Standards for Children's Intensive Community-Based Treatment and Support Services

309-032-1240

Purpose

These rules prescribe standards and procedures for providers of intensive community-based treatment and support services within the continuum of mental health care for children with serious mental, emotional, and behavioral disorders and their families. These rules apply to any certified provider of Community Mental Health Treatment Services for Children and to any certified provider of Children's Intensive Mental Health Treatment Services who are also certified as providers of Intensive Community-Based Treatment and Support Services. Children will be referred to providers certified under these rules based on a Level of Need Determination. The planning and provision of intensive community-based treatment and support services must promote collaboration between families as equal partners with providers and community resources in determining how best to meet the mental health needs of the child and family. These rules set standards for the provision of intensive psychiatric and mental health services and supports that are individualized, comprehensive, coordinated, child-centered, family-driven and culturally competent. The planning and provision of intensive community-based treatment and support services must ensure that the child and family are served in the most natural setting possible and disruptions to the child's school and home life are minimized. The goals of the service planning process are to build on child and family strengths in providing services that are directed toward successful home, school, and community functioning. Service planning must be flexible and responsive to the type, intensity, location, and duration of psychiatric and mental health services and supports that would benefit the child and family.

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Stats. Implemented: ORS 430.630
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309-032-1245

Definitions

Definitions as used in these rules:

(1) "Behavior support plan" means the individualized strategies and techniques that are used by the family and providers to facilitate positive behavioral change in the child.

(2) "Behavior support policy" means the written policies and procedures adopted by the provider that describe the behavioral interventions and practices that may be used by the

provider to support a child who is receiving services from the provider to manage his or her maladaptive or problem behavior.

(3) "Care coordination" means a process oriented activity that provides ongoing communication and collaboration with children and families with multiple needs. Care coordination includes: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.

(4) "Case management" means a goal oriented activity that assists children, youth, and families. Case management includes: identifying strengths and needs; identifying, brokering and linking to community services and resources; assisting in obtaining entitlements; advocating on behalf of families; providing support and consultation to families; facilitating access to intensive services; and providing crisis planning, prevention, and intervention services.

(5) "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 ICTS services.

(6) "Child and family team" means those individuals who are responsible for creating, implementing, reviewing, and revising a service coordination plan. At minimum the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family.

(7) "Clinical supervision" means the documented oversight by a Clinical Supervisor of mental health treatment services provided by Qualified Mental Health Professionals, Qualified Mental Health Associates, or mental health paraprofessionals. Clinical Supervision includes evaluating the effectiveness of the mental health treatment services provided. Clinical Supervision is performed on a regular, routine basis.

(8) "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, Qualified Mental Health Associates, or mental health paraprofessionals.

(9) "Community Mental Health Program" or "CMHP" means an organization that provides all services for persons with mental or emotional disorders, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse

problems, operated by, or contractually affiliated with, a local mental health authority, as provided in ORS 430.630(10) or a local public health authority as provided in ORS 431.375, and operated in a specific geographic area of the state under an omnibus contract with the Department of Human Services.

(10) "Comprehensive mental health assessment" means the written documentation by a QMHP of the child's presenting mental health problem(s) and mental status, and evaluation of the child's functioning in the following domains: emotional, cognitive, family, developmental, behavioral, social, physical health, nutritional, school or vocational, substance use, cultural, spiritual, recreational, and legal. 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 treatment plan.

(11) "Comprehensive mental health assessment update" means the written documentation by a QMHP of the most current information related to all domains of a Comprehensive Mental Health Assessment.

(12) "Department" means the Department of Human Services.

(13) "Discharge criteria" means the diagnostic, behavioral, and functional indicators that, when met, means that service is complete. Discharge criteria must be documented in the child's mental health treatment plan.

(14) "Discharge summary" means written documentation of the last service contact with the child. Documentation must include the diagnosis at enrollment, and a summary statement that describes the effectiveness of treatment modalities and progress, or lack of progress, toward treatment objectives as documented in the mental health treatment plan. The discharge summary also includes the reason for discharge, changes in diagnosis during treatment, current level of functioning, prognosis, and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.

