



Addictions and Mental Health

John A. Kitzhaber, MD, Governor

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January 30, 2012

The Honorable Senator Peter Courtney, President  
The Honorable Representative Bruce Hanna, Co-Speaker  
The Honorable Representative Arnie Roblan, Co-Speaker  
900 Court Street NE  
S-201, H-269 State Capitol  
Salem, OR 97301-4048

**Re: SB 238 (2011) Report - Summary**

Dear Legislators:

Senate Bill 238 (2011) directed OHA to convene a workgroup to conduct a line-by-line review of administrative rules governing service provisions and documentation. The bill was aimed at reducing administrative burdens to providers of addictions and mental health services, and to redirect staff time to the treatment of individuals.

AMH convened a workgroup comprised which met weekly for a period of seven weeks. AMH adopted 55 rules changes from the work group's recommendations. The rule changes were implemented January 1, 2012 through temporary rules, with permanent rules to follow. AMH will continue to look at the other rule recommendations made by the work group through our continued work to streamline and reduce administrative burdens. Attached is the full report. The report, as well as an appendix of all of the rules considered by AMH, is available at: [www.oregon.gov/OHA/legactivity/](http://www.oregon.gov/OHA/legactivity/)

Please do not hesitate to call me with any questions.

Sincerely,

Linda Hammond  
Interim Director  
Addictions and Mental Health Division

CC: Scott Burgess, Legislative Administrator  
Sandy Thiele-Circka, Committee Services

**Oregon Health Authority (OHA)  
Addictions and Mental Health Division (AMH)**

**Report on Implementation of SB 238  
January 30, 2012**

The Oregon Health Authority, Addictions and Mental Health (AMH) Division respectfully submits the following report on implementation of SB 238 (2011), as required by the bill to be submitted by February 2012.

**Background**

Senate Bill 238 passed in the 2011 regular Legislative session and took effect on passage. In an effort to reduce administrative burdens to providers of addictions and mental health services, and to redirect staff time to the treatment of individuals, the law directs the OHA to convene a workgroup to conduct a line-by-line review of administrative rules governing service provisions and documentation. The purpose of the review was to determine and make recommendations to OHA regarding:

- a) Excessive requirements and redundancies that could be eliminated; and
- b) Streamlining the process for collecting patient data.

OHA was required to implement any changes by January 1, 2012.

**Workgroup Methodology**

As required by SB 238, AMH convened a workgroup comprised of two AMH staff, three providers of addiction treatment services, three mental health service providers, and three consumers of addictions and mental health services. The work group met weekly for a period of seven weeks. Most participants attended regularly; however, the consumers who accepted the invitation to participate did not attend or provide feedback.

The Integrated Services and Support Rule (ISSR) and the Medicaid Payment for Rehabilitative Mental Health Services rule were the focus of the meetings. The workgroup went through these rules line by line and discussed and presented recommendations to either delete or change requirements and made recommendations on how to eliminate redundancies and excessive requirements believed to create administrative burdens.

**Outcomes**

AMH established an internal work group to track all recommendations and to provide an analysis of the pros and cons of making the recommended changes. AMH leadership analyzed each of the pros and cons and categorized the proposed changes into the following areas:

- Rule change would have an impact on health and safety of individuals receiving services

- Rule change would require a change in statutory requirements (ORS)
- Rule change would require a change to the Oregon Medicaid State Plan as approved by Federal regulatory agencies
- Rule change would be dependent on the health care system redesign

AMH adopted 55 out of 110 total recommendations provided by the workgroup which were identified as excessive or redundant. As required by SB 238, AMH filed temporary rules to reflect the changes effective January 1, 2012. AMH will continue to review the other rule recommendations through our continued work to streamline administrative burdens, particularly in light of any rules changes needed for health system transformation. The next steps for identifying additional changes are outlined below.

A complete list and analysis of the recommendations made by the workgroup is available for review at: [www.oregon.gov/OHA/legactivity/](http://www.oregon.gov/OHA/legactivity/)

### **Next Steps**

In collaboration with the SB 238 workgroup, AMH is working on the following:

- Immediately expand the scope and membership of the SB 238 workgroup to develop new administrative rules that will permanently replace the ISSR and the Medicaid Payment Rules to:
  - Standardize and streamline payment requirements for both OHP and non-OHP reimbursed services;
  - Create a separate set of rules that will address the certification process for the provider system;
  - Outline a basic structure for ensuring health and safety in programs; and
  - Align rule language with CCO operations.

During the development of the new administrative rules, AMH and the workgroup will re-examine requirements in the rules that are pending changes related to the implementation of HB 3650 (2011) and those that require a change to the Medicaid State Plan and/or require a statutory change. The goal of AMH and the SB 238 workgroup is to complete development, public hearings and filing of the new administrative rules by July 1, 2012.

**Report on Implementation of SB 238**  
**Appendix A: SB 238 Workgroup Recommendations**

| <b>Integrated Services and Supports Rule (ISSR) 309-032-1500 through 1565</b> |   |  |  |  |   |
|---|---|--|--|--|---|
| <b>Section and Number</b>   | <b>Requirement or Summary</b>                       | <b>Workgroup Recommendation</b>                                      | <b>Pros of Eliminating Requirement</b>                       | <b>Cons of Eliminating Requirement</b>                               | <b>AMH Recommendation</b>   |
| <b>Purpose and Scope</b>  | <b>309-032-1500</b>                                 |  |  |  |   |
| Purpose and Scope (1) (b)   | Identifies characteristics of services and supports | Delete   | Streamlines purpose of rules to a minimum standard.          | Identifies a foundation of best practices supported by the Division. | No Change   |
| Purpose and Scope (1) (c)   | Promoting outcomes and defines continuum of care    | Eliminate definition of continuum of care                            | “Continuum of Care” definition is not restricted.            |  | Delete as recommended   |
| <b>Individual Rights</b>  | <b>309-032-1515</b>                                 |  |  |  |   |
| Rights (1) (a)  | Related to choosing services and service setting    | Delete language after “Choose from available services and supports.” | Eliminates confusion about what service choices can be made. | Requires change to ORS 430.210                                       | AMH does not support a change to rule or statutory language pertaining to individual rights. The rights are |
| Rights (1) (b)  | Treated with dignity and                            | Delete   | Eliminates variability                                       | Requires change to   |   |

