

March 27, 2013

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Re: *Arnold vs. ADHS*: Proposed Changes to Department Regulations

Dear Greg, Joe, Joe and Don:

The proposed revisions to the Department's licensing rules present a serious threat to the Department's continued compliance with long standing orders in this case. In particular the changes proposed to the provisions on Patient Rights, Supervisory Care/Assisted Living and Adult Therapeutic Foster Homes are of concern.

I. Client/Patient Rights

The proposed rule changes eliminate almost entirely the rights previously contained in R9-20-203(1-29), including the most fundamental of rights to be treated with dignity, respect, and consideration; to privacy in treatment, including not to be fingerprinted, photographed or recorded; to be free from discrimination; to receive services that support individual choice, supports individual liberty, is provided in the least restrictive environment; to submit grievances and not to be retaliated against for submitting a grievance; to speak to legal counsel in confidence; to receive assistance from family and/or advocacy agencies to enforce rights; to review their own records; to be free from abuse, neglect, exploitation, coercion, manipulation, denied food, sleep or the use of the toilet. Such a wholesale elimination of critical protections for the rights of individuals served by the community mental health system is unconscionable.

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The proposed replacement rules on Patient's Rights, set forth below, would permit the **intentional** infliction of **physical harm** to an individual if the staff could document a medical reason. This is a shocking proposal, but in addition it violates Medicaid and Medicare criteria as well as most professional credentialing standards

R9-10-1007. Patient Rights

An administrator shall ensure that:

- 1 A patient is:
 - a. Provided primacy in treatment and personal care needs; and
 - b. Free from:
 - i. The intentional infliction of physical, mental or emotional harm **when not medically indicated;**
 - ii. Exploitation.
 - iii. Restraint **when not medically indicated** unless necessary to prevent harm to self or others and the reason for restraint is documented in the patient's medical record;
 - iv. Sexual abuse according A R S. § 13-1404; and
 - v. Sexual assault according to A.R.S. § 13-1406

The current rules, which protect the rights of persons with serious mental illness served by licensed behavioral health providers, have existed for years and represent the long standing commitment of the State of Arizona to this population. They must be preserved.

II. Supervisory Care/Assisted Living

Beginning in 1991 with the *Arnold* Implementation Plan, the use of Supervisory Care Homes for housing and supports for class members has been prohibited. The current Assisted Living regulations (which now include Supervisory Care as the lowest level of care) prohibit a facility from accepting a resident who requires behavioral health

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residential services. ACC R9-10-705(3) When the Assisted Living rules were first adopted, the Department included this provision to ensure their ability to enforce the prohibition of using Supervisory Care Homes for class members. The proposed change to the Assisted Living regulations eliminates this prohibition, and in addition, specifically adds behavioral health services to the services that can be provided in all levels of Assisted Living facilities, including Supervisory Care. This proposed change will reverse more than a decade of efforts to ensure that class members are not placed in Supervisory Care Homes and would constitute a direct violation of the longstanding commitments in this case.

In addition, the proposal discussed below to add a new category of licensed behavioral health homes will further jeopardize the progress made in eliminating the use of supervisory care homes for class members.

III. Adult Therapeutic Foster Homes

Adult Therapeutic Foster Homes provide an integrated family type housing option for person with significant behavioral health needs. It has proven to be an important service, particularly for young adults transitioning from the children's system who are still in need of the support of caring parental figures. The current draft of the licensure rules eliminates Adult Therapeutic Foster Homes from the continuum of housing options available to class members. While a comparable licensing category exists in the Assisted Living Health Care Institutions rules, those homes are limited by statute to members enrolled in the Arizona Long Term Care Program, and therefore would not be available to class members.

The Department has proposed a new licensing category, Adult Behavioral Supportive Homes, to theoretically replace Adult Foster Care. However, these homes would be limited to providing supportive services, similar to those provided in board and care homes, which the Department had worked to eliminate in implementing *Arnold*. The Regional Behavioral Health Authorities have already been notified that the current Adult Therapeutic Foster Homes must either obtain an Assisted Living license or make plans to transfer their residents to other more restrictive licensed settings.

This change is reflective of numerous other proposed changes in the current draft rules which, rather than creating more options for integrated community settings, are limiting those options.

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The Department is operating under an exemption to the rule making process and we understand that it intends to implement these changes July 1, 2013. We believe if the current draft rules are adopted they will be in direct conflict with the Department's obligations in *Arnold* and should therefore not be adopted. Please let us know as soon as possible what the State intends to do with respect to these rules so we can promptly consider other options, including raising this matter with the Court.

Sincerely,



Anne Ronan
Steven Schwartz

cc: Steven Schwartz
Charles Arnold
Cory Nelson

Article 10 Outpatient Treatment Centers

1. ~~1003B. Board should not have to approve policies and procedures.~~
2. 1003D. Overall comment: All specialties are treated the same even though they are not. For example, all have to have policies covering advance directives, even OTCs doing only diagnostic imaging. All are required to have policies covering assessment, transfer, discharge plan and discharge, and to cover how personnel will respond to out-of-control behavior.
3. 1003.D4a. 2 hour response; 4 for hospitals. Why less?
4. 1003D6 Patient follow up instructions aren't given for all OTCs
5. 1003E. **NO.** Why do OTCs have this requirement to report? Intend only for behavioral health? Not for hospitals or OSCs. Way beyond the law.
6. 1006. Transport and Transfer sections are not needed for all OTCs. When would Diagnostic Imaging Center transfer if not an emergency?
7. 1007A3 b. meet the needs of a patient "when requested services are provided by the OTC"
8. 1008B2. Policy on advance directives for all OTCs?; why need consent to photograph for patient identification purposes?
9. 1008C. no discrimination based on source of payment—will be denied if no insurance/cannot pay.
10. 1009A3. Outpatient orders do not include the time of order. Mammograms, etc.
11. 1009C. Medical records for all OTCs will NOT include known allergies, H&P, assessment, treatment plan, interval notes, progress notes, disposition upon discharge, follow up instructions, etc
12. 1010A1e. Procedures for assisting in obtaining meds. What does that mean?
13. 101B2. Makes no sense. "If an assessment that complies. Section was completed within 12 months."
14. 1025.6. All personnel at an urgent care center must complete adult and pediatric CPR training????
15. 1028A1c: free from a condition or situation that may cause an individual to suffer. Trip on a rug or stair?

Health Care Institution Licensing-Article 10-Outpatient Treatment Centers

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

We applaud DHS' efforts to define common essential components that each facility should be judged by the regulator in order to provide a basis of public safety regardless of the licensed setting

How can the draft rules be improved?

R9-10-1003 D4a

There is a concern about the requirement to respond within in 2 hours of a Department request. Some of our Centers are located in rural communities with the administrative office at another location and in a few situations we have mobile units or are delivering services at a school based clinic. We want to be responsive, but this may present unintended consequences. Perhaps an alternative is that the Center acknowledges the receipt of the request and complies within one business day followed by providing the requested information within 2 business days. Perhaps a tiered approach might be appropriate if this were classified as an emergency by the Department requiring a "full" response from the licensed facility within one business day.

R9-10-1003 B 7a & C 3.