(15) "DSM" means the text revision of the 4th edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-IV-TR) published by the American Psychiatric Association.

(16) "Evidence-based practice" or "EBP" means clinical and preventive mental health services that are based on the most current information from generally accepted scientific research and approved by OMHAS.

(17) "Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, caregivers and other primary relations to the child whether by blood, adoption, legal or social relationship.

(18) "Family support" means the provision of supportive services. It includes: support to caregivers at community meetings; assistance to families in system navigation and managing multiple appointments; supportive home visits; peer support, parent mentoring and coaching; advocacy; and furthering efforts to develop natural and informal community supports.

(19) "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.

(20) "ICTS discharge criteria" means the written diagnostic, behavioral, and functional indicators the child and family will meet to transition out of ICTS services as documented in a child's service coordination plan.

(21) "ICTS discharge summary" means a written document developed by the child and family team that is completed prior to discharge from intensive community-based treatment and support services that is based on the service coordination plan. It includes: a review of service coordination planning; type and duration of services, supports, and levels of care utilized; concerns that arose during the planning process; and significant child and family accomplishments. The summary will also include recommendations about and planning to coordinate access to ongoing services and supports that would benefit the child and family as well as any other transition planning that will ensure continuity of care.

(22) "Informed consent to treatment" means that the information about a specific diagnosis and the risks or benefits of treatment options and the consequences of not receiving a specific treatment are understood by the child, if able, and the parent or guardian, if involved. The person consenting to treatment voluntarily agrees in writing, as required in ORS 430.210(d), to a prescribed treatment for the specific diagnosis.

(23) "Intensive community-based treatment and support services" or "ICTS" means a specialized set of in-home and community-based supports and mental health treatment services that are delivered in the most normative, least restrictive setting. Intensive community-based treatment and support services include, but are not limited to: crisis prevention and intervention; care coordination; case management; individual, group and family therapy; psychiatric services; skills training; family support; respite care; and team-driven service coordination planning.

(24) "Intensive treatment services" or "ITS" means a specific range of service components in the system of care. Intensive treatment services include treatment foster care, therapeutic group homes, psychiatric day treatment, partial hospitalization, psychiatric residential treatment, sub-acute care or other services as determined by

OMHAS that provide active psychiatric and mental health treatment for children with severe emotional disorders and their families.

(25) "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. 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 supportive involvement.

(26) "Level of need determination" means the OMHAS approved process by which children are assessed for medically appropriate mental health treatment.

(27) "Licensed Medical Practitioner" or "LMP" means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(28) "Local Mental Health Authority" or "LMHA" means one of the following entities:

(a) The board of county commissioners of one or more counties that establishes or operates a community mental health and developmental disabilities program;

(b) The tribal council, in the case of a federally recognized tribe of Native Americans, that elects to enter into an agreement to provide mental health services; or

(c) A regional local mental health authority comprised of two or more boards of county commissioners.

(29) "Medically appropriate" means services, which are required for prevention (including preventing a relapse), diagnosis or treatment of mental health conditions. Services 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. Services are not solely for the convenience of the provider of the services, child or family; and are the most cost effective of the alternative levels of services, which can be safely and effectively provided to the child and family.

(30) "Mental Health Organization" or "MHO" means an entity under a risk-bearing contract with OMHAS to provide mental health services on a prepaid, capitated basis.

(31) "Mental status exam" means the face-to-face assessment by a QMHP of a child's mental functioning within a developmental and cultural context. It 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.

(32) "Office of Mental Health and Addiction Services" or "OMHAS" means the program office of the Department of Human Services responsible for the administration of mental health and addiction services for the State of Oregon.

(33) "Paraprofessional" means a family member, peer, natural support, or other person whose education, experience, and competence are adequate to permit them to provide direct mental health services such as family support and respite care to children, youth, and families under the supervision of a QMHP.

(34) "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 a treatment plan.

(35) "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.

(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 a treatment plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family and/or group therapy within the scope of their training.

(36) "Respite care" means planned and emergency interventions designed to provide temporary relief from care giving in order to maintain a stable and safe living environment. Respite care can be provided in or out of the home and includes supervision of and behavioral support for the child.

