of the child's primary diagnosis on Axis I of a 5-Axis diagnosis supporting the following criteria:
(i) Therapeutic group or treatment foster care home mental health treatment level of care is appropriate to meet the child's treatment needs; and
(ii) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary.
(B) Continued stay in a therapeutic group or treatment foster care home shall be based upon determination by an LMP of the medical appropriateness of the setting treating the psychiatric conditions identified in the child's individual plan of care.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1160 Establishing and Maintaining Clinical Records

(1) Individual record. A single, separate and individualized clinical record shall be maintained for each child served by the provider.
(2) Terminology. All documentation entries in the clinical record shall be written in commonly accepted clinical terms in standard, understandable English.
(3) 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.
(4) Signature of authors. All documentation required in this rule must be signed by the person providing the service and making the entry. Signature must include the person's academic degree or professional credential and the date signed. Documentation that is dictated shall also include the date of dictation and date signed.
(5) Organization of clinical records. Each clinical record shall be uniform in organization, readily identifiable and accessible, and contain all of the content required by these rules in a current and complete manner within required timelines.

(6) Providers shall insure that each clinical record includes the following documentation:
(a) MHOs, FCHP, or other third party insurance enrollment information;
(b) Identifying data including child's name, date of birth, gender, address, phone number and name of parent(s) or legal guardian including an address and phone number if different;
(c) A mental health assessment, comprehensive mental health assessment, diagnoses and clinical formulation;
(d) An individualized plan of care developed by the interdisciplinary team or professional;
(e) Written discharge criteria;
(f) Completed medical history including current prescribed medications and allergies;
(g) Emergency medical and dental resources and primary care physician;
(h) A medication service record of all medications administered;
(i) Documentation by the interdisciplinary team that the child's individual plan of care 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 treatment needs have been implemented;
(j) Progress notes documenting specific treatments, interventions, and activities related to the individual plan of care or have treatment planning implications, and the child's response to the specific treatment or activities;
(k) Special treatment procedures notations in a separate section or in a separate format documenting each incident of manual restraint, seclusion, or mechanical, signed and dated by the staff directing the intervention and if required by the psychiatrist and/or clinical supervisor authorizing the intervention;
(l) Written discharge instructions and discharge summary; and
(m) The clinical documentation received from the referral source.
(7) The child's parent or guardian, or the child if legally emancipated, must give informed consent in writing to treatment including specific informed consent to the initial administration of any medication, or to a subsequent change in the class of the medication. Each informed consent shall state the information in writing, signed and dated by the person giving consent, and placed in the child's clinical record.
(8) The child's parent or guardian, or the child if legally emancipated, has the right to refuse treatment services including those generally accepted such as medication. The consequences of this service refusal shall be

explained verbally and in writing by the provider to the child and parent or guardian, or the child if legally emancipated. A refusal of service shall be documented in the child's record.
(9) The child's clinical record shall be secured, safeguarded, stored and retained in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.
(10) The child has the right to confidentiality when referenced in another child's clinical record.
(11) Providers that use electronic clinical record systems shall establish written policies and procedures to ensure confidentiality in accordance with ORS 179.505 through 179.507. The policies and procedures shall assure the following:
(a) The capacity to regularly provide printed documentation of all content incorporated within the clinical record;
(b) The verification of authentication of the individual making an entry including name, degree and date entered; and
(c) Safeguards to protect access to and the use of information contained in the electronic system.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00
309-032-1170
Child and Family Rights
Providers shall establish written policies and procedures pertaining to child and family rights. The written statement of rights shall be posted prominently in simple, easy to understand language on a form devised by the provider or the Division. This form shall be given by the provider to the person legally giving consent to treatment of the child, at the time of admission. In addition, these rights shall be explained orally at the time of admission to the person giving consent to treatment and to the child, in a manner appropriate to the child's developmental level. 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. Statement of Rights shall include the following:
(1) Right to provide consent to treatment in accordance with ORS 109.640 and ORS 109.675.
(2) Right to refuse services.
(3) Right to confidentiality in accordance with ORS 179.505, 107.154, and 418.312.

