Mental Health Service Definitions

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Adjunctive therapy service (OAC 5122-29-23).

(A) "Adjunctive therapy service" means interventions using a variety of media and activities to develop or maintain social or physical skills.

(B) Adjunctive therapy service includes interventions using a variety of media such as art, dance, music and recreation to develop or maintain social or physical skills. Such interventions shall be developed and reviewed as part of the ISP.

Adult educational service (OAC 5122-29-13).

(A) "Adult educational service" means time-limited and structured educational interventions for adults, such as educational advising, literacy instruction, basic educational instruction or instruction in community and independent living skills.

(B) Adult educational service shall:

(1) Include, but not be limited to, educational counseling, literacy, basic educational instruction and community and independent living skills such as budgeting and money management;
(2) Be provided by staff qualified according to paragraph (D) of this rule;
(3) Promote coordination among similar providers within the community mental health board service district, and with agencies and boards of adjacent community mental health board service districts to maximize the rehabilitation opportunities for persons served by the agency; and
(4) Ensure that the service plan is consistent with the principles of a community support system and promotes peer support and other approaches identified by persons served to achieve their stated educational goals.

(C) The agency shall:

(1) Assess the needs and desires of persons served including, but not limited to reading, writing, arithmetic, and post-secondary education and independent living skills;
(2) Provide access to and coordinate with community educational programs, including adult basic education, vocational schools, technical schools, community colleges, four-year colleges, universities, and peer literacy programs; and
(3) Make every effort to utilize existing community educational programs before directly providing adult educational service.

(D) Adult education service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Assertive community treatment (ACT)(OAC 5122-29-29).

(A) Assertive community treatment (ACT) is a collaborative, multidisciplinary team approach that shall include, at a minimum, behavioral health counseling and therapy service, mental health assessment service, pharmacologic management service, community psychiatric supportive treatment (CPST) service, self-help/peer support service, mental health crisis response service, substance abuse services, and supported employment services.

ACT services are provided to an individual with a major functional impairment(s) and/or behavior which present a high risk to the individual due to severe and persistent mental illness and which necessitate high service intensity. ACT services are also provided to the individual's family and other support systems. A client receiving ACT services may also have coexisting substance abuse, mental

retardation/developmental disabilities, and/or physical health diagnoses. The service is available twenty-four hours a day, seven days a week.

The purpose/intent of ACT team services is to provide the necessary services and supports which maximize recovery, and promote success in employment, housing, and the community.

(B) In addition to the definitions in rule 5122-24-01 of the Administrative Code, the following definitions apply to this rule:

(1) "Competitive employment" means activity conducted as part of a community job for which anyone can apply and for which the individual is paid at least minimum wage.
(2) "Crisis response" means the immediate access and availability of the ACT team, by phone and face-to-face, as clinically indicated, to the client or essential others, and which may include crisis stabilization, safety planning, and the alleviation of the presenting crisis.
(3) "Essential other" means an individual who has regular contact and emotional or functional significance to the person served including family, friends, guardians, landlords, neighbors, etc.
(4) "Peer specialist" means an employee who has experienced serious and persistent mental illness, and who provides direct services, including social and emotional support, coupled with instrumental support, to persons receiving mental health services. A peer specialist promotes recovery through training, role modeling and sharing experiences, and facilitates recovery by providing hope, encouragement, self-determination, validation, and connection to the community.
(5) "Supported employment" means a group of services which assists and supports a person choosing, obtaining, and maintaining competitive employment according to his/her preferences and without requiring prevocational activities.

(C) ACT certified agencies shall be certified to provide behavioral health counseling and therapy service, mental health assessment service, pharmacologic management service, and community psychiatric supportive treatment (CPST) service in accordance with Chapters 5122-24 to 5122-29 of the Administrative Code.

(D) Agencies shall develop clearly identified admission criteria which shall be reflective of the intensive nature of the service. Admission criteria shall include attention to:

(1) Diagnosis, including co-occurring disorders;
(2) Psychiatric service utilization history;
(3) Symptoms; and
(4) Functioning.

(E) The agency must demonstrate that each ACT team meets, at a minimum, the following staff requirements and qualifications:

(1) Designated team leader, who is qualified to supervise the service;
(2) Psychiatrist, including a minimum ratio of .40 full-time equivalent psychiatrist per one hundred clients receiving ACT services. Each ACT team shall have no more than three psychiatrists. The ACT team psychiatrist(s) may collaborate with a nurse practitioner(s) and/or clinical nurse specialist(s) to fulfill part of the psychiatrist(s)'s roles and responsibilities, provided that the nurse practitioner(s) and/or clinical nurse specialist(s) has a nursing specialty in mental health or psychiatric mental health;
(3) A substance abuse team member, including a minimum ratio of one full-time equivalent substance abuse team member per one hundred clients receiving ACT services:
(a) Prior to providing the service, each substance abuse team member receives an assessment of initial training needs based on the skills and competencies necessary to provide ACT service. A training and supervision plan shall be developed based on this assessment ensuring the substance abuse team member has or will obtain within six months the necessary skills and competencies, which may include:

(i) Engagement strategies;
(ii) Motivational strategies; and
(iii) Relapse prevention.

(b) An agency with more than one ACT team may be exempt from this requirement on one or more, but not all, of their ACT teams, providing all of the following conditions are met:
(i) The agency has at least one ACT team for dually-diagnosed individuals with alcohol and other drug service needs. This specialized team shall include a substance abuse team member; and
(ii) The agency's ACT service description, and ACT policies and procedures shall describe the client population needs served by each agency ACT team. In addition, the policies and procedures shall:
(a) Include the requirement that each client receiving ACT services and in need of alcohol and other drug services is served on an ACT team that includes a substance abuse team member; and
(b) Specify the procedures to ensure a client on a team without a substance abuse team member, but who is later assessed to be in need of substance abuse services, receives all ACT services from an ACT team with a substance abuse team member;
(c) All actions by the substance abuse team member and ACT team shall be in compliance with division (B) of section 3793.06 and section 4758.02 of the Ohio Revised Code.

(4) Registered nurse, including a minimum ratio of 1.0 full-time equivalent registered nurse per one hundred clients receiving ACT services. Each registered nurse shall have a specialty or documented competency in psychiatry;

(5) Vocational specialist, including a minimum ratio of 1.0 full time equivalent vocational specialist per one hundred clients receiving ACT services. Prior to providing the service, each vocational specialist receives an assessment of initial training needs based on the skills and competencies necessary to provide ACT service. A training and supervision plan shall be developed based on this assessment ensuring the vocational specialist has or will obtain within six months the necessary skills and competencies, which may include:
(a) Supported employment;
(b) Job placement;
(c) Individualized job development; and
(d) Benefits planning; and

(6) Prior to providing the service, each peer specialist receives an assessment of initial training needs based on the skills and competencies necessary to provide ACT service. A training and supervision plan shall be developed based on this assessment ensuring the peer specialist has or will obtain within six months the necessary skills and competencies, which may include:
(a) Recovery;
(b) Peer support;
(c) Consumer advocacy organizations; and
(d) Psychiatric advance directives:
(i) education and advocacy; and
(ii) information and referral.

(F) The agency must demonstrate that each ACT team member's roles and responsibilities include, at a minimum, the following:

(1) The team leader:
(a) Provides direct supervision of team members; and
(b) Provides direct services.

(2) The psychiatrist:
(a) Provides clinical leadership to the ACT team in assessment, treatment planning, general healthcare, medical and psychosocial approaches; and
(b) Collaborates with each nurse practitioner and/or clinical nurse specialist, when these staff are utilized to fulfill part of the requirement in paragraph (F)(2) of this rule, in assessment, treatment

planning, general healthcare, medical and psychosocial approaches, and a review of each ACT client's progress and treatment.

(3) The psychiatrist, along with the nurse practitioner and clinical nurse specialist when these staff are utilized to fulfill part of the requirement in paragraph (F)(2) of this rule, provides consultation and training to other ACT team members regarding the client's medical psychiatric care, including pharmacologic management needs.

(4) The substance abuse team member:

(a) Provides training to other ACT team members on the signs, symptoms and early identification of alcohol and other drug use and abuse, and the disease of alcoholism and drug dependency;

(b) Assists in coordinating individual treatment planning including aftercare and recovery support services for each client actively involved in alcohol and other drug treatment;

(c) Assists each client receiving drug and alcohol treatment in becoming involved with self-help support groups;

(d) Assists each client receiving drug and alcohol treatment in developing and maintaining social support networks; and

(e) Ensures that each client referred by the ACT team for alcohol and other drug treatment is referred to an individual or program licensed or certified to provide alcohol and other drug treatment.

(5) The registered nurse:

(a) Conducts health assessments;

(b) Coordinates with other health providers; and

(c) Provides training to other ACT team members to help them monitor psychiatric symptoms and medication side effects.

(6) The vocational specialist:

(a) Provides training to other ACT team members to help them integrate interventions to support vocational goals;

(b) Liaisons with other providers of vocational rehabilitation services, if applicable;

(c) Provides or makes appropriate referral for benefits planning; and

(d) Provides a full range of supported employment services. Eligibility is based upon client choice, and efforts are made to engage the client in supported employment regardless of diagnosis, symptoms, work history, substance use, or treatment compliance. Supported employment activities must include:

(i) Interventions to achieve competitive employment. Volunteer jobs, sheltered employment, and enclaves shall not be suggested to a client as preparatory to employment, or as long-term vocational goals;

(ii) Interventions individualized to the client's job preferences, life-style, and mental health coping skills;

(iii) Commencing the employment search within four weeks after the client expresses a desire to work;

(iv) Time unlimited follow-along services. Contact with the client and employer, as appropriate, shall continue for the duration of the job; and

(v) Utilizing a job termination, if any, as a learning opportunity, and beginning a new employment search within four weeks.

(7) The peer specialist:

(a) Engages the client, and provides outreach and support; and

(b) Provides training and education to other ACT team members and clients on:

(i) Recovery;

(ii) Peer support;

(iii) Consumer advocacy organizations; and

(iv) Psychiatric advance directives:

(a) Education and advocacy; and

(b) Information and referral.

(G) The agency must demonstrate that each ACT team:

(1) Consists of a minimum of 4.0 full-time equivalent direct care staff members;

(2) Serves no more than one-hundred twenty clients; and
(3) Provides a minimum of a one-to-fifteen direct service staff-to-client ratio, excluding psychiatrists, and nurse practitioners and/or clinical nurse specialists when these staff are utilized to fulfill part of the requirement in paragraph (F)(2) of this rule.

