DIVISION 032

COMMUNITY TREATMENT AND SUPPORT SERVICES

Standards for Adult Mental Health Services

Purpose and Statutory Authority

309-032-0525 (1) Purpose. These rules prescribe standards and procedures for community mental health rehabilitation services for adults. All adult mental health services provided under this rule will endeavor to promote recovery, independence and successful community living, by or through:

(a) Communication of hope, and promotion of emotional, behavioral and psychological growth through persistent efforts to attain individual goals;

(b) The promotion of skills and knowledge to help individuals effectively manage their mental health concerns and develop a sense of hope and sense of self that is not illness dominated; and

(c) Providing a humane service environment that affords reasonable protection from harm including retraumatization.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 430.640(1)(h) to carry out the provisions of ORS 426.490 through 426.500 and 430.630.

Stat. Auth.: ORS 430.041 and 430.640
Stats. Implemented: OAR 426.490 through 426.500 & 430.630
Hist.:

Definitions

309-032-0535 As used in these rules:

(1) “Abuse” means one or more of the following:

(a) Any death caused by other than accidental or natural means.

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury.

(c) Willful infliction of physical pain or injury.

(d) Sexual harassment or exploitation, including but nor limited to any sexual contact between and employee of a facility or community program and an adult.

(2) “Adult” means and individual 18 years of age or older.

(3) “Case Management” means services provided by a QMHP or QMHA to a consumer who requires access to benefits and services from local, regional or state allied agencies or other service providers. Case management includes advocating for the consumer’s treatment needs, providing assistance in obtaining entitlements based on mental or emotional disability, accessing housing or residential programs, coordinating services including mental health

treatment, educational or vocational activities, and arranging alternatives to inpatient hospital services.

(4) "Client Process Monitoring System" or "CPMS", means the automated consumer data system maintained by the Division.

(5) “Clinical Formulation” means the documentation of the clinical judgments which lead to decisions in regard to diagnosis, prognosis, the priority and sequences of treatment goals and to the type and intensity of clinical interventions described in the treatment plan.

(6) “Clinical Record” means a collection of all documentation regarding a consumer’s mental health treatment and related services. It is a document and provides the basis by which the provider manages service delivery and quality management. For the purpose of confidentiality, it is considered a medical record as defined in ORS Chapter 179.

(7) "Community Mental Health Program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the Division.

(8) "Consumer" means an adult who receives or is eligible to receive mental health services from a provider funded and authorized through the Division.

(9) “Declaration for Mental Health Treatment” means a document that states the consumer’s preferences or instructions regarding mental health treatment as defined by ORS 127.000 through 127.737.

(10) "Diagnosis" means the principal mental disorder(s) identified in a five axis diagnosis listed in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, that constitutes the medically appropriate reason for clinical care and the main focus of treatment for a consumer. The diagnosis is determined through the mental health assessment and any examinations, tests, procedures, or consultation suggested by the assessment.

(11) “Discharge” means the conclusion of the planned course of services described in the individualized treatment plan, regardless of outcome or attainment of goals described in the individualized treatment plan.

(12) “Discharge Summary” means a written description of consumer status and progress related to goals and objectives listed in the treatment plan form the time of admission to the termination of services.

(13) "Division" means the Mental Health and Developmental Disability Services Division of the Oregon Department of Human Services.

(14) "Goal" means an expected result or condition to be achieved that provides a guideline for the direction of care, is reasonable and realistic, and is

related to an identified need or problem in the treatment plan. It also identifies what the consumer wishes to achieve.

(15) "Informed Consent" means the consumer and, if appropriate, guardian, after being provided with a description of the proposed services and information concerning potential risks and benefits of service procedures, has voluntarily agreed to participate in the services. This includes his/her right to participate in the development and periodic review of an individualized treatment plan, to be informed of his/her diagnosis (after the mental health assessment has been conducted), and an explanation of the purpose of any prescribed medication and potential side effects. The consumer is also informed of his/her right to withdraw consent and file a grievance at any time.

(16) "Licensed Medical Practitioner" or “LMP” means a person who meets the following minimum qualifications as documented by the LMHA or designee:

(a) Holds at least one of the following educational degrees and a valid license:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse practitioner licensed to practice in the State of Oregon; or

(C) Physician’s assistant licensed to practice in the State of Oregon;

(b) Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management; and

(c) When the LMP is not a psychiatrist, the LMP is required to have access to consultation services provided by a psychiatrist, either through directs employment by the provider or through written contract between the LMP and the consulting psychiatrist.