(4) Right to immediate inspection of the clinical record in accordance with ORS 179.505.
(a) The child, if able, and the custodial parent(s) or guardian of a minor child has the right to immediate inspection of the record.
(b) A copy of the record is to be provided within five working days of a request for it. The person requesting the record is responsible for payment for the cost of duplication, after the first copy.
(c) Identifying and clinical information about the child shall be protected in provider publications such as newsletters and brochures.
(5) Right to humane treatment in the least restrictive environment.
(6) Right to receive services in a humane environment that provides the child with protection from harm and protects the dignity of the child and his or her family.
(7) Right to participate in treatment planning. The child, to the extent of his or her capability, and the child's parent or guardian, shall have the right to participate in the planning of services, including the right to participate in the development and periodic revision of the child's individual plan of care. The child's attorney or other representative shall also have the right to participate in the planning process, including attending individual plan of care development and review meetings, upon the request of the child or child's parent or guardian.
(8) Right to private and uncensored communications by mail, telephone and visitation.
(a) This right may be restricted only if the treatment provider documents in the child's record that, in the absence of this restriction, significant physical or clinical harm will result to the child 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.
(b) The parent or guardian and the child, in a developmentally appropriate manner, shall be given specific written notice of each restriction of the child's right to communicate. The treatment 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 treatment provider.
(c) A child shall have the right to uncensored communication with licensed attorneys at law and the state protection and advocacy agency.

(d) The state protection and advocacy agency shall be permitted access to a child and the child's records consistent with federal and state statutes and regulations governing such access. The child's juvenile court attorney and court appointed special advocate (CASA), if any, shall have access to the child and the child's records in accordance with applicable statutes and administrative rules.
(9) Right to personal possessions.
(a) A child shall have the right to wear his or her own clothing and to keep personal possessions. The provider must provide the child with a reasonable amount of storage space for this purpose.
(b) Possession and use, including reasonable restriction of the time and place of use, of certain classes of property may be restricted by the treatment provider if necessary to prevent the child or others from harm, provided that notice of this restriction is given to all children and their families upon the child's admission.
(c) An individual item not subject to general restriction but substantially likely to cause significant physical or clinical harm to a particular child or others due to the child's individual clinical condition may be restricted if the harm that would be likely to result is specifically documented in the child's record. The parent or guardian and the child, in a developmentally appropriate manner, shall be given specific written notice of each such restriction.
(10) Right to receive educational services in the least restrictive environment. Including, if the child is eligible, a free appropriate public education under the Individuals with Disabilities Education Act, 20 USC, Secs. 1401 et seq. Section 504 of the Rehabilitation Act of 1973, 29 USC Sec. 794, and related federal and state statutes and regulations.
(11) Right to refuse to perform routine labor tasks for the provider and to receive reasonable compensation for all work performed other than personal housekeeping duties or chores.
(12) Right to be free from unusual or hazardous treatment procedures and to not participate in experimental treatment procedures without voluntary informed consent.
(13) Right to be free from seclusion or restraint unless used in compliance with all applicable statutes and administrative rules.
(14) Right to freely exercise recognized and accepted religious beliefs and other civil rights.
(15) Right to be thoroughly informed of the provider's rules and regulations.

(16) Right to participate regularly in developmentally appropriate indoor and outdoor play and recreation.
(17) Right to make 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.
(18) Right to consent to disclosure of clinical records. The person consenting to treatment, usually the custodial parent or guardian, has the right to authorize disclosure of the child's clinical record in accordance with ORS 179.505. When a child is admitted for treatment under a voluntary placement agreement with SCF, the parent(s) or guardian shall have the right to authorize disclosure.
(19) Right of assertion of rights. The rights contained in this section may be asserted and exercised by the child (except where the law requires that only the parent or guardian may exercise a particular right), the child's parent or guardian, or any representative of the child.
(20) Right of formal complaint. The child, parent or guardian or child's representative shall have the right to assert formal complaints concerning denial of any rights contained in this section in a fair, timely and impartial formal complaint procedure. There shall be no retaliation or punishment for exercise of any rights contained in this section.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1180 Behavior Management

