

Apt 10

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Respondent Type: Normal Response

Collector: Health Care Institution Licensing Rulemaking (Web Link)

Custom Value: empty

IP Address: 68 177 0 66

Response Started: Monday, February 18, 2013 10:25:54 AM

Response Modified: Monday, February 18, 2013 10:30:20 AM

1. If you have any comments or concerns about the rulemaking process or general comments about the rules, please provide your comments or concerns below:

Kathy McCanna asked for us to measure our corridors to identify any facility that may have a corridor narrower than 44 inches. We have one clinic with hallway's that are 36" wide. I hope this will help you as you finalize the rules R9-10-1012 B 8 Thanks for your consideration, Marti Neff North Country HealthCare

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

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

Current regulations R9-20-209 7d notes that a service plan is reviewed "if a client is receiving Opioid treatment services, at least once every three months during the client's first year in treatment and at least once every 6 months after the client's first year in treatment" This is not address in the revised regulations Is this 3 month/6 month requirement a federal requirement or with the change in the regulations, will client's receiving Opioid treatment services be able to update service plan annually like every other outpatient behavioral health service?

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 67 155 83 227

Response Started: Wednesday, February 13, 2013 1:30:38 PM

Response Modified: Wednesday, February 13 2013 1:36:23 PM

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

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**2 How can the draft rules be improved?**

R9-10-1013 has a section on assessments but nothing on treatment plans Is that intentional? Did you mean this: A fire drill is conducted on each shift at least once every 12 months;

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

R9-10-1009 A.B.B. ( 2 B's in a row. An "A" was left out). Needs to be revised. Does not make sense the way it reads now.

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Less prescriptive to allow for flexibility in job duties

**2. How can the draft rules be improved?**

BHPs should be independently licensed- not hold associate licenses. Associate licenses do not require any field experience

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

Question: Can a BHT provide "clinical oversight" to another BHT/BHPP if the services are NOT related to the practice of professional counseling or SW (ie peer and family delivered services)?

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 184 98 115 68

Response Started: Sunday, February 10, 2013 4:37:27 PM

Response Modified: Sunday, February 10, 2013 4:44:04 PM

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

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No Response

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**2. How can the draft rules be improved?**

I understand that Outpatient facilities that offer counseling only will no longer be licensed. This will negatively affect those outpatient counseling programs that provide specialized behavioral health services, without medical services. For example, DSP's (Direct Service Providers) with contracts with Children's Provider Network Organizations in Maricopa County will no longer be able to provide services through their Behavioral Health Professionals that are not yet independently licensed. In the case of my clinic, my BHP's who are L A C's, under my supervision, are highly trained to deal with children affected profoundly by severe childhood trauma, and are working towards their independent licensed. Under these rules, these highly trained therapists could no longer provide services, unless we were to add medical services (which are not needed by our clients, because psychiatric is provided by the PNO).

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

Outpatient Behavioral Health facilities providing highly specialized counseling services, to case managed children of Provider Network Organizations, should be allowed to continue as licensed outpatient facilities.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 70 167 207 164

Response Started: Wednesday, February 6, 2013 5:26:09 AM

Response Modified: Wednesday, February 6 2013 6:08:14 AM

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

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**2. How can the draft rules be improved?**

Ruling R9-10-103, section C 3a- "BHT within 72 hours a BHP reviews and signs the assessment to ensure that the assessment identifies the behavioral health services provided by a patient" What is the basis for the need to have the assessment signed within 72 hours? Why change from 30 days to the abbreviated time of 3 days? Why not extend to 7 days? In small clinics with 1 BHP, especially in rural areas, 72 hours may be a barrier on Mondays that are holidays ( Saturday- Monday would be 72 hours), week long vacations, or even times when the clinic is closed for 4 days (Thursday-Sunday for thanksgiving and day after thanksgiving holidays) Many of the revisions are less prescriptive and will allow for more flexibility in providing effective care; this ruling is more stringent and may create a focus on meeting the 72 hours time frame requirement rather than focusing on the effective documentation.

