

CHAPTER 10 – ARTICLE 1

Browse Responses

Filter Responses

Download Responses

Displaying 11 of 11 respondents

« Prev

Next »

Jump To: 11

Go »

Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 68 99 84 80**Response Started:** Sunday, May 5, 2013 8:06:07 PM**Response Modified:** Sunday, May 5, 2013 8:25:47 PM**1. What parts of the draft rules do you believe are effective?**

Please note that the Office of Human Rights (OHR) is the unit of Arizona Department of Health Services/Division of Behavioral Health Services that provides advocacy to individuals with a Serious Mental Illness (SMI) in Arizona's public behavioral health system. To further our mission – providing advocacy to individuals with a SMI to help them understand, protect and exercise their rights, facilitate self-advocacy through education and obtain access to behavioral health services in the public behavioral system in Arizona – OHR reviews and submits comments on proposed changes to rules, regulations, policies, etc. that affect individuals with a SMI. No comments on this part

2. How can the draft rules be improved?

In general, the use of the word "patient" is not preferred to "client" or even "person" or "individual." The definition of "seclusion" on page 13 is incomplete. "Seclusion" is defined more broadly in the SMI regulations at R9-21-101 so including that definition or at least a reference to "if the person is an individual with a Serious Mental Illness, the definition of seclusion is broader and it is contained in R9-21-101. This is key to avoid confusion at inpatient facilities as persons with a SMI have the right not to be secluded unnecessarily – seclusion would consist of when not only physically prevented from leaving but also the person's perception that could not leave the seclusion. The definition of "time out" on page 15 is misleading as is and should be clarified. If time out is voluntary, then defining it as the person in time out is not physically prevented from leaving is inaccurate. The definition should be clear and concise in noting that time out involves a person initiated option to separate from the milieu for a time period determined by the person and can leave it at any time without being told not to leave or physically prevented from leaving

3. Has anything been left out that should be in the rules?

R9-10-102 contains a list of classes/subclasses but these are not all defined in the definitions section. Suggest defining each to make it clearer what each is

Browse Responses

[Filter Responses](#) [Download Responses](#) [Print](#)Displaying 10 of 11 respondents [« Prev](#) [Next »](#) Jump To: 10 [Go »](#)

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 71.223.19.154

Response Started: Sunday, May 5, 2013 6:00:05 PM

Response Modified: Sunday, May 5, 2013 6:46:13 PM

1. What parts of the draft rules do you believe are effective?

The rules are looking good, thank you for all your work. The Arizona Hospital and Healthcare Association has a few suggestions for the definitions in R9-10-101 below.

2. How can the draft rules be improved?

R9-10-101 (1) - please clarify what is meant by "ancillary services", it is too broad. Also, "health-related services" is not defined. - an "attending physician" is not assigned by a patient, he/she may be assigned by the facility - the definition of "available" is problematic - please remove the word "immediate" from a. This will be very difficult to comply with, it is not always possible for health professionals and others to provide an "immediate" response - the definition of "referral" is problematic. Most often a referral is a verbal conversation with the patient and has never required a list to be given to the patient before. - "signature" requires the first and last name of the individual. Many facilities use the first initial of the first name and full last name. Please revise the definition to allow for this. - Thank you for looking into "transport"

3. Has anything been left out that should be in the rules?

No

Browse Responses

[Filter Responses](#)
[Download Responses](#)
[View Summary](#)

 Displaying 9 of 11 respondents
 [« Prev](#)
[Next »](#)
 Jump To: 9
 [Go »](#)

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 64.88.163.125

Response Started: Saturday, May 4, 2013 4:52:58 PM

Response Modified: Saturday, May 4, 2013 5:09:56 PM

1. What parts of the draft rules do you believe are effective?

My name is Faye Lincoln, Sr. Vice-President, Policy & Government Relations, for Avalon Health Care. I am responding to this section Article 1 - General Section 101. Definitions related to Nursing Care Facilities / SNFs. Most of my comments specifically relate to the integration of Behavioral Health Services. I can be reached via email at flincoln@avalonhcl.com or by cell phone at (801) 518-6565.