(H) Each month the agency must demonstrate that ACT staff provide each client a minimum of the following service contacts for the ACT services specified in paragraph (C) of this rule:

(1) Three face-to-face service contacts. At least sixty-five percent of all face-to-face service contacts shall occur in the community; and
(2) Six total service contacts.
(3) Clinically appropriate reasons for the inability to implement any portion of this paragraph shall be documented in the ICR.

(I) The agency must demonstrate that the ACT team has a minimum of one contact per month with family/essential others, with the consent of and choice by the person served.

(J) The agency must demonstrate that each month sixty-five percent or more of the ACT team clients shall receive contact by more than one ACT team member.

(K) Each ACT team shall meet a minimum of four times each week to plan and review ACT client progress. Telephone conferences are acceptable. Each psychiatrist, as well as each nurse practitioner and clinical nurse specialist when these staff are utilized to fulfill part of the requirement in paragraph (F)(2) of this rule, shall attend a minimum of one team meeting each week. The team shall document attendance and participation at this meeting, as all on-duty ACT team staff are expected to attend.

(L) Each ACT team is responsible for crisis response twenty-four hours a day, seven days a week. Crisis response may be provided through written agreement with another agency, as long as at least one member of the ACT team is accessible to the provider agency, and is available to the client and/or essential other as needed. The agreement shall specify the responsibilities of the ACT team and the provider agency.

(M) The ACT team shall be involved in psychiatric hospital admissions and discharges.

(1) The team is involved in the decision for psychiatric inpatient admissions. The team shall document any instance in which they were unable to collaborate with psychiatric admitting staff.
(2) The team shall collaborate with the psychiatric inpatient treatment team for planning hospital discharges.

(N) For a minimum of ninety days, or until the client has stated his or her desire to discontinue ACT services, the ACT team shall attempt at least two face-to-face contacts per month for a client who has discontinued ACT services unexpectedly. Such attempts and client response, if any, shall be documented in the ICR.

(O) Assertive community treatment service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Behavioral health counseling and therapy service (OAC 5122-29-03).

(A) Behavioral health counseling and therapy service means interaction with a person served in which the focus is on treatment of the person's mental illness or emotional disturbance. When the person served is a child or adolescent, the interaction may also be with the family members and/or parent, guardian and

significant others when the intended outcome is improved functioning of the child or adolescent and when such interventions are part of the ISP.

(B) Behavioral health counseling and therapy service shall consist of a series of time-limited, structured sessions that work toward the attainment of mutually defined goals as identified in the ISP.

(C) Behavioral health counseling and therapy service shall be provided by staff qualified according to paragraph (G) of this rule.

(D) Behavioral health counseling and therapy service may be provided in the agency or in the natural environment of the person served, and regardless of the location shall be provided in such a way as to ensure privacy.

(E) For behavioral health counseling and therapy services for children and adolescents, the agency shall ensure timely collateral contacts with family members, parents or guardian and/or with other agencies or providers providing services to the child/adolescent.

(F) The following shall apply with regard to the use of interactive videoconferencing. Interactive videoconferencing is defined in Chapter 5122-24 of the Administrative Code:

(1) "Client site" means the location of a client at the time at which the service is furnished via interactive videoconferencing technology. .
(2) "Provider site" means the site where the eligible practitioner furnishing the service is located at the time the service is rendered via interactive video conferencing technology.
(3) The agency shall obtain from the client/parent/legal guardian, signed, written consent for the use of videoconferencing technology.
(4) It is the responsibility of the agency to assure contractually that any entity or individuals involved in the transmission of the information guarantee that the confidentiality of the information is protected. When the client chooses to utilize videoconferencing equipment at a client site that is not arranged for by the agency, e.g., at his/her home or that of a family or friend, the agency is not responsible for any breach of confidentiality caused by individuals present at the client site.
(5) The agency shall provide the client written information on how to access assistance in a crisis, including one caused by equipment malfunction or failure.
(6) It is the responsibility of the agency to assure that equipment meets standards sufficient to:
(a) Assure confidentiality of communication;
(b) Provide for interactive videoconferencing communication between the practitioner and the client; and
(c) Assure videoconferencing picture and audio are sufficient to assure real-time interaction between the client and the provider and to assure the quality of the service provided.
(d) The client site must also have a person available who is familiar with the operation of the videoconferencing equipment in the event of a problem with the operation.
(e) If the client chooses to utilize videoconferencing equipment at a client site that is not arranged for by the agency, e.g., at his/her home or that of a family or friend, the agency is only responsible for assuring the equipment standards at the provider site.
(7) The decision of whether or not to provide initial or occasional in-person sessions shall be based upon client choice, appropriate clinical decision-making, and professional responsibility, including the requirements of professional licensing, registration or credentialing boards.

(G) Behavioral health counseling and therapy service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

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Behavioral health hotline service (OAC 5122-29-08).

(A) Behavioral health hotline service means an agency's twenty-four hour per day, seven days per week capability to respond to telephone calls, often anonymous, made to an agency for crisis assistance. The person may or may not become a client of the agency.

(B) Behavioral health hotline service shall:

(1) Be available twenty-four hours per day, seven days per week;
(2) Make crisis intervention mental health service available by referral to another service or agency;
(3) Include, but not be limited to, the following:
(a) Short-term intervention and crisis management provided by telephone;
(b) Suicide prevention intervention;
(c) Appropriate linkages to all needed services and other community resources;
(d) Information and referral services; and
(e) A clearly identified linkage to make available immediate psychiatric and medical services when necessary.
(4) Ensure that all staff and volunteers receive training in crisis intervention;
(5) Be provided by staff qualified according to paragraph (D) of this rule; and
(6) Document the call in the "ICR" if it is known that the person calling is a person served by the agency.

(C) The agency service plan for behavioral health hotline services shall include, but not be limited to the requirements that the service:

(1) Function as part of an integrated, comprehensive system of health, mental health, and other human service providers;
(2) Ensure the ability to use and work with case management systems and pre-hospitalization screening services on a priority basis;
(3) Coordinate with the community's emergency service systems, such as hospital, fire, police, ambulance services, etc.;
(4) Maintain a current listing of available residential or housing placements that can be accessed quickly when emergency housing is needed in conjunction with a crisis intervention mental health service; and
(5) Is provided as part of the community mental health board's emergency crisis plan for the service district.

(D) Behavioral health hotline service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Community psychiatric supportive treatment (CPST) service (OAC 5122-29-17).

(A) Community psychiatric supportive treatment (CPST) service provides an array of services delivered by community based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CPST services is to provide specific, measurable, and individualized services to each person served. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.

(B) Activities of the CPST service shall consist of one or more of the following:

(1) Ongoing assessment of needs;
(2) Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian;
(3) Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian;
(4) Coordination of the ISP, including:
(a) Services identified in the ISP;
(b) Assistance with accessing natural support systems in the community; and
(c) Linkages to formal community service/systems;
(5) Symptom monitoring;
(6) Coordination and/or assistance in crisis management and stabilization as needed;
(7) Advocacy and outreach;
(8) As appropriate to the care provided to individuals, and when appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn;
(9) Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment; and
(10) Activities that increase the individual's capacity to positively impact his/her own environment.

(C) The methods of CPST service delivery shall consist of:

(1) Service delivery to the person served and/or any other individual who will assist in the person's mental health treatment.
(a) Service delivery may be face-to-face, by telephone, and/or by video conferencing; and
(b) Service delivery may be to individuals or groups.
(2) CPST services are not site specific. However, they must be provided in locations that meet the needs of the persons served. When a person served is enrolled in a residential treatment or residential support facility setting, CPST services must be provided by staff that are organized and distinct and separate from the residential service as evidenced by staff job descriptions, time allocation or schedules, and development of service rates.

(D) There must be one CPST staff who is clearly responsible for case coordination. This staff person must be an employee of an agency that is certified by ODMH to provide CPST services. This person may delegate CPST services to eligible providers internal and/or external to the certified agency as long as the following requirements and/or conditions are met:

(1) All delegated CPST activities are consistent with this rule in its entirety;
(2) The delegated CPST services may be provided by an entity not certified by ODMH to provide CPST services as long as there is written agreement between the certified agency and the non-certified entity that defines the service expectations, qualifications of staff, program and financial accountability, health and safety requirements, and required documentation; and
(3) An entity that is not certified by ODMH for CPST service may only seek reimbursement for CPST services through a certified agency and with a written agreement as required in this paragraph.

(E) Providers of CPST service shall have a staff development plan based upon identified individual needs of CPST staff. Evidence that the plan is being followed shall be maintained. The plan shall address, at a minimum, the following:

(1) An understanding of systems of care, such as natural support systems, entitlements and benefits, inter- and intra-agency systems of care, crisis response systems and their purpose, and the intent and activities of CPST;
(2) Characteristics of the population to be served, such as psychiatric symptoms, medications, culture, and age/gender development; and
(3) Knowledge of CPST purpose, intent and activities.

(F) Community psychiatric supportive treatment (CPST) service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Consultation service (OAC 5122-29-19).

(A) "Consultation service" means a formal and systematic information exchange between an agency and a person other than a client, which is directed towards the development and improvement of individualized service plans and/or techniques involved in the delivery of mental health services. Consultation service can also be delivered to a system (e.g., school or workplace) in order to ameliorate conditions that adversely affect mental health.

(B) Consultation services shall be provided according to priorities established to produce the greatest benefit in meeting the mental health needs of the community. Priority systems include schools, law enforcement agencies, jails, courts, human services, hospitals, emergency service providers, and other systems involved concurrently with persons served in the mental health system.

(C) Consultation may be focused on the clinical condition of a person served by another system or focused on the functioning and dynamics of another system. Consultation related to the clinical condition of a person served shall be provided by staff qualified according to paragraph (D) of this rule.

(1) The agency shall survey periodically other community systems to determine mental health consultation needs that may be desired by the systems, persons or families being served by those other systems.
(2) The agency shall maintain a record of all consultation services provided, including the name of the person or system to whom the service was provided, the nature of the consultation, and the outcome of the consultation.

(D) Consultation service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Consumer-operated service (OAC 5122-29-16).

(A) "Consumer-operated service" means any service or activity that is planned, developed, administered, delivered, and evaluated by persons, a majority of whom are receiving or have received inpatient mental health services or other mental health services of significant intensity and duration.

