

BOARD OF PSYCHOLOGIST EXAMINERS (R-18-1001)

Title 4, Chapter 26, Article 4, Behavior Analysis

Amend: R4-26-403; R4-26-407; R4-26-409

New Section: R4-26-404.2

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: October 2, 2018

AGENDA ITEM: D-2

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: BOARD OF PSYCHOLOGIST EXAMINERS (R-18-1001)

Title 4, Chapter 26, Article 4, Behavior Analysis

Amend: R4-26-403; R4-26-407; R4-26-409

New Section: R4-26-404.2

This rulemaking, from the Board of Psychologist Examiners (Board), seeks to amend three rules and create one new rule in A.A.C. Title 4, Chapter 26, Article 4, related to behavior analysis.

An exemption from the rulemaking moratorium was approved by the Governor's Office on March 16, 2017.

Proposed Action

- **Section 403 - Application for Initial License:** A cross reference to Section 404.2 is added.
- **Section 404.2 - Supervised Experience Requirement:** This new rule, the text of which can be found on pages 7-10 of the Notice of Final Rulemaking, sets forth the Board's standards related to the requirement of supervised experience for licensure as a behavior analyst in Arizona. The Board notes that since 2011, when licensure of behavioral analysts began, the Board's statutes have required 1500 hours of supervised experience.
- **Section 407 - License by Reciprocity:** A cross reference to Section 404.2 is added.
- **Section 409 - Continuing Education Requirement:** A clarifying change is made regarding the use of online courses for continuing education.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

Yes. The Board cites to both general and specific authority for the rules. Of particular significance is A.R.S. § 32-2063(A)(9), under which the Board must “[a]dopt rules pursuant to

[T]itle 41, [C]hapter 6 to carry out this chapter [A.R.S. Title 32, Chapter 19.1, Psychologists] and to define unprofessional conduct.”

2. Do the rules establish a new fee or contain a fee increase?

No. The rules do not establish a new fee or contain a fee increase.

3. Summary of the agency's economic impact analysis:

In this rulemaking, the Board is updating the rules for the licensure of behavior analysts. Current licensees will no longer have limits on continuing education hours obtained online. The Board is also promulgating rules for supervised experience requirements for new licensees. The supervised experience requirements are required by state statute.

There are currently 318 individuals licensed as behavior analysts in Arizona. In fiscal year 2017, there were 67 new applicants for licensure. The Board notes that all of these new applicants met the experience requirement of 1,500 hours.

4. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

The Board concludes that this rulemaking benefits current licensees by allowing for greater flexibility for continuing education hours. The experience requirements in this rulemaking are required by state statute. The benefits outweigh the costs.

5. What are the economic impacts on stakeholders?

Key stakeholders are the Board, current behavior analyst licensees, and initial applicants for behavior analyst licensure.

The Board incurred the initial costs associated with promulgating these rules. The Board benefits from this rulemaking because it aligns the Board’s rules with state statute.

Licensed behavior analysts will benefit from this rulemaking because it eliminates the limitations on continuing education hours obtained online.

New applicants for licensure will bear some of the costs associated with this rulemaking. Per statute, new behavior analysts must have at least 1,500 hours of supervised experience. The Behavior Analyst Certification Board has a lower experience threshold. The Board notes that a situation could arise where a Board Certified Behavior Analyst could not be eligible for licensure in Arizona due to the higher Arizona experience requirements. In fiscal year 2017, this situation did not occur. The Board notes that Behavior Analyst Certification Board is changing its requirements, so these requirements will be consistent with Arizona’s licensure requirements.

6. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?

Yes. The Board indicates that it received one written comment on the rulemaking, from Diana Wilson of Aspen Behavioral Consulting, who noted that the Behavior Analyst Certification Board (BACB) eliminated a provision referenced in the Notice of Proposed Rulemaking. In response, the Board removed R4-26-404.2(C)(6)(b) of the Notice of Proposed Rulemaking from the Notice of Final Rulemaking and relabeled remaining subsections accordingly. Council staff believes that the Board has adequately addressed the comment.

7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?

No. The above described change was the only one made between the Notice of Proposed Rulemaking and the Notice of Final Rulemaking.

8. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

No. Federal law is not directly applicable to the subject matter of the rules.

9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

Yes. The Board indicates that the license required for behavior analysts is a general permit consistent with A.R.S. § 41-1037 because it is issued to qualified individuals to conduct activities that are substantially similar in nature.

10. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?

No. The Board did not review or rely on any study for this rulemaking.

11. Conclusion

The Board accepts the usual 60-day delayed effective date for the rulemaking. Council staff recommends approval of the rulemaking.



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Jenna Jones

August 15, 2018

Ms. Nicole O. Colyer, Chair
The Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 305
Phoenix, AZ 85007

**Re: A.A.C. Title 4. Professions and Occupations
Chapter 26. Board of Psychologist Examiners**

Dear Ms. Colyer:

The attached final rule package is submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

- A. Close of record date: The rulemaking record was closed on August 10, 2018, following a period for public comment and an oral proceeding. This rule package is being submitted within the 120 days provided by A.R.S. § 41-1024(B).
- B. Relation of the rulemaking to a five-year-review report: The rulemaking does not relate to a five-year-review report.
- C. New fee: The rulemaking does not establish a new fee.
- D. Fee increase: The rulemaking does not increase an existing fee.
- E. Immediate effective date: An immediate effective date is not requested.
- F. Certification regarding studies: I certify that the preamble accurately discloses the Board did not review or rely on a study in its evaluation of or justification for any rule in this rulemaking.
- G. Certification that the preparer of the EIS notified the JLBC of the number of new full-time employees necessary to implement and enforce the rule: I certify that none of the rules in this rulemaking will require a state agency to employ a new full-time employee. No notification was provided to JLBC.

H. List of documents enclosed:

1. Cover letter signed by the Executive Director;
2. Notice of Final Rulemaking including the preamble, table of contents, and rule text;
3. Economic, Small Business, and Consumer Impact Statement; and
4. Public comment.

Sincerely,



Jenna Jones
Executive Director

A handwritten signature in black ink, appearing to read "Jenna Jones". Below the signature, the name "Jenna Jones" is printed in a standard font, followed by the title "Executive Director" in a smaller font.



Jenna Jones <jenna.jones@psychboard.az.gov>

Quick Info on Rules

1 message

Diana Wilson <diana@aspenbehavioral.com>
To: Jenna Jones <jenna.jones@psychboard.az.gov>

Mon, Jul 30, 2018 at 3:23 PM

Hi,

I just wanted to make sure you are aware that the BACB has done away with the training modules referenced in the rules – page 9. Therefore, these modules no longer exist.

Thank you,

Diana

6. Supervision plan. The Board shall accept, for the purpose of licensure, hours of supervised experience for which the supervisee and supervisor executed a written plan before starting the supervised experience, which includes the following:
 - a. States the responsibilities of both the supervisor and supervisee;
 - b. Requires the supervisor and supervisee to complete BACB's online experience training module;
 - c. Requires the supervisor to complete eight hours of supervision training provided by BACB;
 - d. Includes a description of appropriate activities and instructional objectives;
 - e. Specifies the measurable circumstance under which the supervisor will complete the supervisee's Experience Verification Form;

TITLE 4. PROFESSIONS AND OCCUPATIONS
CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS

(Authority: A.R.S. § 32-2061 et seq.)

ARTICLE 4. BEHAVIOR ANALYSIS

Article 4, consisting of Sections R4-26-401 through R4-26-418, made by final rulemaking effective September 11, 2012 (Supp. 12-3).

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ARTICLE 4. BEHAVIOR ANALYSIS

R4-26-401. Definitions

- A. The definitions in A.R.S. § 32-2091 apply in this Article.
- B. Additionally, in this Article:
 - 1. “Accredited” means an institution of higher education:
 - a. In the U.S. is listed with the Council for Higher Education Accreditation,
 - b. In Canada is a member of the Universities Canada, and
 - c. Outside of the U.S. or Canada is determined by a member of the National Association of Credential Evaluation Services to have standards substantially similar to those of an institution of higher education in the U.S. or Canada.
 - 2. “Advertising” means any media used to disseminate information regarding the qualifications of a behavior analyst in order to solicit clients for behavior analysis services, regardless of whether the behavior analyst pays for the advertising.
 - 3. “Applicant” means an individual who applies to the Board for an initial or renewal license.
 - 4. “BACB” means the Behavior Analyst Certification Board.
 - 5. “Confidential information” means:
 - a. Minutes of an executive session of the Board except as provided under A.R.S. § 38-431.03(B);
 - b. A record that is classified as confidential by a statute or rule applicable to the Board;
 - c. Materials relating to an investigation by the Board, including a complaint, response, client record, witness statement, investigative report, and any information relating to a client’s diagnosis, treatment, or personal family life; and
 - d. The following regarding an applicant or licensee:
 - i. College or university transcripts if requested from the Board by a person other than the applicant or licensee;
 - ii. Home address, telephone number, and e-mail address;
 - iii. Test scores;
 - iv. Date of birth;
 - v. Place of birth; and

- vi. Social Security number.
- 6. “Gross negligence” means an extreme departure from the ordinary standard of care.
- 7. “Inactive status” means a behavior analyst maintains a license as a behavior analyst but is prohibited from practicing behavior analysis or holding oneself out as practicing behavior analysis in Arizona.
- 8. “License period” means:
 - a. For a licensee who holds an odd-numbered license, the two years between the first day of the month after the licensee’s birth month of one odd-numbered year and the last day of the licensee’s birth month of the next odd-numbered year; and
 - b. For a licensee who holds an even-numbered license, the two years between the first day of the month after the licensee’s birth month of one even-numbered year and the last day of the licensee’s birth month of the next even-numbered year.
- 9. “Mitigating circumstances that prevent resolution” means factors the Board considers in reviewing allegations against an applicant or licensee of unprofessional conduct occurring in another regulatory jurisdiction when the allegations would not prohibit licensure in Arizona. The factors may include:
 - a. Nature of the alleged conduct,
 - b. Severity of the alleged conduct,
 - c. Recency of the alleged conduct,
 - d. Actions taken by the applicant to remedy potential violations, and
 - e. Whether the alleged conduct was an isolated incident or part of a recurring pattern.
- 10. “Party” means the Board, an applicant, a licensee, or the state.
- 11. “Psychometric testing materials” means manuals, instruments, protocols, and questions or stimuli used in testing.
- 12. “Raw test data” means test scores, client responses to test questions or stimuli, and a behavior analyst’s notes and recordings concerning client statements and behavior during examination.
- 13. “Regulatory jurisdiction” means a state or territory of the United States, the District of Columbia, or a foreign country with authority to grant or deny entry into a profession or occupation.
- 14. “Renewal year” means:
 - a. Each odd-numbered year for a licensee who holds an odd-numbered license, and
 - b. Each even-numbered year for a licensee who holds an even-numbered license.
- 15. “Supervised experience” means supervised independent fieldwork, practicum, or intensive practicum.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-402. Fees and Charges

- A. As specifically authorized by A.R.S. §§ 32-2091.01(A) and 32-2091.07(B), the Board establishes and shall collect the following fees:
 - 1. Application for an active license: \$350;
 - 2. Renewal of an active license: \$500;
 - 3. Renewal of an inactive license: \$85;
 - 4. Issuance of an initial license: \$500; and
 - 5. Reinstatement of expired license: \$200.
- B. As specifically authorized by A.R.S. § 32-2091.01(B), the Board establishes and shall collect the following charges for the services specified:
 - 1. Duplicate license: \$25;
 - 2. Duplicate renewal receipt: \$5;
 - 3. Copy of the Board’s statutes and rules: \$5;
 - 4. Verification of a license: \$2;
 - 5. Audio recording of a Board meeting: \$10 per meeting;
 - 6. Electronic medium containing the name and address of all licensees: \$.05 per name;
 - 7. Customized electronic medium containing the name and address of all licensees: \$.25 per name;
 - 8. Customized electronic medium: \$.35 per name; and
 - 9. Copy of Board records, letters, minutes, applications, files, policy statements, and other non-confidential documents: \$.25 per page.
- C. Except as provided by law, including A.R.S. § 41-1077, the fees listed in subsection (A) are not refundable.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3).

R4-26-403. Application for Initial License

- A. An individual who wishes to practice as a behavior analyst and is qualified under A.R.S. § 32-2091.02 shall submit an application form, which is available from the Board office and on its website, and provide the following information:
1. Full name;
 2. Other names by which the applicant is or ever has been known;
 3. Home address and telephone number;
 4. Business name and address;
 5. Work telephone and fax numbers;
 6. E-mail address;
 7. Gender;
 8. Date of birth;
 9. Social Security number;
 10. An indication of the address and telephone number to be listed in the agency's public directory and used in correspondence;
 11. Place of birth;
 12. A statement of whether the applicant:
 - a. Is or ever has been licensed or certified as a behavior analyst in any regulatory jurisdiction and if so, the jurisdictions and license numbers;
 - b. Is or ever has been certified as a behavior analyst by the BACB and if so, the date of original certification and if not, whether the applicant has ever taken the examination required under R4-26-404;
 - c. Is or ever has been licensed or certified in other fields or professions and if so, the name of the professions, regulatory jurisdictions, and license numbers;
 - d. Is or ever has been a member of a hospital staff or provider panel and if so, the name of the hospital or provider and dates of service;
 - e. Is or ever has been a member of a professional association and if so, the name of the professional association and dates of membership;
 - f. Has ever had a professional license, certification, or registration refused, revoked, suspended, or restricted in any regulatory jurisdiction for reasons relating to unprofessional conduct;
 - g. Has ever voluntarily surrendered a license, certification, or registration, relinquished responsibilities, resigned a position in lieu of termination, or been involuntary terminated in any regulatory jurisdiction while under investigation or in lieu of administrative proceedings for reasons relating to unprofessional conduct;
 - h. Has ever resigned or been terminated from a professional organization, hospital staff, or provider panel while a complaint against the applicant was investigated or adjudicated;
 - i. Is or ever has been under investigation by any professional organization, health care institution, provider panel of which the applicant is a member or staff, or a regulatory agency in any jurisdiction, including the Arizona Board of Psychologist Examiners, concerning the ethical propriety or legality of the applicant's conduct and if so, the entity doing and dates of the investigation;
 - j. Has ever been disciplined by a regulatory agency in any jurisdiction, including the Arizona Board of Psychologist Examiners, health care institution, provider panel, or ethics panel for acts pertaining to the applicant's conduct as a behavior analyst or as a professional in any field and if so, the regulatory agency, jurisdiction, and date of discipline;
 - k. Has ever been convicted of, pled no contest or guilty to, entered into a diversion program to avoid prosecution, or is under indictment or awaiting trial for a felony or misdemeanor, other than a minor traffic offense, including any conviction that has been expunged, pardoned, reversed, or set aside;
 - l. Has ever been sued in a civil court or charged in a criminal court for an act or omission relating to practice as a behavior analyst or work under a license or certificate in another profession, or work as a member of a profession;
 - m. Currently uses alcohol or another drug that in any way impairs or limits the applicant's ability to practice behavior analysis safely and competently; and
 - n. Has a medical, physical, or psychological condition that limits the applicant's ability to practice behavior analysis safely and competently; and
 13. The applicant's signature attesting that all statements in the application are true in every respect.
- B. Additionally, an applicant shall submit:
1. An original, un-retouched, passport-quality photograph that is no larger than 1.5 X 2 inches in size and taken no more than 60 days before the date of application;
 2. The application fee required under R4-26-402;
 3. As required under A.R.S. § 41-1080(A), the specified documentation of citizenship or alien status indicating

- the applicant's presence in the U.S. is authorized under federal law; and
4. The Board's Mandatory Confidential Information form.
- C. Additionally, an applicant shall ensure that the following is submitted directly to the Board:
1. Verification the applicant passed the examination referenced in R4-26-404 submitted by the BACB;
 2. Verification of supervised experience submitted by an individual with direct knowledge of the supervised experience;
 3. Official transcript for the graduate degree required under R4-26-404.1 submitted by the accredited institution of higher education that awarded the degree;
 4. Official transcript or other official document demonstrating the applicant completed the coursework required under R4-26-405 submitted by the accredited institution of higher education or BACB-approved program in which the coursework was completed; and
 5. Verification of licensure, certification, or registration by another regulatory jurisdiction submitted by the regulatory jurisdiction.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-404. Examination Requirement

To be licensed as a behavior analyst in Arizona, an individual shall take and pass the examination administered by the BACB for Board Certified Behavior Analysts as part of its certification process.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-404.1. Education Requirement

- A. This Section does not apply to an applicant who was certified as a behavior analyst by the BACB before January 1, 2015.
- B. To be licensed as a behavior analyst in Arizona, an individual shall have a master's degree or higher from an accredited institution of higher education in:
1. Behavior analysis, education, psychology, or another subject area related to behavior analysis acceptable to the Board; or
 2. A degree program in which the applicant completed a BACB-approved course sequence.

Historical Note

New Section made by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-405. Coursework Requirement

- A. This Section does not apply to an applicant who was certified as a behavior analyst by the BACB before January 1, 2015.
- B. To be licensed as a behavior analyst in Arizona, an individual shall complete, as part of or in addition to the coursework necessary to obtain the graduate degree required under R4-26-404.1, 270 classroom hours of graduate-level instruction. The individual shall ensure that the classroom hours include the following content areas:
1. Ethical and professional conduct in behavior analysis: 45 hours;
 2. Concepts and principles of behavior analysis: 45 hours;
 3. Research methods in behavior analysis: 45 hours:
 - a. Measurement and data analysis: 25 hours; and
 - b. Experimental design: 20 hours;
 4. Applied behavior analysis: 105 hours:
 - a. Fundamental elements of behavior change and specific behavior change procedures: 45 hours;
 - b. Identification of the problem and assessment: 30 hours;
 - c. Intervention and behavior change considerations: 10 hours;
 - d. Behavior change systems: 10 hours; and
 - e. Implementation, management, and supervision: 10 hours; and
 5. Discretionary content related to behavior analysis: 30 hours.
- C. The Board shall accept classroom hours of graduate-level instruction completed at an accredited institution of higher education or in a program approved by the BACB.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-406. Ethical Standard

The Board incorporates by reference BACB Professional and Ethical Compliance Code for Behavior Analysts, January 1, 2016, published by the BACB and available for review at the Board office and online at www.BACB.com. The incorporated material includes no later editions or amendments.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-407. License by Reciprocity

An individual who is licensed or certified as a behavior analyst in another state may apply for an initial license as a behavior analyst in Arizona by complying with R4-26-403 and submitting evidence that the individual is licensed or certified as a behavior analyst in good standing and:

1. Obtained a graduate degree from an accredited institution of higher education in a subject area specified in R4-26-404.1;
2. Completed a minimum of 1,500 hours of supervised experience;
3. Completed a minimum of 270 classroom hours of graduate-level instruction in the content areas listed in R4-26-405 or was certified as a behavior analyst by the BACB before January 1, 2015; and
4. Passed the examination referenced in R4-26-404.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-408. License Renewal

- A. Beginning May 1, 2017, a license issued by the Board, whether active or inactive, expires on the last day of a licensee's birth month during the licensee's renewal year.
- B. The Board shall provide a licensee with 60 days' notice of the license renewal deadline. Failure to receive the notice does not excuse failure to renew timely.
- C. To renew a license, a licensee shall, on or before the last day of the licensee's birth month during the licensee's renewal year, submit to the Board a renewal application form, which is available from the Board office and on its website, and provide the following information:
 1. License number;
 2. Name;
 3. Other names by which the licensee is or ever has been known;
 4. Home address and telephone number;
 5. Business name and address;
 6. Work telephone and fax number;
 7. E-mail address;
 8. Date of birth;
 9. Social Security number;
 10. BACB certificate number, if applicable;
 11. A statement of whether the licensee:
 - a. Is in compliance with or exempt from the requirements of A.R.S. § 32-3211 regarding secure storage, transfer, and access of patient records and if not, explain;
 - b. Is currently licensed or certified as a behavior analyst in any regulatory jurisdiction other than Arizona and if so, the jurisdictions and license numbers;
 - c. Is currently licensed or certified in other fields or professions and if so, the name of the professions, regulatory jurisdictions, and license numbers;
 - d. Is a member of a hospital staff or provider panel and if so, the name of the hospital or provider;
 - e. Is currently a member of a professional association and if so, the name of the professional association;
 - f. Has, during the last license period, had a professional license, certification, or registration refused, revoked, suspended, or restricted in any regulatory jurisdiction for reasons relating to unprofessional conduct;
 - g. Has, during the last license period, voluntarily surrendered a license, certification, or registration, relinquished responsibilities, resigned a position in lieu of termination, or been involuntary terminated in any regulatory jurisdiction while under investigation or in lieu of administrative proceedings for

- reasons relating to unprofessional conduct;
- h. Has, during the last license period, resigned or been terminated from a professional organization, hospital staff, or provider panel while a complaint against the licensee was investigated or adjudicated;
 - i. Has, during the last license period, been investigated by any professional organization, health care institution, provider panel of which the licensee is a member or staff, or a regulatory agency in any jurisdiction, including the Arizona Board of Psychologist Examiners, concerning the ethical propriety or legality of the licensee's conduct and if so, the entity doing and dates of the investigation;
 - j. Has, during the last license period, been disciplined by a regulatory agency in any jurisdiction, including the Arizona Board of Psychologist Examiners, health care institution, provider panel, or ethics panel for acts pertaining to the licensee's conduct as a behavior analyst or as a professional in any field and if so, the regulatory agency, jurisdiction, and date of discipline;
 - k. Has, during the last license period, been convicted of, pled no contest or guilty to, entered into a diversion program to avoid prosecution, or is under indictment or awaiting trial for a felony or misdemeanor, other than a minor traffic offense, including any conviction that has been expunged, pardoned, reversed, or set aside;
 - l. Has, during the last license period, been sued in a civil court or charged in a criminal court for an act or omission relating to practice as a behavior analyst or work under a license or certificate in another profession, or work as a member of a profession;
 - m. Currently uses alcohol or another drug that in any way impairs or limits the licensee's ability to practice behavior analysis safely and competently; and
 - n. Has a medical, physical, or psychological condition that limits the licensee's ability to practice behavior analysis safely and competently;
- 12. An indication whether the licensee is requesting an active license, voluntary inactive license, or medical inactive license;
 - 13. An attestation that the licensee is in compliance with the continuing education requirement specified in R4-26-409; and
 - 14. The licensee's signature attesting that the information provided is true in every respect.
- D.** Additionally, to renew a license, a licensee shall submit:
- 1. The license renewal fee required under R4-26-402;
 - 2. If the documentation previously submitted under R4-26-403(B)(3) was a limited form of work authorization issued by the federal government, evidence that the work authorization has not expired; and
 - 3. The Board's Mandatory Confidential Information form.
- E.** If a completed application is timely submitted under subsections (C) and (D) to renew an active license, the licensee may continue to practice behavior analysis under the active license until notified by the Board that the application for renewal has been approved or denied. If the Board denies license renewal, the licensee may continue to practice behavior analysis until the last day for seeking review of the Board's decision or a later date fixed by a reviewing court.
- F.** Under A.R.S. § 32-2091.07, the license of a licensee who fails to submit a renewal application on or before the last day of the licensee's birth month during the licensee's renewal year expires and the licensee shall immediately stop practicing as a behavior analyst in Arizona.
- G.** A behavior analyst whose license expires under subsection (F) may have the license reinstated by submitting the following to the Board within two months after last day of the licensee's birth month during the licensee's renewal year:
- 1. The license renewal application required under subsection (C) and the document required under subsection (D)(2),
 - 2. A sworn affidavit that the applicant has not practiced as a behavior analyst in Arizona since the applicant's license expired, and
 - 3. The license renewal and license reinstatement fees.
- H.** A behavior analyst whose license expires under subsection (F) and who fails to have the license reinstated under subsection (G) may have the license reinstated by:
- 1. Complying with subsection (G) within one year after the last day of the licensee's birth month during the licensee's renewal year, and
 - 2. Providing proof of competency and qualifications to the Board.
- I.** A behavior analyst whose license expires under subsection (F) and who fails to have the license reinstated under subsection (G) or (H) may be licensed again only by complying with R4-26-403.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-409. Continuing Education Requirement

- A. A licensee shall complete a minimum of 30 hours of continuing education during each license period. A licensee shall ensure that at least four hours of continuing education addresses ethics.
- B. During a licensee's first license period, the licensee shall complete a pro-rated number of continuing education hours. To determine the number of continuing education hours required during the first license period, the licensee shall multiply the number of whole months from the month of license issuance to the end of the license period by 1.25.
- C. A licensee shall ensure that each continuing education program provides the necessary understanding of current developments, skills, or procedures related to the practice of behavior analysis. The following provide the necessary understanding of current developments, skills, or procedures related to the practice of behavior analysis:
 1. College or university graduate coursework that directly relates to behavior analysis and is provided by an accredited educational institution: 15 hours of continuing education for each semester hour completed and 10 hours of continuing education for each quarter hour completed; a course syllabus and transcript are required for documentation;
 2. Continuing education programs offered by a BACB-approved provider: One hour of continuing education for each hour of participation; a certificate or letter from the BACB-approved provider is required for documentation;
 3. Self-study, online, or correspondence course that is directly related to behavior analysis and offered by BACB-approved provider or approved or offered by an accredited educational institution: Hours of continuing education determined by the course provider; a certificate or letter from the BACB-approved provider or a course syllabus and transcript from the accredited educational institution are required for documentation;
 4. Teaching a continuing education program offered by a BACB-approved provider or teaching a graduate university or college course offered by an accredited educational institution: One hour of continuing education for each hour taught; for graduate courses taught, 15 hours of continuing education for each semester hour completed and 10 hours of continuing education for each quarter hour completed;
 5. Credentialing activities or events pre-approved for continuing education and initiated by the BACB: One hour of continuing education for each hour of participation; documentation from the BACB is required;
 6. Publication of a peer-reviewed article or text book on the practice of behavior analysis or serving as a reviewer or action editor of an article pertaining to behavior analysis: eight hours of continuing education for one publication and one hour of continuing education for one review; and
 7. Attending a Board meeting: Three hours for attending a morning or afternoon session of a Board meeting and six hours for attending a full-day Board meeting.
- D. The number of hours of continuing education is limited as follows:
 1. No more than 50 percent of the required hours may be obtained from teaching a continuing education program or course under subsection (C)(4). A licensee shall not obtain continuing education hours for teaching the same continuing education program or course more than once during each licensing period. A licensee shall earn no continuing education hours for participating as a member of a panel at a continuing education program or course;
 2. No more than 25 percent of the required hours may be obtained from continuing education under each of subsections (C)(3), (5), and (6).
 3. No more than six of the required hours may be obtained under subsection (C)(7). Hours obtained under subsection (C)(7) may be used to complete the ethics requirement under subsection (A).
 4. Hours obtained in excess of the minimum required during a license period shall not be carried over to a subsequent license period.
- E. A licensee shall obtain a certificate or other evidence of attendance from the provider of each continuing education program or course attended that includes the following:
 1. Name of the licensee;
 2. Title of the continuing education;
 3. Name of the continuing education provider;
 4. Date, time, and location of the continuing education; and
 5. Number of hours of continuing education obtained.
- F. A licensee shall maintain the evidence of attendance described in subsection (E) for two licensing periods and make the evidence available to the Board upon request.
- G. The Board may audit a licensee's compliance with the continuing education requirement. The Board may deny license renewal or take other disciplinary action against a licensee who fails to obtain or document the required continuing education hours. The Board may discipline a licensee who commits fraud, deceit, or misrepresentation regarding the continuing education hours.
- H. A licensee who cannot comply with the continuing education requirement for good cause may seek an extension

of time in which to comply by submitting a written request to the Board with the timely submission of the renewal application required under R4-26-408.

1. Good cause includes but is not limited to illness or injury of the licensee or a close family member, death of a close family member, birth or adoption of a child, military service, relocation, natural disaster, financial hardship, or residence in a foreign country for at least 12 months of the license period.
2. The Board shall not grant an extension longer than one year.
3. A licensee who obtains hours of continuing education during an extension of time provided by the Board shall ensure the hours are reported only for the license period extended.
4. A licensee who cannot comply with the continuing education requirement within an extension may apply to the Board for inactive license status under A.R.S. § 32-2091.06(E).

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-410. Voluntary Inactive Status

- A. A licensed behavior analyst may request that the Board place the license on inactive status for one of the following reasons:
 1. The behavior analyst no longer provides behavior analysis services in Arizona,
 2. The behavior analyst is retired, or
 3. The behavior analyst is physically or mentally incapacitated or otherwise disabled.
- B. To place a license on inactive status, a licensee shall comply with R4-26-408.
- C. To remain licensed, a licensee on inactive status shall comply with R4-26-408 on or before the last day of the licensee's birth month during the licensee's renewal year.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-411. License Reinstatement

A licensee seeking reinstatement from an inactive to an active license shall:

1. Comply with the provisions of R4-26-408(C) and (D);
2. Submit evidence of completing a pro-rated number of hours of continuing education. The licensee shall calculate the number of continuing education hours required by multiplying the number of whole months that the license was on inactive status by 1.25; and
3. Complete any other requirements the Board determines are necessary to ensure that the licensee has maintained and updated the licensee's ability to practice as a behavior analyst.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3).

R4-26-412. Client Records

- A. A licensee shall not condition release of a client's record on payment for services by the client or a third party.
- B. A licensee shall release a client's raw test data to another licensed behavior analyst only after obtaining the client's informed, written consent to the release. Without a client's informed, written consent, a licensee shall release the client's raw test data only to the extent required by law or under court order compelling production.
- C. A licensee shall retain all client records under the licensee's control for at least six years from the date of the last client activity. If a client is a minor, the licensee shall retain the client's record for at least three years past the client's 18th birthday or six years from the date of the last client activity, whichever is longer.
- D. Audio or video tapes created primarily for training or supervisory purposes are exempt from the requirement of subsection (C).
- E. A licensee who is notified by the Board or municipal, state, or federal officials of an investigation or pending case shall retain all records relating to the investigation or case until the licensee receives written notice that the investigation is complete or the case is closed.
- F. A licensee may retain client records in electronic form. The licensee shall ensure that client records in electronic form are stored securely and a backup copy is maintained.
- G. The provisions of this Section apply to all licensees including those on inactive status.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3).

R4-26-413. Change of Name, Mailing Address, E-mail Address, or Telephone Number

- A. The Board shall communicate with a licensee using the contact information provided to the Board. To ensure timely communication from the Board, a licensee shall notify the Board, in writing, within 30 days of any change of name, mailing address, e-mail address, or residential or business telephone number.
- B. A licensee who reports a name change shall submit to the Board legal documentation that explains the name change.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3).

R4-26-414. Complaints and Investigations

- A. Anyone, including the Board, may file a complaint. A complainant shall ensure that a complaint filed with the Board involves:
 1. An individual licensed under this Article; or
 2. An individual, including an applicant, believed to be engaged in the unlicensed practice of behavior analysis.
- B. Complaint requirements. A complainant shall:
 1. Submit the complaint to the Board in writing; and
 2. Provide the following information:
 - a. Name and business address of licensee or other individual who is the subject of complaint;
 - b. Name and address of complainant;
 - c. Allegations constituting unprofessional conduct;
 - d. Details of the complaint with pertinent dates and activities;
 - e. Whether the complainant has contacted any other organization regarding the complaint; and
 - f. Whether the complainant has contacted the licensee or other individual concerning the complaint and if so, the response, if any.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-415. Informal Interview

- A. As authorized by A.R.S. § 32-2091.09(H), the Board may facilitate investigation of a complaint by conducting an informal interview. The Board shall send written notice of an informal interview to the individual who is the subject of the complaint, by personal service or certified mail, return receipt requested, at least 30 days before the informal interview.
- B. The Board shall ensure that the written notice of informal interview contains the following information:
 1. The time, date, and place of the informal interview;
 2. An explanation of the informal nature of the proceedings;
 3. The individual's right to appear with legal counsel who is authorized to practice law in Arizona or without legal counsel;
 4. A statement of the allegations and issues involved with a citation to relevant statutes and rules;
 5. The individual's right to a formal hearing under A.R.S. Title 41, Chapter 6, Article 10 instead of the informal interview;
 6. The licensee's right, as specified in A.R.S. § 32-3206, to request a copy of information the Board will consider in making its determination; and
 7. Notice that the Board may take disciplinary action as a result of the informal interview if it finds the individual violated A.R.S. Title 32, Chapter 19.1, Article 4, or this Article;
- C. The Board shall ensure that an informal interview proceeds as follows:
 1. Introduction of the respondent and, if applicable, the complainant, any other witnesses, and legal counsel for the respondent;
 2. Introduction of the Board members, staff, and Assistant Attorney General present;
 3. Swearing in of the respondent, complainant, and witnesses;
 4. Brief summary of the allegations and purpose of the informal interview;
 5. Optional opening comment by the respondent and complainant;
 6. Questioning of the respondent and witnesses by the Board;
 7. Questioning of the complainant by the respondent through the Chair;
 8. Optional additional comments by the respondent and complainant; and
 9. Deliberation by the Board.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3).

R4-26-416. Rehearing or Review of Decision

- A. The Board shall provide for a rehearing and review of its decisions under A.R.S. Title 41, Chapter 6, Article 10.
- B. Except as provided in subsection (H), a party is required to file a motion for rehearing or review of a decision of the Board to exhaust the party's administrative remedies.
- C. A party may amend a motion for rehearing or review at any time before the Board rules on the motion.
- D. The Board may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
 1. Irregularity in the proceedings of the Board or any order or abuse of discretion that deprived the moving party of a fair hearing;
 2. Misconduct of the Board, its staff, or an administrative law judge;
 3. Accident or surprise that could not have been prevented by ordinary prudence;
 4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
 5. Excessive or insufficient penalty;
 6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings; and
 7. The findings of fact or a decision is not justified by the evidence or is contrary to law.
- E. The Board may affirm or modify a decision or grant a rehearing or review to all or some of the parties on all or some of the issues for any of the reasons listed in subsection (D). An order modifying a decision or granting a rehearing or review shall specify with particularity the grounds for the order. If a rehearing or review is granted, the rehearing or review shall cover only the matters specified in the order.
- F. Within 30 days after the date of a decision and after giving the parties notice and an opportunity to be heard, the Board may, on its own initiative, order a rehearing or review of its decision for any reason it might have granted a rehearing or review on motion of a party. The Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion. An order granting a rehearing or review shall specify with particularity the grounds on which the rehearing or review is granted.
- G. When a motion for rehearing is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits.
- H. If, in a particular decision, the Board makes a specific finding that the immediate effectiveness of the decision is necessary for preservation of the public health, safety, or welfare and that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review.
- I. An application for judicial review of any final Board decision may be made under A.R.S. § 12-901 et seq.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3).

R4-26-417. Licensing Time Frames

- A. For the purpose of A.R.S. § 41-1073, the Board establishes the following time frames:
 1. Initial license.
 - a. Overall time frame: 120 days,
 - b. Administrative completeness review time frame: 30 days, and
 - c. Substantive review time frame: 90 days; and
 2. Renewal license.
 - a. Overall time frame: 150 days,
 - b. Administrative completeness review time frame: 60 days, and
 - c. Substantive review time frame: 90 days.
- B. An applicant and the Executive Director of the Board may agree in writing to extend the substantive review and overall time frames by no more than 25% of the overall time frame.
- C. The administrative completeness review time frame begins when the Board receives the application materials required under R4-26-403 or R4-26-408(C) and (D). During the administrative completeness review time frame, the Board shall notify the applicant that the application is either complete or incomplete. If the application is incomplete, the Board shall specify in the notice what information is missing.
- D. An applicant whose application is incomplete shall submit the missing information to the Board within 240 days for an initial license. Both the administrative completeness review and overall time frames are suspended from the date of the Board's notice under subsection (C) until the Board receives all of the missing information.
- E. Upon receipt of all missing information, the Board shall notify the applicant that the application is complete. The Board shall not send a separate notice of completeness if the Board grants or denies a license within the administrative completeness review time frame listed in subsection (A)(1)(b) or (A)(2)(b).

- F. The substantive review time frame begins on the date of the Board's notice of administrative completeness.
- G. If the Board determines during the substantive review that additional information is needed, the Board shall send the applicant a comprehensive written request for additional information.
- H. An applicant who receives a request under subsection (G) shall submit the additional information to the Board within 240 days. Both the substantive review and overall time frames are suspended from the date of the Board's request until the Board receives the additional information.
- I. An applicant may receive a 30-day extension of the time provided under subsection (D) or (H) by providing written notice to the Board before the time expires. If an applicant fails to submit to the Board the missing or additional information within the time provided under subsection (D) or (H) or the time as extended, the Board shall close the applicant's file. To receive further consideration, a person whose file is closed shall re-apply.
- J. Within the overall time frame listed in subsection (A), the Board shall:
 1. Grant a license if the Board determines that the applicant meets all criteria required by statute and this Article; or
 2. Deny a license if the Board determines that the applicant does not meet all criteria required by statute and this Article.
- K. If the Board grants a license under subsection (J)(1), the Board shall send the applicant a notice explaining that the Board shall issue the license only after the applicant pays the license issuance fee specified under R4-26-402 and pro-rated as prescribed under A.R.S. § 32-2091.07(A).
- L. If the Board denies a license, the Board shall send the applicant a written notice explaining:
 1. The reason for denial, with citations to supporting statutes or rules;
 2. The applicant's right to appeal the denial by filing an appeal under A.R.S. Title 41, Chapter 6, Article 10;
 3. The time for appealing the denial; and
 4. The applicant's right to request an informal settlement conference.
- M. If a time frame's last day falls on a Saturday, Sunday, or official state holiday, the next business day is the time frame's last day.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3). Section amended by final rulemaking at 23 A.A.R. 215, effective March 5, 2017 (Supp. 17-1).

R4-26-418. Mandatory Reporting Requirement

- A. As required by A.R.S. § 32-3208, an applicant or licensee who is charged with a misdemeanor involving conduct that may affect client safety or a felony shall provide written notice of the charge to the Board within 10 days after the charge is filed.
- B. A list of reportable misdemeanors is available on the Board's website.

Historical Note

Section made by final rulemaking at 18 A.A.R. 2490, effective September 11, 2012 (Supp. 12-3).

As of August 15, 2018

32-2063. Powers and duties

A. The board shall:

1. Administer and enforce this chapter and board rules.
 2. Regulate disciplinary actions, the granting, denial, revocation, renewal and suspension of licenses and the rehabilitation of licensees pursuant to this chapter and board rules.
 3. Prescribe the forms, content and manner of application for licensure and renewal of licensure and set deadlines for the receipt of materials required by the board.
 4. Keep a record of all licensees, board actions taken on all applicants and licensees and the receipt and disbursal of monies.
 5. Adopt an official seal for attestation of licenses and other official papers and documents.
 6. Investigate charges of violations of this chapter and board rules and orders.
 7. Subject to title 41, chapter 4, article 4, employ an executive director who serves at the pleasure of the board.
 8. Annually elect from among its membership a chairman, a vice-chairman and a secretary, who serve at the pleasure of the board.
 9. Adopt rules pursuant to title 41, chapter 6 to carry out this chapter and to define unprofessional conduct.
 10. Engage in a full exchange of information with other regulatory boards and psychological associations, national psychology organizations and the Arizona psychological association and its components.
 11. By rule, adopt a code of ethics relating to the practice of psychology. The board shall base this code on the code of ethics adopted and published by the American psychological association. The board shall apply the code to all board enforcement policies and disciplinary case evaluations and development of licensing examinations.
 12. Adopt rules regarding the use of telepractice on or before June 30, 2016.
 13. Before the board takes action, receive and consider recommendations from the committee on behavior analysts on all matters relating to the licensing and regulation of behavior analysts, as well as regulatory changes pertaining to the practice of behavior analysis, except in the case of a summary suspension of a license pursuant to section 32-2091.09, subsection E.
- B. Subject to title 41, chapter 4, article 4, the board may employ personnel it deems

necessary to carry out this chapter. The board, in investigating violations of this chapter, may employ investigators who may be psychologists. The board or its executive director may take and hear evidence, administer oaths and affirmations and compel by subpoena the attendance of witnesses and the production of books, papers, records, documents and other information relating to the investigation or hearing.

C. Subject to section 35-149, the board may accept, expend and account for gifts, grants, devises and other contributions, money or property from any public or private source, including the federal government. The board shall deposit, pursuant to sections 35-146 and 35-147, monies received pursuant to this subsection in special funds for the purpose specified, and monies in these funds are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

D. Compensation for all personnel shall be determined pursuant to section 38-611.

32-2091. Definitions

In this article, unless the context otherwise requires:

1. "Active license" means a current license issued by the board to a person licensed pursuant to this article.
2. "Adequate records" means records that contain, at a minimum, sufficient information to identify the client, the dates of service, the fee for service, the payments for service and the type of service given and copies of any reports that may have been made.
3. "Behavior analysis" means the design, implementation and evaluation of systematic environmental modifications by a behavior analyst to produce socially significant improvements in human behavior based on the principles of behavior identified through the experimental analysis of behavior. Behavior analysis does not include cognitive therapies or psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities.
4. "Behavior analysis services" means the use of behavior analysis to assist a person to learn new behavior, increase existing behavior, reduce existing behavior and emit behavior under precise environmental conditions. Behavior analysis includes behavioral programming and behavioral programs.
5. "Behavior analyst" means a person who is licensed pursuant to this article to practice behavior analysis.
6. "Client" means:
 - (a) A person or entity that receives behavior analysis services.
 - (b) A corporate entity, a governmental entity or any other organization that has a professional contract to provide services or benefits primarily to an organization rather than to an individual.

(c) An individual's legal guardian for decision making purposes, except that the individual is the client for issues that directly affect the individual's physical or emotional safety and issues that the legal guardian agrees to specifically reserve to the individual.

7. "Exploit" means an action by a behavior analyst who takes undue advantage of the professional association with a client, student or supervisee for the advantage or profit of the behavior analyst.

8. "Health care institution" means a facility that is licensed pursuant to title 36, chapter 4, article 1.

9. "Incompetent as a behavior analyst" means that a person who is licensed pursuant to article 4 of this chapter lacks the knowledge or skills of a behavior analyst to a degree that is likely to endanger the health of a client.

10. "Letter of concern" means an advisory letter to notify a licensee that while there is insufficient evidence to support disciplinary action the board believes the licensee should modify or eliminate certain practices and that continuation of the activities that led to the information being submitted to the board may result in action against the license.

11. "Supervisee" means a person who acts under the extended authority of a behavior analyst to provide behavioral services and includes a person who is in training to provide these services.

12. "Unprofessional conduct" includes the following activities, whether occurring in this state or elsewhere:

(a) Obtaining a fee by fraud or misrepresentation.

(b) Betraying professional confidences.

(c) Making or using statements of a character tending to deceive or mislead.

(d) Aiding or abetting a person who is not licensed pursuant to this article in representing that person as a behavior analyst.

(e) Gross negligence in the practice of a behavior analyst.

(f) Sexual intimacies or sexual intercourse with a current client or a supervisee or with a former client within two years after the cessation or termination of treatment. For the purposes of this subdivision, "sexual intercourse" has the same meaning prescribed in section 13-1401.

(g) Engaging or offering to engage as a behavior analyst in activities that are not congruent with the behavior analyst's professional education, training and experience.

(h) Failing or refusing to maintain and retain adequate business, financial or professional records pertaining to the behavior analysis services provided to a client.

- (i) Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.
- (j) Making a fraudulent or untrue statement to the board or its investigators, staff or consultants.
- (k) Violating any federal or state law that relates to the practice of behavior analysis or to obtain a license to practice behavior analysis.
- (l) Practicing behavior analysis while impaired or incapacitated to the extent and in a manner that jeopardizes the welfare of a client or renders the services provided ineffective.
- (m) Using fraud, misrepresentation or deception to obtain or attempt to obtain a behavior analysis license or to pass or attempt to pass a behavior analysis licensing examination or in assisting another person to do so.
- (n) Unprofessional conduct in another jurisdiction that resulted in censure, probation or a civil penalty or in the denial, suspension, restriction or revocation of a certificate or license to practice as a behavior analyst.
- (o) Providing services that are unnecessary or unsafe or otherwise engaging in activities as a behavior analyst that are unprofessional by current standards of practice.
- (p) Falsely or fraudulently claiming to have performed a professional service, charging for a service or representing a service as the licensee's own if the licensee has not rendered the service or assumed supervisory responsibility for the service.
- (q) Representing activities or services as being performed under the licensee's supervision if the behavior analyst has not assumed responsibility for them and has not exercised control, oversight and review.
- (r) Failing to obtain a client's informed and written consent to release personal or otherwise confidential information to another party unless the release is otherwise authorized by law.
- (s) Failing to make client records in the behavior analyst's possession promptly available to another behavior analyst on receipt of proper authorization to do so from the client, a minor client's parent, the client's legal guardian or the client's authorized representative or failing to comply with title 12, chapter 13, article 7.1.
- (t) Failing to take reasonable steps to inform or protect a client's intended victim and inform the proper law enforcement officials if the behavior analyst becomes aware during the course of providing or supervising behavior analysis services that a client intends or plans to inflict serious bodily harm on another person.
- (u) Failing to take reasonable steps to protect a client if the behavior analyst becomes

aware during the course of providing or supervising behavior analysis services that a client intends or plans to inflict serious bodily harm on self.

(v) Abandoning or neglecting a client in need of immediate care without making suitable arrangements for continuation of the care.

(w) Engaging in direct or indirect personal solicitation of clients through the use of coercion, duress, undue influence, compulsion or intimidation practices.

(x) Engaging in false, deceptive or misleading advertising.

(y) Exploiting a client, student or supervisee.

(z) Failing to report information to the board regarding a possible act of unprofessional conduct committed by another behavior analyst who is licensed pursuant to this article unless this reporting violates the behavior analyst's confidential relationship with a client pursuant to this article. A behavior analyst who reports or provides information to the board in good faith is not subject to an action for civil damages.

(aa) Violating a formal board order, consent agreement, term of probation or stipulated agreement issued under this article.

(bb) Failing to furnish information in a timely manner to the board or its investigators or representatives if requested or subpoenaed by the board as prescribed by this article.

(cc) Failing to make available to a client or to the client's designated representative, on written request, a copy of the client's record, excluding raw test data, psychometric testing materials and other information as provided by law.

(dd) Violating an ethical standard adopted by the board.

(ee) Representing oneself as a psychologist or permitting others to do so if the behavior analyst is not also licensed as a psychologist pursuant to this chapter.

32-2091.01. Fees

A. The board, by a formal vote, shall establish fees for the following relating to the licensure of behavior analysts:

1. An application for an active license.

2. An application for a temporary license.

3. Renewal of an active license.

4. Issuance of an initial license.

B. The board may charge additional fees for services it deems necessary and appropriate to carry out this article. These fees shall not exceed the actual cost of providing the

service.

C. The board shall not refund fees except as otherwise provided in this article. On special request and for good cause, the board may return the license renewal fee.

32-2091.02. Qualifications of applicant

Beginning January 1, 2011, a person who wishes to practice as a behavior analyst must be licensed pursuant to this article. An applicant for licensure must meet all of the following requirements:

1. Submit an application as prescribed by the board.
2. Be at least twenty-one years of age.
3. Be of good moral character. The board's standard to determine good moral character shall not violate federal discrimination laws.
4. Pay all applicable fees prescribed by the board.
5. Have the physical and mental capability to safely and competently engage in the practice of behavior analysis.
6. Not have committed any act or engaged in any conduct that would constitute grounds for disciplinary action against a licensee pursuant to this article.
7. Not have had a professional license or certificate refused, revoked, suspended or restricted in any regulatory jurisdiction in the United States or in another country for reasons that relate to unprofessional conduct. If the board finds that the applicant committed an act or engaged in conduct that would constitute grounds for disciplinary action in this state, the board shall determine to its satisfaction that the conduct has been corrected, monitored and resolved. If the matter has not been resolved, the board shall determine to its satisfaction that mitigating circumstances exist that prevent its resolution.
8. Not have voluntarily surrendered a license or certificate in another regulatory jurisdiction in the United States or in another country while under investigation for reasons that relate to unprofessional conduct. If another jurisdiction has taken disciplinary action against an applicant, the board shall determine to its satisfaction that the cause for the action was corrected and the matter resolved. If the matter has not been resolved by that jurisdiction, the board shall determine to its satisfaction that mitigating circumstances exist that prevent its resolution.
9. Not have a complaint, allegation or investigation pending before another regulatory jurisdiction in the United States or another country that relates to unprofessional conduct. If an applicant has any such complaints, allegations or investigations pending, the board shall suspend the application process and may not issue or deny a license to the applicant until the complaint, allegation or investigation is resolved.

32-2091.03. Educational and training standards for licensure

An applicant for licensure as a behavior analyst must meet standards adopted by the state board of psychologist examiners, including meeting graduate level education and supervised experience requirements and passing a national examination. The state board of psychologist examiners shall adopt standards consistent with the standards set by a nationally recognized behavior analyst certification board, except that the number of hours required for supervised experience must be at least one thousand five hundred hours of supervised work experience or independent fieldwork, university practicum or intensive university practicum. The standards adopted for supervised experience must also be consistent with the standards set by a nationally recognized behavior analyst certification board. If the state board of psychologist examiners does not agree with a standard set by a nationally recognized behavior analyst certification board, the state board may adopt an alternate standard.

32-2091.04. Reciprocity

The board may issue a license to a person as a behavior analyst if the person is licensed or certified by a regulatory agency of another state that imposes requirements that are substantially equivalent to those imposed by this article at an equivalent or higher practice level as determined by the board, pays the fee prescribed by the board and meets all of the following requirements:

1. Submits a written application prescribed by the board.
2. Is of good moral character. The board's standard to determine good moral character shall not violate federal discrimination laws.
3. Documents to the board's satisfaction proof of initial licensure or certification at an equivalent designation for which the applicant is seeking licensure in this state and proof that the license or certificate is current and in good standing.
4. Documents to the board's satisfaction proof that any other license or certificate issued to the applicant by another state has not been suspended or revoked. If a licensee or certificate holder has been subjected to any other disciplinary action, the board may assess the magnitude of that action and make a decision regarding reciprocity based on this assessment.
5. Meets any other requirements prescribed by the board by rule.

32-2091.06. Temporary licenses; inactive status; reinstatement to active status

A. If the board requires an additional examination, it may issue a temporary license to a behavior analyst who is licensed or certified under the laws of another jurisdiction, if the behavior analyst applies to the board for licensure and meets the educational, experience and first examination requirements of this article.

B. A temporary license issued pursuant to this section is effective from the date the application is approved until the last day of the month in which the applicant receives the results of the additional examination.

C. The board shall not extend, renew or reissue a temporary license or allow it to continue in effect beyond the period authorized by this section.

D. The board's denial of an application for licensure terminates a temporary license.

E. The board may place on inactive status and waive the license renewal fee requirements for a person who is temporarily or permanently unable to practice as a behavior analyst due to physical or mental incapacity or disability. An initial request for the waiver of renewal fees shall be accompanied by the renewal fee for an active license, which the board shall return if the waiver is granted. The board shall judge each request for the waiver of renewal fees on its own merits and may seek the verification it deems necessary to substantiate the facts of the situation. A behavior analyst who is retired is exempt from paying the renewal fee. A behavior analyst may request voluntary inactive status by submitting to the board an application on a form prescribed by the board and an affirmation that the behavior analyst will not practice as a behavior analyst in this state for the duration of the voluntary inactive status and by paying the required fee as prescribed by the board by rule.

F. A behavior analyst who is on any form of inactive status shall renew the inactive status every two years by submitting a renewal form provided by the board and paying any applicable fee as prescribed by the board by rule. A notice to renew is fully effective by mailing the renewal application to the licensee's last known address of record in the board's file. Notice is complete at the time of its deposit in the mail. A behavior analyst who is on inactive status due to physical or mental incapacity or disability or retirement shall use the term "inactive" to describe the person's status and shall not practice as a behavior analyst.

G. A behavior analyst on inactive status may request reinstatement of the license to active status by applying to the board. The board shall determine whether the person has been or is in violation of any provisions of this article and whether the person has maintained and updated the person's professional knowledge and capability to practice as a behavior analyst. The board may require the person to take or retake the licensure examinations and may require other knowledge or skill training experiences. If approved for active status, the person shall pay a renewal fee that equals the renewal fee for the license to be reinstated.

32-2091.07. Active license; issuance; renewal; expiration; continuing education

A. Beginning May 1, 2017, if the applicant satisfies all of the requirements for licensure pursuant to this article, the board shall issue an active license and shall prorate the fee for issuing that license for the period remaining until the last day of the birth month of the applicant of the next odd-numbered year or even-numbered year pursuant to subsection

B, paragraph 1 or 2 of this section.

B. Beginning May 1, 2017, a person holding an active or inactive license shall apply to renew the license on or before the last day of the birth month of the licensee every other year as follows:

1. In each odd-numbered year, if the licensee holds an odd-numbered license.

2. In each even-numbered year, if the licensee holds an even-numbered license.

C. The application shall include any applicable renewal fee as prescribed by the board by rule. Except as provided in section 32-4301 or 41-1092.11, a license expires if the licensee fails to renew the license on or before the last day of the licensee's birth month of the licensee's renewal year pursuant to subsection B of this section. A licensee may reinstate an expired license by paying a reinstatement fee as prescribed by the board by rule within two months after the last day of the licensee's birth month of that year.

Beginning two months after the last day of the licensee's birth month during the licensee's renewal year until the last day of the licensee's birth month the following year, a licensee may reinstate the license by paying a reinstatement fee as prescribed by the board by rule and providing proof of competency and qualifications to the board. This proof may include continuing education, an oral examination, a written examination or an interview with the board. A licensee whose license is not reinstated within a year after the last day of the licensee's birth month of the licensee's renewal year may reapply for licensure as prescribed by this article. A notice to renew is fully effective by mailing or electronically providing the notice to the licensee's last known address of record or last known e-mail address of record in the board's file. Notice is complete at the time of deposit in the mail or when the e-mail is sent.

D. A person renewing a license shall attach to the completed renewal form a report of disciplinary actions or restrictions placed against the license by another state licensing or disciplinary board or disciplinary actions or sanctions imposed by a state or national behavior analysis ethics committee or health care institution. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action.

E. A person who renews an active license to practice behavior analysis in this state shall satisfy a continuing education requirement designed to provide the necessary understanding of current developments, skills, procedures or treatment related to the practice of behavior analysis in the amount and during the period the board prescribes. The board shall prescribe documentation requirements.

32-2091.08. Exemptions from licensure

A. This article does not limit the activities, services and use of a title by the following:

1. A behavior analyst who is employed in a common school, high school or charter school setting and who is certified to use that title by the department of education if the

services or activities are a part of the duties of that person's common school, high school or charter school employment.

2. An employee of a government agency in a subdoctorate position who uses the word "assistant" or "associate" after the title and who is supervised by a doctorate position employee who is licensed as a behavior analyst, including a temporary licensee.
 3. A matriculated graduate student, or a trainee whose activities are part of a defined behavior analysis program of study, practicum, intensive practicum or supervised independent fieldwork. The practice under this paragraph requires direct supervision consistent with the standards set by a nationally recognized behavior analyst certification board, as determined by the state board of psychologist examiners. A student or trainee may not claim to be a behavior analyst and must use a title that clearly indicates the person's training status, such as "behavior analysis student" or "behavior analysis trainee".
 4. A person who resides outside of this state and who is currently licensed or certified as a behavior analyst in that state if the activities and services conducted in this state are within the behavior analyst's customary area of practice, do not exceed twenty days per year and are not otherwise in violation of this article and the client, public or consumer is informed of the limited nature of these activities and services and that the behavior analyst is not licensed in this state.
 5. A person in the employ of Arizona state university, northern Arizona university, the university of Arizona or another regionally accredited university in this state if the services are a part of the faculty duties of that person's salaried position and the person is participating in a graduate program.
 6. A noncredentialed individual who delivers applied behavior analysis services under the extended authority and direction of a licensed behavior analyst. The individual may not claim to be a professional behavior analyst and must use a title indicating the person's nonprofessional status, such as "ABA technician", "behavior technician" or "tutor".
- B. This article does not prevent a member of other recognized professions who is licensed, certified or regulated under the laws of this state from rendering services within that person's scope of practice and code of ethics if that person does not claim to be a behavior analyst.

32-2091.09. Grounds for disciplinary action; duty to report; immunity; proceedings; board action; notice requirements; civil penalty

- A. The board on its own motion may investigate evidence that appears to show that a behavior analyst is incompetent as a behavior analyst, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of behavior analysis. A health care institution shall, and any other person may, report to the board information that appears to show that a behavior analyst is incompetent as a behavior analyst, guilty of unprofessional conduct or mentally or physically unable to safely engage in the

practice of behavior analysis. The board shall notify the licensee about whom information has been received as to the content of the information within one hundred twenty days after receiving the information. A person who reports or provides information to the board in good faith is not subject to an action for civil damages. The board, if requested, shall not disclose the name of the person providing information unless this information is essential to proceedings conducted pursuant to this section. The board shall report a health care institution that fails to report as required by this section to the institution's licensing agency.

B. A health care institution shall inform the board if the privileges of a licensee to practice in that institution are denied, revoked, suspended or limited because of actions by the licensee that appear to show that the person is incompetent as a behavior analyst, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of behavior analysis, along with a general statement of the reasons that led the health care institution to take this action. A health care institution shall inform the board if a licensee under investigation resigns the licensee's privileges or if a licensee resigns in lieu of disciplinary action by the health care institution. Notification must include a general statement of the reasons for the resignation.

C. The board may require the licensee to undergo any combination of mental, physical or psychological competence examinations at the licensee's expense and shall conduct investigations necessary to determine the competence and conduct of the licensee.

D. The committee on behavior analysts shall review all complaints against behavior analysts and, based on the information provided pursuant to subsection A or C of this section, shall submit its recommendations to the full board.

E. If the board finds, based on the information it receives under subsection A or C of this section, that the public health, safety or welfare requires emergency action, the board may order a summary suspension of a license pending proceedings for revocation or other action. If the board issues this order, it shall serve the licensee with a written notice of complaint and formal hearing pursuant to title 41, chapter 6, article 10, setting forth the charges made against the licensee and the licensee's right to a formal hearing before the board or an administrative law judge within sixty days. The board shall notify the committee on behavior analysts of any action taken pursuant to this subsection.

F. If the board finds that the information provided pursuant to subsection A or C of this section is not of sufficient seriousness to merit direct action against the licensee, it may take any of the following actions:

1. Dismiss if the board believes the information is without merit.
2. File a letter of concern.
3. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or

treatment.

G. If the board believes the information provided pursuant to subsection A or B of this section is or may be true, it may request an informal interview with the licensee. If the licensee refuses to be interviewed or if pursuant to an interview the board determines that cause may exist to revoke or suspend the license, it shall issue a formal complaint and hold a hearing pursuant to title 41, chapter 6, article 10. If as a result of an informal interview or a hearing the board determines that the facts do not warrant revocation or suspension of the license, it may take any of the following actions:

1. Dismiss if the board believes the information is without merit.
 2. File a letter of concern.
 3. Issue a decree of censure.
 4. Fix a period and terms of probation best adapted to protect the public health and safety and to rehabilitate or educate the licensee. Probation may include temporary suspension for not more than twelve months, restriction of the license or restitution of fees to a client resulting from violations of this article. If a licensee fails to comply with a term of probation, the board may file a complaint and notice of hearing pursuant to title 41, chapter 6, article 10 and take further disciplinary action.
 5. Enter into an agreement with the licensee to restrict or limit the licensee's practice or activities in order to rehabilitate the licensee, protect the public and ensure the licensee's ability to safely engage in the practice of behavior analysis.
 6. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.
- H. If the board finds that the information provided pursuant to subsection A or C of this section warrants suspension or revocation of a license, it shall hold a hearing pursuant to title 41, chapter 6, article 10. Notice of a complaint and hearing is fully effective by mailing a true copy to the licensee's last known address of record in the board's files. Notice is complete at the time of its deposit in the mail.
- I. The board may impose a civil penalty of at least three hundred dollars but not more than three thousand dollars for each violation of this article or a rule adopted under this article. The board shall deposit, pursuant to sections 35-146 and 35-147, all monies it collects from civil penalties pursuant to this subsection in the state general fund.
- J. If the board determines after a hearing that a licensee has committed an act of unprofessional conduct, is mentally or physically unable to safely engage in the practice of behavior analysis or is incompetent as a behavior analyst, it may do any of the following in any combination and for any period of time it determines necessary:

1. Suspend or revoke the license.
2. Censure the licensee.
3. Place the licensee on probation.

K. A licensee may submit a written response to the board within thirty days after receiving a letter of concern. The response is a public document and shall be placed in the licensee's file.

L. A letter of concern is a public document and may be used in future disciplinary actions against a licensee. A decree of censure is an official action against the behavior analyst's license and may include a requirement that the licensee return fees to a client.

M. Except as provided in section 41-1092.08, subsection H, a person may appeal a final decision made pursuant to this section to the superior court pursuant to title 12, chapter 7, article 6.

N. If during the course of an investigation the board determines that a criminal violation may have occurred involving the delivery of behavior analysis services, it shall inform the appropriate criminal justice agency.

32-2091.10. Right to examine and copy evidence; subpoenas; right to counsel; confidentiality

A. In connection with an investigation conducted pursuant to this article, at all reasonable times the board and its authorized agents may examine and copy documents, reports, records and other physical evidence wherever located relating to the licensee's professional competence, unprofessional conduct or mental or physical ability to safely practice behavior analysis.

B. The board and its authorized agents may issue subpoenas to compel the attendance and testimony of witnesses and the production of documents and other physical evidence as prescribed in subsection A. The board may petition the superior court to enforce a subpoena.

C. Within five days of receiving a subpoena, a person may petition the board to revoke, limit or modify the subpoena. The board shall take this action if it determines that the evidence demanded is not relevant to the investigation. The person may petition the superior court for this relief without first petitioning the board.

D. A person appearing before the board or its authorized agents may be represented by an attorney.

E. Documents associated with an investigation are not open to the public and shall remain confidential. Documents may not be released without a court order compelling their production.

F. This section or any other provision of law making communications between a behavior analyst and client privileged does not apply to an investigation conducted pursuant to this article. The board, its employees and its agents shall keep in confidence the names of clients whose records are reviewed during an investigation.

32-2091.11. Injunction

A. The board may petition the superior court for an order to enjoin the following:

1. A person who is not licensed pursuant to this article from practicing behavior analysis.
2. The activities of a licensee that are an immediate threat to the public.
3. Criminal activities.

B. If the board seeks an injunction to stop the unlicensed practice of behavior analysis, it is sufficient to charge that the respondent on a certain day in a specific county engaged in the practice of behavior analysis without a license and without being exempt from the licensure requirements of this article. It is not necessary to show specific damages or injury.

C. The issuance of an injunction does not limit the board's authority to take other action against a licensee pursuant to this article.

32-2091.12. Violations; classification

A. It is a class 2 misdemeanor for a person who is not licensed pursuant to this article to engage in the practice of behavior analysis.

B. It is a class 2 misdemeanor for any person to:

1. Secure a license to practice pursuant to this article by fraud or deceit.
2. Impersonate a member of the board in order to issue a license to practice pursuant to this article.

C. It is a class 2 misdemeanor for a person who is not licensed pursuant to this article to use any combination of words, initials and symbols that leads the public to believe the person is licensed to practice behavior analysis in this state.

32-2091.13. Confidential communications

A. The confidential relations and communications between a client and a person who is licensed pursuant to this article, including temporary licensees, are placed on the same basis as those provided by law between an attorney and client. Unless the client waives the behavior analyst-client privilege in writing or in court testimony, a behavior analyst shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the behavior analyst's practice. The behavior analyst shall divulge

to the board information it requires in connection with any investigation, public hearing or other proceeding. The behavior analyst-client privilege does not extend to cases in which the behavior analyst has a duty to report information as required by law.

B. The behavior analyst shall ensure that client records and communications are treated by clerical and paraprofessional staff at the same level of confidentiality and privilege required of the behavior analyst.

32-2091.14. Status as behavioral health professional

Notwithstanding any law to the contrary, the Arizona health care cost containment system administration shall recognize a behavior analyst who is licensed pursuant to this article as a behavioral health professional who is eligible for reimbursement of services.

32-2091.15. Committee on behavior analysts; membership; duties; board responsibilities

A. The committee on behavior analysts is established within the state board of psychologist examiners consisting of five members who are appointed by the governor and who serve at the pleasure of the governor. Each member shall serve for a term of five years beginning and ending on the third Monday in January. A committee member may not serve more than two full consecutive terms.

B. All members of the committee shall be licensed behavior analysts in professional practice, two of whom shall be members of the board. The committee shall annually elect a chairperson from among its membership.

C. Within one year after their initial appointment to the committee, members shall receive at least five hours of training prescribed by the board that includes instruction in ethics and open meeting requirements.

D. committee members shall receive reimbursement of all expenses pursuant to title 38, chapter 4, article 2.

E. The committee shall make recommendations to the board on all matters relating to the licensing and regulation of behavior analysts. The committee may recommend regulatory changes to the board that are not specific to an individual licensee, but the committee shall obtain public input from behavior analyst licensees or their designated representatives before making any final recommendation to the board.

DEPARTMENT OF HEALTH SERVICES (R-18-1002)

Title 9, Chapter 10, Article 2, Hospitals; Article 15, Abortion Clinics

Amend: R9-10-223; R9-10-1501; R9-10-1502; R9-10-1503; R9-10-1505; R9-10-1506;
R9-10-1507; R9-10-1508; R9-10-1509; R9-10-1510; R9-10-1511; R9-10-1512;
R9-10-1513; R9-10-1514; R9-10-1515

Renumber: R9-10-1504; R9-10-1505; R9-10-1506; R9-10-1507; R9-10-1508; R9-10-1509;
R9-10-1510; R9-10-1511; R9-10-1512; R9-10-1513; R9-10-1514; R9-10-1515

New Section: R9-10-1504

Repeal: R9-10-1515

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: October 2, 2018

AGENDA ITEM: D-3

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: DEPARTMENT OF HEALTH SERVICES (R-18-1002)

Title 9, Chapter 10, Article 2, Hospitals; Article 15, Abortion Clinics

Amend: R9-10-223; R9-10-1501; R9-10-1502; R9-10-1503; R9-10-1505;
R9-10-1506; R9-10-1507; R9-10-1508; R9-10-1509; R9-10-1510;
R9-10-1511; R9-10-1512; R9-10-1513; R9-10-1514; R9-10-1515

New Section: R9-10-1504

Renumber: R9-10-1504; R9-10-1505; R9-10-1506; R9-10-1507; R9-10-1508;
R9-10-1509; R9-10-1510; R9-10-1511; R9-10-1512; R9-10-1513;
R9-10-1514; R9-10-1515

Repeal: R9-10-1515

This rulemaking, from the Department of Health Services (Department), seeks to amend 15 rules, create one new rule, and repeal one rule in A.A.C. Title 9, Chapter 10, Articles 2 and 15, related to abortion clinics.

The Department has adopted minimum standards for hospitals and for abortion clinics in 9 A.A.C. 10. The Department indicates that statutory changes made by Laws 2017, Ch. 133, require amendments to requirements for abortion clinics and hospitals related to abortions at or after 20 weeks gestational age, measures to maintain the life of an aborted embryo or fetus born alive, equipment necessary to carry out these life-maintaining measures, and abortions when a fetus has a lethal fetal condition. The Department states that additional amendments in Article 15 are made to comply with statute and to simplify and improve the efficiency and effectiveness of the rules.

The Governor's Office provided an exception from the rulemaking moratorium on July 18, 2017.

Proposed Action

- **Section 223 - Perinatal Services:** Subsection (C), containing additional requirements for an administrator of a hospital in which an abortion procedure is performed, is added for consistency with statutory changes made by Laws 2017, Ch. 133.
- **Section 1501 - Definitions:** Definitions are modified in accordance with changes to other rules in Article 15.
- **Section 1502 - Application and Documentation Submission Requirements:** Subsection (B), requiring a licensee to submit the documentation required according to A.R.S. § 36-449.02(B) with the applicable fees required in R9-10-106(C), is added.
- **Section 1503 - Administration:** In addition to clarifying changes, subsection (D) is added to provide that the Department may take enforcement action as specified in R9-10-111 for an abortion clinic that is not in substantial compliance, or that is in substantial compliance but refuses to carry out a plan of correction acceptable to the Department.
- **Section 1504 - Quality Management:** This new rule is added, containing requirements for a licensees to have a documented, established, and implemented plan for an ongoing quality management program.
- **Section 1505 - Incident Reporting:** Subsection (A)(2), requiring the Department to receive verbal notification by the next working day for a fetus delivered alive, is added.
- **Section 1506 - Personnel Qualifications and Records:** In addition to clarifying changes, subsection (5) is added to provide requirements for an individual who is available to perform neonatal resuscitation if the abortion clinic performs an abortion procedure at or after 20 weeks gestational age.
- **Section 1507 - Staffing Requirements:** Subsections (B)(4) and (5) are added to require that a patient care staff member is on the premises to comply with R9-10-1509(H), and if the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, that a patient care staff member qualified according to policies and procedures to perform neonatal resuscitation is available for the abortion procedure.
- **Section 1508 - Patient Rights:** Subsection (3)(e) is added to allow a patient to be informed of their right to receive a print of the ultrasound image.
- **Section 1509 - Abortion Procedures:** Many changes are made to make the rules consistent with statutes, including the addition of subsection (A)(4) to require an ultrasound imaging study of the fetus, performed as required in A.R.S. §§ 36-2156 and 36-2301.02(A), to be included in the medical evaluation of a patient conducted before the patient's abortion is performed.
- **Section 1510 - Patient Transfer and Discharge:** Subsection (A)(2) is added to require a medical director to ensure that a viable fetus requiring emergency care is transferred to a hospital, the transfer of a viable fetus is documented in the viable fetus' medical record, and documentation of an assessment of cardiopulmonary function and treatment provided to a viable fetus is transferred with the viable fetus.
- **Section 1511 - Medications and Controlled Substances:** Subsection (9) is added to require certain information to be documents in the medical record of a fetus delivered alive.

- Section 1512 - **Medical Records**: The rule is largely rewritten to account for the establishment of medical records for fetuses delivered alive, and for changes to the process for Department requests for patient medical records for review.
- Section 1513 - **Environmental and Safety Standards**: Clarifying changes are made.
- Section 1514 - **Equipment Standards**: Subsection (6) is added to require certain equipment to be available for an abortion procedure conducted at or after 20 weeks gestational age.
- Section 1515 (former) - **Enforcement**: The rule is being repealed.
- Section 1515 - **Physical Plant Standards**: The title of the rule is changed from “Physical Facilities.”