In the situation where we have more than one community health center under the control of the "umbrella" agency, we need clarity about how these requirements will be implemented. Will we need to designate an administrator at each site? This may add cost and complexity for our mobile clinics or our school based programs

R-9-10-1005

As Federally Qualified Health Centers develop agreements with local behavioral health providers, many under contract with the local Regional Behavioral Health Authority, we might need some clarification on what level of contracted services that we must maintain a list which describes those services. For example, if a participant needs to see his/her PCP as well as the behavioral health provider at our Center, but needs a translator or transportation to get to the Center, will that be something we must have in our list of contracted services?

R9-10-1006 A.1.a.

If a participant is being transported by taxi, is the Center responsible for his/her health and safety? Does this place the Center at risk if it calls the taxi for a participant at the end of an appointment even if the taxi is not under contract with the Center?

R9-10-1007 2.b

Request this be clarified so that skills and who may verify those skills is defined. Perhaps the fact that continuing education is required to maintain licensure for the professionals will be sufficient, but it is probably best to be specific. Perhaps a cross reference to the professional's licensure authority and what documentation is to be maintained by the Center will achieve the required goal.

For staff not professionally licensed, will documentation of continuing education contained in the Personnel file be sufficient?

R.9-10-1010

Please define medication error. We agree that such is important and should be part of quality oversight by the Center.

R9-10-1011 A5

When a Center utilizes a behavioral health paraprofessional we find that like our behavioral health providers utilize these staff members in activities that might not fall under the traditional "practice" area. For example, a participant may need a skill development or case management which may indeed be consistent with the

planned care but the behavioral health professional may not have to oversee such activity. The professional would want to be assured, however, that the paraprofessional is undertaking those activities consistent with the plan. It may be helpful to clarify the clinical supervision aspect of those other activities.

R9-10-1011 A.b.vi

The requirement to provide a behavioral health technician with clinical oversight at least once per week may present barriers to assure full compliance based upon competing requirements such as training, holidays or illness. We agree the goal is worthy, but advocate for rewording that achieve the goal.

Listed below are a couple of additional thoughts and reactions to the public meeting for your consideration

- Because of our interface with local school districts around the state, we will be requesting clarification about the need to license that location. As discussed at the public meeting these community resources are valuable to assuring access to health care. We might need to have DHS supply what specific components of a memorandum of understanding or contract that will be required to continue this service to the community.
- This additionally raises questions regarding where the Centers should be maintaining the personnel and patient files. We want to assure confidential handling of both sets of records. We do, however, need access to the patient's file at the time of his/her visit to the school clinic.

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

As FQHCs begin to work more cooperatively with the behavioral health providers and move towards integration, it is unclear the degree of flexibility that DHS is offering as we experiment with delivery models both in the rural and urban settings. Developing protocols for such experimentation would be consistent with where the community practice is moving.

Because these regulations represent change, we recommend that DHS offer training so we can all be on the same page. This is not a required rule change, but a suggestion that moves us all towards consistent understand on implementing the changes from our perspective and then helping us understand the interpretations from you as regulators. Our mutual goal is the health and well-being of the people we serve.





April 19, 2013

Ms. Kathryn McCanna
Bureau Chief
Arizona Department of Health Services
Division of Licensing Services
Bureau of Medical Facilities Licensing
150 N. 18th Ave., Suite 405
Phoenix, AZ 85007-3248

RE: Outpatient Treatment Facilities

Dear Kathryn:

In response to HB2634 (Laws 2011, Chapter 96), the Arizona Department of Health Services, ("ADHS") is revising the rules in the Arizona Administrative Code ("A.A.C."), Title 9, Chapter 10 and Chapter 20. Veridus, on behalf of its client First Choice Emergency Room, respectfully requests that the ADHS, consider additional language to guarantee standards of care for outpatient treatment facilities that provide emergency medical care. The proposed changes to Title 9, Chapter 10 of the A.A.C. are attached. The proposed language provides clarity to patients seeking emergency medical treatment and ensures that patients do not end up in a facility with inadequate medical capability to handle true medical emergencies. We propose that ADHS introduce basic standards for freestanding emergency medical care facilities. By introducing such standards, ADHS will greatly enhance the options available to the public when seeking emergency medical treatment.

Freestanding emergency medical care facilities provide a number of unique benefits for patients seeking emergency treatment. These include:

- **Reduced wait times** - In 2010, Arizona was ranked as having the third longest emergency department wait times, averaging 329 minutes (Press Ganey). According to the American College of Emergency Physicians, 89% of doctors believe emergency room visits will increase under the Patient Protection and Affordable Care Act, which means Arizona emergency room wait times are likely to increase.

Ms Kathryn McCanna

April 19, 2013

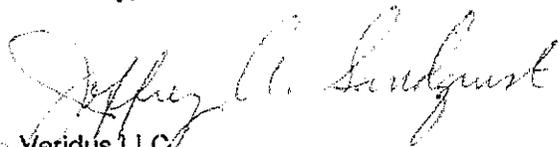
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- **Emergency care experience** - Under our proposed changes to the rule, freestanding emergency medical care facilities would be required to have board-eligible or board-certified emergency medicine physicians on site 24 hours a day, seven days a week, to diagnose and treat patients seeking emergency medical care.
- **Advanced capabilities** - Onsite medical equipment such as computed tomography scan services, Clinical Laboratory Improvement Amendments compliant laboratories, and X-ray machines provide a high level of care for patients.
- **Reduced admission rates** - According to the Centers for Disease Control and Prevention, in 2010, hospital emergency department admission rates were 13.3% compared to freestanding emergency department admission rates of 3%-5%.
- **Access to care** - Freestanding emergency medical care facilities have the ability to locate in underserved and rural areas where emergency medical treatment is not always easily accessible.

In conclusion, freestanding emergency medical care facilities will benefit patients in many ways by providing them with increased options and a high level of emergency medical treatment. Distinguishing a freestanding emergency medical care facility from other types of health care facilities will provide clarity to patients at a time when they need it most

Should you have any questions on the proposed amendment, please call Jeff Sandquist or Wendy Briggs at 602.229.1129. We look forward to working with ADHS on this matter.