(B) Consumer-operated service shall:

(1) Be planned, developed, administered, delivered, and evaluated by persons, a majority of whom are receiving or have received inpatient mental health services or other mental health services of significant intensity and duration;
(2) Be responsive to the needs of persons served and be based on local needs as identified by the individuals providing the service;
(3) Adhere to all applicable local, state, and federal laws, particularly those designed to assure safety of facilities;
(4) Promote coordination among similar providers within the community mental health board service district, and with agencies and boards of adjacent community mental health board service districts to maximize the rehabilitation opportunities for persons served by the agency; and
(5) Ensure that the service plan is consistent with the principles of a community support system and promotes peer support outside the mental health service system.

(C) The department shall waive all or any portion of the certification standards that would prevent or significantly impede the development and operation of a consumer-operated service.

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Crisis intervention mental health service (OAC 5122-29-10).

(A) Crisis intervention is that process of responding to emergent situations and may include: assessment, immediate stabilization, and the determination of level of care in the least restrictive environment in a manner that is timely, responsive, and therapeutic.

Crisis intervention mental health services need to be accessible, responsive and timely in order to be able to safely de-escalate an individual or situation, provide hospital pre-screening and mental status evaluation, determine appropriate treatment services, and coordinate the follow through of those services and referral linkages.

Outcomes may include: de-escalating and/or stabilizing the individual and/or environment, linking the individual to the appropriate level of care and services including peer support, assuring safety, developing a crisis plan, providing information as appropriate to family/significant others, and resolving the emergent situation.

(B) Crisis intervention mental health service shall consist of the following required elements:

(1) Immediate phone contact capability with individuals, parents, and significant others and timely face-to-face intervention shall be accessible twenty-four hours a day/seven days a week with availability of mobile services and/or a central location site with transportation options. Consultation with a psychiatrist shall also be available twenty-four hours a day/seven days a week. The aforementioned elements shall be provided either directly by the agency or through a written affiliation agreement with an agency certified by ODMH for the crisis intervention mental health service;
(2) Provision for de-escalation, stabilization and/or resolution of the crisis;
(3) Prior training of personnel providing crisis intervention mental health services that shall include but not be limited to: risk assessments, de-escalation techniques/suicide prevention, mental status evaluation, available community resources, and procedures for voluntary/involuntary hospitalization. Providers of crisis intervention mental health services shall also have current training and/or certification in first aid and cardio-pulmonary resuscitation (CPR) unless other similarly trained individuals are always present; and
(4) Policies and procedures that address coordination with and use of other community and emergency systems.

(C) Crisis intervention mental health service shall consist of the following elements when clinically indicated:

(1) A face-to-face crisis assessment shall be conducted by an eligible clinician and shall include:
(a) Understanding the presenting crisis;
(b) Risk assessment of lethality, propensity of violence, medical/physical conditions including alcohol/drug screen/assessment, and support systems;
(c) Mental status;
(d) Consumer strengths; and
(e) Identification of treatment needs and level of care determination; and
(2) A crisis plan will be established that includes referral and linkages to appropriate services and coordination with other systems. The crisis plan should also address safety issues, follow-up instructions, alternative actions/steps to implement should the crisis recur, voluntary/involuntary procedures and the wishes/preferences of the individual and parent/guardian, as appropriate.

(D) Documentation shall include the elements of the overall assessment of the crisis and intervention.

(E) Crisis intervention mental health service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

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Employment service (OAC 5122-29-11).

(A) The purpose and intent of an employment service is to promote recovery through the implementation of evidence based and best practices which allow individuals to obtain and maintain integrated competitive meaningful employment by providing training, ongoing individualized support, and skill development that honor client choice. The outcome of an employment service is that individuals will obtain and maintain a job of their choosing through rapid job placement which will increase their self-sufficiency and further their recovery. Employment services should be coordinated with mental health services and substance use treatment and services.

(B) Consistent with the purpose and intent of paragraph (A) of this rule, employment services shall include at least one of the following evidence based and best practice employment activities, unless prior approval has been given for a non-listed activity as provided by paragraph (D) of this rule:

(1) Vocational planning (assessment);
(2) Training (work and personal);
(3) Job seeking skills training (JSST);
(4) Job development and placement;
(5) Job coaching;
(6) Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports;
(7) Benefits planning;
(8) General consultation, advocacy, building and maintaining relationships with employers;
(9) Individualized placement and support supported employment (IPS SE), in accordance with the requirements for qualified providers set forth in rule 5122-29-30 of the Administrative Code;
(10) Rehabilitation guidance and counseling; or,
(11) Time unlimited vocational support.

(C) Any of the following employment supports may be provided in conjunction with at least one employment activity either that is listed in paragraph (B) of this rule or which has received prior approval from OhioMHAS:

(1) Facilitation of natural supports;
(2) Transportation; or,
(3) Peer services.

(D) Individualized placement and support supported employment (IPS SE).

Providers who chose to offer IPS SE employment service shall meet the following requirements to be OhioMHAS qualified providers:

(1) IPS SE is an evidence based practice which is integrated and coordinated with mental health treatment and rehabilitation designed to provide individualized placement and support to assist individuals with a severe and persistent mental illness or co-occurring mental illness and substance use disorder obtain, maintain, and advance within competitive community integrated employment positions.
(2) In order to be an IPS SE qualified provider, the provider must:
(a) Provide the evidence-based practice of IPS SE;
(b) Have periodic fidelity reviews completed by an Ohio department of mental health and addiction services (OhioMHAS) approved fidelity reviewer as required by the developer of the practice, and,
(c) Achieve the minimum fidelity score necessary to maintain fidelity, as defined by the developer of the practice.

(3) In the event a provider fails to achieve the required minimum fidelity score, the provider will receive technical assistance to address areas recommended for improvement as identified in the fidelity review by an OhioMHAS approved fidelity reviewer. If the subsequent fidelity review results in a score of less than the required minimum, the provider will no longer by designated as a qualified IPS provider until their fidelity score again reaches the minimum.

(4) Providers implementing IPS SE may become a provisionally qualified IPS SE provider by participating in a baseline fidelity review. Providers may be provisionally qualified one time only and only between the baseline fidelity review and the next subsequent fidelity review. A provider must meet other requirements of this rule in order to receive provisional qualification.

(E) Employment services shall be provided and supervised by staff who:

(1) Are qualified according to rule 5122-29-30 of the Administrative Code; or,
(2) Have experience working with individuals that have a mental illness or substance use disorder.

Forensic evaluation service (OAC 5122-29-07).

(A) "Forensic evaluation service" means an evaluation resulting in a written expert opinion regarding a legal issue for an individual referred by a criminal court, domestic relations court, juvenile court, adult parole authority, or other agency of the criminal justice system or an ODMH operated. regional psychiatric hospital. Forensic evaluation service includes all related case consultation and expert testimony. Forensic evaluation service also assists courts and the adult parole authority to address mental health legal issues such as those referenced in paragraph (B) of this rule.

(B) Forensic evaluation service addresses mental health legal issues, including the following:

(1) Competency to stand trial, as defined in division (G)(3) of section 2945.371 of the Revised Code;
(2) Criminal responsibility (insanity), as defined in division (G)(4) of section 2945.371 of the Revised Code;
(3) Post-"NGRI" (not guilty by reason of insanity) examination, as defined in division (A) of section 2945.40 of the Revised Code:
(4) Presentence, as defined in section 2951.03 of the Revised Code;
(5) Mitigation of penalty, as defined in section 2947.06 of the Revised Code;
(6) Mitigation of death penalty, as defined in section 2929.03 of the Revised Code;
(7) Domestic violence evaluation, as defined in section 2919.271 of the Revised Code;
(8) Competence to be a witness, as defined in section 2317.01 of the Revised Code;
(9) Adult parole authority, for parole revocation and other legal questions;
(10) Psychological effects of an act upon the victim, as defined in section 2930.13 of the Revised Code;
(11) Domestic relations, for custody and visitation;
(12) Juvenile dependency, neglect, delinquency, competency; or responsibility (Ohio rules of juvenile procedure, rule 32); or waiver to adult court (Ohio rules of juvenile procedure, rule 30);
(13) Battered woman syndrome, as defined in section 2945.392 of the Revised Code;
(14) Violation of anti-stalking protection order, as defined in section 2903.212 of the Revised Code;
(15) Drug intervention in lieu of conviction, as defined in section 2951.041 of the Revised Code;
(16) Non-secured status, as defined in section 2945.401 of the Revised Code;
(17) Post sentence evaluation-probation or parole, as defined in section 2967.22 of the Revised Code;
(18) Modification of sentence, as defined in section 2929.51 of the Revised Code; or
(19) Juvenile competency evaluation for serious youthful offenders, as defined in Chapter 2152. of the Revised Code.

(C) No examiner should undertake a forensic evaluation without an appropriate order from the court ordering the evaluation, or an official written request if the agency requesting the forensic evaluation is a parole or probation department, or ODMH operated regional psychiatric hospital.

(D) Forensic evaluation service shall provide the following standards of confidentiality:

(1) The relationship between the person being evaluated and the examiner is not confidential in the usual understanding of that term. A written report shall be made to the court or adult parole authority, whether or not the person being evaluated cooperates with the examiner. The relationship between the court or adult parole authority shall be explained orally and in writing to the person being evaluated. It shall be clearly noted that information gathered and expert opinions reached by the examiners shall be summarized in a written report and/or testimony to the court or adult parole authority or other referring agency.
(2) Reports to the criminal courts shall be forwarded only to the court that referred the person or to other court officials, prosecution and defense attorneys, as designated by the referring court. The court may, at its discretion, distribute the report, and bears the responsibility for that distribution. Reports to the adult parole authority shall be forwarded only to that agency, which may, at its discretion, distribute the report, and bears the responsibility for that distribution. Reports may be distributed to other parties only with the written authorization of the court or adult parole authority, or other referring agency.
(3) Reports of forensic evaluations shall be stored separately from other types of client records, and shall be considered the property of the court that ordered them or the agency that referred the person.

(E) Each forensic evaluation report shall include at least the following:

(1) The name and qualifications of the examiner(s);
(2) The name of the court or agency that referred the person;
(3) The legal or referral question being assessed;
(4) Identifying information about the person being evaluated, including relevant clinical, social, and criminal history;
(5) The duration and location of the interview(s) with the person being evaluated;
(6) A description of collateral information used to develop the report;
(7) Psychological and/or psychiatric data that address the legal or referral issue, if applicable; and
(8) Opinions and recommendations.