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

Yes. The Department cites to both general and specific authority for the rules. Of particular significance is A.R.S. § 36-136(G), under which the Department “may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.”

2. Do the rules establish a new fee or contain a fee increase?

No. The rules do not establish a new fee or contain a fee increase.

3. Summary of the agency's economic impact analysis:

In this rulemaking, the Department is adopting rules that will align with state statutes regarding abortion procedures. The Department is also improving the clarity of existing rules to make them easier to understand.

In calendar year 2017, the Department received 12,518 reports of abortion procedures from 15 health care institutions. During the same time period, the Department received 227 reports of abortions performed after the 20 weeks gestational age. These represent 1.8% of all abortions reported in 2017.

4. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

The Department concludes that this rulemaking is required by state statute. It also improves the clarity of existing rules. The significant benefits outweigh any minimal costs.

5. What are the economic impacts on stakeholders?

Key stakeholders are the Department; hospitals and outpatient treatment centers in which abortions are performed; abortion clinics; patient care staff members; patients undergoing an abortion procedure; and the general public.

The Department will benefit from this rulemaking because it will clarify the existing rules and comply with state statute. The Department anticipates that the clarifying aspects of the rulemaking will result in fewer stakeholders asking questions or seeking guidance from the Department.

Hospitals and outpatient treatment centers in which abortions are performed will benefit from this rulemaking because it clarifies the existing rules. The resources that these organizations expend on interpreting and complying with rules can be significant. This rulemaking will reduce the quantity of resources expended.

Abortion clinics will be affected in the same manner as hospitals and outpatient treatment centers in which abortions are performed as listed above. In addition, abortion clinics that have not implemented a quality management plan will incur the costs associated with implementing a quality management plan. The Department notes that these costs will be minimal, and the abortion clinic will benefit from better patient health care outcomes.

Patient care staff members will benefit from these rules because it will be easier for them to understand and comply with the requirements.

Patients undergoing an abortion procedure will benefit from this rulemaking because their care providers will be able to comply with regulatory requirements more efficiently and more effectively. This can improve the patient's health care outcomes.

The general public will benefit from the increased clarity of these rules.

6. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?

Not applicable. The Department indicates that it received no public comments on the rulemaking.

7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?

No. No changes were made between the Notice of Proposed Rulemaking and the Notice of Final Rulemaking.

8. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

No. Federal law is not directly applicable to the subject matter of the rules.

9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

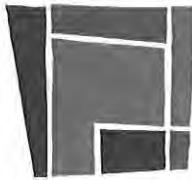
Yes. A.R.S. § 36-407 prohibits a person from establishing, conducting, or maintaining “a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the [D]epartment specifying the class or subclass of health care institution the person is establishing, conducting or maintaining.” The Department states that a health care institution license is specific to the licensee, class or subclass of health care institution, facility location, and scope of services provided. As such, a general permit is not applicable and is not used.

10. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?

No. The Department did not review or rely on any study for this rulemaking.

11. Conclusion

The Department is requesting an immediate effective date for the rulemaking, as the Department believes the changes to the rules are necessary to protect public health and safety and implement requirements in statutes enacted in Laws 2017, Ch. 133 and Laws 2017, Ch. 122. Council staff recommends approval of the rulemaking.



ARIZONA DEPARTMENT OF HEALTH SERVICES

POLICY & INTERGOVERNMENTAL AFFAIRS

August 16, 2018

Nicole O. Colyer, Esq., Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: 9 A.A.C. 10, Articles 2 and 15 Department of Health Services – Health Care Institutions:
Licensing

Dear Ms. Colyer:

Enclosed is the administrative rule package identified above which I am submitting, as the Designee of the Director of the Department of Health Services, for approval by the Governor's Regulatory Review Council under A.R.S. § 41-1052.

The following information is provided for your use in reviewing the enclosed rule package pursuant to A.R.S. § 41-1052 and A.A.C. R1-6-104:

1. The close of record:
The close of record was August 14, 2018. Submission of the rule is within the 120 days allowed for Final Rulemaking.
2. Procedures followed:
As required by the Administrative Procedure Act, a Notice of Rulemaking Docket Opening was filed with the Office of the Secretary of State and published in the *Arizona Administrative Register* on February 9, 2018. A Notice of Proposed Rulemaking was filed with the Office of the Secretary of State and published in the *Arizona Administrative Register* on July 13, 2018. The Department held one oral proceeding on August 14, 2018. The Department received no written comments or oral comments about the proposed rule.
3. Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:
The rulemaking for 9 A.A.C. 10, Articles 2 and 15 do not relate to a five-year-review report.
4. Whether the rule contains a new fee and, if it does, citation of the statute expressly authorizing the new fee:
The rulemaking does not contain a fee.

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

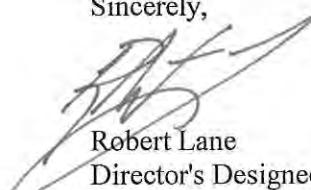
5. Whether the rule contains a fee increase:
The rulemaking does not contain a fee increase.
6. Whether an immediate effective date is requested for the rule under A.R.S. § 41-1032:
The Department is requesting an immediate effective date for this rulemaking.
7. A list of all items enclosed:
 - a. Notice of Final Rulemaking, including the Preamble, Table of Contents, and text of the rule; and
 - b. Economic, Small Business, and Consumer Impact Statement.

The Department is requesting that the rules be heard at the Council meeting on October 2, 2018.

I certify that the Preamble of this rulemaking discloses a reference to any study relevant to the rule that the Department reviewed and either did or did not rely on in its evaluation of or justification for the rule.

I certify that the Department, as the preparer of the economic, small business, and consumer impact statement, has notified the Joint Legislative Budget Committee that no new full-time employees are necessary to implement and enforce the rules.

Sincerely,



Robert Lane
Director's Designee

RL:rms

Enclosures

NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 10. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: LICENSING

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action</u>
R9-10-223	Amend
R9-10-1501	Amend
R9-10-1502	Amend
R9-10-1503	Amend
R9-10-1504	Renumber
R9-10-1504	New Section
R9-10-1505	Renumber
R9-10-1505	Amend
R9-10-1506	Renumber
R9-10-1506	Amend
R9-10-1507	Renumber
R9-10-1507	Amend
R9-10-1508	Renumber
R9-10-1508	Amend
R9-10-1509	Renumber
R9-10-1509	Amend
R9-10-1510	Renumber
R9-10-1510	Amend
R9-10-1511	Renumber
R9-10-1511	Amend
R9-10-1512	Renumber
R9-10-1512	Amend
R9-10-1513	Renumber
R9-10-1513	Amend
R9-10-1514	Renumber
R9-10-1514	Amend

- | | |
|------------|----------|
| R9-10-1515 | Repeal |
| R9-10-1515 | Renumber |
| R9-10-1515 | Amend |
- 2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**
- Authorizing statutes: A.R.S. §§ 36-132(A)(1), 36-136(G)
- Implementing statutes: A.R.S. §§ 36-132(A)(17), 36-405(A) and (B), 36-406, and 36-449.03 and Laws 2017, Ch. 133 and Laws 2017, Ch. 122
- 3. The effective date of the rules:**
- The Arizona Department of Health Services (Department) requests an immediate effective date for these rules under A.R.S. § 41-1032 (A)(1) and (2). The changes to the rules are necessary to protect public health and safety and implement requirements in statutes enacted in Laws 2017, Ch. 133 and Laws 2017, Ch. 122. Changes not specifically required by statutory amendments are less burdensome than the current rules. Therefore, implementing the rule earlier than the usual 60-day time period will provide a benefit to both the regulated entities and the public.
- 4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:**
- Notice of Rulemaking Docket Opening: 24 A.A.R. 310, February 9, 2018
- Notice of Proposed Rulemaking: 24 A.A.R. 1922, July 13, 2018
- 5. The agency's contact person who can answer questions about the rulemaking:**
- Name: Colby Bower, Assistant Director
- Address: Department of Health Services
Public Health Licensing Services
150 N. 18th Ave., Suite 510
Phoenix, AZ 85007
- Telephone: (602) 542-6383
- Fax: (602) 364-4808
- E-mail: Colby.Bower@azdhs.gov
or
- Name: Robert Lane, Chief
- Address: Arizona Department of Health Services
Office of Administrative Counsel and Rules

150 N. 18th Avenue, Suite 200
Phoenix, AZ 85007
Telephone: (602) 542-1020
Fax: (602) 364-1150
E-mail: Robert.Lane@azdhs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

In order to ensure public health, safety, and welfare, Arizona Revised Statutes (A.R.S.) §§ 36-405 and 36-406 require the Arizona Department of Health Services (Department) to adopt rules establishing minimum standards and requirements for construction, modification, and licensure of health care institutions. A.R.S. § 36-449.03 requires the Department to adopt rules that establish minimum standards and requirements for abortion clinics, a class of health care institutions. The Department has adopted minimum standards for hospitals in Arizona Administrative Code (A.A.C.) Title 9, Chapter 10, Article 2 and for abortion clinics in 9 A.A.C. 10, Article 15. Statutory changes made to A.R.S. §§ 36-449.03, 36-2161, and 36-2301 by Laws 2017, Ch. 133, make necessary the revision of requirements for abortion clinics and hospitals related to abortions at or after 20 weeks gestational age, measures to maintain the life of an aborted embryo or fetus born alive, equipment necessary to carry out these life-maintaining measures, and abortions when a fetus has a lethal fetal condition. The Department is also making changes to Article 15 to comply with Laws 2017, Ch. 122, and to simplify and improve the efficiency and effectiveness of the rules. After obtaining an exception from the rulemaking moratorium established by Executive Order 2017-02, the Department has revised the rules in 9 A.A.C. 10, Articles 2 and 15 to comply with Laws 2017, Ch. 133 and Laws 2017, Ch. 122.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review or rely on any study for this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. A summary of the economic, small business, and consumer impact:

Annual cost/revenue changes are designated as minimal when \$10,000 or less, moderate when between \$10,000 and \$50,000, and substantial when \$50,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification. The Department anticipates that persons affected by the rulemaking include the Department, hospitals and outpatient treatment centers in which abortions are performed, abortion clinics, patient care staff members, patients of a hospital or abortion clinic undergoing an abortion and their families, and the general public. This preliminary summary does not include costs or benefits of changes made that are directly required by statutes, since the costs imposed by or benefits derived from the changes are due to the statutes and not the rules.

The Department will receive a significant benefit from changes that clarify requirements, make requirements in Article 15 more consistent with requirements in other Articles in the Chapter, remove duplicative requirements, and correct grammatical errors and incorrect cross-references. Hospitals and outpatient treatment centers in which abortions are performed and abortion clinics may also receive a significant benefit from changes that clarify requirements, remove duplicative requirements, and correct grammatical errors and incorrect cross-references. Abortion clinics may incur minimal costs to comply with changes that make requirements in Article 15 more consistent with requirements in other Articles in the Chapter. These include using more consistent terminology; specifying that documentation required by Article 15, such as personnel records or policies and procedures, is to be provided to the Department within two hours after a Department request; and requiring an abortion clinic to establish and implement a quality management plan.

Patient care staff members include physicians, registered nurse practitioners, nurses, physician assistants, and surgical assistants who provide medical services, nursing services, or health-related services to a patient. The Department anticipates that the rule changes being made to improve the efficiency and effectiveness of the rules may provide a significant benefit to these individuals by enabling them to better understand requirements and, thus, better comply with the requirements. A patient undergoing an abortion procedure may receive better services from a patient care staff member that better understands and, thus, better complies with requirements in the rules. Therefore,

the rule changes may provide a significant benefit to a patient undergoing an abortion procedure and the patient's family. Having rules that are more easily understood, complied with, and enforced may provide a significant benefit to the general public.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No changes were made to the rules between the proposed rulemaking and the final rulemaking.

11. An agency's summary of the public stakeholder comments made about the rulemaking and the agency response to the comments:

No oral or written comments were received.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

A.R.S. § 36-407 prohibits a person from establishing, conducting, or maintaining “a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the [D]epartment specifying the class or subclass of health care institution the person is establishing, conducting or maintaining.” A health care institution license is specific to the licensee, class or subclass of health care institution, facility location, and scope of services provided. As such, a general permit is not applicable and is not used.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No business competitiveness analysis was received by the Department.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and

its location in the rules:

Not applicable

14. Whether the rule was previously made, amended or repealed as an emergency rule.

If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES
CHAPTER 10. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: LICENSING

ARTICLE 2. HOSPITALS

Section

R9-10-223. Perinatal Services

ARTICLE 15. ABORTION CLINICS

Section

R9-10-1501. Definitions

R9-10-1502. Application and Documentation Submission Requirements

R9-10-1503. Administration

R9-10-1504. Quality Management

R9-10-1504.R9-10-1505.

Incident Reporting

R9-10-1505.R9-10-1506.

Personnel Qualifications and Records

R9-10-1506.R9-10-1507.

Staffing Requirements

R9-10-1507.R9-10-1508.

Patient Rights

R9-10-1508.R9-10-1509.

Abortion Procedures

R9-10-1509.R9-10-1510.

Patient Transfer and Discharge

R9-10-1510.R9-10-1511.

Medications and Controlled Substances

R9-10-1511.R9-10-1512.

Medical Records

R9-10-1512.R9-10-1513.

Environmental and Safety Standards

R9-10-1513.R9-10-1514.

Equipment Standards

R9-10-1515. Enforcement

R9-10-1514.R9-10-1515. Physical Facilities Plant Standards

ARTICLE 2. HOSPITALS

R9-10-223. Perinatal Services

- A. An administrator of a hospital that provides perinatal organized services shall ensure that:
1. Perinatal services are provided in a designated area under the direction of a medical staff member;
 2. Only medical and surgical procedures approved by the medical staff are performed in the perinatal services unit;
 3. The perinatal services unit has the capability to initiate an emergency cesarean delivery within the time-frame established by the medical staff and documented in policies and procedures;
 4. Only a patient in need of perinatal services or gynecological services receives perinatal services or gynecological services in the perinatal services unit;
 5. A patient receiving gynecological services does not share a room with a patient receiving perinatal services;
 6. A chronological log of perinatal services provided to patients is maintained that includes:
 - a. The patient's name;
 - b. The date, time, and mode of the patient's arrival;
 - c. The disposition of the patient including discharge, transfer, or admission time; and
 - d. The following information for a delivery of a neonate:
 - i. The neonate's name or other identifier;
 - ii. The name of the medical staff member who delivered the neonate;
 - iii. The delivery time and date; and
 - iv. Complications of delivery, if any; and
 - e. If an abortion procedure was performed at or after 20 weeks gestational age, whether the fetus was delivered alive;
 7. The chronological log required in subsection (A)(6) is maintained by the hospital in the perinatal services unit for at least 12 months after the date the perinatal services are provided and then maintained by the hospital for at least an

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 - 8. The perinatal services unit provides fetal monitoring;
 - 9. The perinatal services unit has ultrasound capability;
 - 10. Except in an emergency, a neonate is identified as required by policies and procedures before moving the neonate from a delivery area;
 - 11. Policies and procedures specify:
 - a. Security measures to prevent neonatal abduction, and
 - b. How the hospital determines to whom a neonate may be discharged;
 - 12. A neonate is discharged only to an individual who:
 - a. Is authorized according to subsection (A)(11), and
 - b. Provides identification;
 - 13. A neonate's medical record identifies the individual to whom the neonate is discharged;
 - 14. A patient or the individual to whom the neonate is discharged receives perinatal education, discharge instructions, and a referral for follow-up care for a neonate in addition to the discharge planning requirements in R9-10-209;
 - 15. Intensive care services for neonates comply with the requirements in R9-10-221;
 - 16. At least one registered nurse is on duty in a nursery when there is a neonate in the nursery except as provided in subsection (A)(17);
 - 17. A nursery occupied only by a neonate, who is placed in the nursery for the convenience of the neonate's mother and does not require treatment as established in this Article, is staffed by a nurse;
 - 18. Equipment and supplies are available to a nursery, labor-delivery-recovery room, or labor-delivery-recovery-postpartum room to meet the needs of each neonate; and
 - 19. In a nursery, only a neonate's bed or bassinet is used for changing diapers, bathing, or dressing the neonate.
- B.** An administrator of a hospital that does not provide perinatal organized services shall comply with the requirements in R9-10-217(C).
- C.** In addition to applicable requirements in A.R.S. Title 36, Chapter 20, an administrator of a hospital in which an abortion procedure is performed shall ensure that:
- 1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that require:

- a. For an abortion procedure performed at or after 20 weeks gestational age, a personnel member or medical staff member qualified according to policies and procedures to perform neonatal resuscitation, other than the physician performing the abortion procedure, is in the room in which the abortion procedure is performed before the delivery of the fetus;
 - b. Compliance with A.R.S. § 36-2301.01, if applicable;
 - c. Neonatal resuscitation of a fetus delivered alive, according to A.R.S. § 36-2301(D)(3); and
 - d. A medical record to be established and maintained for a fetus delivered alive;
2. The medical record of a patient receiving an abortion procedure contains:
 - a. Documentation from the physician providing the abortion procedure and other personnel members present certifying that the fetus was not delivered alive, or
 - b. A link to the medical record of a fetus delivered alive; and
3. For a fetus delivered alive, a medical record contains:
 - a. An identification of the fetus, including:
 - i. The name of the patient from whom the fetus was delivered alive, and
 - ii. The date the fetus was delivered alive;
 - b. Orders issued by a physician, physician assistant, or registered nurse practitioner;
 - c. A record of medical services, nursing services, and health-related services provided to the fetus delivered alive;
 - d. If applicable, information about medication administered to the fetus delivered alive; and
 - e. If the fetus had a lethal fetal condition, the results of the confirmation of the lethal fetal condition.

ARTICLE 15. ABORTION CLINICS

R9-10-1501. Definitions

In addition to the definitions in A.R.S. §§ 36-401, 36-449.01, 36-449.03, 36-2151, 36-2158, and 36-2301.01 and R9-10-101, the following definitions apply in this Article, unless otherwise specified:

1. “Admission” means documented acceptance by a hospital of an individual as an ~~inpatient as defined in R9-10-201 on the order of a physician.~~
- 2.1. “Admitting privileges” means permission extended by a hospital to a physician to allow admission of ~~a patient~~ an individual as an inpatient, as defined in R9-10-201:
 - a. By the patient’s own physician, or
 - b. Through a written agreement between the patient’s physician and another physician that states that the other physician has permission to personally admit the patient to a hospital in this state and agrees to do so.
3. “Conspicuously posted” means placed at a location ~~within an abortion clinic that is accessible and visible to patients and the public.~~
- 4.2. “Course” means training or education, including hands-on practice under the supervision of a physician, ~~training, or education.~~
5. “Discharge” means a patient no longer requires the medical services, nursing services, or health-related services provided by the abortion clinic.
6. Emergency means a potentially life threatening occurrence that requires an immediate response or medical treatment.
- 7.3. “Employee” means an individual who receives compensation from a licensee, but does not provide medical services, nursing services, or health-related services.
- 8.4. “First trimester” means 1 through 14 weeks as measured from the first day of the last menstrual period or 1 through 12 weeks as measured from the date of fertilization.
- 9.5. “Incident” means an abortion-related patient death or serious injury to a patient or ~~viable fetus delivered alive.~~
10. “Licensee” means ~~an individual, a partnership, an association, a limited liability company, or corporation authorized by the Department to operate an abortion~~

eline.

- 11.6. “Local” means under the jurisdiction of a city or county in Arizona.
- 12.7. “Medical director” means a physician who is responsible for the direction of the medical services, nursing services, and health-related services provided to patients at an abortion clinic.
- 13.8. “Medical evaluation” means obtaining a patient’s medical history, performing a physical examination of a patient’s body, and conducting laboratory tests as provided in ~~R9-10-1508~~ R9-10-1509.
- 14.9. “Monitor” means to observe and document, continuously or intermittently, the values of certain physiologic variables on a patient such as pulse, blood pressure, oxygen saturation, respiration, and blood loss.
- 15. ~~“Nationally recognized medical journal” means any publication distributed nationally that contains peer-reviewed medical information, such as the American Journal of Radiology or the Journal of Ultrasound in Medicine.~~
- 10. “Neonatal resuscitation” means procedures to assist in maintaining the life of a fetus delivered alive, as described in A.R.S. § 36-2301(D)(3).
- 16.11. “Patient” means a female receiving medical services, nursing services, or health-related services related to an abortion.
- 17.12. “Patient care staff member” means a physician, registered nurse practitioner, nurse, physician assistant, or surgical assistant who provides medical services, nursing services, or health-related services to a patient.
- 18. ~~“Patient’s representative” means a patient’s legal guardian, an individual acting on behalf of a patient with the written consent of the patient, or a surrogate according to A.R.S. § 36-3201.~~
- 19.13. “Patient transfer” means relocating a patient requiring medical services from an abortion clinic to another health care institution.
- 20.14. “Personally identifiable patient information” means:
 - a. The name, address, telephone number, e-mail address, Social Security number, and birth date of:
 - i. The patient,
 - ii. The patient’s representative,
 - iii. The patient’s emergency contact,
 - iv. The patient’s children,

- v. The patient's spouse;
 - vi. The patient's sexual partner, and
 - vii. Any other individual identified in the patient's medical record other than patient care staff;
- b. The patient's place of employment;
 - c. The patient's referring physician;
 - d. The patient's insurance carrier or account;
 - e. Any "individually identifiable health information" as proscribed in 45 CFR 164-514; and
 - f. Any other information in the patient's medical record that could reasonably lead to the identification of the patient.

24-15. "Personnel" means patient care staff members, employees, and volunteers.

22. "Physical facilities" means property that is:

- a. ~~Designated on an application for a license by the applicant; and~~
- b. ~~Licensed to provide services by the Department according to A.R.S. Title 36, Chapter 4.~~

16. "Serious injury" means a life-threatening physical condition related to an abortion procedure.

23-17. "Surgical assistant" means an individual who is not licensed as a physician, physician assistant, registered nurse practitioner, or nurse who performs duties as directed by a physician, physician assistant, registered nurse practitioner, or nurse.

24-18. "Volunteer" means an individual who, without compensation, performs duties as directed by a ~~member of the patient care staff member~~ at an abortion clinic.

R9-10-1502. Application and Documentation Submission Requirements

- A. An applicant shall submit an application for licensure that meets the requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1.
- B. A licensee shall submit to the Department the documentation required according to A.R.S. § 36-449.02(B) with the applicable fees required in R9-10-106(C).

R9-10-1503. Administration

- A. A licensee is responsible for the organization and management of an abortion clinic.
- B. A licensee shall:
 1. Adopt policies and procedures for the administration and operation of an abortion

- clinic;
2. Designate a medical director who:
 - a. is licensed according to A.R.S. Title 32, Chapter 13, 17, or 29; and
 - b. The licensee and the medical director may May be the same individual as the licensee; and
 3. Ensure the following documents are conspicuously posted ~~at the physical facilities on the premises:~~
 - a. Current abortion clinic license issued by the Department;
 - b. Current telephone number and address of the unit in the Department responsible for licensing the abortion clinic;
 - c. Evacuation map; and
 - d. Signs that comply with A.R.S. § 36-2153(G) 36-2153(H); and
 4. Except as specified in R9-10-1512(D)(4), ensure that documentation required by this Article is provided to the Department within two hours after a Department request.
- C. A medical director shall ensure written policies and procedures are established, documented, and implemented to protect the health and safety of a patient including for:
1. Personnel qualifications, duties, and responsibilities;
 2. Individuals qualified to provide counseling in the abortion clinic and the amount and type of training required for an individual to provide counseling;
 3. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age:
 - a. Individuals qualified in neonatal resuscitation and the amount and type of training required for an individual to provide neonatal resuscitation, and
 - b. Designation of an individual to arrange the transfer to a hospital of a fetus delivered alive;
- 3.4. Verification of the competency of the physician performing an abortion according to R9-10-1505 R9-10-1506;
- 4.5. The storage, administration, accessibility, disposal, and documentation of a medication, and a or controlled substance;
- 5.6. Accessibility and security of patient medical records;
- 6.7. Abortion procedures including:
 - a. recovery Recovery and follow-up care; and the

- b. The minimum length of time a patient remains in the recovery room or area based on:
- a.i. The type of abortion performed;
- b.ii. The estimated gestational age of the fetus;
- e.iii. The type and amount of medication administered; and
- d.iv. The physiologic signs including vital signs and blood loss; and
- c. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, the requirements in A.R.S. § 36-2301(D);

7.8. Infection control including methods of sterilizing equipment and supplies;

8.9. Medical emergencies; and

9.10. Patient discharge and patient transfer.

- D. For an abortion clinic that is not in substantial compliance or that is in substantial compliance but refuses to carry out a plan of correction acceptable to the Department, the Department may take enforcement action as specified in R9-10-111.

R9-10-1504. Quality Management

A medical director shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
 - a. A method to identify, document, and evaluate incidents;
 - b. A method to collect data to evaluate services provided to patients;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
 - d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
 - e. The frequency of submitting a documented report required in subsection (2) to the licensee;
2. A documented report is submitted to the licensee that includes:
 - a. An identification of each concern about the delivery of services related to patient care, and
 - b. Any changes made or actions taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the

licensee.

R9-10-1504.R9-10-1505. Incident Reporting

A. A licensee shall ensure that the Department is notified of an incident as follows:

1. For the death of a patient, verbal notification the next working day;
2. For a fetus delivered alive, verbal notification the next working day; and
- 2.3. For a serious injury of a patient or viable fetus, written notification within 10 calendar days after the date of the serious injury.

B. A medical director shall conduct an investigation of an incident and document an incident report that includes:

1. The date and time of the incident;;
2. The name of the patient;;
3. A description of the incident;;
4. Names of individuals who observed the incident;;
5. Action taken by patient care staff members and employees during the incident and immediately following the incident;; and
6. Action taken by the patient care staff members and employees to prevent the incident from occurring in the future.

C. A medical director shall ensure that the incident report is:

1. Submitted to the Department and, if the incident involved a licensed individual, the applicable professional licensing board within 10 calendar days after the date of the notification in subsection (A); and
2. Maintained in the physical facilities on the premises for at least two years after the date of the incident.

R9-10-1505.R9-10-1506. Personnel Qualifications and Records

A licensee shall ensure that:

1. A physician who performs an abortion demonstrates to the medical director that the physician is competent to perform an abortion by:
 - a. The submission of documentation of education and experience;; and
 - b. Observation by or interaction with the medical director;
2. Surgical assistants and volunteers who provide counseling and patient advocacy receive training in these specific responsibilities and any other responsibilities assigned and that documentation of the training received is maintained in the individual's personnel file of the training received;

3. An individual who performs an ultrasound provides documentation that the individual is:
 - a. A physician;
 - b. A physician assistant, registered nurse practitioner, or nurse who completed a ~~hands-on~~ course in performing ultrasounds under the supervision of a physician; or
 - c. An individual who:
 - i. Completed a ~~hands-on~~ course in performing ultrasounds under the supervision of a physician, and
 - ii. Is not otherwise precluded by law from performing an ultrasound;
 4. An individual has completed a course for the type of ultrasound the individual performs;
 5. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, an individual who is available to perform neonatal resuscitation provides documentation that the individual:
 - a. Is a:
 - i. Physician,
 - ii. Physician assistant,
 - iii. Registered nurse practitioner, or
 - iv. Nurse; and
 - b. Has completed a course in performing neonatal resuscitation that is consistent with training provided by the American Academy of Pediatrics Neonatal Resuscitation Program and includes:
 - i. Instruction in the use of resuscitation devices for positive-pressure ventilation, tracheal intubation, medications that may be necessary for neonatal resuscitation and their administration, and resuscitation of pre-term newborns; and
 - ii. Assessment of the individual's skill in applying the information provided through the instruction in subsection (5)(b)(i);

5-6. A personnel file for each member of the patient care staff member and each volunteer is maintained either electronically or in writing and includes:

 - a. The individual's name and position title;
 - b. The first and, if applicable, the last date of employment or volunteer

- service;
- c. Verification of qualifications, training, or licensure, as applicable;
 - d. Documentation of cardiopulmonary resuscitation certification, as applicable;
 - e. Documentation of verification of competency, as required in subsection (1), and signed and dated by the medical director;
 - f. Documentation of training for surgical assistants and volunteers; ~~and~~
 - g. Documentation of completion of a course as required in subsection (3), for an individual performing ultrasounds; and
 - h. Documentation of competency to perform neonatal resuscitation, as required in subsection (5), if applicable; and

~~6-7.~~ Personnel files are maintained ~~in the physical facilities on the premises~~ for at least two years ~~from~~ after the ending date of employment or volunteer service.

R9-10-1506.R9-10-1507. Staffing Requirements

A. A licensee shall ensure that there is a sufficient number of patient care staff members and employees to:

1. Meet the requirements of this Article;
2. Ensure the health and safety of a patient; and
3. Meet the needs of a patient based on the patient's medical evaluation.

B. A licensee shall ensure that:

1. A ~~member of the~~ patient care staff member other than, ~~except for~~ a surgical assistant, who is current in cardiopulmonary resuscitation certification, is ~~in the physical facilities on the premises~~ until all patients are discharged;
2. A physician, with admitting privileges at a health care institution that is classified by the director as a hospital according to A.R.S. § 36-405(B), remains on the premises of the abortion clinic until all patients who received a medication abortion are stable and ready to leave;
3. A physician, with admitting privileges at a health care institution that is classified by the director as a hospital according to A.R.S. § 36-405(B) and that is within 30 miles of the abortion clinic by road, as defined in A.R.S. § 17-451, remains on the abortion clinic's premises until all patients who received a surgical abortion are stable and ~~ready to leave~~ discharged from the recovery room; ~~and~~
4. A ~~physician, a nurse, a registered nurse practitioner, a physician assistant, or, if a~~

~~physician is able to provide direct supervision as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800 as applicable, a medical assistant under the direct supervision of the physician:~~

- a. ~~Monitors each patient during the patient's recovery following the abortion; and~~
- b. ~~Remains in the abortion clinic until each patient is discharged by a physician.~~
4. A patient care staff member is on the premises to comply with R9-10-1509(H); and
5. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, a patient care staff member qualified according to policies and procedures to perform neonatal resuscitation is available for the abortion procedure.

R9-10-1507.R9-10-1508. Patient Rights

A licensee shall ensure that a patient is afforded the following rights, and is informed of these rights:

1. To refuse treatment, or withdraw consent for treatment;
2. To have medical records kept confidential; and
3. To be informed of:
 - a. Billing procedures and financial liability before abortion services are provided;
 - b. Proposed medical or surgical procedures, associated risks, possible complications, and alternatives;
 - c. Counseling services that are provided ~~in the physical facilities on the premises; and~~
 - d. The right to review the ultrasound results with a physician, a physician assistant, a registered nurse practitioner, or a registered nurse before the abortion procedure; and
 - e. The right to receive a print of the ultrasound image.

R9-10-1508.R9-10-1509. Abortion Procedures

- A. A medical director shall ensure that a medical evaluation of a patient is conducted before the patient's abortion is performed that includes:
1. A medical history including:

- a. Allergies to medications, antiseptic solutions, or latex;
 - b. Obstetrical and gynecological history;
 - c. Past surgeries;
 - d. Medication the patient is currently taking; and
 - e. Other medical conditions;
2. A physical examination, performed by a physician that includes a bimanual examination to estimate uterine size and palpation of adnexa; ~~and~~
3. The following laboratory tests:
 - a. A urine or blood test to determine pregnancy;
 - b. Rh typing, unless the patient provides written documentation of blood type acceptable to the physician;
 - c. Anemia screening; and
 - d. Other laboratory tests recommended by the physician or medical director on the basis of the physical examination; ~~and~~
4. An ultrasound imaging study of the fetus, performed as required in A.R.S. §§ 36-2156 and 36-2301.02(A).

- B.** If the medical evaluation indicates a patient is Rh negative, a medical director shall ensure that:
1. The patient receives information from a physician on this condition;
 2. The patient is offered RhO(d) immune globulin within 72 hours after the abortion procedure;
 3. If a patient refuses RhO(d) immune globulin, the patient signs and dates a form acknowledging the patient's condition and refusing the RhO(d) immune globulin;
 4. The form in subsection (B)(3) is maintained in the patient's medical record; and
 5. If a patient refuses RhO(d) immune globulin or if a patient refuses to sign and date an acknowledgment and refusal form, the physician documents the patient's refusal in the patient's medical record.

- C.** A physician ~~estimates shall estimate~~ the gestational age of the fetus, ~~based on one of the following criteria, and records record~~ the estimated gestational age in the patient's medical record. ~~The estimated age is based upon:~~
1. Ultrasound measurements of the biparietal diameter, length of femur, abdominal circumference, visible pregnancy sac, or crown-rump length or a combination of these; or

2. The date of the last menstrual period or the date of fertilization and a bimanual examination of the patient.

D. A medical director shall ensure that:

1. An ultrasound of a patient required in subsection (A)(4) is performed by an individual who meets the requirements in R9-10-1505(3) R9-10-1506(3);
2. An ultrasound estimate of gestational age of a fetus is performed using methods and tables or charts published in a nationally recognized medical journal in a publication distributed nationally that contains peer-reviewed medical information, such as medical information derived from a publication describing research in obstetrics and gynecology or in diagnostic imaging;
3. An original patient ultrasound print image is:
 - a. Interpreted by a physician; and
 - b. Maintained in the patient's medical record in either electronic or paper form; and
4. If requested by the patient, the ultrasound image is reviewed with the patient by a physician, physician assistant, registered nurse practitioner, or registered nurse.

E. A medical director shall ensure that before an abortion is performed on a patient:

1. Written consent, that meets the requirements in A.R.S. § 36-2152 or 36-2153, as applicable, and A.R.S. § 36-2158, is signed and dated by the patient or the patient's legal guardian representative; and
2. Information is provided to the patient on the abortion procedure, including alternatives, risks, and potential complications.

F. A medical director shall ensure that an abortion is performed according to the abortion clinic's policies and procedures and this Article.

G. A medical director shall ensure that any medication, drug, or substance used to induce an abortion is administered in compliance with the protocol authorized by the United States Food and Drug Administration and that is outlined in the final printing labeling instructions for that medication, drug, or substance.

H.G. A medical director shall ensure that:

1. Patient A patient care staff member monitors a patient's vital signs throughout an abortion procedure to ensure the patient's health and safety;
2. Intravenous access is established and maintained on a patient undergoing an abortion after the first trimester unless the physician determines that establishing

intravenous access is not appropriate for the particular patient and documents that fact in the patient's medical record;

3. If an abortion procedure is performed at or after 20 weeks gestational age, a patient care staff member qualified in neonatal resuscitation, other than the physician performing the abortion procedure, is in the room in which the abortion procedure takes place before the delivery of the fetus; and

3.4. If a viable fetus shows signs of life is delivered alive:

- a. Resuscitative measures, including the following, are used to support life:
 - i. Warming and drying of the fetus,
 - ii. Clearing secretions from and positioning the airway of the fetus,
 - iii. Administering oxygen as needed to the fetus, and
 - iv. Assessing and monitoring the cardiopulmonary status of the fetus;
- b. A determination is made of whether the fetus is a viable fetus;
- c. A viable fetus is provided treatment to support life;
- d. The A viable fetus is transferred as required in R9-10-1509 R9-10-1510; and
- e.e. Resuscitative measures and the transfer, as applicable, are documented.

I.H. To ensure a patient's health and safety, A a medical director shall ensure that following the abortion procedure:

1. A patient's vital signs and bleeding are monitored by a physician, nurse, registered nurse practitioner, physician assistant, or, if a physician is able to provide direct supervision as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, as applicable, a medical assistant under the direct supervision of the physician to ensure the patient's health and safety;:
 - a. A physician;
 - b. A physician assistant;
 - c. A registered nurse practitioner;
 - d. A nurse; or
 - e. If a physician is able to provide direct supervision, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, as applicable, to a medical assistant, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, a medical assistant under the direct supervision of the physician; and

2. A patient remains in the recovery room or recovery area until a physician, physician assistant, registered nurse practitioner, or nurse examines the patient and determines that the patient's medical condition is stable and the patient is ready to leave the recovery room or recovery area.

J.I. A medical director shall ensure that follow-up care ~~includes~~:

1. ~~With a patient's consent, a telephone call to the patient by a member of the patient care staff, except a surgical assistant, within 24 hours after the patient's discharge following a surgical abortion to assess the patient's recovery. If the patient care staff is unable to speak with the patient, for any reason, the attempt to contact the patient is documented in the patient's medical record;~~
 2. ~~Following a surgical abortion, a follow up visit offered and scheduled, if requested, no more than 21 days after the abortion. The follow up visit shall include:~~
 - a. ~~A physical examination;~~
 - b. ~~A review of all laboratory tests as required in R9-10-1508(A)(3); and~~
 - c. ~~A urine pregnancy test; and~~
 3. ~~Following a medication abortion, a follow up visit offered and scheduled between seven and 21 days after the initial dose of a substance used to induce an abortion. The follow up visit shall include:~~
 - a. ~~A urine pregnancy test; and~~
 - b. ~~An assessment of the degree of bleeding.~~
1. For a surgical abortion is offered to a patient that includes:
- a. With a patient's consent, a telephone call made to the patient to assess the patient's recovery:
 - i. By a patient care staff member other than a surgical assistant;
and
 - ii. Within 24 hours after the patient's discharge following a surgical abortion; and
 - b. A follow-up visit scheduled, if requested, no more than 21 calendar days after the abortion that includes:
 - i. A physical examination,
 - ii. A review of all laboratory tests as required in subsection (A)(3),
and
 - iii. A urine pregnancy test;

2. For a medication abortion includes a follow-up visit, scheduled between seven and 21 calendar days after the initial dose of a substance used to induce an abortion, that includes:
 - a. A urine pregnancy test, and
 - b. An assessment of the degree of bleeding; and
3. Is documented in the patient's medical record, including:
 - a. A patient's acceptance or refusal of a follow-up visit following a surgical abortion;
 - b. If applicable, the results of the follow-up visit; and
 - c. If applicable, whether the patient consented to a telephone call and, if so, whether the patient care staff member making the telephone call to the patient:
 - i. Spoke with the patient about the patient's recovery, or
 - ii. Was unable to speak with the patient.

K.J. If a continuing pregnancy is suspected as a result of the follow-up visit required in subsection (J)(2) or (J)(3) (I)(1)(b) or (I)(2), a physician who performs abortions shall be consulted.

R9-10-1509.R9-10-1510. Patient Transfer and Discharge

A. A medical director shall ensure that:

1. For a patient:
 - a. A patient is transferred to a hospital for an emergency involving the patient;
 2. A viable fetus requiring emergency care is transferred to a hospital;
 - 3.b. A patient transfer is documented in the patient's medical record; and
 - 4.c. Documentation of a medical evaluation, treatment given provided, and laboratory and diagnostic information is transferred with a patient; and
2. For a viable fetus:
 - a. A viable fetus requiring emergency care is transferred to a hospital,
 - b. The transfer of a viable fetus is documented in the viable fetus's medical record, and
 - c. Documentation of an assessment of cardiopulmonary function and treatment provided to a viable fetus is transferred with the viable fetus.

B. A medical director shall ensure that before a patient is discharged:

1. A physician signs the patient's discharge order; and

2. A patient receives follow-up instructions at discharge that include:
 - a. Signs of possible complications;
 - b. When to access medical services in response to complications;
 - c. A telephone number of an individual or entity to contact for medical emergencies;
 - d. Information and precautions for resuming vaginal intercourse after the abortion; and
 - e. Information specific to the patient's abortion or condition.

R9-10-1510.R9-10-1511. Medications and Controlled Substances

A medical director shall ensure that:

1. The abortion clinic complies with the requirements for medications and controlled substances in A.R.S. Title 32, Chapter 18, and A.R.S. Title 36, Chapter 27;
 2. A medication is administered in compliance with an order from a physician, physician assistant, registered nurse practitioner, or as otherwise provided by law;
 3. A medication is administered to a patient or to a viable fetus by a physician or as otherwise provided by law;
 4. Medications and controlled substances are maintained in a locked area in the physical facilities on the premises;
 5. Only personnel designated by policies and procedures have access to the locked area containing medications and controlled substances;
 6. Expired, mislabeled, or unusable medications and controlled substances are disposed of according to policies and procedures;
 7. A medication error or an adverse reaction, including any actions taken in response to the medication error or adverse reaction, is immediately reported to the medical director and licensee, and recorded in the patient's medical record;
 8. Medication information for a patient is maintained in a the patient's medical record and contains:
 - a. The patient's name, age, and weight;
 - b. The medications the patient is currently taking; and
 - c. Allergies or sensitivities to medications, antiseptic solutions, or latex; and
- 9-d. If medication is administered to a the patient, the following are documented

~~in the patient's medical record:~~

- a.i. The date and time of administration;
- b.ii. The name, strength, dosage form, amount of medication, and route of administration; and
- e.iii. The identification and signature of the individual administering the medication; and

9. If administered to a fetus delivered alive, the following are documented in the fetus's medical record:

- a. The date and time of oxygen administration;
- b. The amount and flow rate of the oxygen;
- c. The identification and signature of the individual administering the oxygen; and
- d. For a viable fetus:
 - i. The date and time of medication administration;
 - ii. The name, strength, dosage form, amount of medication, and route of administration; and
 - iii. The identification and signature of the individual administering the medication.

R9-10-1511. R9-10-1512. Medical Records

A. A licensee shall ensure that:

- 1. A ~~a~~ medical record is established and maintained for a patient that contains:
 - a.1. Patient identification including:
 - i.a. The patient's name, address, and date of birth;
 - ii.b. The designated patient's representative, if applicable; and
 - iii.c. The name and telephone number of an individual to contact in an emergency;
 - b.2. The patient's medical history required in ~~R9-10-1508(A)(1)~~ R9-10-1509(A)(1);
 - c.3. The patient's physical examination required in ~~R9-10-1508(A)(2)~~ R9-10-1509(A)(2);
 - d.4. The laboratory test results required in ~~R9-10-1508(A)(3)~~ R9-10-1509(A)(3);
 - 5. The ultrasound results, including the original print, required in R9-10-1509(A)(4);
 - e.6. The physician's estimated gestational age of the fetus required in ~~R9-10-1508(C)~~

R9-10-1509(C);

- f. ~~The ultrasound results, including the original print, required in R9-10-1508(D);~~
- g.7. Each consent form signed by the patient or the patient's legal guardian representative;
- h.8. Orders issued by a physician, physician assistant, or registered nurse practitioner;
- i.9. A record of medical services, nursing services, and health-related services provided to the patient; ~~and~~
- j.10. The patient's medication information; ~~and~~
- 11. Documentation related to follow-up care specified in R9-10-1509(I); and
- 12. If the abortion procedure was performed at or after 20 weeks gestational age and the fetus was not delivered alive, documentation from the physician and other patient care staff member present certifying that the fetus was not delivered alive.

B. A licensee shall ensure that a medical record is established and maintained for a fetus

delivered alive that contains:

- 1. An identification of the fetus, including:
 - a. The name of the patient from whom the fetus was delivered alive, and
 - b. The date the fetus was delivered alive;
- 2. Orders issued by a physician, physician assistant, or registered nurse practitioner;
- 3. A record of medical services, nursing services, and health-related services provided to the fetus delivered alive;
- 4. If applicable, information about medication administered to the fetus delivered alive; and
- 5. If the abortion procedure was performed at or after 20 weeks gestational age:
 - a. Documentation of the requirements in R9-10-1509(G)(4); and
 - b. If the fetus had a lethal fetal condition, the results of the confirmation of the lethal fetal condition.

C. A licensee shall ensure that:

- 2.1. A medical record is accessible only to the Department or personnel authorized by policies and procedures;
- 3.2. Medical record information is confidential and released only with the written informed consent of a patient or the patient's representative or as otherwise permitted by law;
- 4.3. A medical record is protected from loss, damage, or unauthorized use and is

maintained and accessible for at least seven years after the date of an adult patient's discharge or if the patient is a child, either for at least three years after the child's 18th birthday or for at least seven years after the patient's discharge, whichever date occurs last;

5.4. A medical record is maintained at the abortion clinic for at least six months after the date of the patient's discharge; and

6.5. Vital records and vital statistics are retained according to A.R.S. § 36-343.

B. ~~A licensee shall comply with Department requests for access to or copies of patient medical records as follows:~~

- ~~1. Subject to the redaction permitted in subsection (B)(5), for patient medical records requested for review in connection with a compliance inspection, the licensee shall provide the Department with the following patient medical records related to medical services associated with an abortion, including any follow up visits to the abortion clinic in connection with the abortion:~~
 - a. Patient identification including:
 - i. The patient's name, address, and date of birth;
 - ii. The designated patient's representative, if applicable; and
 - iii. The name and telephone number of an individual to contact in an emergency;
 - b. The patient's medical history required in R9-10-1508(A)(1);
 - c. The patient's physical examination required in R9-10-1508(A)(2);
 - d. The laboratory test results required in R9-10-1508(A)(3);
 - e. The physician's estimated gestational age of the fetus required in R9-10-1508(C);
 - f. The ultrasound results required in R9-10-1508(D);
 - g. Each consent form signed by the patient or the patient's representative;
 - h. Orders issued by a physician, physician assistant, or registered nurse practitioner;
 - i. A record of medical services, nursing services, and health related services provided to the patient; and
 - j. The patient's medication information.
2. For patient medical records requested for review in connection with an initial licensing or compliance inspection, the licensee is not required to produce for

~~review by the Department any patient medical records created or prepared by a referring physician or any of that referring physician's medical staff, and~~

3. ~~The licensee is not required to provide patient medical records regarding medical services associated with an abortion that occurred before:~~
 - a. ~~The effective date of these rules, or~~
 - b. ~~A previous licensing or compliance inspection of the abortion clinic.~~
4. ~~The patient medical records may be provided to the Department in either paper or in an electronic format that is acceptable to the Department.~~
5. ~~When access to or copies of patient medical records are requested from a licensee by the Department, the licensee shall redact only personally identifiable patient information from the patient medical records before the disclosure of the patient medical records to the Department, except as provided in subsection (B)(8).~~
6. ~~For patient medical records requested for review in connection with an initial licensing or compliance inspection, the licensee shall provide the redacted copies of the patient medical records to the Department within two business days of the Department's request for the redacted medical records if the total number of patients for whom patient medical records are requested by the Department is from one to ten patients, unless otherwise agreed to by the Department and the licensee. The time within which the licensee shall produce redacted records to the Department shall be increased by two business days for each additional five patients for whom patient medical records are requested by the Department, unless otherwise agreed to by the Department and the licensee.~~
7. ~~Upon request by the Department, in addition to redacting only personally identifiable patient information, the licensee shall code the requested patient medical records by a means that allows the Department to track all patient medical records related to a specific patient without the personally identifiable patient information.~~
8. ~~For patient medical records requested for review in connection with a complaint investigation, the Department shall have access to or copies of unredacted patient medical records.~~
9. ~~If the Department obtains copies of unredacted patient medical records, the Department shall:~~
 - a. ~~Allow the examination and use of the unredacted patient medical records only by those Department employees who need access to the patient~~

- ~~medical records to fulfill their investigative responsibilities and duties;~~
- b. ~~Maintain all unredacted patient medical records in a locked drawer, cabinet, or file or in a password protected electronic file with access to the secured drawer, cabinet, or file limited to those individuals who have access to the patient medical records according to subsection (B)(9)(a);~~
- e. ~~Destroy all unredacted patient medical records at the termination of the Department's complaint investigation or at the termination of any administrative or legal action that is taken by the Department as the result of the Department's complaint investigation, whichever is later;~~
- d. ~~If the unredacted patient medical records are filed with a court or other judicial body, including any administrative law judge or panel, file the records only under seal; and~~
- e. ~~Prevent access to the unredacted records by anyone except as provided in subsection (B)(9)(a) or subsection (B)(9)(d).~~

D. If the Department requests patient medical records for review, the licensee:

- 1. Is not required to produce any patient medical records created or prepared by a referring physician's office;
- 2. May provide patient medical records to the Department either in paper or in an electronic format that is acceptable to the Department;
- 3. Shall provide the Department with the following patient medical records related to medical services associated with an abortion, including any follow-up visits to the abortion clinic in connection with the abortion:
 - a. The patient's medical history required in R9-10-1509(A)(1);
 - b. The patient's physical examination required in R9-10-1509(A)(2);
 - c. The laboratory test results required in R9-10-1509(A)(3);
 - d. The physician's estimate of gestational age of the fetus required in R9-10-1509(C);
 - e. The ultrasound results required in R9-10-1509(D)(2);
 - f. Each consent form signed by the patient or the patient's representative;
 - g. Orders issued by a physician, physician assistant, or registered nurse practitioner;
 - h. A record of medical services, nursing services, and health-related services provided to the patient; and

- i. The patient's medication information;
 4. If the Department's request is in connection with a licensing or compliance inspection:
 - a. Is not required to produce any patient medical records associated with an abortion that occurred before the licensing inspection or a previous compliance inspection of the abortion clinic; and
 - b. Shall:
 - i. Redact only personally identifiable patient information from the patient medical records before the licensee discloses the patient medical records to the Department;
 - ii. Upon request by the Department, code the requested patient medical records by a means that allows the Department to track all patient medical records related to a specific patient without the personally identifiable patient information; and
 - iii. Unless the Department and the licensee agree otherwise, provide redacted copies of patient medical records to the Department:
 - (1) For one to ten patients, within two working days after the request, and
 - (2) For every additional five patients, within an additional two working days; and
 5. If the Department's request is in connection with a complaint investigation, shall:
 - a. Not redact patient information from the patient medical records before the licensee discloses the patient medical records to the Department; and
 - b. Ensure the patient medical records include:
 - i. The patient's name, address, and date of birth;
 - ii. The patient's representative, if applicable; and
 - iii. The name and telephone number of an individual to contact in an emergency;
- E.E.** A medical director shall ensure that only personnel authorized by policies and procedures, records or signs an entry in a medical record and:
1. An entry in a medical record is dated and legible;
 2. An entry is authenticated by:
 - a. A ~~written~~ signature; or

- b. An individual's initials if the individual's ~~written~~ signature already appears in the medical record;
 - e. ~~A rubber stamp signature; or~~
 - d. ~~An electronic signature;~~
 - 3. An entry is not changed after it has been recorded, but additional information related to an entry may be recorded in the medical record;
 - 4. When a verbal or telephone order is entered in the medical record, the entry is authenticated within 21 calendar days by the individual who issued the order;
 - 5. If a rubber-stamp signature or an electronic signature is used:
 - a. An individual's rubber stamp or electronic signature is not used by another individual;
 - b. The individual who uses a rubber stamp or electronic signature signs a statement that the individual is responsible for the use of the rubber stamp or the electronic signature; and
 - c. The signed statement is included in the individual's personnel record; and
 - 6. If an abortion clinic maintains medical records electronically, the medical director shall ensure the date and time of an entry is recorded by the computer's internal clock.
- D.F.** As required by A.R.S. § ~~36-449.03(I)~~ 36-449.03(J), the Department shall not release any personally identifiable patient or physician information.

R9-10-1512.R9-10-1513. Environmental and Safety Standards

A licensee shall ensure that:

- 1. Physical facilities The premises:
 - a. Provide lighting and ventilation to ensure the health and safety of a patient;
 - b. Are maintained in a clean condition;
 - c. Are free from a condition or situation that may cause a patient to suffer physical injury;
 - d. Are maintained free from insects and vermin; and
 - e. Are smoke-free;
- 2. A warning notice is placed at the entrance to a room or area where oxygen is in use;
- 3. Soiled linen and clothing are kept:
 - a. In a covered container, and

- b. Separate from clean linen and clothing;
- 4. Personnel wash hands after each direct patient contact and after handling soiled linen, soiled clothing, or biohazardous medical waste;
- 5. A written emergency plan is established, documented, and implemented that includes procedures for protecting the health and safety of patients and other individuals in a fire, natural disaster, loss of electrical power, or threat or incidence of violence; ~~and~~
- 6. An evacuation drill is conducted at least once every six months that includes all personnel ~~in the physical facilities~~ on the premises on the day of the evacuation drill; ~~and~~
- 7. Documentation of the evacuation drill is maintained ~~in the physical facilities~~ on the premises for at least one year after the date of the evacuation drill and includes:
 - a. The date and time of the evacuation drill; ~~and~~
 - b. The names of personnel participating in the evacuation drill.

R9-10-1513. R9-10-1514. Equipment Standards

A licensee shall ensure that:

- 1. Equipment and supplies are maintained in a:
 - a. Clean condition, and
 - b. quantity Quantity sufficient to meet the needs of patients present in the abortion clinic;
- 2. Equipment to monitor vital signs is in each room in which an abortion is performed;
- 3. A surgical or gynecologic examination table is used for an abortion;
- 4. The following equipment and supplies are available in the abortion clinic:
 - a. Equipment to measure blood pressure;
 - b. A stethoscope;
 - c. A scale for weighing a patient;
 - d. Supplies for obtaining specimens and cultures and for laboratory tests; and
 - e. Equipment and supplies for use in a medical emergency including:
 - i. Ventilatory assistance equipment; ~~and~~
 - ii. Oxygen source; ~~and~~
 - iii. Suction apparatus; ~~and~~
 - iv. Intravenous fluid equipment and supplies; and

- f. Ultrasound equipment;
- 5. In addition to the requirements in subsection (4), the following equipment is available for an abortion procedure performed after the first trimester:
 - a. Drugs to support cardiopulmonary function of a patient, and
 - b. Equipment to monitor the cardiopulmonary status of a patient;
- 6. In addition to the requirements in subsections (4) and (5), if the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, the following equipment is available for the abortion procedure:
 - a. Equipment to provide warmth and drying of a fetus delivered alive,
 - b. Equipment necessary to clear secretions from and position the airway of a fetus delivered alive,
 - c. Equipment necessary to administer oxygen to a fetus delivered alive,
 - d. Equipment to assess and monitor the cardiopulmonary status of a fetus delivered alive, and
 - e. Drugs to support cardiopulmonary function in a viable fetus:
- 6.7. Equipment and supplies are clean and, if applicable, sterile before each use;
- 7.8. Equipment required in this Section is maintained in working order, tested and calibrated at least once every 12 months or according to the manufacturer's recommendations, and used according to the manufacturer's recommendations; and
- 8.9. Documentation of each equipment test, calibration, and repair is maintained in the physical facilities on the premises for one year at least 12 months after the date of the testing, calibration, or repair and provided to the Department for review within two hours after the Department requests the documentation.

R9-10-1515. Enforcement

- A. For an abortion clinic that is not in substantial compliance or that is in substantial compliance but refuses to carry out a plan of correction acceptable to the Department, the Department may:
- 1. Assess a civil penalty according to A.R.S. § 36-431.01,
 - 2. Impose an intermediate sanction according to A.R.S. § 36-427,
 - 3. Suspend or revoke a license according to A.R.S. § 36-427,
 - 4. Deny a license, or
 - 5. Bring an action for an injunction according to A.R.S. § 36-430.

- B.** In determining the appropriate enforcement action, the Department shall consider the threat to the health, safety, and welfare of the abortion clinic's patients or the general public, including:
1. Whether the abortion clinic has repeated violations of statutes or rules;
 2. Whether the abortion clinic has engaged in a pattern of noncompliance; and
 3. The type, severity, and number of violations.

R9-10-1514.R9-10-1515. Physical Facilities Plant Standards

- A. A licensee shall ensure that an abortion clinic complies with all local building codes, ordinances, fire codes, and zoning requirements. If there are no local building codes, ordinances, fire codes, or zoning requirements, the abortion clinic shall comply with the applicable codes and standards incorporated by reference in A.A.C. R9-1-412 that were in effect on the date the abortion clinic's architectural plans and specifications were submitted to the Department for approval.
- B. A licensee shall ensure that an abortion clinic provides areas or rooms:
1. That provide privacy for:
 - a. A patient's interview, medical evaluation, and counseling;
 - b. A patient to dress; and
 - c. Performing an abortion procedure;
 2. For personnel to dress;
 3. With a sink and a flushable toilet in working order;
 4. For cleaning and sterilizing equipment and supplies;
 5. For storing medical records;
 6. For storing equipment and supplies;
 7. For hand washing before the abortion procedure; and
 8. For a patient recovering after an abortion.
- C. A licensee shall ensure that an abortion clinic has an emergency exit to accommodate a stretcher or gurney.

TITLE 9. HEALTH SERVICES

CHAPTER 10. HEALTH CARE INSTITUTIONS: LICENSING

ARTICLE 15. ABORTION CLINICS

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

TITLE 9. HEALTH SERVICES

CHAPTER 10. HEALTH CARE INSTITUTIONS: LICENSING

ARTICLE 15. ABORTION CLINICS

1. An identification of the rulemaking

In order to ensure public health, safety, and welfare, Arizona Revised Statutes (A.R.S.) §§ 36-405 and 36-406 require the Arizona Department of Health Services (Department) to adopt rules establishing minimum standards and requirements for construction, modification, and licensure of health care institutions. A.R.S. § 36-449.03 requires the Department to adopt rules that establish minimum standards and requirements for abortion clinics. These statutes have been implemented in A.A.C. Title 9, Chapter 10. Laws 2017, Ch. 133 requires an abortion clinic or hospital that performs an abortion at or after 20 weeks gestational age to implement and document procedures to make sure a physician takes measures to maintain the life of an aborted embryo or fetus born alive and documents and reports those measures. Laws 2017, Ch. 133 also requires the equipment necessary to carry out these life-maintaining measures and includes specific requirements for abortions when a fetus has a lethal fetal condition. The Department is amending the rules in 9 A.A.C. 10, Article 2 for hospitals and Article 15 for abortion clinics to comply with Laws 2017, Ch. 133. Other changes to conform to statutory requirements, such as those revised by Laws 2017, Ch. 122, or to improve efficiency and effectiveness are also being made. The latter includes changes to the rules for clarity, to remove or modify duplicative or outdated language, and to update references and citations.

2. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rules

- The Department
- Hospitals and outpatient treatment centers in which abortions are performed
- Abortion clinics
- Patient care staff members
- Patients of a hospital or abortion clinic undergoing an abortion and their families

- General public

3. Cost/Benefit Analysis

As stated previously, the changes being made through this rulemaking are either to comply with statutory changes or to improve efficiency and effectiveness.

Changes being made to comply with statutes include:

- To comply with A.R.S. § 36-449.02, as amended by Laws 2017, Ch. 122, requiring submission of documentation required by the Article, including verification about a physician's admitting privileges, upon licensure and, thereafter, on or before the anniversary of licensure – included as R9-10-1502(B), as being submitted with the fees required in R9-10-106(C);
- To comply with A.R.S. § 36-449.03, adding a requirement for abortion clinics performing an abortion at or after 20 weeks gestational age to include equipment standards consistent with the revised A.R.S. § 36-2301 – included as R9-10-1514(6);
- To comply with A.R.S. § 36-2161, adding documentation requirements related to whether or not a fetus was delivered alive – included as R9-10-223(C) and R9-10-1512(A)(12) and (B); and
- To comply with A.R.S. § 36-2301, adding requirements for:
 - Confirming the diagnosis for a fetus with a lethal fetal condition; adding a requirement for a woman to be informed of requirements related to a fetus with a lethal fetal condition that is delivered alive – included as R9-10-223(C)(3)(e), R9-10-1509(E), and R9-10-1512(B)(5)(b); and
 - Requiring policies and procedures to ensure compliance with the Section for an abortion clinic or hospital that performs an abortion at or after 20 weeks gestational age that include:
 - Designating a person to arrange the transfer of a fetus delivered alive – included as R9-10-1503(C)(3)(b) and R9-10-1510(A)(2);
 - Having a person trained in neonatal resuscitation present in the room where the abortion is performed - included as R9-10-223(C)(1)(a), R9-10-1503(C)(3)(a), R9-10-1506(5) and (6)(h), R9-10-1507(B)(5), and R9-10-1509(G)(3), with related definitions added or revised in R9-10-1501; and

- Establishing a protocol for rapid neonatal resuscitation; making some exceptions for a fetus with a lethal fetal condition, - included as R9-10-223(C)(1)(c), R9-10-1503(C)(7)(c), R9-10-1509(G)(4), R9-10-1511(9), and R9-10-1512(B).

Since these changes are directly required by statutes, the costs imposed by or benefits derived from the changes are due to the statutes and not the rules. This analysis does not describe effects associated with the statutory changes.

Changes being made to improve efficiency and effectiveness include:

- To clarify requirements in A.R.S. §§ 36-2152, 36-2153, and 36-2108, requiring consent to be obtained as specified in these statutes - included as R9-10-1509(E);
- Removing unnecessary definitions, already defined in R9-10-101, which includes definitions applicable to the Chapter;
- Adding a reference to statutory definitions, rather than listing and citing them individually, and revising definitions to make them clearer and more understandable;
- Removing from R9-10-1501 the term, “nationally recognized medical journal,” that is used only once in the rules, and describing the term in R9-10-1509(D)(2) where it is used;
- Clarifying:
 - Who may be designated as a medical director;
 - That some information or documents may be stored/provided electronically;
 - Requirements for notification of the Department for a fetus delivered alive or viable fetus to be consistent with the definition of “incident”;
 - A patient’s right to receive a print of the ultrasound image, from R9-10-1509(D)(4) and A.R.S. § 36-2156(A)(1)(d);
 - That a medical examination includes an ultrasound imaging study;
 - Who may monitor a patient;
 - Requirements for follow-up care;
 - Documentation, as applicable:
 - That a fetus was not delivered alive,

- Of services provided to a fetus delivered alive, and
- Of confirmation of a lethal fetal condition; and
- The Department's access to patient medical records;
- Making requirements in the Article more consistent with requirements in other Articles in the Chapter, such as:
 - Requiring documentation required by the Article to be provided to the Department within two hours after a Department request, with an exception for patient medical records as required in a 2008 Stipulation of Settlement to *Tucson Woman's Clinic v. Eden*, No. CV-00-00141-RCC (D. Ariz., Sept. 30, 2002);
 - Adding a quality management Section; and
 - Using the term "premises" rather than "physical facilities";
- Removing the duplicative requirement in R9-10-1507(4) and (4)(a) and cross referencing to R9-10-1509(H)(1), retaining the requirement for a patient care staff member to be on the premises to comply with R9-10-1509(H);
- Adding a cross reference in R9-10-1503(D) to R9-10-111 and repealing the duplicative requirements in the current R9-10-1515; and
- Correcting grammatical errors and incorrect cross-references.

This analysis covers costs and benefits associated with these rule changes. No new FTEs will be required due to this rulemaking. Annual costs/revenues changes are designated as minimal when more than \$0 and \$1,000 or less, moderate when between \$1,000 and \$5,000, and substantial when \$5,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification.

Description of Affected Groups	Description of Effect	Increased Cost/ Decreased Revenue	Decreased Cost/ Increased Revenue
A. State and Local Government Agencies			

Department	Removing/amending/adding definitions Clarifying requirements Making requirements in Article 15 more consistent with requirements in other Articles in the Chapter Removing duplicative requirements Correcting grammatical errors and incorrect cross-references	None None None None None	Significant Significant Significant Significant Significant
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B. Privately Owned Businesses

Hospitals and outpatient treatment centers in which abortions are performed and abortion clinics	Removing/amending/adding definitions Clarifying requirements Making requirements in Article 15 more consistent with requirements in other Articles in the Chapter Removing duplicative requirements Correcting grammatical errors and incorrect cross-references	None None None-to-minimal None None	Significant Significant Significant Significant Significant
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C. Private Persons and Consumers

Patient care staff members	Removing/amending/adding definitions Clarifying requirements Making requirements in Article 15 more consistent with requirements in other Articles in the Chapter Removing duplicative requirements Correcting grammatical errors and incorrect cross-references	None None None None None	Significant Significant Significant Significant Significant
Patients of a hospital or abortion clinic undergoing an abortion and their families	Having rules that are easier to understand and more effective	None	Significant
General public	Having rules that are easier to understand and more effective	None	Significant

- **The Department**

During calendar year 2017, the Department received approximately 12,518 reports under A.R.S. § 36-2161 from 15 health care institutions in which abortions are performed, with the number varying from year to year due to many facilities providing a few abortions during one time period, but none during the next time period. These include 6 hospitals,

with the other reports coming from facilities licensed as abortion clinics, outpatient treatment centers that also provide abortions, and a few private medical practices that do not meet the definition of “abortion clinic” in A.R.S. § 36-449.01. Outpatient treatment centers that also provide abortions are required to comply with requirements in Article 15 when performing an abortion procedure. On average over the past six years, the Department has received approximately 200 reports per year of abortions performed at or after 20 weeks gestational age. In 2017, 227 such reports were received, representing approximately 1.8% of all reported abortions. Of these 227 reports, 11 came from hospitals. The Department believes that the changes being made to improve the efficiency and effectiveness of the rules will help the Department enforce the rules, lead to stakeholders asking fewer questions about requirements, and cause the Department to spend less time providing technical assistance to licensed health care institutions in which abortions are performed. Making requirements in Article 15 more consistent with requirements in other Articles in the Chapter, in particular, may make it easier for the Department to conduct compliance inspections for abortion clinics. Thus, the Department anticipates that these changes may provide a significant benefit to the Department.

- **Hospitals and outpatient treatment centers in which abortions are performed and abortion clinics**

The Department believes that the changes being made to improve the efficiency and effectiveness of the rules will help licensed health care institutions in which abortions are performed to better understand requirements and, thus, better comply with the requirements, providing a significant benefit to these licensed health care institutions. The new rules clarify and add requirements to make Article 15 more consistent with requirements in other Articles in the Chapter. These include using more consistent terminology; specifying that documentation required by the Article, such as personnel records or policies and procedures, is to be provided to the Department within two hours after a Department request; and requiring an abortion clinic to establish and implement a quality management plan. The Department believes that the first two will cause an abortion clinic to incur no increased costs and that establishing and implementing a quality management plan is a standard of practice in the health care field and is already occurring in almost all abortion clinics. If an abortion clinic already has a process for reviewing issues related to incidents and services provided to patients, the Department

believes the rule change related to a quality management plan may cause no change in costs. However, if an abortion clinic has not already established and implemented such a plan, the requirement added to the rules may cause an abortion clinic to incur minimal costs to comply with the requirement. An abortion clinic may also receive a significant benefit from providing better care to patients.

- **Patient care staff members**

Patient care staff members include physicians, registered nurse practitioners, nurses, physician assistants, and surgical assistants who provide medical services, nursing services, or health-related services to a patient. The Department anticipates that the rule changes being made to improve the efficiency and effectiveness of the rules will help these individuals to better understand requirements and, thus, better comply with the requirements. Thus, the rule changes may provide a significant benefit to these individuals.

- **Patients undergoing an abortion and their families**

The Department believes that the rule changes being made to improve the efficiency and effectiveness of the rules will help patient care staff members to better understand requirements in the rules and, thus, better comply with the requirements. A patient undergoing an abortion procedure may receive better services from these individuals as a result of their better complying with requirements in the rules. Thus, the rule changes may provide a significant benefit to a patient undergoing an abortion procedure. A similar benefit may be received by a family member accompanying a patient undergoing an abortion.

- **General public**

Having rules that are more easily understood, complied with, and enforced may provide a significant benefit to the general public.

4. **A general description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking**

Public and private employment in the State of Arizona is not expected to be affected due to the changes required in the rule.

5. **A statement of the probable impact of the rules on small business**

- a. **Identification of the small businesses subject to the rules**

Small businesses affected by the rules may include small hospitals and abortion clinics.

b. The administrative and other costs required for compliance with the rules

Anticipated costs for complying with the rules are described under paragraph 3.

c. A description of the methods that the agency may use to reduce the impact on small businesses

Due to statutory changes, there are no methods that the Department may use to reduce the impact on small businesses except by the clarification of existing requirements and making requirements more understandable.

d. The probable costs and benefits to private persons and consumers who are directly affected by the rules

The costs to private persons and consumers from the rules changes are described in paragraph 3.

6. A statement of the probable effect on state revenues

The rulemaking does not include any fees, so the Department does not expect the rules to affect state revenues.

7. A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking

There are no less intrusive or less costly alternatives for achieving the purpose of the rules.

8. A description of any data on which the rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data

Not applicable

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- c. A medical staff member's or radiologist's interpretation of the image;
- d. The type and amount of radiopharmaceutical used, if applicable; and
- e. The adverse reaction to the radiopharmaceutical, if any; and
- 4. A radiologic or diagnostic imaging report is included in the patient's medical record.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-220 renumbered to R9-10-221; new Section R9-10-220 renumbered from R9-10-219 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-221. Intensive Care Services

Except for a special hospital that provides only psychiatric services, an administrator of a hospital that provides intensive care services shall ensure that:

- 1. Intensive care services are provided as an organized service in a designated area under the direction of a medical staff member;
- 2. An inpatient admitted for intensive care services is personally visited by a physician at least once every 24 hours;
- 3. Admission and discharge criteria for intensive care services are established;
- 4. A personnel member's responsibilities for initiation of medical services in an emergency to a patient in an intensive care unit pending the arrival of a medical staff member are established and documented in policies and procedures;
- 5. In addition to the requirements in R9-10-214(C), an intensive care unit is staffed:
 - a. With at least one registered nurse assigned for every two patients, and
 - b. According to an acuity plan as required in R9-10-214;
- 6. Each intensive care unit has a policy and procedure that provides for meeting the needs of the patients;
- 7. If the medical services of an intensive care patient are reduced to a lesser level of care in the hospital, but the patient is not physically relocated, the nurse to patient ratio is based on the needs of the patient;
- 8. Private duty staff do not provide hospital services in an intensive care unit;
- 9. At least one registered nurse assigned to a patient in an intensive care unit is certified in advanced cardiac life support specific to the age of the patient;
- 10. Resuscitation, emergency, and other equipment are available to meet the needs of a patient including:
 - a. Ventilatory assistance equipment,
 - b. Respiratory and cardiac monitoring equipment,
 - c. Suction equipment,
 - d. Portable radiologic equipment, and
 - e. A patient weighing device for patients restricted to a bed; and
- 11. An intensive care unit has at least one emergency cart that is maintained according to R9-10-218.