| <b>Section and Number</b> | <b>Specific Requirement</b>   | <b>Workgroup Recommendation</b>  | <b>Pros</b>   | <b>Cons</b>   | <b>AMH Recommendation</b>   |
|---------------------------|---|--|---|---|---|
|                           | respect   |  | when defining dignity and respect.  | ORS 430.210   | foundational and set forth the basic conditions of the Olmstead ruling. Reducing or changing any of the rights, or posting requirements in statute, puts the state at risk. |
| Rights (1) (c)            | Related to development of ISSR, participation, review and copy of ISSP        | Change to “Participate in development and review of ISSP.”   | Reduces administrative burden.  | Requires change to ORS 430.210 (1)(c)   |   |
| Rights (3)                | Notification and posting of Individual Rights                                 | Delete entire section  | Reduces administrative burden and is more aligned with physical health care settings. | Requires change to ORS 430.210(2)(o)  |   |
| Rights (All)              | All Individual Rights   | Compare with statues related to all programs regulated by the ISSR. Include only what is in statute. | Streamlines list to only those not already constitutional rights.                     | Requires change to ORS 430.210  |   |
| <b>Personnel</b>          | <b>309-032-1520</b>   |  |   |   |   |
| Competencies (2)          | Documentation of competencies and job descriptions                            | Delete   | Eliminates duplication with (5)(c) and reduces paperwork time.                        | 5(c) does not specify that job descriptions list required competencies.   | Delete (2) and add clarification to (5)(c).   |
| Competencies (3)          | Description of competencies for all certified and/or licensed staff positions | Check statute to see if any competencies referenced, if not, eliminate all.                          | Reduces administrative burden.  | Reduces ability of the Division to monitor health and safety by setting standards for staff providing services. | No change. Competencies set a minimum standard for A and D treatment staff who have not yet obtained certification. The competencies for                                    |

| <b>Section and Number</b>            | <b>Specific Requirement</b>  | <b>Workgroup Recommendation</b>       | <b>Pros</b>   | <b>Cons</b>  | <b>AMH Recommendation</b>   |
|--------------------------------------|--|---------------------------------------|---|--|---|
|                                      |  |                                       |   | Takes out competencies that are listed in the Medicaid State Plan. | QMHA and QMHP and clinical supervisors are consistent with those in the Medicaid State Plan.  |
| Competencies (3) (a) (b) All         | Competencies for program administrators/directors and clinical supervisors   | Delete                                |   |  | See above.  |
| Competencies (3) (c) (B)             | A and D treatment staff competencies   | Delete                                |   |  |   |
| Training (8)(a)                      | Pre-service training to be provided within 30 days of hire   | Change “pre-service” to “orientation” | Clarifies that services can begin before training is complete.  |  | Make Change.  |
| Training (8) (a) (A) (B) (E) (F) (G) | Training related to crisis response, emergency procedures, program policies, population-specific info, and community resources | Delete                                | Reduces administrative burden of developing specific training. Allows provider to tailor training to specific needs of the program. | Reduces minimum health and safety standard.                        | Delete only (F) Population specific information and (G) Overview of applicable community resources, and include in practice guideline. Other required pre-service training is related to health and safety. |
| Clinical Supervision (9)             | Clinical supervision requirements  | Delete All                            | Reduces time spent on Clinical Supervision and allows more time spent on improving services.  | Reduces minimum standard to ensure health and safety and quality.  | Keep current requirement, but change to quarterly supervision for licensed staff only.  |

| <b>Section and Number</b>                 | <b>Specific Requirement</b>                                     | <b>Workgroup Recommendation</b>  | <b>Pros</b>  | <b>Cons</b>  | <b>AMH Recommendation</b>   |
|---|---|--|--|--|---|
|   |   |  | Allows provider flexibility to determine where supervision need is greatest and/or required for licensure. |  |   |
| Clinical Supervision (9)(b)               | Addresses CS agreement between provider and clinical supervisor | Delete   | Eliminates redundancy with personnel section.  |  | Delete as recommended.  |
| Clinical Supervision (9)(c)               | Addresses LMP responsibility                                    | Delete   | Eliminates redundancy with assessment and ISSP section.  |  | No change. The agreement stating the specific responsibility of the LMP is required for Medicaid billing. |
| <b>Program Specific Service Standards</b> | <b>309-0032-1540</b>  |  |  |  |   |
| (1) Co-Occurring Disorders                | All   | Delete Entire Section  | Eliminates redundancy with program specific sections for O/P MH and A and D.                               | Eliminates specific requirements for coordinated service planning, case management, outreach and concurrent documentation. | Delete all but (1)(a)(C) to specify concurrent service planning and documentation required.               |
| (2)(a)(B) O/P Mental Health               | Provisional Assessment for crisis services                      | Delete reference to provisional assessment – change to “all services must be documented and show medical necessity.” | Reduces administrative burden of developing both provisional and full assessments.                         | Removes option to do an immediate assessment and ISSP for billing to begin   | No change – needed for Medicaid billing.  |

