TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CHAPTER 27. STANDARDS AND CRITERIA FOR MENTAL ILLNESS SERVICE PROGRAMS

SUBCHAPTER 1. GENERAL PROVISIONS

450:27-1-1. Purpose
(a) This chapter sets forth the Standards and Criteria used in the certification of certain facilities or organizations providing mental health treatment services and implements 43A O.S. § 3-323A which authorizes the Board of Mental Health and Substance Abuse Services, or the Commissioner upon delegation by the Board, to certify facilities as a Mental Illness Service Program.
(b) The rules regarding the certification process including but not necessarily limited to application, fees and administrative sanctions are found in the Oklahoma Administrative Code, Title 450 Chapter 1, Subchapters 5 and 9.
(c) Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC ~~450:1-9-5.3~~450:1-9-5.6.

SUBCHAPTER 3. ORGANIZATION STRUCTURE AND ADMINISTRATIVE OPERATIONS

PART 5. SAFETY AND RISK MANAGEMENT

450:27-3-43. Incident Reporting; procedures
(a) The facility shall have written policies and procedures requiring documentation and reporting of unusual incidents and analysis of the contributors to the incident, with attention to issues that may reflect opportunities for system level or program level improvement.
(b) Policies shall be in accordance with documentation and submission requirements as stipulated in ~~450:27-7-47 Incident Reporting; documentation and notification~~OAC 450:1-9-5.6(f).
(c) Compliance for 450:27-3-43 will be determined by review of policies and procedures, review of incidents reported, as applicable, to ODMSHAS, and staff interviews.

450:27-3-44. Hygiene and sanitation [REVOKED]
~~Facilities shall provide:~~

~~(1) Lavatories and toilet facilities on site in a minimum ration of (1) per twenty (20) persons;~~

~~(2) Water obtained from an approved public water supply or tested at least quarterly and treated as necessary, thereby maintaining a determination as an approved water supply by the authority having jurisdiction and the OSDH or DEQ, as necessary;~~

(3) Housekeeping services so that a hygienic environment is maintained in the facility.

SUBCHAPTER 5. QUALITY MANAGEMENT OF OPERATIONS

PART 3. OPERATIONS FOR SERVICE DOCUMENTATION

450:27-5-21. Clinical record keeping system [REVOKED]

(a) Each facility must establish and maintain an organized clinical record system for the collection and documentation of information appropriate to the treatment processes; and which insures organized, easily retrievable, usable clinical records stored under confidential conditions and with planned retention and disposition.
(b) Compliance with 450:27-5-21 may be determined by on-site observation, a review of policies and procedures, treatment records, performance improvement guidelines, interviews with staff, and other facility documentation.

450:27-5-22. Clinical record system; basic requirements [REVOKED]

(a) The facility's policies and procedures shall:

(1) Define the content of the consumer record.

(2) Define storage, retention and destruction requirements for consumer records.

(3) Require consumer records be maintained in locked equipment which is kept within a locked room, vehicle, or premise.

(4) Require legible entries in consumer records, signed with first name or initial, last name, and dated by the person making the entry.

(5) Require the consumer's name be typed or written on each page in the consumer record; or appear on each screen of an electronic record.

(6) Require a signed consent for treatment before a consumer is admitted on a voluntary basis.

(b) If electronic clinical (medical) records are maintained, the facility will have proof of compliance with federal and state statutes related to electronic medical records, encryption, and other required features.
(c) Compliance with 450:27-5-22 shall be determined by a review of the following: facility policy, procedures or operational methods; clinical records; other facility provided documentation; and PI information and reports.

450:27-5-23. Record access for clinical staff [REVOKED]

(a) The facility shall assure consumer records are readily accessible to all staff providing services to consumers. Such access shall be limited to the minimum necessary to carry out the staff member's job functions or the purpose for the use of the records.
(b) Compliance with 450:27-5-23 shall be determined by on-site observation and staff
interviews.

SUBCHAPTER 7. CLINICAL SERVICES

PART 1. REQUIRED SERVICES

450:27-7-1. Core behavioral health services [REVOKED]

~~(a) Each facility shall minimally provide the following services:~~

~~(1) Screening, assessment and referral services;~~

~~(2) Emergency services; and~~

~~(3) Outpatient therapy services.~~

~~(b) Compliance with 450:27-7-1 shall be determined observation and review of clinical records that document the provision of services the above listed services.~~

450:27-7-3. Assessment services

(a) Facility policies shall describe, upon determination of appropriate admission to the facility service(s), the procedures by which assessment and admission occur.