Historical Note

Former Section R9-10-221 renumbered as R9-10-317 as an emergency effective February 22, 1979, new Section R9-10-221 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-221 renumbered to R9-10-222; new Section R9-10-221 renumbered from R9-10-220 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-222. Respiratory Care Services

An administrator of a hospital that provides respiratory care services shall ensure that:

- 1. Respiratory care services are provided under the direction of a medical staff member;
- 2. Respiratory care services are provided according to an order that includes:
 - a. The patient's name;
 - b. The name and signature of the ordering individual;
 - c. The type, frequency, and, if applicable, duration of treatment;
 - d. The type and dosage of medication and diluent; and
 - e. The oxygen concentration or oxygen liter flow and method of administration;
- 3. Respiratory care services provided to a patient are documented in the patient's medical record and include:
 - a. The date and time of administration;
 - b. The type of respiratory care services;
 - c. The effect of respiratory care services;
 - d. If applicable, any adverse reaction to respiratory care services; and
 - e. The authentication of the individual providing the respiratory care services; and
- 4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-219.

Historical Note

Former Section R9-10-222 renumbered as R9-10-318 as an emergency effective February 22, 1979, new Section R9-10-222 adopted effective February 23, 1979 (Supp. 79-1). Correction, subsection (D)(3) reference to paragraph (E)(2) should read subsection (D)(2). (Supp. 79-6). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-222 renumbered to R9-10-223; new Section R9-10-222 renumbered from R9-10-221 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-223. Perinatal Services

- A. An administrator of a hospital that provides perinatal organized services shall ensure that:
 - 1. Perinatal services are provided in a designated area under the direction of a medical staff member;
 - 2. Only medical and surgical procedures approved by the medical staff are performed in the perinatal services unit;
 - 3. The perinatal services unit has the capability to initiate an emergency cesarean delivery within the time-frame

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- established by the medical staff and documented in policies and procedures;
4. Only a patient in need of perinatal services or gynecological services receives perinatal services or gynecological services in the perinatal services unit;
 5. A patient receiving gynecological services does not share a room with a patient receiving perinatal services;
 6. A chronological log of perinatal services provided to patients is maintained that includes:
 - a. The patient's name;
 - b. The date, time, and mode of the patient's arrival;
 - c. The disposition of the patient including discharge, transfer, or admission time; and
 - d. The following information for a delivery of a neonate:
 - i. The neonate's name or other identifier;
 - ii. The name of the medical staff member who delivered the neonate;
 - iii. The delivery time and date; and
 - iv. Complications of delivery, if any;
 7. The chronological log required in subsection (A)(6) is maintained by the hospital in the perinatal services unit for at least 12 months after the date the perinatal services are provided and then maintained by the hospital for at least an additional 12 months;
 8. The perinatal services unit provides fetal monitoring;
 9. The perinatal services unit has ultrasound capability;
 10. Except in an emergency, a neonate is identified as required by policies and procedures before moving the neonate from a delivery area;
 11. Policies and procedures specify:
 - a. Security measures to prevent neonatal abduction, and
 - b. How the hospital determines to whom a neonate may be discharged;
 12. A neonate is discharged only to an individual who:
 - a. Is authorized according to subsection (A)(11), and
 - b. Provides identification;
 13. A neonate's medical record identifies the individual to whom the neonate is discharged;
 14. A patient or the individual to whom the neonate is discharged receives perinatal education, discharge instructions, and a referral for follow-up care for a neonate in addition to the discharge planning requirements in R9-10-209;
 15. Intensive care services for neonates comply with the requirements in R9-10-221;
 16. At least one registered nurse is on duty in a nursery when there is a neonate in the nursery except as provided in subsection (A)(17);
 17. A nursery occupied only by a neonate, who is placed in the nursery for the convenience of the neonate's mother and does not require treatment as established in this Article, is staffed by a nurse;
 18. Equipment and supplies are available to a nursery, labor-delivery-recovery room, or labor-delivery-recovery-post-partum room to meet the needs of each neonate; and
 19. In a nursery, only a neonate's bed or bassinet is used for changing diapers, bathing, or dressing the neonate.
- B. An administrator of a hospital that does not provide perinatal organized services shall comply with the requirements in R9-10-217(C).
- 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-223 renumbered to R9-10-224; new Section R9-10-223 renumbered from R9-10-222 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).**
- R9-10-224. Pediatric Services**
- A. An administrator of a hospital that provides pediatric services or organized pediatric services according to the requirements in this Section shall ensure that:
 1. Consistent with the health and safety of a pediatric patient, arrangements are made for a parent or a guardian of the pediatric patient to stay overnight;
 2. Policies and procedures are established, documented, and implemented for:
 - a. Infection control for shared toys, books, stuffed animals, and other items in a community playroom; and
 - b. Visitation of a pediatric patient, including age limits if applicable;
 3. A pediatric inpatient is only admitted if the hospital has the staff, equipment, and supplies available to meet the needs of the pediatric patient based on the pediatric patient's medical condition and the hospital's scope of services; and
 4. If the hospital provides pediatric intensive care services, the pediatric intensive care services comply with intensive care services requirements in R9-10-221.
 - B. An administrator of a hospital that provides pediatric organized services shall ensure that pediatric services are provided in a designated area under the direction of a medical staff member.
 - C. An administrator shall ensure that in a multi-organized service unit or a patient care unit that is providing medical and nursing services to an adult patient and a pediatric patient according to this Section:
 1. A pediatric patient is not placed in a patient room with an adult patient, and
 2. A medication for a pediatric patient that is stored in the patient care unit is stored separately from a medication for an adult patient.
 - D. Except as provided in subsections (F) and (G), an administrator of a hospital that does not provide pediatric organized services may admit a pediatric inpatient only in an emergency.
 - E. A hospital may use a bed in a pediatric organized services patient care unit for an adult patient if an administrator establishes, documents, and implements policies and procedures that:
 1. Delineate the specific conditions under which an adult patient is placed in a bed in the pediatric organized services unit, and
 2. Except as provided in subsection (H) and (I), ensure that an adult patient is:
 - a. Not placed in a pediatric organized services patient care unit if a pediatric patient is admitted to and present in the pediatric organized services patient care unit, and
 - b. Transferred out of the pediatric organized services patient care unit to an appropriate level of care when a pediatric patient is admitted to the pediatric organized services patient care unit.
 - F. Subsection (G) only applies to a general hospital or rural general hospital that:
 1. Does not provide pediatric organized services;

Historical Note

Former Section R9-10-223 renumbered as R9-10-319 as an emergency effective February 22, 1979, new Section R9-10-223 adopted effective February 23, 1979 (Supp.

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effective October 1, 2013 (Supp. 13-2). Section R9-10-1417 renumbered to R9-10-1416 by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

Editor's Note: The following Article was adopted under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1999, Ch. 311, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

ARTICLE 15. ABORTION CLINICS

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1501. Definitions

In addition to the definitions in A.R.S. §§ 36-401, 36-449.01, 36-449.03, and R9-10-101, the following definitions apply in this Article, unless otherwise specified:

1. "Admission" means documented acceptance by a hospital of an individual as an inpatient as defined in R9-10-201 on the order of a physician.
2. "Admitting privileges" means permission extended by a hospital to a physician to allow admission of a patient:
 - a. By the patient's own physician, or
 - b. Through a written agreement between the patient's physician and another physician that states that the other physician has permission to personally admit the patient to a hospital in this state and agrees to do so.
3. "Conspicuously posted" means placed at a location within an abortion clinic that is accessible and visible to patients and the public.
4. "Course" means hands-on practice under the supervision of a physician, training, or education.
5. "Discharge" means a patient no longer requires the medical services, nursing services, or health-related services provided by the abortion clinic.
6. "Emergency" means a potentially life-threatening occurrence that requires an immediate response or medical treatment.
7. "Employee" means an individual who receives compensation from a licensee, but does not provide medical services, nursing services, or health-related services.
8. "First trimester" means 1 through 14 weeks as measured from the first day of the last menstrual period or 1 through 12 weeks as measured from the date of fertilization.
9. "Incident" means an abortion related patient death or serious injury to a patient or viable fetus.
10. "Licensee" means an individual, a partnership, an association, a limited liability company, or corporation authorized by the Department to operate an abortion clinic.
11. "Local" means under the jurisdiction of a city or county in Arizona.
12. "Medical director" means a physician who is responsible for the direction of the medical services, nursing services, and health-related services provided to patients at an abortion clinic.
13. "Medical evaluation" means obtaining a patient's medical history, performing a physical examination of a patient's body, and conducting laboratory tests as provided in R9-10-1508.

14. "Monitor" means to observe and document, continuously or intermittently, the values of certain physiologic variables on a patient such as pulse, blood pressure, oxygen saturation, respiration, and blood loss.
15. "Nationally recognized medical journal" means any publication distributed nationally that contains peer-reviewed medical information, such as the *American Journal of Radiology* or the *Journal of Ultrasound in Medicine*.
16. "Patient" means a female receiving medical services, nursing services, or health-related services related to an abortion.
17. "Patient care staff" means a physician, registered nurse practitioner, nurse, physician assistant, or surgical assistant who provides medical services, nursing services, or health-related services to a patient.
18. "Patient's representative" means a patient's legal guardian, an individual acting on behalf of a patient with the written consent of the patient, or a surrogate according to A.R.S. § 36-3201.
19. "Patient transfer" means relocating a patient requiring medical services from an abortion clinic to another health care institution.
20. "Personally identifiable patient information" means:
 - a. The name, address, telephone number, e-mail address, Social Security number, and birth date of:
 - i. The patient,
 - ii. The patient's representative,
 - iii. The patient's emergency contact,
 - iv. The patient's children,
 - v. The patient's spouse,
 - vi. The patient's sexual partner, and
 - vii. Any other individual identified in the patient's medical record other than patient care staff;
 - b. The patient's place of employment;
 - c. The patient's referring physician;
 - d. The patient's insurance carrier or account;
 - e. Any "individually identifiable health information" as proscribed in 45 CFR 164-514; and
 - f. Any other information in the patient's medical record that could reasonably lead to the identification of the patient.
21. "Personnel" means patient care staff, employees, and volunteers.
22. "Physical facilities" means property that is:
 - a. Designated on an application for a license by the applicant; and
 - b. Licensed to provide services by the Department according to A.R.S. Title 36, Chapter 4.
23. "Surgical assistant" means an individual who is not licensed as a physician, physician assistant, registered nurse practitioner, or nurse who performs duties as directed by a physician, physician assistant, registered nurse practitioner or nurse.
24. "Volunteer" means an individual who, without compensation, performs duties as directed by a member of the patient care staff at an abortion clinic.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the

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Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1502. Application Requirements

An applicant shall submit an application for licensure that meets the requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Exhibit was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act, which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

Exhibit A. Repealed**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1503. Administration

- A. A licensee is responsible for the organization and management of an abortion clinic.
- B. A licensee shall:
 - 1. Adopt policies and procedures for the administration and operation of an abortion clinic;
 - 2. Designate a medical director who is licensed according to A.R.S. Title 32, Chapter 13, 17, or 29. The licensee and the medical director may be the same individual; and
 - 3. Ensure the following documents are conspicuously posted at the physical facilities:
 - a. Current abortion clinic license issued by the Department;
 - b. Current telephone number and address of the unit in the Department responsible for licensing the abortion clinic;
 - c. Evacuation map; and
 - d. Signs that comply with A.R.S. § 36-2153(G).
- C. A medical director shall ensure written policies and procedures are established, documented, and implemented for:
 - 1. Personnel qualifications, duties, and responsibilities;
 - 2. Individuals qualified to provide counseling in the abortion clinic and the amount and type of training required for an individual to provide counseling;
 - 3. Verification of the competency of the physician performing an abortion according to R9-10-1505;
 - 4. The storage, administration, accessibility, disposal, and documentation of a medication, and a controlled substance;
 - 5. Accessibility and security of patient medical records;
 - 6. Abortion procedures including recovery and follow-up care; and the minimum length of time a patient remains in the recovery room or area based on:
 - a. The type of abortion performed;
 - b. The estimated gestational age of the fetus;
 - c. The type and amount of medication administered; and
 - d. The physiologic signs including vital signs and blood loss;
 - 7. Infection control including methods of sterilizing equipment and supplies;
 - 8. Medical emergencies; and
 - 9. Patient discharge and patient transfer.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by exempt rulemaking at 20 A.A.R. 2078, effective July 24, 2014 (Supp. 14-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure

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Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1504. Incident Reporting

- A. A licensee shall ensure that the Department is notified of an incident as follows:
 - 1. For the death of a patient, verbal notification the next working day; and
 - 2. For a serious injury, written notification within 10 calendar days after the date of the serious injury.
- B. A medical director shall conduct an investigation of an incident and document an incident report that includes:
 - 1. The date and time of the incident;
 - 2. The name of the patient;
 - 3. A description of the incident;
 - 4. Names of individuals who observed the incident;
 - 5. Action taken by patient care staff and employees during the incident and immediately following the incident; and
 - 6. Action taken by the patient care staff and employees to prevent the incident from occurring in the future.
- C. A medical director shall ensure that the incident report is:
 - 1. Submitted to the Department and, if the incident involved a licensed individual, the applicable professional licensing board within 10 calendar days after the date of the notification in subsection (A); and
 - 2. Maintained in the physical facilities for at least two years after the date of the incident.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1505. Personnel Qualifications and Records

A licensee shall ensure that:

- 1. A physician who performs an abortion demonstrates to the medical director that the physician is competent to perform an abortion by:
 - a. The submission of documentation of education and experience; and
 - b. Observation by or interaction with the medical director;
- 2. Surgical assistants and volunteers who provide counseling and patient advocacy receive training in these specific responsibilities and any other responsibilities assigned and that documentation is maintained in the individual's personnel file of the training received;

- 3. An individual who performs an ultrasound provides documentation that the individual is:
 - a. A physician;
 - b. A physician assistant, registered nurse practitioner, or nurse who completed a hands-on course in performing ultrasounds under the supervision of a physician; or
 - c. An individual who:
 - i. Completed a hands-on course in performing ultrasounds under the supervision of a physician, and
 - ii. Is not otherwise precluded by law from performing an ultrasound;
- 4. An individual has completed a course for the type of ultrasound the individual performs;
- 5. A personnel file for each member of the patient care staff and each volunteer is maintained either electronically or in writing and includes:
 - a. The individual's name and position title;
 - b. The first and, if applicable, the last date of employment or volunteer service;
 - c. Verification of qualifications, training, or licensure, as applicable;
 - d. Documentation of cardiopulmonary resuscitation certification, as applicable;
 - e. Documentation of verification of competency, as required in subsection (1), and signed and dated by the medical director;
 - f. Documentation of training for surgical assistants and volunteers; and
 - g. Documentation of completion of a course as required in subsection (3), for an individual performing ultrasounds; and
- 6. Personnel files are maintained in the physical facilities for at least two years from the ending date of employment or volunteer service.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1506. Staffing Requirements

- A. A licensee shall ensure that there is a sufficient number of patient care staff and employees to:
 - 1. Meet the requirements of this Article;
 - 2. Ensure the health and safety of a patient; and

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3. Meet the needs of a patient based on the patient's medical evaluation.
- B.** A licensee shall ensure that:
1. A member of the patient care staff, except for a surgical assistant, who is current in cardiopulmonary resuscitation certification is in the physical facilities until all patients are discharged;
 2. A physician, with admitting privileges at a health care institution that is classified by the director as a hospital according to A.R.S. § 36-405(B), remains on the premises of the abortion clinic until all patients who received a medication abortion are stable and ready to leave;
 3. A physician, with admitting privileges at a health care institution that is classified by the director as a hospital according to A.R.S. § 36-405(B) and that is within 30 miles of the abortion clinic by road, as defined in A.R.S. § 17-451, remains on the abortion clinic's premises until all patients who received a surgical abortion are stable and ready to leave the recovery room; and
 4. A physician, a nurse, a registered nurse practitioner, a physician assistant, or, if a physician is able to provide direct supervision as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800 as applicable, a medical assistant under the direct supervision of the physician:
 - a. Monitors each patient during the patient's recovery following the abortion; and
 - b. Remains in the abortion clinic until each patient is discharged by a physician.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1507. Patient Rights

A licensee shall ensure that a patient is afforded the following rights, and is informed of these rights:

1. To refuse treatment, or withdraw consent for treatment;
2. To have medical records kept confidential; and
3. To be informed of:
 - a. Billing procedures and financial liability before abortion services are provided;
 - b. Proposed medical or surgical procedures, associated risks, possible complications, and alternatives;

- c. Counseling services that are provided in the physical facilities; and
- d. The right to review the ultrasound results with a physician, a physician assistant, a registered nurse practitioner, or a registered nurse before the abortion procedure.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1508. Abortion Procedures

- A.** A medical director shall ensure that a medical evaluation of a patient is conducted before the patient's abortion is performed that includes:
1. A medical history including:
 - a. Allergies to medications, antiseptic solutions, or latex;
 - b. Obstetrical and gynecological history;
 - c. Past surgeries;
 - d. Medication the patient is currently taking; and
 - e. Other medical conditions;
 2. A physical examination performed by a physician that includes a bimanual examination to estimate uterine size and palpation of adnexa; and
 3. The following laboratory tests:
 - a. A urine or blood test to determine pregnancy;
 - b. Rh typing unless the patient provides written documentation of blood type acceptable to the physician;
 - c. Anemia screening; and
 - d. Other laboratory tests recommended by the physician or medical director on the basis of the physical examination.
- B.** If the medical evaluation indicates a patient is Rh negative, a medical director shall ensure that:
1. The patient receives information from a physician on this condition;
 2. The patient is offered RhO(d) immune globulin within 72 hours after the abortion procedure;
 3. If a patient refuses RhO(d) immune globulin, the patient signs and dates a form acknowledging the patient's condition and refusing the RhO(d) immune globulin;
 4. The form in subsection (B)(3) is maintained in the patient's medical record; and

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5. If a patient refuses RhO(d) immune globulin or if a patient refuses to sign and date an acknowledgment and refusal form, the physician documents the patient's refusal in the patient's medical record.
- C. A physician estimates the gestational age of the fetus, and records the estimated age in the patient's medical record. The estimated age is based upon:
1. Ultrasound measurements of the biparietal diameter, length of femur, abdominal circumference, visible pregnancy sac, or crown-rump length or a combination of these; or
 2. The date of the last menstrual period or the date of fertilization and a bimanual examination of the patient.
- D. A medical director shall ensure that:
1. An ultrasound of a patient is performed by an individual who meets the requirements in R9-10-1505(3);
 2. An ultrasound estimate of gestational age of a fetus is performed using methods and tables or charts published in a nationally recognized medical journal;
 3. An original patient ultrasound print is:
 - a. Interpreted by a physician; and
 - b. Maintained in the patient's medical record in either electronic or paper form; and
 4. If requested by the patient, the ultrasound is reviewed with the patient by a physician, physician assistant, registered nurse practitioner, or registered nurse.
- E. A medical director shall ensure that before an abortion is performed on a patient:
1. Written consent is signed and dated by the patient or the patient's legal guardian; and
 2. Information is provided to the patient on the abortion procedure including alternatives, risks, and potential complications.
- F. A medical director shall ensure that an abortion is performed according to the abortion clinic's policies and procedures and this Article.
- G. A medical director shall ensure that any medication, drug, or substance used to induce an abortion is administered in compliance with the protocol authorized by the United States Food and Drug Administration and that is outlined in the final printing labeling instructions for that medication, drug, or substance.
- H. A medical director shall ensure that:
1. Patient care staff monitor the patient's vital signs throughout an abortion procedure to ensure the patient's health and safety;
 2. Intravenous access is established and maintained on a patient undergoing an abortion after the first trimester unless the physician determines that establishing intravenous access is not appropriate for the particular patient and documents that fact in the patient's medical record; and
 3. If a viable fetus shows signs of life:
 - a. Resuscitative measures are used to support life;
 - b. The viable fetus is transferred as required in R9-10-1509; and
 - c. Resuscitative measures and the transfer are documented.
- I. A medical director shall ensure that following the abortion procedure:
1. A patient's vital signs and bleeding are monitored by a physician, nurse, registered nurse practitioner, physician assistant, or, if a physician is able to provide direct supervision as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, as applicable, a medical assistant under the direct supervision of the physician to ensure the patient's health and safety; and
 2. A patient remains in the recovery room or recovery area until a physician, physician assistant, registered nurse practitioner or nurse examines the patient and determines that the patient's medical condition is stable and the patient is ready to leave the recovery room or recovery area.
- J. A medical director shall ensure that follow-up care includes:
1. With a patient's consent, a telephone call to the patient by a member of the patient care staff, except a surgical assistant, within 24 hours after the patient's discharge following a surgical abortion to assess the patient's recovery. If the patient care staff is unable to speak with the patient, for any reason, the attempt to contact the patient is documented in the patient's medical record;
 2. Following a surgical abortion, a follow-up visit offered and scheduled, if requested, no more than 21 days after the abortion. The follow-up visit shall include:
 - a. A physical examination;
 - b. A review of all laboratory tests as required in R9-10-1508(A)(3); and
 - c. A urine pregnancy test; and
 3. Following a medication abortion, a follow-up visit offered and scheduled between seven and 21 days after the initial dose of a substance used to induce an abortion. The follow-up visit shall include:
 - a. A urine pregnancy test; and
 - b. An assessment of the degree of bleeding.
- K. If a continuing pregnancy is suspected as a result of the follow-up visit required in subsection (J)(2) or (J)(3), a physician who performs abortions shall be consulted.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1509. Patient Transfer and Discharge

- A. A medical director shall ensure that:
1. A patient is transferred to a hospital for an emergency involving the patient;
 2. A viable fetus requiring emergency care is transferred to a hospital;

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- 3. A patient transfer is documented in the patient's medical record; and
- 4. Documentation of a medical evaluation, treatment given, and laboratory and diagnostic information is transferred with a patient.
- B. A medical director shall ensure that before a patient is discharged:
 - 1. A physician signs the patient's discharge order; and
 - 2. A patient receives follow-up instructions at discharge that include:
 - a. Signs of possible complications;
 - b. When to access medical services in response to complications;
 - c. A telephone number of an individual or entity to contact for medical emergencies;
 - d. Information and precautions for resuming vaginal intercourse after the abortion; and
 - e. Information specific to the patient's abortion or condition.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4).

Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1510. Medications and Controlled Substances

A medical director shall ensure that:

1. The abortion clinic complies with the requirements for medications and controlled substances in A.R.S. Title 32, Chapter 18, and A.R.S. Title 36, Chapter 27;
2. A medication is administered in compliance with an order from a physician, physician assistant, registered nurse practitioner, or as otherwise provided by law;
3. A medication is administered to a patient by a physician or as otherwise provided by law;
4. Medications and controlled substances are maintained in a locked area in the physical facilities;
5. Only personnel designated by policies and procedures have access to the locked area containing medications and controlled substances;
6. Expired, mislabeled, or unusable medications and controlled substances are disposed of according to policies and procedures;
7. A medication error or an adverse reaction, including any actions taken in response to the medication error or adverse reaction, is immediately reported to the medical director and licensee, and recorded in the patient's medical record;
8. Medication information is maintained in a patient's medical record and contains:
 - a. The patient's name, age, and weight;

- b. The medications the patient is currently taking; and
- c. Allergies or sensitivities to medications, antiseptic solutions, or latex; and
- 9. If medication is administered to a patient, the following are documented in the patient's medical record:
 - a. The date and time of administration;
 - b. The name, strength, dosage form, amount of medication, and route of administration; and
 - c. The identification and signature of the individual administering the medication.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4).

Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1511. Medical Records

A licensee shall ensure that:

1. A medical record is established and maintained for a patient that contains:
 - a. Patient identification including:
 - i. The patient's name, address, and date of birth;
 - ii. The designated patient's representative, if applicable; and
 - iii. The name and telephone number of an individual to contact in an emergency;
 - b. The patient's medical history required in R9-10-1508(A)(1);
 - c. The patient's physical examination required in R9-10-1508(A)(2);
 - d. The laboratory test results required in R9-10-1508(A)(3);
 - e. The physician's estimated gestational age of the fetus required in R9-10-1508(C);
 - f. The ultrasound results, including the original print, required in R9-10-1508(D);
 - g. Each consent form signed by the patient or the patient's legal guardian;
 - h. Orders issued by a physician, physician assistant or registered nurse practitioner;
 - i. A record of medical services, nursing services, and health-related services provided to the patient; and
 - j. The patient's medication information;
2. A medical record is accessible only to the Department or personnel authorized by policies and procedures;
3. Medical record information is confidential and released only with the written informed consent of a patient or the patient's representative or as otherwise permitted by law;

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4. A medical record is protected from loss, damage, or unauthorized use and is maintained and accessible for seven years after the date of an adult patient's discharge or if the patient is a child, either for at least three years after the child's 18th birthday or for at least seven years after the patient's discharge, whichever date occurs last;
5. A medical record is maintained at the abortion clinic for at least six months after the date of the patient's discharge; and
6. Vital records and vital statistics are retained according to A.R.S. § 36-343.
- B. A licensee shall comply with Department requests for access to or copies of patient medical records as follows:
1. Subject to the redaction permitted in subsection (B)(5), for patient medical records requested for review in connection with a compliance inspection, the licensee shall provide the Department with the following patient medical records related to medical services associated with an abortion, including any follow-up visits to the abortion clinic in connection with the abortion:
 - a. Patient identification including:
 - i. The patient's name, address, and date of birth;
 - ii. The designated patient's representative, if applicable; and
 - iii. The name and telephone number of an individual to contact in an emergency;
 - b. The patient's medical history required in R9-10-1508(A)(1);
 - c. The patient's physical examination required in R9-10-1508(A)(2);
 - d. The laboratory test results required in R9-10-1508(A)(3);
 - e. The physician's estimated gestational age of the fetus required in R9-10-1508(C);
 - f. The ultrasound results required in R9-10-1508(D);
 - g. Each consent form signed by the patient or the patient's representative;
 - h. Orders issued by a physician, physician assistant, or registered nurse practitioner;
 - i. A record of medical services, nursing services, and health-related services provided to the patient; and
 - j. The patient's medication information.
 2. For patient medical records requested for review in connection with an initial licensing or compliance inspection, the licensee is not required to produce for review by the Department any patient medical records created or prepared by a referring physician or any of that referring physician's medical staff.
 3. The licensee is not required to provide patient medical records regarding medical services associated with an abortion that occurred before:
 - a. The effective date of these rules, or
 - b. A previous licensing or compliance inspection of the abortion clinic.
 4. The patient medical records may be provided to the Department in either paper or in an electronic format that is acceptable to the Department.
 5. When access to or copies of patient medical records are requested from a licensee by the Department, the licensee shall redact only personally identifiable patient information from the patient medical records before the disclosure of the patient medical records to the Department, except as provided in subsection (B)(8).
 6. For patient medical records requested for review in connection with an initial licensing or compliance inspection, the licensee shall provide the redacted copies of the patient medical records to the Department within two business days of the Department's request for the redacted medical records if the total number of patients for whom patient medical records are requested by the Department is from one to ten patients, unless otherwise agreed to by the Department and the licensee. The time within which the licensee shall produce redacted records to the Department shall be increased by two business days for each additional five patients for whom patient medical records are requested by the Department, unless otherwise agreed to by the Department and the licensee.
 7. Upon request by the Department, in addition to redacting only personally identifiable patient information, the licensee shall code the requested patient medical records by a means that allows the Department to track all patient medical records related to a specific patient without the personally identifiable patient information.
 8. For patient medical records requested for review in connection with a complaint investigation, the Department shall have access to or copies of unredacted patient medical records.
 9. If the Department obtains copies of unredacted patient medical records, the Department shall:
 - a. Allow the examination and use of the unredacted patient medical records only by those Department employees who need access to the patient medical records to fulfill their investigative responsibilities and duties;
 - b. Maintain all unredacted patient medical records in a locked drawer, cabinet, or file or in a password-protected electronic file with access to the secured drawer, cabinet, or file limited to those individuals who have access to the patient medical records according to subsection (B)(9)(a);
 - c. Destroy all unredacted patient medical records at the termination of the Department's complaint investigation or at the termination of any administrative or legal action that is taken by the Department as the result of the Department's complaint investigation, whichever is later;
 - d. If the unredacted patient medical records are filed with a court or other judicial body, including any administrative law judge or panel, file the records only under seal; and
 - e. Prevent access to the unredacted records by anyone except as provided in subsection (B)(9)(a) or subsection (B)(9)(d).
 - C. A medical director shall ensure that only personnel authorized by policies and procedures, records or signs an entry in a medical record and:
 1. An entry in a medical record is dated and legible;
 2. An entry is authenticated by:
 - a. A written signature;
 - b. An individual's initials if the individual's written signature already appears in the medical record;
 - c. A rubber-stamp signature; or
 - d. An electronic signature;
 3. An entry is not changed after it has been recorded but additional information related to an entry may be recorded in the medical record;
 4. When a verbal or telephone order is entered in the medical record, the entry is authenticated within 21 days by the individual who issued the order;
 5. If a rubber-stamp signature or an electronic signature is used:

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- a. An individual's rubber stamp or electronic signature is not used by another individual;
 - b. The individual who uses a rubber stamp or electronic signature signs a statement that the individual is responsible for the use of the rubber stamp or the electronic signature; and
 - c. The signed statement is included in the individual's personnel record; and
 - 6. If an abortion clinic maintains medical records electronically, the medical director shall ensure the date and time of an entry is recorded by the computer's internal clock.
- D. As required by A.R.S. § 36-449.03(I), the Department shall not release any personally identifiable patient or physician information.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4).

Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by exempt rulemaking at 20 A.A.R. 2078, effective July 24, 2014 (Supp. 14-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1512. Environmental and Safety Standards

A licensee shall ensure that:

1. Physical facilities:
 - a. Provide lighting and ventilation to ensure the health and safety of a patient;
 - b. Are maintained in a clean condition;
 - c. Are free from a condition or situation that may cause a patient to suffer physical injury;
 - d. Are maintained free from insects and vermin; and
 - e. Are smoke-free;
2. A warning notice is placed at the entrance to a room or area where oxygen is in use;
3. Soiled linen and clothing are kept:
 - a. In a covered container, and
 - b. Separate from clean linen and clothing;
4. Personnel wash hands after each direct patient contact and after handling soiled linen, soiled clothing, or biohazardous medical waste;
5. A written emergency plan is established, documented, and implemented that includes procedures for protecting the health and safety of patients and other individuals in a fire, natural disaster, loss of electrical power, or threat or incidence of violence; and
6. An evacuation drill is conducted at least once every six months that includes all personnel in the physical facilities the day of the evacuation drill. Documentation of the

evacuation drill is maintained in the physical facilities for one year after the date of the evacuation drill and includes:

- a. The date and time of the evacuation drill; and
- b. The names of personnel participating in the evacuation drill.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1513. Equipment Standards

A licensee shall ensure that:

1. Equipment and supplies are maintained in a quantity sufficient to meet the needs of patients present in the abortion clinic;
2. Equipment to monitor vital signs is in each room in which an abortion is performed;
3. A surgical or gynecologic examination table is used for an abortion;
4. The following equipment and supplies are available in the abortion clinic:
 - a. Equipment to measure blood pressure;
 - b. A stethoscope;
 - c. A scale for weighing a patient;
 - d. Supplies for obtaining specimens and cultures and for laboratory tests; and
 - e. Equipment and supplies for use in a medical emergency including:
 - i. Ventilatory assistance equipment;
 - ii. Oxygen source;
 - iii. Suction apparatus; and
 - iv. Intravenous fluid equipment and supplies; and
 - f. Ultrasound equipment;
5. In addition to the requirements in subsection (4), the following equipment is available for an abortion procedure performed after the first trimester:
 - a. Drugs to support cardiopulmonary function; and
 - b. Equipment to monitor cardiopulmonary status;
6. Equipment and supplies are clean and, if applicable, sterile before each use;
7. Equipment required in this Section is maintained in working order, tested and calibrated at least once every 12 months or according to the manufacturer's recommendations, and used according to the manufacturer's recommendations; and
8. Documentation of each equipment test, calibration, and repair is maintained in the physical facilities for one year after the date of the testing, calibration, or repair and pro-

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vided to the Department for review within two hours after the Department requests the documentation.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act, which means these rules were not reviewed by the Governor's Regulatory Review Council or approved by the Attorney General's Office.

R9-10-1514. Physical Facilities

- A. A licensee shall ensure that an abortion clinic complies with all local building codes, ordinances, fire codes, and zoning requirements. If there are no local building codes, ordinances, fire codes, or zoning requirements, the abortion clinic shall comply with the applicable codes and standards incorporated by reference in A.A.C. R9-1-412 that were in effect on the date the abortion clinic's architectural plans and specifications were submitted to the Department for approval.
- B. A licensee shall ensure that an abortion clinic provides areas or rooms:
 - 1. That provide privacy for:
 - a. A patient's interview, medical evaluation, and counseling;
 - b. A patient to dress; and
 - c. Performing an abortion procedure;
 - 2. For personnel to dress;
 - 3. With a sink and a flushable toilet in working order;
 - 4. For cleaning and sterilizing equipment and supplies;
 - 5. For storing medical records;
 - 6. For storing equipment and supplies;
 - 7. For hand washing before the abortion procedure; and
 - 8. For a patient recovering after an abortion.
- C. A licensee shall ensure that an abortion clinic has an emergency exit to accommodate a stretcher or gurney.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4).

Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014

(Supp. 14-1).

R9-10-1515. Enforcement

- A. For an abortion clinic that is not in substantial compliance or that is in substantial compliance but refuses to carry out a plan of correction acceptable to the Department, the Department may:
 - 1. Assess a civil penalty according to A.R.S. § 36-431.01,
 - 2. Impose an intermediate sanction according to A.R.S. § 36-427,
 - 3. Suspend or revoke a license according to A.R.S. § 36-427,
 - 4. Deny a license, or
 - 5. Bring an action for an injunction according to A.R.S. § 36-430.
- B. In determining the appropriate enforcement action, the Department shall consider the threat to the health, safety, and welfare of the abortion clinic's patients or the general public, including:
 - 1. Whether the abortion clinic has repeated violations of statutes or rules;
 - 2. Whether the abortion clinic has engaged in a pattern of noncompliance; and
 - 3. The type, severity, and number of violations.

Historical Note

New Section R9-10-1515 made by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1).

ARTICLE 16. BEHAVIORAL HEALTH RESPITE HOMES**R9-10-1601. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following apply in this Article unless otherwise specified:

- 1. "Acceptance" means, after a referral from a collaborating health care institution, an individual receives services from a provider in a behavioral health respite home.
- 2. "Provider" means an individual who lives in a behavioral health respite home and ensures that a recipient receives the behavioral health services and ancillary services in the recipient's treatment plan.
- 3. "Recipient" means an individual referred by a collaborating health care institution to and accepted by a behavioral health respite home.
- 4. "Release" means a documented termination of services by a provider to a recipient that is authorized by a collaborating health care institution.
- 5. "Sibling" means one of two or more individuals having one or both parents in common.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1602. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, an applicant shall include, in a format provided by the Department, the following information for the behavioral health respite home's collaborating health care institution:

1. Name,
2. Address,
3. Class or subclass,
4. License number, and
5. Name and contact information for an individual assigned by the collaborating health care institution to monitor the behavioral health respite home.

36-132. Department of health services; functions; contracts

A. The department, in addition to other powers and duties vested in it by law, shall:

1. Protect the health of the people of the state.
2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.
3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of this state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with chapter 3 of this title and sections 36-693, 36-694 and 39-122.
4. Operate such sanitariums, hospitals or other facilities assigned to the department by law or by the governor.
5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information for the promotion of good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of education of children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.
6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.
7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.
8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of schoolchildren, including special fields such as the prevention of blindness and conservation of sight and hearing.
9. Encourage and aid in the coordination of local programs concerning nutrition of the people of this state.
10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.
11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine

examinations and analyses and for investigations and research in matters affecting public health.

12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection I, paragraph 10.

13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.

14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in the enforcement of the federal food, drug, and cosmetic act (52 Stat. 1040; 21 United States Code sections 1 through 905).

15. Recruit and train personnel for state, local and district health departments.

16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.

17. License and regulate health care institutions according to chapter 4 of this title.

18. Issue or direct the issuance of licenses and permits required by law.

19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.

20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:

(a) Screening in early pregnancy for detecting high-risk conditions.

(b) Comprehensive prenatal health care.

(c) Maternity, delivery and postpartum care.

(d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.

(e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.

21. License and regulate the health and safety of group homes for persons with developmental disabilities. The department shall issue a license to an accredited facility for a period of the accreditation, except that no licensing period shall be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.

B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary

corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.

C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end-stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. Powers and duties of director; compensation of personnel; rules; definitions

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.
2. Perform all duties necessary to carry out the functions and responsibilities of the department.
3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.
4. Administer and enforce the laws relating to health and sanitation and the rules of the department.
5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.
6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.
7. Prepare sanitary and public health rules.
8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.
2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.
3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.
4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:
 - (a) Served at a noncommercial social event such as a potluck.
 - (b) Prepared at a cooking school that is conducted in an owner-occupied home.
 - (c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.

(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fund-raising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) A cottage food product that is not potentially hazardous or a time or temperature control for safety food and that is prepared in a kitchen of a private home for commercial purposes, including fruit jams and jellies, dry mixes made with ingredients from approved sources, honey, dry pasta and roasted nuts. Cottage food products must be packaged at home with an attached label that clearly states the name and registration number of the food preparer, lists all the ingredients in the product and the product's production date and includes the following statement: "This product was produced in a home kitchen that may process common food allergens and is not subject to public health inspection." If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must complete a food handler training course from an accredited program and maintain active certification. The food preparer must register with an online registry established by the department pursuant to paragraph 13 of this subsection. The food preparer must display the preparer's certificate of registration when operating as a temporary food establishment. For the purposes of this subdivision, "not potentially hazardous" means cottage food products that meet the requirements of the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

(i) Produce in a packing or holding facility that is subject to the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112) as administered by the Arizona department of agriculture pursuant to title 3, chapter 3, article 4.1. For the purposes of this subdivision, "holding", "packing" and "produce" have the same meanings prescribed in section 3-525.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of

water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for the preservation or storage of food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparation of food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for

inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.

13. Establish an online registry of food preparers that are authorized to prepare cottage food products for commercial purposes pursuant to paragraph 4 of this subsection. A registered food preparer shall renew the registration every three years and shall provide to the department updated registration information within thirty days after any change.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".

J. The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. For the purposes of this section:

1. "Cottage food product":

(a) Means a food that is not potentially hazardous or a time or temperature control for safety food as defined by the department in rule and that is prepared in a home kitchen by an individual who is registered with the department.

(b) Does not include foods that require refrigeration, perishable baked goods, salsas, sauces, fermented and pickled foods, meat, fish and shellfish products, beverages, acidified food products, nut butters or other reduced-oxygen packaged products.

2. "Fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.

36-405. Powers and duties of the director

A. The director shall adopt rules to establish minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to ensure the public health, safety and welfare. The standards and requirements shall relate to the construction, equipment, sanitation, staffing for medical, nursing and personal care services, and recordkeeping pertaining to the administration of medical, nursing, behavioral health and personal care services, in accordance with generally accepted practices of health care. The director shall use the current standards adopted by the joint commission on accreditation of hospitals and the commission on accreditation of the American osteopathic association or those adopted by any recognized accreditation organization approved by the department as guidelines in prescribing minimum standards and requirements under this section.

B. The director, by rule, may:

1. Classify and subclassify health care institutions according to character, size, range of services provided, medical or dental specialty offered, duration of care and standard of patient care required for the purposes of licensure. Classes of health care institutions may include hospitals, infirmaries, outpatient treatment centers, health screening services centers and residential care facilities. Whenever the director reasonably deems distinctions in rules and standards to be appropriate among different classes or subclasses of health care institutions, the director may make such distinctions.

2. Prescribe standards for determining a health care institution's substantial compliance with licensure requirements.

3. Prescribe the criteria for the licensure inspection process.
 4. Prescribe standards for the selection of health care-related demonstration projects.
 5. Establish nonrefundable application and licensing fees for health care institutions, including a grace period and a fee for the late payment of licensing fees, and fees for architectural plans and specifications reviews.
 6. Establish a process for the department to notify a licensee of the licensee's licensing fee due date.
 7. Establish a process for a licensee to request a different licensing fee due date, including any limits on the number of requests by the licensee.
- C. The director, by rule, shall adopt licensing provisions that facilitate the colocation and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services consistent with article 3.1 of this chapter.
- D. Ninety percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the health services licensing fund established by section 36-414 and ten percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.
- E. Subsection B, paragraph 5 of this section does not apply to a health care institution operated by a state agency pursuant to state or federal law or to adult foster care residential settings.

36-406. Powers and duties of the department

In addition to its other powers and duties:

1. The department shall:
 - (a) Administer and enforce this chapter and the rules, regulations and standards adopted pursuant thereto.
 - (b) Review, and may approve, plans and specifications for construction or modification or additions to health care institutions regulated by this chapter.
 - (c) Have access to books, records, accounts and any other information of any health care institution reasonably necessary for the purposes of this chapter.
 - (d) Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe the manner by which the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of that vaccination in this state as determined by the director.
2. The department may:
 - (a) Make or cause to be made inspections consistent with standard medical practice of every part of the premises of health care institutions which are subject to the provisions of this chapter as well as those which apply for or hold a license required by this chapter.
 - (b) Make studies and investigations of conditions and problems in health care institutions, or any class or subclass thereof, as they relate to compliance with this chapter and rules, regulations and standards adopted pursuant thereto.

(c) Develop manuals and guides relating to any of the several aspects of physical facilities and operations of health care institutions or any class or subclass thereof for distribution to the governing authorities of health care institutions and to the general public.

36-449.03. Abortion clinics; rules; civil penalties

A. The director shall adopt rules for an abortion clinic's physical facilities. At a minimum these rules shall prescribe standards for:

1. Adequate private space that is specifically designated for interviewing, counseling and medical evaluations.
2. Dressing rooms for staff and patients.
3. Appropriate lavatory areas.
4. Areas for preprocedure hand washing.
5. Private procedure rooms.
6. Adequate lighting and ventilation for abortion procedures.
7. Surgical or gynecologic examination tables and other fixed equipment.
8. Postprocedure recovery rooms that are supervised, staffed and equipped to meet the patients' needs.
9. Emergency exits to accommodate a stretcher or gurney.
10. Areas for cleaning and sterilizing instruments.
11. Adequate areas for the secure storage of medical records and necessary equipment and supplies.
12. The display in the abortion clinic, in a place that is conspicuous to all patients, of the clinic's current license issued by the department.

B. The director shall adopt rules to prescribe abortion clinic supplies and equipment standards, including supplies and equipment that are required to be immediately available for use or in an emergency. At a minimum these rules shall:

1. Prescribe required equipment and supplies, including medications, required for the conduct, in an appropriate fashion, of any abortion procedure that the medical staff of the clinic anticipates performing and for monitoring the progress of each patient throughout the procedure and recovery period.
2. Require that the number or amount of equipment and supplies at the clinic is adequate at all times to assure sufficient quantities of clean and sterilized durable equipment and supplies to meet the needs of each patient.
3. Prescribe required equipment, supplies and medications that shall be available and ready for immediate use in an emergency and requirements for written protocols and procedures to be followed by staff in an emergency, such as the loss of electrical power.
4. Prescribe required equipment and supplies for required laboratory tests and requirements for protocols to calibrate and maintain laboratory equipment at the abortion clinic or operated by clinic staff.
5. Require ultrasound equipment.
6. Require that all equipment is safe for the patient and the staff, meets applicable federal standards and is checked annually to ensure safety and appropriate calibration.

C. The director shall adopt rules relating to abortion clinic personnel. At a minimum these rules shall require that:

1. The abortion clinic designate a medical director of the abortion clinic who is licensed pursuant to title 32, chapter 13, 17 or 29.
2. Physicians performing abortions are licensed pursuant to title 32, chapter 13 or 17, demonstrate competence in the procedure involved and are acceptable to the medical director of the abortion clinic.
3. A physician is available:
 - (a) For a surgical abortion who has admitting privileges at a health care institution that is classified by the director as a hospital pursuant to section 36-405, subsection B and that is within thirty miles of the abortion clinic.
 - (b) For a medication abortion who has admitting privileges at a health care institution that is classified by the director as a hospital pursuant to section 36-405, subsection B.
4. If a physician is not present, a registered nurse, nurse practitioner, licensed practical nurse or physician assistant is present and remains at the clinic when abortions are performed to provide postoperative monitoring and care, or monitoring and care after inducing a medication abortion, until each patient who had an abortion that day is discharged.
5. Surgical assistants receive training in counseling, patient advocacy and the specific responsibilities of the services the surgical assistants provide.
6. Volunteers receive training in the specific responsibilities of the services the volunteers provide, including counseling and patient advocacy as provided in the rules adopted by the director for different types of volunteers based on their responsibilities.

D. The director shall adopt rules relating to the medical screening and evaluation of each abortion clinic patient. At a minimum these rules shall require:

1. A medical history, including the following:
 - (a) Reported allergies to medications, antiseptic solutions or latex.
 - (b) Obstetric and gynecologic history.
 - (c) Past surgeries.
2. A physical examination, including a bimanual examination estimating uterine size and palpation of the adnexa.
3. The appropriate laboratory tests, including:
 - (a) Urine or blood tests for pregnancy performed before the abortion procedure.
 - (b) A test for anemia.
 - (c) Rh typing, unless reliable written documentation of blood type is available.
 - (d) Other tests as indicated from the physical examination.
4. An ultrasound evaluation for all patients. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that the person completed a course in the operation of ultrasound equipment as prescribed in rule. The physician or other health care professional shall review, at the request of the patient, the ultrasound evaluation results with the patient before the abortion procedure is performed, including the probable gestational age of the fetus.
5. That the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care

regarding the estimation of fetal age as defined in rule and shall write the estimate in the patient's medical history. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file.

E. The director shall adopt rules relating to the abortion procedure. At a minimum these rules shall require:

1. That medical personnel is available to all patients throughout the abortion procedure.
2. Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule.
3. Appropriate use of local anesthesia, analgesia and sedation if ordered by the physician.
4. The use of appropriate precautions, such as the establishment of intravenous access at least for patients undergoing second or third trimester abortions.
5. The use of appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.
6. For abortion clinics performing or inducing an abortion for a woman whose unborn child is the gestational age of twenty weeks or more, minimum equipment standards to assist the physician in complying with section 36-2301. For the purposes of this paragraph, "abortion" and "gestational age" have the same meanings prescribed in section 36-2151.

F. The director shall adopt rules that prescribe minimum recovery room standards. At a minimum these rules shall require that:

1. For a surgical abortion, immediate postprocedure care, or care provided after inducing a medication abortion, consists of observation in a supervised recovery room for as long as the patient's condition warrants.
2. The clinic arrange hospitalization if any complication beyond the management capability of the staff occurs or is suspected.
3. A licensed health professional who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remains on the premises of the abortion clinic until all patients are discharged.
4. For a surgical abortion, a physician with admitting privileges at a health care institution that is classified by the director as a hospital pursuant to section 36-405, subsection B and that is within thirty miles of the abortion clinic remains on the premises of the abortion clinic until all patients are stable and are ready to leave the recovery room and to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary. A physician shall sign the discharge order and be readily accessible and available until the last patient is discharged.
5. A physician discusses RhO(d) immune globulin with each patient for whom it is indicated and assures it is offered to the patient in the immediate postoperative period or that it will be available to her within seventy-two hours after completion of the abortion procedure. If the patient refuses, a refusal form approved by the department shall be signed by the patient and a witness and included in the medical record.
6. Written instructions with regard to postabortion coitus, signs of possible problems and general aftercare are given to each patient. Each patient shall have specific instructions regarding

access to medical care for complications, including a telephone number to call for medical emergencies.

7. There is a specified minimum length of time that a patient remains in the recovery room by type of abortion procedure and duration of gestation.

8. The physician assures that a licensed health professional from the abortion clinic makes a good faith effort to contact the patient by telephone, with the patient's consent, within twenty-four hours after a surgical abortion to assess the patient's recovery.

9. Equipment and services are located in the recovery room to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the hospital.

G. The director shall adopt rules that prescribe standards for follow-up visits. At a minimum these rules shall require that:

1. For a surgical abortion, a postabortion medical visit is offered and, if requested, scheduled for three weeks after the abortion, including a medical examination and a review of the results of all laboratory tests. For a medication abortion, the rules shall require that a postabortion medical visit is scheduled between one week and three weeks after the initial dose for a medication abortion to confirm the pregnancy is completely terminated and to assess the degree of bleeding.

2. A urine pregnancy test is obtained at the time of the follow-up visit to rule out continuing pregnancy. If a continuing pregnancy is suspected, the patient shall be evaluated and a physician who performs abortions shall be consulted.

H. The director shall adopt rules to prescribe minimum abortion clinic incident reporting. At a minimum these rules shall require that:

1. The abortion clinic records each incident resulting in a patient's or viable fetus' serious injury occurring at an abortion clinic and shall report them in writing to the department within ten days after the incident. For the purposes of this paragraph, "serious injury" means an injury that occurs at an abortion clinic and that creates a serious risk of substantial impairment of a major body organ and includes any injury or condition that requires ambulance transportation of the patient.

2. If a patient's death occurs, other than a fetal death properly reported pursuant to law, the abortion clinic reports it to the department not later than the next department work day.

3. Incident reports are filed with the department and appropriate professional regulatory boards.

I. The director shall adopt rules relating to enforcement of this article. At a minimum, these rules shall require that:

1. For an abortion clinic that is not in substantial compliance with this article and the rules adopted pursuant to this article and section 36-2301 or that is in substantial compliance but refuses to carry out a plan of correction acceptable to the department of any deficiencies that are listed on the department's statement of deficiency, the department may do any of the following:

(a) Assess a civil penalty pursuant to section 36-431.01.

(b) Impose an intermediate sanction pursuant to section 36-427.

(c) Suspend or revoke a license pursuant to section 36-427.

(d) Deny a license.

(e) Bring an action for an injunction pursuant to section 36-430.

2. In determining the appropriate enforcement action, the department consider the threat to the health, safety and welfare of the abortion clinic's patients or the general public, including:

(a) Whether the abortion clinic has repeated violations of statutes or rules.

(b) Whether the abortion clinic has engaged in a pattern of noncompliance.

(c) The type, severity and number of violations.

J. The department shall not release personally identifiable patient or physician information.

K. The rules adopted by the director pursuant to this section do not limit the ability of a physician or other health professional to advise a patient on any health issue.

DEPARTMENT OF HEALTH SERVICES (R-18-1003)

Title 9, Chapter 10, Article 1, General; Article 10, Outpatient Treatment Centers; Article 20, Pain Management Clinics

Amend: R9-10-101; R9-10-102; R9-10-106; R9-10-120; R9-10-1001; R9-10-1021

New Section: R9-10-2001; R9-10-2002; R9-10-2003; R9-10-2004; R9-10-2005; R9-10-2006; R9-10-2007; R9-10-2008; R9-10-2009; R9-10-2010

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: October 2, 2018

AGENDA ITEM: D-4

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: DEPARTMENT OF HEALTH SERVICES (R-18-1003)

Title 9, Chapter 10, Article 1, General; Article 10, Outpatient Treatment Centers; Article 20, Pain Management Clinics

Amend: R9-10-101; R9-10-102; R9-10-106; R9-10-120; R9-10-1001; R9-10-1021

New Section: R9-10-2001; R9-10-2002; R9-10-2003; R9-10-2004; R9-10-2005; R9-10-2006; R9-10-2007; R9-10-2008; R9-10-2009; R9-10-2010

This rulemaking, from the Department of Health Services (Department), seeks to amend six rules and create ten new rules in A.A.C. Title 9, Chapter 10, Articles 1, 10, and 20, related to outpatient treatment centers and pain management clinics.

The Department indicates that statutory changes made by Laws 2018, Ch. 1 require the Department to license a pain management clinic as a health care institution and create rules for a pain management clinic that include informed consent requirements, the responsibilities of the medical director, reporting requirements, and physical examination requirements. The Department states that the 10 new rules in Article 20 prescribe minimum standards for pain management clinics to ensure that opioids are prescribed and administered safely and ensure the health and safety of patients with regard to all aspects of a health care institution, including physical plant, equipment, sanitation, staffing, and recordkeeping.

Proposed Action

- **Section 101 - Definitions:** Definitions are modified in accordance with changes to other rules.
- **Section 102 - Health Care Institution Classes and Subclasses; Requirements:** “Pain management clinic” is added to the list of health care institution classes and subclasses.
- **Section 106 - Fees:** Pain management clinics are added to the list of facilities that shall be charged fees by the Department.

- Section 120 - **Opioid Prescribing and Treatment:** The rule is updated to account for the addition of Article 20.
- Section 1001 - **Definitions:** Definitions are modified in accordance with changes to other rules in Article 10.
- Section 1021 - **Pain Management Services:** The rule is updated to account for the addition of Article 20.
- Article 20 - **Pain Management Clinics:** This new article is added with rules related to definitions; application and documentation submission requirements; administration; quality management; medication services; pain management services; patient rights; medical records; equipment and safety standards; and environmental and physical plant standards.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

Yes. The Department cites to both general and specific authority for the rules. Of particular significance is A.R.S. § 36-136(G), under which the Department “may make and amend rules necessary for the proposer administration and enforcement of the laws relating to the public health.”

2. Do the rules establish a new fee or contain a fee increase?

Yes. A pain management clinics will be charged the same fee as a hospital, a home health agency, a hospice service agency, a hospice inpatient facility, an abortion clinic, a recovery care center, an outpatient surgical center, an outpatient treatment center that is not a behavioral health facility, and an unclassified health care institution:

- For a facility with no licensed capacity, \$365;
- For a facility with a licensed capacity of one to 59 beds, \$365, plus the licensed capacity times \$91;
- For a facility with a licensed capacity of 60 to 99 beds, \$730, plus the licensed capacity times \$91;
- For a facility with a licensed capacity of 100 to 149 beds, \$1,095, plus the licensed capacity times \$91; or
- For a facility with a licensed capacity of 150 beds or more, \$1,825, plus the licensed capacity times \$91;

3. Summary of the agency's economic impact analysis:

In this rulemaking, the Department is promulgating rules that will require pain management clinics to be licensed by the Department. The Department does not have data on the number of pain management clinics that will be required to seek this license, but the Department estimated that there are no more than a few hundred clinics that will be subject to licensure. Most of the economic impact from this rulemaking is created by statutes, not rules.

4. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

The Department concludes that this rulemaking is required by state statute. No alternatives are available. Even so, the minimal costs associated with licensure to pain management clinics is vastly outweighed by the benefits to patients seeking pain management services.

5. What are the economic impacts on stakeholders?

Key stakeholders are the Department, pain management clinics, and patients seeking pain management services.

The Department will bear some costs for this rulemaking because the new license will create an additional workload for the Department. This new license for pain management clinics will also modestly increase the Department's revenue through new licensing application fees. The Department anticipates that these impacts will be minimal.

Pain management clinics will now be subject to new licensing as pain management clinics. The Department anticipates that the new licensing and rules will impose some modest costs on newly licensed pain management clinics. Completing the license applications, application fees of \$365, and new administrative requirements are the major burdens placed on pain management clinics. The Department estimates that many pain management clinics already follow the new policies and procedures codified in the rulemaking. The requirements to license pain management clinics originates from statutes, not rules.

Patients seeking pain management services will greatly benefit from this rulemaking. The Department notes that these rules will prevent opioid addiction for patients. The costs of opioid addiction are significant, and avoiding opioid addiction contributes to better patient outcomes.

6. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?

Yes. The Department indicates that it received two written comments on the rulemaking, as well as one comment at an August 13, 2018 oral proceeding. The text of the comments, along with the Department's responses, can be found on pages 4-8 of the Notice of Final Rulemaking. Council staff believes that the Department has adequately addressed the comments on the proposed rules.

7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?

No. Only non-substantive technical changes were made between the Notice of Proposed Rulemaking and the Notice of Final Rulemaking.

8. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

No. Federal law is not directly applicable to the subject matter of the rules.

9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

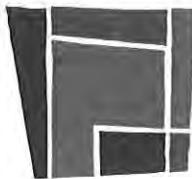
Yes. A.R.S. § 36-407 prohibits a person from establishing, conducting, or maintaining “a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the [D]epartment specifying the class or subclass of health care institution the person is establishing, conducting or maintaining.” The Department states that a health care institution license is specific to the licensee, class or subclass of health care institution, facility location, and scope of services provided. As such, a general permit is not applicable and is not used.

10. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?

No. The Department did not review or rely on any study for this rulemaking.

11. Conclusion

The Department is requesting a January 1, 2019 effective date for the rulemaking, as the delayed effective date will allow the Department adequate time to provide training and technical assistance to individuals who are required to meet pain management clinic licensure requirements beginning January 1, 2019. Council staff recommends approval of the rulemaking.



ARIZONA DEPARTMENT OF HEALTH SERVICES

POLICY & INTERGOVERNMENTAL AFFAIRS

August 21, 2018

Nicole O. Colyer, Esq., Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: 9 A.A.C. 10, Article 20, Department of Health Service, Health Care Institutions: Licensing, Pain Management Clinics

Enclosed is the administrative rule identified above which I am submitting, as the Designee of the Director of the Department of Health Services, for approval by the Governor's Regulatory Review Council (Council) under 41-1052.

The following information is provided for your use in reviewing the enclosed rule package pursuant to A.R.S. § 41-1052 and A.A.C. R1-6-202:

1. The close of record:

The close of record was August 13, 2018. Submission of the rule is within the 120 days allowed for final rulemaking.

2. Procedures followed:

As required by the Administrative Procedure Act, a Notice of Rulemaking Docket Opening was filed with the Office of the Secretary of State and published in the *Arizona Administrative Register* on March 9, 2018. A Notice of Proposed Rulemaking was filed with the Office of the Secretary of State and published in the *Arizona Administrative Register* on July 13, 2018. The Department held an oral proceeding on August 13, 2018. The Department received three written comments or oral comments.

3. Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:

The rulemaking does not relate to a five-year-review report.

4. Whether the rule contains a new fee and, if it does, citation of the statute expressly authorizing the new fee:

The rulemaking adds pain management clinics as a new class of health care institutions and as such, applicants applying for licensure are required to pay an application fee. The application fee is required for all class and subclass of health care institution.

5. Whether the rule contains a fee increase:

The rulemaking does not contain a fee increase.

6. Whether an immediate effective date is requested for the rule under A.R.S. § 41-1032:

The Department requests a January 1, 2019 effective date for the new rules under A.R.S. § 41-1032 (B). A January 1, 2019 effective date will allow the Department time to provide training and technical assistance to individuals who are required to meet pain management clinic licensure requirements in Laws 2018, Ch. 1 beginning January 1, 2019.

7. A list of all items enclosed:

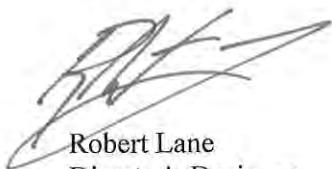
- a. Notice of Final Rulemaking, including the Preamble, Table of Contents, and text of the rule;
- b. 2018 Economic, Small Business, and Consumer Impact Statement,
- c. A copy of the general and specific statutes authorizing the rule, and
- d. A copy of the written comments or oral comments.

The Department is requesting that the rules be heard at the Council meeting on October 2, 2018.

I certify that the Preamble of this rulemaking discloses a reference to any study relevant to the rule that the Department reviewed and either did or did not rely on in its evaluation of or justification for the rule.

I certify that the Department, as the preparer of the economic, small business, and consumer impact statement, has notified the Joint Legislative Budget Committee that no new full-time employees are necessary to implement and enforce the rules.

Sincerely,



Robert Lane
Director's Designee

RL:tk

Enclosure

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 10. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: LICENSING

PREAMBLE

- | <u>1. Article, Part, or Section Affected (as applicable)</u> | <u>Rulemaking Action</u> |
|---|---------------------------------|
| R9-10-101 | Amend |
| R9-10-102 | Amend |
| R9-10-106 | Amend |
| R9-10-120 | Amend |
| R9-10-1001 | Amend |
| R9-10-1021 | Amend |
| R9-10-2001 | New Section |
| R9-10-2002 | New Section |
| R9-10-2003 | New Section |
| R9-10-2004 | New Section |
| R9-10-2005 | New Section |
| R9-10-2006 | New Section |
| R9-10-2007 | New Section |
| R9-10-2008 | New Section |
| R9-10-2009 | New Section |
| R9-10-2010 | New Section |
- 2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**
- Authorizing statute: A.R.S. §§ 36-132(A)(1), A.R.S. 36-136(G)
Implementing statutes: A.R.S. §§ 36-132(A)(17), 36-405, 36-406, 36-448.02, Laws 2018, Ch. 1, and Laws 2018, Ch. 243
- 3. The effective date of the rules:**
The Department requests a January 1, 2019 effective date for the new rules under A.R.S. § 41-1032 (B). A January 1, 2019 effective date will allow the Department time to provide training and technical assistance to individuals who are required to meet pain management clinic licensure requirements in Laws 2018, Ch. 1 beginning January 1,

2019. A January 1, 2019 effective date will provide a benefit to both the regulated persons and the public.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 24 A.A.R. 513, March 9, 2018

Notice of Proposed Rulemaking: 24 A.A.R. 1901, July 13, 2018

5. The agency's contact person who can answer questions about the rulemaking:

Name: Colby Bower, Assistant Director

Address: Department of Health Services

Public Health Licensing Services

150 N. 18th Ave., Suite 510

Phoenix, AZ 85007

Telephone: (602) 542-6383

Fax: (602) 364-4808

E-mail: Colby.Bower@azdhs.gov

or

Name: Robert Lane, Chief

Address: Arizona Department of Health Services

Office of Administrative Counsel and Rules

150 N. 18th Avenue, Suite 200

Phoenix, AZ 85007

Telephone: (602) 542-1020

Fax: (602) 364-1150

E-mail: Robert.Lane@azdhs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

In order to ensure public health, safety, and welfare, Arizona Revised Statutes (A.R.S.) §§ 36-405 and 36-406 require the Arizona Department of Health Services (Department) to adopt rules establishing minimum standards and requirements for construction, modification, and licensure of health care institutions. Laws 2018, Ch. 1 requires the Department to license a pain management clinic as a health care institution and create rules for a pain management clinic that include informed consent requirements, the responsibilities of the medical director, reporting requirements, and physical examination

requirements. To implement Laws 2018, Ch. 1, the Department plans to adopt the new rules in 9 A.A.C. 10, Article 20 and amend 9 A.A.C. 10, Articles 1 and 10. The 10 rules in Article 20 prescribe minimum standards for pain management clinics to ensure that opioids are prescribed and administered safely and ensure the health and safety of patients with regard to all aspects of a health care institution, including physical plant, equipment, sanitation, staffing, and recordkeeping. The Department received an exception from the rulemaking moratorium required by Executive Order 2018-2. The Department has made new rules for pain management clinics in 9 A.A.C. 10, Article 20 and amended 9 A.A.C. 10, Article 1 and Article 10 as they relate to pain management clinics.

- 7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

The Department did not review or rely on any study for this rulemaking.

- 8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

- 9. A summary of the economic, small business, and consumer impact:**

Annual costs/revenue changes are designated as minimal when less than \$10,000, moderate from \$10,000 to \$50,000, and substantial when greater than \$50,000. Costs/benefits that are real and meaningful, but cannot be quantified are designated as significant. Costs that result from a statute, rather than the rules are not included as a cost of the rulemaking. The Department anticipates that persons affected by the rulemaking include the Department, pain management clinics, physicians, and patients seeking pain management. Because pain management clinics have not previously been a class of licensed healthcare institution, licensing them may add to the workload of Department staff. Department staff will implement and oversee the licensing process, take enforcement action, and provide training and technical assistance on the new rules. While these provisions may impose some costs on the Department, the rules are required by statute and therefore not included in this analysis.

Pain management clinics may include outpatient treatment centers and the private

offices of physicians and registered nurse practitioners that meet the definition of pain management clinic. Since the current rules have not been implemented, the Department does not have information about the number of facilities that would meet the definition of pain management clinic. However, the Department anticipates that only a fraction of the facilities currently licensed as health care institutions will be required to be licensed as pain management clinics. The requirements in the rules are minimal standards to protect the health and safety of patients, meet statutory requirements, and mostly specify practices that pain management clinics are already engaging in. Medical practitioners and pain management clinic personnel members are likely to incur no costs or only minimal additional costs as a result of the rules and patients are expected to receive a significant benefit from the rules since the rules will likely lead to increased patient health and safety.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

Two changes were made to the proposed rules based on comments received during the 30-day public comment period of the Notice of Proposed Rulemaking. In A.A.C. R9-10-1001, a definition for “pain management services” was added to clarify for outpatient treatment centers that pain management services do not include the treatment of patient suffering with “acute pain,” and rather, pain management services are intended for patients receiving treatment for “chronic pain.” Additionally, in A.A.C. R9-10-1021(5), the requirement was revised to better clarify that an outpatient treatment center is required to comply with 9 A.A.C. 10 Article 20 if the outpatient treatment center meet the definition of a pain management clinic in A.R.S. § 36-448.01 and the outpatient treatment center is not required to be dual licensed as a pain management clinic. The Department does not believe these are substantive changes.

11. An agency’s summary of the public stakeholder comments made about the rulemaking and the agency response to the comments:

The Department received oral comments from one member of the public during the August 13, 2018 oral proceeding held for the proposed rules and also received two written comments during the 30-day comment period of the 9 A.A.C. 10, Article 20 Notice of Proposed Rulemaking. A summary of the comments and the Department’s responses are shown below:

Comment	Department’s Response
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<u>Oral comments from the public during the oral proceeding (transcribed from recording):</u>	
Asked if pain management clinics (PMC) are going to be a subclass of outpatient treatment centers (OTC), if the institution has to be licensed as a PMC is already licensed as an OTC, would they then be a subclass of an OTC, and would they be operating under both their OTC license and the PMC?	The Department explained that pain management clinics, their own class. OTCs that provide pain management services will continue to exist. Reference to R9-10-1021 was provided.
Asked what happens for those OTCs that are authorized to perform pain management services if they run a metric and let's say they are now at a place where 51% or more of their patients are being prescribed these medications for greater than a 90 day period and required by legislation to now within 60 days license with DHS as a PMC. Will they both still have their OTC license and now this new PMC license because they have exceeded this threshold or is there only one license?	The Department explained that health care institutions can only be licensed for one class or subclass; and once that metric is exceeded, they then would meet the definition of a PMC and would need to be licensed as a PMC or licensed to the highest level that they are providing. The Department also clarified that an OTC providing more than just pain management services and the pain management services metric has now trumped the requirement to be separately licensed, by definition. Department clarified that R9-10-1021 talks about pain management services and what needs to be in existence. Subsection (5) provides that an OTC that is a pain management clinic, as defined in A.R.S. § 36-448.01, will also have to comply with the rules in Article 20.
Asked, if under R9-10-1021(5), does that mean they do not need to do a separate licensure as a PMC or they still have to do a separate licensure as well?	The Department replied that they (OTCs) will not have to do a separate licensure. It will be an OTC that is also a PMC and will need to meet Article 20 rules in addition to all the rules in Article 10.
Asked what happens when there is a rule in Article 10, like plant safety standards and equipment standards that are not exactly like the new Article 20 rules or do they comply with both or do they comply with Article 20? Commenter cited Section R9-10-2010, physical plant standards, stating that if compared to OTC physical plant standards, there are differences. That is also true for R9-10-2009, equipment and safety standards; R9-10-2007, patient rights; and R9-10-2005, medication services.	The Department will require the pain management services to meet the highest regulations.
Asked will there be a definition added for pain management services? So OTCs know when they need to get the additional authorization and/or the licensure; so they can determine if they are a PMC.	The Department explained that in Article 1 a definition of "pain management clinic" was added. Pain management services are the ability to provide pain management (R9-10-1021) as long as you do not exceed the metric. But the concept of pain management services should be the same as the delivery model as you would find if you were required by the metrics to become a pain management clinic.
Asked when you say required by the metrics, are you referring to the opioid epidemic act?	The Department agreed; yes, the Department is referring to the opioid epidemic act.

Asked does that mean you only provide pain management services when you prescribing any of those drugs?	The Department clarified that “those drugs” and less than the metric that requires you to be licensed.
Asked would pain management services include treatments for acute pain or are we only talking about chronic pain?	The Department confirmed typically, chronic pain; and explained that an OTC needs to then consider that relationship to Article 1. Article 1 has added Section R9-10-120, which covers the prescribing and ordering of opioids in any of the licensed health care institutions. So an organization has to look at Article 1 as it relates to R9-10-120 because they are a heath care institution whether you are an OTC, PMC, or hospital. Line them up in order to self-direct based on your business practice – how you are going to operate.
Asked whether an OTC who is also a pain management center will be required to have separate sets of policies and procedures for both Article 10, OTCs and Article 20, PMCs and noted that there are difference when they are prescribing, administering, or ordering for purposes other than pain management services?	The Department communicated that separate policies and procedures are not required. However, existing policies and procedures are required to address the different circumstances that may arise in that clinic. It is at the discretion of the facility to develop their policies and procedures to cover all required categories.
Asked can those services in an OTC also be done under the direction of a naturopathic physician? If so, should there be some clarification to make it clear?	The Department clarified that OTC and naturopathic physician are not in the scope of this rulemaking and the Department did not receive an exception from the Governor to amend Article 10 rules other than as related to Laws 2018, Ch. 1 and Laws 2018, Ch. 243.
<u>First written comment received from the public during the 30-day public comment period:</u>	
Asked the Department to clarify whether an outpatient treatment center (OTC) is limited to only providing pain management services (PMC) if required by law to license as a pain management clinic or/and can continue providing services under its existing OTC license. Asked the Department to clarify if a PMC is a class or subclass of health care institution.	The rules in 9 A.A.C. 10 provide that OTC may provide pain management services, as well as other services, on an outpatient basis as they have before the addition of PMCs as a class of licensed health care institution. An OTC that meets the statutory definition of a PMCs will not be required to be dually licensed, just as an OTC that meets the statutory definition of an abortion clinic is not required to be dually licensed. However, an OTC that meets the definition of a PMC will need to comply with the requirements in Article 20, as stated in subsection (5). To clarify this distinction, the Department plans to revise subsection (5) to read: “An outpatient treatment center that meets the definition of a pain management clinic in A.R.S. § 36-448.01 complies with Article 20 of this Chapter.”