(1) Providers shall have a written behavior management policy specifying which behavior management practices and restrictions may be used by staff and the circumstances under which they may be used. The behavior management policy shall:
(a) Establish a framework, which assures consistent behavior management practices throughout the program and articulates a rationale consistent with the provider's philosophy of treatment;
(b) Require the provider to obtain informed consent upon admission from the parent(s) or guardian in the use of behavior management practices and communicate both verbally and in writing the information to the parent(s) or guardian and the child in a developmentally appropriate manner;
(c) Establish thresholds and tracking mechanisms of behavior management interventions that will activate clinical review and which shall be relevant to the acuity and severity of symptoms, and developmental functioning of the population served by the provider;

(d) Require that when thresholds established in the policy are exceeded that the child's individual plan of care be reviewed and revised if necessary within no more than 24 hours and specifies the individual(s) in the program with designated clinical leadership responsibilities who must participate in the review, and specify that the review be documented in the child's clinical record;
(e) Describe the manner and regime in which all staff will be trained to manage aggressive, assaultive, maladaptive, or problem behavior and de-escalate volatile situations through a Division approved crisis intervention training program, and require that such training shall occur annually; and
(f) Require that the provider review and update behavior management policies, procedures, and practices, minimally annually.
(2) Individual behavior management interventions will be developed, implemented, and reviewed for each child, review shall occur minimally at each individual plan of care review.
(3) Each staff directed behavior management intervention that isolates a child for more than 15 minutes shall be noted in the child's clinical record:
(a) The cumulative data shall be reviewed by the child's interdisciplinary team and be reported in the next required individual plan of care review summary;
(b) The individual plan of care shall outline use of this procedure, therapeutic alternatives, and methods to reduce its use; and
(c) Assure that when incidents of isolation for more than five hours in five days or a single episode of two hours the psychiatrist or designee shall within 24 working hours convene by phone or in person individual(s) in the program with designated clinical leadership responsibilities to review the child's individual plan of care and behavior management interventions and make necessary adjustments. This information shall be documented in the child's clinical record and referred to the Special Treatment Procedures Committee.
Stat. Auth.: ORS 430.041, 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1190 Special Treatment Procedures

(1) Providers shall have policies and procedures and a quality management system to:
(a) Monitor the use of special treatment procedures to assure that children are safeguarded and their rights are always protected; and
(b) Review and approve experimental practices other than medications that are outside usual and customary clinical practices and research

projects. Experimental practices and research require review and approval by the Division Institutional Review Board.
(2) Chemical restraint shall not be used. Medication shall not be used as a restraint, but shall be prescribed and administered according to acceptable nursing, medical, and pharmaceutical practices to treat symptoms of serious emotional disorders.
(3) Mechanical restraint shall be used only in a Sub-Acute program specifically authorized for such use in writing by the Division. Sub-Acute programs that are authorized to use mechanical restraint shall adhere to the standards for special treatment procedures as described in this section and other specific conditions as required by the Division.
(4) The provider shall establish a Special Treatment Procedures Committee or designate this function to an already established Quality Management Committee. Committee membership shall minimally include a staff person 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 special treatment procedures with individual children. The committee shall:
(a) Meet at least monthly and shall report in writing to the provider's Quality Management Committee at least quarterly regarding the committee's activities, findings and recommendations;
(b) Conduct individual and aggregate review of incidents of seclusion and manual restraint;
(c) Conduct individual and aggregate review of incidents of isolation for more than five hours in five days or a single episode of two hours;
(d) Analyze special treatment procedures to determine opportunities to reduce their use, increase the use of alternatives, improve the quality of care of children receiving services, and recommend whether follow up action is needed; and
(e) Review and update special treatment procedures policies and procedures minimally annually.
(5) Obtain informed consent upon admission from the parent(s) or guardian in the use of special treatment procedures. Communicate both verbally and in writing the information to the parent(s) or guardian and the child in a developmentally appropriate manner.
(6) General Conditions of Manual Restraint and Seclusion.
(a) There shall be a systematic approach, documented in written policies and procedures to the treatment of children which employs individualized, preplanned alternatives to manual restraint and seclusion;