(b) The consumer assessment shall be completed by an LBHP or licensure candidate and shall include, but not be limited to, the following information:

(1) Behavioral, including mental health and addictive disorders~~ as well as the following~~;

~~(A) presenting problem and current symptomology;~~

~~(B) previous treatment history;~~

~~(C) current and past psychotropic and addiction medications, including name, dosage and frequency; and~~

~~(D) Family history of mental health and other addictive disorders.~~

(2) Emotional, including issues related to past or current trauma and domestic violence;

(3) Physical/medical~~ including medications~~;

~~(A) health history and current biomedical conditions and complications;~~

~~(B) current and past physical health medications, including name, dosage and frequency.~~

(4) Social and recreational~~; and, including~~;

~~(A) family and other relationships;~~

~~(B) recovery and community supports;~~

~~(C) leisure and wellness activities; and~~

~~(D) culture, including traditions and values.~~

(5) Vocational~~, including~~;

~~(A) educational attainment, difficulties, and history;~~

~~(B) current or previous military service including discharge status; and~~

~~(C) current and desired employment status~~.

(c) The facility shall have policy and procedures specific to each program service which dictate timeframes by when assessments must be completed and documented.

(d) The policy shall specify how screening and assessment information is maintained and stored in the event the consumer is not admitted for program services,

(e) The consumer, family as appropriate, and others as appropriate and approved by the consumer shall be an active participant(s) admission and assessment process.

(f) Compliance with 450:27-7-3 shall be determined by a review of clinical records, and policy and procedures.

PART 3. ADDITIONAL OR OPTIONAL SERVICES

450:27-7-21. Additional treatment services;

(a) If the facility provides the following additional services those shall be provided in accordance with related standards described within OAC 450:27 and other portions of OAC:450, as applicable.

(1) Case Management Services;
(2) Medication Services;
(3) Pharmacy Services; ~~Peer Recovery Support Services;~~
(4) Wellness Activities and Supports;
(5) Behavioral Health Rehabilitation Services;
(6) Day treatment services for children and adolescents; and,
(7) ~~Behavioral Health Home~~Peer Recovery Support Services.

(b) If the facility provides the following services, in addition to those stipulated in 450:27-7-1. and 450:27-7-21, separate ODMHSAS certification will be required in accordance with OAC 450~~.~~, including but not limited to the following:

(1) Community Residential Mental Health Facilities, per OAC 450:16;
(2) Alcohol and Drug Treatment Programs, per OAC 450:18;
(3) Community Based Structured Crisis Services, per OAC 450:23;
(4) Comprehensive Community Addiction Recovery Centers, per OAC 450:24;
(5) Programs of Assertive Community Treatment, per OAC 450:55;
(6) Eating Disorder Treatment Programs, per OAC 450:60;
(7) Gambling Treatment Programs, per OAC 450:65; and/or,
(8) Opioid Substitution Treatment Programs, per OAC 450:70

(c) Compliance with 450:27-7-21 is determined by review of program descriptions, clinical documentation, and review of ODMHSAS Certification findings additional applicable portions of OAC 450.

450:27-7-22. Case management services

(a) If provided, case management services shall empower consumers to access and use needed services and meet self-determined goals. These services include resource skills development and consumer advocacy provided in various settings based on consumer need. These services include referral, linkage, monitoring and support, and advocacy assistance provided in partnership with a client to support that client in self sufficiency and community tenure. Needs should be determined, at least in part, by completion of a strengths based assessment in partnership with the consumer and family members, as applicable, and utilized in the development of a a case management plan. The case management plan can be incorporated in the overall services plan.

(b) If case management services are provided, policies and procedures should articulate that ~~an assessment includes evidence that the following are evaluated:~~ a strengths based assessment for the purpose of assisting in the development of an individual plan of care must be completed.

~~(1) Consumer's level of functioning within the community;~~
~~(2) Consumer's job skills and potential; and/or educational needs;~~
~~(3) Consumer strengths and resources;~~
~~(4) Consumer's present living situation and support system;~~
~~(5) Consumer's use of substances and orientation to changes related to substance use;~~
~~(6) Consumer's medical and health status;~~
~~(7) Consumer's needs or problems which interfere with the ability to successfully function in the community; and~~
~~(8) Consumer's goals.~~

(c) Compliance with 450:27-7-22 shall be determined by a review of policy and procedures and clinical documentation.