<p>Requests that the Department adopt definition of “pain management services” that is consistent with Arizona’s Legislature intent.</p>	<p>The Department does not intend for pain management services to include the treatment of acute pain or recommending that a patient take an aspirin. However, the Department does intend for pain management services to include the treatment of chronic pain by whatever means is used, including opioid pain relievers, nerve blocks, steroid injections, nerve burns, etc. To reduce confusion, the Department plans to add to R9-10-1001 a definition for pain management services as follows: “Pain management services” means medical services, nursing services, or health-related services provided to a patient to reduce or relieve the patient’s chronic pain.</p>
<p>Expressed that the rules is unclear whether an OTC authorized to provide “pain management services” that is not a PMC can also do so under the direction of a naturopathic physician. Requests the Department define “physician” for the purposes of R9-10-1021 as “an individual licensed as a physician according to A.R.S. Title 32, Chapter 13, 14, or 17.”</p>	<p>Because the statutes for PMCs authorize pain management services to be provided under the direction of a naturopathic physician, the rules in Article 20 conform with this provision in statute. However, OTCs may serve patients who have other medical conditions, as well as chronic pain. The current requirements in R9-10-1021 require that pain management services be provided under the direction of a physician, which is defined in A.R.S. § 36-401 as an individual “licensed pursuant to title 32, chapter 13 or 17.” Therefore, the Department did not broaden the definition to include naturopathic physicians. However, the Department did add in subsection (1)(b) that pain management services could be provided under the direction of a nurse practitioner licensed according to A.R.S. Title 32, Chapter 15, with advanced pain management certification from a nationally recognized accreditation or certification entity. This wording is consistent with that in R9-10-2003(B)(2)(a)(ii). The Department does not plan to make a change based on this comment.</p>
<p>Request clarification what opioid treatment regulations apply to OTCs that are authorized to provide “pain management services” but are not PMCs. The commenter believes it is unclear whether OTCs must also comply with R9-10-120 when using opioid for purposes other than pain management services such as the provisions of medication-assisted treatment for substance use disorder and request that the Department require OTC to comply with the requirements in R9-10-120 only.</p>	<p>The provision of “medication-assisted treatment for substance use disorders” may come under the umbrella of “opioid treatment” as defined in R9-10-101. The requirements for an OTC authorized to provide opioid treatment services are in R9-10-1020. The requirements in R9-10-120 apply to these services. If having two sets of requirements is confusing, the Department suggests that the OTC adopt the more stringent, as is done whenever two sets of requirements (such as Medicare and licensing requirements) that are not consistent apply to the facility. The Department does not plan to make a change based on this comment.</p>
<p><u>Second written comment received from the public during the 30-day public comment period:</u></p>	

<p>“AzPPO believes that the State should ensure that ALL health care institutions including pain management clinics in Arizona are protected with professional pest control services from dangerous and deadly pests. Therefore, we propose that these facilities should contract with a professional pest control company licensed and registered with the State.”</p>	<p>In the 9 A.A.C. 10, Article 1 Five-year-review Report (Report) approved by the Governor’s Regulator Review Council (GRRC) in March 2018, the Department identified that “other rules in the Chapter would be improved if requirements in Articles using the defined term [pest control program] were clarified to ensure compliance with requirements in A.A.C. R3-8-201(C) (4).” The Department submitted a request to the Governor for approval to revise the applicable rules in 9 A.A.C. 10 through an expedited rulemaking to clarify and require that implemented pest control program for all licensed health care institutions comply with requirements in A.A.C. R9-8-201(C). The Department believes that the expedited rulemaking will ensure that 9 A.A.C. 10 rules protect the health and safety of Arizonans and are consistent with other Arizona statutes and rules.</p>
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12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

- a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**
A.R.S. § 36-407 prohibits a person from establishing, conducting, or maintaining “a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the [D]epartment specifying the class or subclass of health care institution the person is establishing, conducting or maintaining.” A health care institution license is specific to the licensee, class or subclass of health care institution, facility location, and scope of services provided. As such, a general permit is not applicable and is not used.
- b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**
Not applicable
- c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

No business competitiveness analysis was received by the Department.

- 13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

Not applicable

- 14. Whether the rule was previously made, amended or repealed as an emergency rule.**

If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

- 15. The full text of the rules follows:**

TITLE 9. HEALTH SERVICES
CHAPTER 10. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: LICENSING

ARTICLE 1. GENERAL

Section

- R9-10-101. Definitions
- R9-10-102. Health Care Institution Classes and Subclasses; Requirements
- R9-10-106. Fees
- R9-10-120. Opioid Prescribing and Treatment

ARTICLE 10. OUTPATIENT TREATMENT CENTERS

Section

- R9-10-1001. Definitions
- R9-10-1021. Pain Management Services

ARTICLE 20. PAIN MANAGEMENT CLINICS

Section

- R9-10-2001. Definitions
- R9-10-2002. Application and Documentation Submission Requirements
- R9-10-2003. Administration
- R9-10-2004. Quality Management
- R9-10-2005. Medication Services
- R9-10-2006. Pain Management Services
- R9-10-2007. Patient Rights
- R9-10-2008. Medical Records
- R9-10-2009. Equipment and Safety Standards
- R9-10-2010. Environmental and Physical Plant Standards

ARTICLE 1. GENERAL

R9-10-101. Definitions

In addition to the definitions in A.R.S. § 36-401(A), the following definitions apply in this Chapter unless otherwise specified:

1. “Abortion clinic” has the same meaning as in A.R.S. § 36-449.01.
2. “Abuse” means:
 - a. The same:
 - i. For an individual 18 years of age or older, as in A.R.S. § 46-451; and
 - ii. For an individual less than 18 years of age, as in A.R.S. § 8-201;
 - b. A pattern of ridiculing or demeaning a patient;
 - c. Making derogatory remarks or verbally harassing a patient; or
 - d. Threatening to inflict physical harm on a patient.
3. “Accredited” has the same meaning as in A.R.S. § 36-422.
4. “Active malignancy” means a cancer for which:
 - a. A patient is undergoing treatment, such as through:
 - i. One or more surgical procedures to remove the cancer;
 - ii. Chemotherapy, as defined in A.A.C. R9-4-401; or
 - iii. Radiation treatment, as defined in A.A.C. R9-4-401;
 - b. There is no treatment; or
 - c. A patient is refusing treatment.
- 4.5. “Activities of daily living” means ambulating, bathing, toileting, grooming, eating, and getting in or out of a bed or a chair.
- 5.6. “Adjacent” means not intersected by:
 - a. Property owned, operated, or controlled by a person other than the applicant or licensee; or
 - b. A public thoroughfare.
- 6.7. “Administrative completeness review time-frame” has the same meaning as in A.R.S. § 41-1072.
- 7.8. “Administrative office” means a location used by personnel for recordkeeping and record retention but not for providing medical services, nursing services, or health related services.
- 8.9. “Admission” means, after completion of an individual’s screening or registration by a

- health care institution, the individual begins receiving physical health services or behavioral health services and is accepted as a patient of the health care institution.
- 9.10. “Adult” has the same meaning as in A.R.S. § 1-215.
- 10.11. “Adult behavioral health therapeutic home” means a residence that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to a case manager related to behavior for an individual 18 years of age or older based on the individual’s behavioral health issue and need for behavioral health services and may provide behavioral health services under the clinical oversight of a behavioral health professional.
- 11.12. “Adverse reaction” means an unexpected outcome that threatens the health or safety of a patient as a result of a medical service, nursing service, or health-related service provided to the patient.
- 12.13. “Ancillary services” means services other than medical services, nursing services, or health-related services provided to a patient.
- 13.14. “Anesthesiologist” means a physician granted clinical privileges to administer anesthesia.
- 14.15. “Applicant” means a governing authority requesting:
- a. Approval of a health care institution’s architectural plans and specifications, or
 - b. A health care institution license.
- 15.16. “Application packet” means the information, documents, and fees required by the Department for the:
- a. Approval of a health care institution’s modification or construction, or
 - b. Licensing of a health care institution.
- 16.17. “Assessment” means an analysis of a patient’s need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.
- 17.18. “Assistance in the self-administration of medication” means restricting a patient’s access to the patient’s medication and providing support to the patient while the patient takes the medication to ensure that the medication is taken as ordered.
- 18.19. “Attending physician” means a physician designated by a patient to participate in or coordinate the medical services provided to the patient.
- 19.20. “Authenticate” means to establish authorship of a document or an entry in a medical record by:

- a. A written signature;
 - b. An individual's initials, if the individual's written signature appears on the document or in the medical record;
 - c. A rubber-stamp signature; or
 - d. An electronic signature code.
- 20.21. “Authorized service” means specific medical services, nursing services, or health-related services provided by a specific health care institution class or subclass for which the health care institution is required to obtain approval from the Department before providing the medical services, nursing services, or health-related services.
- 21.22. “Available” means:
- a. For an individual, the ability to be contacted and to provide an immediate response by any means possible;
 - b. For equipment and supplies, physically retrievable at a health care institution; and
 - c. For a document, retrievable by a health care institution or accessible according to the applicable timeframes in this Chapter.
- 22.23. “Behavioral care”:
- a. Means limited behavioral health services, provided to a patient whose primary admitting diagnosis is related to the patient's need for physical health services, that include:
 - i. Assistance with the patient's psychosocial interactions to manage the patient's behavior that can be performed by an individual without a professional license or certificate including:
 - (1) Direction provided by a behavioral health professional, and
 - (2) Medication ordered by a medical practitioner or behavioral health professional; or
 - ii. Behavioral health services provided by a behavioral health professional on an intermittent basis to address the patient's significant psychological or behavioral response to an identifiable stressor or stressors; and
 - b. Does not include court-ordered behavioral health services.
- 23.24. “Behavioral health facility” means a behavioral health inpatient facility, a behavioral health residential facility, a substance abuse transitional facility, a behavioral health specialized transitional facility, an outpatient treatment center that only provides

behavioral health services, an adult behavioral health therapeutic home, a behavioral health respite home, or a counseling facility.

- 24.25. “Behavioral health inpatient facility” means a health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
- a. Have a limited or reduced ability to meet the individual's basic physical needs;
 - b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
 - c. Be a danger to self;
 - d. Be a danger to others;
 - e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
 - f. Be gravely disabled.
- 25.26. “Behavioral health issue” means an individual's condition related to a mental disorder, a personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.
- 26.27. “Behavioral health observation/stabilization services” means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:
- a. Requires nursing services,
 - b. May require medical services, and
 - c. May be a danger to others or a danger to self.
- 27.28. “Behavioral health paraprofessional” means an individual who is not a behavioral health professional who provides, under supervision by a behavioral health professional, the following services to a patient to address the patient's behavioral health issue:
- a. Services that, if provided in a setting other than a health care institution would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or
 - b. Health-related services.
- 28.29. “Behavioral health professional” means:
- a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
 - i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or

- ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101;
 - b. A psychiatrist as defined in A.R.S. § 36-501;
 - c. A psychologist as defined in A.R.S. § 32-2061;
 - d. A physician;
 - e. A behavior analyst as defined in A.R.S. § 32-2091;
 - f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
 - g. A registered nurse.
- 29.30. “Behavioral health residential facility” means a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
- a. Limits the individual’s ability to be independent, or
 - b. Causes the individual to require treatment to maintain or enhance independence.
- 30.31. “Behavioral health respite home” means a residence where respite care services, which may include assistance in the self-administration of medication, are provided to an individual based on the individual’s behavioral health issue and need for behavioral health services.
- 31.32. “Behavioral health specialized transitional facility” means a health care institution that provides inpatient behavioral health services and physical health services to an individual determined to be a sexually violent person according to A.R.S. Title 36, Chapter 37.
- 32.33. “Behavioral health staff” means a:
- a. Behavioral health paraprofessional,
 - b. Behavioral health technician, or
 - c. Personnel member in a nursing care institution or assisted living facility who provides behavioral care.
- 33.34. “Behavioral health technician” means an individual who is not a behavioral health professional who provides, with clinical oversight by a behavioral health professional, the following services to a patient to address the patient’s behavioral health issue:
- a. Services that, if provided in a setting other than a health care institution would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or
 - b. Health-related services.

35. “Benzodiazepine” means any one of a class of sedative-hypnotic medications, characterized by a chemical structure that includes a benzene ring linked to a seven-membered ring containing two nitrogen atoms, that are commonly used in the treatment of anxiety.
- 34.36. “Biohazardous medical waste” has the same meaning as in A.A.C. R18-13-1401.
- 35.37. “Calendar day” means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
- 36.38. “Case manager” means an individual assigned by an entity other than a health care institution to coordinate the physical health services or behavioral health services provided to a patient at the health care institution.
- 37.39. “Certification” means, in this Article, a written statement that an item or a system complies with the applicable requirements incorporated by reference in A.A.C. R9-1-412.
- 38.40. “Certified health physicist” means an individual recognized by the American Board of Health Physics as complying with the health physics criteria and examination requirements established by the American Board of Health Physics.
- 39.41. “Change in ownership” means conveyance of the ability to appoint, elect, or otherwise designate a health care institution's governing authority from an owner of the health care institution to another person.
- 40.42. “Chief administrative officer” or “administrator” means an individual designated by a governing authority to implement the governing authority's direction in a health care institution.
- 41.43. “Clinical laboratory services” means the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or impairment of a human being, or for the assessment of the health of a human being, including procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.
- 42.44. “Clinical oversight” means:
- Monitoring the behavioral health services provided by a behavioral health

- technician to ensure that the behavioral health technician is providing the behavioral health services according to the health care institution's policies and procedures,
- b. Providing on-going review of a behavioral health technician's skills and knowledge related to the provision of behavioral health services,
 - c. Providing guidance to improve a behavioral health technician's skills and knowledge related to the provision of behavioral health services, and
 - d. Recommending training for a behavior health technician to improve the behavioral health technician's skills and knowledge related to the provision of behavioral health services.
- 43.45.** “Clinical privileges” means authorization to a medical staff member to provide medical services granted by a governing authority or according to medical staff bylaws.
- 44.46.** “Collaborating health care institution” means a health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to:
- a. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home, and
 - b. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident’s treatment plan.
- 45.47.** “Communicable disease” has the same meaning as in A.R.S. § 36-661.
- 46.48.** “Conspicuously posted” means placed:
- a. At a location that is visible and accessible; and
 - b. Unless otherwise specified in the rules, within the area where the public enters the premises of a health care institution.
- 47.49.** “Consultation” means an evaluation of a patient requested by a medical staff member or personnel member.
- 48.50.** “Contracted services” means medical services, nursing services, health-related services, ancillary services, or environmental services provided according to a documented agreement between a health care institution and the person providing the medical services, nursing services, health-related services, ancillary services, or environmental services.

- 49.51. “Contractor” has the same meaning as in A.R.S. § 32-1101.
- 50.52. “Controlled substance” has the same meaning as in A.R.S. § 36-2501.
- 51.53. “Counseling” has the same meaning as “practice of professional counseling” in A.R.S. § 32-3251.
- 52.54. “Counseling facility” means a health care institution that only provides counseling, which may include:
- a. DUI screening, education, or treatment according to the requirements in 9 A.A.C. 20, Article 1; or
 - b. Misdemeanor domestic violence offender treatment according to the requirements in 9 A.A.C. 20, Article 2.
- 53.55. “Court-ordered evaluation” has the same meaning as “evaluation” in A.R.S. § 36-501.
- 54.56. “Court-ordered pre-petition screening” has the same meaning as in A.R.S. § 36-501.
- 55.57. “Court-ordered treatment” means treatment provided according to A.R.S. Title 36, Chapter 5.
- 56.58. “Crisis services” means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.
- 57.59. “Current” means up-to-date, extending to the present time.
- 58.60. “Daily living skills” means activities necessary for an individual to live independently and include meal preparation, laundry, housecleaning, home maintenance, money management, and appropriate social interactions.
- 59.61. “Danger to others” has the same meaning as in A.R.S. § 36-501.
- 60.62. “Danger to self” has the same meaning as in A.R.S. § 36-501.
- 61.63. “Detoxification services” means behavioral health services and medical services provided to an individual to:
- a. Reduce or eliminate the individual's dependence on alcohol or other drugs, or
 - b. Provide treatment for the individual's signs or symptoms of withdrawal from alcohol or other drugs.
- 62.64. “Diagnostic procedure” means a method or process performed to determine whether an individual has a medical condition or behavioral health issue.
- 63.65. “Dialysis” means the process of removing dissolved substances from a patient's body by diffusion from one fluid compartment to another across a semi-permeable membrane.
- 64.66. “Dialysis services” means medical services, nursing services, and health-related services provided to a patient receiving dialysis.

- 65.67. “Dialysis station” means a designated treatment area approved by the Department for use by a patient receiving dialysis or dialysis services.
- 66.68. “Dialyzer” means an apparatus containing semi-permeable membranes used as a filter to remove wastes and excess fluid from a patient's blood.
- 67.69. “Disaster” means an unexpected occurrence that adversely affects a health care institution's ability to provide services.
- 68.70. “Discharge” means a documented termination of services to a patient by a health care institution.
- 69.71. “Discharge instructions” means documented information relevant to a patient's medical condition or behavioral health issue provided by a health care institution to the patient or the patient's representative at the time of the patient's discharge.
- 70.72. “Discharge planning” means a process of establishing goals and objectives for a patient in preparation for the patient's discharge.
- 71.73. “Discharge summary” means a documented brief review of services provided to a patient, current patient status, and reasons for the patient's discharge.
- 72.74. “Disinfect” means to clean in order to prevent the growth of or to destroy disease-causing microorganisms.
- 73.75. “Documentation” or “documented” means information in written, photographic, electronic, or other permanent form.
- 74.76. “Drill” means a response to a planned, simulated event.
- 75.77. “Drug” has the same meaning as in A.R.S. § 32-1901.
- 76.78. “Electronic” has the same meaning as in A.R.S. § 44-7002.
- 77.79. “Electronic signature” has the same meaning as in A.R.S. § 44-7002.
- 78.80. “Emergency” means an immediate threat to the life or health of a patient.
- 79.81. “Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.
82. “End-of-life” means that a patient has a documented life expectancy of six months or less.
- 80.83. “Environmental services” means activities such as housekeeping, laundry, facility maintenance, or equipment maintenance.
- 81.84. “Equipment” means, in this Article, an apparatus, a device, a machine, or a unit that is required to comply with the specifications incorporated by reference in A.A.C. R9-1-412.
- 82.85. “Exploitation” has the same meaning as in A.R.S. § 46-451.
- 83.86. “Factory-built building” has the same meaning as in A.R.S. § 41-2142.

- 84.87. “Family” or “family member” means an individual’s spouse, sibling, child, parent, grandparent, or another individual designated by the individual.
- 85.88. “Food services” means the storage, preparation, serving, and cleaning up of food intended for consumption in a health care institution.
- 86.89. “Garbage” has the same meaning as in A.A.C. R18-13-302.
- 87.90. “General consent” means documentation of an agreement from an individual or the individual’s representative to receive physical health services to address the individual’s medical condition or behavioral health services to address the individual’s behavioral health issues.
- 88.91. “General hospital” means a subclass of hospital that provides surgical services and emergency services.
- 89.92. “Gravely disabled” has the same meaning as in A.R.S. § 36-501.
- 90.93. “Hazard” or “hazardous” means a condition or situation where a patient or other individual may suffer physical injury.
- 91.94. “Health care directive” has the same meaning as in A.R.S. § 36-3201.
- 92.95. “Hemodialysis” means the process for removing wastes and excess fluids from a patient's blood by passing the blood through a dialyzer.
- 93.96. “Home health agency” has the same meaning as in A.R.S. § 36-151.
- 94.97. “Home health aide” means an individual employed by a home health agency to provide home health services under the direction of a registered nurse or therapist.
- 95.98. “Home health aide services” means those tasks that are provided to a patient by a home health aide under the direction of a registered nurse or therapist.
- 96.99. “Home health services” has the same meaning as in A.R.S. § 36-151.
- 97.100. “Hospice inpatient facility” means a subclass of hospice that provides hospice services to a patient on a continuous basis with the expectation that the patient will remain on the hospice’s premises for 24 hours or more.
- 98.101. “Hospital” means a class of health care institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient.
- 99.102. “Immediate” means without delay.
- 100.103. “Incident” means an unexpected occurrence that harms or has the potential to harm a patient, while the patient is:
- a. On the premises of a health care institution, or

- b. Not on the premises of a health care institution but directly receiving physical health services or behavioral health services from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution.
- +101.104. “Infection control” means to identify, prevent, monitor, and minimize infections.
- +102.105. “Informed consent” means:
- a. Advising a patient of a proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure; alternatives to the treatment, surgical procedure, psychotropic drug, or diagnostic procedure; and associated risks and possible complications; and
 - b. Obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure from the patient or the patient’s representative.
- +103.106. “In-service education” means organized instruction or information that is related to physical health services or behavioral health services and that is provided to a medical staff member, personnel member, employee, or volunteer.
- +104.107. “Interval note” means documentation updating a patient’s:
- a. Medical condition after a medical history and physical examination is performed, or
 - b. Behavioral health issue after an assessment is performed.
- +105.108. “Isolation” means the separation, during the communicable period, of infected individuals from others, to limit the transmission of infectious agents.
- +106.109. “Leased facility” means a facility occupied or used during a set time period in exchange for compensation.
- +107.110. “License” means:
- a. Written approval issued by the Department to a person to operate a class or subclass of health care institution at a specific location; or
 - b. Written approval issued to an individual to practice a profession in this state.
- +108.111. “Licensed occupancy” means the total number of individuals for whom a health care institution is authorized by the Department to provide crisis services in a unit providing behavioral health observation/stabilization services.
- +109.112. “Licensee” means an owner approved by the Department to operate a health care

- institution.
- ¶10.113. “Manage” means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.
- ¶11.114. “Medical condition” means the state of a patient’s physical or mental health, including the patient’s illness, injury, or disease.
- ¶12.115. “Medical director” means a physician who is responsible for the coordination of medical services provided to patients in a health care institution.
- ¶13.116. “Medical history” means an account of a patient’s health, including past and present illnesses, diseases, or medical conditions.
- ¶14.117. “Medical practitioner” means a physician, physician assistant, or registered nurse practitioner.
- ¶15.118. “Medical record” has the same meaning as “medical records” in A.R.S. § 12-2291.
- ¶16.119. “Medical staff” means physicians and other individuals licensed pursuant to A.R.S. Title 32 who have clinical privileges at a health care institution.
- ¶17.120. “Medical staff by-laws” means standards, approved by the medical staff and the governing authority, that provide the framework for the organization, responsibilities, and self-governance of the medical staff.
- ¶18.121. “Medical staff member” means an individual who is part of the medical staff of a health care institution.
- ¶19.122. “Medication” means one of the following used to maintain health or to prevent or treat a medical condition or behavioral health issue:
- a. Biologicals as defined in A.A.C. R18-13-1401,
 - b. Prescription medication as defined in A.R.S. § 32-1901, or
 - c. Nonprescription medication as defined in A.R.S. § 32-1901.
- ¶20.123. “Medication administration” means restricting a patient’s access to the patient’s medication and providing the medication to the patient or applying the medication to the patient’s body, as ordered by a medical practitioner.
- ¶21.124. “Medication error” means:
- a. The failure to administer an ordered medication;
 - b. The administration of a medication not ordered; or

- c. The administration of a medication:
 - i. In an incorrect dosage,
 - ii. More than 60 minutes before or after the ordered time of administration unless ordered to do so, or
 - iii. By an incorrect route of administration.
- 122.125. “Mental disorder” means the same as in A.R.S. § 36-501.
- 123.126. “Mobile clinic” means a movable structure that:
- a. Is not physically attached to a health care institution's facility;
 - b. Provides medical services, nursing services, or health related service to an outpatient under the direction of the health care institution's personnel; and
 - c. Is not intended to remain in one location indefinitely.
- 124.127. “Monitor” or “monitoring” means to check systematically on a specific condition or situation.
- 125.128. “Neglect” has the same meaning:
- a. For an individual less than 18 years of age, as in A.R.S. § 8-201; and
 - b. For an individual 18 years of age or older, as in A.R.S. § 46-451.
- 126.129. “Nephrologist” means a physician who is board eligible or board certified in nephrology by a professional credentialing board.
- 127.130. “Nurse” has the same meaning as “registered nurse” or “practical nurse” as defined in A.R.S. § 32-1601.
- 128.131. “Nursing personnel” means individuals authorized according to A.R.S. § Title 32, Chapter 15 to provide nursing services.
- 129.132. “Observation chair” means a physical piece of equipment that:
- a. Is located in a designated area where behavioral health observation/stabilization services are provided,
 - b. Allows an individual to fully recline, and
 - c. Is used by the individual while receiving crisis services.
- 130.133. “Occupational therapist” has the same meaning as in A.R.S. § 32-3401.
- 131.134. “Occupational therapist assistant” has the same meaning as in A.R.S. § 32-3401.
- 132.135. “Ombudsman” means a resident advocate who performs the duties described in A.R.S. § 46-452.02.
- 133.136. “On-call” means a time during which an individual is available and required to

- come to a health care institution when requested by the health care institution.
137. “Opioid” means a controlled substance, as defined in A.R.S. § 36-2501, that meets the definition of “opiate” in A.R.S. § 36-2501.
138. “Opioid antagonist” means a prescription medication, as defined in A.R.S. § 32-1901, that:
- a. Is approved by the U.S. Department of Health and Human Services, Food and Drug Administration; and
- b. When administered, reverses, in whole or in part, the pharmacological effects of an opioid in the body.
- 134.139. “Opioid treatment” means providing medical services, nursing services, health-related services, and ancillary services to a patient receiving an opioid agonist treatment medication for opiate addiction.
- 135.140. “Opioid agonist treatment medication” means a prescription medication that is approved by the U.S. Food and Drug Administration under 21 U.S.C. § 355 for use in the treatment of opiate addiction.
- 136.141. “Order” means instructions to provide
- a. Physical health services to a patient from a medical practitioner or as otherwise provided by law; or
- b. Behavioral health services to a patient from a behavioral health professional.
- 137.142. “Orientation” means the initial instruction and information provided to an individual before the individual starts work or volunteer services in a health care institution.
- 138.143. “Outing” means a social or recreational activity that:
- a. Occurs away from the premises,
- b. Is not part of a behavioral health inpatient facility’s or behavioral health residential facility’s daily routine, and
- c. Lasts longer than four hours.
- 139.144. “Outpatient surgical center” means a class of health care institution that has the facility, staffing, and equipment to provide surgery and anesthesia services to a patient whose recovery, in the opinions of the patient’s surgeon and, if an anesthesiologist would be providing anesthesia services to the patient, the anesthesiologist, does not require inpatient care in a hospital.

- 140.145. “Outpatient treatment center” means a class of health care institution without inpatient beds that provides physical health services or behavioral health services for the diagnosis and treatment of patients.
- 141.146. “Overall time-frame” means the same as in A.R.S. § 41-1072.
- 142.147. “Owner” means a person who appoints, elects, or designates a health care institution's governing authority.
148. “Pain management clinic” has the same meaning as in A.R.S. § 36-448.01.
- 143.149. “Participant” means a patient receiving physical health services or behavioral health services from an adult day health care facility or a substance abuse transitional facility.
- 144.150. “Participant’s representative” means the same as “patient’s representative” for a participant.
- 145.151. “Patient” means an individual receiving physical health services or behavioral health services from a health care institution.
- 146.152. “Patient follow-up instructions” means information relevant to a patient’s medical condition or behavioral health issue that is provided to the patient, the patient’s representative, or a health care institution.
- 147.153. “Patient’s representative” means:
- a. A patient’s legal guardian;
 - b. If a patient is less than 18 years of age and not an emancipated minor, the patient’s parent;
 - c. If a patient is 18 years of age or older or an emancipated minor, an individual acting on behalf of the patient with the written consent of the patient or patient’s legal guardian; or
 - d. A surrogate as defined in A.R.S. § 36-3201.
- 148.154. “Person” means the same as in A.R.S. § 1-215 and includes a governmental agency.
- 149.155. “Personnel member” means, except as defined in specific Articles in this Chapter and excluding a medical staff member, a student, or an intern, an individual providing physical health services or behavioral health services to a patient.
- 150.156. “Pest control program” means activities that minimize the presence of insects and vermin in a health care institution to ensure that a patient’s health and safety is not at risk.

- +151.157. “Pharmacist” has the same meaning as in A.R.S. § 32-1901.
- +152.158. “Physical examination” means to observe, test, or inspect an individual’s body to evaluate health or determine cause of illness, injury, or disease.
- +153.159. “Physical health services” means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's medical condition.
- +154.160. “Physical therapist” has the same meaning as in A.R.S. § 32-2001.
- +155.161. “Physical therapist assistant” has the same meaning as in A.R.S. § 32-2001.
- +156.162. “Physician assistant” has the same meaning as in A.R.S. § 32-2501.
- +157.163. “Premises” means property that is designated by an applicant or licensee and licensed by the Department as part of a health care institution where physical health services or behavioral health services are provided to a patient.
164. “Prescribe” means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user’s behalf, a specific dose of a specific medication in a specific quantity and route of administration.
- +158.165. “Professional credentialing board” means a non-governmental organization that designates individuals who have met or exceeded established standards for experience and competency in a specific field.
- +159.166. “Progress note” means documentation by a medical staff member, nurse, or personnel member of:
- a. An observed patient response to a physical health service or behavioral health service provided to the patient,
 - b. A patient’s significant change in condition, or
 - c. Observed behavior of a patient related to the patient’s medical condition or behavioral health issue.
- +160.167. “PRN” means *pro re nata* or given as needed.
- +161.168. “Project” means specific construction or modification of a facility stated on an architectural plans and specifications approval application.
- +162.169. “Provider” means an individual to whom the Department issues a license to operate an adult behavioral health therapeutic home or a behavioral health respite home in the individual’s place of residence.
- +163.170. “Provisional license” means the Department's written approval to operate a health care institution issued to an applicant or licensee that is not in substantial

compliance with the applicable laws and rules for the health care institution.

¶64.171.

“Psychotropic medication” means a chemical substance that:

- a. Crosses the blood-brain barrier and acts primarily on the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition, and behavior; and
- b. Is provided to a patient to address the patient’s behavioral health issue.

¶65.172.

“Quality management program” means ongoing activities designed and implemented by a health care institution to improve the delivery of medical services, nursing services, health-related services, and ancillary services provided by the health care institution.

¶66.173.

“Recovery care center” has the same meaning as in A.R.S. § 36-448.51.

¶67.174.

“Referral” means providing an individual with a list of the class or subclass of health care institution or type of health care professional that may be able to provide the behavioral health services or physical health services that the individual may need and may include the name or names of specific health care institutions or health care professionals.

¶68.175.

“Registered dietitian” means an individual approved to work as a dietitian by the American Dietetic Association’s Commission on Dietetic Registration.

¶69.176.

“Registered nurse” has the same meaning as in A.R.S. § 32-1601.

¶70.177.

“Registered nurse practitioner” has the same meaning as A.R.S. § 32-1601.

¶71.178.

“Regular basis” means at recurring, fixed, or uniform intervals.

¶72.179.

“Research” means the use of a human subject in the systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment, or understanding of a medical condition or behavioral health issue.

¶73.180.

“Resident” means an individual living in and receiving physical health services or behavioral health services from a nursing care institution, a behavioral health residential facility, an assisted living facility, or an adult behavioral health therapeutic home.

¶74.181.
resident.

“Resident’s representative” means the same as “patient’s representative” for a resident.

“Respiratory care services” has the same meaning as “practice of respiratory care” as defined in A.R.S. § 32-3501.

¶76.183.

“Respiratory therapist” has the same meaning as in A.R.S. § 32-3501.

- 177.184. “Respite services” means respite care services provided to an individual who is receiving behavioral health services.
- 178.185. “Restraint” means any physical or chemical method of restricting a patient’s freedom of movement, physical activity, or access to the patient’s own body.
- 179.186. “Risk” means potential for an adverse outcome.
- 180.187. “Room” means space contained by a floor, a ceiling, and walls extending from the floor to the ceiling that has at least one door.
- 181.188. “Rural general hospital” means a subclass of hospital having 50 or fewer inpatient beds and located more than 20 surface miles from a general hospital or another rural general hospital that requests to be and is licensed as a rural general hospital rather than a general hospital.
- 182.189. “Satellite facility” has the same meaning as in A.R.S. § 36-422.
- 183.190. “Scope of services” means a list of the behavioral health services or physical health services the governing authority of a health care institution has designated as being available to a patient at the health care institution.
- 184.191. “Seclusion” means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.
192. “Sedative-hypnotic medication” means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anti-convulsant, and muscle-relaxing properties.
- 185.193. “Self-administration of medication” means a patient having access to and control of the patient’s medication and may include the patient receiving limited support while taking the medication.
- 186.194. “Sexual abuse” means the same as in A.R.S. § 13-1404(A).
- 187.195. “Sexual assault” means the same as in A.R.S. § 13-1406(A).
- 188.196. “Shift” means the beginning and ending time of a continuous work period established by a health care institution’s policies and procedures.
197. “Short-acting opioid antagonist” means an opioid antagonist that, when administered, quickly but for a small period of time reverses, in whole or in part, the pharmacological effects of an opioid in the body.
- 189.198 “Signature” means:
- a. A handwritten or stamped representation of an individual’s name or a symbol intended to represent an individual’s name, or
 - b. An electronic signature.

- 190.199. “Significant change” means an observable deterioration or improvement in a patient’s physical, cognitive, behavioral, or functional condition that may require an alteration to the physical health services or behavioral health services provided to the patient.
- 191.200. “Speech-language pathologist” means an individual licensed according A.R.S. Title 35, Chapter 17, Article 4 to engage in the practice of speech-language pathology, as defined in A.R.S. § 36-1901.
- 192.201. “Special hospital” means a subclass of hospital that:
- Is licensed to provide hospital services within a specific branch of medicine; or
 - Limits admission according to age, gender, type of disease, or medical condition.
- 193.202. “Student” means an individual attending an educational institution and working under supervision in a health care institution through an arrangement between the health care institution and the educational institution.
203. “Substance use disorder” means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental, or social effects on an individual.
204. “Substance use risk” means an individual’s unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.
- 194.205. “Substantial” when used in connection with a modification means:
- A change in a health care institution's licensed capacity, licensed occupancy, or the number of dialysis stations;
 - An addition or deletion of an authorized service;
 - A change in the physical plant, including facilities or equipment, that costs more than \$300,000; or
 - A change in the building where a health care institution is located that affects compliance with applicable physical plant codes and standards incorporated by reference in A.A.C. R9-1-412.
- 195.206. “Substance abuse” means an individual’s misuse of alcohol or other drug or chemical that:
- Alters the individual’s behavior or mental functioning;
 - Has the potential to cause the individual to be psychologically or

- physiologically dependent on alcohol or other drug or chemical; and
- c. Impairs, reduces, or destroys the individual's social or economic functioning.
- 196.207. “Substance abuse transitional facility” means a class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem.
- 197.208. “Supportive services” has the same meaning as in A.R.S. § 36-151.
- 198.209. “Substantive review time-frame” means the same as in A.R.S. § 41-1072.
- 199.210. “Surgical procedure” means the excision or incision of a patient’s body for the:
- a. Correction of a deformity or defect,
- b. Repair of an injury, or
- c. Diagnosis, amelioration, or cure of disease.
- 200.211. “Swimming pool” has the same meaning as “semipublic swimming pool” in A.A.C. R18-5-201.
- 201.212. “System” means interrelated, interacting, or interdependent elements that form a whole.
213. “Tapering” means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.
- 202.214. “Tax ID number” means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.
- 203.215. “Telemedicine” has the same meaning as in A.R.S. § 36-3601.
- 204.216. “Therapeutic diet” means foods or the manner in which food is to be prepared that are ordered for a patient.
- 205.217. “Therapist” means an occupational therapist, a physical therapist, a respiratory therapist, or a speech-language pathologist.
- 206.218. “Time out” means providing a patient a voluntary opportunity to regain self-control in a designated area from which the patient is not physically prevented from leaving.
- 207.219. “Transfer” means a health care institution discharging a patient and sending the patient to another licensed health care institution as an inpatient or resident without intending that the patient be returned to the sending health care institution.

- 208.220. “Transport” means a licensed health care institution:
- a. Sending a patient to a receiving licensed health care institution for outpatient services with the intent of the patient returning to the sending licensed health care institution, or
 - b. Discharging a patient to return to a sending licensed health care institution after the patient received outpatient services from the receiving licensed health care institution.
- 209.221. “Treatment” means a procedure or method to cure, improve, or palliate an individual’s medical condition or behavioral health issue.
- 210.222. “Treatment plan” means a description of the specific physical health services or behavioral health services that a health care institution anticipates providing to a patient.
- 211.223. “Unclassified health care institution” means a health care institution not classified or subclassified in statute or in rule.
- 212.224. “Vascular access” means the point on a patient’s body where blood lines are connected for hemodialysis.
- 213.225. “Volunteer” means an individual authorized by a health care institution to work for the health care institution on a regular basis without compensation from the health care institution and does not include a medical staff member who has clinical privileges at the health care institution.
- 214.226. “Working day” means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state and federal holiday or a statewide furlough day.
- R9-10-102. Health Care Institution Classes and Subclasses; Requirements**
- A. A person may apply for a license as a health care institution class or subclass in A.R.S. Title 36, Chapter 4 or this Chapter, or one of the following classes or subclasses:
1. General hospital,
 2. Rural general hospital,
 3. Special hospital,
 4. Behavioral health inpatient facility,
 5. Nursing care institution,
 6. Recovery care center,
 7. Hospice inpatient facility,
 8. Hospice service agency,
 9. Behavioral health residential facility,

10. Assisted living center,
 11. Assisted living home,
 12. Adult foster care home,
 13. Outpatient surgical center,
 14. Outpatient treatment center,
 15. Abortion clinic,
 16. Adult day health care facility,
 17. Home health agency,
 18. Substance abuse transitional facility,
 19. Behavioral health specialized transitional facility,
 20. Counseling facility,
 21. Adult behavioral health therapeutic home,
 22. Behavioral health respite home, or
 23. Unclassified health care institution- or
 24. Pain management clinic.
- B. A person shall apply for a license for the class or subclass that authorizes the provision of the highest level of physical care services or behavioral health services the proposed health care institution plans to provide. The Department shall review the proposed health care institution's scope of services to determine whether the requested health care institution class or subclass is appropriate.
- C. A health care institution shall comply with the requirements in Article 17 of this Chapter if:
1. There are no specific rules in another Article of this Chapter for the health care institution's class or subclass, or
 2. The Department determines that the health care institution is an unclassified health care institution.

R9-10-106. Fees

- A. An applicant who submits to the Department architectural plans and specifications for the construction or modification of a health care institution shall also submit an architectural drawing review fee as follows:
1. Fifty dollars for a project with a cost of \$100,000 or less;
 2. One hundred dollars for a project with a cost of more than \$100,000 but less than \$500,000; or

3. One hundred fifty dollars for a project with a cost of \$500,000 or more.
- B. An applicant submitting an initial application or a renewal application for a health care institution license shall submit to the Department an application fee of \$50.
- C. Except as provided in subsection (D) or (E), an applicant submitting an initial application or a renewal application for a health care institution license shall submit to the Department a licensing fee as follows:
 1. For an adult day health care facility, assisted living home, or assisted living center:
 - a. For a facility with no licensed capacity, \$280;
 - b. For a facility with a licensed capacity of one to 59 beds, \$280, plus the licensed capacity times \$70;
 - c. For a facility with a licensed capacity of 60 to 99 beds, \$560, plus the licensed capacity times \$70;
 - d. For a facility with a licensed capacity of 100 to 149 beds, \$840, plus the licensed capacity times \$70; or
 - e. For a facility with a licensed capacity of 150 beds or more, \$1,400, plus the licensed capacity times \$70;
 2. For a behavioral health facility:
 - a. For a facility with no licensed capacity, \$375;
 - b. For a facility with a licensed capacity of one to 59 beds, \$375, plus the licensed capacity times \$94;
 - c. For a facility with a licensed capacity of 60 to 99 beds, \$750, plus the licensed capacity times \$94;
 - d. For a facility with a licensed capacity of 100 to 149 beds, \$1,125, plus the licensed capacity times \$94; or
 - e. For a facility with a licensed capacity of 150 beds or more, \$1,875, plus the licensed capacity times \$94;
 3. For a behavioral health facility providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(2), the licensed occupancy times \$94;
 4. For a nursing care institution:
 - a. For a facility with a licensed capacity of one to 59 beds, \$290, plus the licensed capacity times \$73;

- b. For a facility with a licensed capacity of 60 to 99 beds, \$580, plus the licensed capacity times \$73;
 - c. For a facility with a licensed capacity of 100 to 149 beds, \$870, plus the licensed capacity times \$73; or
 - d. For a facility with a licensed capacity of 150 beds or more, \$1,450, plus the licensed capacity times \$73;
 - 5. For a hospital, a home health agency, a hospice service agency, a hospice inpatient facility, an abortion clinic, a recovery care center, an outpatient surgical center, an outpatient treatment center that is not a behavioral health facility, a pain management clinic, or an unclassified health care institution:
 - a. For a facility with no licensed capacity, \$365;
 - b. For a facility with a licensed capacity of one to 59 beds, \$365, plus the licensed capacity times \$91;
 - c. For a facility with a licensed capacity of 60 to 99 beds, \$730, plus the licensed capacity times \$91;
 - d. For a facility with a licensed capacity of 100 to 149 beds, \$1,095, plus the licensed capacity times \$91; or
 - e. For a facility with a licensed capacity of 150 beds or more, \$1,825, plus the licensed capacity times \$91;
 - 6. For a hospital providing behavioral health observation/ stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times \$91; and
 - 7. For an outpatient treatment center that is not a behavioral health facility and provides:
 - a. Dialysis services, in addition to the applicable fee in subsection (C)(5), the number of dialysis stations times \$91; and
 - b. Behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times \$91.
- D.** In addition to the applicable fees in subsections (C)(5) and (C)(6), an applicant submitting an initial application or a renewal application for a single group hospital license shall submit to the Department an additional fee of \$365 for each of the hospital's satellite facilities and, if applicable, the fees required in subsection (C)(7). E. Subsections (C) and (D) do not apply to a health care institution operated by a state agency according

- to state or federal law or to an adult foster care home.
- E. Subsections (C) and (D) do not apply to a health care institution operated by a state agency according to state or federal law or to an adult foster care home.
- F. All fees are nonrefundable except as provided in A.R.S. § 41- 1077.
- R9-10-120. Opioid Prescribing and Treatment**
- A.** This Section does not apply to a health care institution licensed under Article 20 of this Chapter.
- A.B.** In addition to the definitions in A.R.S. § 36-401(A) and R9-10-101, the following definitions apply in this Section:
1. “Active malignancy” means a cancer for which:
 - a. A patient is undergoing treatment, such as through:
 - i. One or more surgical procedures to remove the cancer;
 - ii. Cancer chemotherapy, as defined in A.A.C. R9-4-401; or
 - iii. Radiation treatment, as defined in A.A.C. R9-4-401;
 - b. There is no treatment; or
 - c. A patient is refusing treatment.
 2. “Benzodiazepine” means any one of a class of sedative hypnotic medications, characterized by a chemical structure that includes a benzene ring linked to a seven membered ring containing two nitrogen atoms, that are commonly used in the treatment of anxiety.
 3. “End of life” means that a patient has a documented life expectancy of six months or less.
 4. “Episode of care” means medical services, nursing services, or health-related services provided by a health care institution to a patient for a specific period of time, ending in discharge or the completion of the patient’s treatment plan, whichever is later.
 5. “Opioid” means a controlled substance, as defined in A.R.S. § 36-2501, that meets the definition of “opiate” in A.R.S. § 36-2501.
 6. “Order” means to issue written, verbal, or electronic instructions for a specific dose of a specific medication in a specific quantity and route of administration to be obtained and administered to a patient in a health care institution.
 7. “Prescribe” means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user’s behalf, a

~~specific dose of a specific medication in a specific quantity and route of administration.~~

8. ~~“Sedative hypnotic medication” means any one of several classes of drugs that have sleep inducing, anti-anxiety, anti-convulsant, and muscle relaxing properties.~~
9. ~~“Short acting opioid antagonist” means a drug approved by the U.S. Department of Health and Human Services, Food and Drug Administration, that, when administered, quickly but for a small period of time reverses, in whole or in part, the pharmacological effects of an opioid in the body.~~
10. ~~“Substance use disorder” means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental, or social effects on an individual.~~
11. ~~“Substance use risk” means an individual’s unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.~~
12. ~~“Tapering” means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.~~

B.C. A medical director of a health care institution where opioids are prescribed or ordered as part of treatment shall:

1. Establish, document, and implement policies and procedures for prescribing or ordering an opioid as part of treatment, to protect the health and safety of a patient, that:
 - a. Cover which personnel members may prescribe or order an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
 - b. As applicable and except when contrary to medical judgment for a patient, are consistent with the Arizona Opioid Prescribing Guidelines or national opioid-prescribing guidelines, such as guidelines developed by the:
 - i. Centers for Disease Control and Prevention, or
 - ii. U.S. Department of Veterans Affairs and the U.S. Department of Defense;

- c. Include how, when, and by whom:
 - i. A patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database is reviewed;
 - ii. An assessment is conducted of a patient's substance use risk;
 - iii. The potential risks, adverse outcomes, and complications, including death, associated with the use of opioids are explained to a patient or the patient's representative;
 - iv. Alternatives to a prescribed or ordered opioid are explained to a patient or the patient's representative;
 - v. Informed consent is obtained from a patient or the patient's representative and, if applicable, in what situations, described in subsection ~~(F) or (G)~~ (G) or (H), informed consent would not be obtained before an opioid is prescribed or ordered for a patient;
 - vi. A patient receiving an opioid is monitored; and
 - vii. The actions taken according to subsections ~~(B)(1)(e)(i) through (vi)~~ (C)(1)(c)(i) through (vi) are documented;
- d. Address conditions that may impose a higher risk to a patient when prescribing or ordering an opioid as part of treatment, including:
 - i. Concurrent use of a benzodiazepine or other sedative-hypnotic medication,
 - ii. History of substance use disorder,
 - iii. Co-occurring behavioral health issue, or
 - iv. Pregnancy;
- e. Cover the criteria for co-prescribing a short-acting opioid antagonist for a patient;
- f. Include that, if continuing control of a patient's pain after discharge is medically indicated due to the patient's medical condition, a method for continuing pain control will be addressed as part of discharge planning;
- g. Include the frequency of the following for a patient being prescribed or ordered an opioid for longer than a 30-calendar-day period:
 - i. Face-to-face interactions with the patient,
 - ii. Conducting an assessment of a patient's substance use risk,

- iii. Renewal of a prescription or order for an opioid without a face-to-face interaction with the patient, and
 - iv. Monitoring the effectiveness of the treatment;
 - h. If applicable according to A.R.S. § 36-2608, include documenting a dispensed opioid in the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - i. Cover the criteria and procedures for tapering opioid prescription or ordering as part of treatment; and
 - j. Cover the criteria and procedures for offering or referring a patient for treatment for substance use disorder;
- 2. Include in the plan for the health care institution's quality management program a process for:
 - a. Review of known incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths, and
 - b. Surveillance and monitoring of adherence to the policies and procedures in subsection ~~(B)(1) (C)(1)~~;
- 3. Except as prohibited by Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2, or as provided in subsection ~~(G)(1) (H)(1)~~, ensure that, if a patient's death may be related to an opioid prescribed or ordered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the health care institution learns of the patient's death; and
- 4. Ensure that informed consent required from a patient or the patient's representative includes:
 - a. The patient's:
 - i. Name,
 - ii. Date of birth or other patient identifier, and
 - iii. Condition for which opioids are being prescribed;
 - b. That an opioid is being prescribed or ordered;
 - c. The potential risks, adverse reactions, complications, and medication interactions associated with the use of an opioid;
 - d. If applicable, the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or

- another sedative-hypnotic medication;
 - e. Alternatives to a prescribed or ordered opioid;
 - f. The name and signature of the individual explaining the use of an opioid to the patient; and
 - g. The signature of the patient or the patient's representative and the date signed.
- C.D.** Except as provided in subsection (G) (H), a medical director of a health care institution where opioids are prescribed as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to prescribe an opioid in treating a patient:
1. Before prescribing an opioid for a patient of the health care institution:
 - a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted during the patient's same episode of care;
 - b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted during the same episode of care by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
 - d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;
 - e. Explains alternatives to a prescribed opioid; and
 - f. Obtains informed consent from the patient or the patient's representative that meets the requirements in subsection (B)(4) (C)(4), including the potential risks, adverse outcomes, and complications associated with the

- concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication, if the patient:
- i. Is also prescribed or ordered a sedative-hypnotic medication, or
 - ii. Has been prescribed a sedative-hypnotic medication by another medical practitioner;
2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
 - a. The patient's diagnosis;
 - b. The patient's medical history, including co-occurring disorders;
 - c. The opioid to be prescribed;
 - d. Other medications or herbal supplements being taken by the patient;
 - e. If applicable:
 - i. The effectiveness of the patient's current treatment,
 - ii. The duration of the current treatment, and
 - iii. Alternative treatments tried by or planned for the patient;
 - f. The expected benefit of the treatment and, if applicable, the benefit of the new treatment compared with continuing the current treatment; and
 - g. Other factors relevant to the patient's being prescribed an opioid; and
 3. If applicable, specifies in the patient's discharge plan how medically indicated pain control will occur after discharge to meet the patient's needs.

D.E. Except as provided in subsection (F) or (G) (G) or (H), a medical director of a health care institution where opioids are ordered for administration to a patient in the health care institution as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to order an opioid in treating a patient:

1. Before ordering an opioid for a patient of the health care institution:
 - a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted:
 - i. During the patient's same episode of care; or
 - ii. Within the previous 30 calendar days, at a health care institution transferring the patient to the health care institution or by the medical practitioner who referred the patient for admission to the health care institution;
 - b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's

- profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
- c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted within the previous 30 calendar days by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
 - d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;
 - e. If applicable, explains alternatives to an ordered opioid; and
 - f. Obtains informed consent from the patient or the patient's representative, according to subsection (C)(1)(f) (D)(1)(f); and
2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
 - a. The patient's diagnosis;
 - b. The patient's medical history, including co-occurring disorders;
 - c. The opioid being ordered and the reason for the order;
 - d. Other medications or herbal supplements being taken by the patient; and
 - e. If applicable:
 - i. The effectiveness of the patient's current treatment,
 - ii. The duration of the current treatment,
 - iii. Alternative treatments tried by or planned for the patient,
 - iv. The expected benefit of a new treatment compared with continuing the current treatment, and
 - v. Other factors relevant to the patient's being ordered an opioid.
- E.F.** For a health care institution where opioids are administered as part of treatment or where a patient is provided assistance in the self-administration of medication for a prescribed

opioid, including a health care institution in which an opioid may be prescribed or ordered as part of treatment, a medical director, a manager as defined in R9-10-801, or a provider, as applicable to the health care institution, shall:

1. Establish, document, and implement policies and procedures for administering an opioid as part of treatment or providing assistance in the self-administration of medication for a prescribed opioid, to protect the health and safety of a patient, that:
 - a. Cover which personnel members may administer an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
 - b. Cover which personnel members may provide assistance in the self-administration of medication for a prescribed opioid and the required knowledge and qualifications of these personnel members;
 - c. Include how, when, and by whom a patient's need for opioid administration is assessed;
 - d. Include how, when, and by whom a patient receiving an opioid is monitored; and
 - e. Cover how, when, and by whom the actions taken according to subsections ~~(E)(1)(e) and (d)~~ (F)(1)(c) and (d) are documented;
2. Include in the plan for the health care institution's quality management program a process for:
 - a. Review of incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths, and
 - b. Surveillance and monitoring of adherence to the policies and procedures in subsection ~~(E)(1)~~ (F)(1);
3. Except as prohibited by Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2, or as provided in subsection ~~(G)(1)~~ (H)(1), ensure that, if a patient's death may be related to an opioid administered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the patient's death; and
4. Except as provided in subsection ~~(G)~~ (H), ensure that an individual authorized by policies and procedures to administer an opioid in treating a patient or to provide

- assistance in the self-administration of medication for a prescribed opioid:
- a. Before administering an opioid or providing assistance in the self-administration of medication for a prescribed opioid in compliance with an order as part of the treatment for a patient, identifies the patient's need for the opioid;
 - b. Monitors the patient's response to the opioid; and
 - c. Documents in the patient's medical record:
 - i. An identification of the patient's need for the opioid before the opioid was administered or assistance in the self-administration of medication for a prescribed opioid was provided, and
 - ii. The effect of the opioid administered or for which assistance in the self-administration of medication for a prescribed opioid was provided.

F.G. A medical practitioner authorized by a health care institution's policies and procedures to order an opioid in treating a patient is exempt from the requirements in subsection ~~(D)~~ (E), if:

1. The health care institution's policies and procedures, required in subsection ~~(B)~~ ~~(C)(1)~~ or the applicable Article in 9 A.A.C. 10, contain procedures for:
 - a. Providing treatment without obtaining the consent of a patient or the patient's representative,
 - b. Ordering and administering opioids in an emergency situation, and
 - c. Complying with the requirements in subsection ~~(D) (E)~~ after the emergency is resolved;
2. The order for the administration of an opioid is:
 - a. Part of the treatment for a patient in an emergency, and
 - b. Issued in accordance with policies and procedures; and
3. The emergency situation is documented in the patient's medical record.

G.H. The requirements in subsections ~~(C), (D), and (E)~~(4) (D), (E), and (F)(4), as applicable, do not apply to a health care institution's:

1. Prescribing, ordering, or administration of an opioid as part of treatment for a patient with an end-of-life condition or pain associated with an active malignancy;
2. Prescribing an opioid as part of treatment for a patient when changing the type or

dosage of an opioid, which had previously been prescribed by a medical practitioner of the health care institution for the patient according to the requirements in subsection (C)(D):

- a. Before a pharmacist dispenses the opioid for the patient; or
 - b. If changing the opioid because of an adverse reaction to the opioid experienced by the patient, within 72 hours after the opioid was dispensed for the patient by a pharmacist;
3. Ordering an opioid as part of treatment for no longer than three calendar days for a patient remaining in the health care institution and receiving continuous medical services or nursing services from the health care institution; or
 4. Ordering an opioid as part of treatment:
 - a. For a patient receiving a surgical procedure or other invasive procedure; or
 - b. When changing the type, dosage, or route of administration of an opioid, which had previously been ordered by a medical practitioner of the health care institution for a patient according to the requirements in subsection (D)(E), to meet the patient's needs.

ARTICLE 10. OUTPATIENT TREATMENT CENTERS

R9-10-1001. Definitions

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

1. “Emergency room services” means medical services provided to a patient in an emergency.
2. “Pain management services” means medical services, nursing services, or health – related services provided to a patient to reduce or relieve the patient’s chronic pain.

R9-10-1021. Pain Management Services

A medical director of an outpatient treatment center that is authorized to provide pain management services shall ensure that:

- Pain management services are provided under the direction of:
 - a. a physician; , or
 - b. A nurse practitioner licensed according to A.R.S. Title 32, Chapter 15, with advanced pain management certification from a nationally recognized accreditation or certification entity;
- 2. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center’s premise;
- 3. If a controlled substance is used to provide pain management services:
 - a. A medical practitioner discusses the risks and benefits of using a controlled substance with a patient;
 - b. If the controlled substance is an opioid, the outpatient treatment center complies with the requirements in R9-10-2006; and
 - b.c. The following information is included in a patient’s medical record:
 - i. The patient’s history ~~or alcohol and substance abuse of substance use disorder,~~
 - ii. Documentation of the discussion in subsection (3)(a),
 - iii. The nature and intensity of the patient’s pain, and
 - iv. The objectives used to determine whether the patient is being

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- 4. If an injection or a nerve block is used to provide pain management services:
 - a. Before the injection or nerve block is initially used on a patient, an evaluation of the patient is performed by a physician or nurse anesthetist;
 - b. An injection or nerve block is administered by a physician or nurse anesthetist; and
 - c. The following information is included in a patient's medical record:
 - i. The evaluation of the patient required in subsection (4)(a),
 - ii. A record of the administration of the injection or nerve block, and
 - iii. Any resuscitation measures taken; and
- 5. An outpatient treatment center meets the definition of a pain management clinic in A.R.S. § 36-448.01 complies with Article 20 of this Chapter.

ARTICLE 20. PAIN MANAGEMENT CLINICS

R9-10-2001. Definitions

In addition to the definitions in R9-10-101, the following definitions apply in this Article, unless otherwise specified:

1. “Order” means to issue written, verbal, or electronic instructions for a specific dose of a specific medication in a specific quantity and route of administration to be obtained and administered to a patient in a health care institution.
2. “Physician” means an individual licensed as a physician according to A.R.S. Title 32, Chapter 13, 14, or 17.

R9-10-2002. Application and Documentation Submission Requirements

- A. An applicant shall submit an application for licensure that meets the requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1.
- B. An applicant or licensee shall submit to the Department:
 1. The applicable fees required in R9-10-106(C), and
 2. The documentation required according to A.R.S. § 36-448.02(C)(1).

R9-10-2003. Administration

- A. A licensee is responsible for the organization and management of a pain management clinic.
- B. A licensee shall:
 1. Adopt policies and procedures for the administration and operation of a pain management clinic;
 2. Designate a medical director who:
 - a. Is licensed:
 - i. As a physician according to A.R.S. Title 32, Chapter 13 or 17; or
 - ii. As a nurse practitioner according to A.R.S. Title 32, Chapter 15 with advanced pain management certification from a nationally recognized accreditation or certification entity; and
 - b. May be the same individual as the licensee;
 3. Ensure that there are a sufficient number of personnel members and employees with the required knowledge and qualifications to:
 - a. Meet the requirements of this Article,

- b. Ensure the health and safety of a patient, and
 - c. Meet the needs of a patient based on the patient's medical evaluation; and
4. Ensure the following are conspicuously posted on the premises:
 - a. The current pain management clinic license issued by the Department;
 - b. The current telephone number and address of the unit in the Department responsible for licensing the pain management clinic;
 - c. An evacuation map posted in all hallways; and
 - d. A phone number for:
 - i. An opioid assistance and referral hotline, and
 - ii. A poison control hotline.

C. A medical director shall ensure that:

1. Pain management services are provided under the direction of:
 - a. A physician, or
 - b. A nurse practitioner licensed according to A.R.S. Title 32, Chapter 15 with advanced pain management certification from a nationally recognized accreditation or certification entity;
2. A record that includes cardiopulmonary resuscitation training is maintained for each personnel member, employee, volunteer, or student who is required by policies and procedures to obtain cardiopulmonary resuscitation training; and
3. A personnel member certified in cardiopulmonary resuscitation is available on the pain management clinic's premises while patients are present.

D. A medical director shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:

1. Cover personnel member qualifications, duties, and responsibilities, including who may order, prescribe, or administer an opioid and the required knowledge and qualifications of those personnel members;
2. Cover cardiopulmonary resuscitation training, including:
 - a. The method and content of cardiopulmonary resuscitation training, including a demonstration of an individual's ability to perform cardiopulmonary resuscitation;
 - b. The qualifications required for an individual to provide cardiopulmonary resuscitation training;
 - c. The time-frame for renewal of cardiopulmonary resuscitation training;

and

- d. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;
- 3. Cover the storage, accessibility, disposal, and documentation of a medication;
- 4. Cover the prescribing or ordering of an opioid:
 - a. Including how, when, and by whom:
 - i. A patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database is reviewed;
 - ii. An assessment is conducted of a patient's substance use risk;
 - iii. The potential risks, adverse outcomes, and complications, including death, associated with the use of opioids are explained to a patient or the patient's representative;
 - iv. Alternatives to a prescribed or ordered opioid are explained to a patient or the patient's representative;
 - v. Informed consent is obtained from a patient or the patient's representative;
 - vi. A patient receiving an opioid is monitored; and
 - vii. The actions taken according to subsections (D)(4)(a)(i) through (vi) are documented;
 - b. Addressing conditions that may impose a higher risk to a patient when prescribing or ordering an opioid, including:
 - i. Concurrent use of a benzodiazepine or other sedative-hypnotic medication,
 - ii. History of substance use disorder,
 - iii. Co-occurring behavioral health issue, or
 - iv. Pregnancy;
 - c. Addressing the criteria for co-prescribing a short-acting opioid antagonist for a patient;
 - d. Including the frequency of the following for a patient prescribed an opioid for longer than a 30-calendar-day period:
 - i. Face-to-face interactions with the patient,
 - ii. Assessment of a patient's substance use risk,

- iii. Urine drug testing,
 - iv. Renewal of an opioid prescription without a face-to-face interaction with the patient, and
 - v. Monitoring the effectiveness of the treatment;
 - e. If applicable according to A.R.S. § 36-2608, including documenting a dispensed opioid in the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - f. Addressing the criteria and procedures for tapering opioid prescription or ordering;
 - g. Addressing the criteria and procedures for offering or referring a patient for treatment for substance use disorder; and
 - h. If opioids are administered at the pain management clinic, including how, when, and by whom:
 - i. A patient's need for opioid administration is assessed,
 - ii. A patient receiving an opioid is monitored, and
 - iii. The actions taken according to subsections (D)(4)(h)(i) and (ii) are documented;
5. Cover accessibility and security of medical records;
6. Cover infection control, including methods for sterilizing equipment and supplies and methods for identifying, storing, and disposing of biohazardous medical waste; and
7. Cover emergency treatment, including:
 - a. A list of the medications, supplies, and equipment kept on the premises to provide treatment in response to an emergency caused by a procedure or medication administered at the pain management clinic;
 - b. A requirement that a cart or a container is available for emergency treatment that contains the medications, supplies, and equipment specified in the policies and procedures according to subsection (D)(7) (a);
 - c. A method to verify and document that the contents of the cart or container are available for emergency treatment; and
 - d. A method for ensuring a patient is transferred to a hospital or other health care institution to receive treatment for a medical emergency that

the pain management clinic is not authorized or not able to provide.

- E. As applicable and except when contrary to medical judgment for a patient, a medical director shall ensure that the policies and procedures in subsection (D)(4) are consistent with the Arizona Opioid Prescribing Guidelines or national opioid-prescribing guidelines, such as guidelines developed by the:
1. Centers for Disease Control and Prevention, or
 2. The U.S. Department of Veterans Affairs and the U.S. Department of Defense.
- F. A medical director shall, except as prohibited by Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2, ensure that:
1. If an opioid may have contributed to a patient's death:
 - a. Written notification of the patient's death is provided to the Department in a Department-provided format if:
 - i. A personnel member of the pain management clinic prescribed, ordered, or administered the opioid that may have contributed to the patient's death, or
 - ii. The patient's death occurred while the patient was on the premises of the pain management clinic; and
 - b. The written notification required by subsection (F)(1)(a)(i) is provided within one working day:
 - i. After the patient's death, if an opioid administered as part of treatment may have contributed to the death; or
 - ii. After a personnel member of the pain management clinic learns of the patient's death, if a prescribed opioid may have contributed to the patient's death; and
 - c. The written notification required by subsection (F)(1)(a)(ii) is provided according to R9-4-602; and
 2. Written notification of a suspected opioid overdose is provided to the Department according to R9-4-602.
- G. If the Department requests a patient's medical record for review, the licensee:
1. May provide the patient medical record to the Department either in paper or in an electronic format that is acceptable to the Department, and
 2. Shall ensure that documentation required by this Article is provided to the Department within two hours after a Department request.

R9-10-2004. Quality Management

A medical director shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
 - a. A method to identify, document, and evaluate opioid-related adverse reactions or other incidents;
 - b. A method to collect data on services provided to patients;
 - c. A method to use the data to identify concerns about the delivery of services related to patient care;
 - d. A method to make changes or take action in response to a concern identified according to subsection (1)(c); and
 - e. The frequency with which the documented report required in subsection (2) will be submitted to the licensee;
2. A documented report is submitted to the licensee that includes:
 - a. Each concern about the delivery of services related to patient care, and
 - b. Any changes made or actions taken in response to that concern; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the licensee.

R9-10-2005. Medication Services

A medical director shall ensure that:

1. Medications are stored in a locked area on the premises;
2. Only personnel members designated by policies and procedures have access to the locked area containing medications;
3. Expired, mislabeled, or unusable medications are disposed of according to policies and procedures;
4. If an opioid is administered at a pain management clinic, an opioid antagonist is available on the premises;
5. A medication error or an adverse reaction, including any actions taken in response to the medication error or adverse reaction, is:
 - a. Immediately reported to the medical director and licensee, and
 - b. Recorded in the patient's medical record; and
6. Medication information for a patient is maintained in the patient's medical

record.

R9-10-2006. Pain Management Services

- A.** A medical director shall ensure that a medical practitioner or nurse anesthetist remains on the premises until all patients who received a procedure at the pain management clinic are discharged.
- B.** A medical director shall ensure that, if a procedure other than the administration of an opioid is used to provide pain management services:
- 1.** Before the procedure is initially used on a patient, the patient is evaluated by:
 - a.** A medical practitioner or
 - b.** A nurse anesthetist, according to A.R.S. § 32-1634.04;
 - 2.** The procedure is performed by a personnel member qualified according to policies and procedures to perform the procedure; and
 - 3.** The following information is included in the patient's medical record:
 - a.** The evaluation of the patient required in subsection (B)(1),
 - b.** A record of the procedure, and
 - c.** Any adverse reaction to the procedure and any measures taken to address an adverse reaction.
- C.** Except as provided in subsection (E), a medical director shall ensure that a medical practitioner:
- 1.** Before prescribing an opioid for a patient of the pain management clinic:
 - a.** Conducts a physical examination of the patient;
 - b.** Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c.** Conducts an assessment of the patient's substance use risk;
 - d.** Explains to the patient or the patient's representative the risks and benefits associated with use of an opioid;
 - e.** Explains alternatives to a prescribed opioid; and
 - f.** Obtains informed consent from the patient or the patient's representative that meets the requirements in R9-10-2007(B), including the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication, if the patient:

- i. Is also prescribed or ordered a sedative-hypnotic medication, or
 - ii. Has been prescribed a sedative-hypnotic medication by another medical practitioner;
 - 2. Before ordering an opioid for a patient of the pain management clinic:
 - a. Conducts a physical examination of the patient;
 - b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c. Conducts an assessment of the patient's substance use risk;
 - d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of an opioid as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of an opioid;
 - e. If applicable, explains alternatives to an ordered opioid; and
 - f. Obtains informed consent from the patient or the patient's representative, according to R9-10-2007(B);
 - 3. When administering or causing administration of an opioid to a patient:
 - a. Before administration, identifies the patient's need for the opioid; and
 - b. Monitors the patient's response to the opioid; and
 - 4. Documents the pain management services provided in the patient's medical record according to R9-10-2008.
- D.** A medical practitioner is exempt from the requirements in subsection (C)(2), if:
- 1. An order for an opioid is part of treatment for a patient in an emergency;
 - 2. The order is issued according to policies and procedures that include procedures for:
 - a. Providing treatment without obtaining the consent of a patient or the patient's representative,
 - b. Ordering and administering an opioid in an emergency situation, and
 - c. Complying with the requirements in subsection (C)(2) after the

emergency is resolved; and

3. The emergency situation is documented in the patient's medical record.
- E.** The requirements in subsections (C)(1), (2), and (3), as applicable, do not apply when:
1. A personnel member of a pain management clinic prescribes, orders, or administers an opioid as part of treatment for a patient with an end-of-life condition or pain associated with an active malignancy; or
 2. A prescription for an opioid changes only the type or dosage of an opioid previously prescribed to the patient according to subsection (C)(1):
 - a. Before a pharmacist dispenses the opioid for the patient; or
 - b. If changing the opioid because the patient experienced an adverse reaction to the opioid, within 72 hours after a pharmacist dispensed the opioid for the patient.

R9-10-2007. Patient Rights

- A.** A licensee shall ensure that a patient is afforded the following rights and is informed of these rights:
1. To refuse treatment or withdraw consent for treatment;
 2. To have patient medical records kept confidential; and
 3. To be informed of proposed treatment and associated risks, possible complications, and alternatives before pain management services are provided.
- B.** A medical director shall ensure that before an opioid is prescribed or ordered for a patient, a medical practitioner obtains informed consent from the patient or patient's representative that includes:
1. The patient's:
 - a. Name,
 - b. Date of birth or other patient identifier, and
 - c. Condition for which an opioid is being prescribed or ordered;
 2. That an opioid is being prescribed or ordered;
 3. The potential risks, adverse reactions, complications, and medication interactions associated with the use of an opioid;
 4. If applicable, the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication;

5. Alternatives to a prescribed or ordered opioid;
6. The name and signature of the individual explaining the use of an opioid to the patient; and
7. The signature of the patient or the patient's representative and the date signed.

R9-10-2008. Medical Records

- A.** A medical director shall ensure that a medical record is established and maintained for a patient that contains:
1. Patient identification, including:
 - a. The patient's name, address, and date of birth;
 - b. The patient's representative, if applicable; and
 - c. The name and telephone number of an individual to contact in an emergency;
 2. The patient's medical history;
 3. The patient's physical examination;
 4. Laboratory test results;
 5. The patient's diagnosis, including co-occurring disorders;
 6. The patient's treatment plan;
 7. If applicable:
 - a. The effectiveness of the patient's current treatment,
 - b. The duration of the current treatment,
 - c. Alternative treatments tried by or planned for the patient, and
 - d. The expected benefit of a new treatment compared with continuing the current treatment;
 8. Each consent form signed by the patient or the patient's representative;
 9. The patient's medication information, including:
 - a. The patient's age and weight;
 - b. The medications and herbal supplements the patient is currently taking; and
 - c. Allergies or sensitivities to medications, antiseptic solutions, or latex;
 10. Prescriptions ordered for the patient and, if an opioid is prescribed or ordered:
 - a. The nature and intensity of the patient's pain,
 - b. The specific opioid and the reason for the prescription or order,

- c. The objectives used to determine whether the patient is being successfully treated, and
 - d. Other factors relevant to prescribing or ordering an opioid for the patient;
 - 11. Medications administered to the patient and, if an opioid is administered:
 - a. The patient's need for the opioid before the opioid was administered, and
 - b. The effect of the opioid administered; and
 - 12. A record of services provided to the patient.
- B.** A licensee shall ensure that:
- 1. A medical record is accessible only to the Department or personnel members authorized by policies and procedures;
 - 2. Medical record information is confidential and released only with the written informed consent of a patient or the patient's representative or as otherwise permitted by law; and
 - 3. A medical record is protected from loss, damage, or unauthorized use and is retained according to A.R.S. § 12-2297.
- C.** A medical director shall ensure that:
- 1. Only personnel authorized by policies and procedures record or sign an entry in a medical record;
 - 2. An entry in a medical record is dated and legible;
 - 3. An entry is authenticated;
 - 4. An entry is not changed after it has been recorded, but additional information related to an entry may be recorded in the medical record;
 - 5. When a verbal or telephone order is entered in the medical record, the entry is authenticated according to policies and procedures by the individual who issued the order;
 - 6. If a rubber-stamp signature or an electronic signature is used:
 - a. An individual's rubber-stamp or electronic signature is not used by another individual; and
 - b. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature; and
 - 7. If a pain management clinic maintains medical records electronically, the date

and time of an entry is recorded by the computer's internal clock.