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

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 70 167 207 164**Response Started:** Wednesday, February 6, 2013 6:21:30 AM**Response Modified:** Wednesday, February 6, 2013 6:34:41 AM**1. What parts of the draft rules do you believe are effective?****No Response**

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

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

Are there specific requirements for service planning/treatment planning? Are they noted under different rulings than the outpatient rulings (Chapter 10)? What about established time frames for completion of service plans? Are they due annually or every 6 months or some other time frame?

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by Art 3  
Art 10  
Art 14

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Respondent Type: Normal Response

Collector: Health Care Institution Licensing  
Rulemaking (Web Link)

Custom Value: empty

IP Address: 65 73 173 187

Response Started: Monday, February 4, 2013 10:45:07 AM

Response Modified: Monday, February 4, 2013 10:49:19 AM

1. If you have any comments or concerns about the rulemaking process or general comments about the rules, please provide your comments or concerns below:

Regarding proposed R9-10-317 / R9-10-1020 rules for Observation/Stabilization Services: As a healthcare service provider serving a rural area, in a facility that is always at capacity and very much needed in this rural setting, I find the proposed rules for observation/stabilization services unreasonably difficult to comply with. Mandating that a medical practitioner be present in the facility at all times essentially excludes us from offering this service to our community. Just as, mandating the presence of an RN in the designated service area at all times will drive the costs of providing this service out of our reach. I understand that the motivation is to ensure the immediate availability of medical and nursing services to this recipients of care, but setting the standards for this service higher than those for inpatient services seems unreasonable. Please reconsider these requirements. Having a medical practitioner immediately available and having an RN immediately available would be more consistent with the goal of providing for recipient safety while enabling rural providers to meet these requirements cost effectively. Thank you for your consideration.

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**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 70 96 56 234**Response Started:** Thursday, January 31, 2013 11:52:19 AM**Response Modified:** Thursday January 31, 2013 11:53:22 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?**

We would like you to provide us with collegial and consultative advice/direction regarding the stipulations governing clinical supervision of paraprofessional staff and clinical oversight of technician level staff. We interpret the proposed draft rules to stipulate that in both Behavioral Health Residential Facilities and Outpatient Treatment Centers, staff who perform tasks that would require an independent practice professional practice license from the Arizona Board of Behavioral Health Examiners or Arizona Board of Psychologist Examiners and who are not licensed at the independent practice level by said Boards will require either direct observation real time clinical supervision (paraprofessional level staff) or weekly clinical oversight (technician level staff) from an independently licensed behavioral health professional. We interpret these tasks to include but not sure they are limited to: 1. Clinical Assessments 2. Treatment Plan Development/Redevelopment/Assessment of Treatment Goal Progress and Remediation of Treatment Plan Goal Barriers to Progress 3. Developing Discharge Plans 4. Individual and Group Counseling. Can you please advise if there would be any other tasks performed other than the ones listed in either residential facilities or outpatient treatment centers that you feel would require an independent practice behavioral health professional license? We do understand that unless the proposed draft rules are modified/amended that there is no technician practice level extension for developing Discharge Summaries.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 174 22 244 162

Response Started: Wednesday, January 30, 2013 12:09:14 AM

Response Modified: Wednesday, January 30, 2013 12:10:22 AM

**1 What parts of the draft rules do you believe are effective?****No Response****2. How can the draft rules be improved?**