2. How can the draft rules be improved?

Article 1 – General Section 101 Definitions The definition Behavioral Health Services needs to be improved when integrated within a nursing care institution. There is a lack of clarity as to the application to nursing care institutions given the wide array of services provided in this type of setting. Nursing care institutions / SNFs (NCI/SNF) maintain 3 types of behavioral health services: a) Individual residents with medical conditions who qualify for a NCI/SNF with underlying behavioral health issues; b) Memory care or dementia units for residents with medical conditions who qualify for a NCI/SNF and who exhibit behavioral health issues related to their dementia; c) Behavioral health units serving residents with medical conditions who qualify for a NCI/SNF with underlying behavioral health conditions which may be organic or non-organic in nature; such behavioral health issues are of a higher clinical level than in (a) or (b) above and eligible for specific rate-add-ons. a) All NCIs/SNFs serve residents with medical conditions who may also have an underlying behavioral health issue (which is organic or non-organic in nature). For example: (i) a resident admitted from the hospital who is recovering from a stroke as a primary diagnosis may have an associated moderate depression as a secondary diagnosis; (ii) an elderly resident with any diagnosis may have a history of "sundown" syndrome with exhibited behaviors of restlessness and anxiety into the evening hours; (iii) a resident with a spinal cord injury may have anti-social or triangulating staff behaviors which are challenging and noted in the resident care plan with appropriate staff interventions. All facilities will routinely have residents who may have underlying behavioral health issues associated with their medical condition. Facilities range in the number of residents they service with such behaviors. Most if not all of these residents are adequately and appropriately overseen by a primary care physician who can treat all of these conditions within the NCI/SNF. This is an accepted "standard of medical care" and does not require specialty behavioral health personnel or medical professionals. This type of resident should be clearly differentiated from someone with higher level "behavioral issues" or from the need for "behavioral health services" and it currently is not clearly identified. In the NCI/SNF industry, it would be more appropriate to consider this population to require "behavioral care". (b) Memory care or dementia units for residents with medical conditions and associated behavioral health issues are also standard and routine in the NCI/SNF setting. This type of unit would not rise to a high level, integrated behavioral health service unit. It may be more appropriate to outline certain types of standards and services associated with meeting the needs of such residents in a NCI/SNF, yet this group of residents is not clearly differentiated in the definitions of level of behavioral care. We do not believe that this type of unit requires an integration of "behavioral health services" on their license as this type of care is fairly standard for NCIs/SNFs. Instead, such a setting should have appropriate and supportive policies and procedures specifically addressing the clinical and behavioral health issues for this population, integrated within the NCI/SNF regulations. In the NCI/SNF industry, it would also be more appropriate to differentiate this population as requiring "behavioral care" with policies and procedures unique to this type of setting. (c) Behavioral health units serving SNF qualified residents with medical conditions and a co-morbid underlying behavioral health condition are unique and an exception to a SNF setting. Behavioral health conditions can be either organic or non-organic in nature and are at a much higher clinical level than in Levels (a) or (b) above. This type of unit is unique, specialized and not routinely seen in SNF settings, but available in certain circumstances. The behaviors exhibited in this type of setting are generally much higher than seen in the routine NCI/SNF resident. Most NCIs/SNFs will not accept this level of care without a specifically designed program. The behavioral issues addressed can be non-organic or organic in nature. The non-organic behaviors can be related to such psychiatric diagnoses as schizophrenia, severe depression, or bipolar illness. Those which are organic in nature are based on non-chemical brain imbalances including traumatic head injury, brain tumor, advanced Alzheimer's with more severe behavioral issues and a special needs adult such as someone with hydrocephalus exhibiting severe behavior disorders. This type of unit in a SNF would have specialized psychiatric or behavioral health personnel either on hire or on contract to serve the resident population. The nursing and aide staff would be trained not only in treating medical conditions but also