(b) Manual restraint and seclusion shall only be used in an emergency to prevent immediate injury to a child who is in danger of physically harming him or her self or others in situations such as the occurrence of, or serious threat of violence, personal injury or attempted suicide;
(c) Any use of manual restraint and seclusion shall respect the dignity and civil rights of the child;
(d) A child shall be manually restrained or secluded only when clinically indicated and alternatives are not sufficient to protect the child or others as determined by the interdisciplinary team responsible for the child's individual care plan;
(e) The use of manual restraint and seclusion shall be directly related to the child's individual symptoms and behaviors and the acuity of the symptoms and behaviors. Manual restraint and seclusion shall not be used as punishment, discipline, or for the convenience of staff;
(f) Manual restraint and seclusion shall only be used for the length of time necessary for the child to resume self-control and prevent harm to the child or others;
(g) If manual restraint and seclusion are considered as part of the child's individualized safety needs, then alternatives to manual restraint and seclusion shall be identified and made a part of the child's individual plan of care. The individual plan of care shall outline use of this procedure, and goals addressing therapeutic alternatives and interventions to reduce its use; and
(h) Each incident of manual restraint and seclusion shall be referred to the Special Treatment Procedures Committee.
(A) Manual Restraint:
(i) Each incident of manual restraint shall be documented in the clinical record. The documentation shall specify less restrictive methods attempted prior to the manual restraint, the required authorization, length of time the manual restraint was used, the events precipitating the manual restraint, assessment of appropriateness of the manual restraint based on threat of harm to self or others, assessment of physical injury, and the child's response to the intervention;
(ii) A minimum of two staff shall implement a manual restraint. If in the event of an emergency a single staff manual restraint has occurred, the provider's on-call administrator shall immediately review the intervention;
(iii) A manual restraint intervention that exceeds 30 minutes shall require a documented review and authorization by a QMHP, interventions which exceed one hour shall require a documented review and authorization by a psychiatrist or designee; and

(iv) A designated individual with clinical leadership responsibilities shall review the manual restraint documentation prior to the end of the shift in which the intervention occurred.
(v) If incidents of manual restraint used with an individual child cumulatively exceed five hours in five days or a single episode of one hour, the psychiatrist or designee shall within 24 hours convene by phone or in person individual(s) in the program with designated clinical leadership responsibilities to review the child's individual plan of care and/or behavior management interventions and make necessary adjustments. This information shall be documented in the child's clinical record and referred to the Special Treatment Procedures Committee.
(B) Seclusion:
(i) Each episode of seclusion shall be authorized immediately after initiation of the episode in the child's clinical record by the psychiatrist. A general order for the use of seclusion is not sufficient. The psychiatrist may delegate the authority to authorize seclusion to QMHP staff who have satisfactorily completed a Division-approved crisis intervention training program;
(ii) Written orders for seclusion are limited to two hours for children age nine and older and one hour for children under age nine. The psychiatrist may extend the original order for one additional hour for children under age nine to two hours total, and the original order for two hours for children age nine and older up to six hours total;
(iii) Visual monitoring of a child in seclusion shall occur and be documented at least every fifteen minutes or more often as clinically indicated;
(iv) The child's right to retain personal possessions and personal articles of clothing may be suspended during a seclusion only when necessary to ensure the safety of the child or others. Articles that a child might use to inflict self-injury must be removed;
(v) The child shall have regular meals, bathing, and use of the bathroom during seclusion and their provision shall be documented in the child's clinical record;
(vi) Each incident of seclusion shall be documented in the child's clinical record. The documentation shall include the clinical justification for use, the written order by the authorized individual, the less restrictive methods attempted, length of time the seclusion was used, the precipitating events, assessment of appropriateness of the intervention based on threat of harm to self or others, assessment of physical injury, and the child's response to the intervention; and

(vii) If incidents of seclusion used with an individual child cumulatively exceed five hours in five days or a single episode of more than two hours for children age nine and older and more than one hour for children under age nine, the psychiatrist or designee shall within 24 hours convene by phone or in person individual(s) in the program with designated clinical leadership responsibilities to review the child's individual plan of care and/or behavior management interventions and make necessary adjustments. This information shall be documented in the child's clinical record and referred to the Special Treatment Procedures Committee.
(7) Application for the use of seclusion. Any facility or program in which the use of seclusion occurs shall be authorized by the Division for this purpose and shall meet the following requirements:
(a) A facility or program seeking authorization shall submit a written application to the Division;
(b) Application shall include a comprehensive plan for the need for and use of seclusion of admitted children 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 management 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 the records of the facility's clients, the physical plant of the facility, the employees of the facility, the professional credentials of employees, and shall have the opportunity to observe fully the treatment and seclusion practices employed by the facility;
(e) After the review, the Assistant Administrator or designee shall approve or disapprove the facility's application and if, approved, 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.
(8) Structural and physical requirements for seclusion. Any facility or program in which the use of seclusion occurs shall be certified by the