| Section and Number  | Specific Requirement                                      | Workgroup Recommendation                | Pros  | Cons   | AMH Recommendation   |
|---------------------|---|---|---|--|--|
|                     |   |   | Eliminates confusion of when a provisional is required.<br><br>Aligns with language 410-120-1360(1)(b)    | services immediately when necessary.   |  |
| (2) (d)             | Case management services required                         | Delete list of case management services | Allows provider to use clinical judgment to provide only the case management services that are indicated. | Requires change to ORS 430.630   | No change. Recommend later review for possible change to statute.  |
| (5) (c) ICTS        | Service Coordination requirement included in ISSP         | Remove requirement                      | Reduces duplication with documentation developed by Child and Family Team.                                | If service coordination is not included in the ISSP, it will not be reviewed by a LHP. | No change. Service coordination planning is a core ICTS service and must be included in an ISSP to ensure intended outcomes and clinical oversight occurs. This part of the ISSP can be completed by a QMHA. |
| (6) (b)(B) ITS      | Clinical staffing ratio of one QMHP to nine program staff | Delete                                  | Reduces redundancy with CAF and other licensing entities for children's programs.                         |  | Delete   |
| (6) (c) (C) and (E) | Therapist to child ratio of one to twelve                 | Delete both references                  | Reduces redundancy with CAF and other licensing entities for children's programs                          |  | No change. This is an ITS requirement only and is necessary to meet the health and safety needs of children in all   |

| <b>Section and Number</b> | <b>Specific Requirement</b>  | <b>Workgroup Recommendation</b> | <b>Pros</b>   | <b>Cons</b>  | <b>AMH Recommendation</b>  |
|---------------------------|--|---------------------------------|---|--|--|
|                           |  |                                 |   |  | ITS programs.  |
| (8) (a) Behavior Support  | Take into consideration neurodevelopmental and environmental factors   | Delete                          | Allows clinician to use clinical judgment                                       |  | Delete and include in practice guide.  |
| (8) (b)                   | Develop behavior support strategies based on assessment.   | Delete                          | Eliminates additional requirement to complete a separate behavioral assessment. | Eliminates connection between the assessment and behavior support strategies.                                | No change. Strategies can be based on information in the assessment and/or from other sources, like educational assessments.   |
| (8) (d)                   | Establishes standards for the framework and philosophy of behavior support planning – references trauma policy | Delete                          | Reduces redundancy with trauma policy requirement                               | Takes away requirement to ensure behavior support policies are consistent with the Division’s trauma policy. | No change. Establishes a minimum standard for proactive behavior support to differentiate from emergency safety procedures.  |
| (8) (h)                   | Requires annual training in EBP related to positive behavior support   | Delete                          | Redundant to training section   | Training may not focus on EBP or best practice for positive behavior support.                                | Add to Personnel Pre-service training (8)(a)(H) as follows: “For ICTS, ITS and Enhanced Care Services, positive behavior support training consistent with 309-032-1540 (8).” |
| (8) (i)                   | Requires annual update of behavior support policies  | Delete                          | Policy section already requires current policies                                |  | No change. Behavior support policies must  |

| <b>Section and Number</b>                                | <b>Specific Requirement</b>  | <b>Workgroup Recommendation</b>                     | <b>Pros</b>   | <b>Cons</b>  | <b>AMH Recommendation</b>  |
|--|--|---|---|--|--|
|  |  |   |   |  | be current to ensure health and safety.  |
| (9) (h) Emergency Safety Interventions                   | All requirements for the use of seclusion and the use of seclusion rooms   | Delete  | Reduces redundancy to certification requirements already stated in other rules.       | Requires change to CFR for children's programs – no other rules found to address these standards for children. | No change. Necessary to ensure health and safety and that rights are not violated. |
| (10)(A) and (B) O/P Problem Gambling                     | Phone counseling requirements specifying that individual be enrolled in the program and phone counselor be qualified | Delete  | Eliminates excessive documentation.   | Inconsistent with billing requirements in contract.  | No change. Consistent with fiscal accountability.                                  |
| (12)(c)(C)(vi) Alcohol and Other Drug Treatment Services | Gender-specific service for adolescents  | Delete  | Takes focus off of gender issues that may not be appropriate for adolescent services. |  | Delete and add to practice guide.  |
| (12)(c)(D)(ii) Adolescent                                | Peer support groups provided at school sites   | Delete  | Reduces administrative burden.  |  | Delete and add to practice guide.  |
| (12) (d)(A)  | References to social isolation and self-reliance   | Delete  | Reduces gender bias.  | Inconsistent with SAPT Block Grant language.   | No Change. Only applies to programs receiving SAPT Block Grant funds.              |
| (12) (d)(C) : Women's specific                           | “Supports that meet the special access needs of women like childcare, transportation, etc.”                          | Change to “supports that meet special access needs” | Reduces gender bias.  | Eliminates required supports specifically designed to eliminate barriers to treatment.                         | No change. Only applies to programs receiving SAPT Block Grant funds.              |

| <b>Section and Number</b>                                       | <b>Specific Requirement</b>  | <b>Workgroup Recommendation</b>   | <b>Pros</b>   | <b>Cons</b>  | <b>AMH Recommendation</b>   |
|---|--|---|---|--|---|
|   |  |   |   | Inconsistent with SAPT Block Grant requirements.   |   |
| (12)(d)(F)  | Referrals required for domestic violence counseling and parenting  | Change to “provide referrals for medically necessary services”  | Allows providers to make decisions about which services are needed for referral upon discharge. | Reduces referrals to non-medical services.<br><br>Inconsistent with SAPT Block Grant requirements.       | No change. Only applies to programs receiving SAPT Block Grant funds.                   |
| (12) (e) (C), (D) and (E) :<br>Community based criminal justice | Specific competencies for program directors and/or clinical supervisors and specific staff training requirements | Delete  | Reduces redundancy to personnel section.  | Eliminates specific competencies and training related to criminal justice populations.                   | No change. Competencies are specific to this service and certification is optional.     |
| (12)(f)(I) DUII   | Monitoring case by confirming individual entered and completed the program.                                      | Delete “by confirming that the individual entered the program and that the individual completed the program.” | Reduces redundancy to (III) in the same section.  |  | Delete and consolidate language.  |
| (13)(a) Medical Protocols                                       | Requirement to include medical histories in assessment as part of written medical protocols.                     | Delete  | Reduces redundancy to assessment section requirements.  | Reduces amount of information available to medical director in planning and delivering medical services. | No change. Reword for clarity that medical histories do not have to be completed twice. |
| (13) (c)  | Describe procedures for medical emergencies  | Delete  | Reduces redundancy to policy requirement for emergency procedures.                              | Medical emergencies may not be specifically addressed in emergency                                       | Move to policy section under “medical policies.”  |