(37) "Service coordination plan" means a written summary document that incorporates and supports the relevant plans, services, and supports that are being provided to the child and family by the providers, agencies, and others who comprise the child and family team as well as defining roles and responsibilities of each party. The service coordination plan is formulated by the team and approved by the family.

(38) "Service intensity" means the relative amount, frequency, intensity, and duration of mental health services provided to a child and family that is based on the assessed needs of the child and family specific to the child's diagnosis, level of functioning, and the acuity and severity of the child's psychiatric symptoms.

(39) "Skills training" means providing parenting information and behavior support training and planning to parents or caregivers as well as skills development for children and transitional youth. It may include developing and strengthening competencies that include but are not limited to areas such as anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, managing symptoms, and adapting the home and other settings to mitigate triggers to maladaptive behavior. The goal of this service is to maintain a stable living environment, positive interpersonal relationships, and participation in developmentally appropriate activities.

(40) "Treatment plan" means the written plan developed jointly by the QMHP and the child with his or her family, if appropriate. The treatment plan specifies the DSM diagnosis, goals, measurable objectives, specific treatment modalities and evidence-based practices. It is based on a completed comprehensive mental health assessment or assessment update of the child's functioning and the acuity and severity of psychiatric symptoms.

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Stats. Implemented: ORS 430.630

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309-032-1250

General Conditions of Participation for Children's Intensive Community-Based Treatment and Support Services Providers

Providers delivering or ensuring the provision of children's intensive community-based treatment and support services must:

(1) Hold a valid Certificate of Approval issued by the Office of Mental Health and Addiction Services (OMHAS) to deliver intensive community-based treatment and support services, and, when applicable, a license or certification from the Department of Human Services, State Office for Children, Adults, and Families;

(2) Maintain the organizational capacity and interdisciplinary treatment capability to deliver or ensure the provision of medically appropriate services to meet the assessed needs for treatment in the amount, intensity, and duration for each child specific to the child's diagnosis, level of functioning and the acuity and severity of the child's psychiatric symptoms;

(3) Use evidence-based treatment methods appropriate for children with severe mental, emotional, or behavioral disorders and professional standards of care;

(4) Assure that mental health services are provided under clinical supervision;

(5) Maintain policies describing procedures for admission, transition, and discharge;

(6) Demonstrate family involvement and participation in all phases of assessment, service planning and the child's treatment by documentation in the child's clinical record. At a minimum there must be documentation that all completed assessments have been reviewed and explained to the family or youth of legal age and to the child in a developmentally appropriate fashion;

(7) Maintain a formal relationship with a family organization for the purpose of assuring that family voice is part of all decision making and planning for the development of services, quality assurance, and use of resources. The formal relationship includes the following:

(a) The relationship is defined in a written agreement; and

(b) Family representation is included on governing and advisory bodies in numbers that result in meaningful participation.

(8) Develop a policy on family involvement that includes specific supports to family members that address and prevent barriers to family involvement;

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

(10) Enroll children in Client Process Monitoring System when the child's mental health services are funded all or in part by OMHAS funds;

(11) Maintain policies and procedures prohibiting on- or off-site non-professional relationships and activities between employees and 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 service plan;

(12) Provide services for children in a smoke free environment in accordance with Public Law 103.277, the Pro-Child Act;

(13) Demonstrate education service integration in all phases of assessment, service planning, active treatment, and transition and discharge planning by documentation in the child's clinical record;

(14) Maintain policies and procedures to ensure safety and provide for the emergency needs of children, families, and staff including:

(a) Medical emergencies; and

(b) Facility and environmental emergencies.

(15) Demonstrate cultural competency, gender responsiveness and language appropriateness in the delivery of services to clients and their families;

(16) Demonstrate oversight by a governing body whose membership reflects diverse community interests and whose organization and operation must be set out in writing;

(17) Develop and publish a comprehensive document which describes the mission statement, treatment philosophy, including research or evidence basis for treatment models used, and program descriptions for the provision of intensive community-based treatment and support services; and

(18) Develop policies and procedures for orientation of children and families that consider orientation times convenient for the family and that provide for adequate child and family preparation.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630

Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1255

Award and Applicability of Certificates of Approval to Provide Children's Intensive Community-Based Treatment and Support Services

Certificates of Approval to provide children's intensive community-based treatment and support services may be applied for by a mental health services provider as defined in OAR 309-012-0140. The mental health services provider must either hold a valid Certificate of Approval issued by OMHAS to provide Children's Intensive Mental Health Treatment Services or a Certificate of Approval issued jointly by OMHAS and a CMHP to provide Community Mental Health Treatment Services for Children.