(F) The forensic evaluation shall be presented in non-technical terms and in reasonable detail. The data and recommendations shall be pertinent to the legal or other referral question. Collateral information shall be used in a forensic evaluation to the fullest extent possible. Opinions in a forensic evaluation report shall not be based entirely on self-report of the person being evaluated if collateral information is available.

(G) Reports shall contain sufficient information to substantiate the conclusions and recommendations made. Special caution shall be exercised with self-incriminating statements by the person being evaluated, information about others not being evaluated, or other material of a particularly sensitive, personal nature not related to the issue and for which the forensic evaluation was requested.

(H) For some types of forensic evaluations (e.g., competence to stand trial and sanity), the qualifications of the examiner(s) are regulated by statute. Examinations for which qualifications are not specified by law shall be conducted by staff who are qualified according to paragraph (K) of this rule.

(I) Forensic evaluations shall be completed within the time limits specified by law. Examinations for which no statutory time limit exists shall be completed within a reasonable time, as determined in consultation with the court or agency requesting the service.

(J) The agency shall ensure that:

(1) All staff who perform forensic evaluation services shall have training and continuing education relating to the legal and mental health issues involved in the services they provide; and

(2) All persons who perform forensic evaluation services listed in paragraphs (B)(1)to (B)(19) of this rule shall provide written documentation of at least twenty-four hours of training every three calendar years that is specific to the forensic mental health area.

(K) Forensic evaluation service shall be provided and supervised by staff who are qualified

Health home service for persons with serious and persistent mental illness (OAC 5122-29-33).

(A) Health home service for persons with serious and persistent mental illness is a person-centered holistic approach that provides integrated behavioral health and physical health care coordination and care management for individuals with serious and persistent mental illness.

Health home service goals are to improve care coordination for individuals with serious and persistent mental illness, improve integration of physical and behavioral health care, reduce rates of hospital emergency department use and hospital admissions and readmissions, decrease reliance on long-term care facilities, and improve the experience of care, health outcomes and quality of life for consumers.

(B) The following definitions apply to this rule in addition to or in place of the definitions in rule 5122-24-01 of the Administrative Code:

(1) "Adult with serious and persistent mental illness" means an individual age eighteen or older with:
(a) A DSM-IV-TR (or its successor) diagnosis, with the exception of the following exclusionary diagnoses:
(i) Developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders);
(ii) Substance-related disorders;
(iii) Conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes); and
(iv) Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium sleep disorders; and
(b) Treatment history covers the consumer's lifetime treatment for the DSM IV-TR diagnoses other than those listed as "exclusionary diagnoses" in paragraph (B)(1)(a) of this rule and meets one of the following criteria:
(i) Continuous treatment of twelve months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or twelve months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or
(ii) Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent twelve month period; or
(iii) A history of using two or more of the following services over the most recent twelve month period continuously or intermittently (this includes consideration of a person who might have received care in a correctional setting): psychotropic medication management, behavioral health counseling, community psychiatric supportive treatment, crisis intervention; or
(iv) Previous treatment in an outpatient service for at least twelve months, and a history of at least two mental health psychiatric hospitalizations; or
(v) In the absence of treatment history, the duration of the mental disorder is expected to be present for at least twelve months; and
(c) Global assessment of functioning (GAF) scale ratings of fifty or below.
(2) "Adult with serious mental illness" means an individual age eighteen or older with:
(a) A DSM-IV-TR (or its successor) diagnosis, with the exception of the following exclusionary diagnoses:
(i) Developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders);
(ii) Substance-related disorders;

(iii) Conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes); and

(iv) Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium sleep disorders; and

(b) Treatment history covers the consumer's lifetime treatment for the DSM IV-TR diagnoses other than those listed as "exclusionary diagnoses" in paragraph (B)(2)(a) of this rule and meets one of the following criteria:

(i) Continuous treatment of six months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or six months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or

(ii) Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent twelve month period; or

(iii) A history of using two or more of the following services over the most recent twelve month period continuously or intermittently (this includes consideration of a person who received care in a correctional setting): psychotropic medication management, behavioral health counseling, community psychiatric supportive treatment, crisis intervention; or

(iv) Previous treatment in an outpatient service for at least six months, and a history of at least two mental health psychiatric hospitalizations; or

(v) In the absence of treatment history, the duration of the mental disorder is expected to be present for at least six months; and

(c) Global assessment of functioning (GAF) scale rating between forty and sixty.

(3) "Child or adolescent with serious emotional disturbance" means an individual age seventeen and younger, or an individual eighteen to twenty-one years of age enrolled in high school, in department of youth services or children services custody, or when it is otherwise developmentally/clinically indicated, and:

(a) A DSM-IV-TR (or its successor) diagnosis, with the exception of the following exclusionary diagnoses:

(i) Developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders);

(ii) Substance-related disorder;

(iii) Conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes) unless these conditions co-occur with another diagnosable mental or emotional disorder; and

(b) Assessment of impaired functioning at age appropriate levels and difficulty with age appropriate role performance with a global assessment of functioning (GAF) scale rating below sixty; and

(c) Duration of the mental health disorder has persisted or is expected to be present for six months or longer.

(4) "Community providers" means treatment providers including but not limited to alcohol and other drug (AoD) treatment providers, primary care providers, medical specialists, hospitals, and service providers, including but not limited to housing entities, nutritionists, courts, or others involved in the clinical or non-clinical care of the consumer.

(5) "SPMI" means a person with serious and persistent mental illness, serious mental illness, or serious emotional disturbance.

(C) Health home service may be provided to the consumer and may include any other individuals who will assist in the consumer's treatment, and may be delivered face-to-face, by telephone, and/or by video conferencing in individual, family and group format or as appropriate to perform the service in locations and settings that meet the needs of the health home consumer. Health home service includes the following components:

(1) Comprehensive care management:

(a) Identify consumers with SPMI who need and can benefit from health home service;

(b) Document consumer's informed consent specific to enrollment in the health home service prior to enrollment; informed consent shall include a description of the health home service, benefits and

drawbacks of enrollment in the health home service, including the relationship between the health home service and other services, particularly other care coordination services (e.g. CPST, MCP care management, AoD case management), and the consumer's ability to opt out of enrollment in the health home service;

(c) Orient consumers by discussing the benefits of active participation;

(d) Within thirty days of enrollment in the health home service, conduct a comprehensive assessment of the individual's physical health, behavioral health (i.e., mental health disorders, substance abuse disorders, and developmental disabilities), long-term care (e.g. assistance with activities of daily living, functional status, self-care capability), and social service needs (e.g. financial assistance, housing, family or support system dynamics), incorporating relevant information from screening tools, medical records, the consumer and his/her family, guardian and/or significant others, other providers, health home team members, and other sources as applicable; develop a team of health care professionals to deliver health home service based on the consumer's needs; establish and negotiate roles and responsibilities, including the accountable point of contact;

(e) Within sixty days of enrollment in the health home service, develop a single, person-centered, integrated care plan that addresses and coordinates all of a consumer's clinical and non-clinical needs, and includes prioritized goals and actions with anticipated time frames for completion and reflects the individual's preferences; implement and monitor the integrated care plan to determine adherence to treatment and medication regiment; identify, and to the extent possible, remove barriers to care, or any clinical and non-clinical issues that may impact the individual's health status or progress in achieving the goals and outcomes outlined in the integrated care plan;

(f) At least once every ninety days:

(i) Reassess the consumer and update the comprehensive assessment as needed based upon the results of the reassessment. The reassessment may be based upon clinical interviews with the consumer and/or guardian and review of data or other information (e.g. progress notes, test results, reports from health home and other providers, etc.), and comparing the most recent data with the data collected at earlier assessments.

(ii) Review the integrated care plan, and update it when indicated by the results of the reassessment;

(g) Develop a communication plan to ensure that routine information exchange (clinical consumer summaries, medication profiles, updates on consumer progress toward meeting goals), collaboration, and communication occurs between the team members, providers, payors, and the consumer and the consumer's family, guardian, and/or significant others; and

(h) Develop a crisis management and contingency plan in collaboration with the consumer and the family, guardian, and/or significant others.

(2) Care coordination:

(a) Implement the integrated care plan;

(b) Assist consumer in obtaining health care, including primary, acute and specialty medical care, mental health, substance abuse services and developmental disabilities services, long-term care and ancillary services and supports;

(c) Perform medication management, including medication reconciliation;

(d) Track tests and referrals, and follow-up as necessary;

(e) Coordinate, facilitate and collaborate with the consumer, team of health care professionals and other providers, and the consumer's family, guardian and/or significant others;

(f) Share the crisis management and contingency plan, assist with and coordinate prevention, management and stabilization of crises and ensure post-crisis follow-up care is arranged and received;

(g) Assist consumer in obtaining referrals to community, social and recovery supports, making appointments and confirming that the consumer received the service(s);

(h) Provide clinical summaries and consumer information along with routine reports of integrated care plan compliance to the team of health care professionals, including the consumer and the consumer's family, guardian and/or significant others consistent with the communication plan.

(3) Health promotion.

(a) Provide education to the consumer and the consumer's family, guardian and/or significant others that is specific to the consumer's needs as identified in the assessment;

(b) Assist the consumer in acquiring symptom self-monitoring and management skills so that the consumer learns to identify and minimize the effects of the chronic illnesses that negatively impact his/her daily functioning;
(c) Provide or connect the consumer and the consumer's family, guardian and/or significant others with services that promote a healthy lifestyle and wellness through the use of evidence-based, evidence-informed, best, emerging, and/or promising practices;
(d) Actively engage the consumer and the consumer's family, guardian and/or significant others in developing, implementing and monitoring the integrated care plan;
(e) Connect the consumer with peer supports including self-help/self-management and advocacy groups;
(f) Manage consumer population through use of clinical and consumer data to remind consumers about services needed for both preventive and chronic care;
(g) Promote positive behavioral health and lifestyle choices; and
(h) Provide education to the consumer and the consumer's family, guardian and /or significant others about accessing care in appropriate settings.

(4) Comprehensive transitional care and follow-up.
(a) Coordinate and collaborate with providers;
(b) Facilitate and manage care transitions (e.g., inpatient-to-inpatient, residential, community setting(s) to prevent unnecessary inpatient admissions, inappropriate emergency department use and other adverse outcomes such as homelessness;
(c) Conduct or facilitate effective clinical hand-offs that include timely access to follow-up post discharge care in the appropriate setting, timely receipt and transmission of a transition/discharge plan from the discharging entity, and medication reconciliation. A clinical hand-off is the transfer of care and responsibility from the outgoing clinician/provider to the oncoming clinician/provider and includes verbal and written communication to relay vital information about the consumer and his/her anticipated needs.

