Arkansas Department of Human Services

Behavioral Health Agency Certification Manual

Revised: 7/1/17

www.arkansas.gov/dhs/dhs

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I. PURPOSE:

A. To assure that Outpatient Behavioral Health Services ("OBHS") care and services provided by certified Behavioral Health Agencies comply with applicable laws, which require, among other things, that all care reimbursed by the Arkansas Medical Assistance Program ("Medicaid") must be provided efficiently, economically, only when medically necessary, and is of a quality that meets professionally recognized standards of health care.

B. The requirements and obligations imposed by §§ I-XIII of this rule are substantive, not procedural.

II. SCOPE:

A. Current Behavioral Health Agency certification under this policy is a condition of Medicaid provider enrollment.

B. Department of Human Services ("DHS") Behavioral Health Agency certification must be obtained for each site before application for Medicaid provider enrollment. An applicant may submit one application for multiple sites, but DHS will review each site separately and take separate certification action for each site.

III. DEFINITIONS:

A. "50 mile radius" means 50 miles from a certified site by driving distance. Driving distance is calculated by a method of utilizing a standardized mapping application.

B. "Accreditation" means full accreditation (preliminary, expedited, probationary, pending, conditional, deferred or provisional accreditations will not be accepted) as an outpatient behavioral health care provider issued by at least one of the following:

- Commission on Accreditation for Rehabilitative Facilities (CARF) Behavioral Health Standards Manual
- The Joint Commission (TJC) Comprehensive Accreditation Manual for Behavioral Health Care
- Council on Accreditation (COA) Outpatient Mental Health Services Manual

Accreditation timing for specific programs is defined in the applicable DHS Certification manual for that program.

C. "Adverse license action" means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

D. "Applicant" means an outpatient behavioral health care agency that is seeking DHS certification as a Behavioral Health Agency.

E. "Certification" means a written designation, issued by DHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

F. "Client" means any person for whom a Behavioral Health Agency furnishes, or has agreed or undertaken to furnish, Outpatient Behavioral Health services.

G. "Client Information System" means a comprehensive, integrated system of clinical, administrative, and financial records that provides information necessary and useful to deliver client services. Information may be maintained electronically, in hard copy, or both.

H. "Compliance" means conformance with:

1. Applicable state and federal laws, rules, and regulations including, without limitation:

   a. Titles XIX and XXI of the Social Security Act and implementing regulations;

   b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;

   c. All state laws and rules applicable to Medicaid generally and to Outpatient Behavioral Health services specifically;

   d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;

   e. The Americans With Disabilities Act, as amended, and implementing regulations;

   f. The Health Insurance Portability and Accountability Act ("HIPAA"), as amended and implementing regulations.

2. Accreditation standards and requirements.

I. "Contemporaneous" means by the end of the performing provider's first work period following the provision of care of services to be documented, or as provided in the Outpatient Behavioral Health Services manual, whichever is longer.

J. "Coordinated Management Plan" means a plan that the provider develops and carries out to assure compliance and quality improvement.

K. "Corrective Action Plan" (CAP) means a document that describes both short- term remedial steps to achieve compliance and permanent practices and procedures to sustain compliance.

L. "Covered Health Care Practitioner" means: Any practitioner providing Outpatient Behavioral Health Services that is allowable to be reimbursed pursuant to the Outpatient Behavioral Health Services Medicaid Manual.

M. "Cultural Competency" means the ability to communicate and interact effectively with people of different cultures, including people with disabilities and atypical lifestyles.

N. "Deficiency" means an item or area of noncompliance.

O. "DHS" means the Arkansas Department of Human Services.

P. "Emergency Behavioral Health Agency services" means nonscheduled Behavioral Health Agency services delivered under circumstances where a prudent layperson with an average knowledge of behavioral health care would reasonably believe that Behavioral Health Agency services are immediately necessary to prevent death or serious impairment of health.

Q. "Medical Director" means a physician that oversees the planning and delivery of all Behavioral Health Agency services delivered by the provider.

R. "Mental health professional" or "MHP" means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

S. "Mobile care" means a face-to-face intervention with the client at a place other than a certified site operated by the provider. Mobile care must be:

1. Either clinically indicated in an emergent situation or necessary for the client to have access to care in accordance with the care plan;

2. Delivered in a clinically appropriate setting; and

3. Delivered where Medicaid billing is permitted if delivered to a Medicaid eligible client.

Mobile care may include medically necessary behavioral health care provided in a school that is within a fifty (50) mile radius of a certified site operated by the provider.

T. "Multi-disciplinary team" means a group of professionals from different disciplines that provide comprehensive care through individual expertise and in consultation with one another to accomplish the client's clinical goals. Multi- disciplinary teams promote coordination between agencies; provide a "checks and balances" mechanism to ensure that the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals.

U. "NPDB" means the United States Department of Health and Human Services, Health Resources and Services Administration National Provider Data Bank.

V. "Performing provider" means the individual who personally delivers a care or service directly to a client.

W. "Professionally recognized standard of care" means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice models is evidence

of compliance with professionally recognized standards of care.

X. "Provider" means an entity that is certified by DHS and enrolled by DMS as a Behavioral Health Agency

Y. "Qualified Behavioral Health Provider" means a person who:

1. Does not possess an Arkansas license to provide clinical behavioral health care;

2. Works under the direct supervision of a mental health professional;

3. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned by a mental health professional;

4. Acknowledges in writing that all mental health paraprofessional services are controlled by client care plans and provided under the direct supervision of a mental health professional.

Z. "Quality assurance (QA) meeting" means a meeting held at least quarterly for systematic monitoring and evaluation of clinic services and compliance. See also, Medicaid Outpatient Behavioral Health Services Manual, § 212.000.

AA. "Reviewer" means a person employed or engaged by:

1. DHS or a division or office thereof;

2. An entity that contracts with DHS or a division or office thereof.

BB. "Site" means a distinct place of business dedicated to the delivery of Outpatient Behavioral Health Services within a fifty (50) mile radius. Each site must be a bona fide Behavioral Health Agency, meaning a behavioral health outpatient clinic providing all the services specified in this rule and the Medicaid Outpatient Behavioral Health Services Manual. Sites may not be adjuncts to a different activity such as a school, a day care facility, a long-term care facility, or the office or clinic of a physician or psychologist.

CC. "Site relocation" means closing an existing site and opening a new site no more than a fifty (50) mile radius from the original site.

DD. "Site transfer" means moving existing staff, program, and clients from one physical location to a second location that is no more than a fifty (50) mile radius from the original site.

EE. "Supervise" as used in this rule means to direct, inspect, observe, and evaluate performance.

FF. "Supervision documentation" means written records of the time, date, subject(s), and duration of supervisory contact maintained in the provider's official records.

IV. COMPLIANCE TIMELINE:

A. Entities currently certified as Rehabilitative Services for Persons with Mental Illness (RSPMI) providers will be grandfathered in as certified Behavioral Health Agencies. Current RSPMI agency recertification procedures are based upon national accreditation timelines. Behavioral Health Agency recertification will also be based upon national accreditation timelines.

B. All entities in operation as of the effective date of this rule must comply with this rule within forty-five (45) calendar days in order to maintain certification.

C. DHS may authorize temporary compliance exceptions for new accreditation standards that require independent site surveys and specific service subset accreditations. Such compliance exceptions expire at the end of the provider's accreditation cycle and may not be renewed or reauthorized.

V. APPLICATION FOR DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION:

A. New Behavioral Health Agency applicants must complete DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION Form 100, DHS BEHAVIORAL HEALTH AGENCY FORM 200, and DHS BEHAVIORAL HEALTH AGENCY Form 210

B. DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION Form 100, DHS BEHAVIORAL HEALTH AGENCY FORM 200, and DHS BEHAVIORAL HEALTH AGENCY Form 210 can be found at the following website: www.arkansas.gov/dhs/dhs

C. Applicants must submit the completed application forms and all required attachments for each proposed site to:

Department of Human Services
Division of Behavioral Health Services
Attn. Certification Office
305 S. Palm
Little Rock, AR 72205

D. Each applicant must be an outpatient behavioral health care agency:

1. Whose primary purpose is the delivery of a continuum of outpatient behavioral health services in a free standing independent clinic;

2. That is independent of any DHS certified Behavioral Health Agency.

E. Behavioral Health Agency certification is not transferable or assignable.

F. The privileges of a Behavioral Health Agency certification are limited to the certified site.

G. Providers may file Medicaid claims only for Outpatient Behavioral Health Services delivered by a performing provider engaged by the provider.

H. Applications must be made in the name used to identify the business entity to the Secretary of State and for tax purposes.

I. Applicants must maintain and document accreditation, and must prominently display certification of accreditation issued by the accrediting organization in a public area at each site. Accreditation must recognize and include all the applicant's Behavioral Health Agency programs, services, and sites.

1. Initial accreditation must include an on-site survey for each service site for which provider certification is requested. Accreditation documentation submitted to DHS must list all sites recognized and approved by the accrediting organization as the applicant's service sites.

2. Accreditation documentation must include the applicant's governance standards for operation and sufficiently define and describe all services or types of care (customer service units or service standards) the applicant intends to provide including, without limitation, crisis intervention/stabilization, in-home family counseling, outpatient treatment, day treatment, therapeutic foster care, intensive outpatient, medication management/pharmacotherapy.

3. Any outpatient behavioral health program associated with a hospital must have a free-standing behavioral health outpatient program national accreditation.

J. The applicant must attach the entity's family involvement policy to each application.

VI. APPLICATION REVIEW PROCESS:

A. Timeline:

1. DHS will review Behavioral Health Agency application forms and materials within ninety (90) calendar days after DHS receives a complete application package. (DHS will return incomplete applications to senders without review.)

2. For approved applications, a site survey will be scheduled within forty-five (45) calendar days of the approval date.

3. DHS will mail a survey report to the applicant within twenty-five (25) calendar days of the site visit. Providers having deficiencies on survey reports must submit an approvable corrective action plan to DHS within thirty-five (35) calendar days after the date of a survey report.

4. DHS will accept or reject each corrective action plan in writing within twenty (20) calendar days after receipt.

5. Within thirty (30) calendar days after DHS approves a corrective action plan, the applicant must document implementation of the plan and correction of the

deficiencies listed in the survey report. Applicants who are unable, despite the exercise of reasonable diligence, to correct deficiencies within the time permitted may obtain up to ten (10) additional days based on a showing of good cause.

6. DHS will furnish site-specific certificates via postal or electronic mail within ten (10) calendar days of issuing a site certification.

B. Survey Components: An outline of site survey components is available on the DHS website: www.arkansas.gov/dhs/dhs and is located in appendix # 7.

C. Determinations:

1. Application approved.

2. Application returned for additional information.

3. Application denied. DHS will state the reasons for denial in a written response to the applicant.

VII. DHS Access to Applicants/Providers:

A. DHS may contact applicants and providers at any time;

B. DHS may make unannounced visits to applicants/providers.

C. Applicants/providers shall provide DHS prompt direct access to applicant/provider documents and to applicant/provider staff and contractors, including, without limitation, clinicians, paraprofessionals, physicians, administrative, and support staff.

D. DHS reserves the right to ask any questions or request any additional information related to certification, accreditation, or both.

VIII. ADDITIONAL CERTIFICATION REQUIREMENTS:

A. Care and Services must:

1. Comply with all state and federal laws, rules, and regulations applicable to the furnishing of health care funded in whole or in part by federal funds; to all state laws and policies applicable to Arkansas Medicaid generally, and to Outpatient Behavioral Health Services specifically, and to all applicable Department of Human Services ("DHS") policies including, without limitation, DHS Participant Exclusion Policy § 1088.0.0. The Participant Exclusion Policy is available online at https://dhsshare.arkansas.gov/DHS%20Policies/Forms/By%20Policy.aspx

2. Conform to professionally recognized behavioral health rehabilitative treatment models.

3. Be established by contemporaneous documentation that is accurate and demonstrates compliance. Documentation will be deemed to be contemporaneous if recorded by the end of the performing provider's first work period following the provision of the care or services to be documented, or as provided in the Outpatient

Behavioral Health Services manual, § 252.110, whichever is longer.

B. Applicants and Behavioral Health Agencies must:

1. Be a legal entity in good standing;

2. Maintain all required business licenses;

3. Adopt a mission statement to establish goals and guide activities;

4. Maintain a current organizational chart that identifies administrative and clinical chains of command.

C. Applicants/providers must establish and comply with operating policy that at a minimum implements credible practices and standards for:

1. Compliance;

2. Cultural competence;

3. Provision of services, including referral services, for clients that are indigent, have no source of third party payment, or both, including:

a. Procedures to follow when a client is rejected for lack of a third-party payment source or when a client is discharged for nonpayment of care.

b. Coordinated referral plans for clients that the provider lacks the capacity to provide medically necessary Outpatient Behavioral Health Services. Coordinated referral plans must:

1) Identify in the client record the medically necessary Outpatient Behavioral Health Services that the provider cannot or will not furnish;

2) State the reason(s) in the client record that the provider cannot or will not furnish the care;

3) Provide quality-control processes that assure compliance with care, discharge, and transition plans.

IX. STAFFING REQUIREMENTS FOR CERTIFICATION

A. At a minimum, Behavioral Health Agency staffing shall be sufficient to establish and implement services for each Behavioral Health Agency client, and must include the following:

1. **Chief Executive Officer/Executive Director (or functional equivalent) (full-time position or full-time equivalent positions)**: The person or persons identified to carry out CEO/ED functions:

a. Is/are ultimately responsible for applicant/provider organization, staffing, policies and practices, and Behavioral Health Agency service delivery;

b. Must possess a master's degree in behavioral health care, management, or a related field and experience, and meet any additional qualifications required by the provider's governing body. Other job- related education, experience, or both, may be substituted for all or part of these requirements upon approval of the provider's governing body.

2. **Clinical Director (or functional equivalent) (full-time position or full-time equivalent positions)**: The person or persons identified to carry out clinical director functions must:

   a. Report directly to the CEO/ED;

   b. Be the DHS contact for clinical and practice-related issues;

   c. Be accountable for all clinical services (professional and paraprofessional);

   d. Be responsible for Behavioral Health Agency care and service quality and compliance;

   e. Assure that all services are provided within each practitioner's scope of practice under Arkansas law and under such supervision as required by law for practitioners not licensed to practice independently;

   f. Assure and document in the provider's official records the direct supervision of MHP's, either personally or through a documented chain of supervision.

   g. Assure that licensed mental health professionals directly supervise Qualified Behavioral Health Providers. Direct supervision ratios must not exceed one licensed mental health professional to ten (10) Qualified Behavioral Health Providers;

   h. Possess independent Behavioral Health licensure in Arkansas as a Licensed Psychologist, Licensed Certified Social Worker, (LCSW), Licensed Psychological Examiner – Independent (LPE-I), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), or an Advanced Practice Nurse or Clinical Nurse Specialist (APN or CNS) with a specialty in psychiatry or mental health and a minimum of two years clinical experience post master's degree.

3. **Mental Health Professionals (Independently Licensed Clinicians, Non-Independently Licensed Clinicians):**

   a. MHP's may:

      1) Provide direct behavioral health care;

      2) Delegate and oversee work assignments of Qualified Behavioral Health Provider's;

      3) Delegate and oversee work assignments of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support

Partners

4) Ensure compliance and conformity to the provider's policies and procedures;

5) Provide direct supervision of Qualified Behavioral Health Provider's;

6) Provider direct supervision of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support Partners

7) Provide case consultation and in-service training;

8) Observe and evaluate performance of Qualified Behavioral Health Provider's.

9) Observe and evaluate performance of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support Partners

b. MHP Supervision:

1) Communication between an MHP and the MHP's supervisor must include each of the following at least every twelve (12) months:

a) Assessment and referral skills, including the accuracy of assessments;

b) Appropriateness of treatment or service interventions in relation to the client needs;

c) Treatment/intervention effectiveness as reflected by the client meeting individual goals;

d) Issues of ethics, legal aspects of clinical practice, and professional standards;

e) The provision of feedback that enhances the skills of direct service personnel;

f) Clinical documentation issues identified through ongoing compliance review;

g) Cultural competency issues;

h) All areas noted as deficient or needing improvement.

2) Documented client-specific face-to-face and other necessary communication regarding client care must occur between each MHP's supervisor and the MHP periodically (no less than every ninety (90) calendar days) in accordance with a schedule maintained in the provider's official records.

4. **Qualified Behavioral Health Providers (Including Certified Peer Support Specialist, Certified Youth Support Specialist, Certified Family Support Partners):**

   a. Are MHP service extenders;

   b. Qualified Behavioral Health Provider supervision must conform to the requirements for MHP supervision (See § IX (3)(b)) except that all requirements must be met every six (6) months, and one or more licensed health care professional(s) acting within the scope of his or her practice must have a face-to-face contact with each Qualified Behavioral Health Provider for the purpose of clinical supervision at least every fourteen (14) days, must have at least twelve (12) such face-to-face contacts every ninety (90) days, and such additional face-to-face contacts as are necessary in response to a client's unscheduled care needs, response or lack of response to treatment, or change of condition;

   c. Providers must establish that Qualified Behavioral Health Provider supervision occurred via individualized written certifications created by a licensed mental health professional and filed in the provider's official records on a weekly basis, certifying:

      1) That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records) communicated individualized client-specific instructions to the mental health paraprofessional describing the manner and methods for the delivery of paraprofessional services;

      2) That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records, but no less than every 30 days) personally observed the mental health paraprofessional delivering services to a client; that the observations were of sufficient duration to declare whether paraprofessional services complied with the licensed mental health professional's instructions;

      3) The date, time, and duration of each supervisory communication with and observation of a mental health paraprofessional.

5. **Corporate Compliance Officer:**

   a. Manages policy, practice standards and compliance, except compliance that is the responsibility of the medical records librarian;

   b. Reports directly to the CEO/ED (except in circumstances where the compliance officer is required to report directly to a director, the board of directors, or an accrediting or oversight agency);

   c. Has no direct responsibility for billings or collections;

   d. Is the DHS and Medicaid contact for DHS certification, Medicaid enrollment, and

compliance.

6. **Medical Director:**

   a. Oversees Behavioral Health Agency care planning, coordination, and delivery, and specifically:

      1) Diagnoses, treats, and prescribes for behavioral illness;

      2) Is responsible and accountable for all client care, care planning, care coordination, and medication storage;

      3) Assures that physician care is available 24 hours a day, 7 days a week;

      4) May delegate client care to other physicians, subject to documented oversight and approval;

      5) Assures that a physician participates in treatment planning and reviews;

      6) If the medical director is not a psychiatrist, a psychiatrist certified by one of the specialties of the American Board of Medical Specialties must serve as a consultant to the medical director and to other staff, both medical and non-medical. If the provider serves clients under the age of twenty-one (21), the medical director shall have access to a board certified child psychiatrist, for example, through the Psychiatric Research Institute child/Adolescent Telephone Consultation Service;

      7) Medical director services may be acquired by contract.

   b. If the medical director is not a psychiatrist then the medical director shall contact a consulting psychiatrist within twenty-four (24) hours in the following situations:

      1) When antipsychotic or stimulant medications are used in dosages higher than recommended in guidelines published by the Arkansas Department of Human Services Division of Medical Services;

      2) When two (2) or more medications from the same pharmacological class are used;

      3) When there is significant clinical deterioration or crisis with enhanced risk of danger to self or others.

   c. The consulting psychiatrist(s) shall participate in quarterly quality assurance meetings.

7. **Privacy Officer:** Develops and implements policies to assure compliance with privacy laws, regulations, and rules. Applicants/providers may assign privacy responsibilities to the Corporate Compliance Officer, Grievance Officer, or Medical Records Librarian, but not the CEO/ED.

8. **Quality Control Manager:** Chairs the quality assurance committee and develops

and implements quality control and quality improvement activities. Applicants/providers may assign quality control manager responsibilities to the Corporate Compliance Officer or Medical Records Manager, but not the CEO/ED.

9. Grievance Officer:

a. Develops and implements the applicant's/provider's employee and client grievance procedures.

b. Effectively communicates grievance procedures to staff, contractors, prospective clients, and clients. Communications to clients who are legally incapacitated shall include communication to the client's responsible party.

c. The grievance officer shall not have any duties that may cause him/her to favor or disfavor any grievant.

10. Medical Records Librarian:

a. Must be qualified by education, training, and experience to understand and apply:

1) Medical and behavioral health terminology and usages covering the full range of services offered by the provider;

2) Medical records forms and formats;

3) Medical records classification systems and references such as The American Psychiatric Association's Diagnostic and Statistical Manual – IV-TR (DSM-IV-TR) and subsequent editions, International Classification of Diseases (ICD), Diagnostic Related Groups (DRG's), Physician's Desk Reference (PDR), Current Procedural Terminology (CPT), medical dictionaries, manuals, textbooks, and glossaries.

4) Legal and regulatory requirements of medical records to assure the record is acceptable as a legal document;

5) Laws and regulations on the confidentiality of medical records (Privacy Act and Freedom of Information Act) and the procedures for informed consent for release of information from the record.

6) The interrelationship of record services with the rest of the facility's services.

b. Develops and implements:

1) The client information system;

2) Operating methods and procedures covering all medical records functions.

3) Insures that the medical record is complete, accurate, and compliant.

11. Licensed Psychologist, Licensed Psychological Examiner (LPE), or Licensed Psychological Examiner – Independent (LPE-I):

a. Provides psychological evaluations;

b. Each licensed psychological examiner or licensed psychological examiner-I must have supervision agreements with a doctoral psychologist to provide appropriate supervision or services for any evaluations or procedures that are required under or are outside the psychological examiner's scope of independent practice. Documentation of such agreements and of all required supervision and other practice arrangements must be included in the psychological examiner's personnel record;

c. Services may be acquired by contract.

B. Multidisciplinary Team(s): Any client identified as Tier 2 by the independent assessment shall be assigned a multidisciplinary team that includes professionals and qualified behavioral health providers as necessary to ensure coordination of each client's Outpatient Behavioral Health Services. All Tier 2 clients require the development of a Master Treatment Plan with ongoing reviews at least every one-hundred and eighty (180) calendar days.