(1) Mental health services providers who hold a current and valid Certificate of Approval to provide children's intensive mental health treatment services may apply to OMHAS for a Certificate of Approval to provide intensive community-based treatment and support services. Applications must include evidence that the Local Mental Health Authority has been notified and has been given an opportunity to comment about the ITS provider's efforts to become ICTS certified and about the ITS provider's potential to serve children from the child's LMHA area. Certification of an ICTS provider can be effective for a maximum of three years and may be renewed thereafter by OMHAS.

(2) Mental health services providers who hold a current and valid Certificate of Approval to provide community treatment services for children may apply to the CMHPs to recommend that OMHAS issue a Certificate of Approval to provide intensive community-based treatment and support services. Certification of an ICTS provider can be effective for a maximum of three years and may be renewed thereafter by OMHAS.

(3) Following the completion of the application process, and any reviews deemed necessary by OMHAS or the CMHP, one of the following determinations will be made by OMHAS:

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

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

(c) That the applicant may be awarded a Certificate of Approval with specified conditions as described in OAR 309-012-0200 and at the discretion of OMHAS, receive a time-limited Certificate of Approval of less than three years and may have conditions for compliance placed on the Certificate of Approval to provide intensive community-based treatment and support services.

(4) OMHAS may require a provider who is not in compliance with these rules to develop a Plan of Correction within a time period specified by OMHAS. OMHAS may accept, reject, or modify the Plan of Correction or require the provider to comply with a Plan of Correction directed and approved by OMHAS.

(5) OMHAS, at its discretion, may terminate the provider's Certificate of Approval to provide intensive community-based treatment and support services, withhold funds, or apply other applicable sanctions allowable in rule and statute for failure to comply with these rules.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1260

Service Coordination Planning

ICTS providers must ensure that children and families referred to them through the level of need determination process receive care coordination when supported by the family. Providers must ensure that:

(1) A child and family team is identified and organized jointly with the family;

(2) A child and family team meeting is convened and an initial Service Coordination Plan, including any necessary crisis prevention and intervention planning, is developed no later than 14 calendar days from the date the provider receives an authorized request for ICTS services;

(3) The Service Coordination Plan is completed within 30 calendar days from the date the provider receives an authorized request for ICTS services. The plan is reviewed and revised quarterly, and when changes in service coordination planning occur, by the child and family team. It includes:

(a) A strengths and needs assessment that includes all relevant domains of the comprehensive mental health assessment;

(b) Short- and long-term goals related to identified needs across domains;

(c) Planning that utilizes a combination of existing or modified formal services; newly created services; informal, formal and natural supports and community resources; and documentation of the individuals responsible for providing these services and supports;

(d) A proactive safety/crisis plan that utilizes professional and natural supports to provide 24 hours, seven days per week flexible response and is reflective of strategies to avert

potential crises without placement disruptions and provide appropriate interventions when crises occur; and

(e) ICTS discharge criteria as well as transition planning and coordination of the child's discharge from intensive community-based treatment and support services.

(4) The child receives medically appropriate mental health services and supports that include evidence-based practices, at the appropriate level of care, as determined by the ongoing service coordination planning by the child and family team; and

(5) Services and supports are documented in the child's clinical record.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1265

Intensive Community-Based Treatment and Support Services

ICTS providers must ensure that intensive community-based treatment and support services are made available to children and families referred to them through the level of need determination process. Services and supports must be provided by qualified individuals. Intensive community-based treatment and support services may be delivered at a clinic, facility, home, school, other provider/allied agency location or other setting as identified by the child and family team. Intensive community-based treatment and support services include but are not limited to:

(1) Providing or ensuring the provision of children's crisis services, which includes:

(a) 24 hours, seven days per week face-to-face or telephone screening to determine the need for immediate services for any child requesting assistance or for whom assistance is requested;

(b) 24 hours, seven days per week capability to conduct, by or under the supervision of a QMHP, a mental health status examination to determine the child's condition and the interventions necessary to stabilize the child;

(c) Provision of medically appropriate child and family, psychological, and psychiatric services necessary to stabilize the child;

(d) Referral to the appropriate level of care and linkage to other medically appropriate interventions necessary to protect and stabilize the child; and

(e) Linkage to appropriate social services.