(5) Individual and family supports.
(a) Provide expanded access to and availability of services;
(b) Provide continuity in relationships between consumer, family, guardian and/or significant others with physician and care manager;
(c) Outreach to the consumer and his/her family, guardian and/or significant others, and perform advocacy on the consumer's behalf to identify and obtain needed resources such as medical transportation and other benefits for which he/she may be eligible;
(d) Educate the consumer in self-management of his/her chronic condition:
(i) Facilitate further development of daily living skills;
(ii) Assist with obtaining and adhering to medication and other prescribed treatments;
(iii) Provide interventions that address symptoms and behaviors, and assist the health home consumer in eliminating barriers to seeking or maintaining education, employment or other meaningful activities related to his or her recovery-oriented goal;
(e) Provide opportunities for the family, guardian and/or significant others to participate in assessment and integrated care plan development, implementation and update;
(f) Ensure that health home service is delivered in a manner that is culturally and linguistically appropriate;
(g) Provide assistance in identifying and accessing needed community supports including self-help, peer support and natural supports, i.e. individual resources as identified by and available to the consumer which are independent from formal services, e.g. a relative, teacher, clergy member, etc.;
(h) Promote personal independence and empower the consumer to improve his/her own environment;
(i) Include the consumer's family, guardian and/or significant others in the quality improvement process including but not limited to, surveys to capture experience with health home service, establishment of a consumer and family advisory council; and
(j) Allow the consumer and his/her family, guardian and/or significant others access to the electronic health record or other clinical information.

(6) Referral to community and social support services.
(a) Provide referrals to community/social/recovery support services; and

(b) Assist the consumer in making appointments, confirm that the consumer attended the appointment, and determine the outcome of the visit and any needed follow-up.

(D) A health home provider must be certified by the Ohio department of mental health and addiction services in accordance with Chapters 5122-24 to 5122-29 of the Administrative Code to provide each of the following services:

(1) Behavioral health counseling and therapy;
(2) Mental health assessment;
(3) Pharmacological management; and
(4) Community psychiatric support treatment.

(E) A health home provider shall demonstrate integration of physical and behavioral health care for a minimum of six months prior to the date of application by:

(1) Having an ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded; or
(2) Entering into a written integrated care agreement which is a contract, memorandum of understanding, or other written agreement with a primary care provider for co-located bi-directional coordinated care at each health home site. For the purposes of this rule, when the health home service is co-located in a primary care setting, it is subject to the provisions of this rule and the primary care setting must be identified and reported to the department. The department reserves the right to visit primary care settings where the health home service is co-located.:
(a) Provide preventative and chronic primary care services, ensuring that specific medical screening and treatment services consistent with medical standards of care are provided to health home enrollees on-site;
(b) Participate in care coordination and care management activities (e.g. integrated care plan development, contributing to the assessment, participating in health home team meetings, etc.) with the health home provider; and
(c) Contribute to a shared medical record and/or a integrated care plan maintained by the health home provider

(F) A health home provider shall demonstrate integration of physical and behavioral health care by achieving one of the following:

(1) Successful implementation of accrediting body integrated physical health/primary care standards during the next accreditation survey process following Ohio department of mental health and addiction services certification as a health home provider in which the provider is eligible in accordance with its accrediting body policies and procedures to undergo a review of its integrated physical health/primary care services:
(a) Integrated behavioral health/primary care or health home core program accreditation by the commission on accreditation of rehabilitative facilities; or
(b) Primary physical health care standards by the joint commission behavioral health care accreditation program, or primary care medical home or behavioral health home certification by the joint commission; or
(c) Integrated behavioral health and primary care supplement standards by the council on accreditation; or
(d) Equivalent accreditation or certification approved by the Ohio department of mental health and addiction services; or
(2) Within eighteen months:
(a) Level one patient-centered medical home recognition by the national committee for quality assurance; or
(b) Patient-centered specialty practice recognition by the national committee for quality assurance; or
(c) Equivalent recognition approved by the Ohio department of mental health and addiction services.

(G) A health home provider shall:

(1) Support the delivery of person-centered care by:
(a) Providing expanded, timely access to the services as defined in this rule and provided by the health home provider;
(b) Utilizing a multi-disciplinary team-based approach for the delivery of health home service through the ongoing use of an established team of members as defined in this rule; and
(c) Providing facilitated referrals to specialists when medically necessary.
(2) Have the capacity to receive and utilize electronic data from a variety of sources to facilitate all components of health home service;
(3) Meet the following requirements:
(a) Implement and actively use in clinical services an electronic health record (EHR) product certified by the office of the national coordinator for health information technology , as evidenced by at least one of the following:
(i) Are submitting a minimum of forty per cent of prescriptions electronically;
(ii) Are receiving structured laboratory results;
(iii) Utilize continuity of care records;
(iv) Are participating in an Ohio regional extension center program; or
(v) Are participating in a health information exchange.
(b) Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and
(c) Participate in the statewide health information exchanges when established;
(4) Participate in any health home learning communities;
(5) Allow the Ohio department of mental health and addiction services to conduct site visits to survey health home service standards;
(6) Maintain a comprehensive and continuous quality improvement program in accordance with rule 5122-28-03 (performance improvement) of the Administrative Code and/or the health home provider's national accrediting body;
(7) Collect and report data and meet health home performance measurement requirements which consist of mandatory centers for medicare and medicaid services core measures and measures established by the Ohio department of mental health and addiction services in conjunction with stakeholder input. To the extent possible, measures should be consistent with nationally recognized and other required standards, which may include national committee for quality assurance (NCQA) healthcare effectiveness data and information set (HEDIS) measures, national quality forum (NQF), agency for healthcare research and quality (AHRQ), substance abuse and mental health services administration (SAMHSA) national outcome measures (NOMS);
(8) Establish relationships with medicaid managed care plans (MCPs) in the service area and develop written policies and procedures that include the following:
(a) Notify the MCP of referrals received by the health home provider for the MCP's members, and of any MCP member who is currently receiving health home service. The health home provider will collaboratively develop a transition plan with the MCP for any plan member that will receive health home service in order to prevent unnecessary duplication of, and avoid gaps in, services;
(b) Form a care management team to effectively manage the consumer's needs that includes the health home provider team, the health home consumer and his/her family/supports and primary care provider, a representative from the consumer's MCP, and other providers, as appropriate;
(c) Work collaboratively with the MCP to ensure all of the consumer's needs identified in the health home integrated care plan are met. Ensure that the integrated care plan is accessible to the MCP and providers involved in managing the consumer's health care;
(d) Request care coordination supports from the MCP, if needed;
(e) Identify a designated contact to collaborate with the MCP's designated single point of contact on such activities as the following: exchanging information about the plan's member, soliciting input to the development of the integrated care plan, participating in health home team meetings, and facilitating to the extent possible, access to services that are outside the scope of the health home provider;
(f) Ensure that if the health home provider has direct ownership of or membership in a primary care provider, or practice, it seeks a contract with the MCPs in the service area for the provision of

primary care services. If the health home provider has a co-located relationship with a primary care provider for the provision of primary care services, the health home provider shall encourage the provider to seek a contract with the MCPs in the service area;

(g) The health home provider shall also:

(i) Provide a list and periodic updates of primary care providers, specialists, inpatient facilities, and other providers, as appropriate, to the MCP, for which the health home provider has established relationships or collaboration;

(ii) Refer to the plan's panel of providers when assisting the consumer in obtaining necessary health care services; and

(iii) Collaborate with the MCP to ensure that the consumer's selected, or assigned, primary care provider is informed the MCP member is enrolled with a health home service provider and provided with information as required in paragraph (G)(11) of this rule. If the consumer requests a change to the selected primary care provider, the health home provider shall inform the MCP so that the plan's existing process to change the primary care provider is promptly initiated;

(h) Provide timely notification of all inpatient facility discharges and residential setting transitions to the MCP in order to ensure adequate and timely provision of follow-up care. The health home provider will ensure that a discharge or transition plan is in place prior to the consumer discharge or transition. The health home provider will work with the MCP to ensure that post discharge services are prior authorized, if appropriate, and provided by the plan's contracted providers. The health home provider must ensure that the discharge or transition plan is integrated into the integrated care plan and communicated to the care management team;

(i) Ensure the capacity to send electronic data to MCPs and to produce ad hoc reports to more effectively coordinate care; and

(9) Develop an outreach plan to facilitate establishing relationships and collaboration with providers as follows:

(a) The outreach plan developed by the health home provider shall:

(i) Educate providers, as identified in paragraph (G)(9)(b) of this rule, about the health home service, the health home service goals, and the value of a relationship or collaboration to support the delivery of the service components, as applicable and appropriate, and as outlined in paragraph (C) of this rule;

(ii) Describe how and what type of information will be exchanged between the health home provider and the provider; and

(iii) Describe the role of the provider in coordinating and managing care for the consumer including, but not limited to, integrated care plan development and updates, participation in team meetings, etc.

(b) The health home provider shall establish relationships or collaborations with the following providers, as appropriate:

(i) Specialty care providers including, but not limited to, other behavioral health care or substance abuse treatment providers, pharmacists, cardiologists, pulmonologists, and endocrinologists;

(ii) Long-term care providers including, but not limited to, nursing facilities and home health care providers;

(iii) Hospitals, including emergency departments;

(iv) Community providers;

(v) Alcohol, drug addiction and mental health services or community mental health boards; and

(vi) Third party payor sources as indicated to coordinate benefits; and

(10) Have the ability to track tests and referrals for health care services, and coordinate follow-up care as needed; and

(11) Establish point of care reminders for consumers about services needed for preventive care and/or management of chronic conditions by using consumer information and clinical data.

(12) A health home cannot require a consumer receiving health home services to receive primary care, behavioral health care, specialty care or other services from the health home in instances where the health home offers such service.

(H) A health home provider shall have the capacity to provide all service components described in paragraph (C) of this rule.

(I) A health home provider shall obtain consumer consent, when required, prior to implementing the provisions of this rule regarding involvement of the consumer's family members and/or significant others in the health home service.