R9-10-2009. Equipment and Safety Standards

A. A medical director shall ensure that:

1. The equipment is:
 - a. Sufficient to accommodate:
 - i. The services stated in the pain management clinic's scope of services, and
 - ii. An individual accepted as a patient by the pain management clinic;
 - b. Maintained in working order;
 - c. Tested and calibrated at least once every 12 months or according to the manufacturer's recommendations; and
 - d. Used according to the manufacturer's recommendations;
2. Documentation of each equipment test, calibration, and repair is maintained on the premises for at least 12 months after the date of the testing, calibration, or repair;
3. Equipment and supplies are clean and, if applicable, sterile before each use;
4. Personnel members wash hands after each direct patient contact and after handling soiled linen, soiled clothing, or biohazardous medical waste; and
5. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures.

B. A medical director shall establish an infection control program and ensure that:

1. The infection control program includes:
 - a. A method to identify and document infections that occur at the pain management clinic;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the pain management clinic;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the pain management clinic; and
 - d. Documentation of infection control activities, including:
 - i. The collection and analysis of infection control data,
 - ii. The actions taken related to infections and communicable diseases, and

- iii. Reports of communicable diseases; and
2. Infection control documentation is maintained for at least 12 months after the date of documentation.
- C. A medical director shall ensure that soiled linen and clothing are kept:
1. In a covered container, and
2. Separate from clean linen and clothing.
- D. A licensee shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal;
2. Make and document any repairs or corrections stated on the fire inspection report;
3. Maintain documentation of a current fire inspection;
4. Ensure that a written emergency plan is established, documented, and implemented that includes procedures for protecting the health and safety of patients and other individuals if circumstances arise in the pain management clinic that immediately threaten the life or health of patients and other individuals, such as a fire, natural disaster, loss of electrical power, or threat or incidence of violence; and
5. Ensure that an evacuation drill is conducted at least once every six months that includes all personnel members on the premises on the day of the evacuation drill.
- E. A licensee shall ensure that a pain management clinic has either:
1. Both of the following that are tested and serviced at least once every 12 months:
- a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in A.A.C. R9-1-412, that is in working order; and
- b. A sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in A.A.C. R9-1-412, that is in working order; or
2. Both of the following:
- a. A smoke detector installed in each hallway of the pain management clinic that is:

- i. Maintained in an operable condition;
- ii. Either battery operated or, if hard-wired into the electrical system of the pain management clinic, has a back-up battery; and
- iii. Tested monthly; and
- b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that:
 - i. Is available at the pain management clinic;
 - ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;
 - iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and
 - iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person.

R9-10-2010. Environmental and Physical Plant Standards

- A.** A licensee shall ensure that the premises:
 1. Provide lighting and ventilation to ensure the health and safety of a patient;
 2. Are maintained in a clean condition;
 3. Are free from a condition or situation that may cause a patient to suffer physical injury;
 4. Are maintained free from insects and vermin;
 5. Are smoke-free; and
 6. Are sufficient to accommodate:
 - a. The services stated in the pain management center's scope of services, and
 - b. An individual accepted as a patient by the pain management center.
- B.** A licensee shall ensure that if a pain management clinic collects urine specimens from a patient, the pain management clinic has at least one bathroom on the premises that:
 1. Contains:
 - a. A working sink with running water,

- b. A working toilet that flushes and has a seat,
- c. Toilet tissue,
- d. Soap for hand washing,
- e. Paper towels or a mechanical air hand dryer,
- f. Lighting, and
- g. A means of ventilation; and

2. Is for the exclusive use of the pain management clinic.



Sent via email

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Dear Mr. Bower:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, thank you for the opportunity to comment on the Arizona Department of Health Services (ADHS) proposed Pain Management Clinic (PMC) regulations published at 24 Ariz. Admin. Reg. 1901-1922.¹ As a result of our review with member representatives, AzHHA has four comments for ADHS' consideration. We appreciate the opportunity to submit these comments and hope that ADHS will take them into account in the final rule.

1. Scope of Services and Classification

As currently proposed, the PMC regulations are unclear as to whether an Outpatient Treatment Center (OTC) required by state law to license as a PMC is limited to providing only "pain management services" as a consequence of obtaining PMC status, or whether an OTC can continue to provide services under its existing OTC license. It is also unclear whether ADHS considers PMCs to be an OTC subclass or a separate class of health care institution.

Clarity in the regulations is needed because OTCs operating in rural areas of Arizona—such as community clinics—are often the only treatment provider available to aging populations, many of whom suffer from chronic pain and mental health disorders (like anxiety), and who receive treatment for these ailments from the OTC. As a result, rural community clinics may find that they fall within the legal definition of a PMC under the Opioid Epidemic Act of 2018 (the Act), must license as a PMC and comply with the PMC regulations. This is because the Act requires health care institutions and private

¹ All of the legal citations in this comment letter are to the proposed regulations published in the Arizona Administrative Register.

clinics to apply for licensure as a PMC if 51% or more of the facility's patients, in any month, are prescribed certain medications—opioids, benzodiazepines (commonly prescribed for anxiety), barbiturates or carisoprodol²—for more than 90 days within a 12 month period.³ The Act exempts hospitals, urgent care centers, ambulatory surgical centers, hospice facilities and nursing care institutions.⁴ However, the Act does not broadly exempt all OTCs, such as outpatient community clinics.

Patients, particularly those in rural areas, will suffer from the loss of critically important health services if such clinics are limited to providing “pain management services” only upon PMC licensure.

ADHS has the legal authority to permit OTCs required to license as PMCs to continue to provide other services under their existing OTC licenses or as a PMC. The Act does not require health care institutions or private clinics that fall within the PMC definition to provide “pain management services” only. Rather, the Act simply requires that a PMC meet the same licensure requirements for health care institutions, and that ADHS adopt additional rules covering the following:

1. Informed consent requirements.
2. The responsibilities of the medical director.
3. Record maintenance.
4. Reporting requirements.
5. Physical examination requirements.⁵

A licensed OTC already satisfies the licensure requirements for health care institutions and can satisfy additional licensing requirements relating to its provision of “pain management services,” while continuing to provide other health services to patients. For these reasons, AzHHA respectfully requests that ADHS clarify in the PMC regulations that a PMC may provide services other than pain management services.

Additionally, AzHHA requests that ADHS clarify whether PMCs are a subclass of OTCs. This clarity is needed so that licensed PMCs understand which regulatory requirements apply. ADHS’s proposed rule change to R9-10-1021(5)—the section applicable to OTCs authorized to provide pain management services—suggests that PMCs are a subclass of OTCs. Specifically, R9-10-1021(5) provides that: “An outpatient treatment center that is a pain management clinic, as defined in A.R.S. § 36-448.01, complies with 9 A.A.C. 10, Article 20.” However, the inclusion of PMC-specific provisions for administration, medication services, patient rights, equipment and safety standards, and environmental and physical plant standards suggests the opposite—that PMCs are a separate class and not an OTC subclass. These PMC-specific provisions

² The statute provides an exception if these medications are prescribed for medication-assisted treatment for substance use disorders. A.R.S. § 36-448.01(2).

³ A.R.S. § 36-448.01(2).

⁴ A.R.S. § 36-448.01(2).

⁵ A.R.S. § 36-448.02(B).

are very similar to, but not identical to, the OTC requirements. This raises questions as to which regulations apply to an OTC that is also a PMC.

2. Definition of Pain Management Services

Neither the current licensing regulations nor the proposed PMC regulations define “pain management services.” Yet ADHS requires that OTCs request ADHS approval to provide “pain management services”⁶ and imposes additional requirements on both OTCs and PMCs that provide these services. For example, OTCs and PMCs are required to provide pain management services under the direction of a physician or NP with advanced pain management certification.⁷ Understanding what ADHS’ means by “pain management services” is critical to OTC compliance with these regulations.

For example, AzHHA does not believe ADHS intends the treatment of acute pain to constitute “pain management services.” Nor does AzHHA believe that treating mild to moderate pain with non-narcotic pain killers, like aspirin, to constitute “pain management services.” AzHHA thus requests that ADHS adopt a definition of “pain management services” that is consistent with the Arizona’s Legislature intent behind the PMC licensing requirement in the Act. For instance, ADHS could define “pain management services” as the use of the statutorily listed medications for the treatment of chronic pain.

3. Naturopathic Physicians

The proposed regulations expressly permit a PMC to provide “pain management services” under the direction of a naturopathic physician.⁸ However, it is unclear whether an OTC authorized to provide “pain management services” that is not a PMC can also do so under the direction of a naturopathic physician. AzHHA thus requests that ADHS define “physician” for purposes of R9-10-1021 as “an individual licensed as a physician according to A.R.S. Title 32, Chapter 13, 14, or 17.”

4. Outpatient Treatment Centers and Compliance with Opioid Prescribing and Treatment Regulations

Finally, AzHHA requests that ADHS clarify what opioid treatment regulations apply to OTCs that are authorized to provide “pain management services,” but are not PMCs.

The proposed regulations are clear that the “Opioid Prescribing and Treatment” requirements in R9-10-120 do not apply to PMCs.⁹ This is because PMCs are subject to

⁶ A.A.C. § R9-10-1002(A)(2)(f).

⁷ See, e.g., A.A.C. § R9-10-1021.

⁸ A.A.C. § R9-10-2003(C)(1) (permitting “pain management services” to be provided under the direction of a “physician”); *id.* § R9-10-2001 (defining “physician” as “an individual licensed as a physician according to A.R.S. Title 32, Chapter 13, 14 [naturopathic medicine], or 17”).

⁹ A.A.C. § R9-10-120(A) (“This Section does not apply to a health care institution licensed under Article 20 of this Chapter.”).

the specific requirements in R9-10-2006 with respect to opioid use for treatment purposes. The proposed regulations are equally clear that OTCs authorized to provide “pain management services” must comply with R9-10-2006 when using a controlled substance that is an opioid for those services.¹⁰ However, it is unclear whether OTCs must also comply with R9-10-120 when using opioid for purposes other than “pain management services,” such as the provision of medication-assisted treatment for substance use disorders.

The requirements in R9-10-120 are similar to, but different from, the requirements in R9-10-2006. Both regulations require OTCs to adopt opioid compliance policies and procedures, but what must be done under those policies is sometimes different. For instance, under R9-10-120(E)(1), an OTC provider ordering an opioid for purposes other than “pain management services” can rely on a substance use risk assessment and physical examination done within the last 30 days under certain circumstances. By contrast, under R9-10-2006(C)(2), an OTC provider ordering an opioid for “pain management services” must perform a new assessment and examination.

AzHHA believes it is unduly burdensome and confusing to OTC providers to require compliance with one set of policies and procedures when opioids are used for “pain management services,” and another set when opioids are used to provide other services. Because OTCs authorized to perform “pain management services” will likely be using opioids in connection with other medical services, AzHHA requests that ADHS require such OTCs to comply with the requirements in R9-10-120 only. This could be accomplished by deleting R9-10-1021(3)(b) in the final rule.

Once again, we appreciate the opportunity to comment on the proposed regulations. Please feel free to contact me if you have any questions.

Sincerely,



Debbie Johnston
Senior V.P., Policy Development

CC:
Robert Lane, Chief, Robert.Lane@azdhs.gov

¹⁰ A.A.C. § R9-10-1021(3)(b).



August 7, 2018

Colby Bower, Assistant Director
Arizona Department of Health Services
Public Health Licensing Services
150 N. 18th Ave., Suite 510
Phoenix, AZ 85007

Re: Pest Control, Minimum Standards, and Licensing of Pain Management Clinics in Arizona

Dear Mr. Colby Bower,

The Arizona Pest Professional Organization (AzPPO) represents professional structural pest management or “pest control” companies in Arizona and appreciates the opportunity to comment on the proposed rule published on July 13, 2018, 24 A.A.R. 513, regarding the minimum standards and licensing of pain management clinics in Arizona. AzPPO’s member companies manage pests including rats, mice, ants, cockroaches, bed bugs, mosquitoes, spiders, stinging insects, termites and other pests in countless commercial, residential and institutional settings. AzPPO members are committed to providing quality pest management services that protect public health, food and property.

Health care institutions such as pain management clinics, hospitals, long-term care facilities, emergency medical care centers and physical or mental rehabilitation facilities, face many challenges to ensure that they meet the highest level of pest control, public health protection and sanitation while caring for sensitive populations. Because pests pose a number of health threats through the spread of bacteria, viruses, and contamination of surfaces, medical supplies and equipment, ensuring that the facility remains pest-free is absolutely vital.

The proposed rule outlines the importance of pest control and requires a pest control program pursuant to A.A.C. R9-10-2001 (156) and R9-10-2010 (4). AzPPO believes that the State should ensure that ALL health care institutions including pain management clinics in Arizona are protected with professional pest control services from dangerous and deadly pests. Therefore, we propose that these facilities should contract with a professional pest control company licensed and registered with the State.

It is imperative that healthcare facilities are protected from adverse harm caused by dangerous and deadly pests. The best way to ensure this is to implement minimum standards that require the use of professional pest management companies registered with the State of Arizona with certified and licensed pesticide applicators. Professional pest management companies in Arizona possess the most experience, knowledge and specialized training to execute and uphold the environmental and physical plant standards outlined in A.A.C. R9-10-2010 (4) and the definition of a pest control program pursuant to A.A.C. R9-10-2001(156).

Please find AzPPO's proposed amended language to A.A.C. R9-10-2001(156) and R9-10-2010 (4) in purple below:

R9-10-2001. Definitions

150- 156. "Pest control program" means activities provided by a structural pest control company holding a valid business license pursuant to A.A.C. R3-8-202 and with applicators certified, licensed, and registered in the industrial and institutional category pursuant to A.A.C. R3-8-102(1) that minimize the presence of insects and vermin in a health care institution to ensure that a patient's health and safety is not at risk. The licensee approved to operate a health care institution shall enter into an agreement with a structural pest control company for pest control services and shall maintain a record of the agreement for pest control services on its premises, and shall develop an administrative policy concerning cooperation with a pest control company providing pest control services. The agreement for pest control services required by this section shall be subject to inspection as part of any regular inspection performed by the Department of Health Services.

R9-10-2010. Environmental and Physical Plant Standards

A. A licensee shall ensure that the premises:

1. Provide lighting and ventilation to ensure the health and safety of a patient;
2. Are maintained in a clean condition;
3. Are free from a condition or situation that may cause a patient to suffer physical injury;
4. Are maintained free from insects and vermin through a pest control program pursuant to A.A.C. R9-10-101(156);

Highly Professional, Regulated, and Trained Industry: The U.S. Environmental Protection Agency (EPA) and the Arizona Department of Agriculture are the two primary government agencies that currently regulate the structural pest control industry in our state. In order to serve their customers, certified structural pesticide applicators have to undergo extensive training and certification protocols to meet rigorous federal and state standards and pass an exam with a score of at least a 75% or better. Additionally, structural pesticide applicators must complete continuing education courses to ensure that they are competent and sensitive stewards of our environment.

Pest Management Professionals (PMPs) are highly trained-in and practice Integrated Pest Management (IPM): IPM is a pest management system that uses all suitable techniques in a total management system, to prevent pests from reaching unacceptable levels, or to reduce existing pest populations to acceptable levels. The purpose of IPM is to manage pests with the least possible impact on people, property, and the environment.

IPM Methods include:

- Mechanical control
- Habitat modification
- Biological control
- Sanitation control
- Physical control
- Chemical control

Dangerous and Deadly Pests in Pain Management Clinics and Health Care Facilities:

Cockroaches: Cockroaches spread at least 33 kinds of bacteria, six kinds of parasitic worms and at least seven other kinds of human pathogens. According to the Penn State Department of Entomology, German cockroaches commonly cause:

“Different forms of gastroenteritis (food poisoning, dysentery, diarrhea, and other illnesses) appear to be the principal diseases transmitted by German cockroaches. The organisms causing these diseases are carried on the legs and bodies of cockroaches and are deposited on food and utensils as the cockroaches forage. Cockroach excrement and cast skins also contain a number of allergens to which many people exhibit allergic responses, such as skin rashes, watery eyes and sneezing, congestion of nasal passages, and asthma.”¹

As vectors for disease, cockroaches often carry bacteria such as *Escherichia coli* and *Salmonella* on their bodies, which not only contaminate food, cooking equipment and food preparation surfaces, but also compromise the sterile environment of operating rooms and the cleanliness of exam rooms and patient rooms.² Cockroaches also are responsible for increasing the severity of asthma and indoor allergy symptoms, especially in children and the elderly. Cockroaches are most likely to be found in locker and break rooms, laundry rooms, janitorial closets, food service areas, restaurants and snack bars, vending machine areas, food carts, floor drains and sink areas, intensive care units (ICUs), kidney dialysis and autopsy rooms as well as loading docks and garbage disposal areas.³

Rodents: Rodents transmit diseases like murine typhus and salmonellosis indirectly through their droppings, saliva, urine and hosting fleas. Rodents exacerbate allergies and asthma attacks due to allergenic proteins in their urine and feces. According to the U.S. Centers for Disease Control and Prevention (CDC), rodents transmit over 35 diseases such as hantavirus, rat bite fever, trichinosis,

¹ "German Cockroaches (Department of Entomology)." Department of Entomology (Penn State University). January 2013. <http://ento.psu.edu/extension/factsheets/german-cockroaches>.

² Jim Fredericks, "How to Control Pests in Health Care Facilities." *Health Facilities Management*, www.hfmmagazine.com/articles/1478-how-to-control-pests-in-health-care-facilities.

³ Jim Fredericks, "How to Control Pests in Health Care Facilities."

plague, infectious jaundice, Weil's disease and leptospirosis.⁴ Leptospirosis results in an estimated 1.03 million annual cases and 58,900 deaths around the world.⁵ While the majority of deaths caused by leptospirosis occur in the developing world, the United States is not immune.

Rodents can enter buildings through almost any opening or crack larger than a dime. Once inside, rodents can cause structural damage as they are able to chew through wallboards, cardboard, wood and plaster and through electrical wiring, increasing the potential risk of fire. Additionally, rodents defecate constantly and can easily contaminate any and all food and food preparation surfaces. It's important to inspect for rodent droppings, especially in undisturbed areas like cafeteria pantries, storage areas and along walls. Rodents typically are found in laundry rooms, food service areas, food carts, loading docks and garbage disposal areas.

Ants: While ants can contaminate food and food surfaces, the species of ant that is most worrisome in health care settings is the pharaoh ant. These ants can spread more than a dozen disease pathogens including *Salmonella* and *Streptococcus pyogenes* and are problematic because of their attraction to intravenous units, medical preparations and open wounds.⁶ Ants can be found in a wide range of laundry areas, ICUs, kidney dialysis and autopsy rooms.⁷

Flies: Flies are much more than a buzzing annoyance, in fact, the threats they pose are serious. According to the Penn State Department of Entomology, flies carry a plethora of harrowing diseases because they feed on fecal matter, discharges from wounds and sores, and excrete and vomit on food among other causes:

"House flies are strongly suspected of transmitting at least 65 diseases to humans, including typhoid fever, dysentery, cholera, poliomyelitis, yaws, anthrax, tularemia, leprosy and tuberculosis. Flies regurgitate and excrete wherever they come to rest and thereby mechanically transmit disease organisms."⁸

Additionally, a 2013 National Institute of Health (NIH) published study titled, "Role of Flies as Vectors of Foodborne Pathogens in Rural Areas" has shown that various species of flies not only carry harmful bacteria such as, *Campylobacter*, *E. coli*, *Salmonella*, and *Shigella*, but also multiple viruses and contribute to the resistance of antibiotics across the world. This study found that regarding anti-biotic resistance, "...the carriage of antibiotic resistant bacteria by flies in the environment increases the potential for human exposure to drug-resistant bacteria."⁹

⁴ "Rodents," Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/rodents/diseases/direct.html.

⁵ F Costa, JE Hagan, J Calcagno, M Kane, P Torgerson, MS Martinez-Silveira, C Stein, B Abela-Ridder, Ko AI (2015). "Global Morbidity and Mortality of Leptospirosis: A Systematic Review" <http://journals.plos.org/plosntds/article/file?id=10.1371/journal.pntd.0003898&type=printable>

⁶ Jim Fredericks, "How to Control Pests in Health Care Facilities."

⁷ Jim Fredericks, "How to Control Pests in Health Care Facilities."

⁸ "House Flies (Department of Entomology)." Department of Entomology (Penn State University). January 2013. Accessed July 17, 2017. <http://ento.psu.edu/extension/factsheets/house-flies>.

⁹ C. Barreiro, H. Albano, J. Silva, & P. Teixeira, Role of Flies as Vectors of Foodborne Pathogens in Rural Areas. ISRN Microbiology, 2013, 718780. <http://doi.org/10.1155/2013/718780>

Bedbugs: A 2013 survey conducted by the National Pest Management Association and the University of Kentucky found that 33 percent of pest control professionals have treated for bedbugs in hospitals, while 46 percent did so in nursing homes.¹⁰ Although bedbugs are not considered vectors of disease, their bites can leave itchy, red welts and their presence can cause anxiety and sleeplessness. In some cases, patients also can experience a secondary infection caused by scratching at the bites and causing skin trauma, allowing for a port of entry for infection. Because bedbugs and their eggs hitchhike in bags, shoes and on people, they easily can be brought into a health care facility. Bedbugs most often are found in patient room beds, waiting area furniture, and laundry facilities.¹¹

Conclusion

Pest prevention and management cannot be viewed as being unrelated to the overall safety and cleanliness of health care facilities. Rather, it must be viewed as critical to achieving these goals. Requiring a certified, licensed, and registered pest control company for pest control programs in health care facilities is an investment in the health of patients and staff as well as an investment in maintaining a sound public reputation. The benefits of using a professional pest management company often far outweigh any associated costs and, in the long run, may save the facility valuable funds due to the proactive preventive measures put in place. AzPPO appreciates the opportunity to comment on the proposed rule and we hope that the Arizona Department of Health Services is committed to protecting public health and property by requiring that pain management clinics and health care institutions in Arizona contract with professional pest management companies for their pest control programs. Thank you for your time.

Sincerely,

Stu Keenan
President
AzPPO

Chris Gilles
President-Elect
AzPPO

¹⁰ Jim Fredericks, "How to Control Pests in Health Care Facilities."

¹¹ Jim Fredericks, "How to Control Pests in Health Care Facilities."

Pain Management Clinics Rulemaking Oral Proceeding

COMMENTS RECEIVED DURING ORAL PROCEEDING

August 13, 2018

This public hearing is being held for the purpose of providing adequate discussion and obtaining public comments regarding the new pain management clinics rules, which are being adopted to comply with Laws 2018, Ch. 1 and Laws 2018, Ch. 243. Laws 2018, Ch. 1 requires a pain management clinic to be licensed as a health care institution and requires the Department to adopt rules that prescribe informed consent requirements, the responsibilities of the medical director, record maintenance, reporting requirements, and physical examination requirements. Laws 2018, Ch. 243 allows a nurse practitioner with advanced pain certification to be designated as a medical director for a pain management clinic.

Commenter: Melissa Soliz (Coppersmith Brockelman PLC) ... member of the public representing self

Question: Asked if pain management clinics (PMC) are going to be a subclass of outpatient treatment centers (OTC), if the institution has to be licensed as a PMC is already licensed as an OTC, would they then be a subclass of an OTC, and would they be operating under both their OTC license and the PMC?

Response: These are, pain management clinics, their own class. OTCs that provide pain management services will continue to exist. Reference to R9-10-1021 was provided.

Question: What happens for those OTCs that are authorized to perform pain management services if they run a metric and let's say they are now at a place were 51% or more of their patients are being prescribed these medications for greater than a 90 day period and required by legislation to now within 60 days license with DHS as a PMC. Will they both still have their OTC license and now this new PMC license because they have exceeded this threshold or is there only one license?

Response: Health care institutions can only be licensed for one class or subclass; and once that metrics is exceeded, they then would meet the definition of a PMC and would need to be licensed as a PMC or licensed to the highest level that they are providing.

Program clarified that an OTC providing more than just pain management services and the pain management services metrics has now trumped the requirement to be separately licensed, by definition. Program, referred to page 38 of the proposed rules, stated that R9-10-1021 talks about pain management services and what needs to be in existence. Subsection (5) provides that an OTC that is a pain management clinic, as defined in A.R.S. § 36-448.01, will also have to comply with the rules in Article 20. And will be an OTC, but will have to meet requirements in Article 20 rules for pain management clinics because they have exceeded the metrics.

Question: So under R9-10-1021(5), does that mean they do not need to do a separate licensure as a PMC or they still have to do a separate licensure as well?

Response: They will not have to do a separate licensure. It will be an OTC that also is a PMC and will need to meet Article 20 rules in addition to all the rules in Article 10.

- Question: What happens when there is a rule in Article 10, like plant safety standards and equipment standards that are not exactly like the new Article 20 rules or do they comply with both or do they comply with Article 20? Commenter cited Section 2010, physical plant standards, stating that if compared to OTC physical plant standards, there are differences. That is also true for R9-10-2009, equipment and safety standards; R9-10-2007, patient rights; and R9-10-2005, medication services.
- Response: We will require the pain management services to meet the highest regulations.
- Question: Will there be a definition added for pain management services? So OTCs know when they need to get the additional authorization and/or the licensure; so they can determine if they are a PMC.
- Response: Department has added in Article 1 a definition of “pain management clinic.” Pain management services are the ability to provide pain management (R9-10-1021) as long as you do not exceed the metric. But the concept of pain management services should be the same as the delivery model as you would find if you were required by the metrics to become a pain management clinic.
- Question: When you say required by the metrics, are you referring to the opioid epidemic act?
- Response: Yes.
- Question: Does that mean you only provide pain management services when you prescribing any of those drugs?
- Response: Those drugs and less than the metric that requires you to be licensed.
- Question: Would pain management services include treatments for acute pain or are we only talking about chronic pain?
- Response: Typically, chronic pain. However, you do need to consider that relationship to Article 1. Article 1 has added Section 120 which is the prescribing and ordering of opioids in any of the licensed health care institutions. So an organization has to clearly look at Article 1 as it relates to R9-10-120 because they are a health care institution whether you are an OTC, PMC, or hospital. Line them up in order to self-direct based on your business practice – how you are going to operate.
- Question: So, for example an OTC, they might use opioids for other services where maybe it is for just acute pain or maybe for medication assisted treatment and so for those OTCs, authorized by DHS to provide pain management services, the regulations say in R9-10-1020 do not apply to them (PMC); because they have very specific regulations for opioid prescribing, administering, and ordering. But for the OTCs that are authorized to provide pain management services but are not a PMC that same exclusion does not apply yet they are also required to comply with 20 as pointed out with respect to the pain management services; they have to follow those regulations. Those regulations require that you have policies and procedures in place when you are using opioids for pain management services, but if the OTC in my example, also required to have a separate set of policies and procedures in place for opioid use under R9-10-1020 when they are prescribing, administering, or ordering for purposes other than pain management services? (Time: 18:50 min)

Response: Separate policies and procedures are not required. However, existing policies and procedures are required to address the different circumstances that may arise in that clinic. It is at the discretion of the facility to develop their policies and procedures to cover all required categories.

Question: Can those services in an OTC also be done under the direction of a naturopathic physician? If so, should there be some clarification to make it clear?

Response: OTC and naturopathic physician are not in the scope of this rulemaking and the Department did not receive an exception from the Governor to amend Article 10 rules other than as related to Laws 2018, Ch. 1 and Laws 2018, Ch. 243.

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ARTICLE 1. GENERAL**R9-10-101. Definitions**

In addition to the definitions in A.R.S. § 36-401(A), the following definitions apply in this Chapter unless otherwise specified:

1. "Abortion clinic" has the same meaning as in A.R.S. § 36-449.01.
2. "Abuse" means:
 - a. The same:
 - i. For an individual 18 years of age or older, as in A.R.S. § 46-451; and
 - ii. For an individual less than 18 years of age, as in A.R.S. § 8-201;
 - b. A pattern of ridiculing or demeaning a patient;
 - c. Making derogatory remarks or verbally harassing a patient; or
 - d. Threatening to inflict physical harm on a patient.
3. "Accredited" has the same meaning as in A.R.S. § 36-422.
4. "Activities of daily living" means ambulating, bathing, toileting, grooming, eating, and getting in or out of a bed or a chair.
5. "Adjacent" means not intersected by:
 - a. Property owned, operated, or controlled by a person other than the applicant or licensee; or
 - b. A public thoroughfare.
6. "Administrative completeness review time-frame" has the same meaning as in A.R.S. § 41-1072.
7. "Administrative office" means a location used by personnel for recordkeeping and record retention but not for providing medical services, nursing services, or health-related services.
8. "Admission" means, after completion of an individual's screening or registration by a health care institution, the individual begins receiving physical health services or behavioral health services and is accepted as a patient of the health care institution.
9. "Adult" has the same meaning as in A.R.S. § 1-215.
10. "Adult behavioral health therapeutic home" means a residence that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to a case manager related to behavior for an individual 18 years of age or older based on the individual's behavioral health issue and need for behavioral health services and may provide behavioral health services under the clinical oversight of a behavioral health professional.
11. "Adverse reaction" means an unexpected outcome that threatens the health or safety of a patient as a result of a medical service, nursing service, or health-related service provided to the patient.
12. "Ancillary services" means services other than medical services, nursing services, or health-related services provided to a patient.
13. "Anesthesiologist" means a physician granted clinical privileges to administer anesthesia.
14. "Applicant" means a governing authority requesting:
 - a. Approval of a health care institution's architectural plans and specifications, or
 - b. A health care institution license.
15. "Application packet" means the information, documents, and fees required by the Department for the:
 - a. Approval of a health care institution's modification or construction, or
 - b. Licensing of a health care institution.
16. "Assessment" means an analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.
17. "Assistance in the self-administration of medication" means restricting a patient's access to the patient's medication and providing support to the patient while the patient takes the medication to ensure that the medication is taken as ordered.
18. "Attending physician" means a physician designated by a patient to participate in or coordinate the medical services provided to the patient.
19. "Authenticate" means to establish authorship of a document or an entry in a medical record by:
 - a. A written signature;
 - b. An individual's initials, if the individual's written signature appears on the document or in the medical record;
 - c. A rubber-stamp signature; or
 - d. An electronic signature code.
20. "Authorized service" means specific medical services, nursing services, or health-related services provided by a specific health care institution class or subclass for which the health care institution is required to obtain approval from the Department before providing the medical services, nursing services, or health-related services.
21. "Available" means:
 - a. For an individual, the ability to be contacted and to provide an immediate response by any means possible;
 - b. For equipment and supplies, physically retrievable at a health care institution; and
 - c. For a document, retrievable by a health care institution or accessible according to the applicable time-frames in this Chapter.
22. "Behavioral care":
 - a. Means limited behavioral health services, provided to a patient whose primary admitting diagnosis is related to the patient's need for physical health services, that include:
 - i. Assistance with the patient's psychosocial interactions to manage the patient's behavior that can be performed by an individual without a professional license or certificate including:
 - (1) Direction provided by a behavioral health professional, and
 - (2) Medication ordered by a medical practitioner or behavioral health professional; or
 - ii. Behavioral health services provided by a behavioral health professional on an intermittent basis to address the patient's significant psychological or behavioral response to an identifiable stressor or stressors; and
 - b. Does not include court-ordered behavioral health services.
23. "Behavioral health facility" means a behavioral health inpatient facility, a behavioral health residential facility, a substance abuse transitional facility, a behavioral health specialized transitional facility, an outpatient treatment center that only provides behavioral health services, an adult behavioral health therapeutic home, a behavioral health respite home, or a counseling facility.
24. "Behavioral health inpatient facility" means a health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

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- a. Have a limited or reduced ability to meet the individual's basic physical needs;
 - b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
 - c. Be a danger to self;
 - d. Be a danger to others;
 - e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
 - f. Be gravely disabled.
25. "Behavioral health issue" means an individual's condition related to a mental disorder, a personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.
26. "Behavioral health observation/stabilization services" means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:
- a. Requires nursing services,
 - b. May require medical services, and
 - c. May be a danger to others or a danger to self.
27. "Behavioral health paraprofessional" means an individual who is not a behavioral health professional who provides, under supervision by a behavioral health professional, the following services to a patient to address the patient's behavioral health issue:
- a. Services that, if provided in a setting other than a health care institution would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or
 - b. Health-related services.
28. "Behavioral health professional" means:
- a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
 - i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or
 - ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101; - b. A psychiatrist as defined in A.R.S. § 36-501;
 - c. A psychologist as defined in A.R.S. § 32-2061;
 - d. A physician;
 - e. A behavior analyst as defined in A.R.S. § 32-2091;
 - f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
 - g. A registered nurse.
29. "Behavioral health residential facility" means a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
- a. Limits the individual's ability to be independent, or
 - b. Causes the individual to require treatment to maintain or enhance independence.
30. "Behavioral health respite home" means a residence where respite care services, which may include assistance in the self-administration of medication, are provided to an individual based on the individual's behavioral health issue and need for behavioral health services.
31. "Behavioral health specialized transitional facility" means a health care institution that provides inpatient behavioral health services and physical health services to an individual determined to be a sexually violent person according to A.R.S. Title 36, Chapter 37.
32. "Behavioral health staff" means a:
- a. Behavioral health paraprofessional,
 - b. Behavioral health technician, or
 - c. Personnel member in a nursing care institution or assisted living facility who provides behavioral care.
33. "Behavioral health technician" means an individual who is not a behavioral health professional who provides, with clinical oversight by a behavioral health professional, the following services to a patient to address the patient's behavioral health issue:
- a. Services that, if provided in a setting other than a health care institution would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or
 - b. Health-related services.
34. "Biohazardous medical waste" has the same meaning as in A.A.C. R18-13-1401.
35. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
36. "Case manager" means an individual assigned by an entity other than a health care institution to coordinate the physical health services or behavioral health services provided to a patient at the health care institution.
37. "Certification" means, in this Article, a written statement that an item or a system complies with the applicable requirements incorporated by reference in A.A.C. R9-1-412.
38. "Certified health physicist" means an individual recognized by the American Board of Health Physics as complying with the health physics criteria and examination requirements established by the American Board of Health Physics.
39. "Change in ownership" means conveyance of the ability to appoint, elect, or otherwise designate a health care institution's governing authority from an owner of the health care institution to another person.
40. "Chief administrative officer" or "administrator" means an individual designated by a governing authority to implement the governing authority's direction in a health care institution.
41. "Clinical laboratory services" means the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or impairment of a human being, or for the assessment of the health of a human being, including procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.
42. "Clinical oversight" means:
- a. Monitoring the behavioral health services provided by a behavioral health technician to ensure that the behavioral health technician is providing the behavioral health services according to the health care institution's policies and procedures,
 - b. Providing on-going review of a behavioral health technician's skills and knowledge related to the provision of behavioral health services,
 - c. Providing guidance to improve a behavioral health technician's skills and knowledge related to the provision of behavioral health services, and

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- d. Recommending training for a behavior health technician to improve the behavioral health technician's skills and knowledge related to the provision of behavioral health services.
- 43. "Clinical privileges" means authorization to a medical staff member to provide medical services granted by a governing authority or according to medical staff bylaws.
- 44. "Collaborating health care institution" means a health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to:
 - a. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home, and
 - b. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident's treatment plan.
- 45. "Communicable disease" has the same meaning as in A.R.S. § 36-661.
- 46. "Conspicuously posted" means placed:
 - a. At a location that is visible and accessible; and
 - b. Unless otherwise specified in the rules, within the area where the public enters the premises of a health care institution.
- 47. "Consultation" means an evaluation of a patient requested by a medical staff member or personnel member.
- 48. "Contracted services" means medical services, nursing services, health-related services, ancillary services, or environmental services provided according to a documented agreement between a health care institution and the person providing the medical services, nursing services, health-related services, ancillary services, or environmental services.
- 49. "Contractor" has the same meaning as in A.R.S. § 32-1101.
- 50. "Controlled substance" has the same meaning as in A.R.S. § 36-2501.
- 51. "Counseling" has the same meaning as "practice of professional counseling" in A.R.S. § 32-3251.
- 52. "Counseling facility" means a health care institution that only provides counseling, which may include:
 - a. DUI screening, education, or treatment according to the requirements in 9 A.A.C. 20, Article 1; or
 - b. Misdemeanor domestic violence offender treatment according to the requirements in 9 A.A.C. 20, Article 2.
- 53. "Court-ordered evaluation" has the same meaning as "evaluation" in A.R.S. § 36-501.
- 54. "Court-ordered pre-petition screening" has the same meaning as in A.R.S. § 36-501.
- 55. "Court-ordered treatment" means treatment provided according to A.R.S. Title 36, Chapter 5.
- 56. "Crisis services" means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.
- 57. "Current" means up-to-date, extending to the present time.
- 58. "Daily living skills" means activities necessary for an individual to live independently and include meal preparation, laundry, housecleaning, home maintenance, money management, and appropriate social interactions.
- 59. "Danger to others" has the same meaning as in A.R.S. § 36-501.
- 60. "Danger to self" has the same meaning as in A.R.S. § 36-501.
- 61. "Detoxification services" means behavioral health services and medical services provided to an individual to:
 - a. Reduce or eliminate the individual's dependence on alcohol or other drugs, or
 - b. Provide treatment for the individual's signs or symptoms of withdrawal from alcohol or other drugs.
- 62. "Diagnostic procedure" means a method or process performed to determine whether an individual has a medical condition or behavioral health issue.
- 63. "Dialysis" means the process of removing dissolved substances from a patient's body by diffusion from one fluid compartment to another across a semi-permeable membrane.
- 64. "Dialysis services" means medical services, nursing services, and health-related services provided to a patient receiving dialysis.
- 65. "Dialysis station" means a designated treatment area approved by the Department for use by a patient receiving dialysis or dialysis services.
- 66. "Dialyzer" means an apparatus containing semi-permeable membranes used as a filter to remove wastes and excess fluid from a patient's blood.
- 67. "Disaster" means an unexpected occurrence that adversely affects a health care institution's ability to provide services.
- 68. "Discharge" means a documented termination of services to a patient by a health care institution.
- 69. "Discharge instructions" means documented information relevant to a patient's medical condition or behavioral health issue provided by a health care institution to the patient or the patient's representative at the time of the patient's discharge.
- 70. "Discharge planning" means a process of establishing goals and objectives for a patient in preparation for the patient's discharge.
- 71. "Discharge summary" means a documented brief review of services provided to a patient, current patient status, and reasons for the patient's discharge.
- 72. "Disinfect" means to clean in order to prevent the growth of or to destroy disease-causing microorganisms.
- 73. "Documentation" or "documented" means information in written, photographic, electronic, or other permanent form.
- 74. "Drill" means a response to a planned, simulated event.
- 75. "Drug" has the same meaning as in A.R.S. § 32-1901.
- 76. "Electronic" has the same meaning as in A.R.S. § 44-7002.
- 77. "Electronic signature" has the same meaning as in A.R.S. § 44-7002.
- 78. "Emergency" means an immediate threat to the life or health of a patient.
- 79. "Emergency medical services provider" has the same meaning as in A.R.S. § 36-2201.
- 80. "Environmental services" means activities such as housekeeping, laundry, facility maintenance, or equipment maintenance.
- 81. "Equipment" means, in this Article, an apparatus, a device, a machine, or a unit that is required to comply with the specifications incorporated by reference in A.A.C. R9-1-412.
- 82. "Exploitation" has the same meaning as in A.R.S. § 46-451.

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83. "Factory-built building" has the same meaning as in A.R.S. § 41-2142.
84. "Family" or "family member" means an individual's spouse, sibling, child, parent, grandparent, or another individual designated by the individual.
85. "Food services" means the storage, preparation, serving, and cleaning up of food intended for consumption in a health care institution.
86. "Garbage" has the same meaning as in A.A.C. R18-13-302.
87. "General consent" means documentation of an agreement from an individual or the individual's representative to receive physical health services to address the individual's medical condition or behavioral health services to address the individual's behavioral health issues.
88. "General hospital" means a subclass of hospital that provides surgical services and emergency services.
89. "Gravely disabled" has the same meaning as in A.R.S. § 36-501.
90. "Hazard" or "hazardous" means a condition or situation where a patient or other individual may suffer physical injury.
91. "Health care directive" has the same meaning as in A.R.S. § 36-3201.
92. "Hemodialysis" means the process for removing wastes and excess fluids from a patient's blood by passing the blood through a dialyzer.
93. "Home health agency" has the same meaning as in A.R.S. § 36-151.
94. "Home health aide" means an individual employed by a home health agency to provide home health services under the direction of a registered nurse or therapist.
95. "Home health aide services" means those tasks that are provided to a patient by a home health aide under the direction of a registered nurse or therapist.
96. "Home health services" has the same meaning as in A.R.S. § 36-151.
97. "Hospice inpatient facility" means a subclass of hospice that provides hospice services to a patient on a continuous basis with the expectation that the patient will remain on the hospice's premises for 24 hours or more.
98. "Hospital" means a class of health care institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient.
99. "Immediate" means without delay.
100. "Incident" means an unexpected occurrence that harms or has the potential to harm a patient, while the patient is:
- On the premises of a health care institution, or
 - Not on the premises of a health care institution but directly receiving physical health services or behavioral health services from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution.
101. "Infection control" means to identify, prevent, monitor, and minimize infections.
102. "Informed consent" means:
- Advising a patient of a proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure; alternatives to the treatment, surgical procedure, psychotropic drug, or diagnostic procedure; and associated risks and possible complications; and
 - Obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure from the patient or the patient's representative.
103. "In-service education" means organized instruction or information that is related to physical health services or behavioral health services and that is provided to a medical staff member, personnel member, employee, or volunteer.
104. "Interval note" means documentation updating a patient's:
- Medical condition after a medical history and physical examination is performed, or
 - Behavioral health issue after an assessment is performed.
105. "Isolation" means the separation, during the communicable period, of infected individuals from others, to limit the transmission of infectious agents.
106. "Leased facility" means a facility occupied or used during a set time period in exchange for compensation.
107. "License" means:
- Written approval issued by the Department to a person to operate a class or subclass of health care institution at a specific location; or
 - Written approval issued to an individual to practice a profession in this state.
108. "Licensed occupancy" means the total number of individuals for whom a health care institution is authorized by the Department to provide crisis services in a unit providing behavioral health observation/stabilization services.
109. "Licensee" means an owner approved by the Department to operate a health care institution.
110. "Manage" means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.
111. "Medical condition" means the state of a patient's physical or mental health, including the patient's illness, injury, or disease.
112. "Medical director" means a physician who is responsible for the coordination of medical services provided to patients in a health care institution.
113. "Medical history" means an account of a patient's health, including past and present illnesses, diseases, or medical conditions.
114. "Medical practitioner" means a physician, physician assistant, or registered nurse practitioner.
115. "Medical record" has the same meaning as "medical records" in A.R.S. § 12-2291.
116. "Medical staff" means physicians and other individuals licensed pursuant to A.R.S. Title 32 who have clinical privileges at a health care institution.
117. "Medical staff by-laws" means standards, approved by the medical staff and the governing authority, that provide the framework for the organization, responsibilities, and self-governance of the medical staff.
118. "Medical staff member" means an individual who is part of the medical staff of a health care institution.
119. "Medication" means one of the following used to maintain health or to prevent or treat a medical condition or behavioral health issue:
- Biologicals as defined in A.A.C. R18-13-1401,
 - Prescription medication as defined in A.R.S. § 32-1901, or
 - Nonprescription medication as defined in A.R.S. § 32-1901.
120. "Medication administration" means restricting a patient's access to the patient's medication and providing the med-

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- ication to the patient or applying the medication to the patient's body, as ordered by a medical practitioner.
121. "Medication error" means:
- The failure to administer an ordered medication;
 - The administration of a medication not ordered; or
 - The administration of a medication:
 - In an incorrect dosage;
 - More than 60 minutes before or after the ordered time of administration unless ordered to do so, or
 - By an incorrect route of administration.
122. "Mental disorder" means the same as in A.R.S. § 36-501.
123. "Mobile clinic" means a movable structure that:
- Is not physically attached to a health care institution's facility;
 - Provides medical services, nursing services, or health related service to an outpatient under the direction of the health care institution's personnel; and
 - Is not intended to remain in one location indefinitely.
124. "Monitor" or "monitoring" means to check systematically on a specific condition or situation.
125. "Neglect" has the same meaning:
- For an individual less than 18 years of age, as in A.R.S. § 8-201; and
 - For an individual 18 years of age or older, as in A.R.S. § 46-451.
126. "Nephrologist" means a physician who is board eligible or board certified in nephrology by a professional credentialing board.
127. "Nurse" has the same meaning as "registered nurse" or "practical nurse" as defined in A.R.S. § 32-1601.
128. "Nursing personnel" means individuals authorized according to A.R.S. § Title 32, Chapter 15 to provide nursing services.
129. "Observation chair" means a physical piece of equipment that:
- Is located in a designated area where behavioral health observation/stabilization services are provided,
 - Allows an individual to fully recline, and
 - Is used by the individual while receiving crisis services.
130. "Occupational therapist" has the same meaning as in A.R.S. § 32-3401.
131. "Occupational therapist assistant" has the same meaning as in A.R.S. § 32-3401.
132. "Ombudsman" means a resident advocate who performs the duties described in A.R.S. § 46-452.02.
133. "On-call" means a time during which an individual is available and required to come to a health care institution when requested by the health care institution.
134. "Opioid treatment" means providing medical services, nursing services, health-related services, and ancillary services to a patient receiving an opioid agonist treatment medication for opiate addiction.
135. "Opioid agonist treatment medication" means a prescription medication that is approved by the U.S. Food and Drug Administration under 21 U.S.C. § 355 for use in the treatment of opiate addiction.
136. "Order" means instructions to provide
- Physical health services to a patient from a medical practitioner or as otherwise provided by law; or
 - Behavioral health services to a patient from a behavioral health professional.
137. "Orientation" means the initial instruction and information provided to an individual before the individual starts work or volunteer services in a health care institution.
138. "Outing" means a social or recreational activity that:
- Occurs away from the premises,
 - Is not part of a behavioral health inpatient facility's or behavioral health residential facility's daily routine, and
 - Lasts longer than four hours.
139. "Outpatient surgical center" means a class of health care institution that has the facility, staffing, and equipment to provide surgery and anesthesia services to a patient whose recovery, in the opinions of the patient's surgeon and, if an anesthesiologist would be providing anesthesia services to the patient, the anesthesiologist, does not require inpatient care in a hospital.
140. "Outpatient treatment center" means a class of health care institution without inpatient beds that provides physical health services or behavioral health services for the diagnosis and treatment of patients.
141. "Overall time-frame" means the same as in A.R.S. § 41-1072.
142. "Owner" means a person who appoints, elects, or designates a health care institution's governing authority.
143. "Participant" means a patient receiving physical health services or behavioral health services from an adult day health care facility or a substance abuse transitional facility.
144. "Participant's representative" means the same as "patient's representative" for a participant.
145. "Patient" means an individual receiving physical health services or behavioral health services from a health care institution.
146. "Patient follow-up instructions" means information relevant to a patient's medical condition or behavioral health issue that is provided to the patient, the patient's representative, or a health care institution.
147. "Patient's representative" means:
- A patient's legal guardian;
 - If a patient is less than 18 years of age and not an emancipated minor, the patient's parent;
 - If a patient is 18 years of age or older or an emancipated minor, an individual acting on behalf of the patient with the written consent of the patient or patient's legal guardian; or
 - A surrogate as defined in A.R.S. § 36-3201.
148. "Person" means the same as in A.R.S. § 1-215 and includes a governmental agency.
149. "Personnel member" means, except as defined in specific Articles in this Chapter and excluding a medical staff member, a student, or an intern, an individual providing physical health services or behavioral health services to a patient.
150. "Pest control program" means activities that minimize the presence of insects and vermin in a health care institution to ensure that a patient's health and safety is not at risk.
151. "Pharmacist" has the same meaning as in A.R.S. § 32-1901.
152. "Physical examination" means to observe, test, or inspect an individual's body to evaluate health or determine cause of illness, injury, or disease.
153. "Physical health services" means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's medical condition.

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154. "Physical therapist" has the same meaning as in A.R.S. § 32-2001.
155. "Physical therapist assistant" has the same meaning as in A.R.S. § 32-2001.
156. "Physician assistant" has the same meaning as in A.R.S. § 32-2501.
157. "Premises" means property that is designated by an applicant or licensee and licensed by the Department as part of a health care institution where physical health services or behavioral health services are provided to a patient.
158. "Professional credentialing board" means a non-governmental organization that designates individuals who have met or exceeded established standards for experience and competency in a specific field.
159. "Progress note" means documentation by a medical staff member, nurse, or personnel member of:
- An observed patient response to a physical health service or behavioral health service provided to the patient,
 - A patient's significant change in condition, or
 - Observed behavior of a patient related to the patient's medical condition or behavioral health issue.
160. "PRN" means *pro re nata* or given as needed.
161. "Project" means specific construction or modification of a facility stated on an architectural plans and specifications approval application.
162. "Provider" means an individual to whom the Department issues a license to operate an adult behavioral health therapeutic home or a behavioral health respite home in the individual's place of residence.
163. "Provisional license" means the Department's written approval to operate a health care institution issued to an applicant or licensee that is not in substantial compliance with the applicable laws and rules for the health care institution.
164. "Psychotropic medication" means a chemical substance that:
- Crosses the blood-brain barrier and acts primarily on the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition, and behavior; and
 - Is provided to a patient to address the patient's behavioral health issue.
165. "Quality management program" means ongoing activities designed and implemented by a health care institution to improve the delivery of medical services, nursing services, health-related services, and ancillary services provided by the health care institution.
166. "Recovery care center" has the same meaning as in A.R.S. § 36-448.51.
167. "Referral" means providing an individual with a list of the class or subclass of health care institution or type of health care professional that may be able to provide the behavioral health services or physical health services that the individual may need and may include the name or names of specific health care institutions or health care professionals.
168. "Registered dietitian" means an individual approved to work as a dietitian by the American Dietetic Association's Commission on Dietetic Registration.
169. "Registered nurse" has the same meaning as in A.R.S. § 32-1601.
170. "Registered nurse practitioner" has the same meaning as A.R.S. § 32-1601.
171. "Regular basis" means at recurring, fixed, or uniform intervals.
172. "Research" means the use of a human subject in the systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment, or understanding of a medical condition or behavioral health issue.
173. "Resident" means an individual living in and receiving physical health services or behavioral health services from a nursing care institution, a behavioral health residential facility, an assisted living facility, or an adult behavioral health therapeutic home.
174. "Resident's representative" means the same as "patient's representative" for a resident.
175. "Respiratory care services" has the same meaning as "practice of respiratory care" as defined in A.R.S. § 32-3501.
176. "Respiratory therapist" has the same meaning as in A.R.S. § 32-3501.
177. "Respite services" means respite care services provided to an individual who is receiving behavioral health services.
178. "Restraint" means any physical or chemical method of restricting a patient's freedom of movement, physical activity, or access to the patient's own body.
179. "Risk" means potential for an adverse outcome.
180. "Room" means space contained by a floor, a ceiling, and walls extending from the floor to the ceiling that has at least one door.
181. "Rural general hospital" means a subclass of hospital having 50 or fewer inpatient beds and located more than 20 surface miles from a general hospital or another rural general hospital that requests to be and is licensed as a rural general hospital rather than a general hospital.
182. "Satellite facility" has the same meaning as in A.R.S. § 36-422.
183. "Scope of services" means a list of the behavioral health services or physical health services the governing authority of a health care institution has designated as being available to a patient at the health care institution.
184. "Seclusion" means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.
185. "Self-administration of medication" means a patient having access to and control of the patient's medication and may include the patient receiving limited support while taking the medication.
186. "Sexual abuse" means the same as in A.R.S. § 13-1404(A).
187. "Sexual assault" means the same as in A.R.S. § 13-1406(A).
188. "Shift" means the beginning and ending time of a continuous work period established by a health care institution's policies and procedures.
189. "Signature" means:
- A handwritten or stamped representation of an individual's name or a symbol intended to represent an individual's name, or
 - An electronic signature.
190. "Significant change" means an observable deterioration or improvement in a patient's physical, cognitive, behavioral, or functional condition that may require an alteration to the physical health services or behavioral health services provided to the patient.
191. "Speech-language pathologist" means an individual licensed according A.R.S. Title 35, Chapter 17, Article 4

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- to engage in the practice of speech-language pathology, as defined in A.R.S. § 36-1901.
192. "Special hospital" means a subclass of hospital that:
- Is licensed to provide hospital services within a specific branch of medicine; or
 - Limits admission according to age, gender, type of disease, or medical condition.
193. "Student" means an individual attending an educational institution and working under supervision in a health care institution through an arrangement between the health care institution and the educational institution.
194. "Substantial" when used in connection with a modification means:
- A change in a health care institution's licensed capacity, licensed occupancy, or the number of dialysis stations;
 - An addition or deletion of an authorized service;
 - A change in the physical plant, including facilities or equipment, that costs more than \$300,000; or
 - A change in the building where a health care institution is located that affects compliance with applicable physical plant codes and standards incorporated by reference in A.A.C. R9-1-412.
195. "Substance abuse" means an individual's misuse of alcohol or other drug or chemical that:
- Alters the individual's behavior or mental functioning;
 - Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and
 - Impairs, reduces, or destroys the individual's social or economic functioning.
196. "Substance abuse transitional facility" means a class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem.
197. "Supportive services" has the same meaning as in A.R.S. § 36-151.
198. "Substantive review time-frame" means the same as in A.R.S. § 41-1072.
199. "Surgical procedure" means the excision or incision of a patient's body for the:
- Correction of a deformity or defect,
 - Repair of an injury, or
 - Diagnosis, amelioration, or cure of disease.
200. "Swimming pool" has the same meaning as "semipublic swimming pool" in A.A.C. R18-5-201.
201. "System" means interrelated, interacting, or interdependent elements that form a whole.
202. "Tax ID number" means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.
203. "Telemedicine" has the same meaning as in A.R.S. § 36-3601.
204. "Therapeutic diet" means foods or the manner in which food is to be prepared that are ordered for a patient.
205. "Therapist" means an occupational therapist, a physical therapist, a respiratory therapist, or a speech-language pathologist.
206. "Time out" means providing a patient a voluntary opportunity to regain self-control in a designated area from which the patient is not physically prevented from leaving.
207. "Transfer" means a health care institution discharging a patient and sending the patient to another licensed health care institution as an inpatient or resident without intend-
- ing that the patient be returned to the sending health care institution.
208. "Transport" means a licensed health care institution:
- Sending a patient to a receiving licensed health care institution for outpatient services with the intent of the patient returning to the sending licensed health care institution, or
 - Discharging a patient to return to a sending licensed health care institution after the patient received outpatient services from the receiving licensed health care institution.
209. "Treatment" means a procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.
210. "Treatment plan" means a description of the specific physical health services or behavioral health services that a health care institution anticipates providing to a patient.
211. "Unclassified health care institution" means a health care institution not classified or subclassified in statute or in rule.
212. "Vascular access" means the point on a patient's body where blood lines are connected for hemodialysis.
213. "Volunteer" means an individual authorized by a health care institution to work for the health care institution on a regular basis without compensation from the health care institution and does not include a medical staff member who has clinical privileges at the health care institution.
214. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state and federal holiday or a statewide furlough day.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2).

R9-10-102. Health Care Institution Classes and Subclasses; Requirements

- A person may apply for a license as a health care institution class or subclass in A.R.S. Title 36, Chapter 4 or this Chapter, or one of the following classes or subclasses:
 - General hospital,
 - Rural general hospital,
 - Special hospital,
 - Behavioral health inpatient facility,
 - Nursing care institution,
 - Recovery care center,
 - Hospice inpatient facility,
 - Hospice service agency,
 - Behavioral health residential facility,
 - Assisted living center,
 - Assisted living home,
 - Adult foster care home,
 - Outpatient surgical center,
 - Outpatient treatment center,
 - Abortion clinic,
 - Adult day health care facility,
 - Home health agency,
 - Substance abuse transitional facility,

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- 19. Behavioral health specialized transitional facility,
- 20. Counseling facility,
- 21. Adult behavioral health therapeutic home,
- 22. Behavioral health respite home, or
- 23. Unclassified health care institution.
- B. A person shall apply for a license for the class or subclass that authorizes the provision of the highest level of physical care services or behavioral health services the proposed health care institution plans to provide. The Department shall review the proposed health care institution's scope of services to determine whether the requested health care institution class or subclass is appropriate.
- C. A health care institution shall comply with the requirements in Article 17 of this Chapter if:
 - 1. There are no specific rules in another Article of this Chapter for the health care institution's class or subclass, or
 - 2. The Department determines that the health care institution is an unclassified health care institution.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-103. Licensing Exceptions

- A. A health care institution license is required for each health care institution facility except:
 - 1. A facility exempt from licensing under A.R.S. § 36-402, or
 - 2. A health care institution's administrative office.
- B. The Department does not require a separate health care institution license for:
 - 1. A satellite facility of a hospital under A.R.S. § 36-422(F);
 - 2. An accredited facility of an accredited hospital under A.R.S. § 36-422(G);
 - 3. A facility operated by a licensed health care institution that is:
 - a. Adjacent to and contiguous with the licensed health care institution premises; or
 - b. Not adjacent to or contiguous with the licensed health care institution but connected to the licensed health care institution facility by an all-weather enclosure and:
 - i. Owned by the health care institution, or
 - ii. Leased by the health care institution with exclusive rights of possession;
 - 4. A mobile clinic operated by a licensed health care institution; or
 - 5. A facility located on grounds that are not adjacent to or contiguous with the health care institution premises where only ancillary services are provided to a patient of the health care institution.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-104. Approval of Architectural Plans and Specifications

- A. For approval of architectural plans and specifications for the construction or modification of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in A.A.C. R9-1-412, an applicant shall submit to the Department an application packet including:
 - 1. An application in a format provided by the Department that contains:
 - a. For construction of a new health care institution:
 - i. The health care institution's name, street address, city, state, zip code, telephone number, and e-mail address;
 - ii. The name and address of the health care institution's governing authority;
 - iii. The requested health care institution class or subclass; and
 - iv. If applicable, the requested licensed capacity, licensed occupancy, and dialysis stations for the health care institution;
 - b. For modification of a licensed health care institution:
 - i. The health care institution's license number,
 - ii. The name and address of the licensee,
 - iii. The health care institution's class or subclass, and
 - iv. The health care institution's existing licensed capacity, licensed occupancy, or dialysis stations; and the requested licensed capacity, licensed occupancy, or dialysis stations for the health care institution;
 - c. The health care institution's contact person's name, street address, city, state, zip code, telephone number, and e-mail address;
 - d. The name, street address, city, state, zip code, telephone number, and e-mail address of:
 - i. The project architect; or
 - ii. If the construction or modification of the health care institution does not require a project architect, the project engineer or other individual responsible for the completion of the construction or modification;
 - e. A narrative description of the project;
 - f. If providing or planning to provide medical services, nursing services, or health-related services that require compliance with specific physical plant codes and standards incorporated by reference in A.A.C. R9-1-412, the number of rooms or inpatient beds designated for providing the medical services, nursing services, or health-related services;
 - g. If providing or planning to provide behavioral health observation/stabilization services, the number of behavioral health observation/stabilization chairs designated for providing the behavioral health observation/stabilization services;
 - h. For construction of a new health care institution and if modification of a health care institution requires a project architect, a statement signed and sealed by the project architect, according to the requirements in 4 A.A.C. 30, Article 3, that the:
 - i. Project architect has complied with A.A.C. R4-30-301; and
 - ii. Architectural plans and specifications comply with applicable licensing requirements in A.R.S. Title 36, Chapter 4 and this Chapter;
 - i. If construction or modification of a health care institution requires a project engineer, a statement signed

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- institution denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license;
- viii. Whether the owner or any person with 10% or more business interest in the health care institution has had a health care professional license or certificate denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license or certificate; and
 - ix. The name, title, address, and telephone number of the owner's statutory agent or the individual designated by the owner to accept service of process and subpoenas;
 - h. The name and address of the governing authority;
 - i. The chief administrative officer's:
 - i. Name,
 - ii. Title,
 - iii. Highest educational degree, and
 - iv. Work experience related to the health care institution class or subclass for which licensing is requested; and
 - j. Signature required in A.R.S. § 36-422(B);
2. If the health care institution is located in a leased facility, a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility;
 3. If applicable, a copy of the owner's articles of incorporation, partnership or joint venture documents, or limited liability documents;
 4. If applicable, the name and address of each owner or lessee of any agricultural land regulated under A.R.S. § 3-365 and a copy of the written agreement between the applicant and the owner or lessee of agricultural land as prescribed in A.R.S. § 36-421(D);
 5. Except for a home health agency or a hospice service agency, one of the following:
 - a. If the health care institution or a part of the health care institution is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in A.A.C. R9-1-412, documentation of the health care institution's architectural plans and specifications approval in R9-10-104; or
 - b. If a health care institution or a part of the health care institution is not required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in A.A.C. R9-1-412:
 - i. One of the following:
 - (1) Documentation from the local jurisdiction of compliance with applicable local building codes and zoning ordinances; or
 - (2) If documentation from the local jurisdiction is not available, documentation of the unavailability of the local jurisdiction compliance and documentation of a general contractor's inspection of the facility that states the facility is safe for occupancy as the applicable health care institution class or subclass;
- ii. The licensed capacity requested by the applicant for the health care institution;
 - iii. If applicable, the licensed occupancy requested by the applicant for the health care institution;
 - iv. A site plan showing each facility, the property lines of the health care institution, each street and walkway adjacent to the health care institution, parking for the health care institution, fencing and each gate on the health care institution premises, and, if applicable, each swimming pool on the health care institution premises; and
 - v. A floor plan showing, for each story of a facility, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device;
 - 6. The health care institution's proposed scope of services; and
 - 7. The applicable application fee required by R9-10-106.
- B. In addition to the initial application requirements in this Section, an applicant shall comply with the supplemental application requirements in specific rules in this Chapter for the health care institution class or subclass for which licensing is requested.
- C. The Department shall approve or deny an application in this Section according to R9-10-108.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-106. Fees

- A. An applicant who submits to the Department architectural plans and specifications for the construction or modification of a health care institution shall also submit an architectural drawing review fee as follows:
1. Fifty dollars for a project with a cost of \$100,000 or less;
 2. One hundred dollars for a project with a cost of more than \$100,000 but less than \$500,000; or
 3. One hundred fifty dollars for a project with a cost of \$500,000 or more.
- B. An applicant submitting an initial application or a renewal application for a health care institution license shall submit to the Department an application fee of \$50.
- C. Except as provided in subsection (D) or (E), an applicant submitting an initial application or a renewal application for a health care institution license shall submit to the Department a licensing fee as follows:
1. For an adult day health care facility, assisted living home, or assisted living center:
 - a. For a facility with no licensed capacity, \$280;
 - b. For a facility with a licensed capacity of one to 59 beds, \$280, plus the licensed capacity times \$70;
 - c. For a facility with a licensed capacity of 60 to 99 beds, \$560, plus the licensed capacity times \$70;
 - d. For a facility with a licensed capacity of 100 to 149 beds, \$840, plus the licensed capacity times \$70; or
 - e. For a facility with a licensed capacity of 150 beds or more, \$1,400, plus the licensed capacity times \$70;
 2. For a behavioral health facility:
 - a. For a facility with no licensed capacity, \$375;
 - b. For a facility with a licensed capacity of one to 59 beds, \$375, plus the licensed capacity times \$94;

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- c. For a facility with a licensed capacity of 60 to 99 beds, \$750, plus the licensed capacity times \$94;
- d. For a facility with a licensed capacity of 100 to 149 beds, \$1,125, plus the licensed capacity times \$94; or
- e. For a facility with a licensed capacity of 150 beds or more, \$1,875, plus the licensed capacity times \$94;
- 3. For a behavioral health facility providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(2), the licensed occupancy times \$94;
- 4. For a nursing care institution:
 - a. For a facility with a licensed capacity of one to 59 beds, \$290, plus the licensed capacity times \$73;
 - b. For a facility with a licensed capacity of 60 to 99 beds, \$580, plus the licensed capacity times \$73;
 - c. For a facility with a licensed capacity of 100 to 149 beds, \$870, plus the licensed capacity times \$73; or
 - d. For a facility with a licensed capacity of 150 beds or more, \$1,450, plus the licensed capacity times \$73;
- 5. For a hospital, a home health agency, a hospice service agency, a hospice inpatient facility, an abortion clinic, a recovery care center, an outpatient surgical center, an outpatient treatment center that is not a behavioral health facility, or an unclassified health care institution:
 - a. For a facility with no licensed capacity, \$365;
 - b. For a facility with a licensed capacity of one to 59 beds, \$365, plus the licensed capacity times \$91;
 - c. For a facility with a licensed capacity of 60 to 99 beds, \$730, plus the licensed capacity times \$91;
 - d. For a facility with a licensed capacity of 100 to 149 beds, \$1,095, plus the licensed capacity times \$91; or
 - e. For a facility with a licensed capacity of 150 beds or more, \$1,825, plus the licensed capacity times \$91;
- 6. For a hospital providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times \$91; and
- 7. For an outpatient treatment center that is not a behavioral health facility and provides:
 - a. Dialysis services, in addition to the applicable fee in subsection (C)(5), the number of dialysis stations times \$91; and
 - b. Behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times \$91.
- D. In addition to the applicable fees in subsections (C)(5) and (C)(6), an applicant submitting an initial application or a renewal application for a single group hospital license shall submit to the Department an additional fee of \$365 for each of the hospital's satellite facilities and, if applicable, the fees required in subsection (C)(7).
- E. Subsections (C) and (D) do not apply to a health care institution operated by a state agency according to state or federal law or to an adult foster care home.
- F. All fees are nonrefundable except as provided in A.R.S. § 41-1077.

Historical Note

New Section R9-10-106 renumbered from R9-10-122 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-107. Renewal License Application

- A. A licensee applying to renew a health care institution license shall submit an application packet to the Department at least 60 calendar days but not more than 120 calendar days before the expiration date of the current license that contains:
 - 1. A renewal application in a format provided by the Department including:
 - a. The health care institution's:
 - i. Name, license number, mailing address, telephone number, and e-mail address; and
 - ii. Class or subclass;
 - b. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-10-108;
 - c. Owner information including:
 - i. The owner's name, address, telephone number, and e-mail address;
 - ii. Whether the owner is a sole proprietorship, a corporation, a partnership, a limited liability partnership, a limited liability company, or a governmental agency;
 - iii. If the owner is a partnership or a limited liability partnership, the name of each partner;
 - iv. If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;
 - v. If the owner is a corporation, the name and title of each corporate officer;
 - vi. If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency;
 - vii. Whether the owner or any person with 10% or more business interest in the health care institution has had a license to operate a health care institution denied, revoked, or suspended since the previous license application was submitted; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license;
 - viii. Whether the owner or any person with 10% or more business interest in the health care institution has had a health care professional license or certificate denied, revoked, or suspended since the previous license application was submitted; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license or certificate; and
 - ix. The name, title, address, and telephone number of the owner's statutory agent or the individual designated by the owner to accept service of process and subpoenas;
 - d. The name and address of the governing authority;
 - e. The chief administrative officer's:
 - i. Name,
 - ii. Title,
 - iii. Highest educational degree, and
 - iv. Work experience related to the health care institution class or subclass for which licensing is requested; and
 - f. Signature required in A.R.S. § 36-422(B);

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- a. To a funeral establishment, as defined in A.R.S. § 32-1301;
- b. To a crematory, as defined in A.R.S. § 32-1301; or
- c. According to requirements in A.A.C. R18-13-1406, A.A.C. R18-13-1407, and A.A.C. R18-13-1408; or
- 2. Complies with requirements in A.A.C. R18-13-1405.
- C. For purposes of this Section, the following definition applies:
“Fetal tissue” means cells, or groups of cells with a specific function, obtained from an aborted human embryo or fetus.

Historical Note

New Section made by emergency rulemaking at 21 A.A.R. 1787, effective August 14, 2015 for 180 days (Supp. 15-3). Emergency expired February 10, 2016. Section amended by emergency rulemaking at 22 A.A.R. 420, effective February 11, 2016, for an additional 180 days; filed in the Office February 8, 2016 (Supp. 16-1). New Section made by final rulemaking at 22 A.A.R. 1343, with an immediate effective date upon filing under A.R.S. § 41-1032(A)(1) and (4) of May 5, 2016 (Supp. 16-2).