(2) Comprehensive mental health assessment or assessment update.

(3) Psychiatric services provided by a Licensed Medical Practitioner.

(4) Medication management and monitoring.

(5) Individual, group and family therapy provided by a QMHP who has a child and adolescent mental health background and experience providing community-based, intensive services to families.

(6) Care coordination provided by a QMHP or QMHA supervised by a QMHP who has:

(a) Demonstrated competencies in child and adolescent mental health and experience providing intensive services to families;

(b) Extensive knowledge about services and resources available to children and families in the community;

(c) Experience facilitating service coordination meetings and collaborating with system partners; and

(d) Experience facilitating crisis prevention and intervention services.

(7) Case management provided by a QMHP or QMHA supervised by a QMHP who has:

(a) Demonstrated competencies in child and adolescent mental health and experience providing intensive services to families;

(b) Extensive knowledge about services and resources available to children and families in the community; and

(c) Experience facilitating crisis prevention and intervention services.

(8) Skills training provided by a QMHP or QMHA supervised by a QMHP who has:

(a) Demonstrated competency in child development, serious emotional and behavioral disorders and parenting-behavioral management;

(b) Extensive knowledge of community recreational, social and supportive resources; and

(c) Experience facilitating crisis prevention and intervention services.

(9) Family support and respite care provided by paraprofessionals who have:

(a) Specialized knowledge and experience that enables them to provide supportive services to families; and

(b) Received training that enables them to implement supportive services interventions to children and families coping with developmental, physical, medical, emotional and behavioral disorders.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1270

Staffing Requirements

(1) ICTS providers must have the clinical leadership and sufficient QMHP, QMHA and other staff to meet the 24-hours, seven days per week treatment needs of children served. The provider must establish policies and practices to assure:

(a) Availability of a LMP to meet the following requirements:

(A) Provide medical oversight of the clinical aspects of care and consult on clinical care;

(B) 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 treatment and service coordination goals; and

(C) Participate in the provider's 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) ICTS providers must have adequate numbers of QMHP, QMHA and other staff whose care specialization is consistent with the duties and requirements of the specific level of service intensity. Professional staff must operate within the scope of their training and licensure.

(3) Staffing must be adequate to provide timely response to crises, potential crises, and other urgent and non-urgent child and family service needs 24 hours a day, seven days per week for the clients they serve.

(4) Providers must have adequate numbers of qualified supervisory staff to oversee service delivery in community settings by QMHP, QMHA, and other staff.

(5) Providers must document in personnel files that all supervisory and clinical staff meet all applicable professional licensing and/or certification, and QMHP or QMHA competencies.

(6) Providers must document in personnel files that supervisory and clinical staff are qualified and meet competencies to provide ICTS services as defined by these rules.

(7) Providers must 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.

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Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1275

Behavior Support

Providers must have a written behavior support policy specifying which behavior support practices may be used by the provider, the circumstances under which they may be used, and how the practices will be clinically reviewed. Manual restraint, mechanical restraint, and seclusion may only be used by providers who are certified by OMHAS to use

restraint and seclusion as outlined in OAR 309-032-1100 through 309-032-1230. To ensure that providers are administering and documenting well defined responses of planned and therapeutic interventions to specific target behaviors, the provider's behavior support policy must:

(1) Outline behavior support techniques and treatment interventions used in accordance with a process established by care, treatment, and service leaders;

(2) Require that the selection of interventions considers clinical appropriateness and minimizes restrictiveness of interventions;