(17) "Local Mental Health Authority" (LMHA means the county court or board of county commissioners of one or more counties who choose to operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation which contracts with the Division to operate a CMHP for that county.

(18) "Medication use record" means information kept in the consumer's clinical record which documents medications and/or agents prescribed or recommended by, a LMP and includes medication progress notes as applicable.

(19) "Mental Health Assessment" means a process in which the consumer's need for mental health services is determined through evaluation of the consumer's strengths, goals, needs, and current level of functioning.

(20) "Objective" means the written statement of an expected result or condition that is related to the attainment of a stated or specified goal. The

objective is stated in measurable terms and has a specified time for accomplishment. This also means a step identified in order for a consumer to attain his/her individual goal.

(21) “Outreach” means the delivery of mental health services, referral services and case management services in non-traditional settings, such as, but not limited to, the consumer’s residence, shelters, streets, jails, transitional housing sites, drop-in centers or single room occupancy hotels.

(22) “Personal Care Plan” means a written plan which a case manager or other designated person develops for persons with mental illness after assessing an individual and considering the individual’s physician orders if any. The plan is developed jointly among the consumer, case manager, and residential caregiver, and identifies the care and services to be provided by the caregiver.

(23) “Persons Diagnosed with Serious Mental Illness” means an individual who is:

(a) Diagnosed by a QMHP as suffering from a chronic mental disorder as defined by ORS 426.495(2)(b) which includes, but is not limited to, conditions such as schizophrenia, serious affective and paranoid disorders, and other disorders which manifest symptoms that are not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism; which continue for more than one year, or on the basis of a specific diagnosis, are likely to continue for more than one year; and

(b) Is impaired to an extent which substantially limits the person’s consistent functioning in one or more of the following areas:

(A) Home environment: independently attending to shelter needs, personal hygiene, nutritional needs and home maintenance;

(B) Community negotiation: independently and appropriately utilizing community resources for shopping, recreation and other needs;

(C) Social relations: establishing and maintaining supportive relationships;

(D) Vocational: maintaining employment sufficient to meet personal living expenses or engaging in other age appropriate activities.

(24) “Program” means an organization or other entity certified in accordance with this rule to provide community mental health services to adults.

(25) "Progress Note" means a written summary of how treatment modalities are implemented as described in the consumer's treatment plan.

(26) "Provider" means an organizational entity, agency or individual certified and/or authorized by the Division or its contractors to deliver mental health services to consumers.

(27) "Qualified Mental Health Associate" or "QMHA" means a person who delivers services under the supervision of a QMHP, and who meets the following minimum qualifications as documented by the LMHA or designee:

(a) Has a bachelor's degree in a behavioral sciences field, or a combination of at least three year's work, education, training or experience; and

(b) Has the competencies necessary to:

(A) Communicate effectively;

(B) Understand mental health assessment, treatment and service terminology and to apply the concepts;

(C) Provide psychosocial skills development; and

(D) Implement interventions prescribed on a treatment plan.

(28) "Qualified Mental Health Professional" or "QMHP" means any person designated by the LMHA as a QMHP prior to the adoption of this rule, a LMP, or any other person meeting the following minimum qualifications as documented by the LMHA or designee:

(a) Possess one of the following education 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(s) field;

(E) Graduate degree in recreational art, or music therapy; or

(F) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(b) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental, emotional and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social, and work relationships; conduct a mental status assessment; document a multiaxial DSM diagnosis; write and implement or supervise implementation of a treatment plan; conduct and document a mental health assessment; and provide mental health treatment and rehabilitative services within the scope of his or her practice.

(29) "Recovery" means the process of a person regaining his/her health, safety, and independence following a diagnosis of a psychiatric disorder.

(30) "Supervisor" means a QMHP who has two years of postgraduate experience providing mental health services to adults and who, in accordance with this rule, reviews and oversees the services provided to consumers.

(31) "Treatment plan" means an individualized, written plan developed by a QMHP with consumer involvement which is based on the consumer's mental health assessment and defines specific service and treatment goals and objectives and the proposed interventions.

Stat. Auth.: ORS 430.041 and 430.640

Stats. Implemented: OAR 426.490 through 426.500 & 430.630
Hist.:

Adult Mental Health Services

309-032-0545(1) In accordance with ORS 426 and ORS 430 the following services shall be provided:

(a) Crisis services shall be readily available and include the following:

(A) 24 hours, seven days per week telephone or face-to-face screening to determine a person's need for immediate community mental health services; and

(B) Development of a written initial crisis plan which includes a provisional diagnosis and a brief description of the services necessary to help the individual effectively manage his/her mental health crisis.