For clients not eligible for Rehabilitative (Tier 2) Level or Intensive (Tier 3) Level services, he services offered in the Counseling Level (Tier 1) are a limited array of counseling services provided by a master's level clinician. Establishment of goals and a plan to reach those goals is part of good clinical practice and can be developed with the client during the Mental Health Diagnostic Assessment and Interpretation of Diagnosis. Clinicians should assess client's response to treatment at each session which should include a review of progress towards mutually agreed upon goals.

C. Quality Assurance Meetings:

Each provider must hold a quarterly quality assurance meeting.

D. Health Care Professional Notification/Disqualification:

1. Notice of covered health care practitioners:

a. Within twenty (20) days of the effective date of this rule, applicants/providers must notify the Office of Medicaid Inspector General (OMIG) of the names of covered health care practitioners who are providing Outpatient Behavioral Health Services.

b. On or before the tenth day of each month, providers must notify the Office of Medicaid Inspector General (OMIG) of the names of all covered health care practitioners who are providing Outpatient Behavioral Health Services and whose names were not previously disclosed.

2. Licensed health care professionals may not furnish Outpatient Behavioral Health Services during any time the professional's license is subject to adverse license

action.

3. Applicants/providers may not employ/engage a covered health care practitioner after learning that the practitioner:

    a. Is excluded from Medicare, Medicaid, or both;

    b. Is debarred under Ark. Code Ann. § 19-11-245;

    c. Is excluded under DHS Policy 1088; or

    d. Was subject to a final determination that the provider failed to comply with professionally recognized standards of care, conduct, or both. For purposes of this subsection, "final determination" means a final court or administrative adjudication, or the result of an alternative dispute resolution process such as arbitration or mediation.

E. Applicants/providers must maintain documentation identifying the primary work location of all mental health professionals and qualified behavioral health providers providing services on behalf of the Behavioral Health Agency.

F. Providers must maintain copies of disclosure forms signed by the client, or by the client's parent or guardian before Outpatient Behavioral Health Services are delivered except in emergencies. Such forms must at a minimum:

1. Disclose that the services to be provided are Outpatient Behavioral Health Services;

2. Explain Outpatient Behavioral Health Services eligibility, SED and SMI criteria;

3. Contain a brief description of the Behavioral Health Agency services;

4. Explain that all Outpatient Behavioral Health Services care must be medically necessary;

5. Disclose that third party (e.g., Medicaid or insurance) Outpatient Behavioral Health Service payments may be denied based on the third party payer's policies or rules;

6. Identify and define any services to be offered or provided in addition to those offered by the Behavioral Health Agency, state whether there will be a charge for such services, and if so, document payment arrangements;

7. Notify that services may be discontinued by the client at any time;

8. Offer to provide copies of Behavioral Health Agency and Outpatient Behavioral Health Services rules;

9. Provide and explain contact information for making complaints to the provider regarding care delivery, discrimination, or any other dissatisfaction with care provided by the Behavioral Health Agency;

10. Provide and explain contact information for making complaints to state and federal agencies that enforce compliance under § III(G)(1).

G. Outpatient Behavioral Health Services maintained at each site must include:

1. Psychiatric Evaluation and Medication Management;

2. Outpatient Services, including individual and family therapy at a minimum;

3. Crisis Services.

L. Providers must tailor all Outpatient Behavioral Health Services care to individual client need. If client records contain entries that are materially identical, DHS and the Division of Medical Services will, by rebuttable presumption, that this requirement is not met.

M. Outpatient Behavioral Health Services for individuals under age eighteen (18): Providers must establish and implement policies for family identification and engagement in treatment for persons under age eighteen (18), including strategies for identifying and overcoming barriers to family involvement.

N. Emergency Response Services: Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

1. A 24-hour emergency telephone number;

2. The applicant/provider must:

a. Provide the 24-hour emergency telephone number to all clients;

b. Post the 24-hour emergency number on all public entries to each site;

c. Include the 24-hour emergency phone number on answering machine greetings;

d. Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to client emergencies.

3. Direct access to a mental health professional within fifteen (15) minutes of an emergency/crisis call and face-to-face crisis assessment within two (2) hours;

4. Response strategies based upon:

a. Time and place of occurrence;

b. Individual's status (client/non-client);

c. Contact source (family, law enforcement, health care provider, etc.).

5. Requirements for a face-to-face response to requests for emergency intervention received from a hospital or law enforcement agency regarding a current client.

6. All face-to-face emergency responses shall be:

    a. Available 24 hours a day, 7 days a week;

    b. Made by a mental health professional within two (2) hours of request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the MHP responding to the call).

7. Emergency services training requirements to ensure that emergency service are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency service training in each trainee's personnel file.

8. Requirements for clinical review by the clinical supervisor or emergency services director within 24 hours of each after-hours emergency intervention with such additional reporting as may be required by the provider's policy.

9. Requirements for documentation of all crisis calls, responses, collaborations, and outcomes;

10. Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral health care funded through the community mental health centers and the provider is not a community mental health center with access to these funds, the provider must:

    a. Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and

    b. Contact the appropriate community mental health center (CMHC) for consult and to request the CMHC to access local acute care funds for those over 21.

O. Each applicant/provider must establish and maintain procedures, competence, and capacity:

1. For assessment and individualized care planning and delivery;

2. For discharge planning integral to treatment;

3. For mobile care;

4. To assure that each mental health professional makes timely clinical disposition decisions;

5. To make timely referrals to other services;

6. To refer for inpatient services or less restrictive alternative;

7. To identify clients who need direct access to clinical staff, and to promptly provide such access.

P. Each applicant/provider must establish, maintain, and document a quality improvement program, to include:

1. Evidence based practices;

2. Use of agency wide outcomes measures to improve both client care and clinical practice that are approved by the agency's national accrediting organization. The following must be documented:

   a. Measured outcomes

   b. Sample report

   c. Collection of outcomes, beginning at the initial mental health diagnosis service, which would be completed very close to the client's intake.

3. Requirements for informing all clients and clients' responsible parties of the client's rights while accessing services.

4. Regular (at least quarterly) quality assurance meetings that include:

   a. Clinical Record Reviews: medical record reviews of a minimum number of randomly selected charts. The minimum number is the lesser of a statistically valid sample yielding 95% confidence with a 5% margin of error; or 10% of all charts open at any time during the past three (3) months;

   b. Program and services reviews that:

      1) Assess and document whether care and services meet client needs;

      2) Identify unmet behavioral health needs;

      3) Establish and implement plans to address unmet needs.

X. HOME OFFICE:

A. Each provider must maintain and identify a home office in the State of Arkansas;

B. The home office may be located at a site or may be solely an administrative office not requiring site certification;

C. The home office is solely responsible for governance and administration of all of the provider's Arkansas sites;

D. Home office governance and administration must be documented in a coordinated management plan;

E. The home office shall establish policies for maintaining client records, including policies designating where the original records are stored.

XI. SITE REQUIREMENTS

A. All sites must be located in the State of Arkansas;

B. Accreditation documentation must specifically include each site.

XII. SITE RELOCATION, OPENING, AND CLOSING (Note: temporary service disruptions caused by inclement weather or power outages are not "closings.")

A. Planned Closings:

1. Upon deciding to close a site either temporarily or permanently, the provider immediately must provide written notice to clients, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization.

2. Notice of site closure must state the site closure date;

3. If site closure is permanent, the site certification expires at 12:00 a.m. the day following the closure date stated in the notice;

4. If site closing is temporary, and is for reasons unrelated to adverse governmental action, DHS may suspend the site certification for up to one (1) year if the provider maintains possession and control of the site. If the site is not operating and in compliance within the time specified in the site certification suspension, the site certification expires at 12:00 a.m. the day after the site certification suspension ends.

B. Unplanned Closings:

1. If a provider must involuntarily close a site due to, for example, fire, natural disaster, or adverse governmental action, the provider must immediately notify clients and families, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization of the closure and the reason(s) for the closure.

2. Site certification expires in accordance with any pending regulatory action, or, if no regulatory action is pending, at 12:00 a.m. the day following permanent closure.

C. All Closings:

1. Providers must assure and document continuity of care for all clients who receive Outpatient Behavioral Health Services at the site;

2. Notice of Closure and Continuing Care Options:

a. Providers must assure and document that clients and families receive actual notice of the closure, the closure date, and any information and instructions necessary for the client to obtain transition services;

b. After documenting that actual notice to a specific client was impossible despite the exercise of due diligence, providers may satisfy the client notice requirement

by mailing a notice containing the information described in subsection (a), above, to the last known address provided by the client; and

c. Before closing, providers must post a public notice at each site entry. The public notice must include the name and contact information for all Behavioral Health Agencies within a fifty (50) mile radius of the site.

3. An acceptable transition plan is described below:

Transition Plan:

1. Identify and list all certified sites within a 50 mile radius. Include telephone numbers and physical addresses on the list.

2. Provide clients/families with the referral information and have them sign a transfer of records form/release of information to enable records to be transferred to the provider of their choice.

3. Transfer records to the designated provider.

4. Designate a records retrieval process as specified in Section I of the Arkansas Medicaid Outpatient Behavioral Health Services Provider Policy Manual § 142.300.

5. Submit a reporting of transfer to DHS (Attn: Policy & Certification Office) including a list of client names and the disposition of each referral. See example below:

Name	Referred to:	Records Transfer Status:	RX Needs Met By:
Johnny	OP Provider Name	to be delivered 4/30/20XX	Provided 1 month RX
Mary	Private Provider Name	Delivered 4/28/20XX	No Meds
Judy	Declined Referral	XX	

6. DHS may require additional information regarding documentation of client transfers to ensure that client needs are addressed and met.

DHS BEHAVIORAL HEALTH AGENCY Form 220 shall be used when a site is to be closed.

D. New Sites: Use DHS BEHAVIORAL HEALTH AGENCY Form 250 to apply for new sites, which would include a new Medicaid provider ID number for that site.

E. Site Transfer:

1. At least forty-five (45) calendar days before a proposed transfer of an accredited site, the provider must apply to DHS to transfer site certification. The application must include documentation that:

a. The provider notified the accrediting entity, and the accrediting entity has

extended or will extend accreditation to the second site; or

b. The accrediting entity has established an accreditation timeframe.

2. The provider must notify clients and families, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization at least thirty (30) calendar days before the transfer;

3. DHS does not require an on-site survey, nor does the Division of Medical Services require a new Medicaid provider number. Please use DHS BEHAVIORAL HEALTH AGENCY Form 220 for a site move or transfers.

F. Site Relocation: The provider must follow the rules for closing the original site, and the rules for opening a new site.

XIII. PROVIDER RE-CERTIFICATION:

A. The term of DHS site certification is concurrent with the provider's national accreditation cycle, except that site certification extends six (6) months past the accreditation expiration month if there is no interruption in the accreditation. (The six-month extension is to give the Behavioral Health Agency time to receive a final report from the accrediting organization, which the provider must immediately forward to DHS.)

B. Providers must furnish DHS a copy of:

1. Correspondence related to the provider's request for re-accreditation:

a. Providers shall send DHS copies of correspondence from the accrediting agency within five (5) business days of receipt;

b. Providers shall furnish DHS copies of correspondence to the accrediting organization concurrently with sending originals to the accrediting organization.

2. An application for provider and site recertification:

a. DHS must receive provider and site recertification applications at least fifteen (15) business days before the DHS Behavioral Health Agency certification expiration date;

b. The Re-Certification form with required documentation is DHS BEHAVIORAL HEALTH AGENCY Form 230 and is available at www.arkansas.gov/dhs/dhs.

C. If DHS has not recertified the provider and site(s) before the certification expiration date, certification is void beginning 12:00 a.m. the next day.

XIV. MAINTAINING DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION:

A. Providers must:

1. Maintain compliance;

2. Assure that DHS certification information is current, and to that end must notify DHS within thirty (30) calendar days of any change affecting the accuracy of the provider's certification records;

3. Furnish DHS all correspondence in any form (e.g., letter, facsimile, email) to and from the accrediting organization to DHS within thirty (30) calendar days of the date the correspondence was sent or received except:

   a. As stated in § XII;

   b. Correspondence related to any change of accreditation status, which providers must send to DHS within three (3) calendar days of the date the correspondence was sent or received.

   c. Correspondence related to changes in service delivery, site location, or organizational structure, which providers must send to DHS within ten (10) calendar days of the date the correspondence was sent or received.

4. Display the Behavioral Health Agency certificate for each site at a prominent public location within the site

B. Annual Reports:

1. Providers must furnish annual reports to DHS before July 1 of each year that the provider has been in operation for the preceding twelve (12) months. Community Mental Health Centers and specialty clinics may meet this requirement by submitting the Annual Plan/Basic Services Plan to DHS.

2. Annual report shall be prepared by completing forms provided by DHS. Please use DHS BEHAVIORAL HEALTH AGENCY Form 240 for the Behavioral Health Agency annual report.

XV. NONCOMPLIANCE

A. Failure to comply with this rule may result in one or more of the following:

1. Submission and implementation of an acceptable corrective action plan as a condition of retaining Behavioral Health Agency certification;

2. Suspension of Behavioral Health Agency certification for either a fixed period or until the provider meets all conditions specified in the suspension notice;

3. Termination of Behavioral Health Agency certification.

XVI. APPEAL PROCESS

A. If DHS denies, suspends, or revokes any Behavioral Health Agency certification (takes adverse action), the affected proposed provider or provider may appeal the DHS adverse action. Notice of adverse action shall comply with Ark. Code Ann. §§ 20-77-1701-1705, and §§1708-1713. Appeals must be submitted in writing to the DHS. The

provider has thirty (30) calendar days from the date of the notice of adverse action to appeal. An appeal request received within thirty-five (35) calendar days of the date of the notice will be deemed timely. The appeal must state with particularity the error or errors asserted to have been made by DHS in denying certification, and cite the legal authority for each assertion of error. The provider may elect to continue Medicaid billing under the Behavioral Health Agency program during the appeals process. If the appeal is denied, the provider must return all monies received for Behavioral Health Agency services provided during the appeals process.

B. Within thirty (30) calendar days after receiving an appeal DHS shall: (1) designate a person who did not participate in reviewing the application or in the appealed-from adverse decision to hear the appeal; (2) set a date for the appeal hearing; (3) notify the appellant in writing of the date, time, and place of the hearing. The hearing shall be set within sixty (60) calendar days of the date DHS receives the request for appeal, unless a party to the appeal requests and receives a continuance for good cause.

C. DHS shall tape record each hearing.

D. The hearing official shall issue the decision within forty-five (45) calendar days of the date that the hearing record is completed and closed. The hearing official shall issue the decision in a written document that contains findings of fact, conclusions of law, and the decision. The findings, conclusions, and decision shall be mailed to the appellant except that if the appellant is represented by counsel, a copy of the findings, conclusions, and decision shall also be mailed to the appellant's counsel. The decision is the final agency determination under the Administrative Procedure Act.

E. Delays caused by the appealing party shall not count against any deadline. Failure to issue a decision within the time required is not a decision on the merits and shall not alter the rights or status of any party to the appeal, except that any party may pursue legal process to compel the hearing official to render a decision.

F. Except to the extent that they are inconsistent with this policy, the appeal procedures in the Arkansas Medicaid Outpatient Behavioral Health Services Provider Manual are incorporated by reference and shall control.

Arkansas Department of Human Services

Division of Behavioral Health Services

Independently Licensed Practitioners Certification Manual

Revised: 7/1/17

www.arkansas.gov/dhs/dbhs

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Independently Licensed Practitioner

Provider Certification Rules

I. PURPOSE:

A. To assure that Outpatient Behavioral Health Services ("OBHS") care and services provided by certified Independently Licensed Practitioners comply with applicable laws, which require, among other things, that all care reimbursed by the Arkansas Medical Assistance Program ("Medicaid") must be provided efficiently, economically, only when medically necessary, and is of a quality that meets professionally recognized standards of health care.

B. The requirements and obligations imposed by §§ I-XIII of this rule are substantive, not procedural.

II. SCOPE:

A. Current Independently Licensed Practitioner certification under this policy is a condition of Medicaid provider enrollment.

B. Division of Behavioral Health Services ("DBHS") Independently Licensed Practitioner certification must be obtained for each site before application for Medicaid provider enrollment. An applicant may submit one application for multiple sites, but DBHS will review each site separately and take separate certification action for each site.

III. DEFINITIONS:

A. "Adverse license action" means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

B. "Applicant" means an Independently Licensed Practitioner that is seeking DBHS certification as an Independently Licensed Practitioner.

C. "Certification" means a written designation, issued by DBHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

D. "Client" means any person for whom an Independently Licensed Practitioner furnishes, or has agreed or undertaken to furnish, Counseling Level Outpatient Behavioral Health services.

E. "Client Information System" means a comprehensive, integrated system of clinical, administrative, and financial records that provides information necessary and useful to deliver client services. Information may be maintained electronically, in hard copy, or both.

F. "Compliance" means conformance with:

1. Applicable state and federal laws, rules, and regulations including, without limitation:

a. Titles XIX and XXI of the Social Security Act and implementing regulations;

b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;

c. All state laws and rules applicable to Medicaid generally and to an Independently Licensed Practitioner services specifically;

d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;

e. The Americans With Disabilities Act, as amended, and implementing regulations;

f. The Health Insurance Portability and Accountability Act ("HIPAA"), as amended and implementing regulations.

G. "Contemporaneous" means by the end of the performing provider's first work period following the provision of care of services to be documented, or as provided in the Outpatient Behavioral Health Services manual, whichever is longer.

H. "Coordinated Management Plan" means a plan that the provider develops and carries out to assure compliance and quality improvement.

I. "Corrective Action Plan" (CAP) means a document that describes both short- term remedial steps to achieve compliance and permanent practices and procedures to sustain compliance.

J. "Cultural Competency" means the ability to communicate and interact effectively with people of different cultures, including people with disabilities and atypical lifestyles.

K. "DBHS" means the Arkansas Department of Human Services Division of Behavioral Health Services.

L. "Deficiency" means an item or area of noncompliance.

M. "DHS" means the Arkansas Department of Human Services.

N. "Emergency an Independently Licensed Practitioner services" means nonscheduled an Independently Licensed Practitioner services delivered under circumstances where a prudent layperson with an average knowledge of behavioral health care would reasonably believe that an Independently Licensed Practitioner services are immediately necessary to prevent death or serious impairment of health.

O. "Independently Licensed Practitioner" is an individual that is licensed to engage in private/independent practice by the appropriate State Board. The following licensure can qualify as Independently Licensed Practitioners:

1. Licensed Certified Social Worker (LCSW)

2. Licensed Marital and Family Therapist (LMFT)

3. Licensed Psychologist (LP)

4. Licensed Psychological Examiner – Independent (LPEI)

5. Licensed Professional Counselor (LPC)

P. "Mobile care" means a face-to-face intervention with the client at a place other than a certified site operated by the provider. Mobile care must be:

1. Either clinically indicated in an emergent situation or necessary for the client to have access to care in accordance with the care plan;

2. Delivered in a clinically appropriate setting; and

3. Delivered where Medicaid billing is permitted if delivered to a Medicaid eligible client.

Q. "NPDB" means the United States Department of Health and Human Services, Health Resources and Services Administration National Provider Data Bank.

R. "Performing provider" means an Independently Licensed Practitioner who personally delivers a care or service directly to a client.

S. "Professionally recognized standard of care" means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice models is evidence of compliance with professionally recognized standards of care.

T. "Provider" means an Independently Licensed Practitioner that is certified by DBHS and enrolled by DMS to provide Outpatient Behavioral Health Services.

U. "Reviewer" means a person employed or engaged by:

1. DHS or a division or office thereof;

2. An entity that contracts with DHS or a division or office thereof.

V. "Site" means a distinct place of business dedicated to the delivery of Outpatient Behavioral Health Services. Each site where an Independently Licensed Practitioner performs services at must be certified by the Division of Behavioral Health Services. Colocation within an office or clinic of a physician or psychologist is allowed for an Independently Licensed Practitioner. However, an Independently Licensed Practitioner site cannot be an adjunct to a school, a day care facility, or a long-term care facility. Each site shall be a bona fide an Independently Licensed Practitioner site.

W. "Site relocation" means closing an existing site and opening a new site.

X. "Site transfer" means moving existing staff, program, and clients from one physical

location to a second location.

Y. "Supervise" as used in this rule means to direct, inspect, observe, and evaluate performance.

Z. "Supervision documentation" means written records of the time, date, subject(s), and duration of supervisory contact maintained in the provider's official records.

IV. COMPLIANCE TIMELINE:

A. All Independently Licensed Practitioner sites must receive an on-site inspection in order to obtain DBHS certification as an Independently Licensed Practitioner site.

B. DBHS may authorize temporary compliance exceptions for Independently Licensed Practitioners, if deemed necessary by DHS.

V. APPLICATION FOR DBHS INDEPENDENTLY LICENSED PRACTITIONER CERTIFICATION:

A. Applicants must complete form DMS-633, which can be found at the following website: http://humanservices.arkansas.gov/dbhs/Documents/LMHP%20Form%20633.pdf

B. Applicants must submit the completed application forms and all required attachments for each proposed site to:

Department of Human Services
Division of Behavioral Health Services
Attn. Certification Office
305 S. Palm
Little Rock, AR 72205

C. Each applicant must be an Independently Licensed Practitioner:

1. Whose primary purpose is the delivery of a continuum of outpatient behavioral health services in a free standing independent clinic;

2. That is independent of any DBHS certified Behavioral Health Agency.

D. Independently Licensed Practitioner certification is not transferable or assignable.

E. The privileges of an Independently Licensed Practitioners certification are limited to the certified site.

F. Providers may file Medicaid claims only for Outpatient Behavioral Health Services delivered by an Independently Licensed Practitioner.

G. Applications must be made in the name used to identify the business entity to the Secretary of State and for tax purposes.

H. The applicant must attach the Independently Licensed Practitioner family involvement policy to each application.

VI. APPLICATION REVIEW PROCESS:

A. Timeline:

1. DBHS will review Independently Licensed Practitioner application forms and materials within ninety (90) calendar days after DBHS receives a complete application package. (DBHS will return incomplete applications to senders without review.)