(J) A health home provider shall utilize an integrated, multidisciplinary team to deliver health home service. Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies. Each health home shall have at least one nurse care manager and each team shall include:

(1) Health home team leader:
(a) Minimum qualifications:
(i) Licensed independent social worker, professional clinical counselor, independent marriage and family therapist, registered nurse with a master of science in nursing, certified nurse practitioner, clinical nurse specialist, psychologist or physician.
(ii) Supervisory, clinical and administrative leadership experience.
(iii) Health management experience, and competence in practice management, data management, managed care and quality improvement.
(b) Responsibilities:
(i) Provide administrative and clinical leadership and oversight to the health home team, and monitor provision of health home service.
(ii) Monitor and facilitate consumer identification and engagement, completion of comprehensive health and risk assessments, development of integrated care plans, scheduling and facilitation of treatment team meetings, provision of health home service, consumer status and response to health coordination and prevention activities, and development, tracking and dissemination of outcomes.
(2) Embedded primary care clinician:
(a) Qualifications:
Primary care physician, internist, family practice physician, pediatrician, gynecologist, obstetrician, certified nurse practitioner with primary care scope of practice, clinical nurse specialist with primary care scope of practice, or physician assistant.
(b) Responsibilities:
(i) Provide health home service including identification of consumers, assessment of service needs, development of integrated care plan and treatment guidelines, and monitor health status and service use.
(ii) Provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as a liaison between, the treating primary care provider and the team.
(iii) Meet individually as needed with care managers to review challenging and complex cases.
(iv) It is preferred, but not required, that the embedded primary care clinician also functions as the treating primary care clinician and thus may hold dual roles on the health home team.
(3) Care manager:
(a) Minimum qualifications:
(i) Licensed social worker, independent social worker, professional counselor, professional clinical counselor, marriage and family therapist, independent marriage and family therapist, registered nurse, certified nurse practitioner, clinical nurse specialist, psychologist or physician.
(ii) Possess core and specialty competencies and skills in working with persons with SPMI, including assessment and treatment planning.
(iii) Demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of persons with SPMI and be able to function as a member of an inter-disciplinary team.

(iv) Knowledge of community resources and social support services for persons with SPMI.

(b) Responsibilities:

(i) Accountable for overall care management and care coordination, and both provide and coordinate all of the health home service.

(ii) Responsible for overall management and coordination of the consumer's integrated care plan, including physical health, behavioral health, and social service needs and goals.

(iii) Conduct comprehensive assessments and develop integrated care plans.

(iv) Conduct case reviews on a regular basis.

(4) Qualified health home specialist:

(a) Minimum qualifications:

Pharmacist, licensed practical nurse; qualified mental health specialist with a four-year degree, two-year associate degree or commensurate experience; wellness coach; peer support specialist; certified tobacco treatment specialist, health educator or other qualified individual (e.g., community health worker with associate degree).

(b) Responsibilities:

Assist with care coordination, referral/linkage, follow-up and consumer, family, guardian and/or significant others support and health promotion services.

Inpatient psychiatric service (OAC 5122-29-18).

(A) "Inpatient psychiatric service" means the most intensive level of psychiatric treatment for persons posing a significant danger to self or others and/or displaying severe psychosocial dysfunction or mental instability. Treatment encompasses multi-disciplinary assessments and multimodal interventions. At minimum, twenty-four hour intensive care by physicians and registered nurses, a 1:4 nursing staff-to-patient ratio, and a structured treatment milieu are required. Special treatment and safety measures may include involuntary treatment and a locked unit.

(B) Inpatient psychiatric service refers to residence and treatment provided in a psychiatric hospital or unit licensed or operated by the state of Ohio in accordance with section 5119.20 of the Revised Code.

(C) Inpatient psychiatric services shall be licensed by the department in accordance with section 5119.20 of the Revised Code and rules 5122-14-01 to 5122-14-13 of the Administrative Code. Evidence of a current full, probationary, or interim license issued by the department pursuant to section 5119.20 of the Revised Code shall constitute compliance with certification standards, and the inpatient psychiatric service shall be certified pursuant to division (M) of section 5119.61 of the Revised Code for a time period that is the same as the specified time period of the current full, probationary, or interim license.

Intensive home based treatment (IHBT) service (OAC 5122-29-28).

(A) Intensive home based treatment (IHBT) service is a comprehensive mental health service provided to a child/adolescent and his or her family that integrates community psychiatric supportive treatment (CPST) service or health home service for persons with serious and persistent mental illness for a person enrolled in the service, mental health assessment service, mental health crisis response, behavioral health counseling and therapy service, and social services with the goal of either preventing the out-of-home placement or facilitating a successful transition back to home. IHBT service may also be provided to transitional age youth between the ages of eighteen and twenty-one who have an onset of serious emotional and mental disorders in childhood or adolescence. These intensive, time-limited mental health services are provided in the child/adolescent's natural environment with the purpose of stabilizing and improving his/her mental health functioning.

The purpose of IHBT is to enable a child/adolescent with serious emotional disturbance (SED) to function successfully in the least restrictive, most normative environment. IHBT services are culturally, ethnically, racially, developmentally and linguistically appropriate, and respect and build on the strengths of the child/adolescent and family's race, culture, and ethnicity.

Mental Health Service Definitions

(B) In addition to the definitions in rule 5122-24-01 of the Administrative Code, the following definitions apply to this rule:

(1) "Caseload" means the individual cases open or assigned to each full-time equivalent IHBT staff.
(2) "Continued stay review" means a review of a child/adolescent's functioning to determine the need for further services to achieve or maintain service goals and objectives.
(3) "Crisis response" means the immediate access and availability , by phone and face-to-face, as clinically indicated, to the child/adolescent and family, which may include crisis stabilization, safety planning, and the alleviation of the presenting crisis.
(4) "Face-to-face contacts" means in-person IHBT provided in the home, school, and community working directly with the person served and his or her family, or on the child/adolescent 's behalf.
(5) "Home" means any long-term family living arrangement including biological, kinship, adoptive, and non-custodial families who have made a long-term commitment to the child/adolescent.
(6) "Out-of-home placement" means any removal of the child/adolescent from his or her home. Planned respite, where the child's main residence remains his or her home, is not considered out-of-home placement.

(C) IHBT certified agencies must be certified to provide behavioral health counseling and therapy service, mental health assessment service, and community psychiatric supportive treatment (CPST) service in accordance with Chapters 5122-24 to 5122-29 of the Administrative Code. Persons receiving IHBT service shall receive the services specified in this paragraph from IHBT staff with the exception of a physician providing mental health assessment service. Staff providing CPST service as part of IHBT shall meet the provider qualifications specified under the IHBT portion of rule 5122-29-30 of the Administrative Code.

(D) The agency shall determine who is eligible to receive the service and must document how the child/adolescent meets the following criteria necessary to receive IHBT services:

(1) Is clinically determined to meet the "person with serious emotional disturbance" (SED) criteria in paragraph (B) (48) of rule 5122-24-01 of the Administrative Code . IHBT may also be provided to an individual age eighteen through twenty-one who meets all of the other diagnostic criteria for SED, and is still living at home and/or in the custody of a public child serving agency and/or under the jurisdiction of juvenile court and/or in the custody of the Ohio department of youth services; and
(2) Meets one or more of the following criteria as documented in the ICR:
  (a) Is at risk for out-of-home placement due to his/her behavioral health/mental health condition;
  (b) Has returned within the previous thirty days from an out-of-home placement or is transitioning back to their home within thirty days; or
  (c) Requires a high intensity of mental health interventions to safely remain in or return home; and

(E) The following describes the activities and components of IHBT:

(1) IHBT is an intensive service that consists of multiple face-to-face contacts per week with the child/adolescent and family, which includes collateral contacts related to the mental health needs of the child/adolescent as documented in the ICR. The frequency of contacts may fluctuate based on the assessed needs and unique circumstances of the child, adolescent, and family.
(2) IHBT is strength-based and family-driven, with both the child/adolescent and family regarded as equal partners with the IHBT staff in all aspects of developing the service plan and service delivery;
(3) IHBT is provided in the home, school, and community where the child/adolescent lives and functions;
(4) Provided by staff with a caseload that averages over any six month period and per full time equivalent staff:
  (a) Twelve or less when provided by a team of two, or
  (b) Eight or less when provided by an individual staff;
(5) Crisis response is available twenty-four hours a day, seven days a week. Crisis response may be provided through written agreement with another agency, as long as at least one agency IHBT staff is accessible to the provider agency, and is available to the client and family as needed;

(6) Each child/adolescent and family receiving IHBT is assessed for risk and safety issues. When clinically indicated, a jointly written safety plan shall be developed that is provided to the child/adolescent and family;

(7) Collaboration occurs with other child-serving agencies or systems, e.g., school, court, developmental disabilities, job and family services, and health care providers that are providing services to the child/adolescent and family, as well as family and community supports identified by the child/adolescent and family;

(8) The service is flexible and individually tailored to meet the needs of the child/adolescent and family. Appointments are made at a time that is convenient to the child/adolescent and family, including evenings and weekends if necessary;

(9) The service is time-limited, with length of stay matched to the presenting mental health needs of the child/adolescent. IHBT should not exceed six months length of stay. IHBT certified agencies must have clearly written guidelines for granting extensions and procedures for continued stay of each individual. A continued stay review must be documented for each child/adolescent receiving IHBT beyond six months, and every forty-five days thereafter. The continued stay review must include the criteria in paragraph (C) of this rule; and

(10) The child/adolescent and family's IHBT aftercare service needs are addressed. Continuing care planning shall be collaborative between the child/adolescent, family and IHBT staff.

(F) The agency must demonstrate that the following staff requirements and qualifications are met:

(1) A minimum of two full-time equivalent staff provide the service. Services may be provided by a single person, or team of staff clearly sharing various responsibilities for the same child/adolescent and family. Each child/adolescent shall have a staff assigned with lead responsibility. IHBT direct care staff must be fully dedicated to the IHBT program and cannot have mixed service caseloads (including behavioral health counseling and therapy, diagnostic assessment and CPST services).

(2) The agency must have a documented plan for clinical supervision, which includes:

(a) The IHBT supervisor shall have a designated responsibility to IHBT;

(b) Each staff person shall receive clinical supervision that is appropriate for the staff person's expertise and caseload complexity; and

(c) Consideration of the staff person's assessed training needs.

(3) The IHBT supervisor shall have primary responsibility for providing supervision to the IHBT staff twenty-four hours a day, seven days a week. If the IHBT supervisor is unavailable, then supervision must be provided by staff qualified according to rule 5122-29-30 of the Administrative Code.

