Behavioral Health Outpatient Provider Requirements

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Contents

External Reviews from the Oregon Health Authority (OHA) 3

Risk for Post Payment Audits 3

Access to Services 4

Entry Requirements for Programs who Receive the Substance Use Prevention Treatment and Recovery (SUPTR) Block Grant (For Providers with a COA) 5

Entry process for new clients 5

Individual Rights according to Oregon House Bill 3046 (2021) 7

Required by CCO Contract Exhibit M- Behavioral Health 7

Assessment 8

Assessment, *continued* 9

Service Plans 10

Service Notes 11

Care Coordination 12

Risk Assessment and Safety Planning 14

Staffing Requirements 14

Staff Competencies 15

Staff Orientation 15

Staff Training Requirements 16

Supervision 16

MOTS 18

Special Programming Requirements (e.g., ACT, WRAP) 18

Crisis Response Requirements 18

Required Policies and Procedures 19

Quality Program Requirements 20

Complaints and Grievances 20

Behavioral Health Outpatient Provider Requirements

Requirements for providers of Outpatient Behavioral Health Services stem from multiple sources; these include the Oregon Administrative Rules, the CareOregon Provider Manual, and the Coordinated Care Contract for Medicaid Services. Providers must also follow the applicable ethics and guidelines associated with their professional organizations.

External Reviews from the Oregon Health Authority (OHA)

Behavioral Health Private Practitioners	Behavioral Health Providers Holding a Certificate of Approval (COA)
No required frequency of reviews.	Every 1-3 years as required by the State (OHA) to keep COA status MOTS

Risk for Post Payment Audits

CareOregon completes reviews as needed. There is no required frequency of reviews.	• The State reviews records every 1-3 years. The reviews may include a look at compliance, encounter, and clinical elements. • CareOregon completes reviews as needed. There is no required frequency of reviews.

Continued >

Behavioral Health Outpatient Provider Requirements

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Access to Services

Behavioral Health Private Practitioners

Urgent needs:

- Within 24 hours for all individuals
- Services may include referral to the local county crisis service or to a hospital emergency department, as necessary. Services are to prevent injury or serious harm, especially if the provider is unable to schedule an appointment within 24 hours.

Routine needs:

- Intake/Assessment within 7 days of the request
- Second appointment within 14 days of the request. (May be sooner if clinically indicated).
- Appointments 3-5 within 48 days of the request for services
- Appointments 2-5 as indicated above must be clinical vs administrative in nature.

If the agency/provider cannot provide services within the timelines above, the provider should contact CareOregon Care Coordination services. They will provide further assistance to help the individual access services.

Behavioral Health Providers Holding a Certificate of Approval (COA)

In addition to the timelines outlined in the column to the left, the following access guidelines apply.

Immediate assessment and program entry are required for:

- Pregnant women
- Woman with children
- Veterans and their families
- Unpaid caregivers
- Families
- Children ages birth through 5 years
- Individuals with HIV/AIDS or Tuberculosis
- Individuals at the risk of first episode psychosis
- IV drug users
- Intellectual and Developmental Disability (I/DD) Population

Assessment and entry within 72 hours:

- Individuals with Opioid Use Disorder
- Medication Assisted Treatment (MAT) Individuals

Regarding timeframes listed above:

- If provisional services are necessary due to capacity restrictions, treatment at an appropriate level of care must start within 120 days from placement on a waitlist.
- Admission to treatment in a residential level of care is required within 14 days of request, or if provisional services are necessary due to capacity restrictions, admission must start within 120 days from placement on a waitlist.
- If services cannot be provided within the timelines above, the provider should contact CareOregon Care Coordination services. They will provide further assistance to help the Individual access services.

Entry Requirements for Programs who Receive the Substance Use Prevention Treatment and Recovery (SUPTR) Block Grant (For Providers with a COA)

Document that individuals are prioritized for entry in the following order:

- Individuals who are pregnant and using substances intravenously
- Individuals who are pregnant
- Individuals who are using substances intravenously
- Individuals or families with dependent children

The following information and interim referrals are required for individuals using substances intravenously (IV) prior to entry to reduce adverse health benefits of substance use, promote the health of the individual, and reduce risk of transmission of disease:

- Counseling and education about blood borne pathogens including Hepatitis, HIV, STDs, and Tuberculosis (TB); and the risks of needle and paraphernalia sharing; and the likelihood of transmission to sexual partners and infants.
- Counseling and education about steps that can decrease the likelihood of Hepatitis, HIV, STD, and TB transmission.
- For pregnant individuals, counseling on the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco, and other drug use on the fetus and referral for prenatal care.
- Peer Delivered Services that addresses parenting and youth in transition support, as indicated.