2. For approved applications, a site survey will be scheduled within forty-five (45) calendar days of the approval date.

3. DBHS will mail a survey report to the applicant within twenty-five (25) calendar days of the site visit. Providers having deficiencies on survey reports must submit an approvable corrective action plan to DBHS within thirty-five (35) calendar days after the date of a survey report.

4. DBHS will accept or reject each corrective action plan in writing within twenty (20) calendar days after receipt.

5. Within thirty (30) calendar days after DBHS approves a corrective action plan, the applicant must document implementation of the plan and correction of the deficiencies listed in the survey report. Applicants who are unable, despite the exercise of reasonable diligence, to correct deficiencies within the time permitted may obtain up to ten (10) additional days based on a showing of good cause.

6. DBHS will furnish site-specific certificates via postal or electronic mail within ten (10) calendar days of issuing a site certification.

B. Survey Components: Each site survey will ensure that the site is in compliance with facility environment requirements, location in Section <000.000> of this certification manual. The site survey will also ensure that the Independently Licensed Practitioner complies with policy requirements and record keeping requirements.

C. Determinations:

1. Application approved.

2. Application returned for additional information.

3. Application denied. DBHS will state the reasons for denial in a written response to the applicant.

VII. DBHS Access to Applicants/Providers:

A. DBHS may contact applicants and providers at any time;

B. DBHS may make unannounced visits to applicants/providers.

C. Applicants/providers shall provide DBHS prompt direct access to applicant/provider documents and to applicant/provider staff and contractors.

D. DBHS reserves the right to ask any questions or request any additional information related to certification.

VIII. ADDITIONAL CERTIFICATION REQUIREMENTS:

A. Care and Services must:

1. Comply with all state and federal laws, rules, and regulations applicable to the furnishing of health care funded in whole or in part by federal funds; to all state laws and policies applicable to Arkansas Medicaid generally, and to Outpatient Behavioral Health Services specifically, and to all applicable Department of Human Services ("DHS") policies including, without limitation, DHS Participant Exclusion Policy § 1088.0.0. The Participant Exclusion Policy is available online at https://dhsshare.arkansas.gov/DHS%20Policies/Forms/By%20Policy.aspx

2. Conform to professionally recognized behavioral health rehabilitative treatment models.

3. Be established by contemporaneous documentation that is accurate and demonstrates compliance. Documentation will be deemed to be contemporaneous if recorded by the end of the performing provider's first work period following the provision of the care or services to be documented, or as provided in the Outpatient Behavioral Health Services manual, whichever is longer.

B. Applicants and Independently Licensed Practitioners must:

1. Be a legal entity in good standing;

2. Maintain all required business licenses;

3. Adopt a mission statement to establish goals and guide activities;

4. Maintain a current organizational chart that identifies administrative and clinical chains of command.

C. Applicants/providers must establish and comply with operating policy that at a minimum implements credible practices and standards for:

1. Compliance;

2. Cultural competence;

3. Provision of services, including referral services, for clients that are indigent, have no source of third party payment, or both, including:

a. Procedures to follow when a client is rejected for lack of a third-party payment

source or when a client is discharged for nonpayment of care.

b. Coordinated referral plans for clients that the provider lacks the capacity to provide medically necessary Outpatient Behavioral Health Services. Coordinated referral plans must:

   i. Identify in the client record the medically necessary Outpatient Behavioral Health Services that the provider cannot or will not furnish;

   ii. State the reason(s) in the client record that the provider cannot or will not furnish the care;

   iii. Provide quality-control processes that assure compliance with care, discharge, and transition plans.

IX. REQUIREMENTS FOR CERTIFICATION

A. Independently Licensed Practitioner may not furnish Outpatient Behavioral Health Services during any time the professional's license is subject to adverse license action.

B. Applicants/providers may not employ/engage a covered health care practitioner after learning that the practitioner:

   1. Is excluded from Medicare, Medicaid, or both;

   2. Is debarred under Ark. Code Ann. § 19-11-245;

   3. Is excluded under DHS Policy 1088; or

   4. Was subject to a final determination that the provider failed to comply with professionally recognized standards of care, conduct, or both. For purposes of this subsection, "final determination" means a final court or administrative adjudication, or the result of an alternative dispute resolution process such as arbitration or mediation.

C. Independently Licensed Practitioner must maintain copies of disclosure forms signed by the client, or by the client's parent or guardian before Outpatient Behavioral Health Services are delivered except in emergencies. Such forms must at a minimum:

   1. Disclose that the services to be provided are Outpatient Behavioral Health Services;

   2. Explain Outpatient Behavioral Health Services eligibility, SED and SMI criteria;

   3. Contain a brief description of the Independently Licensed Practitioner services;

   4. Explain that all Outpatient Behavioral Health Services care must be medically necessary;

   5. Disclose that third party (e.g., Medicaid or insurance) Outpatient Behavioral Health Service payments may be denied based on the third party payer's policies or rules;

6. Identify and define any services to be offered or provided in addition to those offered by the Independently Licensed Practitioner, state whether there will be a charge for such services, and if so, document payment arrangements;

7. Notify that services may be discontinued by the client at any time;

8. Offer to provide copies of Independently Licensed Practitioner and Outpatient Behavioral Health Services rules;

9. Provide and explain contact information for making complaints to the provider regarding care delivery, discrimination, or any other dissatisfaction with care provided by the Independently Licensed Practitioner;

10. Provide and explain contact information for making complaints to state and federal agencies that enforce compliance under § III(G)(1).

D. Outpatient Behavioral Health Services maintained by the Independently Licensed Practitioner must include:

1. Outpatient Services, including individual and family therapy at a minimum.

2. Ability to provide Pharmacologic Management at the certified site or the agreement of collaboration with a physician to provide Pharmacologic Management for clients of the Independently Licensed Practitioner.

3. Ability to refer clients to other practitioners or agencies for Outpatient Behavioral Health Services.

E. Providers must tailor all Outpatient Behavioral Health Services care to individual client need. If client records contain entries that are materially identical, DBHS and the Division of Medical Services will, by rebuttable presumption, that this requirement is not met.

F. Outpatient Behavioral Health Services for individuals under age eighteen (18): Providers must establish and implement policies for family identification and engagement in treatment for persons under age eighteen (18), including strategies for identifying and overcoming barriers to family involvement.

G. Emergency Response Services: Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

1. A 24-hour emergency telephone number;

2. The applicant/provider must:

a. Provide the 24-hour emergency telephone number to all clients;

b. Post the 24-hour emergency number on all public entries to each site;

c. Include the 24-hour emergency phone number on answering machine greetings;

d. Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to client emergencies.

3. Direct access to a mental health professional within fifteen (15) minutes of an emergency/crisis call and face-to-face crisis assessment within two (2) hours;

4. Response strategies based upon:

   a. Time and place of occurrence;

   b. Individual's status (client/non-client);

   c. Contact source (family, law enforcement, health care provider, etc.).

5. Requirements for a face-to-face response to requests for emergency intervention received from a hospital or law enforcement agency regarding a current client.

6. All face-to-face emergency responses shall be:

   a. Available 24 hours a day, 7 days a week;

   b. Made by a mental health professional within two (2) hours of request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the MHP responding to the call).

7. Emergency services training requirements to ensure that emergency service are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency service training in each trainee's personnel file.

8. Requirements for clinical review by the clinical supervisor or emergency services director within 24 hours of each after-hours emergency intervention with such additional reporting as may be required by the provider's policy.

9. Requirements for documentation of all crisis calls, responses, collaborations, and outcomes;

10. Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral health care funded through the community mental health centers and the provider is not a community mental health center with access to these funds, the provider must:

    a. Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and

    b. Contact the appropriate community mental health center (CMHC) for consult and to request the CMHC to access local acute care funds for those over 21.

11. The above crisis response requirements can be addressed through an agreement with another provider (i.e., Behavioral Health Agency, Independently Licensed

Practitioner). Crisis response plans must be discussed with clients and must be available for review.

O. Each applicant/provider must establish and maintain procedures, competence, and capacity:

1. For assessment and individualized care planning and delivery;

2. For discharge planning integral to treatment;

3. For mobile care;

4. To assure that each mental health professional makes timely clinical disposition decisions;

5. To make timely referrals to other services;

6. To refer for inpatient services or less restrictive alternative;

P. Each applicant/provider must establish, maintain, and document a quality improvement program, to include:

1. Evidence based practices;

2. Requirements for informing all clients and clients' responsible parties of the client's rights while accessing services.

3. Regular (at least quarterly) quality assurance meetings that include:

X. SITE REQUIREMENTS:

A. All Independently Licensed Practitioner sites must be located inside the State of Arkansas;

B. The Independently Licensed Practitioner site shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.

C. All Independently Licensed Practitioner site staff shall know the exact location, contents, and use of first aid supply kits and fire fighting equipment and fire detection systems. All fire fighting equipment shall be annually maintained in appropriately designated areas within the facility.

D. The Independently Licensed Practitioner site shall post written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather. All exits must be clearly marked.

E. The Independently Licensed Practitioner site shall be maintained in a manner, which provides a safe environment for clients, personnel, and visitors.

F. The Independently Licensed Practitioner site telephone number(s) and actual hours of operation shall be posted at all public entrances.

G. The Independently Licensed Practitioner site shall establish policies for maintaining client records, including policies designating where the original records are stored.

H. Each Independently Licensed Practitioner site shall maintain an organized medical record keeping system to collect and document information appropriate to the treatment processes. This system shall be organized; easily retrievable, usable medical records stored under confidential conditions and with planned retention and disposition.

XI. SITE RELOCATION, OPENING, AND CLOSING (Note: temporary service disruptions caused by inclement weather or power outages are not "closings.")

A. Planned Closings:

1. Upon deciding to close a site either temporarily or permanently, the Independently Licensed Practitioner immediately must provide written notice to clients and to the Department of Human Services, Division of Behavioral Health Services.

2. Notice of site closure must state the site closure date;

3. If site closure is permanent, the site certification expires at 12:00 a.m. the day following the closure date stated in the notice;

4. If site closing is temporary, and is for reasons unrelated to adverse governmental action, DBHS may suspend the site certification for up to one (1) year if the Independently Licensed Practitioner maintains possession and control of the site. If the site is not operating and in compliance within the time specified in the site certification suspension, the site certification expires at 12:00 a.m. the day after the site certification suspension ends.

B. Unplanned Closings:

1. If an Independently Licensed Practitioner must involuntarily close a site due to, for example, fire, natural disaster, or adverse governmental action, the provider must immediately notify clients and families, DBHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization of the closure and the reason(s) for the closure.

2. Site certification expires in accordance with any pending regulatory action, or, if no regulatory action is pending, at 12:00 a.m. the day following permanent closure.

C. All Closings:

1. Independently Licensed Practitioner must assure and document continuity of care

for all clients who receive Outpatient Behavioral Health Services at the site;

2. Notice of Closure and Continuing Care Options:

   a. Independently Licensed Practitioner must assure and document that clients and families receive actual notice of the closure, the closure date, and any information and instructions necessary for the client to obtain transition services;

   b. After documenting that actual notice to a specific client was impossible despite the exercise of due diligence, Independently Licensed Practitioners may satisfy the client notice requirement by mailing a notice containing the information described in subsection (a), above, to the last known address provided by the client; and

   c. Before closing, Independently Licensed Practitioner must post a public notice at the site entry.

3. An acceptable transition plan is described below:

Transition Plan:

1. Provide clients/families with the referral information and have them sign a transfer of records form/release of information to enable records to be transferred to the provider of their choice.

2. Transfer records to the designated provider.

4. Designate a records retrieval process as specified in Section I of the Arkansas Medicaid Outpatient Behavioral Health Services Provider Policy Manual § 142.300.

5. Submit a reporting of transfer to DBHS (Attn: Policy & Certification Office) including a list of client names and the disposition of each referral. See example below:

Name	Referred to:	Records Transfer Status:	RX Needs Met By:
Johnny	OP Provider Name	to be delivered 4/30/20XX	Provided 1 month RX
Mary	Private Provider Name	Delivered 4/28/20XX	No Meds
Judy	Declined Referral	XX	

6. DBHS may require additional information regarding documentation of client transfers to ensure that client needs are addressed and met.

A site closing Form is available at: www.arkansas.gov/dhs/dbhs See appendix # 9

D. New Sites: Providers may apply for a new site by completing the new site Form available at www.arkansas.gov/dhs/dbhs

See appendix # 10 DBHS Form # 5 – (Adding Site)

E. Site Transfer:

1. At least forty-five (45) calendar days before a proposed transfer of a certified site, the provider must apply to DBHS to transfer site certification.

2. The provider must notify clients and families at least thirty (30) calendar days before the transfer;

3. DBHS requires an on-site survey prior to allowance of service at the new site. The Division of Medical Services does not require a new Medicaid provider number. The moving or transferring site form is available at: www.arkansas.gov/dhs/dbhs

See appendix # 9 – DBHS Form # 4 (Closing and Moving Sites)

F. Site Relocation: The provider must follow the rules for closing the original site, and the rules for opening a new site.

XII. PROVIDER RE-CERTIFICATION:

A. The term of DBHS site certification is continuous for 3 years from the date of Certification as long as the site is not transferred and the Independently Licensed Practitioner maintains appropriate Licensure. If an Independently Licensed Practitioner loses appropriate licensure, the site that they operate in will lose certification.

B. Providers must furnish DBHS a copy of:

1. An application for provider and site recertification:

a. DBHS must receive provider and site recertification applications at least fifteen (15) business days before the DBHS Independently Licensed Practitioner certification expiration date;

b. The Re-Certification form with required documentation is available at www.arkansas.gov/dhs/dbhs

See Appendix # 11 DBHS Form 3 (Re-certification)

C. If DBHS has not recertified the provider and site(s) before the certification expiration date, certification is void beginning 12:00 a.m. the next day.

XIII. MAINTAINING DBHS BEHAVIORAL HEALTH AGENCY CERTIFICATION:

A. Providers must:

1. Maintain compliance;

2. Assure that DBHS certification information is current, and to that end must notify DBHS within thirty (30) calendar days of any change affecting the accuracy of the provider's certification records;

3. Display the Independently Licensed Practitioner certificate for each site at a prominent public location within the site

B. Annual Reports:

1. Providers must furnish annual reports to DBHS before July 1 of each year that the provider has been in operation for the preceding twelve (12) months.

1. Annual report shall be prepared by completing forms provided by DBHS. The annual report form is available at www.arkansas.gov/dhs/dbhs and at Appendix # 12 DBHS Form # 6

XIV. NONCOMPLIANCE

A. Failure to comply with this rule may result in one or more of the following:

1. Submission and implementation of an acceptable corrective action plan as a condition of retaining Independently Licensed Practitioner certification;

2. Suspension of Independently Licensed Practitioner certification for either a fixed period or until the provider meets all conditions specified in the suspension notice;

3. Termination of Independently Licensed Practitioner certification.

XV. APPEAL PROCESS

A. If DBHS denies, suspends, or revokes any Independently Licensed Practitioner certification (takes adverse action), the affected proposed provider or provider may appeal the DBHS adverse action. Notice of adverse action shall comply with Ark. Code Ann. §§ 20-77-1701-1705, and §§1708-1713. Appeals must be submitted in writing to the DBHS Director. The provider has thirty (30) calendar days from the date of the notice of adverse action to appeal. An appeal request received within thirty-five (35) calendar days of the date of the notice will be deemed timely. The appeal must state with particularity the error or errors asserted to have been made by DBHS in denying certification, and cite the legal authority for each assertion of error. The provider may elect to continue Medicaid billing under the Outpatient Behavioral Health Services program during the appeals process. If the appeal is denied, the provider must return all monies received for Independently Licensed Practitioner services provided during the appeals process.

B. Within thirty (30) calendar days after receiving an appeal the DBHS Director shall: (1) designate a person who did not participate in reviewing the application or in the appealed-from adverse decision to hear the appeal; (2) set a date for the appeal hearing; (3) notify the appellant in writing of the date, time, and place of the hearing. The

hearing shall be set within sixty (60) calendar days of the date DBHS receives the request for appeal, unless a party to the appeal requests and receives a continuance for good cause.

C. DBHS shall tape record each hearing.

D. The hearing official shall issue the decision within forty-five (45) calendar days of the date that the hearing record is completed and closed. The hearing official shall issue the decision in a written document that contains findings of fact, conclusions of law, and the decision. The findings, conclusions, and decision shall be mailed to the appellant except that if the appellant is represented by counsel, a copy of the findings, conclusions, and decision shall also be mailed to the appellant's counsel. The decision is the final agency determination under the Administrative Procedure Act.

E. Delays caused by the appealing party shall not count against any deadline. Failure to issue a decision within the time required is not a decision on the merits and shall not alter the rights or status of any party to the appeal, except that any party may pursue legal process to compel the hearing official to render a decision.

F. Except to the extent that they are inconsistent with this policy, the appeal procedures in the Arkansas Medicaid Outpatient Behavioral Health Services Provider Manual are incorporated by reference and shall control.

Arkansas Department of Human Services

Partial Hospitalization Certification

I. GENERAL PROVISIONS

a. Purpose

This chapter sets forth the Standards and Criteria used in the certification of Partial Hospitalization Providers by the Arkansas Department of Human Services, Division of Behavioral Health Services. The rules regarding the certification processes including, but not necessarily limited to, applications, requirements for, levels of, and administrative sanctions are found in this manual.

b. Definitions

The following words or terms, when used in this Chapter, shall have the defined meaning, unless the context clearly indicates otherwise:

i. **"Abuse"** means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a resident by a staff responsible for the client's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a resident.

ii. **"Adverse license action"** means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

iii. **"Certification"** means a written designation, issued by DHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

iv. **"Clinical privileging"** means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to clients within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment, and other credentials.

v. **"Client"** means any person for whom a Partial Hospitalization Program furnishes, or has agreed or undertaken to furnish, services.

vi. **"Co-occurring disorder"** means any combination of mental health and substance use disorder symptoms or diagnoses in a client.

vii. **"Co-occurring disorder capability"** means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to individuals with co-occurring disorders.

viii. **"Compliance"** means conformance with:

1. Applicable state and federal laws, rules, and regulations including, without limitation:

    a. Titles XIX and XXI of the Social Security Act and implementing regulations;
    b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;
    c. All state laws and rules applicable to Medicaid generally and to Partial Hospitalization Program services specifically;
    d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;
    e. The Americans With Disabilities Act, as amended, and implementing regulations;
    f. The Health Insurance Portability and Accountability Act ("HIPAA"), as amended, and implanting regulations.

ix. **"Critical incident"** means an occurrence or set of events inconsistent with the routine operation of the facility, or the routine care of a client. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to clients, staff and visitors; medication errors; clients that are absent without leave (AWOL); neglect or abuse of a client; fire; unauthorized disclosure of information; damage to or theft of property belonging to a clients or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

x. "**Deficiency**" means an item or area of noncompliance.

xi. "**DHS**" means the Arkansas Department of Human Services.

xii. **"Initial Assessment"** means examination of current and recent behaviors and symptoms of an individual who appears to be mentally ill or substance dependent.

xiii. **"Intervention plan"** means a description of services to be provided in response to the presenting crisis situation that incorporates the identified problem(s), strengths, abilities, needs and preferences of the individual served.

xiv. **"Linkage services"** means the communication and coordination with other service providers that assure timely appropriate referrals between the Partial Hospitalization Program and other providers.

xv. "**Mental health professional**" or "**MHP**" means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

xvi. **"Minor"** means any person under eighteen (18) years of age.

xvii. **"Performance Improvement"** or **"PI"** means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of clients and others. Synonyms, and near synonyms include continuous performance improvement, continuous improvement, organization-wide performance improvement and total quality management.

xviii. **"Persons with special needs"** means any persons with a condition which is considered a disability or impairment under the "American with Disabilities Act of 1990" including, but not limited to the deaf/hearing impaired, visually impaired, physically dis-abled, developmentally disabled, persons with disabling illness, persons with mental illness and/or substance abuse disorders. See "Americans with Disabilities Handbook," published by U.S. Equal Employment Opportunity Commission and U.S. Department of Justice.

xix. "**Professionally recognized standard of care**" means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice models is evidence of compliance with professionally recognized standards of care.

xx. **"Progress notes"** mean a chronological description of services provided to a client, the client's progress, or lack of, and documentation of the client's response related to the intervention plan.

xxi. "**Provider**" means an entity that is certified by DHS as a Partial Hospitalization Program and enrolled by DMS as a Behavioral Health Agency.

xxii. **"Psychosocial evaluations"** are in-person interviews conducted by professionally trained personnel designed to elicit historical and current information regarding the behavior and experiences of an individual, and are designed to provide sufficient information for problem formulation and intervention.

xxiii. **"Qualified Behavioral Health Provider"** means a person who:

1. Does not possess an Arkansas license to provide clinical behavioral health care;

2. Works under the direct supervision of a mental health professional;

3. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned by a mental health professional;

4. Acknowledges in writing that all mental health paraprofessional services are controlled by client care plans and provided under the direct supervision of a mental health professional.

xxiv. **"Restraint"** refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of the individual's body. For clients: mechanical restraints shall not be used.

xxv. **"Sentinel event"** is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a client, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a client. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms or violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

xxvi. **"Trauma Informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of all clients.

II. Meaning of verbs in rules

The attention of the facility is drawn to the distinction between the use of the words "shall," "should," and "may" in this chapter:

(1) "Shall" is the term used to indicate a mandatory statement, the only acceptable method under the present standards.

(2) "Should" is the term used to reflect the most preferable procedure, yet allowing for the use of effective alternatives.

(3) "May" is the term used to reflect an acceptable method that is recognized but not necessarily preferred.

104.000 Applicability

The standards and criteria for services as subsequently set forth in this chapter are applicable to Partial Hospitalization Providers as stated in each section.

110.000 PARTIAL HOSPITALIZATION PROVIDERS

111.000 Service Definition

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.