(G) The agency must demonstrate that each IHBT staff has an individualized training plan based on an assessment of his/her specific training needs. The following professional training and development criteria must be met:

(1) Each staff receives an assessment of initial training needs based on the skills and competencies necessary to provide IHBT service prior to providing IHBT service; and

(2) The agency shall have a written description of the skills and competencies required to provide IHBT service, which may include the following:

(a) Family systems;

(b) Risk assessment and crisis stabilization;

(c) Parenting skills and supports for children/adolescents with SED;

(d) Cultural competency;

(e) Intersystem collaboration with a focus on schools, courts, and child welfare:

(i) Knowledge of other systems;

(ii) System advocacy; and

(iii) Roles, responsibilities, and mandates of other child/adolescent-serving entities;

(f) Trauma-informed care;

(g) Educational and vocational functioning:

(i) Assessment and intervention strategies for resolving barriers to successful educational and vocational functioning;

(ii) Knowledge of special education laws; and
(iii) Strategies for developing positive home-school partnerships and connections;
(h) IHBT philosophy, including strength-based assessment and treatment planning; and
(i) Differential diagnosis with special needs children/adolescents, including co-occurring substance use disorders and developmental disabilities, for staff credentialed to diagnose.

(H) The agency's training plan must include provisions for ongoing training specific to the identified training needs of the staff as it relates to the population served, including attention to cultural competency, changing demographics, new knowledge or research, and other areas identified by the agency.

(I) The agency must demonstrate that each IHBT supervisor receives training specific to the clinical and administrative supervision of the service.

(J) The agency shall obtain at least one fidelity review of the agency's entire IHBT service every twelve months by an individual or organization external to the agency, utilizing the Ohio department of mental health IHBT fidelity rating tool or other rating tool approved by the department. The agency shall incorporate the results of the fidelity review into the agency's performance improvement program, if indicated.

(K) Intensive home based treatment service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Mental health assessment service (OAC 5122-29-04).

(A) Mental health assessment is a clinical evaluation provided by an eligible individual either at specified times or in response to treatment, or when significant changes occur. It is a process of gathering information to assess client needs and functioning in order to determine appropriate service/treatment based on identification of the presenting problem, evaluation of mental status, and formulation of a diagnostic impression. The outcome of mental health assessment is to determine the need for care, and recommend appropriate services/treatment and/or the need for further assessment. Results of the mental health assessment shall be shared with the client.

(B) An initial mental health assessment must be completed prior to the initiation of any mental health services. The only exceptions to this would be the delivery of crisis intervention mental health services or pharmacologic management services as the least restrictive alternative in an emergency situation.

(1) The initial mental health assessment must, and subsequent mental health assessments may, include at minimum:
(a) An age appropriate psychosocial history and assessment, to include consideration of multi-cultural/ethnic influences;
(b) The presenting problem;
(c) A diagnostic impression and treatment recommendations;
(d) For any service provided in a type 1 residential facility licensed by ODMH pursuant to rules 5122-30-01 to 5122-30-30 of the Administrative Code, a physical health screening to determine the need for a physical health assessment. Such screening shall be completed within one week of admission to the facility; and
(e) As determined by the provider, any other clinically indicated areas. Such areas may include, but are not limited to:
(i) Age appropriate areas of assessment such as for children, e.g., growth and development, family effect on child and child effect on family, and play and daily activities;
(ii) Use of alcohol/drugs;
(iii) Behavioral/cognitive/emotional functioning;
(iv) Mental status exam;
(v) Environment and home;

(vi) Leisure and recreation;
(vii) Childhood history;
(viii) Military service history;
(ix) Financial status;
(x) Usual social, peer-group and environmental setting, (to include involvement in consumer-operated or peer services);
(xi) Sexual orientation/history/issues;
(xii) Family circumstances/custody status;
(xiii) Vocational assessment;
(xiv) Educational assessment;
(xv) Legal assessment;
(xvi) Early detection of mental illness that is life-threatening to self or others;
(xvii) Nutritional status;
(xviii) Maladaptive or problem behaviors;
(xix) Psychiatric evaluation;
(xx) Psychological assessment including intellectual, projective, neuropsychological, and personality testing;
(xxi) Evaluations of language, self-care, visual-motor, and cognitive functioning;
(xxii) Current level of functioning/functional status;
(xxiii) Strengths;
(xxiv) Relationships with family/significant others;
(xxv) Spirituality;
(xxvi) Health/medical history, including current health and dental status as well as the presence of any physical disabilities; and
(xxvii) Indications of abuse and/or neglect.

(2) Mental health service providers may accept mental health assessments from prior evaluations. The clinical record shall reflect that such assessments have been reviewed and updated when appropriate prior to the initiation of any mental health services.

(C) The following shall apply with regard to the use of interactive videoconferencing. Interactive videoconferencing is defined in Chapter 5122-24 of the Administrative Code:

(1) "Client site" means the location of a client at the time at which the service is furnished via interactive videoconferencing technology.
(2) "Provider site" means the site where the eligible practitioner furnishing the service is located at the time the service is rendered via interactive videoconferencing technology.
(3) The agency shall obtain from the client/parent/legal guardian, signed, written consent for the use of videoconferencing technology.
(4) It is the responsibility of the agency to assure contractually that any entity or individuals involved in the transmission of the information guarantee that the confidentiality of the information is protected. When the client chooses to utilize videoconferencing equipment at a client site that is not arranged for by the agency, e.g., at his/her home or that of a family or friend, the agency is not responsible for any breach of confidentiality caused by individuals present at the client site.
(5) The agency shall provide the client written information on how to access assistance in a crisis, including one caused by equipment malfunction or failure.
(6) It is the responsibility of the agency to assure that equipment meets standards sufficient to:
(a) Assure confidentiality of communication;
(b) Provide for interactive videoconferencing communication between the practitioner and the client; and
(c) Assure videoconferencing picture and audio are sufficient to assure real-time interaction between the client and the provider and to assure the quality of the service provided.
(d) The client site must also have a person available who is familiar with the operation of the videoconferencing equipment in the event of a problem with the operation.

(e) If the client chooses to utilize videoconferencing equipment at a client site that is not arranged for by the agency, e.g., at his/her home or that of a family or friend, the agency is only responsible for assuring the equipment standards at the provider site.

(7) The decision of whether or not to provide initial or occasional in-person sessions shall be based upon client choice, appropriate clinical decision-making, and professional responsibility, including the requirements of professional licensing, registration or credentialing boards.

(D) Mental health assessment service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Mental health education service (OAC 5122-29-21).

(A) "Mental health education service" means formal educational presentations made to individuals or groups that are designed to increase community knowledge of and to change attitudes and behaviors associated with mental health problems, needs and services.

(B) Mental health education service shall:

(1) Focus on educating the community about the nature and composition of a community support program;

(2) Be designed to reduce stigma toward persons with severe mental disability or serious emotional disturbances, and may include the use of the media such as newspapers, television, or radio. Community opinion leaders shall be high priority recipients of this service;

(3) Focus mental health education service for the community on issues that affect the population served or populations identified as unserved or underserved by the agency;

(4) Evaluate the effectiveness of services through evaluation mechanisms such as pre-tests and post-tests, when applicable;

(5) Be provided by staff qualified according to paragraph (C) of this rule; and

(6) Include the participation of persons served, and their families or significant others in planning, implementing and evaluating services provided.

(C) Mental health education service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Occupational therapy service (OAC 5122-29-24).

(A) "Occupational therapy service" means the evaluation of learning and performance skills and analysis, selection and adaptation of activities for individuals whose abilities to cope with daily living are threatened or impaired by developmental deficiencies, the aging process, environmental deprivation, physical, psychological, or social injury or illness.

(B) Occupational therapy service shall:

(1) Include assessment and treatment services regarding social, emotional, physical and cognitive functioning as appropriate to the functional level of the person served; and

(2) Ensure linkages with other community services, as appropriate, to provide opportunities for performance of purposeful activities and/or normalizing occupations and other needed services.

(C) Occupational therapy service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Other mental health services (OAC 5122-29-27).

(A) "Other mental health services" means services other than those listed under divisions (A) to (Q) of section 340.09 of the Revised Code. Other mental health services may include representative payeeship, transportation and other supportive mental health services and may be offered by a variety of entities, including YMCAs, churches, children's cluster or family and children first.

(B) Other mental health services approved by the community mental health board and the department shall:

(1) Ensure that the agency or organization providing the service meets the appropriate standards or regulations under which they operate;
(2) Ensure that staff providing the service have participated in orientation or training regarding basic information about mental illness and/or emotional disturbance and know how to obtain assistance from the mental health system if needed; and
(3) Develop mechanisms to solicit and receive feedback about the quality of the service from persons served.

(C) Agencies providing other mental health services shall receive certification to provide the service(s) according to either paragraph (A)(1)(f) or paragraph (A)(2)(g) of rule 5122-25-04 of the Administrative Code.

Partial hospitalization service (OAC 5122-29-06).

(A) Partial hospitalization is an intensive, structured, goal-oriented, distinct and identifiable treatment service that utilizes multiple mental health interventions that address the individualized mental health needs of the client. Partial hospitalization services are clinically indicated by assessment with clear admission and discharge criteria. The environment at this level of treatment is highly structured, and there should be an appropriate staff-to-client ratio in order to guarantee sufficient therapeutic services and professional monitoring, control, and protection. The purpose and intent of partial hospitalization is to stabilize, increase or sustain the highest level of functioning and promote movement to the least restrictive level of care. The outcome is for the individual to develop the capacity to continue to work towards an improved quality of life with the support of an appropriate level of care.

(B) In addition to the definitions found in rule 5122-24-01 of the Administrative Code, the following definition applies to this rule:

(1) "Partial hospitalization program day" means the total amount of hours an individual receives partial hospitalization service during a twenty-four hour calendar day.

(C) Partial hospitalization must be an intense treatment service that consists of high levels of face-to-face mental health interventions that address the individualized mental health needs of the individual as identified in his/her ISP.

(D) The minimum program length of this service shall be in accordance with the appropriate behavioral health standards of the agency's national accrediting body(ies). Such accrediting bodies are identified in rule 5122-25-02 of the Administrative Code.