| Section and Number | Specific Requirement | Workgroup Recommendation | Pros | Cons | AMH Recommendation |
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|                                    |  |  |  |  |   |
|------------------------------------|--|--|--|--|---|
|                                    |  |  |  | procedures.  |   |
| (14) Administration of Medications | All  | Change references to residential programs to “residential only”            | Reduces confusion about where the requirement applies to O/P, residential or both.                   |  | Make change to indicate where requirement only applies to residential programs. |
| <b>Entry and Assessment</b>        | <b>309-032-1525</b>  |  |  |  |   |
| (1) Entry Process                  | Written process required   | Delete “written”   | Reduces burden of documentation that doesn’t improve outcomes.                                       |  | No change. Written process can be included in entry policy.                     |
| (1)(d) Entry Process               | Written informed consent for services and reason if one cannot be obtained | Delete entire second sentence pertaining to reason one cannot be obtained. | Reduces burden of documentation that doesn’t improve outcomes.                                       | Requires change to ORS 430.210(1)(d)   | No change. Required by statute referenced.                                      |
| (1) (h)(A) Entry Process           | Required written information to be given at start of service               | Delete (A) “the program’s philosophical approach to service                | Reduces burden of documentation that doesn’t improve outcomes.                                       | Reduces ability of individual and/or guardian to make informed choice when selecting provider. | No change. Necessary for informed consent to services.                          |
| (1)(f) Entry Process               | Entry information must be reported on state mandated data system.          | Delete   | Reduces paperwork burden at entry. Allows provider to focus more on assessment and service planning. | Requires change to current requirements for CPMS.  | OWITS system will replace CPMS.   |

| <b>Section and Number</b>     | <b>Specific Requirement</b>   | <b>Workgroup Recommendation</b>  | <b>Pros</b>  | <b>Cons</b>  | <b>AMH Recommendation</b>  |
|-------------------------------|---|--|--|--|--|
| (1) (h) (B) Entry Process     | Required written copy of individual rights given at entry             | Delete   | Reduces paperwork burden at entry. Allows provider to focus more on assessment and service planning. | Requires change to ORS 430.210(o)  | No change. Required by statute referenced.   |
| (3) (d) Assessment            | What is to be included in an assessment                               | Delete all and change to “a diagnosis and the medical necessity of services.”      | Allows provider to use clinical judgment.<br><br>Consistent with 410-120-1360(1)(b)                  | Narrows the focus of the assessment and does not stipulate ASAM dimensions or critical screenings.<br><br>Does not stipulate specific information required for providing comprehensive services to children. | No change. MH and A and D services must include social needs as well as medical needs. |
| (3) (d) Assessment            | What is to be included in an assessment                               | Delete all but (A)   | Reduces redundancy to (A) which already specifies all biopsychosocial information.                   | Narrows the focus of the assessment and does not stipulate ASAM dimensions or critical screenings.<br><br>Does not stipulate specific information required for providing comprehensive services to children. | No change. ASAM is required to determine level of care.                                |
| (3)(b) provisional assessment | When services must begin immediately, a provisional assessment can be | Delete reference to provisional assessment in (3)(b) and just require “assessment” | Allows provider to use clinical judgment to determine content and                                    | Eliminates provider flexibility in using a provisional to begin  | No change. Allows individuals to receive services immediately                          |

| Section and Number  | Specific Requirement   | Workgroup Recommendation   | Pros   | Cons  | AMH Recommendation   |
|---|--|--|--|---|--|
|   | completed.   | consistent with DMAP rules (410-120-1360).   | time lines of an assessment.   | services.<br>Providers would not be able to bill until the assessment is completed.                                 | when necessary and allows providers to bill Medicaid before full assessment is complete. The full assessment can be a continuation of the provisional. |
| (3)(e) Assessment   | Referrals required when presence of co-occurring disorders     | Change to “When the assessment process determines there are symptoms indicating the presence of co-occurring substance use and mental health disorders.....” | Clarifies that a full diagnosis for both substance use and mental health does not have to be completed to screen for symptoms. | Reduces standard for coordinated care.  | No change. Consistent with coordinated care.   |
| (3)(g) Assessment   | Annual review of assessment by a LMP                           | Delete   | Reduces administrative burden that does not improve outcomes.  | Current Medicaid State Plan requires LMP approval of annual assessment.   | No change. State Medicaid Plan requiring only annual assessment is already an exception given to the State by CMS.                                     |
| <b>Individual Service and Support Planning and Coordination</b> | <b>309-032-1530</b>  |  |  |   |  |
| (1) Individual Services and Supports                            | (a) through (i) standards for planning and development of ISSP | Delete all and leave only language after (1)   | Reduces administrative burden of documenting planning process.   | Eliminates critical planning requirements (family involvement, coordination with other agencies, including physical | Consolidate (e) and (f). Delete (i)(A) and (C) only.   |

| <b>Section and Number</b> | <b>Specific Requirement</b>   | <b>Workgroup Recommendation</b>   | <b>Pros</b>   | <b>Cons</b>   | <b>AMH Recommendation</b>   |
|---------------------------|---|---|---|---|---|
|                           |   |   |   | health.)  |   |
| (1) (h)                   | Requirement to obtain release of information to communicate with physical health care providers | Delete  | Eliminates barrier to communicating with physical health care providers.      |   | No change. Required for HIPAA compliance and to promote integrated care.  |
| (1)(b)                    | Provisional ISSP  | Delete reference to provisional ISSP if provisional assessment is deleted | Reduces administrative burden of developing both a provisional and full ISSP. | Inconsistent with billing requirements that stipulate there must be an ISSP prior to the start of services. | No change. Provisional allows services to begin immediately when necessary. Full ISSP can be continuation of same document. |
| (2)ISSP                   | What is required in an ISSP   | Delete all but (a)  | Allows provider to use clinical judgment in the development of an ISSP.       | Reduces health and safety component for more complicated services.  | Delete (a)(D) only.   |
| (2) (E) ISSP              | Documenting time lines for the review of progress toward meeting intended outcomes of the ISSP. | Delete  | Reduces redundancy to the service note section.                               |   | Deleted from Individual Service Notes (d).  |
| (2)(D) ISSP               | Criteria for service conclusion   | Delete  | Reduces redundancy to “intended outcomes.”                                    |   | Delete.   |
| (2) (c) (A) and (B) ISSP  | Requirement for a service coordination plan and behavior support plan in ICTS programs.         | Delete  | Reduces paperwork burden of having several different plans.                   | Eliminates behavior support and service coordination components in ITS and ICTS programs.                   | No change. Behavior support and service coordination are key services in ITS and ICTS. These can be documented together     |