Sincerely,


for Veridus LLC
On behalf of First Choice Emergency Room

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APR 22 2013

Medical Facilities Licensing

TITLE 9. HEALTH SERVICES
CHAPTER 10. HEALTH CARE INSTITUTIONS: LICENSING
ARTICLE 10. OUTPATIENT TREATMENT CENTERS
R9-10-1002. Supplemental Application Requirements
R9-10-1003. Administration
R9-10-1004. Quality Management
R9-10-1005. Contracted Services
R9-10-1006. Transport; Transfer
R9-10-1007. Personnel and Staffing
R9-10-1008. Patient Rights
R9-10-1009. Medical Records
R9-10-1010. Medication Services
R9-10-1011. Behavioral Health Services
R9-10-1012. Court-ordered Evaluation
R9-10-1013. Court-ordered Treatment
R9-10-1014. Clinical Laboratory Services
R9-10-1015. Crisis Services
R9-10-1016. Diagnostic Imaging Services
R9-10-1017. Dialysis Services
R9-10-1018. Behavioral Health Observation/Stabilization Services
R9-10-1019. Opioid Treatment Services
R9-10-1020. Pain Management Services
R9-10-1021. Physical Health Services
R9-10-1022. Pre-petition Screening
R9-10-1023. Rehabilitation Services
R9-10-1024. Sleep Disorder Services
R9-10-1025. Urgent Care Services Provided in a Freestanding Urgent Care Setting
R9-10-1026. Emergency Medical Care Provided in a Freestanding Emergency Medical Care Facility Setting
R9-10-1027. Infection Control
R9-10-1028. Emergency, Safety, and Disaster Standards
R9-10-1029. Physical Plant, Environmental Services, and Equipment Standards

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APR 22 2013

Medical Facilities Licensing

ARTICLE 10. OUTPATIENT TREATMENT CENTERS
R9-10-1002. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. §§ 36-422 and 36-424 and 9 A.A.C. 10, Article 1, a governing authority applying for an initial license shall submit a supplemental application form provided by the Department that contains the:

1. Days and hours of clinical operation and, if different from the days and hours of clinical operation, the days and hours of administrative operation; and
2. A request to provide one or more of the following services:
 - a. Behavioral health services and, if applicable;
 - i. Behavioral health observation/stabilization services;
 - ii. Behavioral health services to individuals under 18 years of age,
 - iii. Court-ordered evaluation;
 - iv. Court-ordered treatment;
 - v. Crisis services;
 - vi. Opioid treatment services;
 - vii. Pre-petition screening;
 - viii. Respite services;
 - ix. DUI education,
 - x. DUI screening,
 - xi. DUI treatment, or
 - xii. Misdemeanor domestic violence offender treatment;
 - b. Diagnostic imaging services;
 - c. Clinical laboratory services;
 - d. Dialysis services;
 - e. Pain management services;
 - f. Physical health services;
 - g. Rehabilitation services;
 - h. Sleep disorder services;
 - i. Urgent care services provided in a freestanding urgent care center setting; or
 - j. Emergency medical care provided in a freestanding emergency medical care facility setting

R9-10-1026. Emergency Medical Care Provided in a Freestanding Emergency Medical Care Facility Setting

A In addition to the definitions in R9-10-101 and R9-10-1001, the following definitions apply in this section unless otherwise specified:

1. "Emergency medical care" means health care services provided in a freestanding emergency medical care facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, psychiatric disturbances, or symptoms of substance abuse, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
 - a. placing the person's health in serious jeopardy;
 - b. serious impairment to bodily functions;
 - c. serious dysfunction of a bodily organ or part;
 - d. serious disfigurement; or
 - e. in the case of a pregnant woman, serious jeopardy to the health of the woman or fetus.
2. "Facility" means a freestanding emergency medical care facility.
3. "Freestanding emergency medical care facility" means a facility, structurally separate and distinct from a hospital and not otherwise licensed as a hospital by the state, that receives an individual and provides emergency medical care as defined in paragraph 1 of this section.
4. "Stabilize" means to provide necessary medical treatment of an emergency medical condition to ensure, within reasonable medical probability, that the condition is not likely to deteriorate materially from or during the transfer of the individual from a facility.
5. "Transfer" means the movement including the discharge of an individual outside a facility at the direction of and after personal examination and evaluation by the facility physician. Transfer does not include the movement outside a facility of an individual who has been declared dead or who leaves the facility without the permission of the facility physician.

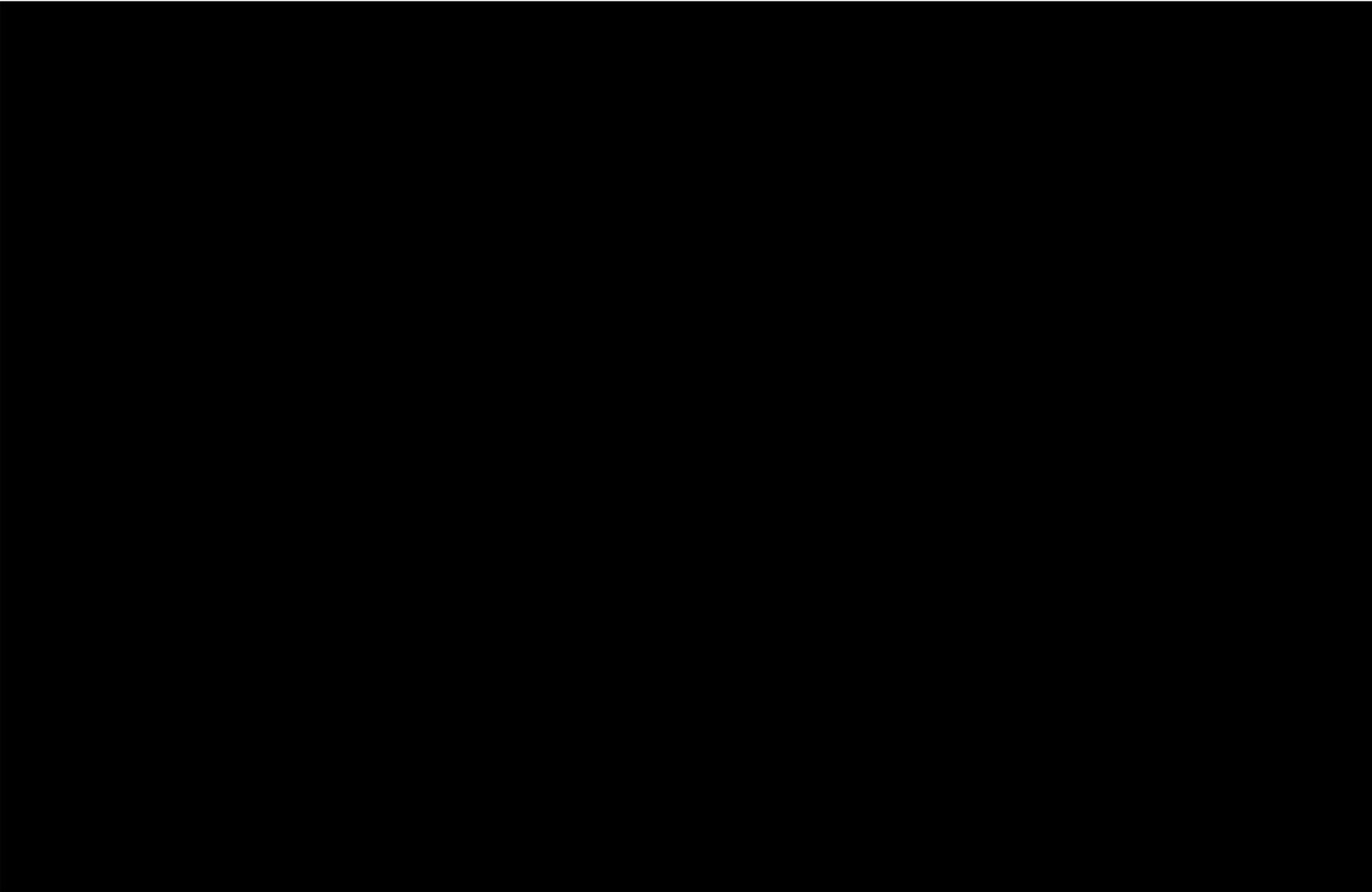
B An administrator of an outpatient treatment center providing emergency medical care services shall ensure that:

1. The facility shall be in continuous operation 24 hours per day and 7 days per week.
2. A physician who is board certified or board eligible in emergency medicine, or board certified in primary care with a minimum of two years of emergency care experience is on the premises during hours of clinical operation to provide the medical services, nursing services, and health-related services included in the outpatient treatment center's scope of services.
3. The facility has the capability to provide services including, but not limited to:
 - a. Computed Tomography scan services that are immediately available on the premises.
 - b. Radiological services that are immediately available on the premises to meet the emergency needs of patients and to adequately support the facility's clinical capabilities, including but not limited to plain film x-ray.