(3) Specify that a behavior support plan that outlines individualized behavior support techniques and interventions will be developed, implemented, and reviewed for each child. The policy must specify that each child must have thresholds of behavior support interventions that will activate a clinical review. The review must occur when thresholds have been surpassed and at each service coordination plan review;

(4) Establish a framework, which assures that the child, family, and others who comprise the child and family team have involvement with the child's behavior support plan, and that families are educated about and consent to the plan and treatment interventions, and are involved in the monitoring and updating of the plan;

(5) Describe the manner in which staff, paraprofessionals, or others identified in the behavior support plan will be trained to maintain the child's behavior support plan and manage aggressive, assaultive, or other problem behaviors and de-escalate volatile situations through a crisis intervention training program;

(6) Specify behavior support interventions and procedures that are prohibited including:

(a) Procedures that are implemented by another client or unauthorized person;

(b) Procedures that deny basic needs such as diet, water, shelter, or essential clothing; and

(c) Physical punishment or fear-eliciting procedures.

(7) Require that the provider review and update the behavior support policies, procedures, and practices annually; and

(8) Be reviewed and approved by the provider's clinical leaders.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1280

Establishment and Maintenance of Clinical Records

(1) A separate, individualized clinical record must be opened and maintained for each child served by an ICTS provider. If the ICTS provider is also the outpatient or ITS provider or both, the clinical record will include documentation of outpatient, ITS, and ICTS services.

(2) Each clinical record must be uniform in organization, readily identifiable and accessible, and contain all of the components required by this rule in a current and complete manner.

(3) All documentation required in this rule must be signed by the staff providing the service and making the entry. Signature must include the person's academic degree or professional credential and the date signed.

(4) All procedures in this rule requiring consent and the provision of such information to the consenting custodial parent or guardian or where appropriate, the child, must be documented in the clinical record on forms describing what the child or adult giving consent has been informed of, and asked to consent to, and signed and dated by the consenting person. If the provider does not obtain the required documentation, the reasons must be specified in the clinical record and signed by the qualified supervisor of the person responsible for provision of treatment services to the child.

(5) Errors in the clinical record must 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 in paper or electronic health records may not be corrected by removal or obliteration.

(6) References to other persons being treated by the CMHP, CMHP subcontractors, or other providers when included in the child's clinical record must preserve the confidentiality of the other clients.

(7) Clinical records must be secured, safeguarded, stored, and retained in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.

(8) All clinical records are confidential to the extent provided for in OAR 309-032-1030(9) and other state and federal laws, rules, or regulations.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1285

Clinical Record Documentation Requirements

The child's clinical record must contain adequate written information that is readily accessible and uniformly placed in the clinical record to include:

(1) Identifying data including the child's name, date of birth, sex, address, phone number, and name of parent(s) or legal guardian including an address and phone number if different;

(2) Level of need determination documentation;

(3) A comprehensive mental health assessment or assessment update to be completed within 14 calendar days from the date the provider receives an authorized request for ICTS services. An assessment update must include the most current information related to all domains of the Comprehensive Mental Health Assessment. Comprehensive mental health assessments and assessment updates are updated annually and reviewed and approved by the LMP;

(4) An individualized treatment plan to be completed within 30 calendar days from the date the provider receives an authorized request for ICTS services. The treatment plan is reviewed and revised quarterly and when changes in treatment planning occur and is approved by the LMP;

(5) A service coordination plan to be completed within 30 calendar days from the date the provider receives an authorized request for ICTS services. The plan is reviewed and revised quarterly, and when changes in service coordination planning occur, by the child and family team;

(6) Documentation of child and family team meetings;

(7) Documentation of the services recommended by the child and family team;

(8) Progress notes documenting specific treatments, interventions, and activities related to the implementation of the service coordination plan and the treatment plan;

(9) In addition to OAR 309-032-1285(7), monthly summary progress notes by the care coordinator that document that the child and family team has discussed progress with treatment and service coordination planning and if necessary convened a child and family team meeting to facilitate timely and appropriate service coordination planning;

(10) Written ICTS discharge criteria as documented in the service coordination plan;

(11) A written ICTS discharge summary related to the service coordination plan;

(12) Written discharge criteria as documented in the treatment plan;