| Section and Number               | Specific Requirement   | Workgroup Recommendation | Pros  | Cons   | AMH Recommendation   |
|----------------------------------|--|--------------------------|---|--|--|
|                                  |  |                          |   |  | and do not need to be separate plans.  |
| (2)(e) ISSP                      | LHP approval and signature required within five days of development of ISSP and when changes are made to the ISSP. | Delete                   | <p>Reduces administrative burdens that do not improve outcomes.</p> <p>Reduces barriers to service.</p> <p>Eliminates unrealistic time line for obtaining approval and timeline is not mandated by federal language it is set by AMH.</p> | 42CFR 440.130(d) requires LHP recommendation of the services listed on the ISSP. | No change. Services cannot start until LHP recommendation has been obtained. A five day maximum time frame gives flexibility while ensuring this requirement is met. |
| (2)(f) ISSP                      | LMP annual approval  | Delete                   | <p>Reduces administrative burden that does not improve outcomes.</p> <p>Reduces barriers to service.</p>  | Current Medicaid State plan requires annual review and approval by LMP.          | No change. State Medicaid Plan requiring only annual assessment is already an exception given to the State by CMS.   |
| (3) (D)Service notes             | Location of service  | Delete                   | Reduces documentation burden.   | Inconsistent with billing requirements for CMS 1500 form.                        | No change. Required for Medicaid billing.  |
| (3)(c),(d) and (e) service notes | All additional information required in service notes   | Delete                   | Reduces documentation burden.   | Eliminates information used to determine if intended outcomes are being met.     | Delete (3)(d) only. Progress information required to determine if outcomes are met.  |
| (3)(d) service                   | Timelines for review of  | Delete                   | Reduces redundancy to   |  | Delete.  |

| Section and Number   | Specific Requirement                                | Workgroup Recommendation   | Pros  | Cons   | AMH Recommendation   |
|--|---|--|---|--|--|
| notes  | progress must be determined and written in the ISSP |  | ISSP section.   |  |  |
| <b>Service Conclusion, Transfer and Continuity of Care</b> | <b>309-032-1550</b>                                 |  |   |  |  |
| Name of Section  | Service conclusion, transfer and continuity of care | Change to “Transfer and Continuity of Care”  | Coordinates with medical system and reduces administrative burden of opening and closing a record every time.<br><br>Promotes continuity of care. | Creates confusion between a “transfer” of services to another provider and the conclusion of services.<br><br>Conflicts with definition of “transfer.” | Change to “Transfer and Continuity of Care” and change definition of Transfer. (Will still have to open and close with CPMS until new system is in place.)                 |
| <b>(3) service conclusion summary</b>                      | Documentation required at service conclusion        | Delete service conclusion summary requirement and remove all references to service conclusion summary – require a transfer or continuity of care document. | Coordinates with medical system and reduces administrative burden of opening and closing a record every time.<br><br>Promotes continuity of care. | Creates confusion between a “transfer” of services to another provider and the conclusion of services.<br><br>Conflicts with definition of “transfer.” | Change definition of transfer. Delete all references to service conclusion and service conclusion summary. Move documentation requirements in (3) to (4) Transfer Process. |
| (1) (d) planned service conclusion                         | Balance of any fees                                 | Delete   | Eliminates documentation burden that does not improve outcomes.   | Needed for DUII certificate documentation.   | Change to: “For DUII services only.”   |

| <b>Section and Number</b>         | <b>Specific Requirement</b>                          | <b>Workgroup Recommendation</b>  | <b>Pros</b>   | <b>Cons</b>  | <b>AMH Recommendation</b>   |
|-----------------------------------|--|--|---|--|---|
| (1)(a)                            | Documented decisions to conclude services            | Change to “decisions to transfer an individual and the reason must be documented.” | Streamlines documentation.  | Conflicts with the definition of “transfer.”<br><br>Doesn’t address whether intended outcomes were met.                        | Make change.  |
| (2)(c)                            | Time lines for service conclusion documentation      | Delete   | Allows transfer documents to be prepared on date of exit for planned transfer | Creates an administrative burden to prepare transfer paperwork on date of exit.  | Delete.   |
| (2) (d)                           | Required documentation of outreach efforts           | Delete or change to only when health and safety are at issue                       | Allows more time for engaging individuals who are seeking services.           | Eliminates outreach that may increase access and re-engagement.  | No change. Critical element of service for reducing access barriers and expanding service provision environments. |
| (2)(g) service conclusion process | ITS documentation requirements at service conclusion | Coordinate requirements with ICTS  | Reduces redundancy with requirements for ICTS service records.                | Creates gap in documentation when ITS and ICTS providers are not the same.   | No change. ITS and ICTS are different services, usually by different providers.                                   |
| (3) Service conclusion summary    | What is required in a service conclusion summary     | Delete all   | See recommendation to remove all references to service conclusion summary     | Eliminates information pertinent to planning and developing ongoing supports for both the individual and any future providers. | Change to “Transfer Summary”<br><br>Consolidate with #4.  |