servicing the behavioral health needs of these residents. This type of model, specialized unit within a SNF is relatively new over the past 10 years in other states. Many residents require these specialized services, but SNFs routinely cannot provide them. This type of unit may be more appropriately identified as "Behavioral Health Services" for the SNF setting as opposed to the more routine programs differentiated in Levels (a) and (b) above, which we would better define as "behavioral care". We would reinforce that this type of unit serves residents only with medical conditions which qualify them for a SNF setting, but who also have co-morbid behavioral conditions. This type of unit in a SNF does not routinely take residents with mental health conditions as a primary diagnosis unless it also impacts their ability to meet their Activities of Daily Living with primary clinical / medical needs such as diabetes. It is also this type of specialty unit that would receive increased add-on rates from managed care plans within the ALTCCS program, differentiated from other levels of care. Recommendations: 1) Differentiate between the 3 levels of care in (a), (b) and (c) above under the definitions, and then developing supportive guidelines for levels (b) and (c) unique to the NCI/SNF setting. We do not believe that Level (a) under these definitions requires additional regulations. 2) We would recommend delaying the implementation of an integrated "behavioral health service" on the NCI /SNF license until these definitions and associated regulations are further clarified. 3) We would also recommend that a small Sub-Committee with the Dept. of Licensing be developed to address the confusion under behavioral health services for NCIs/SNF, made up of representatives of the nursing home industry with behavioral health expertise who can provide clarity to these issues. 4) We have addressed our concerns under the NCI/SNF regulations – Section R9-10-414 related to Behavioral Health Services in Survey Monkey as well.

3. Has anything been left out that should be in the rules?

We refer to the differentiation between "behavioral care" and "behavioral health services" as explained in the question above.

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)

Displaying 8 of 11 respondents [« Prev](#) [Next »](#) Jump To: 8 [Go »](#)

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 64 64 201 91

Response Started: Friday, May 3, 2013 11:15:32 AM

Response Modified: Friday, May 3, 2013 11:30:12 AM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

R9-10-114.1 f Requires 'clinical oversight' at least once during the week for each week services are provided. Clinical oversight/clinical supervision is currently designated as a prescribed number of hours per month. Maintaining the rule on a monthly timeframe rather than weekly allows for providers to meet a designated requirement while accounting for the various barriers that exist in the work environment. A weekly standard will increase the likelihood that a provider may be unable to meet the requirement due to unforeseen circumstances. A monthly requirement will allow providers to adjust to any unforeseen circumstances while ensuring adequate clinical oversight is occurring.

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 7 of 11 respondents [« Prev](#) [Next »](#) Jump To: 7 [Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 64 64 201 91**Response Started:** Friday, May 3, 2013 10:28:38 AM**Response Modified:** Friday, May 3, 2013 10:32:40 AM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

R9-10-101 "Interval Note" - a progress note is entered to correspond with the performance of an assessment. Is the "interval note" differentiated from a progress note in the clinical record and if so, why is it necessary when a progress note documents the patient's status/behavioral health issue?

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

Filter Responses Download Responses View Summary

Displaying 6 of 11 respondents < Prev Next > Jump To: 6 Go >

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 64 64 201 91

Response Started: Friday, May 3, 2013 10:26:40 AM

Response Modified: Friday, May 3, 2013 10:28:33 AM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

R9-10-101 "Clinical Oversight" - The definition doesn't address oversight provided to Behavioral Health Paraprofessionals

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 5 of 11 respondents [« Prev](#) [Next »](#) Jump To: 5 [Go »](#)

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 64 64 201 91

Response Started: Friday, May 3, 2013 10:14:53 AM

Response Modified: Friday, May 3, 2013 10:26:14 AM

1. What parts of the draft rules do you believe are effective?**No Response**

2. How can the draft rules be improved?

R9-10-101 1 Assistance in the Self Administration of Medication - the definition utilizes the term 'restricting' in the SMI outpatient clinic environment individuals assigned to an assertive community treatment level of care may receive medication observation services The recipient may or may not have restricted access to his or her medications The intensity of the service may vary as an individual moves to a higher level of independence, the individual may keep the medications in their home and receive medication observation services to continue to promote medication adherence. How will the term 'restricting' be applied in these instances? Will the proposed definition require all individuals receiving assistance in the self administration to have their medications maintained in a secured environment such as a lock box or will the rule account for individuals as they move to a higher level of independence