The allowable staff, as referenced in the Outpatient Behavioral Health Services Medicaid Manual, included in the staff-to-patient ratio of 1:5 are:

1.) Independently Licensed Clinicians
2.) Non-Independently Licensed Clinicians
3.) Registered Nurse
4.) Advanced Practice Nurse (APN)
5.) Physician

112.000 Partial Hospitalization Provider Certification

(a) A Partial Hospitalization Provider shall be certified by the Department of Human Services as a Behavioral Health Agency. A Partial Hospitalization site shall be certified as a site of a Behavioral Health Agency.

(b) Partial Hospitalization Provider facilities shall be inspected a minimum of once per year, but are subject to visit by the Department's designee at other times to ensure continuing conformance of the operations of the facility with these regulations. The Department may request the facility to provide information concerning programs and fiscal operations at the Department's discretion.

(c) Partial Hospitalization Providers will not be reimbursed for services provided without certification as a Partial Hospitalization Provider by DHS.

(d) The goal of partial hospitalization is to increase the level of patient functioning. The service may be provided to clients with chronic or acute mental disorders who require active treatment.

(e) Partial Hospitalization Providers shall have their programs nationally accredited. A provisional certification for a Partial Hospitalization Program will be issued by the Division of Behavioral Health Services for up to 12 months in order for a Partial Hospitalization Program to have their program become nationally accredited. If after the 12 months provisional certification period, the Partial Hospitalization Program is not nationally accredited, then a DHS Partial Hospitalization Program certification will not be granted. In all instances, the Partial Hospitalization Provider shall comply with all applicable program national accreditation requirements in order to remain certified by DHS.

113.000 Organizational Structure

(a) The partial hospitalization unit shall be as a separate, identifiable organizational unit with its own director, or supervisor, and staffing pattern. When the unit is a portion of a larger organizational structure, the director or supervisor of the unit shall be identified and his responsibilities clearly defined. The organizational structure of the unit shall be described in an organizational chart. A written description of all services provided by the unit shall be on file and available to the Department. The Department shall be notified of any major change in the organizational structure or services.

114.000 Treatment Planning and Records

(a) An individualized treatment plan shall be formulated for patients in partial hospitalization programs by the patient's treatment team. A treatment team shall consist of a treatment team leader, a psychiatrist when the treatment team leader is not a psychiatrist and other appropriate staff. The treatment team leader shall be a mental health professional. Treatment plans shall be reviewed with parents or guardians of persons in children and youth partial hospitalization programs if appropriate.

(b) The treatment plan shall include the following:

(1) Be formulated to the extent possible, with the cooperation and consent of the patient, or a person acting on his behalf.

(2) Be based upon diagnostic evaluation which includes examination of the medical, psychological, social, cultural, behavioral, familial, educational, vocational and developmental aspects of the patient's situation.

(3) Set forth treatment objectives and prescribe an integrated program of therapies, activities, experiences and appropriate education designed to meet these objectives.

(4) Be maintained and updated with signed daily notes, and be kept in the patient's medical record or a form developed by the facility.

(5) Be developed within the first 5 days of service and reviewed by the treatment team a minimum of once every 20 days of service to the individual patient and modified as appropriate.

115.000 Linkage Services to higher or lower levels of care, or longer term placement

(a) Persons needing behavioral health services shall be treated with the least restrictive clinically appropriate methods.

(b) The Partial hospitalization program requires a close relationship with an acute psychiatric inpatient service. A written statement as to the availability of these services to patients is required and shall be maintained on file at the facility.

(c) The Partial hospitalization program shall also assure linkages with other appropriate treatment and rehabilitative services including emergency services, outpatient services, and vocational rehabilitation programs. A written statement documenting such linkages shall be maintained on file at the facility.

116.000 Treatment Policies and Procedures

(a) Each facility shall have a written plan describing the policies and procedures of the partial hospitalization program. The plan shall provide for:

(1) The services to be provided and the scope of such services.

(2) Intake policy and procedures.

(3) Admissions and discharge policies.

(4) Policies providing for continuity care for patients.

(5) There shall be a planned regular, ongoing program for staff development.

120.000 PARTIAL HOSPITLIZATION MEDICAL RECORDS REQUIREMENTS

121.000 Medical record keeping system

Each Partial Hospitalization Program shall maintain an organized medical record keeping system to collect and document information appropriate to the treatment processes. This system shall be organized; easily retrievable, usable medical records stored under confidential conditions and with planned retention and disposition.

122.000 Basic requirements

The Partial Hospitalization Program's policies and procedures shall:

(1) define the content of the client's medical record;

(2) define storage, retention and destruction requirements for client medical records;

(3) require client medical records be confidentially maintained in locked equipment under secure measures;

(4) require legible entries in client medical records signed with first name or initial, last name, credentials, and dated by the person making the entry;

(5) require the client's name be typed or written on each sheet of paper or page in the client record;

(6) require a signed consent for treatment before the client is admitted; and

(7) require a signed consent for follow-up before any contact after discharge is made.

123.000 Record access for clinical staff

The Partial Hospitalization Program shall assure client records are readily accessible to the Partial Hospitalization staff directly caring for the client. Such access shall be limited to the minimum necessary to carry out the staff member's job functions or the purpose for the use of the records.

124.000 Progress notes

(a) The Partial Hospitalization Program shall have a policy and procedure mandating the chronological documentation of progress notes for clients admitted to the Partial Hospitalization Program.

(b) Progress notes shall minimally address the following:

(1) Person(s) to whom services were rendered;

(2) Activities and services provided and as they relate to the goals and objectives of the treatment plan, including ongoing reference to the treatment plan;

(3) Documentation of the progress or lack of progress i as defined in the treatment plan;

(4) Documentation of the treatment plan's implementation, including client activities and services;

(5) The client's current status;

(6) Documentation of the client's response to services, changes in behavior and mood, and outcome of services;

(7) Plans for continuing therapy or for discharge, whichever is appropriate; and

(8) Progress notes shall document progress daily

125.000 Medication record

(a) The Partial Hospitalization Program shall maintain a medication record on all clients who receive medications or prescriptions in order to provide a concise and accurate record of the medications the client is receiving or has been prescribed for the client.

(b) The client medical record shall contain a medication record with information on all medications ordered or prescribed by physician staff which shall include, but not be limited to:

(1) The record of medication administered, dispensed or prescribed shall include all of the following:
(A) Name of medication,

(B) Dosage,

(C) Frequency of administration or prescribed change,

(D) Route of administration, and

(E) Staff member who administered or dispensed each dose, or prescribing physician; and

(2) A record of pertinent information regarding adverse reactions to drugs, drug allergies, or sensitivities shall be updated when required by virtue of new information, and kept in a highly visible location in or on the record.

126.000 Aftercare and discharge planning

(a) Aftercare and discharge planning is to be initiated for the client at the earliest possible point in the Partial Hospitalization service delivery process. Discharge

planning must be matched to the client's needs and address the presenting problem and any identified co-occurring disorders or issues.

(b) The program will have designated staff with responsibility to initiate discharge planning.

(c) Referral and linkage procedures shall be in place so staff can adequately advocate on behalf of the person served as early as possible during the stabilization treatment process to transition to lesser restrictive or alternative treatment settings, as indicated.

127.000 Other records content

(a) The client record shall contain copies of all consultation reports concerning the client.

(b) When psychometric or psychological testing is done, the client record shall contain a copy of a written report describing the test results and implications and recommendations for treatment.

(c) The client medical record shall contain any additional information relating to the client, which has been secured from sources outside the Partial Hospitalization Program.

140.000 CLIENT RIGHTS

141.000 DHS Investigations

The Arkansas Department of Human Services in any investigation or program monitoring regarding client rights shall have access to clients, Partial Hospitalization Program records and Partial Hospitalization Program staff.

150.000 ORGANIZATIONAL MANAGEMENT

151.000 Organizational description

(a) The Partial Hospitalization Program shall have a written organizational description which is reviewed annually by both the Partial Hospitalization Program, Behavioral Health Agency and DHS, which minimally includes:

(1) The overall target population, specifically including those individuals with co-occurring disorders, for whom services will be provided;

(2) The overall mission statement;

(3) The annual facility goals and objectives, including the goal of continued progress for the facility in providing person centered, culturally competent, trauma informed and co-occurring capable services;

(b) The Partial Hospitalization Program's governing body shall approve the mission statement and annual goals and objectives and document their approval.

(c) The Partial Hospitalization Program shall make the organizational description, mission statement and annual goals and objectives available to staff.

(d) The Partial Hospitalization Program shall make the organizational description, mission statement and annual goals and objectives available to the general public upon request.

(e) Each Partial Hospitalization Program shall have a written plan for professional services which shall have in writing the following:

(1) Services description and philosophy;

(2) The identification of the professional staff organization to provide these services;

(3) Written admission and exclusionary criteria to identify the type of clients for whom the services are primarily intended; and

(4) Written goals and objectives.

(5) Delineation of processes to assure accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.

(f) There shall be a written statement of the procedures/plans for attaining the organization's goals and objectives. These procedures/plans should define specific tasks, including actions regarding the organization's co-occurring capability, set target dates and designate staff responsible for carrying out the procedures or plans.

152.000 Information Analysis and Planning

(a) The Partial Hospitalization Program shall have a defined plan for conducting an organizational needs assessment that specifies the methods and data to be collected, which shall include but not limited to information from:

(1) Clients;

(2) Governing Authority;

(3) Staff;

(4) Stakeholders;

(5) Outcomes management processes; and

(6) Quality record review.

(b) The Partial Hospitalization Program shall have a defined system to collect data and information on a quarterly basis to manage the organization.

(c) Information collected shall be analyzed to improve client services and organizational performance.

(d) The Partial Hospitalization Program shall prepare an end of year management report, which shall include but not be limited to:

(1) An analysis of the needs assessment process; and

(2) Performance improvement program findings.

(e) The management report shall be communicated and made available to among others:

(1) The governing authority;

(2) Partial Hospitalization Program staff; and

(3) DHS if and when requested.

155.000 PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT

156.000 Performance improvement program

(a) The Partial Hospitalization Program shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of client care.

(b) The Performance improvement program shall also address the fiscal management of the organization.

(c) There shall be an annual written plan for performance improvement activities. The plan shall include, but not be limited to:

(1) Outcomes management processes specific to each program component minimally measuring:

(A) efficiency;

(B) effectiveness; and

(C) client satisfaction.

(2) A quarterly record review to minimally assess:

(A) quality of services delivered;

(B) appropriateness of services;

(C) patterns of service utilization;

(D) clients, relevant to:

i. their orientation to the Partial Hospitalization Program and services being provided; and

ii. their active involvement in making informed choices regarding the services they receive;

(E) the client assessment information thoroughness, timeliness and completeness;

(F) treatment goals and objectives are based on:

i. assessment findings; and

ii. client input;

(G) services provided were related to the goals and objectives;

(H) services are documented as prescribed by policy;

(I) the treatment plan is reviewed and updated as prescribed by policy

(3) Clinical privileging;

(4) Fiscal management and planning, which shall include:

(A) an annual budget that is approved by the governing authority and reviewed at least annually;

(B) the organization's capacity to generate needed revenue to produce desired client and other outcomes;

(C) monitoring client records to ensure documented dates of services provided coincide with billed service encounters; and,

(5) Review of critical incident reports and client grievances or complaints.

(d) The Partial Hospitalization Program shall monitor the implementation of the performance improvement plan on an ongoing basis and makes adjustments as needed.

(e) Performance improvement findings shall be communicated and made available to, among others:

(1) the governing authority;

(2) Partial Hospitalization Program staff; and

(3) DHS if and when requested.

157.000 Incident reporting

(a) The Partial Hospitalization Program shall have written policies and procedures requiring documentation and reporting of critical incidents.

(b) The documentation for critical incidents shall contain, minimally:

(1) the facility name and name and signature of person(s) reporting the incident;

(2) the name of client(s), staff person(s), or others involved in the incident;

(3) the time, place and date the incident occurred;

(4) the time and date the incident was reported and name of the person within the facility to whom it was reported;

(5) description of the incident; and

(6) the severity of each injury, if applicable. Severity shall be indicated as follows:

(A) No off-site medical care required or first aid care administered on-site;

(B) Medical care by a physician or nurse or follow-up attention required; or

(C) Hospitalization or immediate off-site medical attention was required;

(7) Resolution or action taken, date action taken, and signature of the Partial Hospitalization Program director.

(c) The Partial Hospitalization Program shall report those critical incidents to DHS that include.

(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to DHS Provider Certification within twenty-four (24) hours of the incident being documented.

(2) Critical incidents involving allegations constituting a sentinel event or resident abuse shall be reported to DHS immediately via telephone or fax, but not less than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.

160.000 PERSONNEL

161.000 Personnel policies and procedures

(a) The Partial Hospitalization Program shall have written personnel policies and procedures approved by the governing authority.

(b) All employees shall have access to personnel policies and procedures, as well as other Rules and Regulations governing the conditions of their employment.

(c) The Partial Hospitalization Program shall develop, adopt and maintain policies and procedures to promote the objectives of the program and provide for qualified personnel during all hours of operation to support the functions of the center and provide quality care.

162.000 Job descriptions

(a) The Partial Hospitalization Program shall have written job descriptions for all positions setting forth minimum qualifications and duties of each position.

(b) All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.

165.000 STAFF DEVELOPMENT AND TRAINING

166.000 Staff qualifications

(a) The Partial Hospitalization Program shall document the qualifications and training of staff providing crisis stabilization services which shall be in compliance with the Partial Hospitalization Program's clinical privileging process.

(b) Failure to comply with Section 166.000 will result in the initiation of procedures to deny, suspend and/or revoke certification.

167.000 Staff development

(a) The Partial Hospitalization Program shall have a written plan for the professional growth and development of all administrative, professional clinical and support staff.

(b) This plan shall include but not be limited to:

(1) orientation procedures;

(2) in-service training and education programs;

(3) availability of professional reference materials; and

(4) mechanisms for insuring outside continuing educational opportunities for staff members.

(c) The results of performance improvement activities and accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes.

(d) Staff competency development shall be aligned with the organization's goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.

(e) Staff education and in-service training programs shall be evaluated by the Partial Hospitalization Program at least annually.

168.000 In-service

(a) Trainings are required annually for all employees who provide clinical services within the Partial Hospitalization Program on the following topics:

(1) Fire and safety;

(2) Infection Control and universal precautions;

(3) Client's rights and the constraints of the Mental Health Client's Bill of Rights;

(4) Confidentiality;

(5) Arkansas Adult and Long-Term Care Facility Resident Maltreatment Act, §12-12-1701 et seq.

(6) Facility policy and procedures;

(7) Cultural competence;

(8) Co-occurring disorder competency and treatment principles; and

(9) Trauma informed and age and developmental specific trainings.

(b) All staff providing clinical services shall have a current certification in basic first aid and in Cardiopulmonary Resuscitation (CPR).

(c) All clinical staff shall have training in non-physical intervention techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within 30 days of being hired with annual updates thereafter. This training shall occur prior to direct patient contact

(d) The Partial Hospitalization Executive Director shall designate which positions and employees, including temporary employees, will be required to successfully complete physical intervention training. The employee shall successfully complete this training within 30 days of being hired, with annual updated thereafter. This training shall occur prior to direct patient contact

170.000 FACILITY ENVIRONMENT

(a) Partial Hospitalization Programs shall apply these standards to all sites operated. The primary concern of the Partial Hospitalization Program should always be the safety and wellbeing of the clients and staff. Partial Hospitalization Programs shall be physically located in the State of Arkansas. Partial Hospitalization Programs shall provide a safe and sanitary environment.

(b) A partial hospitalization program is defined by its staff and organizational structure rather than by a specific building or facility. It may operate at more than one site if the respective sites meet all physical facility standards and the sites operate as a portion of a total partial hospitalization program. The Department of Human Services will issue a single certificate of compliance to the parent organization (Behavioral Health Agency) which will list all operational sites.

171.000 Facility environment

(a) Adequate space, equipment and supplies shall be provided in order that the partial hospitalization services can be provided effectively and efficiently. Functional surroundings shall be readily accessible to the patient and community served.

(b) All space and equipment shall be well maintained and shall meet applicable Federal, State and local requirements for safety, fire and health.

(c) There shall be office space for the clinical staff suitably equipped with chairs, desks, tables and other necessary equipment.

(d) There shall be an adequate number of suitably equipped conference rooms to provide for staff conferences and therapy.

(e) There shall be adequate provisions for the privacy of the patient in interview rooms.

(f) The facility shall be appropriate to the age and developmental needs of the persons served.

(g) The Partial Hospitalization Program shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.

(h) Partial Hospitalization Program staff shall know the exact location, contents, and use of first aid supply kits and fire fighting equipment and fire detection systems. All fire fighting equipment shall be annually maintained in appropriately designated areas within the facility.

(i) The Partial Hospitalization Program shall have a written Hazardous Communication Program and staff shall be knowledgeable of chemicals in the workplace, location of Material Safety Data Sheets, personal protective equipment; and toxic or flammable substances shall be stored in approved locked storage cabinets.

(j) The Partial Hospitalization Program's telephone number(s) and actual hours of operation shall be posted at all public entrances.

(k) Signs must be posted at all public entrances informing staff, clients and visitors as to the following requirements:

(1) No alcohol or illicit drugs are allowed in the Partial Hospitalization Program facility,

(2) No firearms, or other dangerous weapons, are allowed in the Partial Hospitalization Program facility with the exception of law enforcement while in the performance of their duties, and

(3) The use of tobacco is not allowed in the Partial Hospitalization Program facility.

(l) A copy of compliance with law Title VI/Title VII of the 1964 Civil Rights Law shall be prominently displayed within the Partial Hospitalization Program Facility.

(m)Plumbing in Partial Hospitalization Program facilities shall be in working condition to avoid any health threat. All toilets, sinks and showers shall be clean and in working order.

(n) A secure locked storage shall be provided for client valuables when requested.

(o) Separate storage areas are provided and designated for:

(1) Food, kitchen, and eating utensils,

(2) Clean linens,

(3) Soiled linens and soiled cleaning equipment, and

(4) Cleaning supplies and equipment.

(p) When handling soiled linen or other potentially infectious material, Universal Precautions are to be followed and address in the Partial Hospitalization Program policies and procedures. Hazardous and regulated waste shall be disposed of in accordance with federal requirements.

(q) Poisons, toxic materials and other potentially dangerous items shall be stored in a secured location.

172.000 Medication clinic, medication monitoring

(a) Medication administration; storage and control; and client reactions shall be continuously monitored.

(b) Partial Hospitalization Programs shall assure proper storage and control of medications, immediate response if incorrect or overdoses occur, and have appropriate emergency supplies available if needed.

(1) Written procedures for medication administration shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications.

(2) All medications shall be kept in locked, non-client accessible areas. Factors which shall be considered in medication storage are light, moisture, sanitation, temperature, ventilation, and the segregation and safe storage of poisons, external medications, and internal medications.

(3) Telephone numbers of the state poison centers shall be immediately available in all locations where medications are prescribed, or administered, or stored.

173.000 Medication, error rates

(a) The Partial Hospitalization Program shall have an ongoing performance improvement program that specifically, objectively, and systematically monitors medications administration or dispensing or medication orders and prescriptions to evaluate and improve the quality of client care.

175.000 Food and Nutrition

(a) If the Partial Hospitalization Program prepares meals on site, the Partial Hospitalization Program shall have a current food establishment health inspection as required by the Arkansas Department of Health

(b) When meals are provided by a food service, a written contract shall be maintained and shall require the food service to have a current food establishment health inspection as required by the Arkansas Department of Health.

(c) Partial Hospitalization Program shall provide at least three meals daily to any client receiving services for up to 23 hours, with no more than fourteen (14) hours between any two meals.

(d) All food shall be stored, prepared, and served in a safe, healthy manner.

(e) Perishable items shall not be used once they exceed their sell by date.

Arkansas Department of Human Services

Therapeutic Communities Certification Manual

100.000 GENERAL PROVISIONS

101.000 Purpose

This chapter sets forth the Standards and Criteria used in the certification of Therapeutic Communities by the Arkansas Department of Human Services, Division of Behavioral Health Services. The rules regarding the certification processes including, but not necessarily limited to, applications, requirements for, levels of, and administrative sanctions are found in this manual.

102.000 Definitions

The following words or terms, when used in this Chapter, shall have the defined meaning, unless the context clearly indicates otherwise:

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a resident by a staff responsible for the resident's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a resident.

"Adverse license action" means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

"Behavioral Health Agency" means an entity that is certified by DHS as meeting the requirements to be certified as a Behavioral Health Agency.

"Certification" means a written designation, issued by DHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

"Client" means any person for whom an Therapeutic Community furnishes, or has agreed or undertaken to furnish, services.

"Co-occurring disorder" means any combination of mental health and substance use disorder symptoms or diagnoses in a client.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to individuals with co-occurring disorders.

"Compliance" means conformance with:

Applicable state and federal laws, rules, and regulations including, without limitation:

1. Titles XIX and XXI of the Social Security Act and implementing regulations;
2. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;
3. All state laws and rules applicable to Medicaid generally and to Therapeutic Community services specifically;
4. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;
5. The Americans With Disabilities Act, as amended, and implementing regulations;
6. The Health Insurance Portability and Accountability Act ("HIPAA"), as amended, and implementing regulations.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of the facility, or the routine care of a client. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to clients, staff and visitors; medication errors; clients that are absent without leave (AWOL); neglect or abuse of a client; fire; unauthorized disclosure of information; damage to or theft of property belonging to a clients or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"**Deficiency**" means an item or area of noncompliance.

"**DHS**" means the Arkansas Department of Human Services.

"Qualified Behavioral Health Provider" means a person who:

1. Does not possess an Arkansas license to provide clinical behavioral health care;
2. Works under the direct supervision of a mental health professional;
3. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned by a mental health professional;
4. Acknowledges in writing that all mental health paraprofessional services are controlled by client care plans and provided under the direct supervision of a mental health professional.

"**Mental health professional**" or "**MHP**" means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

"Minor" means any person under eighteen (18) years of age.