Division for this purpose. A provider seeking this certification under these rules shall have available at least one room that meets the following specifications and requirements:
(a) The room must be of adequate size to permit three adults to move freely and allows for one adult to lie down. Any newly constructed room shall be no less than 64 square feet;
(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;
(c) The room shall contain no protruding, exposed, or sharp objects;
(d) The room shall contain no furniture. A fireproof mattress or mat shall be available for comfort;
(e) Any windows shall be made of unbreakable or shatterproof glass, or plastic. Non-shatterproof glass shall be protected by adequate climb-proof screening;
(f) There shall 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;
(g) 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 must have breakaway strength of under 80 pounds. In lieu of sprinklers, combined smoke and heat detector shall be used with similar protective design or installation;
(h) 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;
(i) The room shall be designed and equipped in a manner that would not allow a child to climb off the ground;
(j) Walls, floor and ceiling shall be solidly and smoothly constructed, to be cleaned easily, and have no rough or jagged portions; and
(k) Adequate and safe bathrooms shall be available.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1200 Quality Management

Providers shall have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to children and families. The Quality Management

system shall include a Quality Management Committee and a Quality Management Plan which together implement a continuous cycle of assessment and improvement of clinical outcomes based on measurement and input from service providers and representatives of the children and families served.
(1) Providers shall have a continuous quality management process that:
(a) Establishes and reviews expectations about quality and outcomes; and
(b) Seeks to correct any observed deficiencies identified through its quality management process.
(2) The overall scope of the Quality Management process is described in a written plan which identifies mechanisms, committees or other means of assigning responsibility for carrying out and coordinating the Quality Management process activities, and which includes:
(a) Indicators of quality;
(b) Methods of monitoring;
(c) Reporting of results; and
(d) Follow-up mechanisms.
(3) The written Quality Management Plan shall describe the implementation and ongoing operation of the functions performed by the Quality Management Committee.
(a) The plan shall be reviewed and revised annually; and
(b) The provider's board shall review the annual Quality Management report and approve the annual Quality Management plan.
(4) The Quality Management Plan shall include:
(a) A description of the Quality Management Committee's authority to identify and implement clinical and organizational changes;
(b) The composition and tenure of the Quality Management Committee;
(c) The schedule of Quality Management Committee(s) meetings;
(d) Provisions which require activities to evaluate and recommend improvements as necessary in the following domains:
(A) Quality of care provided to children and families;
(B) Integration and coordination of services between the provider and other entities associated with the child and family;
(C) Child and parent and/or guardian satisfaction; and
(D) Clinical outcomes.
(e) The requirements that the following review activities are conducted and integrated into the overall Quality Management process:
(A) Review of the use of special treatment procedures;
(B) Review of grievances, formal complaints, incidents or accidents; and

(C) Review of problems with the administration or prescription of medications.
(5) The provider shall have a Quality Management Committee that meets at least quarterly. The Quality Management Committee shall be composed of:
(a) One or more qualified mental health professionals 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; and
(d) A representative of external agencies.
(6) Quality Management activities are conducted with representation of those who have knowledge or ability to effect continuous quality improvement.
(7) The Quality Management process is conducted with input from children, families, and community stakeholders.
(8) The provider has a participatory process whereby all personnel contribute to and recommend changes in the Quality Management process.
(9) The provider assures that the psychiatrist participates and is involved in quality management activities and is recognized within the staff organization as a member of the quality management committee with responsibilities described in the provider's quality management plan.
(10) Quality Management activities are conducted in accord with the applicable Oregon Revised Statutes, Oregon Administrative Rules and the provider's policies and procedures with regard to confidentiality.
(11) Documentation of the pertinent facts and conclusions of each Quality Management Committee meeting shall be maintained and be available for review by the Division.
(12) An annual report of Quality Management activities and data shall be available for review by the Division.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1210 Formal Complaints