Entry process for new clients

Required orientation to:

- Professional standards (such as a Professional Disclosure Statement, as applicable to license)
- Rights and Privacy Practices as outlined in Professional Ethics

Individuals should be considered for entry:

- Without regard to race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when the program eligibility is restricted to children, adults, or older adults), familial status, marital status, source of income, and disability.
- The provider may not deny entry to individuals based on their decision to continue currently prescribed or dispensed medication to treat opioid dependence while receiving outpatient behavioral health services and supports.
- Individuals shall receive services in the timeliest manner feasible consistent with the presenting circumstances.

Entry process for new clients, *continued*

Required Documentation in chart:

- Except as permitted by law in emergencies, informed consent for services must be obtained prior to services. Written, voluntary informed consent for services shall be obtained from the client or guardian, if applicable, prior to the start of services. If consent is not obtained, the reason and any further attempts to obtain informed consent is documented in the service record.
- (e) Per CFR 440.230, the provider shall develop and maintain service records and other documentation that demonstrates the amount, duration and scope of each specific services and supports provided for each client.
- The provider shall submit the identified status and service data, including Non-Medicaid Service Data where required, in the mandated state data system according to the timelines required by the Division for everyone whose services are paid for in-full or in-part by public funds and for individuals enrolled in DUII services.
- In accordance with ORS 179.505, HIPAA, and 42 CFR Part 2, an authorization for the release of information shall be obtained and contained in the service record for the release of any confidential information concerning the individual being considered for or receiving services.

Prior to or at the start of treatment services, program staff shall offer the client and guardian, if appliable, written program orientation information. It should be in a language understood by the client and include:

- An opportunity to complete a Declaration for Mental Health Treatment with the individual's participation and informed consent.
- A description of the client's rights consistent with these rules (in 309-019-0115).
- Policy concerning grievances and appeals consistent with these rules, including an example form.
- Notice of privacy practices
- An opportunity to register to vote

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Individual Rights according to Oregon House Bill 3046 (2021) Required by CCO Contract Exhibit M- Behavioral Health

In 2021, Oregon House Bill 3046 was approved.

The bill says that a "Coordinated Care Organization (CCO) must provide behavioral health services to its clients that include but are not limited to all" listed below. These are the rights outlined in the House Bill, and the rights which the providers of the CCO contracted services must follow:

- For a client who is experiencing a behavioral health crisis:
- A Behavioral Health Assessment
- Services that are Medically Necessary to transition the client to a lower level of care.
- At least the minimum level of services that are Medically Necessary to treat a client's underlying behavioral Health condition, rather than improvement of current symptoms.
- Treatment of co-occurring behavioral health disorders or medical conditions in a coordinated manner.
- Treatment at the least intensive and least restrictive level of care that is safe for the client and is effective to meet the needs of the client's condition.
- For all level of care placement decisions, placement at the level of care consistent with the client's score or assessment using the level of care placement criteria and guidelines.
- If the recommended level of care is not available, placement at the next higher level of care.
- Treatment to maintain functioning or prevent deterioration.
- Treatment for an appropriate duration based on the client's particular needs.
- Treatment appropriate for the unique needs of children and adolescents.
- Treatment appropriate for the unique needs of older adults.
- Treatment appropriate for the unique needs of gay, lesbian, bisexual, and transgender clients and clients of any other minority gender identity or sexual orientation.
- Treatment that is culturally and linguistically appropriate
- Coordinated care and case management

Assessment

Completed before any other mental health service.

- Exception: crisis and stabilization services can be provided at any time.
- "Completed" means signed and dated by a qualified provider.
- The assessment has the individual's diagnosis and documents the medical need for services:
- The diagnosis is documented according to DSM-5-TR standards.
- The individual's diagnosis is documented using all DSM-5-TR criteria (clinically justified) and is individualized to the person.
- The assessment identifies the individual's need for services, including functional impairments (how symptoms affect the individual's daily functioning).
- Updated assessments have all the above information, which supports the continued need for services. Additionally, they document progress, barriers, and updates to symptoms, risk, and personal information.

All assessments are culturally and age relevant.