Thank you for the opportunity to provide feedback during this rule revision process. R9-10-1003. Administration (D 4) mentions the addition of a two hour requirement for submission of requested information to the Department. If a facility manager is on vacation, time will be needed for off-site staff with access to sensitive information to travel to the facility and provide access to those documents. If a secretary happens to be out, current information not yet filed can be kept in elaborate physical systems understood primary by the system designer. Finding documents in such a system if they happen to be absent can be time consuming. Medicare's core survey process also requires filling out questionnaires that would require time that may not be able to be simultaneously spent looking for documentation. R9-10-1003. Administration (E) mentions requirement to intervene in the event of abuse. The need for this requirement is understood given the goal of consolidating rules for many types of outpatient providers (crisis / behavioral health, etc), but may not be appropriate for others (diagnostic, dialysis, sleep disorder, etc). Such a rule could create many safety and liability concerns for some operators given standard expectations related to staff training given the types of services provided. In many outpatient environments staff is typically instructed in dangerous situations not to directly intervene and contact law enforcement, but this rule mandates intervention. In addition, given that many types of abuse are subjective in nature, requiring this level of involvement could in some cases jeopardize patient/caregiver trust by overstepping boundaries in personal privacy, etc. Where and how to draw lines can be difficult to determine, and in the case of many outpatient facilities, be well outside common expectations for scope of services. If this section is kept for all outpatient facilities, what resources would the department provide to assist in compliance/training/liability for non-behavioral entities? R9-10-1012. Medical Emergency, Safety, and Disaster Standards (B 12 c) requires a monthly test of smoke detectors. New systems being installed in our facilities have hardwired alarms with a central battery back-up. If there is an issue the panel will go into a "silent" alarm mode until repairs are made. The question presented to Department personnel in the past is that with such a system, what would the monthly test look like? If the panel is self-monitoring, is there a need for a monthly "test"? R9-10-1012. Medical Emergency, Safety, and Disaster Standards (B 15 c) requires an annual test of fire sprinkler systems. Currently they are serviced and inspected annually by a qualified/licensed vendor, but actually testing the system could be quite messy, and disruptive for facilities with long hours. R9-10-1012. Medical Emergency, Safety, and Disaster Standards (B 19 b) requires oxygen tanks to be stored away from combustible materials. Items in an emergency code cart on to which bottles are stored are combustible but necessary in an emergency. R9-10-1019. Dialysis Services (B 1) requires an administrator to have 12 months of experience. This can limit the available pool of applicants. Could this be more broadly defined as 12 months in healthcare management for example? R9-10-1019. Dialysis Services (D 2) requires plans for modifications to be presented for approval but does not provide a deadline for Department review and respond to those plans. R9-10-1019. Dialysis Services (E 1-4) list history and physical requirements. Can these rules be more closely aligned with Medicare requirements? Arizona provides services to many patients from out-of-state, who come from dialysis units not familiar with adhering to this rule. The effort to comply often rests with local staff and physicians, who can have trouble making these requirements. R9-10-1019. Dialysis Services (E 15 a-b) requires documentation of discharge and notes requirements for that documentation. There have been discussions in the past with Department Surveyors regarding the public health need this rule seeks to serve, since it was not immediately clear to our staff or to the Surveyors. In the absence of a clear public health need, would it be appropriate to remove this requirement and align Arizona rules with Medicare guidelines? R9-10-1019. Dialysis Services (J 10 a) requires a 6 month update that is not consistent with Medicare guidelines. Two items to consider: (1) In practice, changes to patient's dialysis regimen and evaluation of treatments goals are done monthly (especially given requirements in R9-10-1019 sections E4b, E5e, G6, & H6). This six month care plan requirement has become more of an exercise in administrative duties for staff given the monthly requirements already set out. (2) Medicare has indicated that they may be relaxing the unstable assessment and care plan requirements since it has been recognized that the cause for instability can be drowned out in the sheer volume of other information contained in annual assessment and care plan documents. Would this requirement conflict with any potential changes in Medicare interpretation of unstable assessment and plan of care requirements? Thank you again for the opportunity to provide feedback in this process.