(b) Mental health assessment and treatment planning;

(c) Coordination of services including housing, employment, and case planning with other agencies and resources;

(d) Medication management as identified in the consumer's individualized treatment plan;

(e) Individual, family and group therapies and other community-based services identified in the consumer's individualized treatment plan.

(2) In addition to the services listed in OAR 309-032-0545(1) case management services shall be made available to persons diagnosed with serious mental illness in accordance with ORS 426.500(3) and include the following:

(a) Assistance in applying for benefits to which the consumer is entitled. Staff shall routinely help consumers secure resources such as Social Security benefits, General Assistance, food stamps, vocational rehabilitation, and housing assistance. When needed, staff shall accompany consumers to help them apply for benefits.

(b) Assistance in helping the consumer complete and update a personal crisis plan or a declaration for mental health treatment with the consumer's participation and informed consent.

(c) Outreach services to help consumers gain access to needed services;

(d) Symptom-management efforts directed to help each consumer identify the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen their effects;

(e) Promote linkages to work-related services that help the consumer find and maintain employment in community-based job sites;

(f) When a consumer resides in a Residential Treatment Home or Residential Treatment Facility, the case manager will collaborate with the facility to arrange the necessary treatment services and coordinate residential and nonresidential treatment;

(g) When a consumer is placed in an Adult Foster Home, the case manager will assist in development of the Personal Care Plan. Additionally, the case manager shall evaluate the appropriateness of services in relation to the consumers assessed need and review the Personal Care Plan every 180 days;

(h) When a consumer is admitted to a hospital or nonhospital facility for psychiatric reasons, the case manager shall make contact in person or by telephone with the consumer within one working day of admission. The consumer's case manager shall be actively involved with discharge planning from the hospital or nonhospital facility;

(i) If a consumer is hospitalized in a state psychiatric hospital, the case manager shall, from the point of admission, be actively involved with discharging the consumer from long term care; and

(j) Monitoring health and safety needs for consumers who reside in community settings including residential programs licensed by the Department of Human Services. Where significant health and safety concerns are identified, the case manager shall assure that necessary services or actions occur to address the identified health and safety needs for the consumer.

Stat. Auth.: ORS 430.041 and 430.640

Stats. Implemented: OAR 426.490 through 426.500 & 430.630

Hist.:

Consumer Rights

309-032-0555 In addition to consumer rights in applicable Oregon Revised Statutes, Oregon Administrative Rules, and elsewhere in these rules, the following is required specific to services received:

(1) Notification of rights. The provider shall make available to the consumer and, if appropriate, guardian a document which describes the consumers' rights and responsibilities, including, at a minimum, freedom from abuse as defined in ORS 430.735 by an employee of the provider. Information and material shall be provided to the consumers in written form or in alternative format or language appropriate to the consumers' need, upon request. The rights, responsibilities, and how to exercise them, shall be explained to the consumer, and if appropriate, guardian at the beginning of each episode of treatment. The specification of rights and responsibilities shall also be posted visibly in an area frequented by consumers.

(2) The consumer shall have a humane service environment that affords reasonable protection from harm and affords reasonable privacy.

(3) The consumer shall be provided services in a setting under conditions that are least restrictive to the person's liberty, that are least intrusive to the person and that provide for the greatest degree of independence.

(4) The consumer shall receive no services without informed voluntary written consent except as permitted by law.

(5) The consumer and others of the consumer's choice shall be afforded the opportunity to participate in the planning and provision of services with the consumer's consent.

(6) The consumer shall have the right to refuse services, including any specific procedure without suffering punitive consequences. If adverse consequences are expected to result from such refusal, that fact must be explained verbally to the consumer and, if appropriate, guardian.

(7) The consumer shall not be involuntarily terminated or transferred from services without prior notice, notification of available sources of necessary continued services and exercise of a grievance procedure.

(8) The consumer shall have access to and communicate privately with any public or private rights protection program or rights advocate.