(13) A written discharge summary related to the treatment plan; and

(14) A medication service record if medication is prescribed on the treatment plan.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1290

Child & Family Rights

Providers must establish written policies and procedures pertaining to child and family rights. The written statement of rights must be posted prominently in simple, easy to understand language on a form devised by the provider or the OMHAS. Written information must be provided in the non-English languages of the clients served. Information about rights must be available in alternate formats, taking into consideration the special needs of children and families. At the time of admission the provider must give this form to the person legally giving consent to treatment of the child. In addition, these rights must 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. Statement of Rights must include the following:

(1) The right to consent to treatment in accordance with ORS 109.640 and 109.675. A custodial parent or legal guardian, or a minor child under conditions described below, must give written informed consent to diagnosis and treatment.

(a) Minor children can give informed consent for outpatient diagnosis and treatment for a mental or emotional disorder in the following circumstances:

(A) Under age 18 and lawfully married.

(B) Age 14 or older.

(b) If the child is initially served in a crisis situation, these rights must 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.

(c) The custodial parent or legal guardian of any minor, age 14 or older who has consented to outpatient treatment or diagnosis, must be involved before the end of treatment unless:

(A) The parents refuse;

(B) There are clear clinical indications to the contrary;

(C) The child has been sexually abused by the parent; or

(D) The child has been legally emancipated by the court, or has been self sustaining for 90 days prior to obtaining treatment. As required in ORS 109.675, such refusal or the reasons for exclusion must be documented in the child's clinical record.

(2) The right to refuse services. The person giving consent to treatment has the right to refuse service, including any specific treatment procedure. If serious consequences may result from refusing a service, the provider must explain the consequences verbally or in writing to the custodial parent, the guardian, or the child who is refusing service. Service refusal must be documented in the clinical record.

(3) The right to confidentiality in accordance with ORS 179.505, 107.154, 418.312, and any other applicable state and federal regulation.

(4) The 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 and any other applicable state and federal regulation.

(5) The right to immediate inspection of the clinical record unless access is restricted 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 must be protected in provider publications such as newsletters and brochures.

(6) The right to participate in treatment planning and service coordination. The child, if appropriate, and the custodial parent(s) or legal guardian and others of their choosing, must have the opportunity to participate in an informed way in the treatment planning and service coordination process for the child, and in the review, at least every three months,

of the child's progress toward treatment goals and objectives. At a minimum, the following information should be discussed:

(a) Treatment and other interventions to be undertaken;

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

(c) Projected time to complete the treatment process;

(d) Benefits which can reasonably be expected; and

(e) Risks that may be involved in treatment, if any.

(7) The 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.

(8) 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.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1295

Quality Management

Providers must have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to children and families. Rules related to Quality Management and Quality Assurance as set forth in OAR 309-032-1060 are applicable to ICTS providers who are certified as providers of Community Mental Health Treatment Services for Children. Rules related to Quality Management and Quality Assurance as set forth in OAR 309-032-1295 are applicable to ICTS providers who are certified as providers of Children's Intensive Mental Health Treatment Services and providers of both Children's Intensive Mental Health Treatment Services and Community Mental Health Treatment Services for Children. Providers will implement a Quality Assurance system, which will assure compliance with the provisions of OAR 309-032-1240 through 309-032-1305.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1300

Grievances and Complaints

Rules related to grievances, complaints, service denials, appeals, and hearing requests as set forth in OAR 309-032-1030(4)-(6) are applicable to ICTS providers who are certified as providers of Community Mental Health Treatment Services for Children. Rules related to complaints, service denials, appeals, and hearing requests as set forth in OAR 309-032-1210 are applicable to ICTS providers who are certified as providers of Children's Intensive Mental Health Treatment Services and providers of both Children's Intensive Mental Health Treatment Services and Community Mental Health Treatment Services for Children.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1305

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 must submit a written request to the Assistant Administrator of OMHAS, 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 OMHAS must approve or deny the request for variance in writing.

(3) OMHAS will 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 must be to the Administrator of OMHAS whose decision will be final.

(5) All variances must be reapplied for as directed by OMHAS.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05