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



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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 74 39 196 14**Response Started:** Tuesday, January 22, 2013 9:58:47 AM**Response Modified:** Tuesday, January 22, 2013 10:00:13 AM**1. What parts of the draft rules do you believe are effective?****No Response**

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**2. How can the draft rules be improved?**

R9-10-1007 "patient rights" (still not clear if we will need to revise what is currently posted with the limited rights listed here; current list reflects those required by TJC and is inclusive of these "few" rights; too confusing for members to have multiple lists---defeats the purpose of posting to educate members) R9-10-1013 C 3. b "behavioral health professional supervises the behavioral health paraprofessional during the completion of the assessment . " (will Paraprofessionals now be able to be credentialed to perform Assessments with a co-signature/review?) R9-10-1017 B 2 b "a Registered Nurse (present in the outpatient treatment center)" (o/p centers providing crisis services will now be required to be staff at all times with an RN?--- which are not readily available to hire in rural areas and are not fiscally justified with low number of enrolled members at small centers. Should be considered as "available" similar to physician or behavioral health professional)

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

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 68 98 219 102**Response Started:** Tuesday, January 22, 2013 8:51:11 AM**Response Modified:** Tuesday, January 22, 2013 8:55:26 AM**1 What parts of the draft rules do you believe are effective?****No Response**

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**2. How can the draft rules be improved?**

R9-10-1012 (B 12) Requirements for smoke alarms, delete the need for battery operated ones when the facility is hard wired. - R9-10-1003 (D- 2-4) documentation requested by surveyor will be available in 2 Hours of request, 4 hours is more reasonable - R9-10-1012 (B 15) Requirements for sprinkler testing, make them annual? - R9-10-1017 (A-7) (C,1a) (I) Can we request care plan regulations in AZ are the same as Federal requirements? - R9-10-1017 (B,1) The requirement that an Administrator have 12 months experience in dialysis limits our ability to fill AM and DO roles Is this necessary or should the requirement be similar to the federal requirements? Maybe 12 months of Management in health care? - R9-10-1017 (E 2) H&P requirements? Could they be similar to the federal requirement? Delete the 48 hr rule and don't include transient patients in this Progress notes: can they be made quarterly as they were in the past (on stable pts)

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

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**2. How can the draft rules be improved?**

R9-10-1003 (D) e: First Aid training: will medical providers, RNs, LPNs and Medical assistants need first aid training or will their prior medical/nursing training suffice?

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

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All except the ones listed below

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**2. How can the draft rules be improved?**

R9-10-1017 (E2) H&P requirements-we have alot of dialysis patients that travel, some monthly during the summer months. It is labor intensive to get a H&P updated monthly for the travelers Can this rule be similar to the federal requirements? R9-10-1017 (A7) (C, 1a) (I) 6 month care plan, can this be the same as the federal requirements of Initial, 90 day, annual and monthly unstable If a patient has a change between care plans this will be captured in an unstable care plan R9-10-1017 (B 1) The requirement that an administrator have 12 months dialysis experience limits our ability to fill Area Manager and Director of operations positions Can this be changed to 12 months management in health care instead. R9-10-1003 (d 2-4) documentation requested by surveyor will be available in 3 hrs of request I have been involved in 2 of the new surveys and I has taken me at least 4 hrs to get all of this information. Can this be changed to 4-5 hrs.

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

Not that I can see.

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**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 12 172 67 8**Response Started:** Sunday, January 13, 2013 2:23:54 PM**Response Modified:** Sunday, January 13, 2013 2:47:25 PM**1. What parts of the draft rules do you believe are effective?****No Response**

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**2. How can the draft rules be improved?**

After reading the draft rules I have come away with a few areas that I personally think are limiting or need revision - Requirement for Administrators to have 12 months experience in dialysis. This seems like it could delay the hiring process of quality candidates I feel that if there is a quality candidate for a position and they exhibit all the qualities of a strong Administrator someone should be able to hire that person regardless of their experience - H&P My suggestion for H&P would be that they were similar to the Federal requirements -Care Plans My suggestion for care plans would be that they were similar to the Federal requirements -Requested Documentation. My last suggestion for improvement would be a revision of providing documentation to surveyors in 2hrs. If you have personel working in multiple locations there is a high likelihood that documentation may take longer than 2hrs to be produced. There are so many different working parts in a company that for different departments to all come together at once can be difficult. Thank You for reviewing my comments.