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

[Filter Responses](#) [Download Responses](#) [New Summary](#)Displaying 4 of 4 respondents [« Prev](#) [Next »](#) Jump To: 4 [Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 159 36 0 199**Response Started:** Friday, April 26, 2013 8:42:03 AM**Response Modified:** Friday, April 26, 2013 8:45:14 AM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?**No Response**

3. Has anything been left out that should be in the rules?

i don't see a definition for a manager, who is mentioned as the responsible person for many of the rules, there is also no definition for a caregiver, many times resident's are left alone without a trained caregiver, because the caregiver had to leave the facility for a "few minutes", does the person left alone with the resident's then become the caregiver?

Browse Responses

Filter Responses

Download Responses

Displaying 3 of 3 respondents

« Prev

Next »

Jump To: 3

Go »

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 208 242 14 200

Response Started: Tuesday, April 23, 2013 12:47:01 PM

Response Modified: Tuesday, April 23, 2013 12:50:22 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

As a large multi-specialty group with 24 facilities, we have comments and need clarification regarding the following rules:

R9-10-101: Definitions General Consent – What are the Department's expectations? 1 Do we need a general consent to treat prior to every visit? 2 Is the first time w/ the clinician sufficient? 3. If not, is consent to be time limited and/or collected with what frequency? 4. Would it be allowable to have a single consent for evaluation/treatment w/in the Medical Group or will we be required to have a separate consent for each clinician treating? R9-10-104: Approval of Architectural Plans and Specifications Rule does not specify when and for what type of facility architectural review is required. Only on application form does it indicate it is intended for Hospital/ASC Would like to suggest clarification in the rules. R9-10-105: Initial License Application Can we expect revised license applications (initial and renewal) be posted on -line? Under R9-10-105 (A)(1)(g-h) – {note: section mis-lettered w/ 2 x g} 1 Owner information given on application, including identifying our owners as a Corporation How is a Governing Authority different? Our ASC has a governing authority but not our OTCs 2 If separate governing authority required, can it be a single board for all sites or does each facility need to identify their own? R9-10-107: Renewal License Application R9-10-107(A) indicates that a renewal application shall be submitted at least 60 but no more than 120 days before current license's expiration but R9-10-108 Table 1 shows the overall time-frame for "Health care institution renewal license" to be 90 calendar days Please clarify if application may be submitted b/w 120-90 days prior to expiration. Under R9-10-107 (E)(1) – "The Department will renew licenses for one year", does this mean that we can expect to be surveyed annually? R9-10-109: Changes Affecting a License R9-10-109(B) 1 States "a licensee that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-1-412 shall submit an application for approval of architectural plans .. for a modification of the health care institution. Does this apply to an OTC? 2 If not and an OTC falls under R9-10-109(E) requiring written request for a change in the In services provided or modification to the facility, does that mean that, under R9-10-109(F-G), no remodeling or facility changes to floor plan, services provided, etc can proceed w/out prior approval is received from the Department? R9-10-112: Tuberculosis Screening It would be extraordinarily burdensome for a new employee to have completed TB testing by the first day of employment; however, it is realistic for TB testing to be administered on the first day of employment with appropriate action taken subsequent to testing results.