PART 5. CLINICAL DOCUMENTATION

450:27-7-41. Clinical record content, screening, intake and assessment, documentation

(a) The facility shall complete a face-to face screening with each individual to determine appropriateness of admission in accordance with 450:27-7-2. Screening services.
(b) The facility shall document the face-to-face screening conducted how the consumer was assisted to identify goals, how the consumer received integrated screening to identify both immediate and ongoing needs and how the consumer was assisted to determine appropriateness of admission, and/or to access other appropriate services.
(c) Each consumer admitted for treatment for co-occurring services shall be assessed by a qualified professional ~~demonstrating competency in the use of ASAM criteria, according to ASAM criteria, which includes a list of symptoms for all six dimensions and each level of care,~~ to determine a clinically appropriate placement in the least restrictive level of care. Facilities must ensure that a consumer's refusal of a particular service does not preclude the consumer from accessing other needed co-occurring treatment services. Should the service provider determine the consumer's needs cannot be met within the facility, clinical assessments and referrals for the consumer shall be documented.
(d) Upon determination of appropriate admission, consumer demographic information shall be collected, as defined by facility policies and procedures.
(e) For persons admitted to service, the facility shall complete a psychosocial assessment which gathers sufficient information to assist the consumer develop an individualized service plan.
(f) An intake assessment update, to include date, identifying information, source of information, present needs, present life situation, current level of functioning, and what consumer wants in terms of service, is acceptable as meeting requirements

of 450:27-7-41 only on re-admissions within one (1) year of previous admission at the facility.
(g) Compliance with 450:450:27-7-41 shall be determined by a review of the following: psychosocial assessment instruments; consumer records; case management assessments; interviews with staff and consumers; policies and procedures and other facility documentation.

450:27-7-42. Behavioral health service plan; documentation
(a) The service plan is developed and finalized with the active participation of the consumer and a support person or advocate if requested by the consumer. In the case of children under the age of ~~18~~sixteen (16), it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The service plan shall provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon consumer's progress or preference or the identification of new needs, challenges and problems.
(b) The service plan shall completed by a LBHP or licensure candidate and be based on information obtained in the mental health assessment, other information provided on behalf of the consumer, and includes the evaluation of the assessment information by the clinician and the consumer.
(c) For adults, the service plan must be focused on recovery. For children the plan should address school and education concerns and assisting the family in caring for the child in the least restrictive level of care.
(d) Service plans must be completed within six (6) treatment sessions and ~~include:~~adhere to the format and content requirements described in the facility policy and procedures.

~~(1) Consumer strengths, needs, abilities, and preferences;~~
~~(2) Identified presenting challenges, needs, and diagnosis;~~
~~(3) Goals for treatment with specific, measurable, attainable, realistic, and time-limited objectives;~~
~~(4) Type and frequency of services to be provided;~~
~~(5) Description of consumer's involvement in, and response to, the service plan;~~
~~(6) The service provider who will be rendering the services identified in the service plan; and~~
~~(7) Discharge criteria that are individualized for each consumer.~~

(e) Service plans updates should occur at a minimum of every 6 months during which services are provided and ~~include the following:~~adhere to the format and content requirements described in the facility policy and procedures.

~~(1) Progress on previous service plan goals and/or objectives;~~
~~(2) A statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;~~
~~(3) Change in goals and/or objectives based upon consumer's progress or identification of new needs and challenges;~~
~~(4) Change in frequency and/or type of services provided;~~

~~(5) Change in staff who will be responsible for providing services on the plan; and~~

~~(6) Change in discharge criteria.~~

(f) Service plans, both comprehensive and update, must include dated signatures for the consumer (if over age 14), the parent/guardian (if under age 18 or otherwise applicable), and the primary service practitioner. Signatures must be obtained after the service plan is completed.

(g) Compliance with 450:27-7-42 shall be determined by a review of the clinical records, policies and procedures, and interviews with staff and consumers, and other agency documentation.

450:27-7-44. Progress notes

(a) Progress notes shall chronologically describe the services provided by date and, for timed treatment sessions, time of service, the consumer's response to the services provided, and the consumer's progress in treatment. ~~and include the following:~~

~~(1) Date;~~

~~(2) Name of consumer(s) to whom services were rendered;~~

~~(3) Start and stop time for each timed treatment session or service;~~

~~(4) Original signature of the therapist/service provider; in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the clinical file within 30 days and no stamped or photocopied signatures are allowed. Electronic signatures are acceptable;~~

~~(5) Credentials of therapist/service provider;~~

~~(6) Specific service plan need(s), goals and/or objectives addressed;~~

~~(7) Services provided to address need(s), goals and/or objectives;~~

~~(8) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;~~

~~(9) Consumer (and family, when applicable) response to the session or intervention;~~

~~(10) Any new need(s), goals and/or objectives identified during the session or service.~~

~~(b) Progress notes shall be documented according to the following time frames:~~

~~(1) Outpatient staff must document each visit or transaction, except for assessment completion or service plan development, including missed appointments;~~

~~(2) Behavioral health rehabilitation services and day treatment programs for children and adolescents staff must maintain a daily, member sign-in/sign-out record of member attendance, and shall write a progress note daily or a summary progress note weekly.~~

(b) Progress notes must include the consumer's name, be signed by the service provider, and include the service provider's credentials.

(c) Compliance with 450:27-7-44 shall be determined by a review of clinical records and policies and procedures.