- Consider reviewing the DSM-5-TR Cultural Formulation Interview and the National Culturally and Linguistically Appropriate Services Standards.
- Consider reviewing the DSM-5-TR supplementary modules for specific populations.

Providers holding a COA must follow all requirements in the column to the left. They must also follow the applicable 309 Rules.

- Diagnosis requirements that document the medical need for services:
- Follows standards in the column to the left.
- There is enough information to support each DSM-5-TR diagnosis that is the medically necessary reason for services. This includes documenting each DSM-5-TR criteria recognized per diagnosis, and the symptoms supporting each criterion.
- Completed (or updated) and signed at the time of entry by a qualified staff before any other service or support:
- Qualified staff as defined by OAR 309-019-0125 for the specific program.
- Exception: Crisis and Stabilization services can be provided at any time (as defined in OAR 309-019-0105).

The assessment screens for the presence of:

- Substance use
- Problem gambling
- Mental health conditions
- Chronic Medical conditions
- Symptoms related to psychological or physical trauma
- Suicide Risk
- collaborative community provider.
- A documented safety plan is completed with the client, as indicated. It will list actions to use during periods of increased risk. The document is updated as circumstances change or is created if risk presents during treatment.

When the above screening process finds the presence of any of the above conditions or risk to health and safety of the client:

- Further assessments will be completed to determine the need for follow up actions, additional services and support, and the level of risk to the client or others.
- The client chart will have documentation of a referral for further assessment, planning, and intervention from an appropriate professional. This may be with the same provider, or with a collaborative community provider.
- A documented safety plan is completed with the client, as indicated. It will list actions to use during periods of increased risk. The document is updated as circumstances change or is created if risk presents during treatment.

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Assessment, *continued*

The assessment is updated as required:

- The assessment is updated when there are changes to clinical circumstances.
- (MH Only): Any individual continuing to receive services for one or more continuous years shall receive an annual assessment by a QMHP.
- (Substance Use Only): Any changes to the ASAM Level of Care placement decision will be justified with an update to the multidimensional assessment on file.
- Additional Requirements for Substance Use Disorder Providers

Each assessment is a multi-dimensional assessment consistent with The ASAM Criteria, Third Edition that has each of the following components:

- ASAM Level of Care Determinations:
  - A determination for Dimension 1-6, with any discrepancies documented
  - An overall determination, with any discrepancies documented.
- A Risk Assessment that has:
  - A severity of risk for each dimension
  - Identification of immediate needs
  - Consideration of the history of each risk, as well as present concerns
  - Overall determination of the severity of risk the individual is currently experiencing.

Documentation at the time of entry shall include an evaluation that assesses:

- Social isolation
- Self-reliance
- Parenting issues
- Domestic violence
- Physical health
- Housing
- Financial considerations

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Service Plans

The service plan is created in collaboration with the individual, their family, or their chosen representative. This document shows clear evidence of the collaboration.

The service plan is unique to the individual and their presenting needs:

- It contains the date the service plan was created, and the date the clinician signed the document.
- It contains the client's diagnosis.
- It is reflective of the individual's assessment, their diagnosis, and needs.
- It identifies the services and supports that will be utilized to meet goals and objectives (e.g., individual therapy, case management, peer support, etc.).
- It supports the use of evidence-based practices and interventions appropriate to the diagnosis.
- It documents specific and measurable goals to help the individual address needs.
- It has a specific statement outlining the intended outcome for services.

The service plan is completed and signed by a qualified program staff.

The Provider Manual shares that service planning incorporates the principles of resilience and recovery, and:

- Employs strengths-based assessment.
- Is Individualized and person-centered.
- Promotes access and engagement.
- Encourages family participation.
- Supports continuity of care
- Empowers the client.

Providers holding a COA must also follow all requirements in the column to the left. They must follow the applicable 309 rules:

It is completed and signed by qualified program staff before the start of services:

- Substance Use and Problem Gambling Plans:
  - Supervisory or treatment staff.
- Mental Health Plans:
  - QMHP at time of completion.
  - QMHP who meets qualifications of a Clinical Supervisor within 10 business days of the start of Services.
  - QMHP who meets qualifications of a Clinical Supervisor at least annually for each client receiving services for one or more continuous years.