(9) Grievance policy: The consumer shall have the right to file a grievance or complaint, free from retaliation, and receive assistance when needed in submitting a grievance or complaint. The program shall develop, implement, and fully inform consumers of policies and procedures that provide for:

(a) Receipt of oral and written grievances from consumer and, if appropriate, guardian acting on his/her behalf;

(b) Investigation of the facts pertaining to the grievance;

(c) Initiating action on substantiated grievance within a timely manner; and

(d) Documentation in the consumer's record of the receipt, investigation, and action taken regarding the grievance.

(10) Declaration of mental health treatment. The consumers shall be informed of their right to execute a declaration of mental health treatment.

(11) Informed consent to fee-for-service. The amount and schedule of payment of any fees to be charged must be disclosed in writing and agreed to by the consumer and, if appropriate, guardian.

(12) Respect and dignity. A provider shall maintain written policies and procedures with regard to a consumer's rights. The policies and procedures shall assure that the consumer's right to be treated with respect and dignity is safeguarded.

(13) Alternative format. Information and materials shall be provided to the consumer in written form or in an alternative format or language appropriate to the consumer's needs.

(14) Cultural Competence. A provider shall ensure that the provision of care is culturally appropriate by demonstrating both awareness of and sensitivity to cultural differences.

(15) Gender Specific. A provider shall ensure that the provision of care is gender appropriate by demonstrating both awareness of and sensitivity to gender differences.

(16) Mandatory abuse reporting. All providers are required to report incidents of abuse when the provider comes in contact with and has reasonable cause to believe that a consumer has suffered abuse.

(17) Prohibition of discrimination. All providers shall make reasonable modifications in policies, practices, and procedures to avoid discrimination.

(18) American with Disabilities Act (ADA). Providers shall comply with the ADA.

Stat. Auth.: ORS 430.041 and 430.640
Stats. Implemented: OAR 426.490 through 426.500 & 430.630
Hist.:

Clinical Record

309-032-0565 (1) An individualized clinical record shall be maintained for each consumer that includes the following:

(a) Basic identifying information:

(A) CPMS enrollment data where required;

(B) Identifying data including the consumer's name, address, telephone number, date of birth, gender and marital status;

(C) Name, address, and telephone number of legal guardian and family members or other persons to contact in case of an emergency as authorized by the consumer; and

(D) Name, address and telephone number of the consumer's physician;

(b) Written documentation that the consumer and, if appropriate, guardian consents voluntarily to services after being provided with a description of the proposed services and information concerning potential risks and benefits of service procedures. This includes his/her right to participate in the development and periodic review of an individualized treatment plan, to be informed of his/her diagnosis (after the mental health assessment has been completed), and the purpose of any prescribed medication and potential side effects. The consumer is also informed of his/her right to withdraw consent and file a grievance or request a hearing at any time.

(c) If the consumer has a validly executed declaration for mental health treatment, a copy of the declaration for mental health treatment as set forth in ORS 127.736 shall be placed in the clinical record in accordance with ORS 127.703 (1)(b).

(2) Each program shall:

(a) Maintain the consumer clinical record for a minimum of seven years after the consumer has been discharged form services.

(b) Permit inspection of consumer clinical records upon request by the Division to determine compliance with these rules.

(c) Not falsify, alter, or destroy any consumer information required by these rules to be maintained in the clinical record.

(d) Maintain each clinical record to assure permanency, timely completion of documentation, identification, accessibility, uniform organization, and completeness of all components required by these rules. Errors in the permanent clinical record shall be corrected by lining out the incorrect data with a single line in ink, adding the correct information, and dating and initialing the correction. Errors may not be corrected by removal or obliteration through the use of correction fluid or tape so they cannot be read.

(e) Comply with state and federal laws and pertaining to confidentiality of consumer records and shall have authentication protocols for electronic consumer records to ensure the safety and integrity of confidentiality.

Stat. Auth.: ORS 430.041 and 430.640

Stats. Implemented: OAR 426.490 through 426.500 & 430.630

Hist.:

Documentation of Clinical Services

309-032-0575 All providers shall develop and maintain an individual, legible, clinical record for each consumer served under these rules which is completed in a timely manner. Documentation of clinical services shall include the following:

(1) Mental health assessment. The mental health assessment shall be conducted by a QMHP for all consumers receiving community mental health services and include a determination of the consumer's mental status and other documentation to support the determination of a DSM 5-Axis diagnosis and a written clinical formulation. The clinical formulation shall provide a description of the following:

(a) Presenting problems and/or concerns;

(b) Important biological, cultural, psychological and social factors which are a priority for intervention;

(c) Clinical events and/or course of illness including onset, duration, and severity of presenting concerns;

(d) Consumer/family expectations for recovery;

(e) Issues/concerns to be addressed in the consumer's treatment plan which warrant treatment and or management;

(f) Justification for treatment services and prognosis;

(g) For consumers with a diagnosed co-occurring substance use or abuse problem or condition the following shall also be included in the clinical formulation:

(A) Acute intoxication and/or withdrawal potential;

(B) Biomedical conditions or complications;

(C) Emotional/behavioral/cognitive conditions or complications;

(D) Readiness to change including treatment acceptance or resistance;

(E) Relapse/continued use potential; and

(F) Recovery environment and social supports.