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

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**2. How can the draft rules be improved?**

R9-10-1017 (A-7) (C, 1a) (I) Can we request care plan regulations in AZ are the same as Federal requirements? R9-10-1017 (B,1) Change requirement to 12 months mangement, instead of dialysis experience R9-10-1017 (E 2) H&P requirements? Could they be similar to the federal requirement? As aZ's have become too restricitve

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

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**2. How can the draft rules be improved?**

Under R-9-10-13, C, 2, a: with a 24 hour limited time frame on signing assessments, is this 24 business hours? If so-what about weekends when the offices are closed? If an assessment is completed on Friday, and reviewed 24 business days later on Monday, have are auditors to know that the signature is in compliance? Won't they need to have several years of calendars handy to verify?

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

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**2 How can the draft rules be improved?**

Recommend that in R9-10-1015 add language indicating that if crisis services are provided via telephone that a Behavioral Health Professional must be present at all times Recommend clarification in R9-10-104 of whether this section is applicable to both Inpatient and Outpatient HCIs, including those who provide telephonic services only at the physical site. In R9-10-112 we recommend clarification to the initial statement " if tuberculosis screening is required." to indicate how a HCI knows if it is required, for example would a HCI providing telephonic services only be required to conduct tuberculosis screening of its personnel Also, recommend providing clarification regarding conducting tuberculosis screening for individuals admitted to a HCI providing short term crisis services of less than 24 hours as testing can take up to 72 hours. Individuals will need to be served before results are obtained. If this is a new requirement for and HCI, is there any phase-in approach planned to be in compliance? Recommend clarification in R9-10-102, B regarding if a HCI is licensed as a Behavioral Health Inpatient Facility, which Rules are applicable for services provided on an Outpatient basis within the same HCI.

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

Definitions for all items listed in R9-10-102, A 1-19 to assist agencies in determining the appropriate class or sub-class they should apply as for licensure Recommend including definitions for clinical oversight and supervision in each applicable Article as currently the Drafts of Article 1, 3 and 10 do not all contain the definitions within the Article and it is confusing to discern if clinical oversight and supervision are applicable in both Inpatient and Outpatient settings

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 70.167.207.164**Response Started:** Friday, January 4, 2013 11:38:54 AM**Response Modified:** Friday, January 4, 2013 11:49:10 AM**1. What parts of the draft rules do you believe are effective?****No Response**

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**2. How can the draft rules be improved?**

R9-10-13 (C) (3) (9) (10) Is this talking about behavioral health reviews or medical reviews? Is this noting that behavioral health annual reviews are no longer required?

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

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 70.167.207.164

Response Started: Friday, January 4, 2013 11:28:21 AM

Response Modified: Friday, January 4, 2013 11:38:45 AM

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

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**2. How can the draft rules be improved?**

R9-10-1013 (C) (1) and (2) If a BHT completes an assessment, to have a BHP sign within 24 hours seems extreme. What if BHP is only available on site 2 days per week? What if location is small and has only 1 BHP reviewer and reviewer is on vacation or sick? Can this time frame be expanded to within 5 working days or even 7 days? The current standard for a BHP to review an assessment is 30 days, why go to the extreme level of 24 hours?