The Service plan is individualized to the client and their presenting needs:

- It is comprehensive and designed to improve the client's condition to the point where the client's continued participation is no longer necessary.
- It is reflective of the client's assessment, their diagnosis, the ASAM Level of Care (if applicable), and the client's needs.
- It addresses all areas of concern found in the assessment that the client agrees to address.
- It includes the applicable service coordination details to address the identified needs (Substance Use Disorder Specific).
- It includes objectives that support the participation of family and other agencies as appropriate (e.g., social service, child welfare, or corrections agencies, etc.). (Substance Use Disorder Specific).

The service plan has the following elements that are individualized to the client:

- The ASAM Level of Care Placement. When there is a discrepancy, document the client's preferred Level of Care Placement (Substance Use Disorder Specific).
- The expected frequency of each type of planned service or support.
- The schedule for re-evaluating the service plan.

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Service Plans, *continued*

- Respects the right of the individual.
- Involves individual responsibility and hope in achieving and sustaining recovery.
- Uses natural supports as the norm rather than the exception.
- Include objectives that are measurable to help the client evaluate their progress, including baseline evaluation (as defined in OAR 309-019-0105)

For providers of youth substance use disorder services, service plans must:

- Include participation of parents, other family members, schools, children's service agencies, and juvenile corrections. The service plan should include appropriate case management goals and objectives as needed.
- Services or appropriate referrals shall include:
  - Family counseling
  - Community and social skills training
  - Smoking cessation service

Service Notes

The Service Note Connects to the Service Plan:

- The note must document the specific objective(s) that the service is addressing.
- The note must have information regarding how the objective was addressed.

The service note has an evidence-based intervention appropriate for the diagnosis:

- The note documents the specific evidence-based practice being used (examples: CBT, DBT, IFS, MI)
- The note documents the intervention/how the evidence-based practice was applied to meet the specific and measurable goals in the service plan
- The service note has the extent of the services provided (example; Therapist met face to face with the client in the office [setting] for therapy [purpose]).

Providers holding a COA must also follow all requirements in the column to the left. They must follow the 309 rules:

The service note has:

- Periodic updates describing the individual's progress.

Decisions to transfer the client:

- Any decision to transfer the client (internal or external) shall be documented.
- Documentation shall include the following:
  - Date of Transfer
  - Reason for the transfer
  - Substance Use Disorder and Co-Occurring Services, the ASAM level of care recommendation and risk assessment at the time of transfer
  - Referrals to follow up services and other behavioral health providers.
  - Outreach efforts made, as applicable

For providers delivering adolescent substance use disorder treatment services:

- The service record should document continuing care in the appropriate duration and designed in a way to maximize recovery opportunities. Services provided should include:
  - Reintegration services and coordination with family and schools
  - Adolescent self-help groups where available

Service Notes, *continued*

The service note has:

- The number of services being provided (units)
- Name, signature, and credentials of individual who provided the service
- The date on which the service was provided, as well as the date of signature
- The specific service provided (name or CPT code)
- Start and stop times and duration of service (be exact)
- Service note documentation is completed and signed before it is billed.

The Provider Manual Shares that treatment interventions should promote resilience and recovery, as evidenced by:

- Maximized quality of life for individuals and families
- Success in work and/or school
- Improved Mental health status and functioning
- Successful social relationships
- Meaningful participation in the community
- Increase in housing stability
- Increased abstinence in alcohol and/or drugs
  - Referral to emancipation services when appropriate
  - Referral to physical or sexual abuse counseling and support services when appropriate
  - Referral for peer delivered services

For substance use disorder providers:

Please see the following Oregon Administrative Rules for documented standards for the following Levels of Care:

- Early Intervention (ASAM Level 0.5): 309-019-0181
- Outpatient (ASAM Level 1.0): 309-019-0182
- Intensive Outpatient (ASAM Level 2.1): 309-019-0183
- Partial Hospitalization/Day Treatment (ASAM Level 2.5): 309-019-0184
- DUII Services Providers: 309-019-0195

Care Coordination

Coordination with physical health

- CareOregon expects coordination of care and exchange of protected health information between the behavioral health providers and physical health providers.

Providers holding a COA must follow all requirements in the column to the left. They must follow the 309 rules:

Substance Use Disorder Programs:

- The program shall provide or coordinate services and supports that meet special access needs such as childcare, mental health services, and transportation.