R9-10-120. Opioid Prescribing and Treatment

- A. In addition to the definitions in A.R.S. § 36-401(A) and R9-10-101, the following definitions apply in this Section:
 - 1. “Active malignancy” means a cancer for which:
 - a. A patient is undergoing treatment, such as through:
 - i. One or more surgical procedures to remove the cancer;
 - ii. Chemotherapy, as defined in A.A.C. R9-4-401; or
 - iii. Radiation treatment, as defined in A.A.C. R9-4-401;
 - b. There is no treatment; or
 - c. A patient is refusing treatment.
 - 2. “Benzodiazepine” means any one of a class of sedative-hypnotic medications, characterized by a chemical structure that includes a benzene ring linked to a seven-membered ring containing two nitrogen atoms, that are commonly used in the treatment of anxiety.
 - 3. “End-of-life” means that a patient has a documented life expectancy of six months or less.
 - 4. “Episode of care” means medical services, nursing services, or health-related services provided by a health care institution to a patient for a specific period of time, ending in discharge or the completion of the patient’s treatment plan, whichever is later.
 - 5. “Opioid” means a controlled substance, as defined in A.R.S. § 36-2501, that meets the definition of “opiate” in A.R.S. § 36-2501.
 - 6. “Order” means to issue written, verbal, or electronic instructions for a specific dose of a specific medication in a specific quantity and route of administration to be obtained and administered to a patient in a health care institution.
 - 7. “Prescribe” means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user’s behalf, a specific dose of a specific medication in a specific quantity and route of administration.
 - 8. “Sedative-hypnotic medication” means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anti-convulsant, and muscle-relaxing properties.
 - 9. “Short-acting opioid antagonist” means a drug approved by the U.S. Department of Health and Human Services, Food and Drug Administration, that, when administered, quickly but for a small period of time reverses, in whole

- or in part, the pharmacological effects of an opioid in the body.
- 10. “Substance use disorder” means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental, or social effects on an individual.
- 11. “Substance use risk” means an individual’s unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.
- 12. “Tapering” means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.
- B. An administrator of a health care institution where opioids are prescribed or ordered as part of treatment shall:
 - 1. Establish, document, and implement policies and procedures for prescribing or ordering an opioid as part of treatment, to protect the health and safety of a patient, that:
 - a. Cover which personnel members may prescribe or order an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
 - b. As applicable and except when contrary to medical judgment for a patient, are consistent with the Arizona Opioid Prescribing Guidelines or national opioid-prescribing guidelines, such as guidelines developed by the:
 - i. Centers for Disease Control and Prevention, or
 - ii. U.S. Department of Veterans Affairs and the U.S. Department of Defense;
 - c. Include how, when, and by whom:
 - i. A patient’s profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database is reviewed;
 - ii. An assessment is conducted of a patient’s substance use risk;
 - iii. The potential risks, adverse outcomes, and complications, including death, associated with the use of opioids are explained to a patient or the patient’s representative;
 - iv. Alternatives to a prescribed or ordered opioid are explained to a patient or the patient’s representative;
 - v. Informed consent is obtained from a patient or the patient’s representative and, if applicable, in what situations, described in subsection (F) or (G), informed consent would not be obtained before an opioid is prescribed or ordered for a patient;
 - vi. A patient receiving an opioid is monitored; and
 - vii. The actions taken according to subsections (B)(1)(c)(i) through (vi) are documented;
 - d. Address conditions that may impose a higher risk to a patient when prescribing or ordering an opioid as part of treatment, including:
 - i. Concurrent use of a benzodiazepine or other sedative-hypnotic medication,
 - ii. History of substance use disorder,
 - iii. Co-occurring behavioral health issue, or
 - iv. Pregnancy;
 - e. Cover the criteria for co-prescribing a short-acting opioid antagonist for a patient;
 - f. Include that, if continuing control of a patient’s pain after discharge is medically indicated due to the

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- patient's medical condition, a method for continuing pain control will be addressed as part of discharge planning;
- g. Include the frequency of the following for a patient being prescribed or ordered an opioid for longer than a 30-calendar-day period:
 - i. Face-to-face interactions with the patient,
 - ii. Conducting an assessment of a patient's substance use risk,
 - iii. Renewal of a prescription or order for an opioid without a face-to-face interaction with the patient, and
 - iv. Monitoring the effectiveness of the treatment;
 - h. If applicable according to A.R.S. § 36-2608, include documenting a dispensed opioid in the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - i. Cover the criteria and procedures for tapering opioid prescription or ordering as part of treatment; and
 - j. Cover the criteria and procedures for offering or referring a patient for treatment for substance use disorder;
2. Include in the plan for the health care institution's quality management program a process for:
 - a. Review of known incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths; and
 - b. Surveillance and monitoring of adherence to the policies and procedures in subsection (B)(1);
 3. Except as prohibited by Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2, or as provided in subsection (G), ensure that, if a patient's death may be related to an opioid prescribed or ordered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the health care institution learns of the patient's death; and
 4. Ensure that informed consent required from a patient or the patient's representative includes:
 - a. The patient's:
 - i. Name,
 - ii. Date of birth or other patient identifier, and
 - iii. Condition for which opioids are being prescribed;
 - b. That an opioid being prescribed or ordered;
 - c. The potential risks, adverse reactions, complications, and medication interactions associated with the use of an opioid;
 - d. If applicable, the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication;
 - e. Alternatives to a prescribed opioid;
 - f. Name and signature of the individual explaining the use of an opioid to the patient; and
 - g. The signature of the patient or the patient's representative and the date signed.
- C. Except as provided in subsection (G), an administrator of a health care institution where opioids are prescribed as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to prescribe an opioid in treating a patient:
1. Before prescribing an opioid for a patient of the health care institution:
 - a. Conducts a physical examination of the patient or reviews the documentation from a physical exam-
ination conducted during the patient's same episode of care;
 - b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted during the same episode of care by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
 - d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;
 - e. Explains alternatives to a prescribed opioid; and
 - f. Obtains informed consent from the patient or the patient's representative that meets the requirements in subsection (B)(4), including the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication, if the patient:
 - i. Is also prescribed or ordered a sedative-hypnotic medication; or
 - ii. Has been prescribed a sedative-hypnotic medication by another medical practitioner;
 2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
 - a. The patient's diagnosis;
 - b. The patient's medical history, including co-occurring disorders;
 - c. The opioid to be prescribed;
 - d. Other medications or herbal supplements being taken by the patient;
 - e. If applicable:
 - i. The effectiveness of the patient's current treatment,
 - ii. The duration of the current treatment, and
 - iii. Alternative treatments tried by or planned for the patient;
 - f. The expected benefit of the treatment and, if applicable, the benefit of the new treatment compared with continuing the current treatment; and
 - g. Other factors relevant to the patient's being prescribed an opioid; and
 3. If applicable, specifies in the patient's discharge plan how medically indicated pain control will occur after discharge to meet the patient's needs.
 - D. Except as provided in subsection (F) or (G), an administrator of a health care institution where opioids are ordered for administration to a patient in the health care institution as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to order an opioid in treating a patient:
 1. Before ordering an opioid for a patient of the health care institution:

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- a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted:
 - i. During the patient's same episode of care; or
 - ii. Within the previous 30 calendar days, at a healthcare institution transferring the patient to the health care institution or by the medical practitioner who referred the patient for admission to the health care institution;
 - b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted within the previous 30 calendar days by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
 - d. Explains to the patient the risks and benefits associated with the use of opioids or ensures that the patient understands the risks and benefits associated with the use of opioids, as explained to the patient by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient the risks and benefits associated with the use of opioids;
 - e. If applicable, explains alternatives to a prescribed opioid; and
 - f. Obtains informed consent from the patient or the patient's representative, according to subsection (C)(1)(f); and
2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
- a. The patient's diagnosis;
 - b. The patient's medical history, including co-occurring disorders;
 - c. The opioid being ordered and the reason for the order;
 - d. Other medications or herbal supplements being taken by the patient; and
 - e. If applicable:
 - i. The effectiveness of the patient's current treatment,
 - ii. The duration of the current treatment,
 - iii. Alternative treatments tried by or planned for the patient,
 - iv. The expected benefit of a new treatment compared with continuing the current treatment, and
 - v. Other factors relevant to the patient's being ordered an opioid.
- E. For a health care institution where opioids are administered as part of treatment or where a patient is provided assistance in the self-administration of medication for a prescribed opioid, including a health care institution in which an opioid may be prescribed or ordered as part of treatment, an administrator, a manager as defined in R9-10-801, or a provider, as applicable to the health care institution, shall:
1. Establish, document, and implement policies and procedures for administering an opioid as part of treatment or providing assistance in the self-administration of medication for a prescribed opioid, to protect the health and safety of a patient, that:
 - a. Cover which personnel members may administer an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
 - b. Cover which personnel members may provide assistance in the self-administration of medication for a prescribed opioid and the required knowledge and qualifications of these personnel members;
 - c. Include how, when, and by whom a patient's need for opioid administration is assessed;
 - d. Include how, when, and by whom a patient receiving an opioid is monitored; and
 - e. Cover how, when, and by whom the actions taken according to subsections (E)(1)(c) and (d) are documented;
 2. Include in the plan for the health care institution's quality management program a process for:
 - a. Review of incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths; and
 - b. Surveillance and monitoring of adherence to the policies and procedures in subsection (E)(1);
 3. Except as prohibited by Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2, or as provided in subsection (G)(1), ensure that, if a patient's death may be related to an opioid administered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the patient's death; and
 4. Except as provided in subsection (G), ensure that an individual authorized by policies and procedures to administer an opioid in treating a patient or to provide assistance in the self-administration of medication for a prescribed opioid:
 - a. Before administering an opioid or providing assistance in the self-administration of medication for a prescribed opioid in compliance with an order as part of the treatment for a patient, identifies the patient's need for the opioid;
 - b. Monitors the patient's response to the opioid; and
 - c. Documents in the patient's medical record:
 - i. An identification of the patient's need for the opioid before the opioid was administered or assistance in the self-administration of medication for a prescribed opioid was provided, and
 - ii. The effect of the opioid administered or for which assistance in the self-administration of medication for a prescribed opioid was provided.
 - F. A medical practitioner authorized by a health care institution's policies and procedures to order an opioid in treating a patient is exempt from the requirements in subsection (D), if:
 1. The health care institution's policies and procedures, required in subsection (B)(1) or the applicable Article in 9 A.A.C. 10, contain procedures for:
 - a. Providing treatment without obtaining the consent of a patient's or the patient's representative,
 - b. Ordering and administering opioids in an emergency situation, and
 - c. Complying with the requirements in subsection (D) after the emergency is resolved;
 2. The order for the administration of an opioid is:
 - a. Part of the treatment for a patient in an emergency, and
 - b. Issued in accordance with policies and procedures; and

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3. The emergency situation is documented in the patient's medical record.
- G. The requirements in subsections (C), (D), and (E)(4), as applicable, do not apply to a health care institution's:
1. Prescribing, ordering, or administration of an opioid as part of treatment for a patient with an end-of-life condition or pain associated with an active malignancy;
 2. Prescribing an opioid as part of treatment for a patient when changing the type or dosage of an opioid, which had previously been prescribed by a medical practitioner of the health care institution for the patient according to the requirements in subsection (C):
 - a. Before a pharmacist dispenses the opioid to the patient; or
 - b. If changing the opioid because of an adverse reaction to the opioid experienced by the patient, within 72 hours after the opioid was dispensed for the patient by a pharmacist;
 3. Ordering an opioid as part of treatment for no longer than three calendar days for a patient remaining in the health care institution and receiving continuous medical services or nursing services from the health care institution; or
 4. Ordering an opioid as part of treatment:
 - a. For a patient receiving a surgical procedure or other invasive procedure; or
 - b. When changing the type, dosage, or route of administration of an opioid, which had previously been ordered by a medical practitioner of the health care institution for a patient according to the requirements in subsection (D), to meet the patient's needs.

Historical Note

New Section made by emergency rulemaking at 23 A.A.R. 2203, effective July 28, 2017, for 180 days (Supp. 17-3). Emergency expired; new Section renewed by emergency rulemaking at 24 A.A.R. 303, effective January 25, 2018, for 180 days; new Section made by final rulemaking at 24 A.A.R. 657, with an immediate effective date of March 6, 2018 (Supp. 18-1).

R9-10-121. Repealed**Historical Note**

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3).

R9-10-122. Repealed**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 2145, effective May 1, 2001 (Supp. 01-2). Amended by final rulemaking at 8 A.A.R. 3578, effective July 26, 2002 (Supp. 02-3). Amended by exempt rulemaking at 14 A.A.R. 3958, effective September 26, 2008 (Supp. 08-3). Amended by exempt rulemaking at 15 A.A.R. 2100, effective January 1, 2010 (Supp. 09-4). Section repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-123. Repealed**Historical Note**

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3).

R9-10-124. Repealed**Historical Note**

Former Section R9-10-124 repealed, new Section R9-10-124 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3).

ARTICLE 2. HOSPITALS**R9-10-201. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following definitions apply in this Article unless otherwise specified:

1. "Acuity" means a patient's need for hospital services based on the patient's medical condition.
2. "Acuity plan" means a method for establishing nursing personnel requirements by unit based on a patient's acuity.
3. "Adult" means an individual the hospital designates as an adult based on the hospital's criteria.
4. "Care plan" means a documented guide for providing nursing services and rehabilitation services to a patient that includes measurable objectives and the methods for meeting the objectives.
5. "Continuing care nursery" means a nursery where medical services and nursing services are provided to a neonate who does not require intensive care services.
6. "Critically ill inpatient" means an inpatient whose severity of medical condition requires the nursing services of specially trained registered nurses for:
 - a. Continuous monitoring and multi-system assessment,
 - b. Complex and specialized rapid intervention, and
 - c. Education of the inpatient or inpatient's representative.
7. "Device" has the same meaning as in A.R.S. § 32-1901.
8. "Diet" means food and drink provided to a patient.
9. "Diet manual" means a written compilation of diets.
10. "Dietary services" means providing food and drink to a patient according to an order.
11. "Diversion" means notification to an emergency medical services provider, as defined in A.R.S. § 36-2201, that a hospital is unable to receive a patient from an emergency medical services provider.
12. "Drug formulary" means a written list of medications available and authorized for use developed according to R9-10-218.
13. "Emergency services" means unscheduled medical services provided in a designated area to an outpatient in an emergency.
14. "Gynecological services" means medical services for the diagnosis, treatment, and management of conditions or diseases of the female reproductive organs or breasts.
15. "Hospital services" means medical services, nursing services, and health-related services provided in a hospital.
16. "Infection control risk assessment" means determining the probability for transmission of communicable diseases.
17. "Inpatient" means an individual who:
 - a. Is admitted to a hospital as an inpatient according to policies and procedures,
 - b. Is admitted to a hospital with the expectation that the individual will remain and receive hospital services for 24 consecutive hours or more, or
 - c. Receives hospital services for 24 consecutive hours or more.
18. "Intensive care services" means hospital services provided to a critically ill inpatient who requires the services

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Historical Note

Adopted effective October 20, 1982 (Supp. 82-5).
Repealed effective February 17, 1995 (Supp. 95-1).

Attachment 1.**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5).
Repealed effective February 17, 1995 (Supp. 95-1).

Attachment 2.**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5).
Repealed effective November 6, 1985 (Supp. 85-6).

Editor's Note: *The proposed summary action repealing R9-10-1011 through R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rules. Sections in effect before the proposed summary action have been restored (Supp. 97-1). Subsequently, those Sections were repealed by final rulemaking (Supp. 99-2).*

ARTICLE 10. OUTPATIENT TREATMENT CENTERS**R9-10-1001. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

"Emergency room services" means medical services provided to a patient in an emergency.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1002. Supplemental Application Requirements

- A. In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority applying for an initial license shall submit, in a format provided by the Department:
1. The days and hours of clinical operation and, if different from the days and hours of clinical operation, the days and hours of administrative operation; and
 2. A request to provide one or more of the following services:
 - a. Behavioral health services and, if applicable:
 - i. Behavioral health observation/stabilization services,
 - ii. Children's behavioral health services,
 - iii. Court-ordered evaluation,
 - iv. Court-ordered treatment,
 - v. Counseling,
 - vi. Crisis services,
 - vii. Opioid treatment services,
 - viii. Pre-petition screening,
 - ix. Respite services,
 - x. Respite services for children on the premises,
 - xi. DUI education,
 - xii. DUI screening,
 - xiii. DUI treatment, or
 - xiv. Misdemeanor domestic violence offender treatment;
 - b. Diagnostic imaging services;
 - c. Clinical laboratory services;
 - d. Dialysis services;
 - e. Emergency room services;
 - f. Pain management services;

- g. Physical health services;
- h. Rehabilitation services;
- i. Sleep disorder services; or
- j. Urgent care services provided in a freestanding urgent care center setting.

- B. In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority of an:

1. Affiliated outpatient treatment center, as defined in R9-10-1901, applying for an initial or renewal license for the affiliated outpatient treatment center shall submit, in a format provided by the Department, the following information for each counseling facility for which the affiliated outpatient treatment center is providing administrative support:
 - a. Name, and
 - b. Either:
 - i. The license number assigned to the counseling facility by the Department; or
 - ii. If the counseling facility is not currently licensed, the:
 - (1) Counseling facility's street address, and
 - (2) Date the counseling facility submitted to the Department an application for an initial health care institution license; and
2. Outpatient treatment center, applying for an initial or renewal license that includes a request for authorization to provide respite services for children on the premises, shall include the requested respite capacity, as defined in R9-10-1025(A).

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2).

R9-10-1003. Administration

- A. If an outpatient treatment center is operating under a single group license issued to a hospital according to A.R.S. § 36-422(F) or (G), the hospital's governing authority is the governing authority for the outpatient treatment center.
- B. A governing authority shall:
1. Consist of one or more individuals accountable for the organization, operation, and administration of an outpatient treatment center;
 2. Establish, in writing:
 - a. An outpatient treatment center's scope of services, and
 - b. Qualifications for an administrator;
 3. Designate, in writing, an administrator who has the qualifications established in subsection (B)(2)(b);
 4. Adopt a quality management program according to R9-10-1004;
 5. Review and evaluate the effectiveness of the quality management program in R9-10-1004 at least once every 12 months;
 6. Designate, in writing, an acting administrator who has the qualifications established in subsection (B)(2)(b) if the administrator is:

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2. A physician or a medical practitioner under the direction of a physician:
 - a. Performs a medical history and physical examination on the patient within 30 calendar days before admission or within 48 hours after admission, and
 - b. Documents the medical history and physical examination in the patient's medical record within 48 hours after admission;
3. Before receiving opioid treatment, the patient is informed of the following:
 - a. The progression of opioid addiction and the patient's apparent stage of opioid addiction;
 - b. The goal and benefits of opioid treatment;
 - c. The signs and symptoms of overdose and when to seek emergency assistance;
 - d. The characteristics of opioid agonist treatment medication, including common side-effects and potential interaction effects with other drugs;
 - e. The requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law;
 - f. Confidentiality requirements;
 - g. Drug screening and urinalysis procedures;
 - h. Requirements for dispensing to a patient one or more doses of an opioid agonist treatment medication for use by the patient off the premises;
 - i. Testing and treatment available for HIV and other communicable diseases; and
 - j. The patient complaint process;
4. Documentation of the provision of the information specified in subsection (C)(3) is included in the patient's medical record;
5. The patient receives a dose of an opioid agonist treatment medication only on the order of a medical practitioner;
6. The patient begins detoxification treatment only at the request of the patient or according to the outpatient treatment center's policy and procedure for discontinuing opioid treatment services required in subsection (B)(1)(b);
7. If the patient has an adverse reaction during opioid treatment, a personnel member and, if appropriate, a medical practitioner responds by implementing the policy and procedure required in subsection (B)(1)(i);
8. Before the patient's discharge from opioid treatment services, the patient is provided with patient follow-up instructions that:
 - a. Include information that may reduce the risk of relapse; and
 - b. May include a referral for counseling, support groups, or medication for depression or sleep disorders; and
9. After the patient's discharge from opioid treatment services provided by or at the outpatient treatment center, the medical practitioner responsible for the opioid treatment services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
 - a. A description of the patient's medical condition and the opioid treatment services provided to the patient, and
 - b. The signature of the medical practitioner.
- D. An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that an assessment for each patient receiving opioid treatment services:
 1. Includes, in addition to the information in R9-10-1010(B):
 - a. An assessment of the patient's need for opioid treatment services,
 - b. An assessment of the patient's medical conditions that may be affected by opioid treatment,
 - c. An assessment of other medications being taken by the patient and conditions that may be affected by opioid treatment, and
 - d. A plan to prevent relapse;
 2. Identifies the treatment to be provided to the patient and treatment goals; and
 3. Specifies whether the patient may receive an opioid agonist treatment medication for use off the premises and, if so, the number of doses that may be dispensed.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1020 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1020 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1021. Pain Management Services

An administrator of an outpatient treatment center that is authorized to provide pain management services shall ensure that:

1. Pain management services are provided under the direction of a physician;
2. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise;
3. If a controlled substance is used to provide pain management services:
 - a. A medical practitioner discusses the risks and benefits of using a controlled substance with a patient; and
 - b. The following information is included in a patient's medical record:
 - i. The patient's history or alcohol and substance abuse,
 - ii. Documentation of the discussion in subsection (3)(a),
 - iii. The nature and intensity of the patient's pain, and
 - iv. The objectives used to determine whether the patient is being successfully treated; and
4. If an injection or a nerve block is used to provide pain management services:
 - a. Before the injection or nerve block is initially used on a patient, an evaluation of the patient is performed by a physician or nurse anesthetist;
 - b. An injection or nerve block is administered by a physician or nurse anesthetist; and
 - c. The following information is included in a patient's medical record:

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- i. The evaluation of the patient required in subsection (4)(a),
- ii. A record of the administration of the injection or nerve block, and
- iii. Any resuscitation measures taken.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1021 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1021 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1022. Physical Health Services

An administrator of an outpatient treatment center that is authorized to provide physical health services shall ensure that:

- 1. Medical services provided at or by the outpatient treatment center are provided under the direction of a physician or a registered nurse practitioner,
- 2. Nursing services provided at or by the outpatient treatment center are provided under the direction of a registered nurse, and
- 3. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1022 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1022 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1023. Pre-petition Screening

An administrator of an outpatient treatment center that is authorized to provide pre-petition screening shall comply with the requirements for pre-petition screening in A.R.S. Title 36, Chapter 5, Article 4.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1023 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed

by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1023 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1024. Rehabilitation Services

An administrator shall ensure that if an outpatient treatment center is authorized to provide:

1. Occupational therapy services, an occupational therapist provides direction for the occupational therapy services provided at or by the outpatient treatment center;
2. Physical therapy services, a physical therapist provides direction for the physical therapy services provided at or by the outpatient treatment center; or
3. Speech-language pathology services, a speech-language pathologist provides direction for the speech-language pathology services provided at or by the outpatient treatment center.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). New Section R9-10-1024 adopted as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1024 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1025. Respite Services

A. In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-1001, the following definitions apply in this Section:

1. "Emergency safety response" has the same meaning as in R9-10-701.
 2. "Outing" means travel by a child, who is receiving respite services provided by an outpatient treatment center, to a location away from the outpatient treatment center premises or, if applicable, the child's residence for a specific activity.
 3. "Parent" means a child's:
 - a. Mother or father, or
 - b. Legal guardian.
 4. "Respite capacity" means the total number of children for whom an outpatient treatment center is authorized by the Department to provide respite services on the outpatient treatment center's premises.
- B. An administrator of an outpatient treatment center that is authorized to provide respite services shall ensure that:
1. Respite services are not provided in a personnel member's residence unless the personnel member's residence is licensed as a behavioral health respite home;

36-132. Department of health services; functions; contracts

A. The department, in addition to other powers and duties vested in it by law, shall:

1. Protect the health of the people of the state.
2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.
3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of this state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with chapter 3 of this title and sections 36-693, 36-694 and 39-122.
4. Operate such sanitariums, hospitals or other facilities assigned to the department by law or by the governor.
5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information for the promotion of good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of education of children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.
6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.
7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.
8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of schoolchildren, including special fields such as the prevention of blindness and conservation of sight and hearing.
9. Encourage and aid in the coordination of local programs concerning nutrition of the people of this state.
10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing

dental health care services and shall deposit the monies in the oral health fund established by section 36-138.

11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.
12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection I, paragraph 10.
13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.
14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in the enforcement of the federal food, drug, and cosmetic act (52 Stat. 1040; 21 United States Code sections 1 through 905).
15. Recruit and train personnel for state, local and district health departments.
16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.
17. License and regulate health care institutions according to chapter 4 of this title.
18. Issue or direct the issuance of licenses and permits required by law.
19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.
20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:
 - (a) Screening in early pregnancy for detecting high-risk conditions.
 - (b) Comprehensive prenatal health care.
 - (c) Maternity, delivery and postpartum care.
 - (d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.
 - (e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.

21. License and regulate the health and safety of group homes for persons with developmental disabilities. The department shall issue a license to an accredited facility for a period of the accreditation, except that no licensing period shall be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.
- B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.
- C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.
- D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end-stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. Powers and duties of director; compensation of personnel; rules; definitions

- A. The director shall:
1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.
 2. Perform all duties necessary to carry out the functions and responsibilities of the department.
 3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.
 4. Administer and enforce the laws relating to health and sanitation and the rules of the department.
 5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.
 6. Exercise general supervision over all matters relating to sanitation and health throughout this

state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.

7. Prepare sanitary and public health rules.

8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles

that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

- (a) Served at a noncommercial social event such as a potluck.
 - (b) Prepared at a cooking school that is conducted in an owner-occupied home.
 - (c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.
 - (d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fund-raising or an employee social event.
 - (e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.
 - (f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.
 - (g) A cottage food product that is not potentially hazardous or a time or temperature control for safety food and that is prepared in a kitchen of a private home for commercial purposes, including fruit jams and jellies, dry mixes made with ingredients from approved sources, honey, dry pasta and roasted nuts. Cottage food products must be packaged at home with an attached label that clearly states the name and registration number of the food preparer, lists all the ingredients in the product and the product's production date and includes the following statement: "This product was produced in a home kitchen that may process common food allergens and is not subject to public health inspection." If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must complete a food handler training course from an accredited program and maintain active certification. The food preparer must register with an online registry established by the department pursuant to paragraph 13 of this subsection. The food preparer must display the preparer's certificate of registration when operating as a temporary food establishment. For the purposes of this subdivision, "not potentially hazardous" means cottage food products that meet the requirements of the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.
 - (h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.
 - (i) Produce in a packing or holding facility that is subject to the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112) as administered by the Arizona department of agriculture pursuant to title 3, chapter 3, article 4.1. For the purposes of this subdivision, "holding", "packing" and "produce" have the same meanings prescribed in section 3-525.
5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for

sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for the preservation or storage of food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparation of food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or

semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.
 12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.
 13. Establish an online registry of food preparers that are authorized to prepare cottage food products for commercial purposes pursuant to paragraph 4 of this subsection. A registered food preparer shall renew the registration every three years and shall provide to the department updated registration information within thirty days after any change.
 14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".
- J. The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.
- K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.
- L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.
- M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to

nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. For the purposes of this section:

1. "Cottage food product":

(a) Means a food that is not potentially hazardous or a time or temperature control for safety food as defined by the department in rule and that is prepared in a home kitchen by an individual who is registered with the department.

(b) Does not include foods that require refrigeration, perishable baked goods, salsas, sauces, fermented and pickled foods, meat, fish and shellfish products, beverages, acidified food products, nut butters or other reduced-oxygen packaged products.

2. "Fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151

36-405. Powers and duties of the director

A. The director shall adopt rules to establish minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to ensure the public health, safety and welfare. The standards and requirements shall relate to the construction, equipment, sanitation, staffing for medical, nursing and personal care services, and recordkeeping pertaining to the administration of medical, nursing, behavioral health and personal care services, in accordance with generally accepted practices of health care. The director shall use the current standards adopted by the joint commission on accreditation of hospitals and the commission on accreditation of the American osteopathic association or those adopted by any recognized accreditation organization approved by the department as guidelines in prescribing minimum standards and requirements under this section.

B. The director, by rule, may:

1. Classify and subclassify health care institutions according to character, size, range of services provided, medical or dental specialty offered, duration of care and standard of patient care required for the purposes of licensure. Classes of health care institutions may include hospitals, infirmaries, outpatient treatment centers, health screening services centers and residential care facilities. Whenever the director reasonably deems distinctions in rules and standards to be

appropriate among different classes or subclasses of health care institutions, the director may make such distinctions.

2. Prescribe standards for determining a health care institution's substantial compliance with licensure requirements.
 3. Prescribe the criteria for the licensure inspection process.
 4. Prescribe standards for the selection of health care-related demonstration projects.
 5. Establish nonrefundable application and licensing fees for health care institutions, including a grace period and a fee for the late payment of licensing fees, and fees for architectural plans and specifications reviews.
 6. Establish a process for the department to notify a licensee of the licensee's licensing fee due date.
 7. Establish a process for a licensee to request a different licensing fee due date, including any limits on the number of requests by the licensee.
- C. The director, by rule, shall adopt licensing provisions that facilitate the colocation and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services consistent with article 3.1 of this chapter.
- D. Ninety percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the health services licensing fund established by section 36-414 and ten percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.
- E. Subsection B, paragraph 5 of this section does not apply to a health care institution operated by a state agency pursuant to state or federal law or to adult foster care residential settings.

36-406. Powers and duties of the department

In addition to its other powers and duties:

1. The department shall:
 - (a) Administer and enforce this chapter and the rules, regulations and standards adopted pursuant thereto.
 - (b) Review, and may approve, plans and specifications for construction or modification or additions to health care institutions regulated by this chapter.
 - (c) Have access to books, records, accounts and any other information of any health care institution reasonably necessary for the purposes of this chapter.
 - (d) Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe the manner by which the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a

vaccination available if there is a shortage of that vaccination in this state as determined by the director.

2. The department may:

(a) Make or cause to be made inspections consistent with standard medical practice of every part of the premises of health care institutions which are subject to the provisions of this chapter as well as those which apply for or hold a license required by this chapter.

(b) Make studies and investigations of conditions and problems in health care institutions, or any class or subclass thereof, as they relate to compliance with this chapter and rules, regulations and standards adopted pursuant thereto.

(c) Develop manuals and guides relating to any of the several aspects of physical facilities and operations of health care institutions or any class or subclass thereof for distribution to the governing authorities of health care institutions and to the general public.

36-448.01. Definitions

In this article, unless the context otherwise requires:

1. "Medication-assisted treatment" has the same meaning prescribed in section 32-3201.01.

2. "Pain management clinic":

(a) Means a health care institution or a private office or clinic of a health care provider licensed under title 32 in which a majority of the facility's patients in any month are prescribed opioids, benzodiazepines, barbiturates or carisoprodol, not including for medication-assisted treatment, by a health care provider from the health care institution or private office or clinic for more than ninety days in a twelve-month period.

(b) Does not include a hospital, urgent care center, ambulatory surgical center, hospice facility or nursing care institution.

36-448.02. Pain management clinics; licensure requirements; rules

A. Beginning January 1, 2019, a pain management clinic shall meet the same licensure requirements as prescribed in article 2 of this chapter for health care institutions. At the time of licensure, a pain management clinic shall submit to the director all documentation required by this article.

B. The department shall adopt rules that prescribe the following for pain management clinics:

1. Informed consent requirements.
2. The responsibilities of the medical director.
3. Record maintenance.
4. Reporting requirements.
5. Physical examination requirements.

C. Within sixty days after a health care institution or a private office or clinic of a health care provider that is licensed pursuant to title 32 meets the definition of pain management clinic, the health care institution or private office or clinic shall apply for licensure pursuant to this section.

D. Each pain management clinic shall:

1. On or before each anniversary of the issue date of the pain management clinic's license, submit to the director all documentation required by this article.
2. Comply with all department rules that govern pain management clinics.
3. Have a medical director who is a physician licensed pursuant to title 32, chapter 13 or 17 and who is under an unrestricted and unencumbered license or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15, who has advanced pain certification from a nationally recognized accreditation or certification entity and who is under an unrestricted and unencumbered license.

32-3201.01. Definition of medication-assisted treatment

In this title, unless the context otherwise requires, "medication-assisted treatment" means the use of pharmacological medications that are approved by the United States food and drug administration, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.

GOVERNOR'S REGULATORY REVIEW COUNCIL (R-18-1004)

Title 1, Chapter 6, All Articles

Amend: R1-6-101; R1-6-201; R1-6-202; R1-6-301; R1-6-302; R1-6-303; R1-6-401

New Section: R1-6-105

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: October 2, 2018

AGENDA ITEM: D-5

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: GOVERNOR'S REGULATORY REVIEW COUNCIL (R-18-1004)

Title 1, Chapter 6, Article 1, General Rules of Procedure; Article 2, Rulemaking Procedures; Article 3, Five-Year Review Reports; Article 4, Appeals and Petitions

Amend: R1-6-101; R1-6-201; R1-6-202; R1-6-301; R1-6-302; R1-6-303;
R1-6-401

New Section: R1-6-105

The Governor's Regulatory Review Council (GRRC or Council) seeks to amend seven rules and create one new rule in A.A.C. Title 1, Chapter 6.

The rulemaking was precipitated by the passage of Senate Bill 1273, signed by the Governor in May 2018, which modifies A.R.S. § 41-1033. Provisions that are unnecessary and duplicative of statute are removed from Sections 201, 202, and 301. In addition, R1-6-105, requiring state agencies to provide the Council office with one electronic copy of any public comment received by the agency within 10 business days of receipt, is being added. This new rule is intended to protect, in accordance with A.R.S. § 41-1001.01(A)(6), the public's right to participate in the rulemaking process. Other amendments make the rules more clear and effective with respect to agency handling of public comments.

An exemption from the rulemaking moratorium was approved by the Governor's Office on June 18, 2018.

Proposed Action

- **Section 101 - Definitions:**
 - The definition of “electronic copy” is expanded to include all electronic means of filing or submitting a document.
 - A definition of “public comment” is added.

- **Section 105 - Public Comments:** This new rule requires an agency to submit to the Council office, within 10 business days of receipt, one electronic copy of any written public comment received by the agency.
- **Section 201 - Submitting a Regular Rule:**
 - To streamline the submission process, agencies will no longer be required to submit a copy of the text of an existing rule.
 - A new subsection (F) is added to clarify that after an agency responds to any public comment received in accordance with A.R.S. § 41-1023, the agency must provide a copy of its response to both the commenter and the Council office.
- **Section 202 - Submitting an Expedited Rule:**
 - To streamline the submission process, agencies will no longer be required to submit a copy of the text of an existing rule.
 - A new subsection (D) is added to clarify that after an agency responds to any public comment received in accordance with A.R.S. § 41-1023, the agency must provide a copy of its response to both the commenter and the Council office.
- **Section 301 - Submitting a Five-Year Review Report:** Subsections (B), (D), and (G) are repealed to remove unnecessary requirements and to make the rules more clear and concise.
- **Section 302 - Rescheduling a Five-Year Review Report:** Clarifying changes are made.
- **Section 303 - Extension of the Due Date for a Five-Year Review Report:** Clarifying changes are made.
- **Section 401 - Applicability:**
 - Subsection (4) is added to account for the new A.R.S. § 41-1033(G) Petition to request a review of an existing agency practice, substantive policy statement, final rule, or regulatory licensing requirement that is not specifically authorized by statute pursuant to Title 32 based on the person's belief that the existing agency practice, substantive policy statement, final rule or regulatory licensing requirement is unduly burdensome or is not demonstrated to be necessary to specifically fulfill a public health, safety or welfare concern.
 - Subsection (5) is amended to account for language added to A.R.S. § 41-1033(H).

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

Yes. GRRC cites to both general and specific authority for the rules. Of particular significance is A.R.S. § 41-1051(E), under which the Council "may make rules pursuant to this chapter [A.R.S. Title 41, Chapter 6, Administrative Procedure] to carry out the purposes of this chapter."

2. Do the rules establish a new fee or contain a fee increase?

No. The rules do not establish a new fee or contain a fee increase.

3. Summary of the agency's economic impact analysis:

In this rulemaking, GRRC is adopting rules that will align with statutory mandates that should make public participation in the rulemaking process less burdensome. GRRC is also requiring agencies to submit public comments to the Council within 10 business days after the agency receives the public comment. GRRC oversees the rulemaking process for over 80 state agencies.

4. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

GRRC concludes that this rulemaking is required by state statute. State agencies will incur minimal costs to supply GRRC with copies of public comments. The public will greatly benefit from increased access to the rulemaking process. The benefits outweigh the costs.

5. What are the economic impacts on stakeholders?

Key stakeholders are GRRC, state agencies subject to GRRC's oversight, political subdivisions participating in the rulemaking process, businesses participating in the rulemaking process, and individuals participating in the rulemaking process.

GRRC incurred the costs associated with creating the rulemaking. GRRC will benefit from this rulemaking because it will align the Council's rules with recent changes to state statute.

State agencies will bear minimal administrative burdens by submitting public comments to GRRC within 10 business days of receipt. These same agencies will receive benefits from the removal of unnecessary provisions from the current rules.

Political subdivisions, businesses, and individuals that participate in the rulemaking process will benefit from this rulemaking. The rulemaking aligns GRRC's rules with recent changes to state statute, which will reduce confusion for stakeholders. The requirement of agencies to submit copies of public comments to GRRC will benefit these stakeholders because it will notify GRRC of possible deficiencies in rules within 10 business days instead of every 5 years as a part of the five-year review report.

6. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?

Not applicable. No comments were received on the rulemaking.

7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?

No. Only non-substantive clarifying and technical changes were made between the Notice of Proposed Rulemaking and the Notice of Final Rulemaking.

8. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

No. Federal law is not directly applicable to the subject matter of the rules.

9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

No. The rules do not require a permit or license.

10. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?

No. GRRC did not review or rely on any study for this rulemaking.

11. Conclusion

GRRC requests an immediate effective date for the rulemaking to prevent the rules from being inconsistent with state law, namely the amendments to A.R.S. § 41-1033 that took effect on August 3, 2018, in accordance with A.R.S. § 41-1032(A)(2). Council staff recommends approval of the rulemaking.

NOTICE OF FINAL RULEMAKING
TITLE 1. RULES AND THE RULEMAKING PROCESS
CHAPTER 6. GOVERNOR'S REGULATORY REVIEW COUNCIL
PREAMBLE

- | <u>1. Article, Part, or Section Affected (as applicable)</u> | <u>Rulemaking Action</u> |
|---|---------------------------------|
| R1-6-101 | Amend |
| R1-6-105 | New Section |
| R1-6-201 | Amend |
| R1-6-202 | Amend |
| R1-6-301 | Amend |
| R1-6-302 | Amend |
| R1-6-303 | Amend |
| R1-6-401 | Amend |
-
- 2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**
- Authorizing statute: A.R.S. § 41-1051(E)
Implementing statutes: A.R.S. §§ 41-1001.01(A)(6), 41-1023, 41-1027, 41-1033, 41-1052, 41-1053, 41-1055, 41-1056
-
- 3. The effective date for the rules:**
- a. **If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**
- The rules will become effective immediately upon filing with the Secretary of State. The Council has selected this immediate effective date to prevent the rules from being inconsistent with state law, namely the amendments to A.R.S. § 41-1033 that took effect on August 3, 2018, in accordance with A.R.S. § 41-1032(A)(2). The need for this effective date was not created due to the Council's delay or inaction.

- b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rule:

Notice of Rulemaking Docket Opening: 24 A.A.R. 2031, July 20, 2018

Notice of Proposed Rulemaking: 24 A.A.R. 2007, July 20, 2018

5. The agency's contact person who can answer questions about the rulemaking:

Name: Chris Kleminich

Address: 100 North 15th Avenue, Suite 305
Phoenix, AZ 85007

Telephone: (602) 542-2024

E-mail: christopher.kleminich@azdoa.gov

Web site: <http://grrc.az.gov>

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Governor's Regulatory Review Council (Council) is amending the rules in 1 A.A.C. 6 to implement SB 1273, signed by the Governor in May 2018, which modifies A.R.S. § 41-1033. In addition, provisions that are unnecessary and duplicative of statute are removed from Sections 201, 202, and 301. Furthermore, R1-6-105, requiring state agencies to provide the Council office with one electronic copy of any public comment received by the agency within 10 business days of receipt, is being added. This new rule is intended to protect, in accordance with A.R.S. § 41-1001.01(A)(6), the public's right to participate in the rulemaking process. Other amendments make the rules more clear and effective with respect to agency handling of public comments. An exception from Executive Order 2018-02 was provided by the Governor's Office on June 18, 2018.

- 7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

None.

- 8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable.

- 9. A summary of the economic, small business, and consumer impact:**

The Council anticipates that the economic impact of the rulemaking is expected to be minimal (less than \$1,000) for all stakeholders. State agencies may face minimal costs from providing copies of public comments to the Council office and responses to public comments to the commenter and the Council. The removal of unnecessary provisions from Sections 201, 202, and 301 may provide a minimal beneficial economic impact to state agencies. The rulemaking will apply to all state agencies subject to Council review, currently estimated at 100 agencies.

- 10. A description of any changes between the proposed rulemaking, including supplemental notices, and the final rulemaking:**

Only clarifying and technical changes, none of which are substantial under the standards set forth in A.R.S. § 41-1025, have been made between the proposed rulemaking and the final rulemaking.

- 11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to comments:**

The Council did not receive any written public comments about the rulemaking. No comments were made at the oral proceeding held on August 20, 2018.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

None.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rules do not require issuance of a regulatory permit, license or agency authorization.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

No corresponding federal laws apply. The rules are being promulgated under state law.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

None.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None.

14. Whether the rule was previously made, amended, or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

The rules were not previously made as emergency rules.

15. The full text of the rules follows:

TITLE 1. RULES AND THE RULEMAKING PROCESS
CHAPTER 6. GOVERNOR'S REGULATORY REVIEW COUNCIL

ARTICLE 1. GENERAL RULES OF PROCEDURE

- R1-6-101.** **Definitions**
- R1-6-105.** **Repealed Public Comments**

ARTICLE 2. RULEMAKING PROCEDURES

- R1-6-201.** **Submitting a Regular Rule**
- R1-6-202.** **Submitting an Expedited Rule**

ARTICLE 3. FIVE-YEAR REVIEW REPORTS

- R1-6-301.** **Submitting a Five-year Review Report**
- R1-6-302.** **Rescheduling a Five-year Review Report**
- R1-6-303.** **Extension of the Due Date for a Five-year Review Report**

ARTICLE 4. APPEALS AND PETITIONS

- R1-6-401.** **Applicability**

ARTICLE 1. GENERAL RULES OF PROCEDURE

R1-6-101. Definitions

- A. The definitions in A.R.S. § 41-1001 apply to this Chapter.
- B. In this Chapter:
 1. “Agency head” means the chief officer of an agency or another person directly or indirectly purporting to act on behalf or under the authority of the agency head.
 2. “Chair” means the chairperson of the Council or the chairperson’s designee.
 3. “Electronic copy” means a document submitted or filed by e-mail or ~~or other electronic means~~.
 4. “Expedited rule” means a rule made according to the procedures in A.R.S. §§ 41-1027 and 41-1053.
 5. “Five-year Review Report” means a report submitted to the Council according to the procedures in A.R.S. § 41-1056 or 41-1095.
 6. “Open Meeting Law” means A.R.S. Title 38, Chapter 3, Article 3.1.
 7. “Public Comment” means a written comment or criticism submitted to an agency that relates in whole or in part to a proposed rule or an existing rule, or a comment made at an oral proceeding held in accordance with A.R.S. § 41-1023.
 8. 7. “Regular rule” means a rule made according to the procedures in A.R.S. §§ 41-1021 through 41-1024 and 41-1052.

R1-6-105. Repeated Public Comments

Within 10 business days of receipt, an agency shall submit to the Council office one electronic copy of any written public comment received by the agency.

ARTICLE 2. RULEMAKING PROCEDURES

R1-6-201. Submitting a Regular Rule

- A. To submit a regular rule for consideration by the Council, an agency shall submit to the Council office one electronic copy of each rulemaking document that follows, prepared in the manner required by this subsection, ~~subsection (B)~~, and the rules of the Office of the Secretary of State:

1. A request for approval, in the form of a cover letter signed by the agency head. The cover letter shall specify:
 - a. The close of record date;
 - b. Whether the rulemaking activity relates to a five-year review report and, if applicable, the date the report was approved by the Council;
 - c. Whether the rule establishes a new fee and, if it does, citation of the statute expressly authorizing the new fee;
 - d. Whether the rule contains a fee increase;
 - e. Whether an immediate effective date is requested for the rule under A.R.S. § 41-1032;
 - f. A certification that the preamble discloses a reference to any study relevant to the rule that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rule;
 - g. If one or more full-time employees are necessary to implement and enforce the rule, a certification that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule; and
 - h. A list of all documents enclosed.
2. A Notice of Final Rulemaking, including the preamble, table of contents for the rulemaking, and text of each rule;
3. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
4. The written comments received by the agency concerning the proposed rule and a written record, transcript, or minutes of any testimony received if the agency maintains a written record, transcript, or minutes; **and**
5. Any analysis submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states; **;**
- B. In addition to the documents required in subsection (A), an agency shall submit one electronic copy of each reference document that follows:**
 6. 1. Material incorporated by reference, if any;
 7. 2. The general and specific statutes authorizing the rule, including relevant statutory definitions; **and**

8. 3. If a term is defined in the rule by referring to another rule or a statute other than the general and specific statutes authorizing the rule, the statute or other rule referred to in the definition; and.
4. ~~The existing rule if any subsections within the existing rule are designated as “no change” in the revised text of a rule the agency is amending.~~
- E. B.** After a rule is placed on a Council agenda, Council staff shall review the rule for compliance with the requirements of A.R.S. §§ 41-1021 through 41-1024 and 41-1052 and this Chapter and may ask questions or suggest changes to the agency. If the agency revises any rulemaking document in response to a question or suggested change, the agency shall submit one electronic copy of the revised rulemaking document to the Council for review.
- D. C.** After a rule is placed on a Council agenda, an agency may have the rule moved to the agenda of a later meeting by having the agency head send a written notice to the Chair that includes the date of the later meeting. If the agency makes a subsequent request that the rule be moved, the Chair may grant or deny the request at the Chair’s discretion.
- E. D.** Council staff shall notify the agency of any written comments received by the Council related to an agency’s rulemaking.
- F. E.** If it is necessary for a rule to be heard at more than one Council meeting, the agency shall submit any revised documents for the later meeting, consistent with this Section.
- F.** An agency shall respond to any public comment received in accordance with A.R.S. § 41-1023.
An agency shall provide a copy of its response to the commenter and the Council office.

R1-6-202. Submitting an Expedited Rule

- A.** To submit an expedited rule for consideration by the Council, an agency shall submit to the Council office one electronic copy of each rulemaking document that follows, prepared in the manner required by this subsection—subsection (B); and the rules of the Office of the Secretary of State:
1. A request for approval, in the form of a cover letter signed by the agency head. The cover letter shall specify:
 - a. The close of record date;
 - b. An explanation of how the expedited rule meets the criteria in A.R.S. § 41-1027(A);
 - c. Whether the rulemaking activity relates to a five-year review report and, if applicable, the date the report was approved by the Council;

- d. A certification that the preamble discloses a reference to any study relevant to the rule that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rule; and
 - e. A list of all documents enclosed.
- 2. A Notice of Final Expedited Rulemaking, including the preamble, table of contents for the rulemaking, and text of each rule;
- 3. The written comments, including objections that the rulemaking does not meet the criteria in A.R.S. § 41-1027(A), received by the agency or contained in a notice concerning the proposed rule; **and**
- 4. Any analysis submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states; **and**
- B.** ~~In addition to the documents required in subsection (A), an agency shall submit one electronic copy of each reference document that follows:~~
 - 5.1. Material incorporated by reference, if any;
 - 6.2. For a statute declared unconstitutional, the court's decision;
 - 7.3. The general and specific statutes authorizing the rule, including relevant statutory definitions;
 - 8.4. If a term is defined in the rule by referring to another rule or a statute other than the general and specific statutes authorizing the rule, the statute or other rule referred to in the definition; **and**
 - 5. ~~The text of the existing rule.~~
- C.** ~~B.~~ After a rule is placed on a Council agenda, Council staff shall review the rule for compliance with the requirements of A.R.S. §§ 41-1027, 41-1053, and this Chapter and may ask questions or suggest changes to the agency. If the agency revises any rulemaking document in response to a question or suggested change, the agency shall submit one electronic copy of the revised rulemaking document to the Council for review.
- D.** ~~C.~~ After a rule is placed on a Council agenda, an agency may have the rule moved to the agenda of a later meeting by having the agency head send a written notice to the Chair that includes the date of the later meeting. If the agency makes a subsequent request that the rule be moved, the Chair may grant or deny the request at the Chair's discretion.
- D.** An agency shall respond to any public comment received in accordance with A.R.S. § 41-1023.
An agency shall provide a copy of the response to the commenter and an electronic copy to the Council office.

ARTICLE 3. FIVE-YEAR REVIEW REPORTS

R1-6-301. Submitting a Five-year Review Report

- A. To submit a five-year review report for consideration by the Council, an agency shall submit to the Council office one electronic copy of the cover letter signed by the agency head and the five-year review report required by A.R.S. § 41-1056. ~~Consistent with subsection (B), the~~ The agency shall concisely analyze and provide the following information in the five-year review report in the following order for each rule:
1. General and specific statutes authorizing the rule, including any statute that authorizes the agency to make rules;
 2. Objective of the rule, including the purpose for the existence of the rule;
 3. Effectiveness of the rule in achieving the objective, including a summary of any available data supporting the conclusion reached;
 4. Consistency of the rule with state and federal statutes and other rules made by the agency, and a listing of the statutes or rules used in determining the consistency;
 5. Agency enforcement policy, including whether the rule is currently being enforced and, if so, whether there are any problems with enforcement;
 6. Clarity, conciseness, and understandability of the rule;
 7. Summary of ~~the any written criticisms~~ criticism of the rule received by the agency within the five years immediately preceding the five-year review report. An agency shall respond to any written criticism and shall provide a copy of its response to the commenter; including letters, memoranda, reports, written analyses submitted to the agency questioning whether the rule is based on valid scientific or reliable principles or methods, and written allegations made in litigation or administrative proceedings in which the agency was a party that the rule is discriminatory, unfair, unclear, inconsistent with statute, or beyond the authority of the agency to enact, and the result of the litigation or administrative proceedings;
 8. A comparison of the estimated economic, small business, and consumer impact of the rule with the economic, small business, and consumer impact statement prepared on the last making of the rule or, if no economic, small business, and consumer impact statement was prepared on the last making of the rule, an assessment of the actual economic, small business, and consumer impact of the rule;

9. Any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states;
 10. If applicable, how the agency completed the course of action indicated in the agency's previous five-year review report;
 11. A determination after analysis that the probable benefits of the rule within this state outweigh the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective;
 12. A determination after analysis that the rule is not more stringent than a corresponding federal law unless there is statutory authority to exceed the requirements of that federal law;
 13. For a rule adopted after July 29, 2010, that requires issuance of a regulatory permit, license or agency authorization, whether the rule complies with A.R.S. § 41-1037; and
 14. Course of action the agency proposes to take regarding each rule, including the month and year in which the agency anticipates submitting the rules to the Council if the agency determines it is necessary to amend or repeal an existing rule, or to make a new rule. If no issues are identified for a rule in the report, an agency may indicate that no action is necessary for the rule.
- B.** ~~To avoid repetition, an agency shall use a narrative format rather than a tabular format to present the information in the report. The narrative shall be organized according to the categories in subsection (A). For subsection (A)(2), the agency shall provide a specific objective, including the purpose for the existence of each individual rule. Within the remaining categories, an agency shall analyze each rule individually or, if the analysis for each rule is the same, consolidate the analysis, either by article or for all rules in the report. If the analysis for a category is identical for all of the rules in a report, the agency shall specify that the analysis within that category applies to all of the rules in the report. If the analysis for a category is identical for all of the rules in an article, the agency shall specify that the analysis within that category applies to all of the rules in the article.~~
- C.** **B.** In addition to the documents required in subsection (A), an agency shall submit one electronic copy of the cover letter. The cover letter shall provide the following information:
1. A person to contact for information regarding the report,
 2. Any rule that is not reviewed with the intention that the rule will expire under A.R.S. § 41-1056(J),

3. Any rule that is not reviewed because the Council rescheduled the review of an article under A.R.S. § 41-1056(H), and
 4. The certification that the agency is in compliance with A.R.S. § 41-1091.
- D.** ~~In addition to the documents required in subsections (A) and (C), an agency shall submit one electronic copy of the following reference documents:~~
1. Rules being reviewed;
 2. General and specific statutes authorizing the rules, including any statute that authorizes the agency to make rules; and
 3. If an economic, small business, and consumer impact statement was prepared on the last making of a rule being reviewed, the economic, small business, and consumer impact statement for the rule.
- E.** ~~C.~~ After a five-year review report is placed on a Council agenda, Council staff shall review the report for compliance with the requirements of A.R.S. § 41-1056 and this Chapter and may ask questions or suggest changes to the agency. If the agency revises any document in response to a question or suggested change, the agency shall submit one electronic copy of the revised document to the Council for review.
- F.** ~~D.~~ After a five-year review report is placed on a Council agenda, an agency may have the report moved to the agenda of a later meeting by having the agency head submit one electronic copy of a written notice to Council staff that includes the date of the later meeting. If the agency makes a subsequent request to have a five-year review report moved, the Chair may grant or deny the request at the Chair's discretion.
- G.** ~~A person may submit written comments to the Council. The Council may also permit testimony at a Council meeting.~~

R1-6-302. Rescheduling a Five-year Review Report

- A.** To request that a five-year review report be rescheduled under A.R.S. § 41-1056(H), an agency head shall submit one electronic copy of a letter to the Chair before the report is due that includes the following information:
1. The ~~title, chapter, and article~~ Title, Chapter, and Article of the rules for which rescheduling is sought;
 2. Whether the rules were initially made or substantially revised with an effective date or date of Council approval that is within two years before the due date of the report; and
 - a. If substantially revised:

- i. A description of the revisions,
 - ii. Why the revisions are believed to be substantial,
 - iii. The date of Council approval of the rules, if applicable, and
 - iv. The date on which the rules were published in the *Register* by the Office of the Secretary of State and the effective date of the rules; or
- b. If initially made:
 - i. The date of Council approval of the rules, if applicable, and
 - ii. The date on which the rules were published in the *Register* by the Office of the Secretary of State and the effective date of the rules.
- B. The Chair, in the Chair's discretion, may grant the rescheduling of a five-year review report for the rules within an ~~article~~ Article that meet the requirements of this Section.
 - C. The Chair may, on the Chair's own initiative, reschedule a five-year review report if all rules within an ~~article~~ Article meet the requirements of this Section.

R1-6-303. Extension of the Due Date for a Five-year Review Report

- A. An agency may obtain an extension of 120 days to submit a five-year review report by ~~filling~~ submitting one electronic copy of a written notice of extension with to the Council office before the due date of the report. The agency shall specify in the notice the reason for the extension.
- B. An agency may, as an alternative, request a longer extension that is more than 120 days but does not exceed one year by ~~sending~~ submitting one electronic copy of a written request to the Chair at least 40 days prior to the due date of the report. The agency shall specify the length of the requested extension and the reason for the requested extension.
 - 1. A request for an extension that is more than 120 days but does not exceed one year shall be placed on the agenda of a Council meeting scheduled to occur prior to the due date of the report.
 - 2. The Council shall consider the reason for the requested extension and may grant a request for an extension that is more than 120 days but does not exceed one year.

ARTICLE 4. APPEALS AND PETITIONS

R1-6-401. Applicability

For purposes of this article, the term "petition or appeal" refers to the following:

1. The A.R.S. § 41-1008(G) Petition for an alternative expiration date for fees established or increased by exempt rulemaking;
2. The A.R.S. § ~~41-1033(B)~~ 41-1033(E) Appeal of an agency's decision on a petition requesting the making of a final rule or a review of an existing agency practice or substantive policy statement that the petitioner alleges to constitute a rule;
3. The A.R.S. § ~~41-1033(C)~~ 41-1033(F) Petition to request a review of a final rule based on a person's belief that a final rule does not meet the requirements prescribed in A.R.S. § 41-1030;
4. The A.R.S. § 41-1033(G) Petition to request a review of an existing agency practice, substantive policy statement, final rule, or regulatory licensing requirement that is not specifically authorized by statute pursuant to Title 32 based on the person's belief that the existing agency practice, substantive policy statement, final rule or regulatory licensing requirement is unduly burdensome or is not demonstrated to be necessary to specifically fulfill a public health, safety or welfare concern;
5. Pursuant to A.R.S. § ~~41-1033(D)~~ 41-1033(H), the Council's receipt of information indicating that an existing agency practice or substantive policy statement may constitute a rule or that a final rule does not meet the requirements prescribed in A.R.S. § 41-1030 or that an existing agency practice, substantive policy statement, final rule or regulatory licensing requirement does not meet the guidelines prescribed under A.R.S. § 41-1033(G);
6. 6. The A.R.S. § 41-1052(B) Early Review Petition;
7. 7. The A.R.S. § 41-1055(E) Petition for a determination that an agency is not required to file an economic, small business, and consumer impact statement;
8. 8. The A.R.S. § 41-1056(M) Petition to require an agency that has an obsolete rule to consider including the rule in a five-year review report with a recommendation for repeal of the rule;
9. 9. The A.R.S. § 41-1056(N) Petition to require an agency to consider including a recommendation for reducing a licensing time frame in a five-year review report;
10. 10. The A.R.S. § 41-1056.01(D) Appeal related to the economic, small business, and consumer impact of a rule; and
11. 11. The A.R.S. § 41-1081(F) Appeal of a delegation agreement.

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

TITLE 1. RULES AND THE RULEMAKING PROCESS

CHAPTER 6. GOVERNOR'S REGULATORY REVIEW COUNCIL

ARTICLES 1-4

1. Identification of the rulemaking:

- a. The conduct and its frequency of occurrence that the rule is designed to change:

The rules are designed to bring clarity to the areas in which agencies and members of the public interact with, or submit documents to, the Governor's Regulatory Review Council (Council):

- Section 401 is amended to implement SB 1273, signed by the Governor in May 2018, which modifies A.R.S. § 41-1033.
- To protect the public's right to participate in the rulemaking process, in accordance with A.R.S. § 41-1001.01(A)(6), Section 105 is added to require agencies to provide the Council office with one electronic copy of any written public comment received by the agency within 10 business days of receipt. As agencies are already responsible for receiving and retaining such comments as part of the five-year review process, any economic impacts are anticipated to be minimal.
- The rulemaking also eliminates requirements for agencies to provide copies of existing rules when submitting rulemakings and reports to the Council. Approximately 80 five-year review reports and 50 rulemakings are annually submitted to the Council.

- b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

- Leaving Section 401 unchanged will result in the rule being unclear and inconsistent with statute.

- The primary purpose of the addition of Section 105 is to reduce the likelihood of a public comment “falling through the cracks” and going unaddressed during the five-year review process. Due to the nature of this potential problem, Council staff does not have the requisite information to definitively estimate how often this harm may occur.
 - Requirements for agencies to provide copies of existing rules when submitting rulemakings and reports to the Council pose an unnecessary burden on agencies that would remain in place if the rules are not changed.
- c. The estimated change in frequency of the targeted conduct expected from the rule change:
Council staff does not anticipate any significant changes in the frequency of submissions of rulemakings, five-year review reports, petitions, or public comments because of the rulemaking.
2. A brief summary of the information included in the economic, small business, and consumer impact statement:
The Council is amending the rules in 1 A.A.C. 6 to implement SB 1273, signed by the Governor in May 2018, which modifies A.R.S. § 41-1033. In addition, provisions that are unnecessary and duplicative of statute are removed from Sections 201, 202, and 301. Furthermore, R1-6-105, requiring state agencies to provide the Council office with one electronic copy of any public comment received by the agency within 10 business days of receipt, is being added. This new rule is intended to protect, in accordance with A.R.S. § 41-1001.01(A)(6), the public’s right to participate in the rulemaking process. Other amendments make the rules more clear and effective with respect to agency handling of public comments.

The rulemaking will apply to all state agencies subject to Council review, currently estimated at 100 agencies. The rulemaking will also apply to members of the public

making comments or filing petitions and appeals with the Council. The Council anticipates that the economic impact of the rulemaking is expected to be minimal (less than \$1,000) for all stakeholders.

3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:

Name: Chris Kleminich

Address: 100 N. 15th Ave, Suite 305, Phoenix, AZ 85007

Telephone number: (602) 542-2024

Website: grrc.az.gov

E-mail address: christopher.kleminich@azdoa.gov

4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

The rulemaking will apply to all state agencies subject to Council review, currently estimated at 100 agencies. State agencies may face minimal costs from providing copies of public comments to the Council office and responses to public comments to the commenter and the Council. The removal of unnecessary provisions from Sections 201, 202, and 301 may provide a minimal beneficial economic impact to agencies. The rulemaking affects members of the public filing a public comment with an agency, or any type of petition or appeal with the Council, but no measurable economic impact is anticipated. Any contractors performing rulewriting services for state agencies may see minimal benefits from elimination of the unnecessary requirement to provide copies of existing rules when submitting rulemakings and reports to the Council.

5. Cost-benefit analysis:

a. Costs and benefits to state agencies directly affected by the rulemaking:

State agencies may face minimal costs from providing copies of public comments to the Council office and responses to public comments to the commenter and the Council. The removal of unnecessary provisions from Sections 201, 202, and 301 may provide a minimal beneficial economic impact to agencies. The economic impact of the rulemaking is expected to be minimal (less than \$1,000) for all agencies involved in the rulemaking, five-year review, and petition/appeal processes.

The number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:

The Council does not anticipate any new full-time employees will be required because of the rulemaking.

b. Costs and benefits to political subdivisions directly affected by the rulemaking:

Political subdivisions participating in the rulemaking process will be subject to the rules if they make a public comment or file any petitions or appeals with the Council. The economic impact of the rulemaking is expected to be minimal (less than \$1,000) for all political subdivisions involved in the rulemaking, five-year review, and petition/appeal processes.

c. Costs and benefits to businesses directly affected by the rulemaking:

Businesses participating in the rulemaking process will be subject to the rules if they make a public comment or file any petitions or appeals with the Council. The economic impact of the rulemaking is expected to be minimal (less than \$1,000) for all businesses involved in the rulemaking, five-year review, and petition/appeal processes.

6. **Impact on private and public employment:**

The rulemaking will have no impact on private or public employment.

7. **Impact on small businesses:**

a. **Identification of the small business subject to the rulemaking:**

Small businesses participating in the rulemaking process will be subject to the rules if they make a public comment or file any petitions or appeals with the Council. Contractors who perform rulemaking functions for state agencies or political subdivisions may see minimal benefits from elimination of the unnecessary requirement to provide copies of existing rules when submitting rulemakings and reports to the Council.

b. **Administrative and other costs required for compliance with the rulemaking:**

It is anticipated the only additional potential administrative costs on small business will be the cost of printing a copy of the Council's new rules and implementing the changes in the process. These costs will primarily be borne by small businesses working for agencies.

c. **Description of methods that may be used to reduce the impact on small businesses:**

i. **Establish less costly or less stringent compliance or reporting requirements:**

Council staff believes that these rules impose the least burden possible on small businesses.

ii. **Establish less costly schedules or less stringent deadlines for compliance:**

There are no less costly schedules or less stringent deadlines that would achieve the purposes of the rulemaking.

iii. Consolidate or simplify compliance or reporting requirements:

Council staff believes there are no compliance or reporting requirements in these rules that impact small businesses.

iv. Establish separate performance standards:

There are no performance standards in these rules.

v. Exempt small businesses from any or all requirements:

It is not practical to exempt small businesses from the requirements.

8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:

The rulemaking affects members of the public filing a public comment with an agency, or any type of petition or appeal with the Council, but no measurable economic impact is anticipated.

9. Probable effects on state revenues:

None.

10. Less intrusive or less costly alternative methods considered:

The Council believes the economic impact of the methods chosen minimizes the economic impact of the rules on Council staff, agency personnel, and the public through rules that are clear and that reflect current statutory requirements. The alternative of not doing a rulemaking was not selected because of the potential costs of confusion that results from rules that no longer match statutory processes.



For rules filed in the third quarter between
July 1 - September 30
2017

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified; or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office; or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

TITLE 01. Rules and the Rulemaking Process

Chapter 06. Governor's Regulatory Review Council

Sections, Parts, Exhibits, Tables or Appendices modified

R1-6-101 through R1-6-104, R1-6-201 through R1-6-207, R1-6-301 through R1-6-304, R1-6-401 through R1-6-404, R1-6-501, R1-6-502, R1-6-601, R1-6-701, R1-6-801, R1-6-802

Article 4. Appeals and Petitions; Article 5. Repealed; Article 6. Repealed; Article 7. Repealed; Article 8.
Repealed

REMOVE Supp. 13-3
Pages: 1 - 12

REPLACE with Supp. 17-3
Pages: 1 - 11

The agency's contact person who can answer questions about rules in this Chapter:

Name: Chris Kleminich
Address: 100 N. 15th Ave., Suite 305
Phoenix, AZ 85007
Telephone: (602) 542-2024
E-mail: christopher.kleminich@azdoa.gov

Disclaimer: Please be advised the person listed is the contact of record as submitted in the rulemaking package for this supplement. The contact and other information may change and is provided as a public courtesy.

PUBLISHER
Arizona Department of State
Office of the Secretary of State, Administrative Rules Division

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the Administrative Code. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION
September 30, 2017

RULES

A.R.S. § 41-1001(17) states: “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The Arizona Administrative Code is where the official rules of the state of Arizona are published. The Code is the official codification of rules that govern state agencies, boards, and commissions. Virtually everything in your life is affected in some way by rules published in the Arizona Administrative Code, from the quality of air you breathe to the licensing of your dentist. This chapter is one of more than 230 in the Code compiled in 21 Titles.

ADMINISTRATIVE CODE SUPPLEMENTS

Rules filed by an agency to be published in the Administrative Code are updated quarterly. Supplement release dates are printed on the footers of each chapter:

First Quarter: January 1 - March 31

Second Quarter: April 1 - June 30

Third Quarter: July 1 - September 30

Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2017 is cited as Supp. 17-1.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the Arizona Administrative Register for recent updates to rule Sections.

ARTICLES AND SECTIONS

Rules in chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering system separated into subsections.

HISTORICAL NOTES AND EFFECTIVE DATES

Historical notes inform the user when the last time a Section was updated in the Administrative Code. Be aware, since the Office publishes each quarter by entire chapters, not all Sections are updated by an agency in a supplement release. Many times just one Section or a few Sections may be updated in the entire chapter.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in the introduction of a chapter can be found at the Secretary of State’s website, www.azsos.gov/services/legislative-filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the Arizona Administrative Register online at www.azsos.gov/rules, click on the Administrative Register link.

In the Administrative Code the Office includes editor’s notes at the beginning of a chapter indicating that certain rulemaking Sections were made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

EXEMPTIONS AND PAPER COLOR

If you are researching rules and come across rescinded chapters on a different paper color, this is because the agency filed a Notice of Exempt Rulemaking. At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

PERSONAL USE/COMMERCIAL USE

This chapter is posted as a public courtesy online, and is for private use only. Those who wish to use the contents for resale or profit should contact the Office about Commercial Use fees. For information on commercial use fees review A.R.S. § 39-121.03 and 1 A.A.C. 1, R1-1-113.

Public Services managing rules editor, Rhonda Paschal, assisted with the editing of this chapter.

TITLE 1. RULES AND THE RULEMAKING PROCESS**CHAPTER 6. GOVERNOR'S REGULATORY REVIEW COUNCIL**

(Authority: A.R.S. § 41-1051)

ARTICLE 1. GENERAL RULES OF PROCEDURE

Article 1, consisting of Sections R1-6-101 through R1-6-106 and R1-6-108, adopted effective May 25, 1995 (Supp. 95-2).

Article 1, consisting of Sections R1-6-102 three R1-6-109, repealed effective May 25, 1995 (Supp. 95-2).

Article 1 consisting of Sections R1-6-102 through R1-6-109 adopted effective December 16, 1987.

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ARTICLE 2. RULEMAKING PROCEDURES

Article 2, consisting of Section R1-6-201, repealed by final rulemaking; new Article 2, consisting of Sections R1-6-201 to R1-6-207 made by final rulemaking effective October 5, 2013 (Supp. 13-3).

Article 2, consisting of Section R1-6-201, adopted effective May 25, 1995 (Supp. 95-2).

Article 2, consisting of Sections R1-6-202 three R1-6-206, repealed effective May 25, 1995 (Supp. 95-2).

Article 2, consisting of Section R1-6-201, adopted effective May 25, 1995 (Supp. 95-2).

Article 2, consisting of Sections R1-6-202 through R1-6-206, repealed effective May 25, 1995 (Supp. 95-2).

Article 2 consisting of Sections R1-6-202 through R1-6-206 adopted effective March 16, 1988.

Section

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ARTICLE 3. FIVE-YEAR REVIEW REPORTS

Article 3, consisting of Sections R1-6-301 and R1-6-302 repealed by final rulemaking; new Article 3, consisting of Sections R1-6-301 to R1-6-305 made by final rulemaking effective October

5, 2013 (Supp. 13-3).

Article 3, consisting of Section R1-6-301, adopted effective April 3, 1996 (Supp. 96-2).

Section

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ARTICLE 4. APPEALS AND PETITIONS

Article 4, consisting of Section R1-6-401, repealed by final rulemaking; new Article 4, consisting of Section R1-6-401, made by final rulemaking effective October 5, 2013 (Supp. 13-3).

Article 4, consisting of Section R1-6-401, adopted effective April 3, 1996 (Supp. 96-2).

Section

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ARTICLE 5. REPEALED

Article 5, consisting of Sections R1-6-501 and R1-6-502, repealed by final rulemaking at 23 A.A.R. 2265, effective August 9, 2017 (Supp. 17-3).

Article 5, consisting of Section R1-6-501, repealed by final rulemaking; new Article 5, consisting of Sections R1-6-501 and R1-6-502, made by final rulemaking, effective October 5, 2013 (Supp. 13-3).

Article 5, consisting of Section R1-6-501, made at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3).

Section

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ARTICLE 6. REPEALED

Article 6, consisting of Section R1-6-601, repealed by final rulemaking at 23 A.A.R. 2265, effective August 9, 2017 (Supp. 17-3).

Article 6, consisting of Section R1-6-601, made by final rulemaking, effective October 5, 2013 (Supp. 13-3).

Section

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ARTICLE 7. REPEALED

Article 7, consisting of Section R1-6-701, repealed by final rulemaking at 23 A.A.R. 2265, effective August 9, 2017 (Supp. 17-3).

Article 7, consisting of Section R1-6-701, made by final rulemaking, effective October 5, 2013 (Supp. 13-3).

Section
R1-6-701. Repealed 10

Article 8, consisting of Sections R1-6-801 and R1-6-802, made by final rulemaking, effective October 5, 2013 (Supp. 13-3).

ARTICLE 8. REPEALED

Article 8, consisting of Sections R1-6-801 and R1-6-802, repealed by final rulemaking at 23 A.A.R. 2265, effective August 9, 2017 (Supp. 17-3).