(E) For purposes of this rule, a partial hospitalization program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive activities that may include, but are not limited to, the following:

(1) Determination of needed mental health interventions;
(2) Skills development
(a) Interpersonal and social competency as age, developmentally, and clinically appropriate, such as:

(i) Functional relationships with adults;
(ii) Functional relationship with peers;
(iii) Functional relationship with the community/schools;
(iv) Functional relations with employer/family; and
(v) Functional relations with authority figures.
(b) Problem solving, conflict resolution, and emotions/behavior management.
(c) Developing positive coping mechanisms;

(3) Managing mental health and behavioral symptoms to enhance vocational/school opportunities and/or independent living; and

(4) Psycho-educational interventions including individualized instruction and training of persons served in order to increase their knowledge and understanding of their psychiatric diagnosis(es), prognosis(es), treatment, and rehabilitation in order to enhance their acceptance of these psychiatric disabilities, increase their cooperation and collaboration with treatment and rehabilitation, improve their coping skills, and favorably affect their outcomes. Such education shall be consistent with the individual's ISP and be provided with the knowledge and support of the interdisciplinary/intersystem team providing treatment in coordination with the ISP.

(F) When an agency provides more than one partial hospitalization service to an individual within the partial hospitalization program day, and the length of one or more of those partial hospitalization services consists of the daily minimum of two hours, the agency must ensure that each service provided is separate and distinct from the others.

(G) Providers of partial hospitalization services shall have a staff development plan based upon identified individual needs of partial hospitalization program staff. Evidence that the plan is being followed shall be maintained.

(H) Partial hospitalization service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Pharmacologic management service (OAC 5122-29-05).

(A) Pharmacologic management service is a psychiatric/mental health/medical intervention used to reduce/stabilize and/or eliminate psychiatric symptoms with the goal of improved functioning, including management and reduction of symptoms. Pharmacologic management services should result in well-informed/educated individuals and family members and in decreased/minimized symptoms and improved/maintained functioning for individuals receiving the service. The purpose/intent is to:

(1) Address psychiatric/mental health needs as identified in the mental health assessment and documented in the client's ISP;
(2) Evaluate medication prescription, administration, monitoring, and supervision;
(3) Inform individuals and family regarding medication and its actions, effects and side effects so that they can effectively participate in decisions concerning medication that is administered/dispensed to them;
(4) Assist individuals in obtaining prescribed medications, when needed; and
(5) Provide follow-up, as needed.

(B) Pharmacologic management service shall consist of one or more of the following elements as they relate to the individual's psychiatric needs, and as clinically indicated:

(1) Performance of a psychiatric/mental health examination;
(2) Prescription of medications and related processes which include:
(a) Consideration of allergies, substance use, current medications, medical history, and physical status;

(b) Behavioral health education to individuals and/or families, (e.g., purpose, risks, side effects, and benefits of the medication prescribed); and

(c) Collaboration with the individual and/or family, including their response to the education, as clinically indicated. The method of delivery of education can be to an individual or group of individuals.

(3) Administration and supervision of medication and follow-up, as clinically indicated. Prescription, administration and supervision of medication is governed by professional licensure standards, Ohio Revised Code, Administrative Code, and scope of practice.

(a) Clinicians who order medications and persons who receive medication orders shall be appropriately licensed and acting within the scope of their practice.

(4) Medication monitoring consisting of monitoring the effects of medication, symptoms, behavioral health education and collaboration with the individual and/or family as clinically indicated. The method of delivery of medication monitoring can be to an individual or group of individuals.

(C) The following shall apply with regard to the use of interactive videoconferencing. Interactive videoconferencing is defined in Chapter 5122-24 of the Administrative Code.

(1) "Client site" means the location of a client at the time at which the service is furnished via interactive videoconferencing technology.

(2) "Provider site" means the site where the eligible practitioner furnishing the service is located at the time the service is rendered via interactive videoconferencing technology.

(3) The agency shall obtain from the client/parent/legal guardian, signed, written consent for the use of videoconferencing technology.

(4) It is the responsibility of the agency to assure contractually that any entity or individuals involved in the transmission of the information guarantee that the confidentiality of the information is protected. When the client chooses to utilize videoconferencing equipment at a client site that is not arranged for by the agency, e.g., at his/her home or that of a family or friend, the agency is not responsible for any breach of confidentiality caused by individuals present at the client site.

(5) The agency shall provide the client written information on how to access assistance in a crisis, including one caused by equipment malfunction or failure.

(6) It is the responsibility of the agency to assure that equipment meets standards sufficient to:

(a) Assure confidentiality of communication;

(b) Provide for interactive videoconferencing communication between the practitioner and the client; and

(c) Assure videoconferencing picture and audio are sufficient to assure real-time interaction between the client and the provider and to assure the quality of the service provided.

(d) The client site must also have a person available who is familiar with the operation of the videoconferencing equipment, in the event of a problem with the operation.

(e) If the client chooses to utilize videoconferencing equipment at a client site that is not arranged for by the agency, e.g., at his/her home or that of a family or friend, the agency is only responsible for assuring the equipment standards at the provider site.

(7) The decision of whether or not to provide initial or occasional in-person sessions shall be based upon client choice, appropriate clinical decision-making, and professional responsibility, including the requirements of professional licensing, registration or credentialing boards.

(D) Pharmacologic management service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Prevention service (OAC 5122-29-20).

(A) "Prevention service" means action oriented either toward reducing the incidence, prevalence, or severity of specific types of mental disabilities or emotional disturbances; or actions oriented toward population groups with multiple service needs and systems that have been identified through recognized needs assessment techniques. Included in this service are actions such as personal and social competency building, stress management, and systems change.

(B) Prevention service shall:

(1) Be based upon a needs assessment and delivered to a population according to identified priorities. The population may include a range of persons from infancy to elderly age groups:
(2) Be provided by staff qualified according to paragraph (E) of this rule; and
(3) Be planned, implemented, and evaluated with the participation of persons served, and their families or significant others.

(C) Prevention service may include competency skills building, stress management, self-esteem building, mental health promotion, life-style management and ways in which community systems can meet the needs of their citizens more effectively.

(D) The agency shall maintain documentation of the following:

(1) Services provided and numbers and characteristics of people served; and
(2) Training and utilization of volunteers.

(E) Prevention service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Referral and information service (OAC 5122-29-22).

(A) "Referral and information service" means responses, usually by telephone, to inquiries from people about services in the community. Referral may include contacting any agency or a provider in order to secure services for the person requesting assistance.

(B) Referral and information service shall be planned and coordinated with other health and human service providers, and shall:

(1) Have a mechanism to compile information about services available in the service system and the community; and
(2) Have mechanisms to determine whether persons referred were able to access services, were satisfied with the services, or experienced any problems with the referral source. This information shall be used to determine if particular providers shall continue to be used as referrals for persons seeking services. All state and federal confidentiality laws shall be adhered to in this process.

(C) The agency shall ensure access and availability of referral and information service including:

(1) A referral and information service shall have a published telephone number, including a published telephone number for special telephone services for the hearing impaired; and
(2) The agency shall ensure access and availability for persons whose primary means of communication is a language other than english, and for persons with communication impairments such as speech, language or hearing disorders, access to telecommunication devices for the deaf (TDD), and for persons with visual impairments.

(D) Each call and contact shall be logged and shall include the date, time and person answering the call or contact.

School psychology service (OAC 5122-29-25).

(A) School psychology services shall:

(1) Include mental health services related to school behavior and learning problems;

(2) Be coordinated with school personnel, as appropriate, in the school setting attended by the person served; and
(3) Be included in the "ISP" with evidence of coordination between and approval of mental health and educational personnel, and in consultation with the person served, and parent or guardian, as appropriate.

(B) School psychology service shall be provided and supervised by staff who are qualified

Self-help/peer support service (OAC 5122-29-15).

(A) Self-help/peer support service means individual or group interactions conducted by persons receiving services, persons who have received services, or their families or significant others, for the purpose of providing emotional support and understanding, sharing experiences in coping with problems, and developing a network of people that provides on-going support outside the formal mental health service system.

(B) Self-help/peer support service shall:

(1) Ensure consultation with persons providing self-help/peer support service to identify an agency staff person to serve as an advisor, help gain access to educational information, or participate in planning as requested by the self-help/peer support service;
(2) Promote coordination among similar providers within the community mental health board service district, and with agencies and boards of adjacent community mental health board service districts to maximize the opportunities for self-help/peer support; and
(3) Ensure that the service plan is consistent with the principles of a community support system and other approaches identified by persons served to maximize supports outside the mental health service system.

(C) Self-help/peer support services may be provided in the home of a person served as part of an effort to enhance a person's support network and to enhance their ability to live in the least restrictive setting.

(D) The agency shall facilitate the establishment of self-help/peer support when such supports are unavailable or inaccessible in the community. Services shall be available to groups such as persons with mental illness and their families and significant others, women, children and adolescents and ethnic and racial minorities.

Social and recreational service (OAC 5122-29-14).

(A) "Social and recreational service" means a service that includes structured and non-structured activities and support to enhance the quality of life of the person served.

(B) Social and recreational service shall:

(1) Be designed to meet the needs of persons with severe mental disabilities;
(2) Be provided by staff qualified according to paragraph (D) of this rule;
(3) Occur, whenever possible, in facilities used for social and recreational purposes by other members of the community;
(4) Promote coordination among similar providers within the community mental health board service district, and with agencies and boards of adjacent community mental health board service districts to maximize the rehabilitation opportunities for persons served by the agency; and
(5) Ensure that the service plan is consistent with the principles of a community support system and promotes peer support and other approaches identified by persons served to maximize supports outside the mental health service system.

(C) The agency plan for social and recreational service shall be developed with the participation of persons served and shall include hours, location, and days of operation.

(D) Social and recreational service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

Cross-Walk from FIS-040 to New OhioMHAS Housing Categories

FIS-040 Housing Category	New OhioMHAS Housing Categories
• M-Residential Care	Residential Care: • Adult Care Facility/ Group Home • Residential Care Facility (Health) • Child Residential Care/Group Home
• M-Community Residential • M-Housing Subsidy	Permanent Housing: • Permanent Supportive Housing • Community Residence • Private Apartments • Recovery Housing • Home Ownership
• M-Crisis Bed • M-Respite Bed • M-Temporary Housing • M-Foster Care	Time Limited/ Temporary: • Crisis • Respite • Temporary • Foster Care

Service Categories Not Found in FIS-040:

M-Residential Treatment
M-Transitional Housing (Time Limited/Temporary Category)
M-Home Ownership