Behavioral Health Outpatient Provider Requirements

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Care Coordination, *continued*

- As best practice, the behavioral health provider handles informing the PCP of the following after a proper release of information has been signed by the individual or their guardian:
  - The client's entry into care
  - Any significant change in the client's mental status
  - Any significant change in the client's medications
- If a client has a chronic medical condition, decide the extent to which ongoing care is being received, and compliance with medical plan. The provider will encourage and/or assist the client to obtain necessary treatment as appropriate.
- If client does not have a PCP, the amount of help given to the client is determined by their functioning level/need for assistance. For clients diagnosed with a Severe and Persistent Mental Illness, Clinicians are expected to make an active role in seeking PCP services for the client.
- Integrated Care for Clients:
- The CCO, and the Provider team members work together to coordinate integrated care for the client. This includes but is not limited to coordination with physical health (as stated above), intellectual and developmental disability, DHS, Oregon Youth Authority, Oregon/US Department of Veterans Affairs, ancillary services, and addressing social determinants of health.

"Care Coordination" according to the CCO contract, means the organized coordination of a client's health care services and support activities and resources.

- The program shall additionally provide or coordinate the following services and supports:
  - Gender-Specific
  - Family services, including therapeutic services for children in the custody of women in treatment
  - Reintegration with family or community
  - Peer delivered services
  - Smoking cessation
  - Housing
  - Transportation
  - Housing and employment support services for those who qualify under OAR 309-019-0105
- The program shall coordinate referral services with the following:
  - Agencies providing services to individuals who have experienced physical abuse, sexual abuse, or other types of domestic violence.
  - Parenting training
  - Continuing care treatment services shall be consistent with The ASAM Criteria and include referrals to support groups where available.
- Programs that receive SUPTR block grant funding shall provide or coordinate the following services for clients:
  - Primary medical care, including referral for prenatal care if applicable, and child-care and transportation where needed.
  - Primary pediatric care, including immunizations for their children.
  - Gender specific substance use disorder treatment and other therapeutic interventions that may include but are not limited to relationship issues, sexual and physical abuse, parenting, access to child-care and transportation while receiving these services.
  - Therapeutic interventions for children in the custody of individuals in treatment may include, but are not limited to addressing their developmental needs, any issues concerning sexual and physical abuse and neglect, and sufficient case management and transportation to ensure that individuals and their children have access to services.

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Risk Assessment and Safety Planning

Appropriate in quality and quantity to meet the professional standards applicable to the provider:

- Among behavioral health professionals working with individuals at risk, a complete risk assessment and follow up safety plan when indicated are considered a key component of a comprehensive treatment plan.
- A thorough documented safety plan would be indicated for any client who presents with identified risk factors, including, but not limited to, suicidal ideation, self-harm, indicators of inability to care for their own health or safety, thoughts of harming others, presence of domestic violence, harm reduction within substance use disorder patterns, and/or food or housing insecurity.
- The creation of a safety plan is for the purpose of both risk mitigation and client-centered practice and the following components are recommended: Warning signs (internal/external), coping skills, environmental factors (means restrictions, activating factors, triggers, etc.), supports (natural, professional, pets, etc.), Resources (crisis lines, walk in centers, etc.).

The chart must include a safety plan when the assessment or ongoing services indicate risk to the health and safety of the individual or others and be updated as circumstances change. The following definitions apply:

Risk Assessment:

- "A "Best Practice Risk Assessment" means a research-informed methodology that provides guidelines or tools to determine an individual's level of risk for attempting or completing self-inflicted injury or death and may include tools such as the Columbia Suicide Severity Rating Scale or other tools accepted for the Substance Abuse and Mental Health Services Administration National Registry of Evidence-based Programs and Practices or the Suicide Prevention Resource Center Best Practices Registry."

Safety Plan:

- Defined as "best practice, research-based, individualized and directive document developed through a collaborative process in which the provider assists the individual in listing actions to use when self-harm, harm to others, or suicide ideation is elevated following suicidal or parasuicidal behavior.
- You can find helpful information online at the Suicide Prevention Resource Center

Staffing Requirements

Specific details are not outlined in the Oregon Administrative Rules

Licensed Medical Practitioner (LMP)

- Required involvement to review and approve services for day treatment, PTRS, Subacute, etc.

QMHP who Meets Qualifications of Clinical Supervisor:

- Required to review and approve all Mental Health service plans within 10 days of the start of services.
- Required to review and approve all Mental Health service plans annually.