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

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**Respondent Type:** Normal Response

**Collector:** New Link (Web Link)

**Custom Value:** empty

**IP Address:** 70 102 207 98

**Response Started:** Thursday, December 27, 2012 2:00:54 PM

**Response Modified:** Thursday, December 27, 2012 2:03:30 PM

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

Most are the same

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**2. How can the draft rules be improved?**

There are some that may not make sense The evacuation routes posted in every room where a patient is seems like it may not be necessary to be posted in every operating room where patients are attended to by staff that are responsible for evacuating patients

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

No Response

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 68 98 215 104

Response Started: Wednesday, December 19, 2012 10:47:18 AM

Response Modified: Wednesday, December 19, 2012 10:54:13 AM

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

The draft rules are effective in that they provide a streamlined way for organizations to become licensed, and the rules recognize the importance of integrated care.

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**2. How can the draft rules be improved?**

The rules could be improved by working with agencies who do not currently provide integrated care to get them on that type of track, rather than cutting them out of the licensure process altogether. Smaller agencies that have been providing clinical services for decades and have great reputations within the community for such care, but do not offer integrated care, need a path to help them work towards integration. It would be helpful if thought went into how to support these agencies moving forward, perhaps offering different types of licensure, so that agencies focusing primarily on clinical (counseling) services will be able to identify ways and opportunities for integrating medical/psychiatric care. There are numerous programs being advertised through national behavioral health entities that coach smaller agencies on integration; perhaps requiring that an agency enroll in some type of program the first year and then develop a plan of action would be appropriate to work towards integration in a timely manner, not simply denying a license. Without licensure, several staff levels (such as behavioral health techs and other unlicensed professionals) would be unable to practice with the agency unless they obtain licensure. For some, this would be possible but for others it is simply not an immediate, achievable goal. This would result in staff layoffs, increasing unemployment, and drawing down resources for programs that are desperately needed.

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

Finding an effective way to work collaboratively with AHCCCS and the legislature on the impacts of these rule revisions before finalizing them to ensure these unintended impacts do not occur. Finding an effective way to work with the AZ Board of Behavioral Health Examiners to streamline or expedite licensure for those non-licensed therapists to be able to comply with loss of exemption by the July 1, 2013 effective date of the new rules.

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[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 10 of 30 respondents [« Prev](#) [Next »](#) Jump To: 10 [Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 64 119 39 78**Response Started:** Monday, December 17, 2012 2:37:08 PM**Response Modified:** Monday, December 17, 2012 3:07:51 PM**1 What parts of the draft rules do you believe are effective?**

I haven't studied them enough to answer this one but there are definite adverse impacts to a few key items.

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**2 How can the draft rules be improved?**

Licensure of Outpatient Services needs to continue and not be tied to a health care facility or medication management. For "out of the great state of Maricopa" providers, we are dependent on small counseling groups for specialty services. These groups currently have LAC and LMSW staff that could not meet the criteria for an independently licensed practitioner. These groups have no interest in working for public behavioral health agencies as they can barely tolerate the non-sensical compliance requirements of the system. An example of that? In a Data Validation audit last week, one of these agencies received errors for having an assessment in the file from the referring provider that had a BHP provider signature that was 30 days beyond the signature of the case manager. It wasn't their assessment, they were just asked to provide counseling services but got dinged due to data validation rules. When experienced therapists experience this type of compliance craziness, they have no motivation to work in the behavioral health field. We have to compete with AOC, DES, VOCA, Head Start and federal grants for the very limited pool of therapists in more rural areas. So the proposed rules will impact capacity of good, experienced specialty providers for our members.

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

Addressing how current clinics that are licensed can be able to claim and bill in another way if not through OBHL.

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This is a great start into Arizona creating a more streamlined licensing process for organizations and agencies to have integrated practices and licensure.