| <b>Section and Number</b>                             | <b>Specific Requirement</b>  | <b>Workgroup Recommendation</b>   | <b>Pros</b>   | <b>Cons</b>   | <b>AMH Recommendation</b>  |
|---|--|---|---|---|--|
| (4) Transfer process                                  | Documentation to be included with transfer and time line                                     | Change to “provide appropriate referrals, transfer and after care instructions to support continued care based on medical necessity.” | Allows provider to arrange services and resources applicable to the individual.       | Does not specify referrals to be made to non-medical providers.<br><br>No indication of whether or not services were effective. | Consolidate with #3.   |
| <b>Quality Assessment and Performance Improvement</b> | <b>309-032-1555</b>  |   |   |   |  |
| (2)(3)  | Specific requirements for a Quality Improvement Committee and a Performance Improvement Plan | Delete all  | Allows providers to determine best process and quality measurements for their agency. | Eliminates requirement to review critical incidents.  | No change. These requirements are consistent with the development of CCO’s and health care transformation. |
| <b>Grievances and Appeals</b>                         | <b>309-032-1560</b>  |   |   |   |  |
| (1)   | Reference to parent and/or guardian  | Delete “parent” and leave in “legal guardian” only  | Clarifies that person acting as legal guardian may not be parent.                     |   | No change. All references to parent already include “or guardian which is the term defined in the rule.”   |
| (2) through (8)                                       | All  | Revise and simplify this section to be consistent with  | Aligns grievance procedures with  | 410-141-0260 is more complicated  | No change. Current process is simpler than   |

| Section and Number                 | Specific Requirement  | Workgroup Recommendation   | Pros  | Cons  | AMH Recommendation  |
|------------------------------------|---|--|---|---|---|
|                                    |   | 410-141-0260.  | Medicaid to reduce administrative burden of multiple forms, processes, reporting requirements, etc.   | than the process outlined in the ISSR. This would create a bigger burden for grievance procedures for non-OHP recipients. | 410-141-0260.   |
| <b>Variations</b>                  | <b>309-032-1565</b>   |  |   |   |   |
| (2)(d)(D) Application for Variance | Description of individual's opinion and participation in requesting the variance. | Change to "When the variance directly affects service, the individual's opinion and participation in requesting the variance." | Clarifies that the term "individual" refers to the person receiving services.<br><br>Clarifies that this is only required when the variance directly affects the services provided. |   | Make change.  |
| <b>Provider Policies</b>           | <b>309-032-1510</b>   |  |   |   |   |
| (1)(a) Personnel                   | Hiring, promotion, disciplinary, dismissal and use of interns or students         | Delete   | Reduces administrative burden not mandated by federal standards.  | Increases legal risk to provider and State if there are not personnel policies to substantiate personnel actions.         | Delete all but (1) (b) Personnel Qualifications and Credentialing, (1)(e)Mandatory Abuse Reporting, (1)(h)Criminal Records Checks and (1)(i) Fraud, Waste and Abuse in Federal Medicaid programs. |
|                                    |   |  |   |   |   |

| <b>Section and Number</b>     | <b>Specific Requirement</b>                    | <b>Workgroup Recommendation</b>   | <b>Pros</b>  | <b>Cons</b>   | <b>AMH Recommendation</b>   |
|-------------------------------|--|---|--|---|---|
| (1)(b) Personnel              | Personnel qualifications                       | Delete portion that says “including policies to establish standards for the ethical conduct of staff. | Reduces administrative burden not mandated by federal standards. | Increases legal risk to provider and State if there are not personnel policies to substantiate personnel actions.   | Delete.   |
| (1)(c) and (d) Personnel      | Policies for training and supervision          | Delete  | Reduces administrative burden not mandated by federal standards. | Increases legal risk to provider and State if there are not personnel policies to substantiate personnel actions.   | Delete.   |
| (1)(f) and (g) Personnel      | Policies for harassment and non-discrimination | Delete  | Reduces administrative burden not mandated by federal standards. | Increases legal risk to provider and State if there are not personnel policies to substantiate personnel actions.   | Delete.   |
| (1)(j) Personnel              | Policies for use of volunteers                 | Delete  | Reduces administrative burden not mandated by federal standards. | Increases legal risk to provider and State if there are not personnel policies to substantiate personnel actions.   | Delete.   |
| (2) Service Delivery Policies | All service delivery policies                  | Delete entire section   | Reduces administrative burden not mandated by federal standards. | Reduces opportunity for provider to individualize services and establish time lines, processes, etc. based on need. | No change. Service delivery policies are directly related to certification and ability of AMH to ensure compliance. |
|                               |  |   |  |   |   |

| <b>Section and Number</b>        | <b>Specific Requirement</b>  | <b>Workgroup Recommendation</b>  | <b>Pros</b>   | <b>Cons</b>   | <b>AMH Recommendation</b>   |
|----------------------------------|--|--|---|---|---|
| (2)(a) Service                   | Summary of service policies must be available upon request   | Delete   | Reduces duplication with Individual Rights section 309-032-1515 (1)(o).             | Clarifies that policies must be provided upon request.  | Delete "summary."   |
| (4)(c)                           | A and D policies regarding behavior  | Move to Section 3: Residential Services  | Reduces confusion with behavior policies required for children's programs.          |   | Make change.  |
| <b>Individual Service Record</b> | <b>309-032-1535</b>  |  |   |   |   |
| (2) (a) General Requirements     | MHO, FCHP or other insurance information in the record   | Delete   | Reduces paperwork burden at entry.  | Decreases opportunities for collaboration among service providers.  | Delete  |
| (2)(b)(A) General                | Identifying information: Marital status and military status  | Delete or specify not required for children                                    | Reduces paperwork burden at entry.  |   | Specify that this is for adults only.   |
| (2)(b)(C) and (D)                | Identifying information: name, address and phone of physician and emergency medical and dental resources | Change (C) to "Name and contact information for medical and dental providers." | Streamlines requirement and allows provider to obtain relevant contact information. |   | Make change.  |
| (2)(d)                           | Written refusal of any services offered  | Delete   | Reduces paperwork burden at entry.  | Increases risk to provider and State if there is no documentation to show a service was offered, but refused. | No change. Records must show refusal of any services offered to protect both individuals and providers. |