4. The facility shall develop a written procedure for immediate transfer to a hospital for patients requiring emergency medical care beyond the capabilities of the facility
5. The facility shall maintain adequate laboratory services to correspond with the level of care. Laboratory services shall comply with Clinical Laboratory Improvement Amendments of 1988 (CLIA 1988), in accordance with the requirements specified in 42 C.F.R. §§ 493.1 - 493.1780.
6. The facility may provide drugs, controlled substances, and biologicals in a safe and effective manner in accordance with professional practices. The facility shall be in compliance with all state and federal laws and regulations. The facility shall be licensed as required by the Arizona State Board of Pharmacy. The facility shall adopt, implement, and enforce policy and procedures for pharmaceutical services. The facility may make pharmaceutical services available through contractual agreement. Pharmaceutical services provided under contract shall meet the same ethical practices, professional practices, and legal requirements that would be required if those services were provided directly by the facility.

Received

27 2013



From: Chase, Justin [<mailto:JChase@magellanhealth.com>]
Sent: Friday, April 19, 2013 1:05 PM
To: Steven Dingle, MD; Pat Benchik
Cc: 'Brenda Benage'
Subject: UPC Observation/Stabilization Recommended Licensure Language

Good Afternoon,

Attached is my analysis and recommendations related to the impact of the currently proposed licensure language for observation/stabilization services.

I cannot emphasize enough the adverse impact this will have on our crisis system if the language is not modified.

Sincerely,

Justin Chase, LMSW, CPHQ, CSSGB
Senior Director of Adult Clinical Care
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Observation/Stabilization Licensure Concerns & Recommendations

Overview:

GSA 6 has five (5) facilities that are currently licensed to provide crisis stabilization/observation services, meaning they have a Level I Sub-Acute License (pursuant to R9-20-506), a Crisis Services Supplement (pursuant to R9-20-503) as well as a designated area for stabilization/observation services. These facilities are: Urgent Psychiatric Care Center (UPC); Recovery Response Center-West (RRC-W); Central City Detox (CCARC); East Valley Detox (EVARC); and the Banner Psychiatric Center (BPC). In addition, the UPC and RRC-W are the only Pre-Petition Screening (R9-20-801) facilities serving GSA 6. All five (5) of these facilities function as psychiatric and substance abuse emergency rooms for our recipients as an alternative to acute care emergency rooms and unnecessary incarcerations.

Magellan supports the shift of stabilization/observation services from an inpatient setting to an outpatient setting as written into the current draft rules (ver. April 2013). This shift aligns stabilization/observation services with emergency room services, which are classified as an outpatient services under CMS. By classifying stabilization/observation as an outpatient service it provides far more flexibility in where and how crisis services are administered as well as expanding the opportunities to encounter for services rendered that currently do not receive encounter value under an inpatient classification.

Magellan greatly opposes the establishment of creating licensed capacity for each stabilization/observation unit as written into the current draft rules (ver. April 2013)

Issue:

Currently, each stabilization/observation unit has a capacity management plan that is designed to ensure that walk-in crises and police drop offs will never be turned away. To achieve this, once a facility reaches roughly 85% of capacity the facility goes on 'Hospital Hold,' which means that any referrals (voluntary or involuntary) coming from a hospital will not be admitted until capacity is freed up. This is justified as a hospital, under EMTALA (42 CFR 489), is considered a safe environment and has resources available to reasonably manage behavioral health conditions on an interim basis. This process is critical for maintaining the confidence of law enforcement, 1st responders, stakeholders, recipients and family members as they know that if they are in need of care 24/7 we will accept and treat them, returning them safely to the community as quickly as possible with a host of quality resources. Due to the extensive demands currently on the behavioral health system, we frequently exceed the target capacity, which is managed through adjusting staffing patterns to accommodate the needs of the recipients currently receiving services.

By establishing a hard capacity cap on each stabilization/observation unit creates a significant risk for the RBHA, managing provider and community members at large. Under this proposed language many of our facilities will be forced to reduce their current target capacity as well as close the doors to ANY admission once this capacity is reached. This is especially troubling for our pre-petition screening facilities (UPC and RRC-W) who will be forced to turn away emergent petitions. This will result in a crumbling of the crisis system as a whole over a short period of time.

Recommendations:

Magellan believes strongly that the stabilization/observation services should function as an Emergency Department for psychiatric, substance use and co-morbid conditions. Emergency Department capacity management is universally driven by constantly monitoring and shifting staffing patterns to handle the fluctuations in occupancy and acuity as long as the total occupancy at any given time remains below the capacity limits of the space identified by the local fire marshal.

Magellan recommends that any future facility construction should make every effort to provide spacing to meet the requirements identified in the current draft rules: *"Each observation chair has at least three feet of clear floor space (1) On at least two sides of the observation chair, and (2) Between the observation chair and any other observation chair."* These guidelines should be written into contracts or policy manuals, but not into licensure as there are very few opportunities to modify licensure rules based on new standards, recommendations or best practices that may emerge between periods of licensure rule edits.