Section
R1-6-801. Repealed 11
R1-6-802. Repealed 11

ARTICLE 1. GENERAL RULES OF PROCEDURE

R1-6-101. Definitions

- A. The definitions in A.R.S. § 41-1001 apply to this Chapter.
- B. In this Chapter:
 - 1. "Agency head" means the chief officer of an agency or another person directly or indirectly purporting to act on behalf or under the authority of the agency head.
 - 2. "Chair" means the chairperson of the Council or the chairperson's designee.
 - 3. "Electronic copy" means a document submitted or filed by e-mail or CD.
 - 4. "Expedited rule" means a rule made according to the procedures in A.R.S. §§ 41-1027 and 41-1053.
 - 5. "Five-year Review Report" means a report submitted to the Council according to the procedures in A.R.S. § 41-1056 or 41-1095.
 - 6. "Open Meeting Law" means A.R.S. Title 38, Chapter 3, Article 3.1.
 - 7. "Regular rule" means a rule made according to the procedures in A.R.S. §§ 41-1021 through 41-1024 and 41-1052.

Historical Note

Adopted effective May 25, 1995 (Supp. 95-2). Amended effective April 3, 1996 (Supp. 96-2). Former Section R1-6-101 renumbered to R1-6-102; new Section R1-6-101 adopted by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-102. Meetings

- A. The Chair, in consultation with the Council, shall set monthly meeting dates of the Council and a schedule containing submission deadlines based on those meeting dates for each calendar year by the preceding September 15 and shall post notice of each monthly meeting according to the Open Meeting Law.
- B. The Chair or Council may schedule a special meeting to consider any matter it may consider at a regularly scheduled monthly meeting. The Council shall post notice of a special meeting according to the Open Meeting Law at least 24 hours before the special meeting.
- C. The Council may recess a regularly scheduled monthly or special meeting to a later date if, before recessing, the Chair gives notice of the date and time of the resumption of the meeting and posts a notice of resumption of the meeting according to the Open Meeting Law.
- D. The Chair may temporarily adjourn or recess a regularly scheduled monthly or special meeting on the meeting day in an effort to ensure that a quorum of the Council is present.
- E. For the purpose of responding to questions from the Council, a representative of an agency shall appear at a Council meeting at which the agency has been notified that its rule or five-year review report is on the agenda for consideration.

Historical Note

Adopted effective December 16, 1987 (Supp. 87-4). Section repealed, new Section adopted effective May 25, 1995 (Supp. 95-2). Amended effective April 3, 1996 (Supp. 96-2). Former Section R1-6-102 renumbered to R1-6-103; new Section R1-6-102 renumbered from R1-6-101 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

5, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-103. Submitting a Petition for Council Rulemaking or Review

- A. A person may petition the Council under A.R.S. § 41-1033(A) for a:
 - 1. Rulemaking action relating to a rule promulgated by the Council, including making a new rule or amending or repealing an existing rule; or
 - 2. Review of an existing Council practice or substantive policy statement alleged to constitute a rule.
- B. To act under A.R.S. § 41-1033(A) and this Section, a person shall submit to the Council office one electronic copy of a petition, in the form of a letter signed by the person submitting the petition, that includes the following information:
 - 1. Name, mailing address, e-mail address, and telephone number of the person submitting the petition;
 - 2. Name of any person represented by the person submitting the petition; and
 - 3. If the petition is for rulemaking action:
 - a. A statement of the rulemaking action sought, including the *Arizona Administrative Code* citation of all existing rules, and the specific language of a new rule or rule amendment; and
 - b. Reasons for the rulemaking action, including an explanation of why an existing rule is inadequate, unreasonable, unduly burdensome, or unlawful;
 - 4. If the petition is for a review of an existing practice or substantive policy statement:
 - a. Subject matter of the existing practice or substantive policy statement, and
 - b. Reasons why the existing practice or substantive policy statement constitutes a rule.
- C. The petition shall not exceed five double-spaced pages and shall be in a clear and legible typeface.
- D. A person may submit supporting information with a petition, including:
 - 1. Statistical data; and
 - 2. A list of other persons likely to be affected by the rulemaking action or the review, with an explanation of the likely effects.
- E. The Council shall send a letter in response to the petition no later than 60 calendar days after the date the Council receives the petition.

Historical Note

Adopted effective December 16, 1987 (Supp. 87-4). Section repealed, new Section adopted effective May 25, 1995 (Supp. 95-2). Amended effective April 3, 1996 (Supp. 96-2). Former Section R1-6-103 renumbered to R1-6-104; new Section R1-6-103 renumbered from R1-6-102 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-104. A.R.S. § 41-1008(E) Extension Requests

- A. Under A.R.S. § 41-1008(E), an agency may file a written request for an extension of the two-year period during which a fee established or increased by exempt rulemaking is effective.
- B. The agency shall file a request, in the form of a letter signed by the agency head, at least 40 days before expiration of the two-

- year period so that the request may be considered at a regularly scheduled Council meeting. The agency representative filing a request shall submit to the Council office one electronic copy of the request. The request shall contain:
1. The name, mailing address, e-mail address, and telephone number of the agency and the agency representative filing the request;
 2. The statutory authority under which the request is allowed;
 3. The length of the extension sought;
 4. The reasons why the two-year period should be extended; and
 5. Other supporting information, such as statistical data or a description of persons likely to be adversely affected if the request is denied, if applicable.
- C. The request shall not exceed five double-spaced pages and shall be in a clear and legible typeface.
- D. The Council shall schedule consideration of the request for a Council meeting as soon as practicable after receipt of the agency's request.
- E. Within seven calendar days after the Council's decision on the request, the Chair shall provide written notification of the Council's decision to the affected agency head, including the reasons for and date of the decision.

Historical Note

Adopted effective December 16, 1987 (Supp. 87-4). Section repealed, new Section adopted effective May 25, 1995 (Supp. 95-2). Amended effective April 3, 1996 (Supp. 96-2). Former Section R1-6-104 renumbered to R1-6-108; new Section R1-6-104 renumbered from R1-6-103 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). R1-6-104 renumbered to R1-6-201; new Section R1-6-104 renumbered from R1-6-110 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-105. Repealed**Historical Note**

Adopted effective December 16, 1987 (Supp. 87-4). Section repealed, new Section adopted effective May 25, 1995 (Supp. 95-2). Amended effective April 3, 1996 (Supp. 96-2). Former Section R1-6-105 renumbered to R1-6-109; new Section R1-6-105 adopted by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Repealed by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

R1-6-106. Repealed**Historical Note**

Adopted effective December 16, 1987 (Supp. 87-4). Section repealed, new Section adopted effective May 25, 1995 (Supp. 95-2). Former Section R1-6-106 renumbered to R1-6-110; new Section R1-6-106 adopted by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Repealed by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013

(Supp. 13-3).

R1-6-107. Renumbered**Historical Note**

Adopted effective December 16, 1987 (Supp. 87-4). Repealed effective May 25, 1995 (Supp. 95-2). New Section adopted effective April 3, 1996 (Supp. 96-2). Former Section R1-6-107 renumbered to R1-6-111; new Section R1-6-107 adopted by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Section R1-6-107 renumbered to R1-6-204 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

R1-6-108. Renumbered**Historical Note**

Adopted effective December 16, 1987 (Supp. 87-4). Section repealed, new Section adopted effective May 25, 1995 (Supp. 95-2). Amended effective April 3, 1996 (Supp. 96-2). Former Section R1-6-108 renumbered to R1-6-112; new Section R1-6-108 renumbered from R1-6-104 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Section R1-6-108 renumbered to R1-6-205 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

R1-6-109. Renumbered**Historical Note**

Adopted effective December 16, 1987 (Supp. 87-4). Repealed effective May 25, 1995 (Supp. 95-2). New Section R1-6-109 renumbered from R1-6-105 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Section R1-6-109 renumbered to R1-6-206 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

R1-6-110. Renumbered**Historical Note**

New Section R1-6-110 renumbered from R1-6-106 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Section R1-6-110 renumbered to R1-6-104 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013; clerical error of not showing renumbering in Supp. 13-3 corrected in Supp. 17-3.

R1-6-111. Renumbered**Historical Note**

New Section R1-6-111 renumbered from R1-6-107 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Former R1-6-111 renumbered to R1-6-112; new R1-6-111 renumbered from R1-6-112 and amended by final rulemaking at 17 A.A.R. 1410, effective Septem-

ber 5, 2011 (Supp. 11-3). Section R1-6-111 renumbered to R1-6-301 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

R1-6-112. Renumbered

Historical Note

New Section R1-6-112 renumbered from R1-6-108 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Former R1-6-112 renumbered to R1-6-111; new R1-6-112 renumbered from R1-1-111 and amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Section R1-6-112 renumbered to R1-6-203 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

R1-6-113. Renumbered

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Section R1-6-113 renumbered to R1-6-302 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

R1-6-114. Renumbered

Historical Note

New Section made by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). Section R1-6-114 renumbered to R1-6-303 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

R1-6-115. Renumbered

Historical Note

New Section made by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). R1-6-115 renumbered to R1-6-304 by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

ARTICLE 2. RULEMAKING PROCEDURES

R1-6-201. Submitting a Regular Rule

A. To submit a regular rule for consideration by the Council, an agency shall submit to the Council office one electronic copy of each rulemaking document that follows, prepared in the manner required by this subsection, subsection (B), and the rules of the Office of the Secretary of State:

1. A request for approval, in the form of a cover letter signed by the agency head. The cover letter shall specify:
 - a. The close of record date;
 - b. Whether the rulemaking activity relates to a five-year review report and, if applicable, the date the report was approved by the Council;
 - c. Whether the rule establishes a new fee and, if it does, citation of the statute expressly authorizing the new fee;
 - d. Whether the rule contains a fee increase;
 - e. Whether an immediate effective date is requested for the rule under A.R.S. § 41-1032;
 - f. A certification that the preamble discloses a reference to any study relevant to the rule that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rule;

g. If one or more full-time employees are necessary to implement and enforce the rule, a certification that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule; and

- h. A list of all documents enclosed.
2. A Notice of Final Rulemaking, including the preamble, table of contents for the rulemaking, and text of each rule;
3. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
4. The written comments received by the agency concerning the proposed rule and a written record, transcript, or minutes of any testimony received if the agency maintains a written record, transcript, or minutes; and
5. Any analysis submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states.

B. In addition to the documents required in subsection (A), an agency shall submit one electronic copy of each reference document that follows:

1. Material incorporated by reference, if any;
2. The general and specific statutes authorizing the rule, including relevant statutory definitions;
3. If a term is defined in the rule by referring to another rule or a statute other than the general and specific statutes authorizing the rule, the statute or other rule referred to in the definition; and
4. The existing rule if any subsections within the existing rule are designated as "no change" in the revised text of a rule the agency is amending.

C. After a rule is placed on a Council agenda, Council staff shall review the rule for compliance with the requirements of A.R.S. §§ 41-1021 through 41-1024 and 41-1052 and this Chapter and may ask questions or suggest changes to the agency. If the agency revises any rulemaking document in response to a question or suggested change, the agency shall submit one electronic copy of the revised rulemaking document to the Council for review.

D. After a rule is placed on a Council agenda, an agency may have the rule moved to the agenda of a later meeting by having the agency head send a written notice to the Chair that includes the date of the later meeting. If the agency makes a subsequent request that the rule be moved, the Chair may grant or deny the request at the Chair's discretion.

E. Council staff shall notify the agency of any written comments received by the Council related to an agency's rulemaking.

F. If it is necessary for a rule to be heard at more than one Council meeting, the agency shall submit any revised documents for the later meeting, consistent with this Section.

Historical Note

Adopted effective May 25, 1995 (Supp. 95-2). Amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). R1-6-201 renumbered to R1-6-401; new Section R1-6-201 renumbered from R1-6-104 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-202. Submitting an Expedited Rule

- A. To submit an expedited rule for consideration by the Council, an agency shall submit to the Council office one electronic copy of each rulemaking document that follows, prepared in the manner required by this subsection, subsection (B), and the rules of the Office of the Secretary of State:
 - 1. A request for approval, in the form of a cover letter signed by the agency head. The cover letter shall specify:
 - a. The close of record date;
 - b. An explanation of how the expedited rule meets the criteria in A.R.S. § 41-1027(A);
 - c. Whether the rulemaking activity relates to a five-year review report and, if applicable, the date the report was approved by the Council;
 - d. A certification that the preamble discloses a reference to any study relevant to the rule that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rule; and
 - e. A list of all documents enclosed.
 - 2. A Notice of Final Expedited Rulemaking, including the preamble, table of contents for the rulemaking, and text of each rule;
 - 3. The written comments, including objections that the rulemaking does not meet the criteria in A.R.S. § 41-1027(A), received by the agency or contained in a notice concerning the proposed rule; and
 - 4. Any analysis submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states.
- B. In addition to the documents required in subsection (A), an agency shall submit one electronic copy of each reference document that follows:
 - 1. Material incorporated by reference, if any;
 - 2. For a statute declared unconstitutional, the court's decision;
 - 3. The general and specific statutes authorizing the rule, including relevant statutory definitions;
 - 4. If a term is defined in the rule by referring to another rule or a statute other than the general and specific statutes authorizing the rule, the statute or other rule referred to in the definition; and
 - 5. The text of the existing rule.
- C. After a rule is placed on a Council agenda, Council staff shall review the rule for compliance with the requirements of A.R.S. §§ 41-1027, 41-1053, and this Chapter and may ask questions or suggest changes to the agency. If the agency revises any rulemaking document in response to a question or suggested change, the agency shall submit one electronic copy of the revised rulemaking document to the Council for review.
- D. After a rule is placed on a Council agenda, an agency may have the rule moved to the agenda of a later meeting by having the agency head send a written notice to the Chair that includes the date of the later meeting. If the agency makes a subsequent request that the rule be moved, the Chair may grant or deny the request at the Chair's discretion.

Historical Note

Adopted effective March 16, 1988 (Supp. 88-1).
 Repealed effective May 25, 1995 (Supp. 95-2). New Section made by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-203. Delivering a Notice of Proposed Expedited Rulemaking

- A. Under A.R.S. § 41-1027(B), before filing a Notice of Proposed Expedited Rulemaking with the Office of the Secretary of State, an agency is required to submit an electronic copy of the Notice of Proposed Expedited Rulemaking to the Council.
- B. Upon filing a Notice of Proposed Expedited Rulemaking with the Office of the Secretary of State, the agency shall:
 - 1. Post the Notice of Proposed Expedited Rulemaking on its website as soon as practicable; and
 - 2. Notify Council staff of the filing as soon as practicable. Upon receipt of this notice, Council staff shall post the Notice of Proposed Expedited Rulemaking on the Council's website as soon as practicable.
- C. For the purposes of submitting a final expedited rule for consideration by the Council in accordance with R1-6-202, if the agency and the Council post the Notice of Proposed Expedited Rulemaking on their respective websites on different dates, the Council shall consider the 30-day public comment window established in A.R.S. § 41-1027(C) to have opened on the date of the agency's posting.

Historical Note

Adopted effective March 16, 1988 (Supp. 88-1).
 Repealed effective May 25, 1995 (Supp. 95-2). New Section R1-6-203 renumbered from R1-6-112 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-204. Submitting an Approved Regular or Expedited Rule with Changes

- A. If a final regular or expedited rule is approved by the Council with changes, an agency shall submit to the Council office within 14 calendar days after Council approval, unless a later date is arranged under subsection (B), one electronic copy of each rulemaking document that follows, prepared in the manner required by this Chapter and the rules of the Office of the Secretary of State:
 - 1. A letter identifying each change made at the direction of the Council; and
 - 2. The following rulemaking documents:
 - a. A notice of Final Rulemaking or Notice of Final Expedited Rulemaking, as applicable; and
 - b. An economic, small business, and consumer impact statement, if applicable.
- B. If an agency is unable to submit an approved regular rule or expedited rule to the Council office within the time specified in subsection (A), the agency shall contact the Council office in writing and arrange to submit the approved rule at a later date.

Historical Note

Adopted effective March 16, 1988 (Supp. 88-1).
 Repealed effective May 25, 1995 (Supp. 95-2). New Section R1-6-204 renumbered from R1-6-107 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-205. Filing a Regular or Expedited Rule Approved by the Council

- A. If the Council approves a final regular or expedited rule as submitted, an agency shall file the final regular or expedited rule according to the rules of the Office of the Secretary of State.
- B. If the Council approves a final regular or expedited rule subject to the agency making changes as directed by the Council, and the agency submits the rulemaking documents required by R1-6-204:

1. Council staff shall verify whether each change required by the Council was made.
2. Once Council staff notifies the agency that the verification process is complete, the agency shall file the final regular or expedited rule according to the rules of the Office of the Secretary of State.
3. If an agency submits a revised preamble; table of contents; rule; or economic, small business, and consumer impact statement that does not contain the exact words approved by the Council, Council staff shall notify the agency and require that the items be submitted as approved or schedule the matter for reconsideration by the Council.
- C. Except as specified in subsection (B), an agency shall not make any change to a preamble; table of contents; rule; economic, small business, and consumer impact statement; or materials incorporated by reference after Council approval.

Historical Note

Adopted effective March 16, 1988 (Supp. 88-1). Repealed effective May 25, 1995 (Supp. 95-2). New Section R1-6-205 renumbered from R1-6-108 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-206. Returned Rules

The Council may vote to return a preamble; table of contents; rule; or economic, small business, and consumer impact statement under A.R.S. § 41-1052(C), after identifying the manner in which the returned portion does not meet the standards at A.R.S. § 41-1052(D) through (G).

1. The Council may schedule a date for resubmission in consultation with the agency representative.
2. An agency shall resubmit the notice, with a revised preamble; table of contents; rule; or economic, small business, and consumer impact statement to the Council, and attach to each resubmitted document a letter that:
 - a. Identifies all changes made in response to the Council's explanation for the returned portion;
 - b. Explains how the changes ensure that the document meets the standards at A.R.S. § 41-1052(D) through (G), and
 - c. If applicable, shows that the resubmitted rule is not substantially different from the proposed rule under the standards in A.R.S. § 41-1025.
3. In accordance with R1-6-102, an agency representative shall appear at the Council meeting at which the resubmitted notice, with a revised preamble, table of contents, or rule, or economic, small business, and consumer impact statement is to be considered for legal action.

Historical Note

Adopted effective March 16, 1988 (Supp. 88-1). Repealed effective May 25, 1995 (Supp. 95-2). New Section R1-6-206 renumbered from R1-6-109 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-207. Repealed**Historical Note**

New Section R1-6-207 made by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Section repealed by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

ARTICLE 3. FIVE-YEAR REVIEW REPORTS**R1-6-301. Submitting a Five-year Review Report**

- A. To submit a five-year review report for consideration by the Council, an agency shall submit to the Council office one electronic copy of the cover letter signed by the agency head and the five-year review report required by A.R.S. § 41-1056. Consistent with subsection (B), the agency shall concisely analyze and provide the following information in the five-year review report in the following order for each rule:
 1. General and specific statutes authorizing the rule, including any statute that authorizes the agency to make rules;
 2. Objective of the rule, including the purpose for the existence of the rule;
 3. Effectiveness of the rule in achieving the objective, including a summary of any available data supporting the conclusion reached;
 4. Consistency of the rule with state and federal statutes and other rules made by the agency, and a listing of the statutes or rules used in determining the consistency;
 5. Agency enforcement policy, including whether the rule is currently being enforced and, if so, whether there are any problems with enforcement;
 6. Clarity, conciseness, and understandability of the rule;
 7. Summary of the written criticisms of the rule received by the agency within the five years immediately preceding the five-year review report, including letters, memoranda, reports, written analyses submitted to the agency questioning whether the rule is based on valid scientific or reliable principles or methods, and written allegations made in litigation or administrative proceedings in which the agency was a party that the rule is discriminatory, unfair, unclear, inconsistent with statute, or beyond the authority of the agency to enact, and the result of the litigation or administrative proceedings;
 8. A comparison of the estimated economic, small business, and consumer impact of the rule with the economic, small business, and consumer impact statement prepared on the last making of the rule or, if no economic, small business, and consumer impact statement was prepared on the last making of the rule, an assessment of the actual economic, small business, and consumer impact of the rule;
 9. Any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states;
 10. If applicable, how the agency completed the course of action indicated in the agency's previous five-year review report;
 11. A determination after analysis that the probable benefits of the rule within this state outweigh the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective;
 12. A determination after analysis that the rule is not more stringent than a corresponding federal law unless there is statutory authority to exceed the requirements of that federal law;
 13. For a rule adopted after July 29, 2010, that requires issuance of a regulatory permit, license or agency authorization, whether the rule complies with A.R.S. § 41-1037; and
 14. Course of action the agency proposes to take regarding each rule, including the month and year in which the agency anticipates submitting the rules to the Council if the agency determines it is necessary to amend or repeal

- an existing rule, or to make a new rule. If no issues are identified for a rule in the report, an agency may indicate that no action is necessary for the rule.
- B.** To avoid repetition, an agency shall use a narrative format rather than a tabular format to present the information in the report. The narrative shall be organized according to the categories in subsection (A). For subsection (A)(2), the agency shall provide a specific objective, including the purpose for the existence of each individual rule. Within the remaining categories, an agency shall analyze each rule individually or, if the analysis for each rule is the same, consolidate the analysis, either by article or for all rules in the report. If the analysis for a category is identical for all of the rules in a report, the agency shall specify that the analysis within that category applies to all of the rules in the report. If the analysis for a category is identical for all of the rules in an article, the agency shall specify that the analysis within that category applies to all of the rules in the article.
- C.** In addition to the documents required in subsection (A), an agency shall submit one electronic copy of the cover letter. The cover letter shall provide the following information:
1. A person to contact for information regarding the report,
 2. Any rule that is not reviewed with the intention that the rule will expire under A.R.S. § 41-1056(J),
 3. Any rule that is not reviewed because the Council rescheduled the review of an article under A.R.S. § 41-1056(H), and
 4. The certification that the agency is in compliance with A.R.S. § 41-1091.
- D.** In addition to the documents required in subsections (A) and (C), an agency shall submit one electronic copy of the following reference documents:
1. Rules being reviewed;
 2. General and specific statutes authorizing the rules, including any statute that authorizes the agency to make rules; and
 3. If an economic, small business, and consumer impact statement was prepared on the last making of a rule being reviewed, the economic, small business, and consumer impact statement for the rule.
- E.** After a five-year review report is placed on a Council agenda, Council staff shall review the report for compliance with the requirements of A.R.S. § 41-1056 and this Chapter and may ask questions or suggest changes to the agency. If the agency revises any document in response to a question or suggested change, the agency shall submit one electronic copy of the revised document to the Council for review.
- F.** After a five-year review report is placed on a Council agenda, an agency may have the report moved to the agenda of a later meeting by having the agency head submit a written notice to Council staff that includes the date of the later meeting. If the agency makes a subsequent request to have a five-year review report moved, the Chair may grant or deny the request at the Chair's discretion.
- G.** A person may submit written comments to the Council. The Council may also permit testimony at a Council meeting.

Historical Note

Adopted effective April 3, 1996 (Supp. 96-2). Former Section R1-6-301 renumbered to R1-6-302; new Section R1-6-301 adopted by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). R1-6-301 renumbered to R1-6-501; new R1-6-301 renumbered from R1-6-111 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-302. Rescheduling a Five-year Review Report

- A. To request that a five-year review report be rescheduled under A.R.S. § 41-1056(H), an agency head shall submit a letter to the Chair before the report is due that includes the following information:
 1. The title, chapter, and article of the rules for which rescheduling is sought;
 2. Whether the rules were initially made or substantially revised with an effective date or date of Council approval that is within two years before the due date of the report; and
 - a. If substantially revised:
 - i. A description of the revisions,
 - ii. Why the revisions are believed to be substantial,
 - iii. The date of Council approval of the rules, if applicable, and
 - iv. The date on which the rules were published in the *Register* by the Office of the Secretary of State and the effective date of the rules;
 - b. If initially made:
 - i. The date of Council approval of the rules, if applicable, and
 - ii. The date on which the rules were published in the *Register* by the Office of the Secretary of State and the effective date of the rules.
 - B. The Chair, in the Chair's discretion, may grant the rescheduling of a five-year review report for the rules within an article that meet the requirements of this Section.
 - C. The Chair may, on the Chair's own initiative, reschedule a five-year review report if all rules within an article meet the requirements of this Section.

Historical Note

New Section renumbered from R1-6-301 and amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). R1-6-302 renumbered to R1-6-502; new R1-6-302 renumbered from R1-6-113 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-303. Extension of the Due Date for a Five-year Review Report

- A. An agency may obtain an extension of 120 days to submit a five-year review report by filing a written notice of extension with the Council before the due date of the report. The agency shall specify in the notice the reason for the extension.
- B. An agency may, as an alternative, request a longer extension that is more than 120 days but does not exceed one year by sending a written request to the Chair at least 40 days prior to the due date of the report. The agency shall specify the length of the requested extension and the reason for the requested extension.
 1. A request for an extension that is more than 120 days but does not exceed one year shall be placed on the agenda of a Council meeting scheduled to occur prior to the due date of the report.
 2. The Council shall consider the reason for the requested extension and may grant a request for an extension that is more than 120 days but does not exceed one year.

Historical Note

New Section R1-6-303 renumbered from R1-6-114 and

amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-304. Repealed

Historical Note

New Section R1-6-304 renumbered from R1-6-115 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Section repealed by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-305. Returned Five-year Review Reports

The Council may vote to return, in whole or in part, a five-year review report after identifying the manner in which the five-year review report does not meet the standards in A.R.S. § 41-1056(A).

1. The Council, in consultation with the agency, shall schedule submission of a revised report.
2. An agency submitting a revised five-year review report shall attach to the revised report a letter that:
 - a. Identifies all changes made in response to the Council's explanation for return of the five-year review report, and
 - b. Explains how the changes ensure that the five-year review report meets the standards in A.R.S. § 41-1056(A).

Historical Note

New Section R1-6-305 made by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

ARTICLE 4. APPEALS AND PETITIONS

R1-6-401. Applicability

For purposes of this article, the term "petition or appeal" refers to the following:

1. The A.R.S. § 41-1008(G) Petition for an alternative expiration date for fees established or increased by exempt rulemaking;
2. The A.R.S. § 41-1033(B) Appeal of an agency's decision on a petition requesting the making of a final rule or a review of an existing agency practice or substantive policy statement that the petitioner alleges to constitute a rule;
3. The A.R.S. § 41-1033(C) Petition to request a review of a final rule based on a person's belief that a final rule does not meet the requirements prescribed in A.R.S. § 41-1030;
4. Pursuant to A.R.S. § 41-1033(D), the Council's receipt of information indicating that an existing agency practice or substantive policy statement may constitute a rule or that a final rule does not meet the requirements prescribed in A.R.S. § 41-1030;
5. The A.R.S. § 41-1052(B) Early Review Petition;
6. The A.R.S. § 41-1055(E) Petition for a determination that an agency is not required to file an economic, small business, and consumer impact statement;
7. The A.R.S. § 41-1056(M) Petition to require an agency that has an obsolete rule to consider including the rule in a five-year review report with a recommendation for repeal of the rule;
8. The A.R.S. § 41-1056(N) Petition to require an agency to consider including a recommendation for reducing a licensing time frame in a five-year review report;

9. The A.R.S. § 41-1056.01(D) Appeal related to the economic, small business, and consumer impact of a rule; and
10. The A.R.S. § 41-1081(F) Appeal of a delegation agreement.

Historical Note

Adopted effective April 3, 1996 (Supp. 96-2). Amended by final rulemaking at 6 A.A.R. 8, effective December 8, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 5538, effective December 2, 2003 (Supp. 03-4). Amended by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). R1-6-401 renumbered to R1-6-601; new Section R1-6-401 renumbered from R1-6-201 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-402. Filing of Petitions or Appeals; Agency Response; Council Decision

- A. A person filing a petition or appeal shall submit to the Council one electronic copy of the petition or appeal. The petition or appeal shall contain:
 1. The name, mailing address, e-mail address, and telephone number of the person filing the petition or appeal;
 2. The name of the person being represented by the person filing the petition or appeal, if applicable;
 3. The reasons for submitting the petition or appeal, including relevant facts, laws, and statutory authority;
 4. The reasons why the Council should grant the petition or appeal; and
 5. Any supporting documents relevant to the petition or appeal.
- B. The petition or appeal shall not exceed five double-spaced pages and shall be in a clear and legible typeface.
- C. If applicable, the Council shall notify the affected agency head of the petition or appeal by 5:00 p.m. of the business day following receipt of the petition or appeal. The agency may submit a response to the petition or appeal to the Council.
- D. When required by statutes, within 14 calendar days after a petition or appeal is received by the Council, the Chair shall send written notice to the person filing the petition or appeal and the affected agency head stating whether the required number of Council members have requested that a given petition or appeal be considered at a Council meeting.
- E. No later than seven calendar days after the Council renders a decision on a petition or appeal, the Chair shall send a letter to the affected agency head and the person filing the petition, advising them of the reasons for, and date of, the decision.

Historical Note

New Section made by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-403. Additional Requirements for an Appeal of a Delegation Agreement

- A. Under A.R.S. § 41-1081(F), a person who has filed a written comment with a delegating agency in objection to all or part of a proposed delegation agreement may, within thirty days after the agency gives written notice of its decision pursuant to A.R.S. § 41-1081(E), appeal an agency's decision to enter into a delegation agreement.
- B. In addition to the information required by R1-6-402(A), an appeal of a delegation agreement shall contain:
 - 1. The name of each agency and each political subdivision entering into the delegation agreement;
 - 2. The subject matter of the delegation agreement;
 - 3. Copies of all written comments made by the appellant that object to the delegation agreement and have been filed with the delegating agency; and
 - 4. The reasons why the appellant is objecting to the delegation agreement and filing the appeal.
- C. The Council shall notify the delegating agency head of an appeal of a delegation agreement by 5:00 p.m. of the business day following receipt of the appeal.
- D. The delegating agency head shall submit electronic copies of the following information and documentation by 5:00 p.m. on the third business day following notification by the Council of the appeal:
 - 1. A memorandum that includes:
 - a. The date the delegating agency gave written notice of the decision to enter into the delegation agreement;
 - b. The dates of all public proceedings regarding the delegation agreement; and
 - c. The name, mailing address, e-mail address, and telephone number of the contact persons for each agency and each political subdivision involved in the agreement.
 - 2. A copy of the delegation agreement; and
 - 3. The agency's written summary, prepared as required by A.R.S. § 41-1081(E), responding to all oral or written comments received by the agency regarding the delegation agreement.

Historical Note

New Section made by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-404. Additional Requirements for an Appeal Related to the Economic, Small Business, and Consumer Impact of a Rule

- A. Under A.R.S. § 41-1056.01(D), a person who is or may be affected by an agency's final decision on a petition filed pursuant to A.R.S. § 41-1056.01(A) may, within thirty days of publication of the decision, file an appeal.
- B. In addition to the information required by R1-6-402(A), an appeal of an agency's final decision on a petition filed pursuant to A.R.S. § 41-1056.01(A) shall contain a statement indicating how the person filing the appeal is or may be affected by the agency's decision.
- C. The Council shall notify the affected agency head of an appeal of an agency's final decision on a petition filed pursuant to A.R.S. § 41-1056.01(A) by 5:00 p.m. of the business day following receipt of the appeal.
- D. The affected agency head shall submit electronic copies of the following information and documentation by 5:00 p.m. on the third business day following notification by the Council of the appeal:
 - 1. A memorandum that includes:

- a. The date of publication of the agency's final decision under A.R.S. § 41-1056.01(C);
- b. The name, mailing address, e-mail address, and telephone number of the agency's contact person; and
- c. Reasons why the agency believes that:
 - i. The actual economic, small business, and consumer impact did not significantly exceed the estimated economic, small business, and consumer impact;
 - ii. The actual economic, small business, and consumer impact was estimated on approval of the rule and the impact does not impose a significant burden on persons subject to the rule; or
 - iii. The agency selected the alternative that imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.
- 2. A copy of final judgments, if any, issued by a court of competent jurisdiction that are based on whether the contents of the rule's economic, small business, and consumer impact statement were insufficient or inaccurate;
- 3. A copy of the rule being appealed; and
- 4. A copy of the agency's written summary of comments received, the agency's response to those comments, and the agency's final decision on whether to initiate rulemaking, prepared and published as required by A.R.S. § 41-1056.01(C).

Historical Note

New Section made by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

ARTICLE 5. REPEALED**R1-6-501. Repealed****Historical Note**

New Section made by final rulemaking at 17 A.A.R. 1410, effective September 5, 2011 (Supp. 11-3). R1-6-501 renumbered to R1-6-701; new Section R1-6-501 renumbered from R1-6-301 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Section repealed by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-502. Repealed**Historical Note**

New Section R1-6-502 renumbered from R1-6-302 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Section repealed by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

ARTICLE 6. REPEALED**R1-6-601. Repealed****Historical Note**

New Section R1-6-601 renumbered from R1-6-401 and amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Section repealed by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

ARTICLE 7. REPEALED**R1-6-701. Repealed****Historical Note**

New Section R1-6-701 renumbered from R1-6-501 and

amended by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3). Section repealed by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

Section repealed by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

R1-6-802. Repealed**Historical Note**

New Section R1-6-802 made by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).
Section repealed by final rulemaking at 23 A.A.R. 2265 effective August 9, 2017 (Supp. 17-3).

ARTICLE 8. REPEALED**R1-6-801. Repealed****Historical Note**

New Section R1-6-801 made by final rulemaking at 19 A.A.R. 2731, effective October 5, 2013 (Supp. 13-3).

41-1001.01. Regulatory bill of rights; small businesses

A. To ensure fair and open regulation by state agencies, a person:

1. Is eligible for reimbursement of fees and other expenses if the person prevails by adjudication on the merits against an agency in a court proceeding regarding an agency decision as provided in section 12-348.
2. Is eligible for reimbursement of the person's costs and fees if the person prevails against any agency in an administrative hearing as provided in section 41-1007.
3. Is entitled to have an agency not charge the person a fee unless the fee for the specific activity is expressly authorized as provided in section 41-1008.
4. Is entitled to receive the information and notice regarding inspections and audits prescribed in section 41-1009.
5. May review the full text or summary of all rulemaking activity, the summary of substantive policy statements and the full text of executive orders in the register as provided in article 2 of this chapter.
6. May participate in the rulemaking process as provided in articles 3, 4, 4.1 and 5 of this chapter, including:
 - (a) Providing written comments or testimony on proposed rules to an agency as provided in section 41-1023 and having the agency adequately address those comments as provided in section 41-1052, subsection D, including comments or testimony concerning the information contained in the economic, small business and consumer impact statement.
 - (b) Filing an early review petition with the governor's regulatory review council as provided in article 5 of this chapter.
 - (c) Providing written comments or testimony on rules to the governor's regulatory review council during the mandatory sixty-day comment period as provided in article 5 of this chapter.
7. Is entitled to have an agency not base a licensing decision in whole or in part on licensing conditions or requirements that are not specifically authorized by statute, rule or state tribal gaming compact as provided in section 41-1030, subsection B.
8. Is entitled to have an agency not make a rule under a specific grant of rulemaking authority that exceeds the subject matter areas listed in the specific statute or not make a rule under a general grant of rulemaking authority to supplement a more specific grant of rulemaking authority as provided in section 41-1030, subsection C.
9. May allege that an existing agency practice or substantive policy statement constitutes a rule and have that agency practice or substantive policy statement declared void because the practice or substantive policy statement constitutes a rule as provided in section 41-1033.
10. May file a complaint with the administrative rules oversight committee concerning:
 - (a) A rule's, practice's or substantive policy statement's lack of conformity with statute or legislative intent as provided in section 41-1047.
 - (b) An existing statute, rule, practice alleged to constitute a rule or substantive policy statement that is alleged to be duplicative or onerous as provided in section 41-1048.

11. May have the person's administrative hearing on contested cases and appealable agency actions heard by an independent administrative law judge as provided in articles 6 and 10 of this chapter.
 12. May have administrative hearings governed by uniform administrative appeal procedures as provided in articles 6 and 10 of this chapter and may appeal a final administrative decision by filing a notice of appeal pursuant to title 12, chapter 7, article 6.
 13. May have an agency approve or deny the person's license application within a predetermined period of time as provided in article 7.1 of this chapter.
 14. Is entitled to receive written notice from an agency on denial of a license application:
 - (a) That justifies the denial with references to the statutes or rules on which the denial is based as provided in section 41-1076.
 - (b) That explains the applicant's right to appeal the denial as provided in section 41-1076.
 15. Is entitled to receive information regarding the license application process before or at the time the person obtains an application for a license as provided in sections 41-1001.02 and 41-1079.
 16. May receive public notice and participate in the adoption or amendment of agreements to delegate agency functions, powers or duties to political subdivisions as provided in section 41-1026.01 and article 8 of this chapter.
 17. May inspect all rules and substantive policy statements of an agency, including a directory of documents, in the office of the agency director as provided in section 41-1091.
 18. May file a complaint with the office of the ombudsman-citizens aide to investigate administrative acts of agencies as provided in chapter 8, article 5 of this title.
 19. Unless specifically authorized by statute, may expect state agencies to avoid duplication of other laws that do not enhance regulatory clarity and to avoid dual permitting to the extent practicable as prescribed in section 41-1002.
 20. May have the person's administrative hearing on contested cases pursuant to title 23, chapter 2 or 4 heard by an independent administrative law judge as prescribed by title 23, chapter 2 or 4.
 21. Pursuant to section 41-1009, subsection E, may correct deficiencies identified during an inspection unless otherwise provided by law.
- B. The enumeration of the rights listed in subsection A of this section does not grant any additional rights that are not prescribed in the sections referenced in subsection A of this section.
- C. Each state agency that conducts audits, inspections or other regulatory enforcement actions pursuant to section 41-1009 shall create and clearly post on the agency's website a small business bill of rights. The agency shall create the small business bill of rights by selecting the applicable rights prescribed in this section and section 41-1009 and any other agency-specific statutes and rules. The agency shall provide a written document of the small business bill of rights to the authorized on-site representative of the regulated small business. In addition to the rights listed in this section and section 41-1009, the agency notice of the small business bill of rights shall include the process by which a small business may file a complaint with the agency employees who are designated to assist members of the public or regulated community pursuant to section 41-1006. The notice must provide the contact information of the agency's

designated employees. The agency notice must also state that if the regulated person has already made a reasonable effort with the agency to resolve the problem and still has not been successful, the regulated person may contact the office of ombudsman-citizens aide.

41-1023. Public participation; written statements; oral proceedings

- A. After providing notice of docket openings, an agency may meet informally with any interested party for the purpose of discussing the proposed rule making action. The agency may solicit comments, suggested language or other input on the proposed rule. The agency may publish notice of these meetings in the register.
- B. For at least thirty days after publication of the notice of the proposed rule making, an agency shall afford persons the opportunity to submit in writing statements, arguments, data and views on the proposed rule, with or without the opportunity to present them orally.
- C. An agency shall schedule an oral proceeding on a proposed rule if, within thirty days after the published notice of proposed rule making, a written request for an oral proceeding is submitted to the agency personnel listed pursuant to section 41-1021, subsection B.
- D. An oral proceeding on a proposed rule may not be held earlier than thirty days after notice of its location and time is published in the register. The agency shall determine a location and time for the oral proceeding which affords a reasonable opportunity to persons to participate. The oral proceeding shall be conducted in a manner that allows for adequate discussion of the substance and the form of the proposed rule, and persons may ask questions regarding the proposed rule and present oral argument, data and views on the proposed rule.
- E. The agency, a member of the agency or another presiding officer designated by the agency shall preside at an oral proceeding on a proposed rule. If the agency does not preside, the presiding official shall prepare a memorandum for consideration by the agency summarizing the contents of the presentations made at the oral proceeding. Oral proceedings must be open to the public and recorded by stenographic or other means.
- F. Each agency may make rules for the conduct of oral rule making proceedings. Those rules may include provisions calculated to prevent undue repetition in the oral proceedings.

41-1027. Expedited rulemaking

- A. An agency may conduct expedited rulemaking pursuant to this section if the rulemaking does not increase the cost of regulatory compliance, increase a fee or reduce procedural rights of persons regulated and does one or more of the following:
 1. Amends or repeals rules made obsolete by repeal or supersession of an agency's statutory authority.
 2. Amends or repeals rules for which the statute on which the rule is authorized has been declared unconstitutional by a court with jurisdiction, there is a final judgment and no statute has been enacted to replace the unconstitutional statute.
 3. Makes, amends or repeals rules that repeat verbatim existing statutory authority granted to the agency.
 4. Makes, amends or repeals rules relating only to internal governmental operations that are not subject to violation by a person.
 5. Corrects typographical errors, makes address or name changes or clarifies language of a rule without changing its effect.

6. Adopts or incorporates by reference without material change federal statutes or regulations pursuant to section 41-1028, statutes of this state or rules of other agencies of this state.
 7. Reduces or consolidates steps, procedures or processes in the rules.
 8. Amends or repeals rules that are outdated, redundant or otherwise no longer necessary for the operation of state government.
- B. If the proposed expedited rulemaking is solely for a purpose prescribed in subsection A, paragraph 1, 3, 5 or 8 of this section, an agency shall notify the governor, the president of the senate, the speaker of the house of representatives and the council of the proposed expedited rulemaking. The notice shall contain the name, address and telephone number of the agency contact person and the exact wording of the proposed expedited rulemaking and indicate how the proposed expedited rulemaking achieves the purpose prescribed in subsection A, paragraph 1, 3, 5 or 8 of this section.
- C. If the proposed expedited rulemaking is for a purpose prescribed in subsection A, paragraph 2, 4, 6 or 7 of this section, an agency shall file a request for proposed expedited rulemaking with the governor and notify the president of the senate, the speaker of the house of representatives and the council of the request. The request shall contain the name, address and telephone number of the agency contact person and the exact wording of the proposed expedited rulemaking and an explanation of how the proposed expedited rulemaking meets the criteria in subsection A of this section.
- D. The governor may approve the request for expedited rulemaking if the request complies with subsection A of this section.
- E. On delivery of the notice required in subsection B of this section or on approval by the governor of a request for proposed expedited rulemaking the agency shall file a notice of the proposed expedited rulemaking with the secretary of state for publication in the next state administrative register containing the information and provisions of the proposed rulemaking filed with the governor pursuant to subsection B or C of this section and allow any person to provide written comment to the agency for at least thirty days after publication in the register, including objections to the rulemaking because it does not meet the criteria pursuant to subsection A of this section. The agency shall adequately respond in writing to the comments on the proposed expedited rulemaking.
- F. An agency may not submit an expedited rule to the council that is substantially different from the proposed rule contained in the notice of proposed expedited rulemaking. However, an agency may terminate an expedited rulemaking proceeding pursuant to subsection K of this section and commence a new rulemaking proceeding for the purpose of making a substantially different rule. An agency shall use the criteria prescribed in section 41-1025, subsection B for determining whether an expedited rule is substantially different from the published proposed expedited rule.
- G. After adequately addressing, in writing, any written objections, an agency shall file a request for approval with the council. The request shall contain the notice of proposed expedited rulemaking filed with the secretary of state pursuant to this section and the agency's responses to any written comments. The council may require a representative of an agency whose proposed expedited rulemaking is under examination to attend a council meeting and answer questions. The council may communicate to the agency its comments on the proposed

expedited rule making within the scope of subsection A of this section and require the agency to respond to its comments or testimony in writing. A person may submit written comments to the council that are within the scope of subsection A of this section.

H. Before an agency files a notice of final expedited rulemaking with the secretary of state, the council shall approve any proposed expedited rulemaking. The council shall not approve the rule unless:

1. The rule satisfies the criteria for expedited rulemaking pursuant to subsection A of this section.
 2. The rule is clear, concise and understandable.
 3. The rule is not illegal, inconsistent with legislative intent or beyond the agency's statutory authority.
 4. The agency, in writing, adequately addressed the comments on the proposed rule and any supplementary proposal.
 5. If applicable, the permitting requirements comply with section 41-1037.
 6. The rule is not a substantial change, considered as a whole, from the proposed rule and any supplementary proposal.
 7. The rule imposes the least burden and costs to persons regulated by the rule.
- I. On receipt of council approval, the agency shall file a notice of final expedited rulemaking with the secretary of state that contains the information and provisions required in subsection B or C of this section and that the agency did receive approval from the council pursuant to this section.
- J. The expedited rulemaking becomes effective thirty days following publication of the notice of final expedited rulemaking.
- K. An agency may terminate an expedited rulemaking proceeding on approval of the governor and written notice to the president of the senate, the speaker of the house of representatives and the council.

41-1033. Petition for a rule or review of an agency practice, substantive policy statement, final rule or unduly burdensome licensing requirement; notice

A. Any person may petition an agency to do either of the following:

1. Make, amend or repeal a final rule.
 2. Review an existing agency practice or substantive policy statement that the petitioner alleges to constitute a rule.
- B. An agency shall prescribe the form of the petition and the procedures for the petition's submission, consideration and disposition. The person shall state on the petition the rulemaking to review or the agency practice or substantive policy statement to consider making into a rule.
- C. Not later than sixty days after submission of the petition, the agency shall either:
1. Reject the petition and state its reasons in writing for denial to the petitioner.
 2. Initiate rulemaking proceedings in accordance with this chapter.
 3. If otherwise lawful, make a rule.
- D. The agency's response to the petition is open to public inspection.
- E. If an agency rejects a petition pursuant to subsection C of this section, the petitioner has thirty days to appeal to the council to review whether the existing agency practice or substantive policy statement constitutes a rule. The council chairperson shall place this appeal on the

agenda of the council's next meeting if at least three council members make such a request of the council chairperson within two weeks after the filing of the appeal.

F. A person may petition the council to request a review of a final rule based on the person's belief that the final rule does not meet the requirements prescribed in section 41-1030.

G. A person may petition the council to request a review of an existing agency practice, substantive policy statement, final rule or regulatory licensing requirement that is not specifically authorized by statute pursuant to title 32 based on the person's belief that the existing agency practice, substantive policy statement, final rule or regulatory licensing requirement is unduly burdensome or is not demonstrated to be necessary to specifically fulfill a public health, safety or welfare concern. If the council determines that the existing agency practice, substantive policy statement, final rule or regulatory licensing requirement applies to a profession for which the average wage in that profession in this state does not exceed two hundred percent of the federal poverty guidelines for a family of four, the council shall review the existing agency practice, substantive policy statement, final rule or regulatory licensing requirement as prescribed by this section. This subsection does not apply to an individual or institution that is subject to title 36, chapter 4, article 10 or chapter 20.

H. If the council receives information that indicates an existing agency practice or substantive policy statement may constitute a rule, that a final rule does not meet the requirements prescribed in section 41-1030 or that an existing agency practice, substantive policy statement, final rule or regulatory licensing requirement does not meet the guidelines prescribed in subsection G of this section and at least four council members request of the chairperson that the matter be heard in a public meeting:

1. Within ninety days after receipt of the fourth council member's request, the council shall determine whether the agency practice or substantive policy statement constitutes a rule, whether the final rule meets the requirements prescribed in section 41-1030 or whether an existing agency practice, substantive policy statement, final rule or regulatory licensing requirement meets the guidelines prescribed in subsection G of this section.

2. Within ten days after receipt of the fourth council member's request, the council shall notify the agency that the matter has been or will be placed on an agenda.

3. Not later than thirty days after receiving notice from the council, the agency shall submit a statement to the council that addresses whether the existing agency practice, substantive policy statement constitutes a rule or whether the final rule meets the requirements prescribed in section 41-1030 or whether an existing agency practice, substantive policy statement, final rule or regulatory licensing requirement meets the guidelines prescribed in subsection G of this section.

I. For the purposes of subsection H of this section, the council meeting shall not be scheduled until the expiration of the agency response period prescribed in subsection H, paragraph 3 of this section.

J. An agency practice, substantive policy statement, final rule or regulatory licensing requirement considered by the council pursuant to this section shall remain in effect while under consideration of the council. If the council ultimately decides the agency practice or substantive policy statement constitutes a rule or that the final rule does not meet the requirements prescribed in section 41-1030, the practice, policy statement or rule shall be considered void. If the council determines that the existing agency practice, substantive policy statement, final rule or regulatory licensing requirement is unduly burdensome or is not demonstrated to be necessary to specifically fulfill a public health, safety or welfare concern and meets the requirements of subsection G of this section, the council may modify, revise or declare void any

such existing agency practice, substantive policy statement, final rule or regulatory licensing requirement.

K. A council decision pursuant to this section shall include findings of fact and conclusions of law, separately stated. Conclusions of law shall specifically address the agency's authority to act consistent with section 41-1030.

L. A decision by the agency pursuant to this section is not subject to judicial review, except that, in addition to the procedure prescribed in this section or in lieu of the procedure prescribed in this section, a person may seek declaratory relief pursuant to section 41-1034.

M. Each agency and the secretary of state shall post prominently on their websites notice of an individual's right to petition the council for review pursuant to this section.

41-1051. Governor's regulatory review council; membership; terms; compensation; powers

A. The governor's regulatory review council is established consisting of six members who are appointed by the governor pursuant to section 38-211 and who are subject to sections 38-291 and 38-295 and the director of the department of administration or the assistant director of the department of administration who is responsible for administering the council. The director or assistant director is an ex officio member and chairperson of the council. The council shall elect a vice-chairperson to serve as chairperson in the chairperson's absence. The governor shall appoint at least one member who represents the public interest, at least one member who represents the business community, at least one member who is a small business owner, one member from a list of three persons who are not legislators submitted by the president of the senate and one member from a list of three persons who are not legislators submitted by the speaker of the house of representatives. At least one member of the council shall be an attorney licensed to practice law in this state. The governor shall appoint the members of the council for staggered terms of three years. A vacancy occurring during the term of office of any member shall be filled by appointment by the governor for the unexpired portion of the term in the same manner as provided in this section.

B. The council shall meet at least once a month at a time and place set by the chairperson and at other times and places as the chairperson deems necessary.

C. Members of the council are eligible to receive compensation in an amount of two hundred dollars for each day on which the council meets and reimbursement of expenses pursuant to title 38, chapter 4, article 2.

D. The chairperson, subject to chapter 4, article 4 and, as applicable, articles 5 and 6 of this title, shall employ, determine the conditions of employment of and specify the duties of administrative, secretarial and clerical employees as the chairperson deems necessary.

E. The council may make rules pursuant to this chapter to carry out the purposes of this chapter.

F. The council shall make a list of agency rules approved or returned pursuant to sections 41-1027 and 41-1052 and section 41-1056, subsection C for the previous twelve-month period available to the public on request and on the council's website.

41-1052. Council review and approval

A. Before filing a final rule subject to this section with the secretary of state, an agency shall prepare, transmit to the council and the committee and obtain the council's approval of the rule

and its preamble and economic, small business and consumer impact statement that meets the requirements of section 41-1055. The office of economic opportunity shall prepare the economic, small business and consumer impact statement.

B. The council shall accept an early review petition of a proposed rule, in whole or in part, if the proposed rule is alleged to violate any of the criteria prescribed in subsection D of this section and if the early petition is filed by a person who would be adversely impacted by the proposed rule. The council may determine whether the proposed rule, in whole or in part, violates any of the criteria prescribed in subsection D of this section.

C. Within one hundred twenty days after receipt of the rule, preamble and economic, small business and consumer impact statement, the council shall review and approve or return, in whole or in part, the rule, preamble or economic, small business and consumer impact statement. An agency may resubmit a rule, preamble or economic, small business and consumer impact statement if the council returns the rule, economic, small business and consumer impact statement or preamble, in whole or in part, to the agency.

D. The council shall not approve the rule unless:

1. The economic, small business and consumer impact statement contains information from the state, data and analysis prescribed by this article.

2. The economic, small business and consumer impact statement is generally accurate.

3. The probable benefits of the rule outweigh within this state the probable costs of the rule and the agency has demonstrated that it has selected the alternative that imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

4. The rule is written in a manner that is clear, concise and understandable to the general public.

5. The rule is not illegal, inconsistent with legislative intent or beyond the agency's statutory authority.

6. The agency adequately addressed, in writing, the comments on the proposed rule and any supplemental proposals.

7. The rule is not a substantial change, considered as a whole, from the proposed rule and any supplemental notices.

8. The preamble discloses a reference to any study relevant to the rule that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rule.

9. The rule is not more stringent than a corresponding federal law unless there is statutory authority to exceed the requirements of that federal law.

10. If a rule requires a permit, the permitting requirement complies with section 41-1037.

E. The council shall verify that a rule with new fees does not violate section 41-1008. The council shall not approve a rule that contains a fee increase unless two-thirds of the voting quorum present vote to approve the rule.

F. The council shall verify that a rule with an immediate effective date complies with section 41-1032. The council shall not approve a rule with an immediate effective date unless two-thirds of the voting quorum present vote to approve the rule.

G. If the rule relies on scientific principles or methods, including a study disclosed pursuant to subsection D, paragraph 8 of this section, and a person submits an analysis to the council questioning whether the rule is based on valid scientific or reliable principles or methods, the council shall not approve the rule unless the council determines that the rule is based on valid scientific or reliable principles or methods that are specific and not of a general nature. In making a determination of reliability or validity, the council shall consider the following factors as applicable to the rule:

1. The authors of the study, principle or method have subject matter knowledge, skill, experience, training and expertise.
2. The study, principle or method is based on sufficient facts or data.
3. The study is the product of reliable principles and methods.
4. The study and its conclusions, principles or methods have been tested or subjected to peer reviewed publications.
5. The known or potential error rate of the study, principle or method has been identified along with its basis.
6. The methodology and approach of the study, principle or method are generally accepted in the scientific community.

H. The council may require a representative of an agency whose rule is under examination to attend a council meeting and answer questions. The council may also communicate to the agency its comments on any rule, preamble or economic, small business and consumer impact statement and require the agency to respond to its comments in writing.

I. At any time during the thirty days immediately following receipt of the rule, a person may submit written comments to the council that are within the scope of subsection D, E, F or G of this section. The council may permit testimony at a council meeting within the scope of subsection D, E, F or G of this section.

J. If the agency makes a good faith effort to comply with the requirements prescribed in this article and has explained in writing the methodology used to produce the economic, small business and consumer impact statement, the rule may not be invalidated after it is finalized on the ground that the contents of the economic, small business and consumer impact statement are insufficient or inaccurate or on the ground that the council erroneously approved the rule, except as provided by section 41-1056.01.

K. The absence of comments pursuant to subsection D, E, F or G of this section or article 4.1 of this chapter does not prevent the council from acting pursuant to this section.

L. The council shall review and approve or reject a notice of proposed expedited rule making pursuant to section 41-1027.

41-1053. Council review of expedited rules

A. After receipt of the expedited rule package from the agency, the council shall place the expedited rule on its consent agenda for approval unless a member of the council or the committee requests a hearing.

B. If a hearing is requested, the council shall act on the expedited rule pursuant to section 41-1052 or shall remand the expedited rule to the agency for initiation of a rule making pursuant to sections 41-1022, 41-1023 and 41-1024.

C. The council, at any time a proposed expedited rule is pending, may disapprove the expedited rule making and order initiation of a regular rule making pursuant to sections 41-1022, 41-1023 and 41-1024.

41-1055. Economic, small business and consumer impact statement

A. The economic, small business and consumer impact summary in the preamble shall include:

1. An identification of the proposed rule making, including all of the following:
 - (a) The conduct and its frequency of occurrence that the rule is designed to change.
 - (b) The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed.
 - (c) The estimated change in frequency of the targeted conduct expected from the rule change.
2. A brief summary of the information included in the economic, small business and consumer impact statement.
3. If the economic, small business and consumer impact summary accompanies a proposed rule or a proposed expedited rule, the name and address of agency employees who may be contacted to submit or request additional data on the information included in the economic, small business and consumer impact statement.

B. The economic, small business and consumer impact statement shall include:

1. An identification of the proposed rule making.
2. An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rule making.
3. A cost benefit analysis of the following:
 - (a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rule making. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.
 - (b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rule making.
 - (c) The probable costs and benefits to businesses directly affected by the proposed rule making, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rule making.
4. A general description of the probable impact on private and public employment in businesses, agencies and political subdivisions of this state directly affected by the proposed rule making.
5. A statement of the probable impact of the proposed rule making on small businesses. The statement shall include:
 - (a) An identification of the small businesses subject to the proposed rule making.
 - (b) The administrative and other costs required for compliance with the proposed rule making.
 - (c) A description of the methods prescribed in section 41-1035 that the agency may use to reduce the impact on small businesses, with reasons for the agency's decision to use or not to use each method.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rule making.

6. A statement of the probable effect on state revenues.

7. A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rule making, including the monetizing of the costs and benefits for each option and providing the rationale for not using nonselected alternatives.

8. A description of any data on which a rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

C. If for any reason adequate data are not reasonably available to comply with the requirements of subsection B of this section, the agency shall explain the limitations of the data and the methods that were employed in the attempt to obtain the data and shall characterize the probable impacts in qualitative terms. The absence of adequate data, if explained in accordance with this subsection, shall not be grounds for a legal challenge to the sufficiency of the economic, small business and consumer impact statement.

D. An agency is not required to prepare an economic, small business and consumer impact statement pursuant to this chapter and is not required to file a petition pursuant to subsection E of this section for the following rule makings:

1. Initial making, but not renewal, of an emergency rule pursuant to section 41-1026.

2. Proposed expedited rule making or final expedited rule making.

E. Before filing a proposed rule with the secretary of state, an agency may petition the council for a determination that the agency is not required to file an economic, small business and consumer impact statement. The petition shall demonstrate both of the following:

1. The rule making decreases monitoring, record keeping, costs or reporting burdens on agencies, political subdivisions, businesses or persons.

2. The rule making does not increase monitoring, record keeping, costs or reporting burdens on persons subject to the proposed rule making.

F. The council shall place a petition under subsection E of this section on the agenda of its next meeting if at least four council members make such a request of the council chairperson within two weeks after the filing of the petition.

G. The preamble for a rule making that is exempt pursuant to subsection D or E of this section shall state that the rule making is exempt from the requirements to prepare and file an economic, small business and consumer impact statement.

H. The cost-benefit analysis required by subsection B of this section shall calculate only the costs and benefits that occur in this state.

I. If a person submits an analysis to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states, the agency shall consider the analysis.

A. At least once every five years, each agency shall review all of its rules, including rules made pursuant to an exemption from this chapter or any part of this chapter, to determine whether any rule should be amended or repealed. The agency shall prepare and obtain council approval of a written report summarizing its findings, its supporting reasons and any proposed course of action. The report shall contain a certification that the agency is in compliance with section 41-1091. For each rule, the report shall include a concise analysis of all of the following:

1. The rule's effectiveness in achieving its objectives, including a summary of any available data supporting the conclusions reached.
2. Written criticisms of the rule received during the previous five years, including any written analyses submitted to the agency questioning whether the rule is based on valid scientific or reliable principles or methods.
3. Authorization of the rule by existing statutes.
4. Whether the rule is consistent with statutes or other rules made by the agency and current agency enforcement policy.
5. The clarity, conciseness and understandability of the rule.
6. The estimated economic, small business and consumer impact of the rules as compared to the economic, small business and consumer impact statement prepared on the last making of the rules.
7. Any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states.
8. If applicable, that the agency completed the previous five-year review process.
9. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.
10. A determination that the rule is not more stringent than a corresponding federal law unless there is statutory authority to exceed the requirements of that federal law.
11. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license or agency authorization, whether the rule complies with section 41-1037.

B. An agency may also include as part of the report the text of a proposed expedited rule pursuant to section 41-1027.

C. The council shall schedule the periodic review of each agency's rules and shall approve or return, in whole or in part, the agency's report on its review. The council may grant an agency an extension from filing an agency's report. If the council returns an agency's report, in whole or in part, the council shall inform the agency of the manner in which its report is inadequate and, in consultation with the agency, shall schedule submission of a revised report. The council shall not approve a report unless the report complies with subsection A of this section.

D. The council may review rules outside of the five-year review process if requested by at least four council members.

E. The council may require the agency to propose an amendment or repeal of the rule by a date no earlier than six months after the date of the meeting at which the council considers the

agency's report on its rule if the council determines the agency's analysis under subsection A of this section demonstrates that the rule is materially flawed, including that the rule:

1. Is not authorized by statute.
2. Is inconsistent with other statutes, rules or agency enforcement policies and the inconsistency results in a significant burden on the regulated public.
3. Imposes probable costs, including costs to the regulated person, that significantly exceed the probable benefits of the rule within this state.
4. Is more stringent than a corresponding federal law and there is no statutory authority to exceed the requirements of federal law.
5. Is not clear, concise and understandable.
6. Does not use general permits if required under section 41-1037.
7. Does not impose the least burden to persons regulated by the rule as necessary to achieve the underlying regulatory objective of the rule.
8. Does not rely on valid scientific or reliable principles and methods, including a study, if the rule relies on scientific principles or methods, and a person has submitted an analysis under subsection A of this section questioning whether the rule is based on valid scientific or reliable principles or methods. In making a determination of validity or reliability, the council shall consider the factors listed in section 41-1052, subsection G.

F. An agency may request an extension of no longer than one year from the date specified by the council pursuant to subsection E of this section by sending a written request to the council that:

1. Identifies the reason for the extension request.
2. Demonstrates good cause for the extension.

G. The agency shall notify the council of an amendment or repeal of a rule for which the council has set an expiration date under subsection E of this section. If the agency does not amend or repeal the rule by the date specified by the council under subsection E of this section or the extended date under subsection F of this section, the rule automatically expires. The council shall file a notice of rule expiration with the secretary of state and notify the agency of the expiration of the rule.

H. The council may reschedule a report or portion of a report for any rule that is scheduled for review and that was initially made or substantially revised within two years before the due date of the report as scheduled by the council.

I. If an agency finds that it cannot provide the written report to the council by the date it is due, the agency may file an extension with the council before the due date indicating the reason for the extension. The timely filing for an extension permits the agency to submit its report on or before the date prescribed by the council.

J. If an agency fails to submit its report, including a revised report, pursuant to subsection A or C of this section, or file an extension before the due date of the report or if it files an extension and does not submit its report within the extension period, the rules scheduled for review expire and the council shall:

1. Cause a notice to be published in the next register that states the rules have expired and are no longer enforceable.

2. Notify the secretary of state that the rules have expired and that the rules are to be removed from the code.
 3. Notify the agency that the rules have expired and are no longer enforceable.
- K. If a rule expires as provided in subsection J of this section and the agency wishes to reestablish the rule, the agency shall comply with the requirements of this chapter.
- L. Not less than ninety days before the due date of a report, the council shall send a written notice to the head of the agency whose report is due. The notice shall list the rules to be reviewed and the date the report is due.
- M. A person who is regulated or could be regulated by an obsolete rule may petition the council to require an agency that has the obsolete rule to consider including the rule in the five-year report with a recommendation for repeal of the rule.
- N. A person who is required to obtain or could be required to obtain a license may petition the council to require an agency to consider including a recommendation for reducing a licensing time frame in the five-year report.

41-1056.01. Impact statements; appeals

A. Within two years after a rule is finalized, a person who is or may be affected by the rule may file a written petition with an agency objecting to all or part of a rule on any of the following grounds:

1. The actual economic, small business or consumer impact significantly exceeded the impact estimated in the economic, small business and consumer impact statement submitted during the making of the rule.
2. The actual economic, small business or consumer impact was not estimated in the economic, small business and consumer impact statement submitted during the making of the rule and that actual impact imposes a significant burden on persons subject to the rule.
3. The agency did not select the alternative that imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

B. The burden of proof is on the petitioner to show that any of the provisions set forth in subsection A of this section are met.

C. Within thirty days after receiving the copy of the petition, the agency shall reevaluate the rule and its economic impacts and publish notice of the petition in the register. For at least thirty days after publication of the notice the agency shall afford persons the opportunity to submit in writing statements, arguments, data and views on the rule and its impacts. Within thirty days after the close of comment, the agency shall publish a written summary of comments received, the agency's response to those comments, and the final decision of the agency on whether to initiate a rule making or to amend or repeal the rule. The agency shall initiate any such rule making within forty-five days after publication of its final decision.

D. Any person who is or may be affected by the agency's final decision on whether to initiate a rule making pursuant to subsection C of this section may appeal that decision to the council within thirty days after publication of the agency's final decision.

E. The council shall place on its agenda the appeal if at least three council members make such a request of the council chairman within two weeks after the filing of the appeal with the council.

F. If the appeal is placed on the council's agenda, the council chairman shall provide a copy of the appeal and written notice to the agency that the council will consider the appeal. The agency shall provide the council with a copy of the written summary described in subsection C of this section.

G. The council shall require an agency to promptly initiate a rule making or to amend or repeal the rule or the rule package, as prescribed by section 41-1024, subsection E, objected to in the petition if the council finds that any of the provisions set forth in subsection A of this section are met.

H. This section shall not apply to a rule for which there is a final judgment of a court of competent jurisdiction based on the grounds of whether the contents of the economic, small business and consumer impact statement were insufficient or inaccurate.

41-1081. Standards for delegation

A. No agency may enter into or amend any delegation agreement unless the delegation agreement clearly sets forth all of the following:

1. Each function, power or duty being delegated by the agency, the term of the agreement and the procedures for terminating the agreement.
2. The standards of performance required to fulfill the agreement.
3. The types of fees that will be imposed on regulated parties and the legal authority for imposing any such fees.
4. The qualifications of the personnel of the political subdivision responsible for exercising the delegated functions, powers or duties.
5. Record keeping and reporting requirements.
6. Auditing requirements if the delegation agreement includes the transfer of funds from the delegating agency to the political subdivision.
7. A definition of the enforcement role if enforcement authority is being delegated.
8. Procedures for resolving conflicts between the parties to the delegation agreement.
9. Procedures for amending the delegation agreement.
10. The names and addresses of primary contact persons at both the delegating agency and the political subdivision.

B. An agency that seeks to delegate functions, powers or duties shall file with the secretary of state a summary of the proposed delegation agreement. The summary shall provide the name of a person to contact in the agency with questions or comments and shall state that a copy of the proposed delegation agreement may be obtained upon request from the agency. The secretary of state shall publish the summary in the next register.

C. For at least thirty days after publication of the notice of the proposed delegation agreement in the register, the agency shall provide persons the opportunity to submit in writing statements, arguments, data and views on the proposed delegation agreement and shall provide an opportunity for a public hearing if there is sufficient public interest.

D. A public hearing on the delegation agreement shall not be held earlier than thirty days after the notice of its location and time is published in the register. The agency shall determine a location and time for the public hearing that affords a reasonable opportunity for persons to

participate. At that public hearing persons may present oral argument, data and views on the proposed delegation agreement.

E. After the conclusion of the public comment period and hearing, if any, the agency shall prepare a written summary, responding to the comments received, whether oral or written. The agency shall consider the comments received from the public in determining whether to enter into the proposed delegation agreement. The agency shall give written notice to those persons who submitted comments of the agency's decision on whether to enter into the proposed delegation agreement. The delegation agreement is effective thirty days after written notice of the agency's final decision is given unless an appeal is filed and pending before the council pursuant to subsection F.

F. A person who filed written comments with the delegating agency objecting to all or part of the proposed delegation agreement may appeal to the council the delegating agency's decision to enter into the delegation agreement within thirty days after the agency gives written notice to enter into the delegation agreement pursuant to subsection E. The council shall place the appeal of the delegation agreement on its next meeting agenda if at least three council members make such a request of the council chairman within two weeks of the filing of the appeal.

G. Delegation agreements that are appealed to and considered by the council shall become effective upon council approval of the delegation agreement. Delegation agreements that are appealed to the council and not considered by the council are effective either thirty days after written notice of the agency's final decision is given pursuant to subsection E, or two weeks after an appeal is filed if at least three council members do not request council consideration of the delegation agreement pursuant to subsection F, whichever date is later.

H. The council shall not approve the delegation agreement if it does not meet the provisions set forth in subsection A or if the agency has not provided adequate notice and an opportunity for comment to the public.

ARIZONA STATE PERSONNEL BOARD (F-18-0902)

Title 2, Chapter 5.1, Article 1, General Provisions

GOVERNOR'S REGULATORY REVIEW COUNCIL
STAFF MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-1

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: **ARIZONA STATE PERSONNEL BOARD (F-18-0902)**
Title 2, Chapter 5.1, Article 1, General Provisions

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report:

The purpose of the State Personnel Board (Board) is to “hear and review appeals relating to personnel actions taken against state employees and dismissals from state service, suspensions for more than forty hours and demotions resulting from disciplinary actions.” Laws 2006, Ch. 41, § 3.

This five-year review report covers four rules in A.A.C. Title 2, Chapter 5.1, Article 1. The rules include definitions; meeting procedures, including procedures regarding agendas, notice to agencies and parties, and minutes; and appeal and complaint procedures.

The Board amended the rules via exempt rulemaking in 2014 to implement the proposed course of action in its previous five-year review report.

Proposed Action

The Board intends to make statutory changes by June 2020 and revise the rules to address the issues identified in this report by December 2020.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. The Board cites to both general and specific authority. A.R.S. § 41-782(C) states that the Board “may adopt rules it deems necessary for the administration of hearings and the review of appeals and complaints....”

2. Summary of the agency's economic impact comparison and identification of stakeholders:

The Board states that there are no estimated changes of impact since the economic impact statement was submitted in 2014. The stakeholders impacted by the rules include the Board, state employees, and state agencies.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

Yes. The Board believes that the rules impose the least burden and costs to stakeholders regulated by the rule.

4. Has the agency received any written criticisms of the rules over the last five years?

No. The Board indicates that it did not receive any written criticism of the rules over the last five years.

5. Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. The Board indicates that the rules are consistent with other rules and statutes, and clear, concise, and understandable. However, Sections 102, 103 and 104 should be amended to be more effective.

- Section 102: The rule is unnecessary and redundant, as the Board follows the Open Meeting Law statutes.
- Section 103: The requirement that the Board hold a hearing within 30 days of receiving an appeal is unrealistic. The Board is pursuing legislative amendments to change the time-frame. In addition, the Board believes that an appeal filed with the Board should include the employee's disciplinary letter, as defined in A.R.S. § 41-783(A).
- Section 104: The requirement that the Board hold a hearing within 30 days of receiving a complaint is unrealistic. Once legislative changes have been made to mirror the timeframes for both appeals and complaints, the Board will revise the rule accordingly. Additionally, the Board believes that a complaint filed with the Board should include a disclosure, as defined in A.R.S. § 38-532(B).

6. Has the agency analyzed the current enforcement status of the rules?

Yes. The Board indicates that the rules are enforced as written.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

No. The Board indicates that no federal laws directly apply to the rules.

8. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

No. The Board indicates that the rules do not require a permit or license.

9. Conclusion

As noted above, the Board plans to amend the rules by December 2020. This report complies with A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval of this report.