| <b>Section and Number</b>          | <b>Specific Requirement</b>  | <b>Workgroup Recommendation</b>  | <b>Pros</b>  | <b>Cons</b>   | <b>AMH Recommendation</b>   |
|------------------------------------|--|--|--|---|---|
| (2)(b)(B)                          | “Next of Kin” only   | Delete   | Reduces time obtaining information that is not useful.   |   | Delete  |
| (2)(c)                             | Informed consent for services, including medications.....          | Delete “including medications”   | Eliminates confusion that there needs to be two types of consents.   | Eliminates language to ensure consent has been given for medication services.           | No change. ORS 430.210(d) requires informed consent for all services.   |
| (2)(f)(g)(h)(i)                    | Assessment, ISSP, service notes and service conclusion summary     | Delete requirement to have four separate documents and replace with “required service documentation as applicable” | Reduces documentation burden and allows flexibility to create documents in format and detail that best fits the program. | Decreases clarity that the each required element of documentation needs to be included. | No change. This can be completed as one document as long as all required elements are present.                          |
| (3) Medical Service Records        | Requirements for documentation when medical services are provided. | Delete all of (3) and add to the end of (2).   | Streamlines (2) and (3).   |   | No change. Does not create added burden.  |
| (4) Residential service records    | Requirements for documentation in residential programs only.       | Clarify that (4) is for ITS (PRTS) and Alcohol and Other Drug Residential Treatment only.                          | Reduces confusion.   |   | Make change.  |
| (4)(c) Residential service records | Background information included in service records.                | Delete “strengths and interests.”  | Eliminates redundancy with information already included in the assessment.   | Reduces minimum standard related to strengths-based treatment.                          | No change. This information is critical to children’s services. Does not have to be re-documented if in the assessment. |
|                                    |  |  |  |   |   |

| <b>Section and Number</b>          | <b>Specific Requirement</b>  | <b>Workgroup Recommendation</b>  | <b>Pros</b>  | <b>Cons</b>  | <b>AMH Recommendation</b>  |
|------------------------------------|--|--|--|--|--|
| (4)(c) Residential service records | Background information included in service records.                          | Clarify that this information is only as “made available.”   | Reduces burden of trying to obtain previous documentation that may not be relevant or available.   |  | No change. The language already indicates only records that are “available.”                                   |
| <b>Definitions</b>                 | <b>309-032-1505</b>  |  |  |  |  |
| ISSR Terminology                   | Use of new terms to refer to those served and certain types of documentation | Align terminology with CCOs  | Facilitates referral and coordination with partnering providers.<br><br>Reduces administrative burden.                                       |  | Review ISSR language when CCO language is determined.  |
| (8)                                | “Assessment”   | Delete “as identified by the individual, family and collateral sources”                            | Reduces burden of obtaining information from sources that may not be relevant.   | Deletes only reference to inclusion of individual, family and other sources in the assessment process.                                     | Change to “identified by the individual, family and collateral sources as relevant, to determine a diagnosis.” |
| (11)                               | “Behavior Support Plan”  | Delete definition  | Reduces confusion between “plan” and “strategies” listed in the ISSP.  |  | No change. Behavior support plan is required for ECS, ICTS and ITS.  |
| (14)                               | “Care Coordination”  | Delete “between levels of care and transitions for transition-age young adults to adult services.” | Takes out prescriptive element of the definition and allows more flexibility to individualize coordination for other transitions that may be | Eliminates language that corresponds with health system change goals to improve transitions between levels of care and transitions for the | No change. Definition needed to specify the enhanced characteristics of ICTS services.                         |

| <b>Section and Number</b> | <b>Specific Requirement</b>     | <b>Workgroup Recommendation</b>   | <b>Pros</b>  | <b>Cons</b>   | <b>AMH Recommendation</b>   |
|---------------------------|---------------------------------|---|--|---|---|
|                           |                                 |   | applicable.  | YAT population.   |   |
| (18)                      | “Child and Family Team”         | Delete “service coordination section of the ISSP in ICTS programs.”   | Reduces confusion, as the ISSP is not written by child and family team.                              |   | No change. Child and family team participate in the service coordination planning.  |
| (20)                      | “Clinical Supervision”          | Delete all  | Corresponds with recommendation to delete clinical supervision requirements in personnel section.    | Reduces minimum standard to ensure health and safety and quality. | No change. Clinical supervision not deleted from personnel section.   |
| (38)                      | “DSM Five-axis” Diagnosis       | Change to “DSM V.”  | Aligns with current version of DSM.  | DSM V will be completed in 2013.                                  | Change to “current version of the DSM.”   |
| (38)                      | “DSM Five-axis” Diagnosis       | Delete “resulting from the assessment.”   |  |   | No change. Assessment is critical to making diagnosis.  |
| (40)                      | “Emergency”                     | Change to “emergent”  | Creates consistency with Medicaid definitions for urgent, emergent and routine.                      |   | Make change.  |
| (42)                      | “Employee”                      | Delete  | Reduces confusion between “employee” and “program staff”   |   | Delete and change to “program staff.”   |
| (71) (e)                  | “Licensed Medical Practitioner” | Delete “ICTS” from “For ICTS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the | Reduces burden for ICTS providers so that time and resources can be focused on service coordination. | Lowers standard of care for ICTS.                                 | No change. These high level services require psychiatrist with special training pertaining to children. Review is only required annually. |