Existing Licensure Language	Current Language in Draft Rules	Recommended Changes to Draft Rules
<p>R9-20-101 Definitions</p> <p>37. "Crisis services" means immediate and unscheduled behavioral health services provided:</p> <ul style="list-style-type: none"> a. In response to an individual's behavioral health issue to prevent imminent harm or to stabilize or resolve an acute behavioral health issue; and b. At a Level 1 psychiatric acute hospital or a Level 1 sub-acute agency. 	<p>R9-10-101. Definitions</p> <p>"Behavioral health observation/stabilization services" means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:</p> <ul style="list-style-type: none"> a. Requires nursing services, b. May require medical services, and c. May be a danger to others as defined in A.R.S. § 36-501 or a danger to self as defined in A.R.S. § 36-501 	<p>R9-10-101. Definitions</p> <p>"Behavioral health observation/stabilization services" means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:</p> <ul style="list-style-type: none"> a. Requires nursing services, b. May require medical services, and c. May be a danger to others as defined in A.R.S. § 36-501 or a danger to self as defined in A.R.S. § 36-501
<p>R9-20 Article 5: Inpatient Treatment Program Requirements</p> <p>R9-20-503. Supplemental Requirements for Crisis Services</p> <p>A A licensee of an agency that provides crisis services shall ensure that:</p> <ul style="list-style-type: none"> 1. Policies and procedures are developed, implemented, and complied with for providing crisis services and ensuring that a staff member providing crisis services has skills and knowledge in providing crisis services; and 2. Crisis services are available at all times. <p>B A licensee of an agency that provides crisis services shall ensure that:</p> <ul style="list-style-type: none"> 1. A psychiatrist or a physician with behavioral health work experience is present at the facility or on-call at all times; 2. A registered nurse is present at the facility at all times; and 3. A staff member who provides crisis services has skills and knowledge in providing crisis services that are verified according to R9-20-204(F)(2) and documented according to R9-20-204(G)(1) through (4) <p>C A licensee of an agency that provides crisis services shall ensure that:</p> <ul style="list-style-type: none"> 1. An individual who arrives at the agency and is in need of immediate medical services is examined by a physician or a registered nurse as soon as possible and is admitted to the agency or transferred to an entity capable of meeting the individual's immediate medical needs; 2. Within 24 hours after an individual has arrived at the agency, a physician determines whether the individual will be: <ul style="list-style-type: none"> a. Admitted to the agency for treatment, b. Transferred to another entity capable of meeting the individual's needs, or c. Provided a referral to another entity capable of meeting the individual's needs; and 	<p>R9-10 Article 10: Outpatient Treatment Centers</p> <p>R9-10-1018. Behavioral Health Observation/Stabilization Services</p> <p>A An administrator of an outpatient treatment center that provides behavioral health observation/stabilization services shall ensure that:</p> <ul style="list-style-type: none"> 1. Ensure that observation/stabilization services are available 24 hours a day, every calendar day; 2. Behavioral health observation/stabilization services are provided in a designated area that: <ul style="list-style-type: none"> a. Is used exclusively for behavioral health observation/stabilization services; and b. For every 15 observation chairs or less, has one bathroom that contains: <ul style="list-style-type: none"> i. A working sink with running water, ii. A working toilet that flushes and has a seat, iii. Toilet tissue, iv. Soap for hand washing, v. Paper towels or a mechanical air hand dryer, vi. Lighting, and vii. A means of ventilation; 3. If the outpatient treatment center is authorized to provide behavioral health observation/stabilization services to individuals under 18 years of age: <ul style="list-style-type: none"> a. There is a separate designated area for providing behavioral health observation/stabilization services to individuals under 18 years of age that: <ul style="list-style-type: none"> i. Meets the requirements in subsection (B)(2), and ii. Has floor to ceiling walls that separate the designated area from other areas of the outpatient treatment center; b. A registered nurse is present in the separate designated area; and c. A patient under 18 years of age does not share any space, participate in any activity or treatment, or have verbal or visual interaction with a patient 	<p>R9-10 Article 10: Outpatient Treatment Centers</p> <p>R9-10-1018. Behavioral Health Observation/Stabilization Services</p> <p>A An administrator of an outpatient treatment center that provides behavioral health observation/stabilization services shall ensure that:</p> <ul style="list-style-type: none"> 1. Ensure that observation/stabilization services are available 24 hours a day, every calendar day; 2. Behavioral health observation/stabilization services are provided in a designated area that: <ul style="list-style-type: none"> a. Is used exclusively for behavioral health observation/stabilization services; and b. For every 15 occupants or less, has one bathroom that contains: <ul style="list-style-type: none"> i. A working sink with running water, ii. A working toilet that flushes and has a seat, iii. Toilet tissue, iv. Soap for hand washing, v. Paper towels or a mechanical air hand dryer, vi. Lighting, and vii. A means of ventilation; 3. If the outpatient treatment center is authorized to provide behavioral health observation/stabilization services to individuals under 18 years of age: <ul style="list-style-type: none"> a. There is a separate designated area for providing behavioral health observation/stabilization services to individuals under 18 years of age that: <ul style="list-style-type: none"> i. Meets the requirements in subsection (B)(2), and ii. Has floor to ceiling walls that separate the designated area from other areas of the outpatient treatment center; b. A registered nurse is present in the separate designated area; and c. A patient under 18 years of age does not share any space, participate in any activity or treatment, or have verbal or visual interaction with a patient

- 3. A client who, in the judgment of a physician or registered nurse, does not need immediate medical services receives:
 - a. An assessment and treatment plan, according to R9-20-209; and
 - b. The treatment identified in the individual's treatment plan.

- 18 years of age or older;
- 4 A medical practitioner is available;
- 5. If the medical practitioner present at the outpatient treatment center is a registered nurse practitioner or a physician assistant, a physician is on-call;
- 6. A registered nurse is present and provides direction for behavioral health observation/stabilization services in the designated area;
- 7 A nurse monitors each individual at the intervals determined according to subsection (B)(18) and documents the monitoring in the individual's medical record;
- 8 An individual who arrives at the designated area for behavioral health observation/stabilization services in the outpatient treatment center is screened within 30 minutes after entering the designated area to determine whether the individual is in need of immediate physical health services;
- 9. If a screening indicates that an individual needs immediate physical health services that the outpatient treatment center is:
 - a. Able to provide according to the outpatient treatment center's scope of services, the individual is examined by a medical practitioner within 30 minutes after being screened; or
 - b. Not able to provide, the individual is transferred to a health care institution capable of meeting the individual's immediate physical health needs;
- 10. An individual admitted for behavioral health observation/stabilization services is provided an observation chair;
- 11. If an observation chair is not available for an individual's use, the individual is not admitted for behavioral health observation/stabilization services;
- 12 If an individual is not admitted for behavioral health observation/stabilization services because there is not an observation chair available for the individual's use, a personnel member provides support to the individual to access the services or resources necessary for the individual's health and safety which may include:
 - a. Admitting the individual to the outpatient treatment center to provide behavioral health services other than behavioral health observation/stabilization services;
 - b. Establishing a method to notify the individual when there is an observation chair available;
 - c Referring or providing transportation to the individual to another health care institution;
 - d Assisting the individual to contact the individual's support system; and
 - e. If the individual is enrolled with a Regional Behavioral Health Authority,

- 18 years of age or older;
- 4. A medical practitioner is available;
- 5. If the medical practitioner present at the outpatient treatment center is a registered nurse practitioner or a physician assistant, a physician is on-call;
- 6 A registered nurse is present and provides direction for behavioral health observation/stabilization services in the designated area;
- 7 A nurse monitors each individual at the intervals determined according to subsection (B)(18) and documents the monitoring in the individual's medical record;
- 8. An individual who arrives at the designated area for behavioral health observation/stabilization services in the outpatient treatment center is screened within 30 minutes after entering the designated area to determine whether the individual is in need of immediate physical health services;
- 9. If a screening indicates that an individual needs immediate physical health services that the outpatient treatment center is:
 - a. Able to provide according to the outpatient treatment center's scope of services, the individual is examined by a medical practitioner within 30 minutes after being screened; or
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 - b. Establishing a method to notify the individual when there is an observation chair available;
 - c Referring or providing transportation to the individual to another health care institution;
 - d. Assisting the individual to contact the individual's support system; and
 - e. If the individual is enrolled with a Regional Behavioral Health Authority,

contacting the appropriate person to request assistance for the individual;

13. Personnel members establish a log of individuals who were not admitted because there was not an observation chair available and document the individual's name, actions taken to provide support to the individual to access the services or resources necessary for the individual's health and safety, and date and time the actions were taken;