"Performance Improvement" or **"PI"** means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of clients and others. Synonyms, and near synonyms include continuous performance improvement, continuous improvement, organization-wide performance improvement and total quality management.

"Persons with special needs" means any persons with a condition which is considered a disability or impairment under the "American with Disabilities Act of 1990" including, but not limited to the deaf/hearing impaired, visually impaired, physically disabled, developmentally disabled, persons with disabling illness, persons with mental illness and/or substance abuse disorders. See "Americans with Disabilities Handbook," published by U.S. Equal Employment Opportunity Commission and U.S. Department of Justice.

"**Professionally recognized standard of care**" means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice models is evidence of compliance with professionally recognized standards of care.

"Progress notes" mean a chronological description of services provided to a client, the client's progress, or lack of, and documentation of the client's response related to the intervention plan.

"**Provider**" means an entity that is certified by DHS as a Therapeutic Community and enrolled by DMS as a Behavioral Health Agency.

"Restraint" refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of the individual's body. Mechanical restraints shall not be used.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a client, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a client. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms or violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Trauma Informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of all clients.

103.000 Meaning of verbs in rules

The attention of the facility is drawn to the distinction between the use of the words "shall," "should," and "may" in this chapter:

(1) "Shall" is the term used to indicate a mandatory statement, the only acceptable method under the present standards.

(2) "Should" is the term used to reflect the most preferable procedure, yet allowing for the use of effective alternatives.

(3) "May" is the term used to reflect an acceptable method that is recognized but not necessarily preferred.

104.000 Applicability

The standards and criteria for services as subsequently set forth in this chapter are applicable to Therapeutic Communities as stated in each section.

110.000 THERAPEUTIC COMMUNITIES

111.000 Required services

(a) Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.

(b) Depending on the needs of the client and eligibility determination of the client, there are two levels of Therapeutic Community, Level 1 and Level 2. Level 1 Therapeutic Communities are reimbursed at $250.00 per diem while Level 2 Therapeutic Communities are reimbursed at $175.00 per diem.

(c) In order to be certified by DHS as a Therapeutic Community, the site must be certified by DHS as a Behavioral Health Agency site. A Therapeutic Community shall not be certified without being certified as a Behavioral Health Agency.

(d) Each Therapeutic Community program shall be certified. All locations where clients reside will be inspected and approved as an allowable location for clients to live while receiving services within the Therapeutic Community. If clients are

living in a residential setting in the same location that they are receiving treatment (Level 1 Therapeutic Communities), the site shall not have more than 16 beds.

(e) Level 1 Therapeutic Communities shall have 24 hours a day monitoring and is a secure facility.

(f) Level 2 Therapeutic Communities must ensure daily contact with clients and the ability for residents to be seen by appropriate caregivers when necessary 24 hours a day. Appropriate supervision must be documented and maintained at Level 2 Therapeutic Communities.

112.000 Minimum Service Requirements

(a) At a minimum, Therapeutic Communities shall provide the following amount, duration, and scope of services for any client eligible and approved for Therapeutic Communities.

(b) Therapeutic Community services shall be provided in the least restrictive setting possible. Services should be provided within, or as close to the community in which they reside as possible.

(c) A physician shall be available at all times for clients in the Therapeutic Community, either on-duty or on call. If the physician is on call, he or she shall respond by telephone or in person to the licensed staff on duty at the Therapeutic Community within 20 minutes.

(d) Therapeutic Community services shall have written policy and procedures for both Levels of Therapeutic Communities and shall maintain policy and procedures for all services provided. This information shall be provided to all clients who enter care at a Therapeutic Community.

(e) Qualified staff, acting within their scope of license, if applicable, shall ensure that they are knowledgeable about applicable laws, DHS rules, and facility policy and procedures. All staff at Therapeutic Communities must be trained and certified as a staff member of the Therapeutic Community provider. This certification must be documented within the employee's employment record.

(f) The Therapeutic Community shall have written policy and procedures addressing restraints, and these shall be in compliance with Section 142.000 of this manual.

(g) All clients in a Therapeutic Community shall have an Individualized Plan of Care that indicates the appropriate medically necessary services for the client, including those listed within the Outpatient Behavioral Health Services Manual.

(h) All services provided to a client shall be documented in a daily progress note. Each daily progress note shall consist of a log and narrative section. The log

shall record each planed service delivered to the client, indicating the service name, time service began, time services ended, and the name and signature of the staff members providing the service. The summary shall include the activities performed and the client's progress or lack of progress of achieving the treatment goal(s) established in the Individualized Plan of Care. The narrative shall also indicate the reason(s) for the client not participating in any planned service, efforts to engage the client in services and any alternative service provided when the client does not participate in a planned service. The narrative progress note shall be signed by the Mental Health Professional (Independently Licensed Practitioners, Non-Independently Licensed Practitioner, Advanced Practice Nurse, or Physician) who is primarily responsible for the client's treatment on that day. This Mental Health Professional (Independently Licensed Practitioners, Non-Independently Licensed Practitioner, Advanced Practice Nurse, or Physician) MUST have been physically present at the Therapeutic Community site on the day of the services being documented.

113.000 Therapeutic Communities, Level 1 Service Requirements

(a) Therapeutic Communities, Level 1 are the highest level of care in a Therapeutic Community. Eligibility for this service will be determined by an Independent Assessment and an authorization for service at this level of care.

(b) A Level 1 Therapeutic Community shall have no less than the following staff-to-client ratios to ensure safety of clients receiving services:

a. 1 staff member for every 3 clients during daytime (8:00 A.M. – 5:00 P.M.)

b. 1 staff member for every 8 clients during evening and overnight (5:00 P.M to 8:00 A.M.)

(c) Each client served in a Level 1 Therapeutic Community shall have an Individualized Plan of Care. This Plan shall specify the minimum service requirements listed below, which shall include a minimum of 42 hours of planned Counseling Level or Rehabilitative Level services per week that are specified within the Outpatient Behavioral Health Services Manual.

114.000 Therapeutic Communities, Level 1, Physician Services

(a) Physician services include any service allowed to be performed by a Physician within the Outpatient Behavioral Health Services Manual. Physician Services include Pharmacologic Management to provide prescriptions for medications.

(b) There shall be no less than 2 Physician Service encounters per month provided to each client.

(c) Documentation in the client's medical record requires services to be put in the daily service log for all clients. All medications for the client must be identified within the client's medical record.

115.000 Therapeutic Communities, Level 1, Professional Services

(a) Professional services include any service allowed to be performed by a Mental Health Professional (independently licensed or non-independently licensed clinician) within the Outpatient Behavioral Health Services Manual.

(b) There shall be no less than 10 hours per week of Professional Services provided to each client. Of the 10 hours required per week, 3 hours shall be delivered on an individual basis (for example, Individual Behavioral Health Counseling). Services provided to a group of individuals at the same time do not count towards the 3 hours of individual services required. Of the 10 hours required per week, 7 hours may be delivered to multiple clients in a group.

(c) Documentation in the client's medical record requires services to be put in the daily service log for all clients. Services shall include activities to address client's treatment goal(s) established in the Individualized Plan of Care.

116.000 Therapeutic Communities, Level 1, Qualified Behavioral Health Provider Services

(a) Qualified Behavioral Health Provider services include any service allowed to be performed by a Qualified Behavioral Health Provider, Certified Peer Support Specialist, Certified Youth Support Specialist, and Certified Family Support Partner within the Outpatient Behavioral Health Services Manual.

(b) Of the 42 total hours of services required per week per client, 10 hours of Qualified Behavioral Health Provider services shall be delivered on an individual basis (for example, Behavioral Assistance). Services provided to a group of clients at the same time do not count towards the 10 hours of individual Qualified Behavioral Health Provider services required.

(c) Documentation in the client's medical record requires services to be put in the daily service log for all clients. Services shall include activities to address client's treatment goal(s) established in the Individualized Plan of Care.

117.000 Therapeutic Communities, Level 1, Supportive Activities

(a) Supportive activities may be provided to clients in a Therapeutic Community based upon the individual client's needs.

(b) Documentation in the client's medical record requires services to be put in the daily service log for all clients. Services shall include activities to address client's treatment goal(s) established in the Individualized Plan of Care.

118.000 Therapeutic Communities, Level 2, Service Requirements

(a) Therapeutic Communities, Level 2 are a lower level of care of a Therapeutic Community. Eligibility for this service will be determined by an Independent Assessment and an authorization for service at this level of care.

(b) A Level 2 Therapeutic Community client shall have no less than the following staff-to-client ratios to ensure safety of clients receiving services:

a. 1 staff member for every 8 clients during daytime (8:00 A.M. – 5:00 P.M.)

b. Appropriate staff supervision shall be documented in policies and procedures of the Therapeutic Community for clients during evening and overnight (5:00 P.M to 8:00 A.M.). Level 2 Therapeutic Communities must have the ability for residents to be seen by appropriate caregivers when necessary 24 hours a day. Appropriate supervision must be documented and maintained at Level 2 Therapeutic Communities.

(c) Each client served in a Level 2 Therapeutic Community shall have an Individualized Plan of Care. This Plan shall specify the minimum service requirements listed below, which shall include a minimum of 42 hours of planned Counseling Level or Rehabilitative Level services per week that are specified within the Outpatient Behavioral Health Services Manual.

119.000 Therapeutic Communities, Level 2, Physician Services

(a) Physician services include any service allowed to be performed by a Physician within the Outpatient Behavioral Health Services Manual. Physician Services include Pharmacologic Management to provide prescriptions for medications.

(b) There shall be no less than 1 Physician Service encounter per month provided to each client.

(c) Documentation in the client's medical record requires services to be put in the daily service log for all clients. All medications for the client must be identified within the client's medical record.

118.000 Therapeutic Communities, Level 2, Professional Services

(a) Professional services include any service allowed to be performed by a Mental Health Professional (independently licensed or non-independently licensed clinician) within the Outpatient Behavioral Health Services Manual.

(b) There shall be no less than 6 hours per week of Professional Services provided to each client. Of the 6 hours required per week, 1 hour shall be delivered on an individual basis (for example, Individual Behavioral Health Counseling). Services provided to a group of individuals at the same time do not count towards the 1 hour of individual services required. Of the 6 hours required per week, 5 hours may be delivered to multiple clients in a group.

(c) Documentation in the client's medical record requires services to be put in the daily service log for all clients. Services shall include activities to address client's treatment goal(s) established in the Individualized Plan of Care.

119.000 Therapeutic Communities, Level 2, Qualified Behavioral Health Provider Services

(a) Qualified Behavioral Health Provider services include any service allowed to be performed by a Qualified Behavioral Health Provider, Certified Peer Support Specialist, Certified Youth Support Specialist, and Certified Family Support Partner within the Outpatient Behavioral Health Services Manual.

(b) Of the 42 total hours of services required per week per client, 8 hours of Qualified Behavioral Health Provider services shall be delivered on an individual basis (for example, Behavioral Assistance). Services provided to a group of clients at the same time do not count towards the 8 hours of individual Qualified Behavioral Health Provider services required.

(c) Documentation in the client's medical record requires services to be put in the daily service log for all clients. Services shall include activities to address client's treatment goal(s) established in the Individualized Plan of Care.

120.000 Therapeutic Communities, Level 2, Supportive Activities

(a) Supportive activities may be provided to clients in a Therapeutic Community based upon the individual client's needs.

(b) Documentation in the client's medical record requires services to be put in the daily service log for all clients. Services shall include activities to address client's treatment goal(s) established in the Individualized Plan of Care.

130.000 THERAPEUTIC COMMUNITY MEDICAL RECORDS REQUIREMENTS

131.000 Medical record keeping system

Each Therapeutic Community shall maintain an organized medical record keeping system to collect and document information appropriate to the treatment processes. This system shall be organized; easily retrievable, usable medical records stored under confidential conditions and with planned retention and disposition.

132.000 Basic requirements

(a) The Therapeutic Community's policies and procedures shall:

(1) Define the content of the client's medical record.

(2) Define storage, retention and destruction requirements for client medical records;

(3) Require client medical records be confidentially maintained in locked equipment under secure measures;

(4) Require legible entries in client medical records signed with first name or initial, last name, credentials, and dated by the person making the entry;

(5) Require the client's name be typed or written on each sheet of paper or page in the client record;

(6) Require a signed consent for treatment before the client is admitted; and

(7) Require a signed consent for follow-up before any contact after discharge is made.

133.000 Record access for clinical staff

(a) The Therapeutic Community shall assure client records are readily accessible to the Therapeutic Community staff directly caring for the client. Such access shall be limited to the minimum necessary to carry out the staff member's job functions or the purpose for the use of the records.

134.000 Clinical record content, intake and assessment

(a) The Therapeutic Community shall assess each individual to determine appropriateness of admission. Initial assessments by an MHP are to be completed on all clients.

(b) Client intake information shall contain, but not be limited to the following identification data:

(1) Client name;

(2) Name and identifying information of the legal guardian(s)

(3) Home address;

(4) Telephone number;

(5) Referral source;

(6) Reason for referral;

(7) Significant other to be notified in case of emergency;

(8) Intake data core content;

(9) Presenting problem and disposition;

(10) A record of pertinent information regarding adverse reactions to drugs, drug allergies, or sensitivities shall be obtained during intake and kept in a highly visible location in or on the record; and

(11) Screening for co-occurring disorders, trauma, medical and legal issues.

(c) Client assessment information for clients admitted to Therapeutic Communities shall be completed within 12 hours of admission.

(1) Integrated mental health and substance abuse psychosocial evaluation that minimally addresses:

(A) The client's strengths and abilities to be considered during community re-entry;

(B) Economic, vocational, educational, social, family and spiritual issues as indicated

(2) Interpretive summary of relevant assessment findings that results in the development of an intervention plan addressing mental health, substance use disorder, and other related issues contributing to admission to a Therapeutic Community;

(3) An integrated intervention plan that minimally addresses the client's:

(A) Presenting crisis situation that incorporates the identified problem(s);

(B) Strengths and abilities;

(C) Needs and preferences; and

(D) Goals and objectives.

135.000 Health, mental health, substance abuse, and drug history

(a) A health and drug history shall be completed for each client at the time of admission in Therapeutic Community (as soon as practical). The medical history shall include obtainable information regarding:

(1) Name of medication;

(2) Strength and dosage of current medication;

(3) Length of time patient was on the medication if known;

(4) Benefit(s) of medication;

(5) Side effects;

(6) The prescribing medical professional if known; and

(7) Relevant drug history of family members.

(b) A mental health history, including symptoms and safety screening, shall be completed for each client at the time of admission in a Therapeutic Community (as soon as practical).

(c) A substance abuse history, including checklist for use, abuse, and dependence for common substances (including nicotine and caffeine) and screening for withdrawal risk and IV use shall be completed for each client at the time of admission

136.000 Progress notes

(a) The Therapeutic Community shall have a policy and procedure mandating the chronological documentation of progress notes for clients admitted to Therapeutic Communities.

(b) All services provided to a client shall be documented in a daily service log to indicate when particular services were provided to clients. This daily log shall also include a daily summary indicating the goals and objectives within the Plan of Care that were addressed during treatment during the day. This summary shall include the activities performed and the client's progress or lack of progress of achieving the treatment

goal(s) established in the Individualized Plan of Care. This daily service log shall be reviewed and signed by a Mental Health Professional (Independently Licensed Practitioners, Non-Independently Licensed Practitioner) This daily service log must be easily accessible to any auditors and must be updated and signed daily by appropriate staff.

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

(1) Therapeutic Community staff shall document progress notes daily

137.000 Medication record

(a) The Therapeutic Community shall maintain a medication record on all clients who receive medications or prescriptions in order to provide a concise and accurate record of the medications the client is receiving or has been prescribed for the client.

(b) The client medical record shall contain a medication record with information on all medications ordered or prescribed by physician staff which shall include, but not be limited to:

(1) The record of medication administered, dispensed or prescribed shall include all of the following:
(A) Name of medication,

(B) Dosage,

(C) Frequency of administration or prescribed change,

(D) Route of administration, and

(E) Staff member who administered or dispensed each dose, or prescribing physician; and

(2) A record of pertinent information regarding adverse reactions to drugs, drug allergies, or sensitivities shall be updated when required by virtue of new information, and kept in a highly visible location in or on the record.

138.000 Referral and Linkage Procedures

(a) Referral and linkage procedures shall be in place so staff can adequately advocate on behalf of the person served as early as possible during the stabilization treatment process to transition to lesser restrictive or alternative

treatment settings, as indicated. Discharge planning shall occur at admission and be continuously updated during treatment plan reviews and updates.

139.000 Aftercare and discharge summary

(a) An aftercare plan shall be entered into each client's medical record upon discharge from the Therapeutic Community. A copy of the plan shall be given to the client, the client's legal guardian, or both the client and legal guardian as applicable, as well as to any facility designated to provide follow-up with a valid written authorization by the client, the client's legal guardian, or both the client and legal guardian as applicable.

(b) An aftercare plan shall include a summary of progress made toward meeting the goals and objectives of the intervention plan, as well as an overview of psychosocial considerations at discharge, and recommendations for continued follow-up after release from the Therapeutic Community.

(c) The aftercare plan shall minimally include:

(1) Presenting problem at intake;

(2) Any co-occurring disorders or issues, and recommended interventions for each;

(3) Physical status and ongoing physical problems;

(4) Medications prescribed at discharge;

(5) Medication and lab summary, when applicable;

(6) Names of family and significant other contacts;

(7) Any other considerations pertinent to the client's successful functioning in the community;

(8) The Client's, the client's legal guardian, or as indicated both the client's and legal guardian's comments on participation in his or her crisis resolution efforts; and

(9) The credentials of the staff members treating the client and their dated signatures.

140.000 Other records content

(a) The client record shall contain copies of all consultation reports concerning the client.

(b) When psychometric or psychological testing is done, the client record shall contain a copy of a written report describing the test results and implications and recommendations for treatment.

(c) The client medical record shall contain any additional information relating to the client, which has been secured from sources outside the Therapeutic Community.

135.000 CONFIDENTIALITY

136.000 Confidentiality of mental health and drug or alcohol abuse treatment information

Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards. Laws and regulations on the confidentiality of medical records (Privacy Act and Freedom of Information Act) and the procedures for informed consent for release of information from the record must be followed.

140.000 CLIENT RIGHTS

141.000 DHS Investigations

The Arkansas Department of Human Services in any investigation or program monitoring regarding client rights shall have access to clients, Therapeutic Community Records and Therapeutic Community staff.

142.000 Mechanical restraints

(a) Mechanical restraints shall not be used on any client.

150.000 ORGANIZATIONAL MANAGEMENT

151.000 Organizational description

(a) The Therapeutic Community shall have a written organizational description which is reviewed annually by both the Therapeutic Community and DHS, which minimally includes:

(1) The overall target population, specifically including those individuals with co-occurring disorders, for whom services will be provided;

(2) The overall mission statement;

(3) The annual facility goals and objectives, including the goal of continued progress for the facility in providing person centered, culturally competent, trauma informed and co-occurring capable services;

(b) The Therapeutic Community's governing body shall approve the mission statement and annual goals and objectives and document their approval.

(c) The Therapeutic Community shall make the organizational description, mission statement and annual goals and objectives available to staff.

(d) The Therapeutic Community shall make the organizational description, mission statement and annual goals and objectives available to the general public upon request.

(e) Each Therapeutic Community shall have a written plan for professional services which shall have in writing the following:

(1) Services description and philosophy;

(2) The identification of the professional staff organization to provide these services;

(3) Written admission and exclusionary criteria to identify the type of clients for whom the services are primarily intended; and

(4) Written goals and objectives.

(5) Delineation of processes to assure accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.

(f) There shall be a written statement of the procedures/plans for attaining the organization's goals and objectives. These procedures/plans should define specific tasks, including actions regarding the organization's co-occurring capability, set target dates and designate staff responsible for carrying out the procedures or plans.

152.000 Information Analysis and Planning

(a) The Therapeutic Community shall have a defined plan for conducting an organizational needs assessment that specifies the methods and data to be collected, which shall include but not limited to information from:

(1) Clients;

(2) Governing Authority;

(3) Staff;

(4) Stakeholders;

(5) Outcomes management processes; and

(6) Quality record review.

(b) The Therapeutic Community shall have a defined system to collect data and information on a quarterly basis to manage the organization.

(c) Information collected shall be analyzed to improve client services and organizational performance.

(d) The Therapeutic Community shall prepare an end of year management report, which shall include but not be limited to:

(1) An analysis of the needs assessment process; and

(2) Performance improvement program findings.

(e) The management report shall be communicated and made available to among others:

(1) The governing authority;

(2) Therapeutic Community staff; and

(3) DHS if and when requested.

155.000 PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT

156.000 Performance improvement program

(a) The Therapeutic Community shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of client care.

(b) The Performance improvement program shall also address the fiscal management of the organization.

(c) There shall be an annual written plan for performance improvement activities. The plan shall include, but not be limited to:

(1) Outcomes management processes specific to each program component minimally measuring:

(A) efficiency;

(B) effectiveness; and

(C) client satisfaction.

(2) A quarterly record review to minimally assess:

(A) quality of services delivered;

(B) appropriateness of services;

(C) patterns of service utilization;

(D) clients, relevant to:

i. their orientation to the Therapeutic Community and services being provided; and

ii. their active involvement in making informed choices regarding the services they receive;

(E) the client assessment information thoroughness, timeliness and completeness;

(F) treatment goals and objectives are based on:

i. assessment findings; and

ii. client input;

(G) services provided were related to the goals and objectives;

(H) services are documented as prescribed by policy;

(I) the treatment plan is reviewed and updated as prescribed by policy

(3) Clinical privileging;

(4) Fiscal management and planning, which shall include:

(A) an annual budget that is approved by the governing authority and reviewed at least annually;

(B) the organization's capacity to generate needed revenue to produce desired client and other outcomes;

(C) monitoring client records to ensure documented dates of services provided coincide with billed service encounters; and,

(5) Review of critical incident reports and client grievances or complaints.

(d) The Therapeutic Community shall monitor the implementation of the performance improvement plan on an ongoing basis and makes adjustments as needed.