| <b>Section and Number</b> | <b>Specific Requirement</b>            | <b>Workgroup Recommendation</b>   | <b>Pros</b>  | <b>Cons</b>  | <b>AMH Recommendation</b>   |
|---------------------------|--|---|--|--|---|
|                           |  | State of Oregon.  |  |  |   |
| (76)                      | “Medical Director”                     | Clarify that the definition only applies to alcohol and other drug treatment programs.                | Reduces confusion for MH programs that have medical directors who are not responsible for all of the program’s medical services. |  | No change. Definition refers to A and D programs only.                                |
| (107)                     | “Qualified Mental Health Professional” | Include Master’s level interns and/or students who meet certain requirements.                         | Allows Master’s level interns to complete assessments and ISSPs and gain other experience that is now limited to only QMHPs.     | Requires change to Medicaid State Plan.<br><br>Possible health and safety risk and lower standard of care. | No change at present. Review and discuss when health care transformation is complete. |
| (121)                     | “Service Conclusion”                   | Delete  | Consistent with recommendation to eliminate service conclusion terminology.  |  | Delete and change all references to “transfer.”                                       |
| (122)                     | “Service Conclusion Summary”           | Delete  | Consistent with recommendation to change “Service Conclusion Summary” to “Transfer Summary”                                      |  | Delete and change to “transfer summary.”  |
| (133)                     | “Transfer”                             | Rewrite to reflect changes made to the “Service Conclusion, Transfer and Continuity of Care” Section. | Consistent with recommendations made for 309-032-1550  |  | Change definition to reflect changes to “service conclusion.”                         |
| (141)                     | “Wellness-informed                     | Delete  | Term is not used in the  |  | Delete  |

| <b>Section and Number</b>   | <b>Specific Requirement</b>             | <b>Workgroup Recommendation</b>   | <b>Pros</b>  | <b>Cons</b>  | <b>AMH Recommendation</b>   |
|---|---|---|--|--|---|
|   | Services”                               |   | ISSR other than in defintions.   |  |   |
| <b>Facility Standards for Alcohol and Other Drug Residential Treatment Programs</b>         | <b>309-032-1545</b>                     |   |  |  |   |
| All   | All                                     | Integrate with MH Residential Rules   | Coordinates requirements with other rules that address facility standards. | Requires change to Mental Health residential licensing rules.      | No change at present. Review and discuss during revision of MH residential licensing rules.                             |
| (2) Interiors   | Standards for each room of the facility | Integrate to one overall statement about standards for windows, coverings, doors, etc. for all rooms rather than repeating for each room. | Streamlines physical requirements.<br><br>Reduces auditing burden.         |  | No change at present. No additional burden added. Review and discuss during revision of MH residential licensing rules. |
| (3)(a) Food Service and Storage   | Requirements for menus                  | Delete “must be adjusted for seasonal changes”  | Eliminates an excessive requirement not related to health and safety.      |  | Delete.   |
| <b>Medicaid Payment for Rehabilitative Mental Health Services 309-016-0060 through 0755</b> |   |   |  |  |   |
| 309-016-0610  | Clinical Documentation                  | Take documentation requirements out of ISSR and add to this rule, requiring only the federal minimum standard.                            | Reduces administrative burden of going beyond federal requirements.        | Would limit documentation standards to Medicaid clients only. ISSR | No change. ISSR must include documentation standards for both Medicaid and non-   |

| Section and Number            | Specific Requirement                                    | Workgroup Recommendation   | Pros   | Cons  | AMH Recommendation  |
|-------------------------------|---|--|--|---|---|
|                               |   |  | Streamlines documentation requirements into one rule.  | addresses standard for both Medicaid and non-Medicaid.  | Medicaid individuals.   |
| 309-016-0610                  | Clinical Documentation                                  | Change reference to ISSR to 309-032-1525 (3) through 1535.   | Clarifies that referenced documentation starts at (3) Assessment.  |   | Make change.  |
| 309-016 (All)                 | References to DHS                                       | Change to OHA and change website reference in 0675(1).   | Updates information and provides correct web link.   |   | Make change.  |
| 309-016-0750 (1) through (8)  | Children's Psychiatric Residential Treatment (Payments) | Update to reflect current language pertaining to interdisciplinary team.                                       | Creates consistency with CFR definition and current process.   |   | Make change.  |
| <b>Other Recommendations:</b> |   |  |  |   |   |
| N/A                           | CPMS Data System  | Discontinue on 7/1/2012 and review ISSR for requirements that relate directly to CPMS (ex. Service Conclusion) | Reduces administrative burden of opening and closing for every episode of care.<br><br>Reduces barriers to access.                             | OWITS not currently implemented.  | Make change when OWITS is available.                                      |
| N/A                           | Requirements that address best practices.               | Develop practice guidelines to accompany the ISSR.   | Allows ISSR to be streamlined to only necessary requirements related to Medicaid standard and health and safety.<br><br>Provides a resource to | Creates a risk to providers and individuals served.<br><br>Reduces the ability of AMH to enforce critical safety and quality standards. | Develop practice guidelines following development of CCOs and new system. |

| Section and Number             | Specific Requirement | Workgroup Recommendation   | Pros  | Cons  | AMH Recommendation   |
|--------------------------------|----------------------|--|---|---|--|
|                                |                      |  | encourage and guide best practice in service delivery.                  |   |  |
| ISSR                           | All                  | <p>Suspend the entire ISSR and file a temporary rule on 1-1-12 that includes only the minimum federal Medicaid standards.</p> <p>After the legislative session, start a new process that takes the outcome requirements for CCO's and the base federal rules and create a new rule that focuses on core requirements necessary to produce outcomes and meet federal Medicaid/Medicare standards.</p> | Opens the door to the necessary flexibility to move toward integration. | <p>Creates a gap in standards for program operation between 1-1-12 and 7-1-12.</p> <p>Conflicts with Federal requirements for states to develop a plan to ensure compliance with minimum standard.</p> <p>Conflicts with current Medicaid State Plan.</p> | No change at present. AMH will extend the scope and representation of the SB 238 Workgroup immediately, to begin development of new rules to address both payment and certification, related to this recommendation and to align standards with the new service delivery system. |
| ISSR 309-032-1500 through 1565 | All                  | Exempt providers who are accredited by the Joint Commission or the COA, from compliance with the ISSR.   | Reduces burden of compliance with two sets of requirements.             |   | No change. Historically, accreditation alone has not been sufficient to ensure health and safety of individuals served.  |