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Staff Competencies

Mental Health Services

- The staff qualifications and competencies are outlined in OAR 410-172-0660

Substance Use Disorder Services

- The staff qualifications and competencies are outlined in OAR 410-172-0670
- Background checks completed by Licensing Board and by the standards of the Licensing Board
- Credentialing is completed by the CCO.

- Specific competencies for Mental Health, Substance Use Disorder and Problem Gambling Staff are outlined in OAR 309-019-0125

Staff Orientation

- Background checks completed by Licensing Board and by the standards of the Licensing Board
- Credentialing is completed by the CCO.

Providers shall maintain personnel records for each program staff that contains ALL of the following:

- Verification of a criminal record check, and when applicable to the current position or title:
  - For personnel who render mental health services or have access to mental health protected health inform such as service records or billing information, the program shall use The Oregon
  - Criminal Records Check and those processes and procedures required by OAR 943-007-001 through 0501.
  - For personnel who render only substance use disorder treatment services or have access to only substance use disorder protected health information such as service records or billing information, the program shall use national and state-wide criminal records check processes.
- A current job description that includes applicable competencies
- Copies of relevant licensure or certification, registration for licensure or certification, diploma, or certified transcripts from an accredited college, indicating that the program staff meets applicable qualifications.

Staff Orientation, *continued*

Periodic performance appraisals

- Program orientation documentation
- Disciplinary documentation
- Documentation of trainings required by OARs and other applicable rules.
- Documentation of clinical supervision.

Staff Training Requirements

The following trainings are required:

- Fraud Waste and Abuse (FWA) Training (New Hire and Annually) (careoregon.org/providers/support)
- Integration and Foundations of Trauma Informed Care (https://traumainformedoregon.org/resources/training/tic-intro-training-modules/)
- Recovery principles and Motivational Interviewing

Providers holding a COA must follow all requirements in the column to the left. They must follow the 309 rules:

Within 30 days of hire, at minimum a review of the following population specific trainings is completed and documented for all staff providing or supervising services or supports:

- Crisis prevention and response procedures
- Emergency evacuation procedures
- Program policies and procedures
- Procedures for each certified ASAM Level of Care for substance use disorder treatment program staff.
- Rights of individuals receiving services and supports.
- Mandatory abuse reporting procedures
- Confidentiality policies and procedures
- Fraud, Waste and Abuse policies and procedures
- Care coordination policies and procedures
- Agreement to abide by the Code of Conduct

The following trainings are required:

- Strategies for the delivery of trauma informed and culturally responsive treatment services
- Substance use disorder treatment staff and clinical supervisors shall complete a training on the ASAM Criteria within the first 3 months of employment rendering substance use disorder services or supports or have it documented as completed within the most recent two years.
- Enhanced Care Services staff shall complete a training on positive behavior support.

Supervision

Fully Licensed Providers

- No specific requirements

Board Registered Interns

- Must follow Board approved supervision plan

Supervision is required for:

- Program staff, peer support and peer wellness specialists, volunteers and interns providing direct services and supports.

Supervision, *continued*

- Supervision to be provided by a qualified clinical supervisor related to the development, implementation, and outcome of services.
- Supervision to be provided to assist program staff to increase their skills within their scope of practice, improve quality of services to individuals and oversee program staff and volunteers' compliance with the code of conduct and program policies and procedures.
- Clinical supervision shall be provided to assist the staff to
  - Increase their skills within their scope of practice.
  - Improve quality of services to individuals.
  - Ensure understanding, application and compliance with the code of conduct and program policies and procedures.

Documentation of clinical supervision to be in staff file. Documentation is to include:

- Date supervision took place.
- Amount of supervision time per session
- Brief description of relevant topics addressed
- Progress toward certification and recertification
- Demonstrate the minimum house of clinical supervision for full time staff, as indicated in the "Frequency of supervision" section below.

Note: Half the total supervision hours required may be accomplished through group supervision. Individual face-to face contact may include real time, two-way audio or audio-visual conferencing,

Frequency of Supervision Required:

- Non-licensed program staff shall receive at least two hours per month of clinical supervision. The two hours shall include one hour of individual face-to-face supervision.
- Program staff holding a license issued by a Division recognized credentialing body and volunteers meeting the definition of program staff shall receive at least two hours of clinical supervision quarterly.
- Mental Health Interns and Student Interns shall receive one-hour of individual clinical supervision per week.
- When available, a qualified Peer Delivered Services Supervisor shall provide one of the two hours of required monthly supervision to program staff providing direct Peer Delivered Services. Remaining hours of supervision shall be provided by a qualified clinical supervisor.