14. The log required in subsection (B)(13) is maintained for one year after the date of documentation;

15. Each observation chair:

- a. Has at least three feet of clear floor space;
- i. On at least two sides of the observation chair, and
- ii. Between the observation chair and any other observation chair; and
- b. Is visible to a personnel member;

16. A patient is not admitted for behavioral health observation/stabilization services for longer than 23 hours and 59 minutes;

17. Within 24 hours after a patient is admitted for behavioral health observation/stabilization services, a medical practitioner determines whether the patient will be:

- a. If the behavioral health observation/stabilization services are provided in health care institution that also provided inpatient services and is capable of meeting the individual's needs, admitted to the health care institution as an inpatient;
- b. Transferred to another health care institution capable of meeting the individual's needs,
- c. Provided a referral to another entity capable of meeting the individual's needs; or
- d. Discharged and provided patient follow-up instructions;

18. When an individual is admitted to a designated area for behavioral health observation/stabilization services, an assessment of the individual includes the interval for monitoring the individual based on the individual's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the individual;

19. If an individual is not being admitted as an inpatient to a health care institution, before discharging the individual from a designated area for behavioral health observation/stabilization services, a personnel member:

- a. Identifies the specific needs of the individual after discharge necessary to assist the individual to function independently;
- b. Identifies any resources including family members, community social services, peer support services, and Regional Behavioral Health Agency staff that may be available to assist the individual; and

contacting the appropriate person to request assistance for the individual;

13. Personnel members establish a log of individuals who were not admitted because there was not an observation chair available and document the individual's name, actions taken to provide support to the individual to access the services or resources necessary for the individual's health and safety, and date and time the actions were taken;

14. The log required in subsection (B)(13) is maintained for one year after the date of documentation;

15. Each occupant:

- a. Is visible to a personnel member; and
- b. Has the opportunity to stand up, sit down, lay down and move freely throughout the designated area (except during periods of seclusion and/or restraint);

16. A patient is not admitted for behavioral health observation/stabilization services for longer than 23 hours and 59 minutes;

17. Within 24 hours after a patient is admitted for behavioral health observation/stabilization services, a medical practitioner determines whether the patient will be:

- a. If the behavioral health observation/stabilization services are provided in health care institution that also provided inpatient services and is capable of meeting the individual's needs, admitted to the health care institution as an inpatient;
- b. Transferred to another health care institution capable of meeting the individual's needs,
- c. Provided a referral to another entity capable of meeting the individual's needs; or
- d. Discharged and provided patient follow-up instructions;

18. When an individual is admitted to a designated area for behavioral health observation/stabilization services, an assessment of the individual includes the interval for monitoring the individual based on the individual's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the individual;

19. If an individual is not being admitted as an inpatient to a health care institution, before discharging the individual from a designated area for behavioral health observation/stabilization services, a personnel member:

- a. Identifies the specific needs of the individual after discharge necessary to assist the individual to function independently;
- b. Identifies any resources including family members, community social services, peer support services, and Regional Behavioral Health Agency staff that may be available to assist the individual; and

	<p>c. Documents the information in subsection (B)(19)(a) and the resources in subsection (B)(19)(b) in the individual's medical record;</p> <p>20. When an individual is discharged from a designated area for behavioral health observation/stabilization services a personnel member:</p> <ul style="list-style-type: none">a. Provides the individual with discharge information that includes:<ul style="list-style-type: none">i. The identified specific needs of the individual after discharge, andii. Resources that may be available for the individual; andb. Contacts any resources identified as required in subsection (B)(19)(b); <p>21. Except as provided in subsection (B)(22), an individual is not re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the individual's discharge from designated area in the outpatient treatment center that provides behavioral health observation/stabilization services; and</p> <p>22. An individual may be re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the individual's discharge if:</p> <ul style="list-style-type: none">a. It is at least one hour since the time of the individual's discharge;b. A law enforcement officer accompanies the individual to the outpatient treatment center;c. Based on a screening of the individual, it is determined that re-admission for behavioral health observation/stabilization is necessary for the individual; andd. The name of the law enforcement officer and the reasons for the determination in subsection (B)(22)(c) are documented in the individual's medical record. <p>C. An administrator of an outpatient treatment center that provides behavioral health observation/stabilization services shall comply with the requirements for restraint and seclusion in R9-10-316.</p>	<p>c. Documents the information in subsection (B)(19)(a) and the resources in subsection (B)(19)(b) in the individual's medical record;</p> <p>20. When an individual is discharged from a designated area for behavioral health observation/stabilization services a personnel member:</p> <ul style="list-style-type: none">a. Provides the individual with discharge information that includes:<ul style="list-style-type: none">i. The identified specific needs of the individual after discharge, andii. Resources that may be available for the individual; andb. Contacts any resources identified as required in subsection (B)(19)(b); <p>21. Except as provided in subsection (B)(22), an individual is not re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the individual's discharge from designated area in the outpatient treatment center that provides behavioral health observation/stabilization services; and</p> <p>22. An individual may be re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the individual's discharge if:</p> <ul style="list-style-type: none">a. It is at least one hour since the time of the individual's discharge;b. A law enforcement officer accompanies the individual to the outpatient treatment center;c. Based on a screening of the individual, it is determined that re-admission for behavioral health observation/stabilization is necessary for the individual; andd. The name of the law enforcement officer and the reasons for the determination in subsection (B)(22)(c) are documented in the individual's medical record. <p>C. An administrator of an outpatient treatment center that provides behavioral health observation/stabilization services shall comply with the requirements for restraint and seclusion in R9-10-316.</p>
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CHAPTER 10 – ARTICLE 10

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 68 99 84 80**Response Started:** Sunday, May 5, 2013 7:55:17 PM**Response Modified:** Sunday, May 5, 2013 8:25:40 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 section.

2. How can the draft rules be improved?

Rights R9-10-1008 covers individual rights but it fails to under A.2 make a reference to sharing SMI rights and specifically R9-21-101, et seq. with individuals who are identified as SMI. This section also omits a significant number of rights that is contained in the current licensure rules – which should not be omitted. We are shocked to see that subsection B 1.a permits the "intentional infliction of physical, mental or emotional pain" that is related to the "patient's condition." How can this be? We strongly support removal of the qualifier about relation to the individual's condition. We also strongly suggest that a section noting the word "abuse" is also inserted – as that would cover instances of negligence that would not fall under "intentional." In the same subsection under f & g, we note concern that the term "sexual abuse" is used and then two references to Arizona criminal law are made – is this sufficient to cover such, as not all acts may fall under a criminal definition yet still should be prohibited. Subsection C (& D) addresses when a person's activity (rights in B 2) can be limited under certain circumstances. This could be clarified and more individual rights-focused by adding a subsection 3 that notes that individual must be informed about what needs to occur to have the restriction lifted, a subsection 4 that specifies that a timeframe for review of the restriction must be set and changing the existing #3 to #5. Medical Records Subsection C of R9-10-1009 should note a requirement that when a resident has a representative, proof of the legal authority of the representative must also be stored in the records. This makes it clear who holds the power to give consent and also supports appropriate communication with the representative.