(e) Performance improvement findings shall be communicated and made available to, among others:

(1) the governing authority;

(2) Therapeutic Community staff; and

(3) DHS if and when requested.

157.000 Incident reporting

(a) The Therapeutic Community shall have written policies and procedures requiring documentation and reporting of critical incidents.

(b) The documentation for critical incidents shall contain, minimally:

(1) the facility name and name and signature of person(s) reporting the incident;

(2) the name of client(s), staff person(s), or others involved in the incident;

(3) the time, place and date the incident occurred;

(4) the time and date the incident was reported and name of the person within the facility to whom it was reported;

(5) description of the incident; and

(6) the severity of each injury, if applicable. Severity shall be indicated as follows:

(A) No off-site medical care required or first aid care administered on-site;

(B) Medical care by a physician or nurse or follow-up attention required; or

(C) Hospitalization or immediate off-site medical attention was required;

(7) Resolution or action taken, date action taken, and signature of the Therapeutic Community director.

(c) The Therapeutic Community shall report those critical incidents to DHS that include.

(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to DHS Provider Certification within twenty-four (24) hours of the incident being documented.

(2) Critical incidents involving allegations constituting a sentinel event or resident abuse shall be reported to DHS immediately via telephone or fax, but not less than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.

160.000 PERSONNEL

161.000 Personnel policies and procedures

(a) The Therapeutic Community shall have written personnel policies and procedures approved by the governing authority.

(b) All employees shall have access to personnel policies and procedures, as well as other Rules and Regulations governing the conditions of their employment.

(c) The Therapeutic Community shall develop, adopt and maintain policies and procedures to promote the objectives of the program and provide for qualified personnel during all hours of operation to support the functions of the center and provide quality care.

162.000 Job descriptions

(a) The Therapeutic Community shall have written job descriptions for all positions setting forth minimum qualifications and duties of each position.

(b) All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.

165.000 STAFF DEVELOPMENT AND TRAINING

166.000 Staff qualifications

(a) The Therapeutic Community shall document the qualifications and training of staff providing crisis stabilization services which shall be in compliance with the Therapeutic Community's clinical privileging process.

(b) Failure to comply with Section 166.000 will result in the initiation of procedures to deny, suspend and/or revoke certification.

167.000 Staff development

(a) The Therapeutic Community shall have a written plan for the professional growth and development of all administrative, professional clinical and support staff.

(b) This plan shall include but not be limited to:

(1) orientation procedures;

(2) in-service training and education programs;

(3) availability of professional reference materials; and

(4) mechanisms for insuring outside continuing educational opportunities for staff members.

(c) The results of performance improvement activities and accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes.

(d) Staff competency development shall be aligned with the organization's goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.

(e) Staff education and in-service training programs shall be evaluated by the Therapeutic Community at least annually.

168.000 In-service

(a) Trainings are required annually for all employees who provide clinical services within the Therapeutic Community program on the following topics:

(1) Fire and safety;

(2) Infection Control and universal precautions;

(3) Client's rights and the constraints of the Mental Health Client's Bill of Rights;

(4) Confidentiality;

(5) Arkansas Adult and Long-Term Care Facility Resident Maltreatment Act, §12-12-1701 et seq.

(6) Facility policy and procedures;

(7) Cultural competence;

(8) Co-occurring disorder competency and treatment principles; and

(9) Trauma informed and age and developmental specific trainings.

(b) All staff providing clinical services shall have a current certification in basic first aid and in Cardiopulmonary Resuscitation (CPR).

(c) All clinical staff shall have training in non-physical intervention techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within 30 days of being hired with annual updates thereafter. This training shall occur prior to direct patient contact.

(d) The Therapeutic Community Executive Director shall designate which positions and employees, including temporary employees, will be required to successfully complete physical intervention training. The employee shall successfully complete this training within 30 days of being hired, with annual updated thereafter. This training shall occur prior to direct patient contact.

170.000 FACILITY ENVIRONMENT

Therapeutic Communities shall apply these standards to all sites operated. The primary concern of the Therapeutic Community should always be the safety and wellbeing of the clients and staff. Therapeutic Communities shall be physically located in the State of Arkansas. Therapeutic Communities shall provide a safe and sanitary environment.

171.000 Facility environment

(a) The Therapeutic Community shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.

(b) Therapeutic Community staff shall know the exact location, contents, and use of first aid supply kits and firefighting equipment and fire detection systems. All firefighting equipment shall be annually maintained in appropriately designated areas within the facility.

(c) The Therapeutic Community shall post written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather. All exits must be clearly marked.

(d) Facility grounds shall be maintained in a manner, which provides a safe environment for clients, personnel, and visitors.

(e) The Therapeutic Community Facility Director or, designee, shall appoint a safety officer.

(f) The Therapeutic Community shall have an emergency preparedness program designed to provide for the effective utilization of available resources so client care can be continued during a disaster. The Therapeutic Community shall evaluate the emergency preparedness program annually and update as needed.

(g) Policies for the use and control of personal electrical equipment shall be developed and implemented.

(h) The Therapeutic Community shall have an emergency power system to provide lighting throughout the facility.

(i) The Therapeutic Community Facility Director shall ensure there is a written plan to respond to internal and external disasters. External disasters include, but are not limited to, tornadoes, explosions, and chemical spills.

(j) All Therapeutic Communities shall be inspected annually by designated fire and safety officials of the municipality who exercise fire/safety jurisdiction in the facility's location which results in the facility being allowed to continue to operate.

(k) The Therapeutic Community shall have a written Infection Control Program and staff shall be knowledgeable of Center for Disease Control (CDC) Guidelines for Tuberculosis and of the Blood Borne Pathogens Standard, location of spill kits, masks, and other personal protective equipment.

(l) The Therapeutic Community shall have a written Hazardous Communication Program and staff shall be knowledgeable of chemicals in the workplace, location of Material Safety Data Sheets, personal protective equipment; and toxic or flammable substances shall be stored in approved locked storage cabinets.

(m) The Therapeutic Community's telephone number(s) and actual hours of operation shall be posted at all public entrances.

(n) Signs must be posted at all public entrances informing staff, clients and visitors as to the following requirements:

(1) No alcohol or illicit drugs are allowed in the Therapeutic Community facility,

(2) No firearms, or other dangerous weapons, are allowed in the Therapeutic Community facility with the exception of law enforcement while in the performance of their duties, and

(3) The use of tobacco is not allowed in the Therapeutic Community facility.

(o) A copy of compliance with law Title VI/Title VII of the 1964 Civil Rights Law shall be prominently displayed within the Therapeutic Community Facility.

(p) Therapeutic Communities shall:

(1) Provide separate bedroom areas for males and females,

(2) Provide sufficient clean linens for clients, and

(3) Provide adequate barriers to divide clients.

(q) Plumbing in Therapeutic Communities shall be in working condition to avoid any health threat. All toilets, sinks and showers shall be clean and in working order.

(r) There shall be at least one toilet, one sink, and one shower or tub per every eight (8) Therapeutic Community beds. This means that an Therapeutic Community shall have no less than one toilet, one sink, and one shower or tub.

(s) A secure locked storage shall be provided for client valuables when requested.

(t) Separate storage areas are provided and designated for:

(1) Food, kitchen, and eating utensils,

(2) Clean linens,

(3) Soiled linens and soiled cleaning equipment, and

(4) Cleaning supplies and equipment.

(u) When handling soiled linen or other potentially infectious material, Universal Precautions are to be followed and address in the Therapeutic Community policies and procedures. Hazardous and regulated waste shall be disposed of in accordance with federal requirements.

(v) Poisons, toxic materials and other potentially dangerous items shall be stored in a secured location.

172.000 Medication clinic, medication monitoring

(a) Medication administration; storage and control; and client reactions shall be continuously monitored.

(b) Therapeutic Communities shall assure proper storage and control of medications, immediate response if incorrect or overdoses occur, and have appropriate emergency supplies available if needed.

(1) Written procedures for medication administration shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications.

(2) All medications shall be kept in locked, non-client accessible areas. Factors which shall be considered in medication storage are light, moisture, sanitation, temperature, ventilation, and the segregation and safe storage of poisons, external medications, and internal medications.

(3) Telephone numbers of the state poison centers shall be immediately available in all locations where medications are prescribed, or administered, or stored.

(4) An Therapeutic Community physician shall supervise the preparation and stock of an emergency kit which shall be readily available, but accessible only to Therapeutic Community staff.

173.000 Medication, error rates

The Therapeutic Community shall have an ongoing performance improvement program that specifically, objectively, and systematically monitors medications administration or dispensing or medication orders and prescriptions to evaluate and improve the quality of client care.

174.000 Technology

The Therapeutic Community shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:

(1) Hardware and software.

(2) Security.

(3) Confidentiality.

(4) Backup policies.

(5) Assistive technology.

(6) Disaster recovery preparedness.

(7) Virus protection.

175.000 Food and Nutrition

(a) If the Therapeutic Community prepared meals on site, the Therapeutic Community shall have a current food establishment health inspection as required by the Arkansas Department of Health.

(b) When meals are provided by a food service, a written contract shall be maintained and shall require the food service to have a current food establishment health inspection as required by the Arkansas Department of Health.

(c) Therapeutic Communities shall provide at least three meals daily, with no more than fourteen (14) hours between any two meals.

(d) All food shall be stored, prepared, and served in a safe, healthy manner.

(e) Perishable items shall not be used once they exceed their sell by date.

180.000 GOVERNING AUTHORITY

181.000 Documents of authority

(a) There shall be a duly constituted authority and governance structure for assuring legal responsibility and for requiring accountability for performance and operation of the Therapeutic Community.

(b) The governing authority shall have written documents of its source of authority, which shall be available to the public upon request.

(c) The governing body's bylaws, rules or regulations shall identify the chief executive officer who is responsible for the overall day-to-day operation of the Therapeutic Community, including the control, utilization and conservation of its physical and financial assets and the recruitment and direction of the staff.

(1) The source of authority document shall state:

(A) The eligibility criteria for governing body membership;

(B) The number and types of membership

(C) The method of selecting members;

(D) The number of members necessary for a quorum;

(E) Attendance requirements for governing body membership;

(F) The duration of appointment or election for governing body members and officers.

(G) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.

(2) There shall be an organizational chart setting forth the structure of the organization.

Arkansas Department of Human Services

Behavioral Health Acute Crisis Unit Certification

Need Table of Contents and Update of Number System

100.000 GENERAL PROVISIONS

101.000 Purpose

This chapter sets forth the Standards and Criteria used in the certification of Acute Crisis Units by the Arkansas Department of Human Services. The rules regarding the certification processes including, but not necessarily limited to, applications, requirements for, levels of, and administrative sanctions are found in this manual.

102.000 Definitions

The following words or terms, when used in this Chapter, shall have the defined meaning, unless the context clearly indicates otherwise:

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a resident by a staff responsible for the resident's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a resident.

"Acute Crisis Unit" means a program of non-hospital emergency services for mental health and substance use disorder crisis stabilization, including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance use disorder treatment services. This service is limited to individual sites which are certified by the Arkansas Department of Human Services, (DHS) or facilities operated by the Arkansas Department of Human Services. Acute Crisis Units shall be freestanding facilities that must the following:

1.) Have 16 beds or less

2.) Are independently certified by DHS outside of an existing Hospital

"Adverse license action" means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

"Certification" means a written designation, issued by DHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

"Clinical privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to clients within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment, and other credentials.

"Client" means any person for whom an Acute Crisis Unit furnishes, or has agreed or undertaken to furnish, services.

"Co-occurring disorder" means any combination of mental health and substance use disorder symptoms or diagnoses in a client.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to individuals with co-occurring disorders.

"Compliance" means conformance with:

Applicable state and federal laws, rules, and regulations including, without limitation:

A. Titles XIX and XXI of the Social Security Act and implementing regulations;

B. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;

C. All state laws and rules applicable to Medicaid generally and to Acute Crisis Unit services specifically;

D. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;

E. The Americans With Disabilities Act, as amended, and implementing regulations;

F. The Health Insurance Portability and Accountability Act ("HIPAA"), as amended, and implanting regulations.

"Crisis intervention" means an immediately available service to meet the psychological, physiological and environmental needs of individuals who are experiencing a mental health and/or substance abuse crisis.

"Crisis stabilization" means emergency psychiatric and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment and referral.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of the facility, or the routine care of a client. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to clients, staff and visitors; medication errors; clients that are absent without leave (AWOL); neglect or abuse of a client; fire; unauthorized disclosure of information; damage to or theft of property belonging to a clients or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Emergency examination" For adults: means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or drug-dependent person and a person requiring treatment, and whose condition is such that it appears that emergency detention may be warranted, by a licensed mental health professional to determine if emergency detention of the person is warranted. The examination must occur within twelve (12) hours of being taken into protective custody.

"DHS" means the Arkansas Department of Human Services Division of Behavioral Health Services.

"**Deficiency**" means an item or area of noncompliance.

"**DHS**" means the Arkansas Department of Human Services.

"Initial Assessment" means examination of current and recent behaviors and symptoms of an individual who appears to be mentally ill or substance dependent.

"Intervention plan" means a description of services to be provided in response to the presenting crisis situation that incorporates the identified problem(s), strengths, abilities, needs and preferences of the individual served.

"Licensed mental health professional" or **"LMHP"** as defined.

"Linkage services" means the communication and coordination with other service providers that assure timely appropriate referrals between the Acute Crisis Unit and other providers.

"**Mental health professional**" or "**MHP**" means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

"Minor" means any person under eighteen (18) years of age.

"Performance Improvement" or **"PI"** means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of clients and others. Synonyms, and near synonyms include continuous performance improvement, continuous improvement, organization-wide performance improvement and total quality management.

"Persons with special needs" means any persons with a condition which is considered a disability or impairment under the "American with Disabilities Act of 1990" including, but not limited to the deaf/hearing impaired, visually impaired, physically disabled, developmentally disabled, persons with disabling illness, persons with mental illness and/or substance abuse disorders. See "Americans with Disabilities Handbook," published by U.S. Equal Employment Opportunity Commission and U.S. Department of Justice.

"**Professionally recognized standard of care**" means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent

reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice models is evidence of compliance with professionally recognized standards of care.

"Progress notes" mean a chronological description of services provided to a client, the client's progress, or lack of, and documentation of the client's response related to the intervention plan.

"**Provider**" means an entity that is certified by DHS as an Acute Crisis Unit and enrolled by DMS as a Behavioral Health Agency.

"Psychosocial evaluations" are in-person interviews conducted by professionally trained personnel designed to elicit historical and current information regarding the behavior and experiences of an individual, and are designed to provide sufficient information for problem formulation and intervention.

"**Qualified Behavioral Health Provider**" means a person who:

A. Does not possess an Arkansas license to provide clinical behavioral health care;

B. Works under the direct supervision of a mental health professional;

C. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned by a mental health professional;

D. Acknowledges in writing that all mental health paraprofessional services are controlled by client care plans and provided under the direct supervision of a mental health professional.

"Restraint" refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of the individual's body. Mechanical Restraints shall not be utilized within a certified Acute Crisis Unit.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a client, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a client. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms or violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Triage" means a dynamic process of evaluating and prioritizing the urgency of crisis intervention needed based on the nature and severity of clients' presenting situations.

"Trauma Informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of all clients.

103.000 Meaning of verbs in rules

The attention of the facility is drawn to the distinction between the use of the words "shall," "should," and "may" in this chapter:

A. "Shall" is the term used to indicate a mandatory statement, the only acceptable method under the present standards.

B. "Should" is the term used to reflect the most preferable procedure, yet allowing for the use of effective alternatives.

C. "May" is the term used to reflect an acceptable method that is recognized but not necessarily preferred.

104.000 Applicability

The standards and criteria for services as subsequently set forth in this chapter are applicable to Acute Crisis Units as stated in each section.

110.000 ACUTE CRISIS UNITS

111.000 Required services

Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons ages 18 and above who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.

112.000 Acute Crisis Unit crisis stabilization

A. The Acute Crisis Unit shall provide crisis stabilization to individuals who are in crisis as a result of a mental health and/or substance use disorder related problem. Each Acute Crisis Unit must be specifically accessible to individuals who present with co-occurring disorders. The Acute Crisis Unit may provide services in excess of 24 hours during one episode, but not more than 96 hours during one episode.

B. Acute Crisis Unit services shall be provided in the least restrictive setting possible. Services should be provided within, or as close to the community in which they reside as possible.

C. A physician shall be available at all times for the crisis unit, either on-duty or on call. If the physician is on call, he or she shall respond by telephone or in person to the licensed staff on duty at the crisis unit within 20 minutes.

D. Acute Crisis Unit services shall include, but not be limited to, the following service components and each shall have written policy and procedures and each shall be co-occurring disorder capable and trauma informed, with policies and procedures that support this capability:

1. Triage services;

2. Co-occurring capable Psychiatric crisis stabilization; and

3. Co-occurring capable Drug/alcohol crisis stabilization.

E. The Acute Crisis Unit shall have written policy and procedures addressing restraints, and these shall be in compliance with Section 503.000.

113.000 Crisis stabilization, triage

A. Crisis stabilization services shall include twenty-four (24) hour triage services and emergency examination.

B. Qualified staff providing triage services shall be:

1. A Mental Health Professional (MHP) capable of providing crisis stabilization services within the scope of their individual licensure; and

2. Knowledgeable about applicable laws, DHS rules, facility policy and procedures, and referral sources.

C. Components of this service shall minimally include the capacity to provide:

1. Immediate response, on-site and by telephone;

2. Screening for the presence of co-occurring disorders;

3. integrated Emergency mental health and/or substance use disorder examination on site or via telemedicine; and

4. Referral, linkage, or a combination of the two services.

D. The Acute Crisis Unit shall have written policy and procedures minimally:

1. Providing twenty-four (24) hour, seven (7) days per week, triage crisis services; and

2. Defining methods and required content for documentation of each triage crisis response service provided.

3. Ensuring that individuals who present in crisis with co-occurring disorders are identified, and that there are no barriers to access triage crisis response based on arbitrary alcohol or drug levels, types of diagnosis or medications while remaining in compliance with facility certification, licensure, and medical standards. Nothing in this Section shall require a facility to treat a client that is not medically stable.

114.000 Crisis stabilization, psychiatric, substance use disorder and co-occurring services

A. Crisis stabilization services shall provide continuous twenty-four (24) hour evaluation, observation, crisis stabilization, and social services intervention seven (7) days per week for clients experiencing mental health or substance use disorder related crises; or those who present with co-occurring disorders.

B. Licensed nurses and other support staff shall be adequate in number to provide care needed by clients twenty-four (24) hours a day seven (7) days per week.

C. Crisis stabilization services shall be provided by a co-occurring disorder capable multidisciplinary team of medical, nursing, social services, clinical, administrative, and other staff adequate to meet the clinical needs of the individuals served.

D. Staff members assigned to a medical supervised detoxification component shall be knowledgeable about the physical signs of withdrawal, the taking of vital signs and the implication of those vital signs, and emergency procedures as well as demonstrating core competencies in addressing the needs of individuals receiving detoxification services who may have co-occurring mental health disorders and be on psychotropic medication.

E. Services shall minimally include:

1. Medically-supervised substance use disorder and mental health screening, observation and evaluation;

2. Initiation and medical supervision of rapid stabilization regimen as prescribed by a physician, including medically monitored detoxification where indicated;

3. Medically-supervised and co-occurring disorder capable detoxification, in compliance with procedures outlined in the Arkansas DHS Regional Alcohol and Drug Detoxification Manual.

4. Intensive care and intervention during acute periods of crisis stabilization;

5. Motivational strategies to facilitate further treatment participation for mental health and/or substance abuse needs; and,

6. Providing referral, linkage or placement, as indicated by client needs.

F. Crisis stabilization services, whether psychiatric, substance use disorder, or co-occurring, shall be utilized only after less restrictive community resources have been determined to be inadequate to meet the current needs of the client.

115.000 Linkage Services to higher or lower levels of care, or longer term placement

A. Persons needing mental health services shall be treated with the least restrictive clinically appropriate methods.

B. In cases where clients are not able to stabilize in or are not appropriate for the Acute Crisis Unit, linkage services shall be provided, including the following steps:

1. Qualified Acute Crisis Unit staff shall perform the crisis intervention and referral process to the appropriate treatment facility.

2. The referral process shall require referral to the least restrictive service to meet the needs of the client. The referral shall be discussed with the client, the client's legal guardian, or both the client and legal guardian as applicable, and shall include a discussion of why a less restrictive community resource was not utilized if applicable. This discussion shall be documented in the client's record. If an adult client wishes to include family members in the decision making process, appropriate releases should be obtained.

3. Staff shall make referral to an appropriate treatment facility to include demographic and clinical information and documentation. Appropriate releases should be obtained as indicated.

C. The Acute Crisis Unit shall have a written plan for addressing non-psychiatric medical emergencies, including transfer to a general medical-surgical hospital when necessary. All emergencies must be documented and reviewed by appropriate Acute Crisis Unit staff.

D. If the Acute Crisis Unit is referring an adult to a state-operated inpatient facility, the client must meet the Arkansas State Hospital admission criteria and the Acute Crisis Unit must comply with Arkansas State Hospital admission criteria.

116.000 Pharmacy services

A. The Acute Crisis Unit shall provide specific arrangements for pharmacy services to meet clients' needs. Provision of services may be made through agreement with another program or through a pharmacy in the community.

B. Medical records must contain valid prescriptions for medications administered while a client is in the care in an Acute Crisis Unit.

C. The Acute Crisis Unit shall have the capacity to administer medications, including injectables, twenty-four (24) hours per day.

120.000 ACUTE CRISIS UNIT MEDICAL RECORDS REQUIREMENTS

121.000 Medical record keeping system

Each Acute Crisis Unit shall maintain an organized medical record keeping system to collect and document information appropriate to the treatment processes. This system shall be organized; easily retrievable, usable medical records stored under confidential conditions and with planned retention and disposition.