Supervision, *continued*

	• Mental Health Interns and Student Interns shall render services and supports under the active supervision of a qualified supervisor, as defined in these rules. • Individualized non-clinical supervision shall be utilized as needed and documented.

MOTS

No specific requirements	Utilization of MOTS system required

Special Programming Requirements (e.g., ACT, WRAP)

Required when applicable to the agency	Required when applicable to the agency

Crisis Response Requirements

All behavioral health providers (regardless of size or number of clients served) are required at minimum to: • Provide clients with the phone number for the crisis line in the county where they live. • Coordinate care with the crisis line as needed.	"Crisis' means an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted, and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care or death." **All behavioral health providers (regardless of size or number of clients served) are required at minimum to:** • Provide clients with the phone number for the crisis line in the county where they live. • Coordinate care with the crisis line as needed. **Provider agencies will have a crisis response system for enrolled clients:** • At minimum, the provider agency will always have a clinician available by phone for consultation, including after regular business hours. This individual shall be familiar with the client or will have the ability to access relevant information to help in crisis response. • Enrolled clients who come to the attention of the crisis line should be referred to their current provider for crisis response during normal business hours. If a client who is enrolled with a provider agency comes to attention of a crisis program, the team will contact the provider directly to request assistance in responding to the situation.

Required Policies and Procedures

Behavioral Health Outpatient Provider Requirements

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There are 3 policies required by the CCO Contract:

- Drug-Free workplace
- Record Keeping System
- HIPAA

OAR 309-019-0110 outlines the following policies and procedures that must be made available to individuals and family members upon request:

- Personnel qualifications and credentialing
- Mandatory abuse reporting
- Criminal records checks that address program and volunteer staff
- Fraud, wase, and abuse in federal Medicaid and Medicare programs
- Drug and gambling free workplaces.
- Fee agreements
- Confidentiality and compliance with HIPAA, 42 CFR, Part 2, and state confidentiality requirements
- Compliance with Title 2 of the Americans with Disabilities Act of 1990
- Grievances and appeals.
- Individual Rights
- Quality assessment and performance improvement
- Trauma informed service delivery
- Provision of culturally and linguistically appropriate services
- Crisis prevention and response
- Incident Reporting
- Peer delivered services.
- Prevention of communicable disease transmission
- Emergency evacuation
- Care Coordination
- Delivery of substance use disorder treatment services and support consistent with the ASAM Criteria for each certified level of care.
- Code of conduct that includes professional boundaries and ethics.
- Referral, care coordination, and transfer of services
- Medical protocols consistent with OARs
- Urinalysis Testing

See the linked OAR for more information regarding the listed policies as well as content which should be included in the policies.

Quality Program Requirements

No specific requirements	• Providers shall develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families. • OAR 309-019-0210

Complaints and Grievances

Individuals have the right to file complaints and grievances in accordance with Oregon Administrative Rules and Centers for Medicare and Medicaid Services (CMS) guidelines. CareOregon encourages Individuals and providers to resolve complaints and problems directly with those involved. CareOregon provides formal procedures for addressing complaints and problems when they cannot be resolved otherwise. If they are not resolved with the provider, clients can request a hearing through OHA. Individuals can call the customer services department to file their complaint	Individuals have the right to file complaints, grievances, and appeal decisions as outlined in OAR 309-019-0215. **The providers grievance process shall:** • Designate a program staff individual to receive and process the grievance. • Notify each individual/guardian of the grievance procedure in writing upon entry. • Assist individuals understand the grievance process and notify them of the results and basis for the decision. • Encourage and facilitate resolution of the grievance at the lowest possible level. • Complete an investigation within 30 calendar days. • Implement a procedure for accepting, processing, and responding to grievances including specific timelines for each. • Document any action taken on a substantiated grievance within a timely manner. • Document receipt, investigation and action taken in response to a grievance. • Post Grievance Process Notice in a common area stating the telephone numbers for OHA, Disability Rights Oregon, the CCO, and Governor's Advocacy Oregon In circumstances where the matter of the grievance is likely to cause harm to an individual before the grievance procedures are completed, the individual may request an expedited review. A response is needed in writing within 48 hours of receipt of the grievance and shall include information about the appeal process. Please review the linked OAR for further information regarding the appeal process and prohibition of retaliation.