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

Filter Responses

Download Responses

Displaying 2 of 3 respondents

« Prev

Next »

Jump To: 2

Go »

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 98.191.114.135

Response Started: Tuesday, April 23, 2013 12:08:10 PM

Response Modified: Tuesday, April 23, 2013 12:12:00 PM

1. What parts of the draft rules do you believe are effective?**No Response**

2. How can the draft rules be improved?

CPR and first aid certification required for all personnel (why??) This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file. (isn't this a waste of resources for those who don't need it i.e maintenance staff, business office, etc?) Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs "Submit written report within 48 hours (why can't we just follow the Federal guidelines on the reporting requirement and timeframe??) 3. Under E.1 2 and 3. – the administrator must provide written notification within 1 working day after a resident's death within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management Talks about Quality Assurance activities but under 2 and 3 – it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted. (QA is a facilities internal privelege)

3. Has anything been left out that should be in the rules?**No Response**

Article I. General

- 1 "Ancillary service" means anything at all What is intended? Financial counseling? Gift shop services?
- 2 "Attending physician" is NOT designated by the patient Hospitals assign hospitalists Long gone are the days when patients pick a PCP who follows them in the hospital
- 3 "Available" does not mean able to provide an IMMEDIATE response Practitioners are available even when they cannot respond immediately
- 4 "Behavioral health paraprofessional" . . . to provide behavioral health services that would require a license under ARS Title 32... Delete "or for the healthcare institution "
5. "Behavioral health technician" see Behavioral health paraprofessional
6. "Hazard" is defined broadly enough to include a step or a rug
- 7 "Restraint" is too broad and should include CMS language: used "to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition " Current language would consider restraints to include strapping a patient when on a gurney to move to the OR or a medication that is given for clinical purposes.
8. **R9-10-112 TB:** applies to Medical Staff but does not track Medical Staff requirements in hospital rules We reached agreement on these rules.

**Title 9 Health Services
Chapter 10 Health Care Institutions: Licensing
Article 1 General**

These comments are based on the 4/4/13 Version of the draft rules. At the meeting we were informed that a more recent version was available. Subsequently some of these issues may have been addressed.

R9 10 -101 Organizations who have achieved national accreditation have been granted a reduced frequency of OBHL on-site reviews. Does this provision remain in place?

R9 10 -101 "*Behavior Health Technician means an individual who is not a Behavior Health Professional*". Why is this not in the same format as a Behavior Health Paraprofessional who is qualified according to the health care institutions policies and procedures? Defining something by what it is not, leave significant room for interpretation

R9 10 -101 "*Clinical Oversight*" Does not address the oversight provided to Behavior health Paraprofessionals. In addition, we assume the oversight is provided for technicians delivering services that are professional in nature (Assessment, Treatment Planning and Counseling) and not for other duties they may perform.

R9-10-114 1 f Requires '*clinical oversight*' at least once during the week for each week services are provided. Clinical oversight/clinical supervision is currently designated as a prescribed number of hours per month. Maintaining the rule on a monthly timeframe rather than weekly allows for providers to meet a designated requirement while accounting for the various barriers that exist in the work environment. A weekly standard will increase the likelihood that a provider may be unable to meet the requirement due to unforeseen circumstances. A monthly requirement will allow providers to adjust to any unforeseen circumstances while ensuring adequate clinical oversight is occurring.

The definition of clinical oversight does not include behavioral health paraprofessional.

R9 10 -101 "*Incident*" Please clarify what "*directly receiving*" means. Does it mean that all incidents are reported simply if the person is enrolled in a facilities program or does it only include incidents that occur off the program site when the facility staff are present but would not require a report if staff are not "*directly observing*" the incident. For example, a person is enrolled in your Outpatient Program; he reports that he had a physical altercation with his neighbor last weekend at his own independent apartment. Should this be reported as an incident?

R9 10 -101 "*Satellite facility*" In the previous rules, behavioral health services such as Counseling were allowed to be delivered off site as long as it was under twenty hours. Is this still possible? If not, this will cause a significant reduction in out of office services which is the foundation of a number of critical services in both the adult and children's behavioral health system.

R9 101 "*Medical Staff By-Laws*". Unclear why this is in here or why it falls under DHS licensure scope of authority.

R9 10 -114 Not sure why this appears in this section since it is partially stated in the definitions and then repeated in other articles throughout the rules.