(h) The mental health assessment shall be updated annually to include, at a minimum, the charges in the consumer's mental status, social support system, level of functioning, and shall document the consumer's participation in treatment planning.

(2) Treatment plan. An individualized treatment plan shall be developed no later than 45 calendar days after the date of initiation of services and include the following:

(a) Identify problems to be addressed based upon the needs identified in the mental health assessment and the consumer's readiness for treatment services;

(b) Include goals and objectives that are individualized, recovery-oriented, measurable, timely, and appropriate to the identified service needs;

(c) Specify the service regimen including:

(A) Services and activities to achieve identified goal(s) and objectives;

(B) Estimated frequency and duration of each service activity, or where flexible service delivery methods are identified as the treatment method of choice, a description of the flexible services to be provided to the consumer;

(C) The person(s) and/or program(s) who will be providing the service or activity;

(D) Documentation indicting the consumer and/or guardian (and family, where appropriate) was involved in treatment planning to the degree the consumer and/or guardian and family were capable of assisting;

(d) Documentation indicating that the treatment plan has been updated at least annually or in response to changes in the consumer's condition or relationships, such as changes in place of residence, employment status, divorce, homelessness, or improved or worsening symptomology.

(3) Progress notes shall meet the following requirements:

(a) A progress note shall be recorded and legible and signed by the person providing the service each time a service is provided and at any time a significant change occurs in the consumer's condition. However, a two week summary progress note may be done to record the delivery of Daily Structure and Support, and Skills Training, provided the number, dates of delivery, and time taken to provide the services are recorded;

(b) Each progress note shall specify the type of service(s) provided, the date provided, and the setting in which service was provided. Progress notes shall also document:

(A) Consumer/Family involvement in accomplishing goals as planned;

(B) Periodic discussions with the consumer concerning progress toward meeting goals identified in the treatment plan;

(C) Significant changes in the consumer's condition or functioning;

(D) Description of other significant problems or events as they occur and their effect on the consumer; and

(E) Contacts with other agencies providing services to the consumer or for the purpose of referral.

(4) Medical services. Medical services shall be provided and documented in a legible manner consistent with professional and community standards of care and shall include the following:

(a) Orders for medication, laboratory and other medical procedures shall be recorded in the clinical record in conformance with standard medical practice. Such orders, whether written or verbal, shall be initiated and authenticated by a LMP. Consultation and/or exchange of information with other medical personnel who are not employed by, or under contract to, the provider shall be documented in the clinical record.

(b) Written documentation of medications prescribed for the consumer by a LMP shall maintained in the clinical record. Documentation for each medication prescribed shall include the following:

(A) A copy or detailed written description of the signed prescription order;

(B) The name of medication prescribed;

(C) The prescribed dosage and method of administration;

(D) The date medications were prescribed, reviewed, or renewed;

(E) The date, the signature and credentials of staff administering and/or prescribing medications; and

(F) Medication use record which contain:

(a) Observed side effects including laboratory findings;

(b) Medication allergies and adverse reaction; and

(c) Documentation that the consumer was asked about possible adverse effects of medications, including sexual dysfunction, and evaluation for tardive dyskinesia when appropriate.

(5) A discharge summary shall include the following:

(a) Written documentation of the last service contact with the consumer, the diagnosis at admission and a summary statement that describes the effectiveness of treatment modalities and progress relative to goals listed in the treatment plan while in service;

(b) The reason(s) for discharge, changes in diagnosis during the course of treatment, current diagnosis and level of functioning, and prognosis and recommendations for further treatment. Discharge summaries shall be completed within 30 calendar days after a planned discharge and within 45 calendar days after an unplanned discharge.

(c) Consumer participation in planning for the termination of services and preparation to further his/her recovery.

(d) When participation in services is terminated for a consumer who no longer appears for services, the provider shall document efforts made to locate

or contact the consumer, or document the reason why such efforts were not made.