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

The rules are missing a reference to the SMI regulations – R9-21-101 et seq. The current rules contain such a reference which is essential to ensure facilities are reminded of and abide by the additional requirements in the SMI rules. R9-10-1010 covers medication services but no reference is made for the center to coordinate medication/knowledge of current medication prescribed by any other inpatient provider already in place and/or primary care provider or other provider who has prescribed medication to the individual. This addition would be beneficial to individuals to ensure stronger coordination of care with respect to prescribed medications. R9-10-1018 needs to have the discharge requirements for crisis stabilization provided at an outpatient center strengthened to include coordination with any case management provider already involved with the individual and ensuring a safe "discharge" – that is, the person should not simply be discharged to the street. This clarification will ensure all legal, ethical and clinical obligations are better met while also serving the individual more seamlessly on an outpatient basis.

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 71 223 19 154**Response Started:** Sunday, May 5, 2013 7:40:30 PM**Response Modified:** Sunday, May 5, 2013 7:59:39 PM**1. What parts of the draft rules do you believe are effective?**

Thank you for your work on the rules, some suggestions from the Arizona Hospital and Healthcare Association below

2. How can the draft rules be improved?

R9-10-1003 (E) - please rewrite so it is more clear Suggested language: If it is alleged or suspected that an OTC's patient has been abused, neglected, or exploited, an administrator shall: R9-10-1003 (E) (5) - please change the reporting requirement to within 5 working days rather than 48 hours Thank you for looking into Transfer; Transport R9-10-1008 (C) - please remove "source of payment" Patients can be denied treatment based on insurance status R9-10-1009 (A)(3) - outpatient orders do not include the time R9-10-1010 (A) (1)(e) - what does this mean? how do you assist a patient in obtaining medication? Please clarify or remove

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

No

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 206 213 209 31**Response Started:** Friday, May 3, 2013 10:46:07 PM**Response Modified:** Friday, May 3, 2013 10:50:04 PM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

We have significant concerns regarding licensure changes that impact Outpatient Facilities. The first concern relates to the space requirement for observation chairs. This concern has also been echoed by the community, including those voiced by first responders. The proposed changes to the space requirement will decrease providers' patient capacity. Providers will be challenged to meet the community's needs. Individuals will end up being sent to local emergency rooms, jails and other inappropriate settings. The decrease in capacity will also increase monetary costs to providers, especially the higher cost settings such as the emergency department, which runs counter to the stated goals of HB2634. Our second concern regards the requirement that "If an observation chair is not available for an individual's use, the individual is not admitted for behavioral health observation/stabilization services." This rule can have a substantial impact on the community and the ability of facilities to be flexible in meeting the community's needs. If in place, this rule will significantly impact first responders, particularly law enforcement. If an observation chair is not available at the time a first responder brings an individual to the facility, this rule will cause the first responder to have to take the individual to another facility or setting, such as an emergency room, creating undue burden on the first responder and, more important, the individual. The long term effect of turning away first responders such as the police will result in a change in behavior of these responders making the emergency room the first "stop" for these individuals. This may result in a more costly solution to solve the issue of square feet for individuals. Furthermore, we ask that one define why this additional one foot perimeter would increase "safety" for individuals. We suggest that additional options be reviewed and the rule be amended, for example, to allow individuals to be held in a triage area at the facility and have their level of care needs further assessed.

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

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[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 204.193.81.15**Response Started:** Friday, May 3, 2013 3:00:38 PM**Response Modified:** Friday, May 3, 2013 3:03:16 PM**1. What parts of the draft rules do you believe are effective?**

Magellan supports the shift of stabilization/observation services from an inpatient setting to an outpatient setting as written into the current draft rules (ver April 2013). This shift aligns stabilization/observation services with emergency room services, which are classified as an outpatient services under CMS. By classifying stabilization/observation as an outpatient service it provides far more flexibility in where and how crisis services are administered as well as expanding the opportunities to encounter for services rendered that currently do not receive encounter value under an inpatient classification.

2. How can the draft rules be improved?

However, Magellan greatly opposes the establishment of licensed capacity as provided for in the proposed rule, R9-10-1018 paragraph 15. This proposed rule requires each observation chair to have at least three feet of clear floor space on at least two sides and between observation chairs. This rule fails to account for the acuity of the recipients and the resulting staffing levels. Both the acuity and staffing requirements vary widely. Each stabilization/observation unit has a capacity management plan that is designed to ensure that walk-in crises and police drop offs will never be turned away. This process is critical for maintaining the confidence of law enforcement, first responders, stakeholders, recipients and family members, as they know that if they are in need of care at anytime, we will accept and treat them, returning them safely to the community as quickly as possible with a host of quality resources. To achieve this, once a facility reaches roughly 85% of capacity the facility goes on 'Hospital Hold,' which means that any referrals (voluntary or involuntary) coming from a hospital will not be admitted until capacity is freed up. Due to the extensive demands currently on the behavioral health system, we frequently exceed the target capacity, which is managed through adjusting staffing patterns to accommodate the needs of the recipients currently receiving service. Under the proposed rule, many facilities will be forced to reduce their capacity and may turn away emergent petitions. We recommend this capacity rule not be adopted and any capacity rule for stabilization/observation facilities be based on needs of the recipients and the resulting staffing requirements.

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

See above

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[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 204 193 81 15**Response Started:** Friday, May 3, 2013 3:00:38 PM**Response Modified:** Friday, May 3, 2013 3:03:16 PM**1. What parts of the draft rules do you believe are effective?**

Magellan supports the shift of stabilization/observation services from an inpatient setting to an outpatient setting as written into the current draft rules (ver April 2013) This shift aligns stabilization/observation services with emergency room services, which are classified as an outpatient services under CMS By classifying stabilization/observation as an outpatient service it provides far more flexibility in where and how crisis services are administered as well as expanding the opportunities to encounter for services rendered that currently do not receive encounter value under an inpatient classification

2. How can the draft rules be improved?

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

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[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 11:33:49 AM**Response Modified:** Friday, May 3, 2013 11:58:24 AM**1. What parts of the draft rules do you believe are effective?**No Response

2. How can the draft rules be improved?

R9-10-1007.A 2 b - Verification of skills and knowledge at least every 12 months This section of the rule seems to be procedural overkill as staff are required to receive orientation and complete a verification of skills and knowledge initially, monthly supervision/clinical oversight is conducted, annual training requirements must be met and an annual performance evaluation is required The current requirements appear to adequately address this issue.