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**2. How can the draft rules be improved?**

It is important to recognize that there currently exists a lack of professionals (psychiatrists and psychiatric nurse practitioners) licensed to provide this service in Arizona, and specifically in Pima County. This is even more pronounced when you drill down to child and adolescent psychiatric and geriatric psychiatric services (psychiatrist and NP). Should this requirement be instituted, there will not be adequate human resources to meet the need of the community (as there is not enough now) and smaller providers, such as JFCS of Southern AZ, would be at a competitive financial disadvantage in recruiting the necessary professionals in comparison to hospitals and comprehensive service providers. Providing more support and time to allow for community planning and recruiting so that those agencies wishing to remain licensed will be able to build in the psychiatric role if that is the most logical choice for that agency. Otherwise the rules are encouraging the agencies to create services just to comply as opposed to creating a service that will most fit within the organizations' mission and need of the individuals and families they are serving. Provide clarity and support as to how the streamlining and improvement of the individual licensing process (with AZBBHE) will fit into this since organizations clinical therapists will need to be licensed more quickly; currently there can be quite an extensive lag between the time an individual graduates, and the time that he/she is able to make it through the licensing process. This lag also exists for individuals moving to AZ and seeking reciprocity. We would support greater statewide involvement in making a smoother, more effective and efficient licensing process so that we can meet the tremendous need that exists for strong integrated health that will now more comprehensively include behavioral health practices.

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

Greater clarity on the branch licensing changes

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 68 98 215 104

Response Started: Friday, December 7, 2012 2:59:39 PM

Response Modified: Friday, December 7, 2012 3:01:42 PM

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

1 Providing a more streamlined way for organizations providing integrated care to become licensed

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**2. How can the draft rules be improved?**

2 Provide a mechanism to ensure that agencies providing only behavioral health services are either licensed in a different way, or that they can stay in existence providing much needed services to "systems" clients regardless of no longer being state-licensed. Our communities rely on these organizations, many of whom specialize in particular populations and have been preferred providers for decades, to meet the needs of the populations statewide. Adding a physical health or medication service is not financially feasible for many of these smaller agencies, nor is it often consistent with their mission. Also, these organizations would lose the exemption to employ not-yet-licensed Master's level therapists under appropriate clinical supervision, thus significantly reducing the pool of available therapists to meet the considerable need statewide and adding to state unemployment. Though not intentional, the impacts of this reform would be far-reaching and devastating to these valuable organizations and to the people they serve. Making the rules more favorable (and easier) for organizations who provide integrated care is a noble goal. Let's not make things more difficult for those organizations that do not or cannot integrate, however.

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

3 Finding an effective way to work collaboratively with AHCCCS on the impacts of these rule revisions before finalizing them to ensure these unintended impacts do not occur. Finding an effective way to work with the AZ Board of Behavioral Health Examiners to streamline or expedite licensure for those non-licensed therapists to be able to comply with loss of exemption by the July 1, 2013 effective date of the new rules.

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Providing a more streamlined way for organizations providing integrated care to become licensed

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**2 How can the draft rules be improved?**

Provide a mechanism to ensure that agencies providing only behavioral health services are either licensed in a different way, or that they can stay in existence providing much needed services to "systems" clients regardless of no longer being state-licensed. Our communities rely on these organizations, many of whom specialize in particular populations and have been preferred providers for decades, to meet the needs of the populations statewide. Adding a physical health or medication service is not financially feasible for many of these smaller agencies, nor is it often consistent with their mission. Also, these organizations would lose the exemption to employ not-yet-licensed Master's level therapists under appropriate clinical supervision, thus significantly reducing the pool of available therapists to meet the considerable need statewide and adding to state unemployment. Though not intentional, the impacts of this reform would be far-reaching and devastating to these valuable organizations and to the people they serve. Making the rules more favorable (and easier) for organizations who provide integrated care is a noble goal. Let's not make things more difficult for those organizations that do not or cannot integrate, however.

---

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

Finding an effective way to work collaboratively with AHCCCS on the impacts of these rule revisions before finalizing them to ensure these unintended impacts do not occur. Finding an effective way to work with the AZ Board of Behavioral Health Examiners to streamline or expedite licensure for those non-licensed therapists to be able to comply with loss of exemption by the July 1, 2013 effective date of the new rules.