Stat. Auth.: ORS 430.041 and 430.640
Stats. Implemented: OAR 426.490 through 426.500 & 430.630
Hist.:

Service Supervision

309-032-0585 Except as provided for by section (2) of this rule, any staff providing services to a consumer shall be supervised.

(1) Employees of programs certified in accordance with this rule and other contracted persons providing services to consumers shall receive supervision by a qualified supervisor in regard to the development and implementation of the treatment plan and in monitoring the effectiveness of services.

(2) Service supervision exceptions. Notwithstanding the supervision requirements above, the provider may modify the requirements specified in these rules for supervision of independent contractors who are QMHPs and are licensed under existing Oregon Revised Statutes to conduct independent practice without supervision.

Stat. Auth.: ORS 430.041 and 430.640
Stats. Implemented: OAR 426.490 through 426.500 & 430.630
Hist.:

Quality Management Requirements

309-032-0595 Providers shall develop and implement a planned, systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to adults. The quality management system shall include a quality management committee and a quality management plan which together implement a continuous cycle of measurement, assessment and improvement of clinical outcomes based on input from other service providers and consumers.

(1) The quality management committee shall develop and implement the quality management plan and shall be a catalyst for improvement in the organization’s clinical outcomes. The quality management committee shall be composed of:

(a) One or more QMHPs, including an LMP, who are representative of the scope of services delivered;

(b) A representative or representatives of the adults served. Additionally the organization shall invite and support representatives of family members of consumers to participate as members of the quality management committee;

(c) Other persons who have the ability to identify, design, measure, assess and implement clinical and organizational changes; and

(d) Other persons as deemed necessary to assure the provision of culturally competent and non-discriminatory service delivery.

(2) The quality management committee duties shall:

(a) Identify indicators of quality;

(b) Identify measurable and time-specific performance objectives;

(c) Identify data sources and methodology to measure performance;

(d) Develop a process to systematically collect outcome data and identify staff who will collect and analyze data;

(e) Oversee the data collection process;

(f) Analyze the information collected and measure progress toward performance objectives;

(g) Identify clinical and operational changes necessary to achieve performance objectives;

(h) Implement clinical or operational changes that are indicated by the achievement or non-achievement of performance objectives; and

(i) Reassess and, if necessary, revise objectives and methods to measure performance on an ongoing basis.

(3) The quality management committee shall meet at least quarterly.

(4) The written quality management plan shall describe the implementation and ongoing operation of the functions performed by the quality management committee. 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 meetings;

(d) The policies and procedures for identifying measurable performance objectives;

(e) The policy and procedures for identifying and using data sources;

(f) The indicators of quality in the following domains:

(A) Access to services;

(B) Quality of care;

(C) Integration and coordination; and

(D) Outreach and prevention.

(g) The policies and procedures for reporting, tracking, investigating, and analyzing reports of critical incidents;

(h) The policies and procedures for both reviewing documentation and determining that the staff have the required competencies and credentials to perform assigned duties and meet the provider's performance objectives;

(i) The policies and procedures to manage utilization of services;

(j) The policies and procedures for reviewing and responding to complaint and grievance information; and

(k) The policies and procedures for conducting clinical record reviews.

(5) A written summary of the pertinent facts and conclusions of each quality management committee meeting will be maintained and be available for review.

(6) The quality management committee shall evaluate the quality management plan at least annually and update the quality management plan as necessary.

Stat. Auth.: ORS 430.041 and 430.640
Stats. Implemented: OAR 426.490 through 426.500 & 430.630
Hist.:

Variances

309-032-0605 (1) Criteria for a variance. Variances may be granted to a CMHP or provider if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The CMHP or provider requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the LMHA or designee recommending approval for the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office of Mental Health Services shall approve or deny the request for a variance.

(4) Notification. The Office of Mental Health Services shall notify the CMHP and/or provider in writing of the decision to approve or deny the requested variance. This notice shall be given to the CMHP and provider within 30 days of the receipt of the request by the Office of Mental Health Services.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The CMHP or provider may implement a variance only after written approval from the Division.

(7) Duration of variance. A variance to these rules shall be valid for a period of no more than two years. A variance may be reissued through written

application for a variance from the CMHP or provider, as described above, and upon written approval by the Office of Mental Health Services.

Stat. Auth.: ORS 430.041 and 430.640
Stats. Implemented: OAR 426.490 through 426.500 & 430.630
Hist.:

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07/25/01