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

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 174 17 251 189

Response Started: Wednesday, May 1 2013 1:29:29 PM

Response Modified: Wednesday May 1 2013 1:33:33 PM

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

No Response

2. How can the draft rules be improved?

Clarify "Administrator" role for private Outpatient clinic, For-profit or Non-profit Administrator or Ownership qualifications are fuzzy as well Current language is seeming to mostly address hospital-related clinics

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 68 14 245 150

Response Started: Wednesday May 1, 2013 1:13:06 PM

Response Modified: Wednesday May 1, 2013 1:13:49 PM

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

No Response

2. How can the draft rules be improved?

• Section 10-1003 E - Please provide clarification on whether abuse or neglect needing to be investigated applies to accusations against staff members, reports by clients regarding abuse by others (guardians etc), or both—while HCI s would certainly want to investigate allegations against staff to ensure that appropriate administrative actions are taken, law enforcement and protection agencies often request that investigation be left to them and the current wording would likely lead to HCI's completing investigations outside of those processes. Please also provide clarification as to what format is required in the report to the department, and again, does this apply only to allegations against HCI staff or against anyone (guardians, etc)—is the department's intent to be notified of all abuse suspected or alleged that comes to the attention of a HCI, or only that which involves HCI staff/volunteers/etc • Sections 10-1009 C 13 and section 10-1003 D 6 a and b - please provide clarification on how "follow-up instructions" apply to behavioral health services? Particularly after each assessment, family meeting, counseling service, group etc? How does this apply when services happen in the community, as many behavioral health agencies provide community-based services rather than in-office? Some combination of behavioral health services occur over several hours with community-based services • Assessment needs to be more clearly defined. In behavioral health assessment means something different than in the medical field. Also, for routine assessment not connected to crisis or discharge, requiring BHP review within 72 hours may present administrative challenges • Clinical supervision and clinical oversight needs to be more clearly defined and differences between distinguished. In behavioral health, the expectation that weekly supervision/oversight be documented may present administrative challenges

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 70 58 127 254

Response Started: Thursday, April 25, 2013 12:23:43 PM

Response Modified: Thursday, April 25, 2013 12:25:23 PM

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

2. How can the draft rules be improved?

In response to R9-10-1018 Outpatient Observation/Stabilization rules. The use of the word "chair" implies that this is the only level of assignment that can occur. This does not allow a facility to use beds, which would offer more comfort and support for the person in services. If an individual requires a more comfortable place to rest, and a bed is available, as long as this bed is properly monitored this option should exist for facilities. In essence those facilities that would prefer to offer something above and beyond a 'chair' should not be penalized for doing so. Suggest looser language such as: "Chair and/or Bed." This type of language offers more choice to the person in services and gives facilities more options for individuals who may need a more comfortable place to rest. Given the goal of this process is to allow for appropriate/safe observation and to provide an opportunity for early resolution of the issues that brought the individual to that facility in the first place it would follow that offering the necessary opportunity for an individual to sleep (a therapeutic intervention) is reasonable and prudent.

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

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 8.17.179.226**Response Started:** Friday, April 19, 2013 9:46:46 AM**Response Modified:** Friday, April 19, 2013 10:38:54 AM**1. What parts of the draft rules do you believe are effective?****No Response****2. How can the draft rules be improved?**

R9-10-1017 Regarding H&P This should be aligned with the Medicare guidelines which requires an annual H&P For patients visiting Arizona obtaining an H&P prior to travel may not be possible if the patient is traveling for an emergency The visit may be only one time over a weekend Given current information from the home clinic and reviewed by a nephrologist who would then provide the prescription for dialysis should be appropriate The local nephrologist can contact the home nephrologist if there are any concerns. Assessment and Care planning process should follow the Medicare requirement (V494.80 & V494.90 V501, V502) in which the patient is assessed and a plan of care developed by the Interdisciplinary team(IDT) within 30 days (or 13 treatments) of admission and reevaluated 90 days later and then annually. (this would be what the state regulations is calling "long term care plan" A term that is no longer appropriate.) Since the Medicare rules effectively require a monthly review that the plan of care is still appropriate, the state requirement for a 6 month plan of care is redundant and administratively burdensome. Also it conflicts with section G and H as the Nutrition and Psychosocial assessment be conducted annually AND as it reads in R9-10-1017 J 10 would it be appropriate to simply write a note on the Plan of Care that is was "reviewed and remains in effect" and signed by members of the IDT? The requirement for the administrator specifically have dialysis experience is unnecessary They should have 12 months of health care experience A time frame must be included for the Department to review and respond to requests for modifications to outpatient treatment centers A response within 60 days of submission and a final approval within 120 days of original submission date should provide the Department with sufficient time to review and request modifications to a plan

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

Special circumstances should apply for transient/visitors of less than 30 days H&P within the last year as well as the patients effective plan of care, Current treatment plan to be reviewed by a local nephrologist who will then provide the prescription for the patient treatment in Arizona

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

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

I read somewhere about a proposed limit of 20 persons in group therapy. Someone has not thought that rule all the way through. That is fine number for adults -- 10 clients and 10 significant others-- but it is definitely not in line with the reality for adolescent group therapy. Teens, remember, have 2 parents (sometimes more actually, with stepparents), and providers can never and should never be forced to say "well mom you can't come to therapy because dad is coming." In other words, the rule should read 20 max group members for adult groups (up to 10 clients and 10 significant others) and 30 for adolescent group (10 clients and up to 2 parents for each adolescent). Gotta gotta gotta gotta include both mom and dad -- Dr. Walling, ASAP

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 12 23 250 195

Response Started: Wednesday April 17 2013 4:45:35 PM

Response Modified: Wednesday April 17 2013 4:52:01 PM

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

The new outpatient facility rules are very well written. In the past, numerous unclassified facilities were operating throughout Arizona and there have been a lot of safety issues because many of them do not feel they have to develop or update policies monitor clinical competencies, address infection control and risk issues and for the most part the new rules will force all outpatient facilities to adhere to safer practice

2. How can the draft rules be improved?

Will any of the older outpatient treatment centers be allowed to practice under the old unclassified rules, or will notification be sent out that all these facilities have to adhere to Title 9, Chapter 10, Article 10 [the new rules] for any entities that are providing outpatient services--to include behavioral health [especially in the event they are also providing medication management]

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 72 244 150 58

Response Started: Wednesday April 17 2013 4:40:38 PM

Response Modified: Wednesday April 17 2013 4:45:02 PM

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

Very little of thi is needed for Urgent Care Centers As we have maintained since licensing went into effect to include Urgent Care Centers-we function exactly the same as physician offices but do not require appointments All of these rules add substantially to the cost of doing business We are reimbursed the same or less than primary care offices and are at a financial disadvantage due to these rules As there are so many primary care practices and specialists offices doing much more invasive procedures with no rules to follow-patient safety is not enhanced by these rules imposed on Urgent Care provicers

2. How can the draft rules be improved?

Eliminate the beauracracic nature of these rules Administrators will spend countless useless hours putting together manuals that have no benefit to the patients being treated in Urgent Care Centers Unless all licensed practitioners follow these rules in their private practices this is a costly and discriminatory practice that has no benefit to patient care

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

No

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 74 118 0 2

Response Started: Monday, April 15, 2013 10:00:49 AM

Response Modified: Monday, April 15, 2013 10:04:17 AM

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

Thank you for making supervision/clinical oversight reasonable rather than the required hour Managers had no time to manage for supervision time when it wasn't really needed Same with now allowing group supervision Clients can't get services while two staff are doing supervision.

2. How can the draft rules be improved?

Really need to clarify in EASY TO UNDERSTAND ENGLISH the gottas and gotchas around the different levels of licensure, independent, associate, non-licensed very confusingly written as is

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

Clarify in EASY TO UNDERSTAND ENGLISH whether or not an associates level licensed person can be a clinical director with supervision by an independently licensed person - like the current regs . or are you saying that can't happen under the new regs