122.000 Basic requirements

The Acute Crisis Unit's policies and procedures shall:

A. define the content of the client's medical record in accordance with Section 300.000 through Section 310.000 of this manual.

B. define storage, retention and destruction requirements for client medical records;

C. require client medical records be confidentially maintained in locked equipment under secure measures;

D. require legible entries in client medical records signed with first name or initial, last name, and dated by the person making the entry;

E. require the client's name be typed or written on each sheet of paper or page in the client record;

F. require a signed consent for treatment before the client is admitted on a voluntary basis; and

G. require a signed consent for follow-up before any contact after discharge is made.

123.000 Record access for clinical staff

The Acute Crisis Unit shall assure client records are readily accessible to the Acute Crisis Unit staff directly caring for the client. Such access shall be limited to the minimum necessary to carry out the staff member's job functions or the purpose for the use of the records.

124.000 Clinical record content, intake and assessment

A. The Acute Crisis Unit shall assess each individual to determine appropriateness of admission. Initial assessments by an MHP are to be completed on all clients voluntary or involuntary prior to admission.

B. Client intake information shall contain, but not be limited to the following identification data:

1. Client name;
2. Name and identifying information of the legal guardian(s)
3. Home address;
4. Telephone number;
5. Referral source;
6. Reason for referral;
7. Significant other to be notified in case of emergency;
8. Intake data core content;
9. Presenting problem and disposition;
10. A record of pertinent information regarding adverse reactions to drugs, drug allergies, or sensitivities shall be obtained during intake and kept in a highly visible location in or on the record; and
11. Screening for co-occurring disorders, trauma, medical and legal issues.

C. Client assessment information for clients admitted to Acute Crisis Units shall be completed within 12 hours of admission.

1. Integrated mental health and substance abuse psychosocial evaluation that minimally addresses:
   a) The client's strengths and abilities to be considered during community re-entry;
   b) Economic, vocational, educational, social, family and spiritual issues as indicated; and
   c) An initial discharge plan.
2. Interpretive summary of relevant assessment findings that results in the development of an intervention plan addressing mental health, substance use disorder, and other related issues contributing to the crisis;

3. An integrated intervention plan that minimally addresses the client's:

    a) Presenting crisis situation that incorporates the identified problem(s);

    b) Strengths and abilities;

    c) Needs and preferences; and

    d) Goals and objectives.

125.000 Health, mental health, substance abuse, and drug history

A. A health and drug history shall be completed for each client at the time of admission in Acute Crisis Unit (as soon as practical). The medical history shall include obtainable information regarding:

    1. Name of medication;

    2. Strength and dosage of current medication;

    3. Length of time patient was on the medication if known;

    4. Benefit(s) of medication;

    5. Side effects;

    6. The prescribing medical professional if known; and

    7. Relevant drug history of family members.

B. A mental health history, including symptoms and safety screening, shall be completed for each client at the time of admission in an Acute Crisis Unit (as soon as practical).

C. A substance abuse history, including checklist for use, abuse, and dependence for common substances (including nicotine and caffeine) and screening for withdrawal risk and IV use shall be completed for each client at the time of admission

126.000 Progress notes

A. The Acute Crisis Unit shall have a policy and procedure mandating the chronological documentation of progress notes for clients admitted to Acute Crisis Units.

B. Progress notes shall minimally address the following:

1. Person(s) to whom services were rendered;

2. Activities and services provided and as they relate to the goals and objectives of the intervention plan, including ongoing reference to the intervention plan;

3. Documentation of the progress or lack of progress in crisis resolution as defined in the intervention plan;

4. Documentation of the intervention plan's implementation, including client activities and services;

5. The client's current status;

6. Documentation of the client's response to intervention services, changes in behavior and mood, and outcome of intervention services;

7. Plans for continuing therapy or for discharge, whichever is appropriate; and

C. Progress notes shall be documented according to the following time frames:

1. Intervention team shall document progress notes daily; and

2. Nursing service shall document progress notes on each shift.

127.000 Medication record

A. The Acute Crisis Unit shall maintain a medication record on all clients who receive medications or prescriptions in order to provide a concise and accurate record of the medications the client is receiving or has been prescribed for the client.

B. The client medical record shall contain a medication record with information on all medications ordered or prescribed by physician staff which shall include, but not be limited to:

1. The record of medication administered, dispensed or prescribed shall include all of the following:

a) Name of medication,

b) Dosage,

c) Frequency of administration or prescribed change,

d) Route of administration, and

e) Staff member who administered or dispensed each dose, or prescribing physician; and

2. A record of pertinent information regarding adverse reactions to drugs, drug allergies, or sensitivities shall be updated when required by virtue of new information, and kept in a highly visible location in or on the record.

128.000 Aftercare and discharge planning

A. Aftercare and discharge planning is to be initiated for the client at the earliest possible point in the crisis stabilization service delivery process. Discharge planning must be matched to the client's needs and address the presenting problem and any identified co-occurring disorders or issues.

B. The program will have designated staff with responsibility to initiate discharge planning.

C. Referral and linkage procedures shall be in place so staff can adequately advocate on behalf of the person served as early as possible during the stabilization treatment process to transition to lesser restrictive or alternative treatment settings, as indicated.

129.000 Aftercare and discharge summary

A. An aftercare plan shall be entered into each client's medical record upon discharge from the Acute Crisis Unit. A copy of the plan shall be given to the client, the client's legal guardian, or both the client and legal guardian as applicable, as well as to any facility designated to provide follow-up with a valid written authorization by the client, the client's legal guardian, or both the client and legal guardian as applicable.

B. An aftercare plan shall include a summary of progress made toward meeting the goals and objectives of the intervention plan, as well as an overview of psychosocial considerations at discharge, and recommendations for continued follow-up after release from the Acute Crisis Unit.

C. The aftercare plan shall minimally include:

1. Presenting problem at intake;

2. Any co-occurring disorders or issues, and recommended interventions for each;

3. Physical status and ongoing physical problems;

4. Medications prescribed at discharge;

5. Medication and lab summary, when applicable;

6. Names of family and significant other contacts;

7. Any other considerations pertinent to the client's successful functioning in the community;

8. The Client's, the client's legal guardian, or as indicated both the client's and legal guardian's comments on participation in his or her crisis resolution efforts; and

9. The credentials of the staff members treating the client and their dated signatures.

130.000 Other records content

A. The client record shall contain copies of all consultation reports concerning the client.

B. When psychometric or psychological testing is done, the client record shall contain a copy of a written report describing the test results and implications and recommendations for treatment.

C. The client medical record shall contain any additional information relating to the client, which has been secured from sources outside the Acute Crisis Unit.

135.000 CONFIDENTIALITY

136.000 Confidentiality of mental health and drug or alcohol abuse treatment information

Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards. Laws and regulations on the confidentiality of medical records (Privacy Act and Freedom of Information Act) and the procedures for informed consent for release of information from the record must be followed.

140.000 CLIENT RIGHTS

141.000 DHS Investigations

The Arkansas Department of Human Services in any investigation or program monitoring regarding client rights shall have access to clients, Acute Crisis Unit records and Acute Crisis Unit staff.

142.000 Mechanical restraints

A. Mechanical restraints shall not be used on any client.

B. Failure to comply with Section 142.000 will result in the initiation of procedures to deny, suspend and/or revoke certification by DHS.

150.000 ORGANIZATIONAL MANAGEMENT

151.000 Organizational description

A. The Acute Crisis Unit shall have a written organizational description which is reviewed annually by both the Acute Crisis Unit and DHS, which minimally includes:

1. The overall target population, specifically including those individuals with co-occurring disorders, for whom services will be provided;

2. The overall mission statement;

3. The annual facility goals and objectives, including the goal of continued progress for the facility in providing person centered, culturally competent, trauma informed and co-occurring capable services;

B. The Acute Crisis Unit's governing body shall approve the mission statement and annual goals and objectives and document their approval.

C. The Acute Crisis Unit shall make the organizational description, mission statement and annual goals and objectives available to staff.

D. The Acute Crisis Unit shall make the organizational description, mission statement and annual goals and objectives available to the general public upon request.

E. Each Acute Crisis Unit shall have a written plan for professional services which shall have in writing the following:

1. Services description and philosophy;

2. The identification of the professional staff organization to provide these services;

3. Written admission and exclusionary criteria to identify the type of clients for whom the services are primarily intended; and

4. Written goals and objectives.

5. Delineation of processes to assure accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.

F. There shall be a written statement of the procedures/plans for attaining the organization's goals and objectives. These procedures/plans should define specific tasks, including actions regarding the organization's co-occurring capability, set target dates and designate staff responsible for carrying out the procedures or plans.

152.000 Information Analysis and Planning

A. The Acute Crisis Unit shall have a defined plan for conducting an organizational needs assessment that specifies the methods and data to be collected, which shall include but not limited to information from:

1. Clients;

2. Governing Authority;

3. Staff;

4. Stakeholders;

5. Outcomes management processes; and

6. Quality record review.

B. The Acute Crisis Unit shall have a defined system to collect data and information on a quarterly basis to manage the organization.

C. Information collected shall be analyzed to improve client services and organizational performance.

D. The Acute Crisis Unit shall prepare an end of year management report, which shall include but not be limited to:

1. An analysis of the needs assessment process; and

2. Performance improvement program findings.

E. The management report shall be communicated and made available to among others:

1. The governing authority;

2. Acute Crisis Unit staff; and

3. DHS if and when requested.

155.000 PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT

156.000 Performance improvement program

A. The Acute Crisis Unit shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of client care.

B. The Performance improvement program shall also address the fiscal management of the organization.

C. There shall be an annual written plan for performance improvement activities. The plan shall include, but not be limited to:

1. Outcomes management processes specific to each program component minimally measuring:

a) efficiency;

b) effectiveness; and

c) client satisfaction.

2. A quarterly record review to minimally assess:

a) quality of services delivered;

b) appropriateness of services;

c) patterns of service utilization;

d) clients, relevant to:

1) their orientation to the Acute Crisis Unit and services being provided; and

2) their active involvement in making informed choices regarding the services they receive;

e) the client assessment information thoroughness, timeliness and completeness;

f) treatment goals and objectives are based on:

1) assessment findings; and

2) client input;

g) services provided were related to the goals and objectives;

h) services are documented as prescribed by policy;

i) the treatment plan is reviewed and updated as prescribed by policy

3. Clinical privileging;

4. Fiscal management and planning, which shall include:

a) an annual budget that is approved by the governing authority and reviewed at least annually;

b) the organization's capacity to generate needed revenue to produce desired client and other outcomes;

c) monitoring client records to ensure documented dates of services provided coincide with billed service encounters; and,

5. Review of critical incident reports and client grievances or complaints.

D. The Acute Crisis Unit shall monitor the implementation of the performance improvement plan on an ongoing basis and makes adjustments as needed.

E. Performance improvement findings shall be communicated and made available to, among others:

1. the governing authority;

2. Acute Crisis Unit staff; and,

3. DHS if and when requested.

157.000 Incident reporting

A. The Acute Crisis Unit shall have written policies and procedures requiring documentation and reporting of critical incidents.

B. The documentation for critical incidents shall contain, minimally:

1. the facility name and name and signature of person(s) reporting the incident;

2. the name of client(s), staff person(s), or others involved in the incident;

3. the time, place and date the incident occurred;

4. the time and date the incident was reported and name of the person within the facility to whom it was reported;

5. description of the incident; and

6. the severity of each injury, if applicable. Severity shall be indicated as follows:

   a) No off-site medical care required or first aid care administered on-site;

   b) Medical care by a physician or nurse or follow-up attention required; or

   c) Hospitalization or immediate off-site medical attention was required;

7. Resolution or action taken, date action taken, and signature of the Acute Crisis Unit director.

C. The Acute Care Unit shall report those critical incidents to DHS that include.

1. Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to DHS Provider Certification within twenty-four (24) hours of the incident being documented.

2. Critical incidents involving allegations constituting a sentinel event or resident abuse shall be reported to DHS immediately via telephone or fax, but not less than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.

160.000 PERSONNEL

161.000 Personnel policies and procedures

A. The Acute Crisis Unit shall have written personnel policies and procedures approved by the governing authority.

B. All employees shall have access to personnel policies and procedures, as well as other Rules and Regulations governing the conditions of their employment.

C. The Acute Crisis Unit shall develop, adopt and maintain policies and procedures to promote the objectives of the program and provide for qualified personnel during all hours of operation to support the functions of the center and provide quality care.

162.000 Job descriptions

A. The Acute Crisis Unit shall have written job descriptions for all positions setting forth minimum qualifications and duties of each position.

B. All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.

165.000 STAFF DEVELOPMENT AND TRAINING

166.000 Staff qualifications

A. The Acute Crisis Unit shall document the qualifications and training of staff providing crisis stabilization services which shall be in compliance with the Acute Crisis Unit's clinical privileging process.

B. Failure to comply with Section 166.000 will result in the initiation of procedures to deny, suspend and/or revoke certification.

167.000 Staff development

A. The Acute Crisis Unit shall have a written plan for the professional growth and development of all administrative, professional clinical and support staff.

B. This plan shall include but not be limited to:

1. orientation procedures;

2. in-service training and education programs;

3. availability of professional reference materials; and

4. mechanisms for insuring outside continuing educational opportunities for staff members.

C. The results of performance improvement activities and accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes.

D. Staff competency development shall be aligned with the organization's goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.

E. Staff education and in-service training programs shall be evaluated by the Acute Crisis Unit at least annually.

168.000 In-service

A. Trainings are required annually for all employees who provide clinical services within the Acute Crisis Unit program on the following topics:

1. Fire and safety;
2. Infection Control and universal precautions;
3. Client's rights and the constraints of the Mental Health Client's Bill of Rights;
4. Confidentiality;
5. Arkansas Adult and Long-Term Care Facility Resident Maltreatment Act, §12-12-1701 et seq.
6. Facility policy and procedures;
7. Cultural competence;
8. Co-occurring disorder competency and treatment principles; and
9. Trauma informed and age and developmental specific trainings.

B. All staff providing clinical services shall have a current certification in basic first aid and in Cardiopulmonary Resuscitation (CPR).

C. All clinical staff shall have training in non-physical intervention techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within 30 days of being hired with annual updates thereafter. This training shall occur prior to direct patient contact.

D. The Acute Crisis Unit Executive Director shall designate which positions and employees, including temporary employees, will be required to successfully complete physical intervention training. The employee shall successfully complete this training within 30 days of being hired, with annual updated thereafter. This training shall occur prior to direct patient contact.

170.000 FACILITY ENVIRONMENT

Acute Crisis Units shall apply these standards to all sites operated. The primary concern of the Acute Crisis Unit should always be the safety and well-being of the clients and staff. Acute Crisis Units shall be physically located in the State of Arkansas. Acute Crisis Units shall provide a safe and sanitary environment.

171.000 Facility environment

A. The Acute Crisis Unit shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.

B. Acute Crisis Unit staff shall know the exact location, contents, and use of first aid supply kits and firefighting equipment and fire detection systems. All firefighting equipment shall be annually maintained in appropriately designated areas within the facility.

C. The Acute Crisis Unit shall post written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather. All exits must be clearly marked.

D. Facility grounds shall be maintained in a manner, which provides a safe environment for clients, personnel, and visitors.

E. The Acute Crisis Unit Facility Director or, designee, shall appoint a safety officer.

F. The Acute Crisis Unit shall have an emergency preparedness program designed to provide for the effective utilization of available resources so client care can be continued during a disaster. The Acute Crisis Unit shall evaluate the emergency preparedness program annually and update as needed.

G. Policies for the use and control of personal electrical equipment shall be developed and implemented.

H. The Acute Crisis Unit shall have an emergency power system to provide lighting throughout the facility.

I. The Acute Crisis Unit Facility Director shall ensure there is a written plan to respond to internal and external disasters. External disasters include, but are not limited to, tornadoes, explosions, and chemical spills.

J. All Acute Crisis Units shall be inspected annually by designated fire and safety officials of the municipality who exercise fire/safety jurisdiction in the facility's location which results in the facility being allowed to continue to operate.

K. The Acute Crisis Unit shall have a written Infection Control Program and staff shall be knowledgeable of Center for Disease Control (CDC) Guidelines for Tuberculosis and of the Blood Borne Pathogens Standard, location of spill kits, masks, and other personal protective equipment.

L. The Acute Crisis Unit shall have a written Hazardous Communication Program and staff shall be knowledgeable of chemicals in the workplace, location of Material Safety Data Sheets, personal protective equipment; and toxic or flammable substances shall be stored in approved locked storage cabinets.

M. The Acute Crisis Unit's telephone number(s) and actual hours of operation shall be posted at all public entrances.

N. Signs must be posted at all public entrances informing staff, clients and visitors as to the following requirements:

1. No alcohol or illicit drugs are allowed in the Acute Crisis Unit facility,

2. No firearms, or other dangerous weapons, are allowed in the Acute Crisis Unit facility with the exception of law enforcement while in the performance of their duties, and

3. The use of tobacco is not allowed in the Acute Crisis Unit facility.

O. A copy of compliance with law Title VI/Title VII of the 1964 Civil Rights Law shall be prominently displayed within the Acute Crisis Unit Facility.

P. Acute Crisis Units shall:

1. Provide separate bedroom areas for males and females,

2. Provide sufficient clean linens for clients, and

3. Provide adequate barriers to divide clients.

Q. Plumbing in Acute Crisis Units shall be in working condition to avoid any health threat. All toilets, sinks and showers shall be clean and in working order.

R. There shall be at least one toilet, one sink, and one shower or tub per every eight (8) Acute Crisis Unit beds. This means that an Acute Crisis Unit shall have no less than one toilet, one sink, and one shower or tub.

S. A secure locked storage shall be provided for client valuables when requested.

T. Separate storage areas are provided and designated for:

1. Food, kitchen, and eating utensils,

2. Clean linens,

3. Soiled linens and soiled cleaning equipment, and

4. Cleaning supplies and equipment.

U. When handling soiled linen or other potentially infectious material, Universal Precautions are to be followed and address in the Acute Crisis Unit policies and procedures. Hazardous and regulated waste shall be disposed of in accordance with federal requirements.

V. Poisons, toxic materials and other potentially dangerous items shall be stored in a secured location.

W. An Acute Crisis Unit is a free-standing facility that is not an adjunct to an existing hospital. The Acute Crisis Unit shall not have more than 16 beds.

172.000 Medication clinic, medication monitoring

A. Medication administration; storage and control; and client reactions shall be continuously monitored.

B. Acute Crisis Units shall assure proper storage and control of medications, immediate response if incorrect or overdoses occur, and have appropriate emergency supplies available if needed.

1. Written procedures for medication administration shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications.

2. All medications shall be kept in locked, non-client accessible areas. Factors which shall be considered in medication storage are light, moisture, sanitation, temperature, ventilation, and the segregation and safe storage of poisons, external medications, and internal medications.

3. Telephone numbers of the state poison centers shall be immediately available in all locations where medications are prescribed, or administered, or stored.

4. An Acute Crisis Unit physician shall supervise the preparation and stock of an emergency kit which shall be readily available, but accessible only to Acute Crisis Unit staff.

173.000 Medication, error rates

The Acute Crisis Unit shall have an ongoing performance improvement program that specifically, objectively, and systematically monitors medications administration or dispensing or medication orders and prescriptions to evaluate and improve the quality of client care.

174.000 Technology

The Acute Crisis Unit shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:

A. Hardware and software.

B. Security.

C. Confidentiality.

D. Backup policies.

E. Assistive technology.

F. Disaster recovery preparedness.

G. Virus protection.

175.000 Food and Nutrition

A. If the Acute Crisis Unit prepared meals on site, the Acute Crisis Unit shall have a current food establishment health inspection as required by the Arkansas Department of Health

B. When meals are provided by a food service, a written contract shall be maintained and shall require the food service to have a current food establishment health inspection as required by the Arkansas Department of Health.

C. Acute Crisis Units shall provide at least three meals daily, with no more than fourteen (14) hours between any two meals.

D. All food shall be stored, prepared, and served in a safe, healthy manner.

E. Perishable items shall not be used once they exceed their sell by date.

180.000 GOVERNING AUTHORITY

181.000 Documents of authority

A. There shall be a duly constituted authority and governance structure for assuring legal responsibility and for requiring accountability for performance and operation of the Acute Crisis Unit.

B. The governing authority shall have written documents of its source of authority, which shall be available to the public upon request.

C. The governing body's bylaws, rules or regulations shall identify the chief executive officer who is responsible for the overall day-to-day operation of the Acute Crisis Unit, including the control, utilization and conservation of its physical and financial assets and the recruitment and direction of the staff.

1. The source of authority document shall state:

   a) The eligibility criteria for governing body membership;

   b) The number and types of membership

   c) The method of selecting members;

   d) The number of members necessary for a quorum;

   e) Attendance requirements for governing body membership;

   f) The duration of appointment or election for governing body members and officers.

   g) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.

2. There shall be an organizational chart setting forth the structure of the organization.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR BEHAVIORAL HEALTH AGENCY CERTIFICATION

To be completed upon initial application to become certified as a Behavioral Health Agency

Name of Agency: _____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent):_____

Administrative Address: _____

County: _____

Telephone: _____ Fax: _____

E-mail: _____

Website: _____

The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

____ Joint Commission on Accreditation of Healthcare Organizations (J-CO)
____ Commission on Accreditation for Rehabilitation Facilities (CARF)
____ Council on Accreditation (COA)

Date(s) of most recent survey: _____

Accreditation Period: _____ through _____

The accredited provider is located within the State of Arkansas.

_____ Yes _____ No

As the Chief Executive Officer (or equivalent) of the agency named above, I verify that all information contained in this form and in all attachments is correct and complete.

_____ _____
Signature of Chief Executive Officer (or equivalent) Date

_____
Name of Chief Executive Officer (or equivalent) typed or printed

Required Documents to begin processing Behavioral Health Agency Provider Certification

All of the following information must be attached to the Behavioral Health Agency Certification. Applications not submitted in full will not be processed.

1. Latest accreditation survey results. (The entire survey report covering outpatient behavioral health services must be included.)