(1) The child, or the person consenting to the child's treatment, has the right to file an oral or written formal complaint with the entity providing services and receive a timely response. All providers will:
(a) Have written procedures for accepting, processing and responding to oral or written formal complaints. The written procedures must include:
(A) The process for registering an oral or written formal complaint;

(B) The time lines for processing an oral or written formal complaint; and
(C) Notification of the appeals process, including time lines for a formal complaint and the provision of the appropriate appeal forms.
(b) Designate a staff person to coordinate formal complaint information, receive formal complaint information, assist any person who needs assistance with the process, and enter the information into a log. The log will identify, at a minimum, the person lodging the formal complaint, the date of the formal complaint, the nature of the formal complaint, the resolution and the date of the resolution.
(c) Have written procedures for informing children and their legal guardian orally and in writing about the provider's formal complaint procedures.
(d) Have written procedures for processing an expedited formal complaint request if it is believed the child's health is at risk. A request for expedited formal complaint must be filed by the child or the person consenting to the child's treatment and must include the following:
(A) A statement requesting an expedited formal complaint;
(B) An explanation of the urgency of resolving the issue; and
(C) A description of the consequences of following the regular formal complaint process.
(2) 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 shall have written policies and procedures in compliance with applicable Oregon Medical Assistance Program Administrative Rules for accepting, processing and responding in writing within five working days to service denial complaints. 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.
(3) Hearing request for Medicaid and CHIP eligible children. In accordance with applicable Oregon Administrative Rules, providers shall have a written appeals process whereby a Medicaid or CHIP eligible child, or the person consenting to treatment for the child, can assert his or her right to file a request for hearing as a result of a denial of service or an adverse finding against the complainant.
(4) Hearing request for children who are not Medicaid or CHIP eligible. Providers shall have a written appeals process for non-Medicaid, non-CHIP eligible children with at least one level of appeal at the provider

level. The appeals process must culminate in a hearing by the Division Administrator or designee if the complaint cannot be satisfactorily resolved at the provider level.
Stat. Auth.: ORS 430.041, ORS 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1220

Certificate of Approval

(1) Providers shall be in compliance with these rules and hold a valid Certificate of Approval issued by the Division to provide children's intensive mental health treatment services as described in these rules.
(2) A provider who is determined by the Division to be in substantial compliance with these rules may receive a Certificate of Approval valid for up to three years.
(3) A provider who is determined by the Division to be not in substantial compliance with these rules may, at the discretion of the Division, receive a time-limited Certificate of Approval of less than three years and may have conditions for compliance placed on the Certificate of Approval.
(4) The Division may require a provider who is not in compliance with these rules to develop a Plan of Correction within a time period specified by the Division. The Division may accept, reject, or modify the Plan of Correction or require the provider to comply with a Plan of Correction directed and approved by the Division.
(5) The Division at its discretion may terminate the provider's Certificate of Approval to provide children's intensive mental health treatment services, withhold funds, or apply other applicable sanctions allowable in rule and statute for failure to comply with these rules.
Stat. Auth.: ORS 430.041, ORS 743.556 & ORS 430.640(1)(h)
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1230

Variance

A variance from portions of these rules that are not derived from federal regulations or the Office of Medical Assistance Program (OMAP) General Rules may be granted for a period of up to one year or a time period specified on the provider's Certificate of Approval in the following manner:
(1) The provider shall submit to the Assistant Administrator of the Division a written request which includes:
(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;
(c) The alternative practice proposed; and
(d) A plan and timetable for compliance with the section of the rule from which the variance is sought.
(2) The Assistant Administrator of the Division shall approve or deny the request for variance in writing.
(3) The Division shall notify the provider of the decision in writing within 30 days of the receipt of the request.
(4) Appeal of the denial of a variance request shall be to the Administrator of the Division whose decision shall be final.
(5) All variances must be reapplied for as directed by the Division.
Stat. Auth.: ORS 430.041, ORS 743.556 & ORS 430.640(1)(h)
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00