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 209 180 79 18**Response Started:** Thursday, December 6, 2012 10:45:06 AM**Response Modified:** Thursday, December 6, 2012 10:47:25 AM**1. What parts of the draft rules do you believe are effective?****No Response**

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**2. How can the draft rules be improved?**

It is not necessary for a physician to be employed /subcontracted with a facility as a condition for licensure. Many outpatient smaller organizations are delivering high quality behavioral health services and will be put out of business or significantly impacted by having to establish a relationship with a physician/prescriber skilled in behavioral health

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

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 64 119 42 50**Response Started:** Tuesday, December 4, 2012 3:50:53 PM**Response Modified:** Tuesday, December 4, 2012 3:58:45 PM**1. What parts of the draft rules do you believe are effective?****No Response**

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**2. How can the draft rules be improved?**

I believe it will be detrimental to outpatient behavioral health services statewide if medical management becomes a requirement to service delivery. In many communities there are outpatient mental health clinics that provide therapeutic counseling and no medical management. These community based organizations are vital to the health of our behavioral health system and provide great capacity and expertise to service consumers in our communities. Adding the additional burden of having to provide some form of medical management creates a layer of compliance and cost that will drive many out of the public behavioral health system. This will create a workforce shortage in meeting the needs of children and adults in our public behavioral health system. At a time when we are facing the possibility of more people coming into care with the Affordable Care Act creating barriers to service delivery seems counter productive. Arizona already has a shortage of licensed therapist available to serve our population. The impact is even greater for children providers who may serve a large portion of younger children with no need for medical management.

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

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 24 117 41 131**Response Started:** Tuesday, November 27, 2012 3:03:53 PM**Response Modified:** Tuesday, November 27, 2012 3:05:44 PM

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

See no changes of any real significance.

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2. How can the draft rules be improved?

A method to identify when there is a change from existing rules. Otherwise it becomes necessary to compare line by line.

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

no

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 74 202 196 178**Response Started:** Monday, November 12, 2012 2:02:12 PM**Response Modified:** Monday, November 12, 2012 2:17:09 PM**1 What parts of the draft rules do you believe are effective?**

all but Medication services, SEction C

**2. How can the draft rules be improved?**

Assistance with self-administration of medications is not recovery focused and will likely lead to the client's dependence on the behavioral health system. For clients who can safely keep their medications at home, assistance with self-admin of medications should be done in their home setting, eventually leading to self-reliance when the service is discontinued.

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

a process for allowing some clients to keep their own medications when receiving assistance with self-admin of medications.

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n/a

**2 How can the draft rules be improved?**

Pg 16 states, "If an outpatient treatment center provides assistance in the self-administration of medication, an administrator shall ensure that A)a patients medication is stored by the outpatient treatment center". This does not reflect the recovery philosophy and does not promote independence in regards to taking medication. Clients need to be able to experience a step-down process with their medications which ensures safety as well as independence. The proposed can be part of the process if needed, but needs to be flexible and allow client's the ability to store their own medications if that is what they need to do for their recovery and independence.

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

Again, stated above, there needs to be more flexibility with the storage of medication and a step-down process regarding the client's storing their own medication.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 159.36.0.199

Response Started: Wednesday, November 7, 2012 4:49:55 PM

Response Modified: Wednesday, November 7, 2012 4:59:20 PM

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

In a perfect world, these are excellent rules for OTCs.

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**2 How can the draft rules be improved?**

Many OTCs are struggling to be in compliance with the current rules, due to lack of resources. Small OTCs, OTCs in poor rural areas, will not be able to come into compliance with these rules. Requiring OTCs to be in compliance with rules that may be appropriate only for organizations with the resources to implement them, may actually take the provision of affordable healthcare from the areas of the state that need the OTCs the most. Medical licensing does not currently have challenges with health and safety issues in OTCs, yet it will require considerable resources to survey to/write deficiencies for these rules. Small OTCs, or specialty OTCs will not be able to be in compliance. Exponentially more surveyors will be required if these rules go into effect.

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

No Response

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