2. Copies of all correspondence and e-mails (e-mails may be copied to the DHS) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient behavioral health services.

3. A signed agreement that DHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery. (See DHS BEHAVIORAL HEALTH AGENCY Form 200)

4. All Evidence of Compliance, Measures of Success, Performance Improvement Plans, and any Corrective Action Plans submitted to the accreditation organization pertaining to outpatient behavioral health services.

5. Annual Behavioral Health Agency Services and Resource Summary Report with all attachments as designated in the Behavioral Health Agency Services and Resource Summary Form (DHS BEHAVIORAL HEALTH AGENCY Form 210).

DHS WILL SCHEDULE AN ONSITE SURVEY WITHIN FORTY-FIVE (45) CALENDAR DAYS OF APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

Please send a cover letter and all application materials to be certified by DHS as a Behavioral Health Agency to the following address:

Department of Human Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Accreditation Organization Release of Information Consent

I, _____, hereby consent to the exchange of information between
CEO (or equivalent)

_____ and
Accrediting Agency

The Arkansas Department of Human Services for the specific purpose of obtaining or sharing information relevant to Behavioral Health Agency Certification.

I consent to information regarding my agency's national accreditation or state certifications being released by facsimile (FAX) _____ Yes _____ No.

I understand that the information I authorize for release may include sensitive information. I understand that a facsimile of this consent is considered as valid as if it were the original.

_____ _____
Signature of CEO (or equivalent) Date

_____ _____
Signature of Witness Date

ARKANSAS DEPARTMENT OF HUMAN SERVICES

BEHAVIORAL HEALTH AGENCY RESOURCE SUMMARY

STATE FISCAL YEAR _____: 7/01/20____ THROUGH 6/30/20_____

Name of Agency:

_____

Chief Executive Officer (or equivalent):

_____

Corporate Compliance Officer (or equivalent):

_____

Clinical Director (or equivalent):

_____

Medical Director

_____

Administrative Address: _____

Telephone: _____ Fax: _____

E-mail: _____

Provider Type: _____ Private Non-Profit _____ Private For Profit _____ Public Entity

Other (Specify): _____

Chief Executive Officer (or equivalent) **Certification:** By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

Chief Executive Officer (or equivalent): _____

Date: _____

PERSONNEL RESOURCES (as of the date this report is submitted)	SFY _____
1. Psychiatrists	
2. M.D. Non-psychiatrists	
3. Psychologists	
4. Independently Licensed Clinicians	
5. Non-Independently Licensed Clinicians	
6. Registered Nurses	
7. Qualified Behavioral Health Providers (Including Certified Peer Support Specialist, Certified Youth Support Specialist, Certified Family Support Partners)	
8. All other staff not included above	
9. Sum of lines 1-8	
PROGRAM RESOURCES (round to nearest whole number)	
10. Number of counties in service area	
11. Number of counties in service area in which agency operates a service site	
12. Total number of service sites operated by Agency	
13. Average daily clients served by Agency	
14. Number of School Based Behavioral Health Programs run by agency	
15. Total projected daily average of clients in all school based sites combined	
16. Total projected number of clients served in the outpatient clinic	
17. Please list other mental health services provided by the organization and provide capacity information, as appropriate (i.e. residential beds, crisis beds, inpatient beds, housing, therapeutic foster care, partial hospitalization, therapeutic communities, etc.)	
17.A.	
17.B.	
17.C	
17.D	

If more room is needed, please list on a separate page and attach to this report.

FINANCIAL RESOURCES – PROJECTED MEDICAID/MEDICARE INCOME (Projected for current fiscal year – July 1 through June 30)	SFY _____	SFY _____
18. Total Medicaid revenues		
19. Total Medicare revenues		

CONTACT INFORMATION	
20. Contact person regarding this report	
21. Telephone number of contact person for this report	
22. E-mail address of contact person for this report	

ARKANSAS DEPARTMENT OF HUMAN SERVICES

NOTIFICATION FORM FOR CLOSING OR MOVING OF A BEHAVIORAL HEALTH AGENCY SITE

Moving a site constitutes a closing of one site and a move of the program(s), move of existing staff and move of existing client base to another location. If a provider relocates a currently certified site within a fifty (50) mile radius the accrediting agency, DBHS and Medicaid must be notified thirty (30) days prior to that relocation. Neither an on-site survey nor a new Medicaid number is required in order to extend certification to the moved location if within a fifty (5) miles radius.

Name of Agency: _____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent): _____

Administrative Address: _____

_____

Telephone: _____ Fax: _____

E-mail: _____

This is notification that the following site(s) have: _____ moved _____closed

CLOSING **Date of Closing**: _____

ADDRESS:

_____

_____

_____

MOVING **Date of Move:** _____

PREVIOUS ADDRESS (Include: street, city, county, telephone & fax)	NEW ADDRESS
_____	_____
_____	_____
_____	_____

Please attach all documentation to and from your accrediting organization regarding the above information. Certification will not be granted to the new site address until all information from the accrediting organization indicates that the new site address is accredited.

Chief Executive Officer (or equivalent) **Certification**: By my signature I verify that all information contained in this form and in all attachments is correct and complete.

_____ _____

Signature of Chief Executive Officer (or equivalent) Date

_____

Name of Chief Executive Officer (or equivalent) typed or printed

1. In addition to this form, please provide any information that is specific to the site/s for which certification is being requested that is different from those agency sites already certified by DHS.

2. Include a photograph of outside entrance to building, staff offices, and waiting area for all new site locations.

Please send this form with required documentation to the following address:

Department of Human Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES

BEHAVIORAL HEALTH AGENCY PROVIDER RE-CERTIFICATION

To be submitted to renew DHS Behavioral Health certification after receiving re-accreditation from the national accrediting agency at the time of the new accreditation cycle.

Name of Agency:

_____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent): _____

Administrative Address: _____

Telephone: _____ Fax: _____

E-mail: _____

1. The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

____ Joint Commission (J-CO)

____ Commission on Accreditation for Rehabilitation Facilities (CARF)

____ Council on Accreditation (COA)

2. Date of most recent survey: _____

3. National Accreditation Period: _____ through _____

4. The accredited provider is located within the state of Arkansas.

_____ Yes _____ No

Chief Executive Officer (or equivalent) Certification: By my signature I certify that all information contained in this form and in all attachments are correct and complete.

_____ _____

Signature of Chief Executive Officer (or equivalent) Date

_____

Name of Chief Executive Officer (or equivalent) typed or printed

Qualifications for Behavioral Health Agency Re-Certification

All of the following information must be attached to Behavioral Health Agency Re-certification form. Applications must be submitted in full. Partial submissions will not be accepted.

1. Latest accreditation survey results. (The entire survey report with a listing of all provider service sites providing outpatient behavioral health services must be included.)

2. Copies of all correspondence and e-mails (e-mails may be copied to DHS) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient behavioral health services.

3. A signed agreement that DHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery (BEHAVIORAL HEALTH AGENCY Form 200).

4. All Evidence of Compliance, Measures of Success, Quality Improvement Plans, and any Corrective Action Plans that were required and submitted to the accrediting organization pertaining to outpatient behavioral health services related to the latest accreditation survey.

5. Identify any significant changes (since last certification period) in program resources (i.e. number of sites operated by agency, changes in administrative staff, and number of school-based Mental Health Programs). Please attach additional pages if needed.

6. Identify any significant changes (since last certification period) in personnel qualifications and resources (i.e. changes in code of ethics and client grievance policy, changes in how psychological testing services are delivered and changes in the plan for staff training and supervision). Please attach additional pages if needed.

7. Identify any significant changes (since last certification period) in the physical plant(s). (i.e. changes in address and phone numbers of service delivery sites, any structural/cosmetic changes). Please attach additional pages if needed.

8. Describe any significant changes (since last certification period) in the service delivery plan (i.e. types of services available at each site, changes in the crisis services plan and any plans for expansion or reduction in services). Please attach additional pages if needed.

Please send a cover letter and all application materials to be re-certified by DHS as an Behavioral Health Agency to the following address:

Department of Human Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES

BEHAVIORAL HEALTH AGENCY ANNUAL REPORTING FORM

State Fiscal Year 20_____: 7/01/____ through 6/30/_____

Name of Agency:

_____

Chief Executive Officer (or equivalent):

_____

Corporate Compliance Officer (or equivalent):

_____

Clinical Director (or equivalent):

_____

Medical Director

_____

Administrative Address:

_____

_____

Phone Number : _____ **Fax Number:** _____

Contact E-Mail: _____

Provider Type (please check one): Private Non-Profit ☐ Private For Profit ☐ Public Entity ☐Other

(Specify): _____

Chief Executive Officer Certification (or equivalent)**:** By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

_____ _____

Signature of Chief Executive Officer (or equivalent) Date

_____

Name of Chief Executive Officer (or equivalent) typed or printed

THIS REPORT RELATES TO AGENCY WIDE INFORMATION

1. **Please include all annual reporting requirements from the accrediting organization.** This includes Annual Conformance to Quality Report, Maintenance of Accreditation or Intra-Cycle Monitoring Profile. Please include all correspondence to and from the accrediting organization related to annual reporting requirements.

2. **Provider's plans and activities to overcome cultural and linguistic barriers to treatment** (Include a brief statement regarding on-going efforts to serve clients from diverse backgrounds as well as those clients that may have physical disabilities.)

3. **Staff Composition Chart** (Please fill out the following chart)
   As of the date this report is submitted, report the number of agency employees. Indicate whether the employee is salary (W-2) or contract (1099).

THIS INFORMATION RELATES TO AGENCY WIDE INFORMATION
PERSONNEL RESOURCES

	TOTAL	W-2	1099
1. Psychiatrist			
2. M.D. Non-psychiatrist			
3. Psychologist			
4. Independently Licensed Clinicians			
5. Non-Independently Licensed Clinicians			
6. Registered Nurse			
7. Qualified Behavioral Health Providers (Including Certified Peer Support Specialist, Certified Youth Support Specialist, Certified Family Support Partners)			
8. All other staff not included above			
9. Sum of lines 1-7			

4. **Interagency involvement** (Please identify all existing formal or informal contracts the agency has with other providers or agencies to provide Outpatient Behavioral Health services. Briefly explain how the agency utilizes and interfaces with other community resources to provide services for the client.)

5. **Agency wide quality improvement and outcomes activities** (Please include agency organizational chart and the outcomes of identified quality improvement efforts to improve client care/outcomes.)

As a part of the outcomes activities report include:

a. Measured outcomes

b. Sample report

c. Collection of outcomes, beginning at the initial behavioral health diagnosis service, which would be completed very close to the client's intake.

PLEASE SUBMIT THIS FORM AND SUPPORTING DOCUMENTATION TO:

Department of Human Services
Policy and Certification
305 South Palm Street
Little Rock, AR 72205

FOR DHS INTERNAL USE ONLY:

1) Cultural/Linguistic Barriers — Yes ___ No ___
   Status: Complete

2) Staff Composition — Yes ___ No ___
   Status: Complete

3) Interagency Involvement — Yes ___ No ___
   Status: Complete

4) Quality Improvement — Yes ___ No ___
   Status: Complete

5) ACQR MOA PPR — Yes ___ No ___

Comments:

ARKANSAS DEPARTMENT OF HUMAN SERVICES

BEHAVIORAL HEALTH AGENCY NEW SITE APPLICATION

Name of Agency:

_____

Chief Executive Officer (or equivalent):

_____

Corporate Compliance Officer (or equivalent):

_____

Administrative Address:

_____

_____

_____

_____

Telephone: _____ **Fax:** _____

E-mail: _____

NEW SITE PHYSICAL ADDRESS: **DATE SITE OPENED:** _____

_____

_____

_____

_____

Telephone: _____ **Fax Number:** _____

E-mail: _____

Chief Executive Officer (or equivalent) Certification: By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

_____ _____

Name of Chief Executive Officer (or equivalent) typed or printed Date

_____

Signature of Chief Executive Officer (or equivalent)

PERSONNEL RESOURCES FOR NEW SITE ONLY (As of the date this report is submitted)	**SFY2012**
1. Psychiatrists	
2. M.D. Non-psychiatrists	
3. Psychologists	
4. Independently Licensed Clinicians	
5. Non-Independently Licensed Clinicians	
6. Registered Nurses	
7. Qualified Behavioral Health Providers (Including Certified Peer Support Specialist, Certified Youth Support Specialist, Certified Family Support Partners)	
8. All other staff not included above	
9. Sum of lines 1-8	
PROGRAM RESOURCES FOR NEW SITE ONLY (Round to nearest whole number)	
10. Number of counties in service area	
11. Number of counties in service area in which agency operates a service site	
12. Total number of service sites operated by Agency	
13. Average daily clients served by Agency	
14. Number of School Based Behavioral Health Programs run by agency	
15. Total projected daily average of clients in all school based sites combined	
16. Total projected number of clients served in the outpatient clinic	
17. Please list other mental health services provided by the organization and provide capacity information, as appropriate (i.e. residential beds, crisis beds, inpatient beds, housing, therapeutic foster care, partial hospitalization, therapeutic communities, etc.)	
17.A.	
17.B.	
17.C	
17.D	
If more room is needed, please list on a separate page and attach to this report.	

CONTACT INFORMATION	
18. Contact person regarding this report	
19. Telephone number of contact person for this report	
20. E-mail address of contact person for this report	

PERSONNEL QUALIFICATIONS & RESOURCES

1. Attach administrative structure for the new site/s for which extension of certification is being requested.

2. Attach licenses or certifications and resumes of all administrators of the new site. Include the medical director or consulting psychiatrist information if different from the main office site.

3. Attach any contracts with consulting professionals specific to the new site only if additional to the original certification.

PHSYICAL PLANT

1. Attach a list of all new service delivery sites including each site's address (street, city & county), telephone number, fax number, the name of the designated contact person, for each site and that person's email address, the geographic area served by each site and the Outpatient Behavioral Health services available at each site.

2. Attach a photograph of each service delivery site for which you are requesting a certification extension. Include outside entrance to building, staff offices, and waiting area.

SERVICE DELIVERY PLAN THAT IS CURRENTLY IN PLACE FOR EACH NEW SITE

In a narrative report, describe the agency's plan for the provision of services including all requested information in compliance with the current Behavioral Health Agency Certification Policy and Outpatient Behavioral Health Services Medicaid Manual. Please utilize the following format:

1. Type of services available at additional site/s, hours of operation and type of clients served (i.e. children, adults, Seriously Mentally Ill, Seriously Emotionally Disturbed, Juvenile Justice Population, etc.)

2. Provide any information that is specific to the site/s for which certification is being requested that is different from those agency sites already certified by DBHS.

3. Description of agency's crisis services plan that is available at the new site including the policy and procedures for provision of crisis services 24 hours a day 7 days a week.

4. Briefly explain how the new site will utilize and interface with other community resources to provide services for the client.

5. Describe how the new site will be integrated into the Quality Improvement Program of the agency.

ACCREDITATION INFORMATION

I. Attach documentation notifying your accrediting organization of the site/s addition/s and the accrediting organization's acknowledgement of the accreditation extension. Certification extension **WILL NOT BE GRANTED** until you have the accrediting organization's documentation.

II. Include dates of current accreditation cycle.

Reimbursement by Arkansas Medicaid services shall not occur until the site is certified by the Department of Human Services.

Please send this form along with your application to be certified by DHS as a Behavioral Health Agency to the following address:

Department of Human Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR THERAPEUTIC COMMUNITIES CERTIFICATION

To be completed upon initial application to become certified as a Therapeutic Community

Name of Behavioral Health Agency:
_____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent):_____

Administrative Address: _____

County: _____

Telephone: _____ Fax: _____

E-mail: _____

Website: _____

The provider named above shall be certified by the Department of Human Services as a Behavioral Health Agency. A Therapeutic Communities certification will not be issued if the provider is not a part of a DHS certified Behavioral Health Agency. A Certified Behavioral Health Agency can submit one (1) application for multiple Therapeutic Communities, with the Personnel Resources to be completed for each site.

Behavioral Health Agency Certification Period: _____ through _____

As the Chief Executive Officer (or equivalent) of the agency named above, I verify that all information contained in this form and in all attachments is correct and complete.

_____ _____
Signature of Chief Executive Officer (or equivalent) Date

_____
Name of Chief Executive Officer (or equivalent) typed or printed

Required Documents to begin processing Therapeutic Communities Certification

All of the following information must be attached to the Therapeutic Communities Certification. Applications not submitted in full will not be processed.

1. Valid Behavioral Health Agency Certification from the Department of Human Services.

2. Physical Address of all requested Therapeutic Communities sites. An on-site inspection will occur at all sites prior to DHS issuing a certification as a Therapeutic Community.

3. Personnel Resources for Each Therapeutic Community to be certified.

DHS WILL SCHEDULE AN ONSITE SURVEY WITHIN FORTY-FIVE (45) CALENDAR DAYS OF APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

Please send a cover letter and all application materials to be certified by DHS as a Therapeutic Community to the following address:

Department of Human Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

PERSONNEL RESOURCES FOR EACH INDIVIDUAL THERAPUETIC COMMUNITY (as of the date this is submitted)	
Site Address:	
Therapeutic Communities Facility Director:	
1. Psychiatrists	
2. M.D. Non-psychiatrists	
3. Psychologists	
4. Independently Licensed Clinicians	
5. Non-independently Licensed Clinicians	
6. Registered Nurses	
7. Qualified Behavioral Health Providers (Including Certified Peer Support Specialist, Certified Youth Support Specialist, Certified Family Support Partners)	
8. All other staff not included above	
9. Sum of lines 1-8	

ARKANSAS DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR PARTIAL HOSPITALIZATION CERTIFICATION

To be completed upon initial application to become certified as a Partial Hospitalization Program

Name of Behavioral Health Agency:
_____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent):_____

Administrative Address: _____

County: _____

Telephone: _____ Fax: _____

E-mail: _____

Website: _____

The provider named above shall be certified by the Department of Human Services as a Behavioral Health Agency. A Partial Hospitalization certification will not be issued if the provider is not a part of a DHS certified Behavioral Health Agency. A Certified Behavioral Health Agency can submit one (1) application for multiple Partial Hospitalization sites, with the Personnel Resources to be completed for each site.

Behavioral Health Agency Certification Period: _____ through _____

As the Chief Executive Officer (or equivalent) of the agency named above, I verify that all information contained in this form and in all attachments is correct and complete.

_____ _____
Signature of Chief Executive Officer (or equivalent) Date

_____
Name of Chief Executive Officer (or equivalent) typed or printed

Required Documents to begin processing Partial Hospitalization Certification

All of the following information must be attached to the Partial Hospitalization Certification. Applications not submitted in full will not be processed.

1. Valid Behavioral Health Agency Certification from the Department of Human Services.

2. Physical Address of all requested Partial Hospitalization sites. An on-site inspection will occur at all sites prior to DHS issuing a certification for a Partial Hospitalization program.

3. Personnel Resources for Each Partial Hospitalization program to be certified.

DHS WILL SCHEDULE AN ONSITE SURVEY WITHIN FORTY-FIVE (45) CALENDAR DAYS OF APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

Please send a cover letter and all application materials to be certified by DHS as a Partial Hospitalization program to the following address:

Department of Human Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

PERSONNEL RESOURCES FOR EACH INDIVIDUAL PARTIAL HOSPITALIZATION PROGRAM (as of the date this is submitted)	
Site Address:	
Partial Hospitalization Facility Director:	
1. Psychiatrists	
2. M.D. Non-psychiatrists	
3. Psychologists	
4. Independently Licensed Clinicians	
5. Non-independently Licensed Clinicians	
6. Registered Nurses	
7. Qualified Behavioral Health Providers (Including Certified Peer Support Specialist, Certified Youth Support Specialist, Certified Family Support Partners)	
8. All other staff not included above	
9. Sum of lines 1-8	

ARKANSAS DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR INDIVIDUALLY LICNESED PRACTITIONER

To be completed upon initial application to become certified as an Individually Licensed Practitioner

Name: _____

Address: _____

County: _____

Telephone: _____ Fax: _____

E-mail: _____

Website: _____

Description of outpatient behavioral health services provided:

_____

_____

_____

_____

_____

Business Hours: _____

Description of how and by whom clients are covered 24 hours a day/7 days a week, addressing crisis services as well as routing services delivery:

_____

_____

_____

_____

_____

Do you provide medication management through your facility?

_____

If not, how is medication management handled for your clients?

Description of how you will collaborate with other agencies/individuals to facilitate quality and continuity of care for clients:

Signature of Individually Licensed Practitioner

Date

Name of Individually Licensed Practitioner

Required Documents to begin processing Independently Licensed Practitioner Certification

All of the following information must be attached to the Independently Licensed Practitioner Certification. Applications not submitted in full will not be processed.

1. Names, credentials and relevant experiences for backup and medication management physicians.

2. Names, credentials and relevant experience of applicant's experience providing behavioral health services.

3. Copies of any affiliation agreements with other agencies/professionals that provide behavioral health services for your clients.

4. Copies of pertinent certifications and/or licenses (i.e. JCAHO, CARF, staff licensure or certification by State boards to practice behavioral health services, etc.). Applicant MUST submit Arkansas licensure which grants the applicant that authority to engage in private/independent practice by the appropriate State Board.

5. Copies of any forms used for documentation (treatment plan, psychosocial history, etc.)

6. Copies of all correspondence and e-mails (e-mails may be copied to the DHS) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient behavioral health services.

DHS WILL SCHEDULE AN ONSITE SURVEY WITHIN FORTY-FIVE (45) CALENDAR DAYS OF APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

Please send a cover letter and all application materials to be certified by DHS as an Independently Licensed Practitioner to the following address:

Department of Human Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Behavioral Health Services

PERSON COMPLETING THIS STATEMENT _____

TELEPHONE _____ **FAX** 501-404-4619 **EMAIL:** _____

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE DHS Behavioral Health Provider Certification Manuals and Forms

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   _____

   (b) The reason for adoption of the more costly rule;

   _____

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   _____

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

   _____

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total	$0	Total	$0

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

---

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$	$

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
   (a) justifies the agency's need for the proposed rule; and
   (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.