BOARD MEMBERS:

Chad Kirkpatrick, Chair
Joe Beers, Vice Chair
Kevin Donnellan
Mark Ziska



DOUGLAS A. DUCEY, Governor
ROBIN VAN STAEMYEN, Interim Executive Director

STATE PERSONNEL BOARD

1740 West Adams Street, Suite 3007
Phoenix, Arizona 85007
Phone: (602) 542-3888

June 26, 2018

The Honorable Douglas A. Ducey
Governor of the State of Arizona
1700 West Washington Street, 9th Floor
Phoenix, AZ 85007

Dear Governor Ducey:

The State Personnel Board has evaluated its rules and has identified some areas of concern. There have been no written criticisms of the Personnel Board's rules since they were last updated, August 3, 2014, however, we feel that the changes we plan to implement will better meet our objectives.

Enclosed is a copy of the report as well as the rules and statutes that govern the Personnel Board. In addition, the Board certifies that it is in compliance with A.R.S. § 41-1091 and has a directory of all agency rules and substantive policy statements available for public inspection in the Executive Director's office. Furthermore, the agency's rules and governing statutes are available for review on the State Personnel Board website.

The Personnel Board is not a regulatory board and does not issue licenses or permits.

If you have any questions or need additional information, please contact me.

Sincerely,

Robin Van Staeyen

Robin Van Staeyen
Interim Executive Director

STATE OF ARIZONA
ARIZONA STATE PERSONNEL BOARD
FIVE-YEAR RULES REVIEW REPORT

Title 2. Administration
Chapter 5.1. State Personnel Board
Article 1. General Provisions

FOR
GOVERNOR'S REGULATORY REVIEW
COUNCIL (GRRC)

Submitted: June 26, 2018

Article 1. General Provisions

ANALYSIS OF INDIVIDUAL RULES

R2-5.1-101. Definitions

1. Authorization of the rule by existing statutes:

General Authority: A.R.S. § 38-531

Specific Authority: A.R. S. § 38-531

2. Objective of the rule:

The objective is to provide definitions for terms commonly used during the progression of an appeal or whistleblower complaint.

3. Analysis of effectiveness of achieving the objective:

The rule is effective.

4. Analysis of consistency with other statutes and rules:

The rule is consistent with other statutes and rules.

5. Status of enforcement of the rule as written:

The rule is being enforced as written.

6. Analysis of clarity, conciseness, and understandability:

The rule is clear, concise, and understandable.

7. Written criticisms of the rule within the last five years:

The Board has not received written criticism of the rule within the last five years.

8. Economic, small business, and consumer impact comparison:

There are no estimated changes of impact since the Economic Impact Statement of 2014.

9. Has the agency received any business competitiveness analyses of the rule?

There has been no business competitiveness analysis received.

10. Status of completion of action indicated in the agency's previous five-year review report:

The Board completed the proposed course of action in 2014 by Exempt Rulemaking.

11. Analysis of cost vs. benefit:

The Board believes that the rule imposes the least burden and costs to persons regulated by the rule.

12. Are the rules more stringent than corresponding federal laws?

Federal law does not apply.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

The Personnel Board does not issue permits, licenses or agency authorizations.

14. Proposed course of action:

No actions proposed at this time.

R2-5.1-102. Personnel Board Procedures

1. Authorization of the rule by existing statutes:

General Authority: A.R.S. § 41-781

Specific Authority: A.R. S. § 41-781

2. Objective of the rule:

This rule was adopted to provide Board procedures for noticing meetings, sending out agendas, and recording the minutes of meetings to provide the public with as much information as possible regarding the Board's activities.

3. Analysis of effectiveness of achieving the objective:

The Board adheres to Open Meeting Law statutes whereby the objective of the rule is met; therefore, the rule is redundant and unnecessary.

4. Analysis of consistency with other statutes and rules:

The rule is consistent with other statutes and rules.

5. Status of enforcement of the rule as written:

The rule is enforced as written.

6. Analysis of clarity, conciseness, and understandability:

The rule is clear, concise and understandable.

7. Written criticisms of the rule within the last five years:

The Board has not received written criticism of the rules within the last five years.

8. Economic, small business, and consumer impact comparison:

There are no estimated changes of impact since the Economic Impact Statement of 2014.

9. Has the agency received any business competitiveness analyses of the rule?

There has been no business competitiveness analysis received.

10. Status of completion of action indicated in the agency's previous five-year review report:

The Board completed the proposed course of action in 2014 by Exempt Rulemaking.

11. Analysis of cost vs. benefit:

The Board believes that the rule imposes the least burden and costs to persons regulated by the rule.

12. Are the rules more stringent than corresponding federal laws?

Federal law does not apply.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

The Personnel Board does not issue permits, licenses or agency authorizations.

14. Proposed course of action:

At the next available opportunity for rule revision, the Board plans to amend or repeal the rule to address the issue raised in paragraph 3. It is the Board's intention to make the rule change by December 2020.

R2-5.1-103. Appeal Procedures

1. Authorization of the rule by existing statutes:

General Authority: A.R.S. § 41-781 *et seq.*

Specific Authority: A.R.S. § 41-783

2. Objective of the rule:

The objective of this rule is to clarify the procedures of the appeal process to the parties of the appeal, which is conducive to a more expeditious hearing process.

3. Analysis of effectiveness of achieving the objective:

The Board finds that the timeframe for holding a hearing within 30 days of receiving an appeal is unrealistic. The rule is bound by statute; once statute is changed to allow for additional time to go to hearing, the proposed change is more likely to meet the objective. The Board also believes that an appeal filed with the Board should include the employee's "disciplinary letter" as described in A.R.S. § 41-783(A), which would facilitate timely processing. Add language, wherever necessary, to include "electronic" means for sending and receiving information.

4. Analysis of consistency with other statutes and rules:

The rule is consistent with other statutes and rules.

5. Status of enforcement of the rule as written:

The Board enforces the rule.

6. Analysis of clarity, conciseness, and understandability:

This rule is clear, concise and understandable.

7. Written criticisms of the rule within the last five years:

The Board has not received written criticism of the rules within the last five years.

8. Economic, small business, and consumer impact comparison:

There are no estimated changes of impact since the Economic Impact Statement of 2014.

9. Has the agency received any business competitiveness analyses of the rule?

There has been no business competitiveness analysis received.

10. Has the agency complete the course of action indicated in the agency's previous five-year review report?

The Board completed the proposed course of action in 2014 by Exempt Rulemaking.

11. Analysis of cost vs. benefit:

The Board believes that the rule imposes the least burden and costs to persons regulated by the rule.

12. Are the rules more stringent than corresponding federal laws?

Federal law does not apply.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

The Personnel Board does not issue permits, licenses or agency authorizations.

14. Proposed course of action:

The Board's intent is to change the statute by June 2020. After the statute has been changed, the Board plans to amend the rule to address the issues raised in paragraphs 3 and 5 at the next available opportunity for rule revision.

R2-5.1-104. Complaint Procedures

1. Authorization of the rule by existing statutes:

General Authority: A.R.S. § 38-532

Specific Authority: A.R.S. § 38-532

2. Objective of the rule:

The objective of this rule is to clarify the procedures of the complaint process to the parties of the complaint, which is conducive to a more expeditious hearing process.

3. Analysis of effectiveness of achieving the objective:

The Board finds that the timeframe for holding a hearing within 30 days of receiving a complaint is unrealistic. The Board further finds that the timeframe for filing a complaint is “10 calendar days”, which contradicts “10 business days” for filing an appeal. To be consistent, the Board believes the timeframes should be the same for both. Once the statute has been changed to allow for additional time to go to hearing and a change in the filing timeframe to mirror the appeal timeframe, the rule is more likely to meet the objective. The Board also agrees that a complaint filed with the Board should include the “disclosure” as outlined in A.R.S. § 38-532(B), which would facilitate timely processing. Add language, wherever possible, to include “electronic” means for sending and receiving information.

4. Analysis of consistency with other statutes and rules:

The rule is consistent with other statutes and rules.

5. Status of enforcement of the rule as written:

The Board enforces the rule.

6. Analysis of clarity, conciseness, and understandability:

This rule is clear, concise and understandable.

7. Written criticisms of the rule within the last five years:

The Board has not received written criticism of the rules within the last five years.

8. Economic, small business, and consumer impact comparison:

There are no estimated changes of impact since the Economic Impact Statement of 2014.

9. Has the agency received any business competitiveness analysis of the rule?

There has been no business competitiveness analysis received.

10. Has the agency complete the course of action indicated in the agency's previous five-year review report?

The Board completed the proposed course of action in 2014 by Exempt Rulemaking.

11. Analysis of cost vs. benefits:

The Board believes that the rule imposes the least burden and costs to persons regulated by the rule.

12. Are the rules more stringent than corresponding federal laws?

Federal law does not apply.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

The Personnel Board does not issue permits, licenses or agency authorizations.

14. Proposed course of action

The Board's intent is to change the statute by June 2020. After the statute has been changed, the Board plans to amend the rule to address the issues raised in paragraphs 3 and 5 at the next available opportunity for rule revision.

TITLE 2. ADMINISTRATION**CHAPTER 5.1. STATE PERSONNEL BOARD**

(Authority: A.R.S. § 41-781 et seq.)

Laws 1983, Ch. 98, § 162 limited authority of the Personnel Board. Prior rules and regulations for the Board were found in A.C.R.R. Title 2, Chapter 5, now consisting of rules and regulations of Personnel Administration, Department of Administration.

ARTICLE 1. GENERAL PROVISIONS

Section

- R2-5.1-101. Definitions
- R2-5.1-102. Personnel Board Procedures
- R2-5.1-103. Appeal Procedures
- R2-5.1-104. Complaint Procedures

ARTICLE 1. GENERAL PROVISIONS**R2-5.1-101. Definitions**

Unless the context requires otherwise, the following definitions govern in this Chapter:

1. “Agency” for purposes of appeal from a disciplinary action, means an employing state entity that takes an appealable disciplinary action against a covered employee in covered service as defined by A.R.S. § 41-741.
2. “Appeal” means a written request filed with the Board by a permanent covered employee in covered service seeking relief from dismissal, involuntary demotion, or suspension of more than 80 working hours.
3. “Appellant” means a permanent covered employee in covered service who files an appeal with the Board.
4. “Complainant” means an employee or former employee as defined in A.R.S. § 38-531 who files a complaint with the Board.
5. “Complaint” means a written request for relief under A.R.S. § 38-532 filed with the Board by an employee or former employee.
6. “Day” means a calendar day, unless otherwise stated.
7. “Deposition” means a form of discovery in which testimony of a witness given under oath or affirmation and subject to cross-examination is recorded in writing prior to a hearing.
8. “Hearing” means an administrative proceeding at which the appellant or complainant and the respondent are given the opportunity to present oral or written evidence.
9. “Hearing officer” means a person appointed by the Board, including any member of the Board to act as the trier of fact.
10. “Respondent” means an agency or individual whose interests are adverse to those of an appellant or complainant or who will be directly affected by the Board’s decision.
11. “Subpoena” means a legal document issued under authority of the Board to compel the appearance of a witness at a hearing.
12. “Subpoena duces tecum” means a legal document issued under authority of the Board to compel a witness to appear and to bring specified documents, records, or things.

Historical Note

Adopted effective November 10, 1983 (Supp. 83-6). Former Section R2-5.1-101 renumbered to R2-5.1-102; new Section R2-5.1-101 adopted by final rulemaking at 7

A.A.R. 44, effective December 13, 2000 (Supp. 00-4). Amended by final rulemaking at 9 A.A.R. 22, effective February 7, 2003 (Supp. 02-4). Amended by exempt rulemaking at 18 A.A.R. 2926, effective October 29, 2012 (Supp. 12-4). Amended by final rulemaking at 20 A.A.R. 1379, effective August 3, 2014 (Supp. 14-2).

R2-5.1-102. Personnel Board Procedures

- A. Meetings. The Board shall provide public notice of the date, time, and place of its monthly meetings and any special, emergency, or other meetings it deems necessary. The Board shall give notice as required by law.
- B. Agenda. The agenda shall be mailed or electronically provided, as required by law, to each member of the Board, a state agency indicating an interest in receiving the agenda, and all parties in a matter scheduled for a Board meeting. The Board’s failure to mail or electronically provide the agenda, or failure of an agency to receive the agenda, does not affect the validity of the meeting or of any action taken by the Board at the meeting.
- C. Minutes. The Board shall record in the Board’s minutes the date, time, and place of each meeting of the Board, names of the Board members present, all official acts of the Board, the votes of each Board member except when the acts are unanimous, and, when requested by a member, a member’s dissent with the member’s reasons. Board staff shall prepare and present the minutes for approval by the Board members at the next regular meeting. The Board shall provide copies of the approved minutes to the appellant, complainant, and respondent within seven days of the regular meeting at which the minutes are approved.

Historical Note

Adopted effective November 10, 1983 (Supp. 83-6). Amended subsection (B)(2) effective March 3, 1988 (Supp. 88-1). Corrections to subsections (B)(2) and (4) from revised format edition published February 1991 (Supp. 96-1). Former Section R2-5.1-102 renumbered to R2-5.1-103; new Section R2-5.1-102 renumbered from R2-5.1-101 and amended by final rulemaking at 7 A.A.R. 44, effective December 13, 2000 (Supp. 00-4). Manifest typographical error corrected in Section heading (Supp. 01-2). Amended by final rulemaking at 9 A.A.R. 22, effective February 7, 2003 (Supp. 02-4). Amended by final rulemaking at 20 A.A.R. 1379, effective August 3, 2014 (Supp. 14-2).

R2-5.1-103. Appeal Procedures

- A. Appeal. A permanent status, covered employee who wishes to appeal a disciplinary action shall, no later than 10 business days after the effective date of the action, file a written appeal with the Board in accordance with A.R.S. § 41-783. The appeal shall include:
 1. The appellant’s name, telephone number, address and e-mail address, if applicable;
 2. The name of the agency taking the disciplinary action being appealed;
 3. The name, telephone number, address, and e-mail address of the appellant’s representative, if applicable;

4. A specific response to the causes for disciplinary action upon which the appeal is based; and
 5. The action requested of the Board.
- B.** Change of address. An appellant or respondent shall notify the Board in writing of a change of address or telephone number within five business days of the change. If written notice is not provided, future notices by the Board that are sent to the appellant's or respondent's prior address shall be deemed to have been received.
- C.** Routing of appeal. The Board shall provide a copy of an appeal to the respondent within five business days from the date of filing, and not less than 20 days before the hearing.
- D.** Hearing officer. The Board, including any member of the Board, may assign an appeal or may direct staff to assign an appeal to a hearing officer for hearing. When an appeal is assigned to a hearing officer, the hearing officer is the authorized representative of the Board and is empowered to grant or refuse extensions of time, to set proceedings for hearing, to conduct the hearing and to take any action in connection with the proceedings that the Board is authorized by law to take other than making the final findings of fact, conclusions of law, and order. The assignment of an appeal to a hearing officer does not preclude the Board, including any member of the Board, from withdrawing the assignment and the Board conducting the hearing or from reassigning the appeal to another hearing officer.
- E.** Change of hearing officer. A party may request to change the hearing officer assigned to hear an appeal by filing a request in writing with the Board within five business days after receipt of the first hearing notice. The request shall state the reasons for the change of hearing officer. The Board shall not grant a change of hearing officer unless the party demonstrates a clear case of bias or prejudice.
- F.** Notice of hearing. The Board shall provide the appellant and respondent with written notice of the time, date, and place of hearing of an appeal, and the name and contact information of the hearing officer at least 20 days before the date of the hearing.
- G.** Prehearing conference. The Board or the Board's hearing officer may hold a prehearing conference with the parties either in person or telephonically. Any agreement reached at the prehearing conference shall be binding at the hearing.
- H.** Time for hearing. The Board or the Board's hearing officer shall hold a hearing on an appeal within 30 calendar days after the Board receives the appeal unless the Board or the Board's hearing officer finds good cause to extend the time pursuant to a written request under this subsection. A request for continuance shall be made no less than five days prior to the scheduled hearing date and shall not be granted absent a showing of good cause. Good cause includes, but is not limited to, scheduling conflicts and unavailability of witnesses. The hearing officer shall grant or deny a request for continuance in his or her discretion.
- I.** Nature of hearing. Every hearing shall be open to the public unless the appellant requests a confidential hearing. A party may be self-represented or may designate a representative as provided by law. Every hearing shall be conducted as a quasi-judicial proceeding. All witnesses shall testify under oath or by affirmation, and a record of the proceeding shall be made and kept by the Board for three years. Hearings shall be conducted in a manner that promotes and upholds the due process rights of the parties. The respondent has the burden of proof and shall present its case first.
- J.** Rules of evidence. The Board or the Board's hearing officer shall grant a request for a confidential hearing made by the respondent if the hearing involves evidence the state is precluded by law from disclosing. The appellant, respondent, or hearing officer may request that portions of the record be sealed or adequately protected if testimony of a witness is of a sensitive nature. The Board or the Board's hearing officer is not bound by common law, statutory rules of evidence, or technical or formal rules of procedure, except the rule of privilege as recognized by law.
- K.** Requesting, serving, and enforcing subpoenas. A party may request a subpoena to require the attendance of a witness or a subpoena duces tecum to require the production of a document. A party shall file with the Board a completed request for subpoena prior to the scheduled hearing date. The Board shall prepare the subpoena and return the subpoena to the requesting party for service. A person who is not a party and is at least 18 years of age may serve a subpoena. If enforcement of a subpoena for appearance of a witness is necessary, enforcement proceedings shall be taken to Superior Court by the party requesting enforcement, and enforcement shall be determined by the Superior Court. The party requesting enforcement shall name the Board as a party to any proceedings. The Board shall follow any orders entered by the court.
- L.** Exhibits. A party introducing an exhibit shall furnish the opposing party with a copy of the exhibit no later than 10 calendar days prior to the hearing. Both parties should be prepared with two additional copies of proposed exhibits for presentation of their cases on the day of the hearing for utilization by the witness and the hearing officer. The hearing officer shall make the determination at the hearing as to whether additional evidence and exhibits are necessary to ensure the Board has a complete record for review. The hearing officer shall consider the prejudice to the party who has not seen the additional evidence when making the determination to either include or preclude the evidence.
- M.** Witnesses. No later than 10 days prior to the hearing, parties shall exchange a list of the witnesses each party intends to call to testify at the hearing, along with a brief statement as to the substance and relevancy of the testimony.
- N.** Exclusion of witnesses. Upon the motion of an appellant or respondent, the hearing officer may exclude from the hearing room any witness who is not at the time under examination. The hearing officer shall not exclude a party to the hearing or a party's representative.
- O.** Witness fees. A witness who is not a state employee and is subpoenaed to attend a hearing is entitled to the same fee as is allowed witnesses in civil cases in the Arizona Superior Court. If the hearing officer, on the hearing officer's own motion, subpoenas a witness, fees and mileage shall be paid from funds of the Board. If the appellant or respondent subpoenas a witness, the fees and mileage shall be paid by the party requesting the witness. Reimbursement to state employees subpoenaed as witnesses is limited to payment of mileage at the current Arizona Department of Administration reimbursement rate, available from the DOA General Accounting Office website regarding travel reimbursement.
- P.** Telephonic testimony. The appellant or respondent may request through a motion that a party or witness testify telephonically if personal attendance would present an undue or excessive hardship for the party or witness and would not cause undue prejudice to a party. Undue prejudice will be defined as improper or unfair treatment which impacts a due process right of a party. The hearing officer shall rule on the request, in his or her discretion, whether telephonic testimony is warranted and whether the moving party will be required to pay for the cost of obtaining the telephonic testimony.
- Q.** Deposition. A party may request that a witness' deposition be used as evidence if the presence of a witness cannot be pro-

State Personnel Board

- cured at the time of hearing. The hearing officer shall grant or deny the request.
- R. Failure of a party to appear. If a party fails to appear at a hearing, the hearing officer shall allow the appearing party to present evidence.
- S. Conclusion of hearing. The Board shall consider the hearing concluded when the Board receives the hearing officer's proposed findings of fact, conclusions of law, and recommendation or, if objections are filed, on the date the objections are filed. The Board may request that the hearing officer be present during the consideration of the appeal by the Board, and, if requested, the hearing officer shall assist and advise the Board.
- T. Proposed findings of fact. Appellant and respondent may request permission to file proposed findings of fact and conclusions of law. The hearing officer shall grant or deny the request.
- U. Hearing officer report. The hearing officer shall submit written proposed findings of fact, conclusions of law, and a recommendation, including a brief statement of reasons for the hearing officer's findings and conclusions, within 30 days after the last date of the hearing. If the parties are required to file written closing arguments or briefs to the hearing officer, the hearing officer shall submit proposed findings, conclusions, recommendation, and reasons within 30 days after the closing arguments or briefs are due.
- V. Objections to findings. The Board shall send a copy of the hearing officer's proposed findings of fact, conclusions of law, and recommendation to the appellant and respondent. The appellant and respondent may file written objections, but not post-hearing evidence, to the hearing officer's proposed findings of fact and conclusions of law with the Board within 15 calendar days after receipt of the hearing officer's proposed findings of fact and conclusions of law, unless extended by the Board upon a written motion filed with the Board, and shall serve copies of the objections upon the other party. The opposing party may file a written response to the objections with the Board at least 48 hours before a Board meeting. The Board shall not consider untimely objections or responses.
- W. Withdrawal of appeal. An appellant may withdraw an appeal at any time prior to the decision of the Board by submitting a written withdrawal letter to the Board.
- X. State Personnel Board decision. Within the time required by law, the Board shall notify the appellant and respondent of the date, time, and place of the Board meeting at which the appeal will be decided. The Board may affirm, reverse, adopt, modify, supplement, or reject the hearing officer's proposed findings of fact and conclusions of law in whole or in part, may recommit the matter to the hearing officer with instructions, may convene itself as a hearing body, or may make any other disposition of the appeal allowed by law. The Board shall make a decision on the appeal in an open meeting within 45 days after the conclusion of the hearing and shall send a copy of the decision to the appellant and respondent by certified mail, return receipt requested. If the Board orders the respondent to reinstate the appellant, it may also order the respondent to reinstate the appellant with or without back pay in the amount and for the period the Board determined to be proper.
- Y. Appeal of Board decisions in court. The appellant or respondent may appeal the Board's decision to the Superior Court as provided in A.R.S. § 41-783.

Historical Note

New Section renumbered from R2-5.1-103 renumbered from R2-5.1-102 and amended by final rulemaking at 7 A.A.R. 44, effective December 13, 2000 (Supp. 00-4). Amended by final rulemaking at 9 A.A.R. 22, effective February 7, 2003 (Supp. 02-4). Amended by exempt

rulemaking at 18 A.A.R. 2926, effective October 29, 2012 (Supp. 12-4). Amended by final rulemaking at 20 A.A.R. 1379, effective August 3, 2014 (Supp. 14-2).

R2-5.1-104. Complaint Procedures

- A. Complaint. An employee or former employee as defined in A.R.S. § 38-531 who wishes to file a complaint shall, no later than 10 calendar days after the effective date of the alleged prohibited personnel practice that is the subject of the complaint, file a written complaint with the Board in accordance with A.R.S. § 38-532. The complaint shall include:
1. The complainant's name, telephone number, address, and e-mail address, if applicable;
 2. The name, telephone number, address, and e-mail address of the complainant's representative, if applicable;
 3. A concise statement of the facts constituting the alleged prohibited personnel practice;
 4. The name of the agency or employee believed to have knowingly committed the prohibited personnel practice; and
 5. The date and place of the alleged prohibited personnel practice.
- B. Change of address. A complainant or respondent shall notify the Board in writing of a change of address or telephone number within five business days of the change. If written notice is not provided, future notices by the Board that are sent to the complainant's or respondent's prior address shall be deemed to have been received.
- C. Routing of complaint. The Board shall provide a copy of a complaint to the respondent within five business days from the date of filing, and not less than 20 days before the hearing.
- D. Amending a complaint. A complainant may move to amend a complaint. An amendment shall relate only to the facts and circumstances under the original complaint and shall not relate to new causes of action. The hearing officer shall grant or deny the motion or shall refer the motion to the Board for disposition.
- E. Hearing officer. The Board, including any member of the Board, may assign a complaint or may direct staff to assign a complaint to a hearing officer for hearing. When a complaint is assigned to a hearing officer, the hearing officer is the authorized representative of the Board and is empowered to grant or refuse extensions of time, to set proceedings for hearing, to conduct the hearing, and to take any action in connection with the proceedings that the Board is authorized by law to take other than making the final findings of fact, conclusions of law, and order. The assignment of a complaint to a hearing officer does not preclude the Board, including any member of the Board, from withdrawing the assignment and the Board conducting the hearing or from reassigning the complaint to another hearing officer.
- F. Change of hearing officer. A party may request to change the hearing officer assigned to hear a complaint by filing a request in writing with the Board within five business days after receipt of the first hearing notice. The request shall state the reasons for the change of hearing officer. The Board shall not grant a change of hearing officer unless the party demonstrates a clear case of bias or prejudice.
- G. Notice of hearing. The Board shall provide the complainant and respondent with written notice of the time, date, and place of hearing of a complaint, and the name and contact information of the hearing officer at least 20 days before the date of the hearing.
- H. Prehearing conference. The Board or the Board's hearing officer may hold a prehearing conference with the parties either in person or telephonically. Any agreement reached at the prehearing conference shall be binding at the hearing.

- I. Time for hearing. The Board or the Board's hearing officer shall hold a hearing on a complaint within 30 calendar days after the Board receives the complaint unless the Board or the Board's hearing officer finds good cause to extend the time pursuant to a written request under this subsection. A request for continuance shall be made no less than five days prior to the scheduled hearing date and shall not be granted absent a showing of good cause. Good cause includes, but is not limited to, scheduling conflicts and unavailability of witnesses. The hearing officer shall grant or deny a request for continuance in his or her discretion.
- J. Nature of hearing. Every hearing shall be open to the public unless the complainant requests a confidential hearing. A party may be self-represented or may designate a representative as provided by law. Every hearing shall be conducted as a quasi-judicial proceeding. All witnesses shall testify under oath or by affirmation, and a record of the proceeding shall be made and kept by the Board for three years. Hearings shall be conducted in a manner that promotes and upholds the due process rights of the parties. The complainant has the burden of proof and shall present its case first.
- K. Rules of evidence. The Board or the Board's hearing officer shall grant a request for a confidential hearing made by the respondent if the hearing involves evidence the state is precluded by law from disclosing. The complainant, respondent, or hearing officer may request that portions of the record be sealed or adequately protected if testimony of a witness is of a sensitive nature. The Board or the Board's hearing officer is not bound by common law, statutory rules of evidence, or technical or formal rules of procedure, except the rule of privilege as recognized by law.
- L. Requesting, serving, and enforcing subpoenas. A party may request a subpoena to require the attendance of a witness or a subpoena duces tecum to require the production of a document. A party shall file with the Board a completed request for subpoena prior to the scheduled hearing date. The Board shall prepare the subpoena and return the subpoena to the requesting party for service. A person who is not a party and is at least 18 years of age may serve a subpoena. If enforcement of a subpoena for appearance of a witness is necessary, enforcement proceedings shall be taken to Superior Court by the party requesting enforcement, and enforcement shall be determined by the Superior Court. The party requesting enforcement shall name the Board as a party to any proceedings. The Board shall follow any orders entered by the court.
- M. Exhibits. A party introducing an exhibit shall furnish the opposing party with a copy of the exhibit no later than 10 calendar days prior to the hearing. Both parties should be prepared with two additional copies of proposed exhibits for presentation of their cases on the day of the hearing for utilization by the witness and the hearing officer. The hearing officer shall make the determination at the hearing as to whether additional evidence and exhibits are necessary to ensure the Board has a complete record for review. The hearing officer shall consider the prejudice to the party who has not seen the additional evidence when making the determination to either include or preclude the evidence.
- N. Witnesses. No later than 10 days prior to the hearing, parties shall exchange a list of the witnesses each party intends to call to testify at the hearing, along with a brief statement as to the substance and relevancy of the testimony.
- O. Exclusion of witnesses. Upon the motion of a complainant or respondent, the hearing officer may exclude from the hearing room any witness who is not at the time under examination. The hearing officer shall not exclude a party to the hearing or a party's representative.
- P. Witness fees. A witness who is not a state employee and is subpoenaed to attend a hearing is entitled to the same fee as is allowed witnesses in civil cases in the Arizona Superior Court. If the hearing officer, on the hearing officer's own motion, subpoenas a witness, fees and mileage shall be paid from funds of the Board. If the complainant or respondent subpoenas a witness, the fees and mileage shall be paid by the party requesting the witness. Reimbursement to state employees subpoenaed as witnesses is limited to payment of mileage at the current Arizona Department of Administration reimbursement rate, available from the DOA General Accounting Office website regarding travel reimbursement.
- Q. Telephonic testimony. The complainant or respondent may request through a motion that a party or witness testify telephonically if personal attendance would present an undue or excessive hardship for the party or witness and would not cause undue prejudice to a party. Undue prejudice will be defined as improper or unfair treatment which impacts a due process right of a party. The hearing officer shall rule on the request, in his or her discretion, whether telephonic testimony is warranted and whether the moving party will be required to pay for the cost of obtaining the telephonic testimony.
- R. Deposition. A party may request that a witness' deposition be used as evidence if the presence of a witness cannot be procured at the time of hearing. The hearing officer shall grant or deny the request.
- S. Failure of a party to appear. If a party fails to appear at a hearing, the hearing officer shall allow the appearing party to present evidence.
- T. Conclusion of hearing. The Board shall consider the hearing concluded when the Board receives the hearing officer's proposed findings of fact, conclusions of law, and recommendation or, if objections are filed, on the date the objections are filed. The Board may request that the hearing officer be present during the consideration of the complaint by the Board, and, if requested, the hearing officer shall assist and advise the Board.
- U. Proposed findings of fact. Complainant and respondent may request permission to file proposed findings of fact and conclusions of law. The hearing officer shall grant or deny the request.
- V. Hearing officer report. The hearing officer shall submit written proposed findings of fact, conclusions of law, and a recommendation, including a brief statement of reasons for the hearing officer's findings and conclusions, within 30 days after the last date of the hearing. If the parties are required to file written closing arguments or briefs to the hearing officer, the hearing officer shall submit proposed findings, conclusions, recommendation, and reasons within 30 days after the closing arguments or briefs are due.
- W. Objections to findings. The Board shall send a copy of the hearing officer's proposed findings of fact, conclusions of law, and recommendation to the complainant and respondent. The complainant and respondent may file written objections, but not post-hearing evidence, to the hearing officer's proposed findings of fact and conclusions of law with the Board within 15 calendar days after receipt of the hearing officer's proposed findings of fact and conclusions of law, unless extended by the Board upon a written motion filed with the Board, and shall serve copies of the objections upon the other party. The opposing party may file a written response to the objections with the Board at least 48 hours before a Board meeting. The Board shall not consider untimely objections or responses.
- X. Withdrawal of complaint. A complainant may submit a written request to withdraw a complaint at any time prior to the decision of the Board. The Board shall rule on the request.

State Personnel Board

- Y. State Personnel Board decision. Within the time required by law, the Board shall notify the complainant and respondent of the date, time, and place of the Board meeting at which the complaint will be decided. The Board may affirm, reverse, adopt, modify, supplement, or reject the hearing officer's proposed findings of fact and conclusions of law in whole or in part, may recommit the matter to the hearing officer with instructions, may convene itself as a hearing body, or may make any other disposition of the complaint allowed by law. The Board shall determine the validity of the complaint and whether a prohibited personnel practice was committed against the employee or former employee as a result of the employee or former employee's disclosure of information of a matter of public concern. The Board shall make a decision on the complaint in an open meeting within 45 days after the con-
- clusion of the hearing and shall send a copy of the decision to the complainant and respondent by certified mail, return receipt requested. If the Board determines a prohibited personnel practice was committed as a result of a disclosure of information by the employee or former employee, the Board shall act in accordance with the requirements of A.R.S. § 38-532.
- Z. Appeal of Board decisions in court. The complainant or respondent may appeal the Board's decision to the Superior Court as provided in A.R.S. § 38-532.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 22, effective February 7, 2003 (Supp. 02-4). Amended by final rulemaking at 20 A.A.R. 1379, effective August 3, 2014 (Supp. 14-2).

38-531. Definitions

In this article, unless the context otherwise requires:

1. "Employee" means an officer or employee of this state or any of its departments, commissions, agencies or boards. Employee includes employees and officers of community college districts, school districts and counties of this state and law enforcement officers of a city or town but does not include officers or employees of a municipal corporation established for the purpose of reclamation and distribution of water and the generation of electricity.
2. "Former employee" means an employee who was dismissed.
3. "Law enforcement officer" has the same meaning prescribed in section 38-1101.
4. "Personnel action" means:
 - (a) Appointment.
 - (b) Promotion.
 - (c) Disciplinary or corrective action.
 - (d) Detail, transfer or reassignment.
 - (e) Suspension, demotion or dismissal.
 - (f) Reinstatement.

 - (g) Restoration.
 - (h) Reemployment.
 - (i) Performance evaluation.
 - (j) Decision concerning pay, benefits or awards.
 - (k) Elimination of the employee's position without a reduction in force by reason of lack of monies or work.
 - (l) Other significant change in duties or responsibilities that is inconsistent with the employee's salary or grade level.
5. "Public body" means the attorney general, the legislature, the governor, a federal, state or local law enforcement agency, the county attorney, the governing board of a community college district or school district, the board of supervisors of a county or an agency director.
6. "Reprisal" means to take a personnel action the result of which is adverse to an employee.

38-533. Exemptions

This article does not apply to an employee or former employee of a state university or the board of regents which has in effect at the time a personnel action is taken against the employee a rule or provision for the protection of its employees from reprisal for the disclosure of information to a public body, except that the employee or former employee may appeal the final administrative decision to the superior court as provided in title 12, chapter 7, article 6. Notwithstanding section 12-910, an employee or former employee who has been dismissed is entitled to a trial de novo in superior court.

41-781. State personnel board; members; appointment; term; meetings; compensation

A. The state personnel board consists of five members appointed by the governor pursuant to section 38-211. No more than three members shall belong to the same political party. Persons eligible for appointment shall have had a continuous recorded registration pursuant to title 16, chapter 1 with either the same political party or as an independent for at least two years immediately preceding appointment. Of the members appointed one shall be a person who for more than five years has managed a component or unit of government or industry with more than twenty employees, one shall be a professional personnel administrator, one a state employee, one a person active in business management and one a member of the public. Members may be removed by the governor for cause. The chairperson of the state personnel board shall serve as an ex officio member of the law enforcement merit system council established by section 41-1830.11 without voting privileges.

B. The term of office for each member is three years, each term to expire three years from the date of appointment. On the expiration of the term of a member a successor shall be appointed for a full term of three years.

C. The state personnel board may hold regular monthly meetings and, in addition, may hold special meetings the board deems necessary. A chairperson and vice chairperson shall be elected by the members at the first meeting of each year and the chairperson shall not serve successive terms as chairperson. Meetings of the state personnel board shall be open to the public, and executive sessions may be held as provided by law.

D. Any one of the following constitutes the resignation of a board member and authorizes the governor to appoint a new member to fill the unexpired term so vacated:

1. Becoming a candidate for any elective public office.
2. Accepting any appointive office or employment in the state personnel system, except the state employee who is designated to serve on the board.

E. Members of the state personnel board, except the person designated as the state employee, are eligible to receive compensation of one hundred dollars for each meeting attended, prorated for partial days for each meeting attended. The member of the state personnel board designated as the state employee shall be paid the state employee's regular compensation for meetings of the board.

41-782. Powers and duties of the state personnel board

- A. Except as provided by section 41-1830.16, the state personnel board shall hear and review appeals as provided in this article relating to dismissal of a covered employee from covered service, suspension for more than eighty working hours or involuntary demotion resulting from disciplinary action as defined in the personnel rules for an employee in covered service.
- B. The state personnel board shall hear and review complaints as provided in title 38, chapter 3, article 9, relating to any personnel action taken against an employee or former employee of this state, except an employee or former employee of a state university or the board of regents, which the employee or former employee believes was taken in reprisal for the employee's or former employee's disclosure of information to a public body. The state personnel board shall recommend the dismissal of a supervisor or other responsible person, other than an elected official, who it determines committed a prohibited personnel practice.
- C. The state personnel board may adopt rules it deems necessary for the administration of hearings and the review of appeals and complaints as prescribed in this section.
- D. The state personnel board shall only exercise authority that is specifically granted to the board pursuant to this article.

41-783. Appeals to the state personnel board for covered employees; notice of charges; hearings

A. Except as provided by section 41-1830.16, a covered employee who has completed the covered employee's original probationary period of service as provided by the personnel rules may appeal to the state personnel board the covered employee's dismissal from covered service, suspension for more than eighty working hours or involuntary demotion resulting from disciplinary action. The appeal shall be filed not later than ten working days after the effective date of such action. The covered employee shall be furnished with specified charges in writing when the action is taken. Such appeal shall be in writing and must state specific facts relating directly to the charges on which the appeal is based and shall be heard by the state personnel board within thirty days after its receipt. The state personnel board shall provide the employing agency with a copy of the appeal not less than twenty days in advance of the hearing.

B. Hearings on such appeals shall be open to the public, except in cases where the covered employee requests a confidential hearing, and shall be informal with technical rules of evidence not applying to the proceedings except the rule of privilege recognized by law. Both the covered employee and the employing agency shall be notified of any hearing or meeting date not less than twenty days in advance of the hearing or not less than ten days in advance of a meeting and may select representatives of their choosing, present and cross-examine witnesses and give evidence before the state personnel board. The state personnel board may appoint a hearing officer to conduct the hearing and take evidence on behalf of the board and exercise the rights prescribed by section 12-2212. The state personnel board shall prepare an official record of the hearing, including all testimony recorded manually or by mechanical device, and exhibits. Either party may request that the record be transcribed. If a party requests that the record be transcribed, an entity, other than the state personnel board, selected by the requesting party shall transcribe the record at the cost of the requesting party. If the disciplinary hearing would involve evidence the state is prevented by law from disclosing, then a confidential hearing upon the state's request shall be granted.

C. The state personnel board:

1. Shall determine whether the state agency has proven by a preponderance of the evidence the material facts on which the discipline was based. On such a finding, the board shall affirm the decision of the state agency head, unless the disciplinary decision was arbitrary and capricious.

2. May recommend modification of a disciplinary action if the agency has not proven by a preponderance of the evidence the material facts on which the discipline was based or if a disciplinary decision is found to be arbitrary and capricious.

3. Shall reverse the decision of the state agency head if the board finds that cause did not exist for any discipline to be imposed and, in the case of dismissal or demotion, return the covered employee to the same position the employee held before the dismissal or demotion with or without back pay.

D. On a finding that the agency has not proven by a preponderance of the evidence the material facts on which the discipline was based, the board shall identify the material facts that the board found were not supported by a preponderance of the evidence and may recommend a proposed disciplinary action in light of the facts proven. On a finding that the disciplinary decision was arbitrary and capricious, the board shall include the board's reasons for the board's finding and may recommend a proposed disciplinary action in light of the facts proven.

E. Within forty-five days after the conclusion of the hearing, the state personnel board shall enter its decision or recommendation and shall at the same time send a copy of the decision or recommendation by certified mail to the employing agency and to the covered employee at the employee's address as given at the hearing or to a representative designated by the covered employee to receive a copy of the decision or recommendation. The agency director or the director's designee shall accept, modify or reverse the board's decision or accept, modify or reject the board's recommendation within fourteen days of receipt of the findings or recommendation from the state personnel board. The decision of the agency director or director's designee is final and binding. The

agency director shall send a copy of the agency's final determination to the covered employee pursuant to this section.

F. Any party may appeal the decision of the state personnel board or the final decision of the agency pursuant to title 12, chapter 7, article 6 to the superior court in the covered employee's county of residence on one or more of the following grounds that the order was:

1. Founded on or contained error of law that shall specifically include error of construction or application of any pertinent rules.
2. Unsupported by any evidence as disclosed by the entire record.
3. Materially affected by unlawful procedure.
4. Based on a violation of any constitutional provision.
5. Arbitrary or capricious.

G. An appeal shall be available to the court of appeals from the order of the superior court pursuant to title 12, chapter 7, article 6 as in other civil cases.

H. A covered employee may represent himself or designate a representative, not necessarily an attorney, before any board hearing or any quasi-judicial hearing held pursuant to this section providing that no fee may be charged for any services rendered in connection with such hearing by any such designated representative who is not an attorney admitted to practice.

BOARD OF NURSING (F-10-1002)

Title 4, Chapter 19, Article 3, Licensure; Article 8, Certified and Licensed Nursing Assistants and Certified Medication Assistants

GOVERNOR'S REGULATORY REVIEW COUNCIL
STAFF MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-2

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: BOARD OF NURSING (F-18-1002)

Title 4, Chapter 19, Article 3, Licensure; Article 8, Certified and Licensed Nursing Assistants and Certified Medication Assistants

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report:

This five-year review report, from the Arizona State Board of Nursing (Board), covers 28 rules in A.A.C. Title 4, Chapter 19, Articles 3 and 8.

The rules in Article 3 relate to the Board's licensure requirements. The rules in Article 8 relate to Certified Nursing Assistants (CNAs) and Certified Medication Assistants (CMAs), including program requirements, fees, and standards of conduct. The Board completed rulemakings in 2014 and 2016 to largely fulfill the course of action proposed in its 2013 five-year review report on these rules.

Proposed Action

The Board intends to amend Sections 307, 309, 310, 801, 802, 809, 810, 811, and 815 by June 30, 2019.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. The Board cites to both general and specific authority. A.R.S. § 32-1606(A)(1) states that the Board "may [a]dopt and revise rules necessary to carry into effect this chapter [A.R.S. Title 32, Chapter 15, Nursing]."

2. Summary of the agency's economic impact comparison and identification of stakeholders:

The Board has determined that Article 3 has not had any measurable economic impact to either the Board or the regulated public.

The Board projected moderate economic gains from Article 8 due to the ability to conduct telephonic interviews. The Board notes that these gains were not realized due to conducting fewer telephonic interviews than originally anticipated. The Board indicates that the Article 8 rules have not increased costs for the regulated public.

The stakeholders include the Board and the Board's licensees. The Board regulates the following occupations:

- Advanced Practice Registered Nurses (APRNs)
- Registered Nurses (RNs)
- Licensed Practical Nurses (LPNs)
- Licensed Nursing Assistants (LNAs)
- Certified Nursing Assistants (CNAs)

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

The Board has determined that the Article 3 rules impose the least costs and burdens on those regulated with the exception of school nurse certification requirements. The Board anticipates completing a rulemaking by June 30, 2019 in order to amend this rule.

The Board has determined that the rules impose the least costs and burdens on the stakeholders regulated by the rules.

4. Has the agency received any written criticisms of the rules over the last five years?

No. The Board indicates that it did not receive any written criticisms of the rules over the last five years.

5. Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. The Board has identified that the following rules could be amended to be made more clear and effective:

- Section 307: The rule is outdated and can be repealed, as the Board is moving to a paperless system and will no longer issue any paper licenses.
- Section 309: Specific criteria for school nurses should be amended to match the basic requirements for nurse licensure.

- Section 310: A statutory citation needs to be updated.
- Section 801: The title of the rule should be changed to clarify that the training programs are for nursing assistants generally, not just certified nursing assistants.
- Section 802: The title of the rule should be changed to clarify that the training programs are for nursing assistants generally, not just certified nursing assistants.
- Section 809: Technical corrections need to be made.
- Section 810: Nursing assistants should be allowed to renew registry status even if they have only performed volunteer work.
- Section 811: The rule is outdated, as the Board is moving to a paperless system for issuance of licenses and certificates.
- Section 815: Clarifying changes, related to reissuance of licenses or certificates, need to be made.

6. Has the agency analyzed the current enforcement status of the rules?

Yes. The Board indicates that the rules are currently enforced as written.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

No. The Board indicates that the rules are not more stringent than any federal laws that apply to the Board's operations.

8. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

Yes. The Boards indicates that the licenses, certifications, authorizations, and approvals it issues are general permits as defined in A.R.S. § 41-1001.

9. Conclusion

As noted above, the Board plans to amend the rules by June 30, 2019. This report complies with A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval of this report.

5 Year Review Report

Agency Overview

Arizona State Board of Nursing

Background

- At the turn of the 19th century, nurse registration emerged in order to separate trained from untrained nurses as a means to protect the public. In 1921, the Arizona Legislature determined, as a matter of public policy, that the practice of nursing is a privilege granted by the people of Arizona as defined by the laws enacted by the elected representatives. It is not a natural right of individuals. Therefore, in the interest of public health, safety and welfare and to protect people from unprofessional and incompetent nursing practices, only qualified persons hold the privilege to be licensed as a nurse. The Nurse Practice Act's fundamental purpose is to protect the public and any license/certificate issued pursuant to the statutes shall be a revocable privilege; thereby no holder shall acquire any irrevocable right.

General Purpose of the Agency

The purposes of the Board of Nursing are to protect the public by:

- Promoting public protection through education and informational services to prevent violations of the Nurse Practice Act.
- Establishing eligibility standards for licensure for Advanced Practice Registered Nurses (APRNs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Licensed Nursing Assistants (LNAs).
- Maintaining a Registry that meets federal requirements for Certified Nursing Assistants (CNAs).
- Determining eligibility, examine and license/certify/register qualified applicants.
- Providing for interstate/foreign endorsements.
- Renewing licenses/certificates, grant temporary licenses/certificates, and provide for inactive status for those already licensed as requested.
- Setting procedures for relicensure/reinstatement/recertification for previously licensed and certified individuals.
- Establishing minimum educational standards for programs of nursing.
- Approving nursing education programs.
- Investigating and resolve complaints against regulated parties, and if violations are substantiated, impose disciplinary sanctions.
- Monitoring regulated parties on probation to ensure patient safety.

- Denying licensure/certification to applicants deemed unsafe to practice due to serious convictions, behaviors or acts.
- Enforcing legal prohibitions against the unlicensed practice of registered nursing/licensed practical nursing and use of title, and referring unlicensed practice to law enforcement.
- Ordering evaluations of licensees/certificate holders to determine their ability to practice safely; take disciplinary action based on the results of the evaluation.
- Establishing the scope of practice for nurses within limits of legislative authority.
- Promulgating rules that regulate nursing.
- Issuing Advisory Opinions regarding the function of nursing practice and education.
- Establishing a non-disciplinary rehabilitation option for nurses at risk for or experiencing medical, substance abuse, or mental health conditions that could impair nursing practice entitled Alternative to Discipline Programs, including the previously established CANDO (Chemically Addicted Nurse Diversion Option) as an alternative to traditional disciplinary action.
-
- Enforcing the provisions of applicable statutes/rules.
- Establishing competency standards for maintaining a license

Changes in agency objectives since establishment.

The Arizona State Board of Nursing (AZBN) has made a number of regulatory improvements since the agency began in 1921.

- Disciplinary Actions were rare during the early days (1921-1977), when few complaints were received by the Board. Beginning in the 1980's the number of drug related cases increased significantly. In 1987, the AZBN developed an effective, non-disciplinary, confidential program entitled "CANDO" (Chemically Addicted Nurse Diversion Option) to monitor and assist nurses entering into rehabilitation when impaired by substance abuse and thereby reduce the risk to the public. This program has since legislatively expanded July 2018 to become the "Alternative to Discipline Program," which includes nurses with medical or mental health conditions that may affect nursing practice, and nurses at risk for any of these conditions. While participating in an Alternative to Discipline Program, and depending on the individual nurse's condition, the nurse may agree to cease practicing nursing during a period of rehabilitation, and may only return after an experienced evaluator assures the nurse is safe to practice. CANDO averaged 50-70 admissions per year with approximately 200 individuals participating in the program on an annual basis, and the AZBN expects these numbers to increase with the expansion of this non-disciplinary, rehabilitative program.
- The Executive Director may accept a voluntary surrender of a license or certificate if a respondent chooses this option instead of a Board-imposed disciplinary action.
- The AZBN continues to develop AZBN-approved policies to increase efficiency in triage and resolution of complaints against regulated parties. These include policies establishing criteria as to when to open investigations, when investigations may be

closed without presentation to the AZBN, either by dismissal, or non-disciplinary resolution.

- In 1995, the legislature authorized the Board to certify and maintain a register of nursing assistants, a workforce of approximately 22,000. Combined with approximately 92,000 RNs, 11,000 LPNs, and 7,000 LNAs, the AZBN manages the largest investigator case load of all the Arizona health profession licensing boards. This legislative change, along with improved investigative procedures, increased the volume of investigative reports to the Board from an average of 64 cases per month in 1996 to approximately 150 in FY2018.
- Initial licensure examinations are psychometrically sound and legally defensible, as the test questions clearly relate to the practice of the profession at entry level. The National Council Licensing Exam (NCLEX) is based on empirical job analyses that are performed at a national level every 3 years by the National Council of State Boards of Nursing. Test plans and passing standards are re-evaluated on the same triennial basis to ensure the content and NCLEX RN and NCLEX PN are reflective of current competencies required for safe and effective practice.
- In 1994, all boards of nursing began offering computerized adaptive testing (CAT), which is offered year round in testing centers with high speed turn around of less than 24 hours, providing qualified applicants with reduced times for licensure.
- In 1999, the AZBN mandated that applicants for licensure/certificate have criminal history reports from the DPS/FBI to allow the AZBN to evaluate potential harm to the public. Depending on the seriousness of an applicant's criminal history, they may be required to provide information about prior behavior before a decision is made to grant the individual legal authority to practice and issue a license/certificate. In approximately 2001, the Board adopted triage criteria to exclude some minor, remote in time, or isolated criminal incidents from a requirement to investigate.
- Mandatory reporting of licensee/certificate holders suspected of violating the Arizona Nurse Practice Act has been required for over 25 years. AZBN complies with Federal mandatory reporting laws; when final disciplinary actions are taken, the disciplinary information must be reported to the National Practitioner Data Bank.
- In 1987, the federal Nursing Home Reform Act was passed as part of the Omnibus Budget Reconciliation Act (OBRA), establishing various regulatory requirements for nurse aides employed in long-term care facilities receiving federal funds. The AZBN has a contract with Department of Health Services (DHS) to monitor, register and approve educational programs for nurse aides employed in nursing home settings. In 1995, the authority to regulate CNAs was placed under the jurisdiction of the AZBN. The basic argument for assigning jurisdiction to nursing boards was that, if nurses are to delegate nursing tasks to nurse aides, then nursing boards should control that aspect of the nurse aide training and approval. Because the job description of nurse aides fall within the nursing practice domain and licensed nurses are accountable for nursing care on a 24 hour basis, it was reasonable that the AZBN would assume authority and oversight of the regulation of CNAs.

- In 2001, as part of an Auditor General Sunset review, the agency proposed amendments to the Nurse Practice Act, including setting standards for continued competency. The AZBN rules were amended to require that all nurses practice nursing for a minimum of 960 hours within the past 5 years in order to qualify to renew licensure. New graduates of nursing programs must become licensed within 2 years of graduation. Applicants who fail to meet these qualifications must take and pass a Board-approved refresher course.
- In 2009, omnibus legislation to amend the Nurse Practice Act provided delegated authority to the Executive Director to dismiss cases, issue letters of concern, close complaints through settlement and enter into a consent agreement for summary suspension. Other features of the legislation allow the AZBN to engage in pilot studies for innovation in nursing education, practice and regulation; allow the AZBN to receive monies for specific projects without an appropriation to the state general fund; exempt certain short-term nursing assignments from licensure; changed the licensure renewal date to April 1 and specified conditions for obtaining the medical records of the licensee.
- In 2010 legislation was enacted to allow the AZBN to certify medication assistants, implementing successful aspects of a 4 year pilot program examining the role in long term care facilities and the effect on medication errors.
- In 2012, the legislature defined the term Certified Registered Nurse Anesthetist and established qualifications and a scope of practice.
- Due to federal laws that prevent the Board from charging for nursing assistant certification, the costs of conducting fingerprint background checks on nursing assistants, and the necessity to use licensing fees from RNs and LPNs to support the nursing assistant program, in 2015 the legislature authorized two levels of nursing assistant, effective 7/1/2016. Certified Nursing Assistants (CNAs), a new category of nursing assistant, are those individuals who meet minimal federal requirements, are not subject to criminal background checks and are under limited AZBN jurisdiction. CNAs pay no fees. Licensed Nursing Assistants (LNAs), similar to pre-7/1/2016 nursing assistants, are subject to criminal background checks and full Board jurisdiction. LNAs pay a \$50 licensure fee, a one-time \$50 fingerprint fee and a \$50 renewal fee every 2 years. Applicants may choose either level.

Agency's major accomplishments.

As part of its initial strategic plan, the AZBN continually examines its operations and customer services, including workflow and evolution of job duties. In response to the internal assessment and reports from outside entities, Board staff was involved in the following recent accomplishments:

- Developed and implemented new Alternative to Discipline Program
- Assisted with development of new enhanced Nurse Licensure Compact, adopted by Arizona, and implemented January 2018
- Continuous use and improvement of online license/certificate verification, and renewal of licenses and certificates.

- Upgraded and streamlined phone systems for more effective and efficient customer service.
- Provides annual conferences for nurse educators and nursing assistant educators.
- Publishes a Journal semi-annually
- Provides outreach education in response to community requests.
- Meet with stakeholders on a regular basis: nurse recruiters, nurse educators, nurse executives.
- Continues to conduct paperless Board and Education Committee meetings.
- Continues to provide oversight for use of Certified Nursing Assistants to administer specified medications in long term care facilities.
- Improved processing time of licensure applications from 14 days in 2002 to 2 days in 2017.
- Approved three alternative agencies for credential evaluation of foreign educated nurses.
- Utilizes a legally defensible simulation exam of nursing competency starting in 2008 and began using the exam in 2012 to identify unsafe practices in nurses reported to the Board for unsafe practice
- Collects annual data on RN/LPN renewal information related to nursing workforce to allow for workforce planning meeting the future health needs of Arizona.
- Implementation of new categories of nursing assistants, as authorized by the legislature in 2015. The new categories are: CNAs and LNAs, and these changes went into effect on July 1, 2016. All categories of nursing assistant are required to complete an approved nursing assistant training and competency evaluation program (NATCEP) and have the same scope of practice. Licensure is optional for nursing assistants who choose to pay a fee and submit to a criminal background check and are under the full authority of the Board. Licensed Nursing Assistants (LNA) would pay application and renewal fees. Certification is open to nursing assistants upon completion of a NATCEP, whereby the nursing assistant would be placed on a registry that meets federal requirements. The jurisdiction of the Board is limited to substantiated instances of abuse, neglect and misappropriation of property.

Rules promulgated in the past 5 years

During the past five years the following rules actions were taken:

- Article 2—amended effective July 6, 2013
- Article 3—amended effective July 6, 2013
- R4-19-311—amended effective May 31, 2013 and Sept. 10, 2013
- Article 5—amended effective July 6, 2013
- R4-19-702—amended effective July 6, 2013
- R4-19-101—amended effective July 6, 2013
- Article 1, Table 1—amended effective July 6, 2013
- Article 8—amended effective September 8, 2014

- Article 8 – amended effective July 1, 2016
- Article 1, Definitions – amended effective July 1, 2017
- Article 2 – amended effective July 1, 2017
- Article 3 – amended effective July 1, 2017
- Article 5 – amended effective July 1, 2017
- Article 8 - amended effective July 1, 2017
- Article 5 – amended by emergency rulemaking, effective May 23, 2018

5 Year Rule Review

Articles 3 & 8

ARTICLE 3. LICENSURE

**A.A.C. R4-19-301, R4-19-302, R4-19-303, R4-19-304, R4-19-305, R4-19-306,
R4-19-307, R4-19-308, R4-19-309, R4-19-310 R4-19-311, R4-19-312, R4-19-313**

The Board promulgated R4-19-313 in 2013, and amended all other rules in this Article at that time, except R4-19-311, Nurse Licensure Compact, that became effective January 19, 2018.

Information that is Identical Within All Rules—Article 3

1. Authority

These rules were adopted under the Board's general rulemaking authority pursuant to A.R.S. § 32-1606(A) (1) and A.R.S. §32-1664. Additional statutory authority for specific sections can be found in A.R.S. §§ 32-1601, 32-1605.01 (B) (3) and (B) (4), 32-1606(A), 32-1606 (B) (4), (B) (5), (B) (9), (B) (13), (B) (15) and (B) (21), 32-1635, 32-1636, 32-1640, 32-1643, 32-1644, 32-1660, 32-1660.01 - 32-1660.03, 32-1664, 32-3208, 41-1080, 41-1092 *et seq.*, and 41-1701.

3. Analysis of Effectiveness in Achieving Objectives

These rules effectively achieve their objectives, except for R4-19-309, School Nurse Certification Requirements, which the AZBN is in the process of amending, and R4-19-307 (issuance of duplicate licenses), which the AZBN may seek to repeal as it is becoming paperless.

4. Analysis of Consistency with State and Federal Statutes and Rules

These rules are consistent with federal and state statutes and rules. This Article complies with lawful presence requirements of federal and state law, 8 U.S.C. § 1641, and A.R.S. §

1-501. The rules are also consistent with federal reporting requirements for the National Practitioner Data Bank.

5. Agency Enforcement of the Rules

These rules are currently enforced as written.

6. Clarity, Conciseness, and Understandability of the Rules

The rules in this Article are clear, concise and understandable as written.

7. Written Criticisms Of the Rules Over The Past Five Years

The Board has not received any written criticisms of these rules during the past five years.

8. Economic, Small Business and Consumer Impact Summary

The Economic, Small Business and Consumer Impact Statement (EIS) submitted with the amendments to Article 3 in 2016 have not changed. There has been no measurable economic impact to the Board or regulated public as a result of these rules in the past 5 years.

9. Analysis submitted by another person that compares the rule's impact on this state's business competitiveness to the impact on businesses in other states.

The Board has not received any analysis as described above.

10. If applicable, how the agency completed the course of action indicated in the agency's previous five year review.

The AZBN made amendments, effective July 6, 2013, consistent with the prior five year review, including updating licensure requirements and adding retirement status.

11. Probable Benefits of the Rule Outweigh the Costs

The Board believes that all Article 3 rules, except Rule 4-19-309, impose the least burden and costs to persons regulated by these rules, including compliance costs necessary to achieve the underlying regulatory objective, which is patient and public protection.

12. More Stringent than Federal Law

These rules are not more stringent than federal law.

13. Issuance of a regulatory permit, license or agency authorization and compliance with A.R.S. § 41-1037

The AZBN believes that the licenses certifications, authorizations, and approvals it issues fall within the definition of general permit under ARS § 41-1001.

14. Proposed Course of Action

The AZBN is currently seeking an exemption to the Governor's Rulemaking Moratorium to amend Rule 4-19-309 to reduce regulatory requirements for school nurses. As soon as the Board receives approval from the Governor's Office, it will initiate the rulemaking process, with an anticipated completion date of June 30, 2019. Rule 4-19-311 is automatically updated due to the implementation of the Enhanced Nurse Licensure Compact for multistate licensure. Rules 4-19-307 and 811 are being submitted for approval by the AZBN and Governor's Office to seek repeal because they address issuance of paper duplicate licenses, but the Board has been moving to paperless system, and will not issue paper licenses after September, 2018. No other changes are anticipated at this time.

Analysis of Individual Rules Article 3

R4-19-301. Licensure by Examination

1. Authorization

This rule is specifically authorized by A.R.S § 32-1605.01 (B) (3) and (B) (4), 32-1606(B) (5) and (B) (15) and (16), and implements the provisions of A.R.S. §§ 32-1632, 32-1633, 32-1634.01, 32-1637, 32-1638, 32-1639.01. and 32-1643 (A) (3) and (4).

2. Objective

This rule specifies criteria for licensure by exam of registered and practical nurses. There are provisions within the rule for graduates of Arizona, out-of-state, and international nursing programs. Included are requirements for proof of U.S. citizenship or alien status, and criminal background checks.

3. Proposed Action

There is no proposed action for this rule at this time.

R4-19-302. Licensure by Endorsement

1. Authorization

This rule is specifically authorized by A.R.S § 32-1605.01 (B) (3) and (B) (4) and 32-1606 (B) (15). Implementing statutes include A.R.S. §§ 32-1634, 32-1634.02, 32-1639, 32-1639.02 and 32-1643 (A) (3) and (4).

2. Objective

This rule specifies criteria for licensure by endorsement of registered and practical nurses. There are provisions within the rule for graduates of international nursing programs, and applicants from other states who can verify safe practice.

3. Proposed Action

There is no proposed action for this rule at this time.

R4-19-303. Requirements for Credential Evaluation Service

1. Authorization

This rule is specifically authorized by A.R.S § §32-1606(B) (9) and implements the provisions of A.R.S. § 32-1634.01, 32-1634.02, 32-1639.01, and 32-1639.02.

2. Objective

This rule establishes the criteria that a credential evaluation service must meet in order to examine the credentials for internationally educated nurses applying for licensure in AZ.

3. Proposed Action

There is no proposed action for this rule at this time.

R4-19-304. Temporary License

1. Authorization

This rule is specifically authorized by A.R.S § §32-1605.01(B) (3) and implements the provisions of A.R.S. §§32-1635, 32-1640 and 32-1643 (A) (9).

2. Objective

This rule establishes the criteria and conditions for issuance of a temporary license, including for issuance of a temporary license for the purpose of completing a refresher course.

3. Proposed Action

There is no proposed action for this rule at this time.

R4-19-305. License Renewal

1. Authorization

This rule is specifically authorized by A.R.S § §32-1605.01 (B) (3) and (B) (4) and implements provisions of §32-1642.

2. Objective

This rule establishes the requirements to renew a nursing license.

3. Proposed course of action

There is no proposed action for this rule at this time.

R4-19-306. Inactive License

1. Authorization

This rule is authorized by general rulemaking authority of the Board A.R.S § 32-1606(A) (1) and implements provisions of A.R.S. §32-1636 (E).

2. Objective

This rule establishes procedures for transferring a license to either inactive or retirement status.

3. Proposed course of action

There is no proposed action for this rule at this time.

R4-19-307. Application for a Duplicate License

1. Authorization

This rule is authorized by general rulemaking authority of the Board A.R.S § 32-1606 (A) (1) and is referenced in A.R.S. §32-1643 (A) (14).

2. Objective

This rule establishes the process for obtaining a duplicate license if the nurse's license is lost or stolen.

3. Proposed Course of Action

The AZBN no longer issues many paper licenses, as it is nearly completely transitioned to a paperless system. As a result, the AZBN no longer issues duplicate licenses unless there has been a name change. In September, 2018, the AZBN will move to a new database and will no longer issue any paper licenses. The AZBN will seek repeal of this outdated rule.

R4-19-308. Change of Name or Address

1. Authorization

This rule is authorized by general rulemaking authority of the Board A.R.S § 32-1606 (A) (1) and implements provisions of A.R.S. §32-1609.

2. Objective

This rule establishes the process for changing the name or address of a licensee or applicant, in writing or electronically.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-309. School Nurse Certification Requirements

1. Authorization

This rule is specifically authorized and required by A.R.S §32-1606(B) (13).

2. Objective

This rule establishes standards for certification of school nurses.

3. Proposed Course of Action

Proposed removal of specific criteria for school nurses has been submitted to the Governor's Office for consideration for an exemption to the Rulemaking Moratorium. To maintain compliance with the requirements of A.R.S §32-1606(B) (13), the proposed amendment will not eliminate the rule, but the criteria will match the basic requirements for nurse licensure.

R4-19-310. Certified Registered Nurse

1. Authorization

This rule is authorized by general rulemaking authority of the Board A.R.S § 32-1606 (A) (1) and implements A.R.S. §32-1601(7).

2. Objective

The rule establishes the standards for recognition of additional certifications.

9. Proposed Course of Action

The statutory citation will be updated from the prior A.R.S. § 32-1601(5), to the current A.R.S. § 32-1601(7) by informal process with the Secretary of State's Office.

R4-19-311. Nurse Licensure Compact

1. Authorization

This rule was previously specifically authorized by A.R.S. §32-1668 and implemented provisions of A.R.S. 32-1669. The new, Enhanced Nurse Licensure Compact rule, effective January 18, 2018, are authorized by and implement provisions of A.R.S. §§ 32-1660 and 32-1660.01-1660.03.

2. Objective

This rule serves to implement provisions of the Enhanced Nurse Licensure Compact (eNLC).

3. Proposed Course of Action

This rule is updated with implementation of eNLC, including the eNLC rules.

R4-19-312. Practice Requirement

1. Authorization

This rule is specifically authorized by A.R.S. §32-1606(B) (20) and implements provisions of A.R.S. § 32-1633 (C) and 32-1638 (C).

2. Objective

This rule establishes a practice requirement for nurses to renew or obtain a license as a measure of competency, and includes a provision for meeting the requirements by providing nursing care for a family member or in a foreign country, under specific requirements.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-313. Background

1. Authorization

This rule is authorized by general rulemaking authority of the Board A.R.S § 32-1606 (A) (1) and implements A.R.S. §32-1664, and specifically §32-1664(F) and Rule 4-19-405.

2. Objective

This rule protects the public from sexual predators and identifies potential and scope for rehabilitation for qualified applicants.

3. Proposed Action

There is no proposed action for this rule at this time.

ARTICLE 8. CERTIFIED AND LICENSED NURSING ASSISTANTS AND CERTIFIED MEDICATION ASSISTANTS

A.A.C. **R4-19-801, R4-19-802, R4-19-803, R4-19-804, R4-19-805, R4-19-806, R4-19-807, R4-19-808, R4-19-809, R4-19-810, R4-19-811, R4-19-812, R4-19-813, R4-19-814, and R4-19-815.**

The AZBN promulgated these rules in 2000 with publication in the *Register* on February 4, 2000. The AZBN amended all rules except R4-19-811 and R4-19-815, in 2005 with

publication in the *Register* on October 28, 2005. R4-19-814 was again amended in 2009 with publication in the *Register* on December 19, 2008. This Article was amended in 2014, 2016, and 2017. Article 8 was extensively revised, effective July 1, 2017, related to statutory creation of two, new categories of nursing assistants.

Information that is Identical Within All Rules - Article 8

1. Authority

These rules were adopted under the Board's general rulemaking authority pursuant to A.R.S. § 32-1606(A) (1). Additional statutory authority for this Article can be found in A.R.S. §§ 32-1601(6), (14), and (25), 32-1605.01 (B) (3) and (B) (4), 32-1606 (B) (1), (B) (2), (B) (8), (B) (10), (B) (11) and (B) (16), 32-1615, 32-1646, 32-1647, 32-1648, 32-1649, 32-1650, 32-1650.01-07, 32-1663, 32-1664, 32-1666, 32-1666.01, and 32-1667.

3. Analysis of Effectiveness in Achieving Objectives

These rules are generally effective in achieving their objectives, and have been recently updated through amendments since the last five year review. The Board plans to amend R4-19-810, 811, and 815 for technical corrections and to allow volunteer work to count towards hours requirements, under certain conditions.

4. Analysis of Consistency with State and Federal Statutes and Rules

These rules are consistent with state statutes and 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

5. Agency Enforcement of the Rules

The AZBN experiences no difficulty in enforcing these rules.

6. Clarity, Conciseness, and Understandability of the Rules

The rules in this Article are generally clear, concise and understandable as written. Where the AZBN has identified some potential room for improvement, it plans to amend those rules as soon as possible. Those are for R4-19-810, and 815.

7. Written Criticisms Of the Rules Over The Past Five Years

The AZBN has not received any written criticisms of these rules during the past five years.

8. Economic, Small Business and Consumer Impact Summary

The Economic, Small Business and Consumer Impact Statement accompanying changes to all Sections of Article 8 except R4-19-811 and R4-19-815 were projected at most moderate gains for the Board of Nursing from the ability to conduct a telephonic interview. These gains have proven to be minimal as few telephonic interviews have been conducted. Nursing assistant programs were not projected to have increases in cost and this has been the case. Some programs have been challenged to find long-term care facilities for clinical experiences in remote rural areas. Students have benefitted from the standards set by these rules as the first-time pass rates for the Arizona Nursing Assistant Exam have been 80-88% for the written portion and 75-77% for the manual skills exam for the past 2 years. The pass rates benefit the employers, the nursing assistant and ensure the public that nursing assistants from AZ programs are competent and qualified. The EIS (2005) defined “Minimal” as less than \$1000, and “moderate” means an amount from \$1000 to \$5000. The economic impact for the original R4-19-811 and R4-19-815 (2000) has not changed from the Economic Impact Statement. The economic impact for amendments to R4-19-814 (2009) has not changed from the Economic Impact Statement.

The Board regulates approximately 150 Nursing Assistant Training Programs and 22,000 Certified Nursing Assistants and 7,000 Licensed Nursing Assistants..

9. Analysis submitted by another person that compares the rule's impact on this state's business competitiveness to the impact on businesses in other states.

The Board has not received any analysis as described above.

10. If applicable, how the agency completed the course of action indicated in the agency's previous five year review.

The AZBN made amendments, effective September 8, 2014, and again July 1, 2016, consistent with the prior five year review and changes in statute.

11. Probable Benefits of the Rule Outweigh the Costs

The Board believes that all Article 8 rules impose the least burden and costs to persons regulated by these rules, including compliance costs necessary to achieve the underlying regulatory objective, which is patient and public protection. This is particularly evident in the recent, July 1, 2016, change to two levels of nursing assistant, so that individuals have a choice as to which level of review they wish to seek.

12. More Stringent than Federal Law

These rules are not more stringent than federal law.

13. Issuance of a regulatory permit, license or agency authorization and compliance with A.R.S. § 41-1037

The AZBN believes that the licenses certifications, authorizations, and approvals it issues fall within the definition of general permit under ARS § 41-1001.

Proposed Course of Action

The AZBN has extensively updated this Article several times in the past five years, and has proposed, additional amendments currently pending with the Governor's Office in a request for an exemption to the Rulemaking Moratorium. The rules in the pending proposal include R4-19-809 (technical changes), 810 (allowing volunteer work to count towards practice requirement), 815 (technical and consistent with R4-19-404 reissuance process). In addition, the AZBN, upon approval, will submit a request for repeal of R4-19-811, similar to R4-19-307, regarding issuance of paper duplicate licenses, because the Board is moving to a paperless system. As soon as the Board receives approval from the Governor's Office, it will initiate the rulemaking process, with an anticipated completion date of June 30, 2019.

Analysis of Individual Rules - Article 8

R4-19-801. Common Standards for Certified Nursing Assistant (CNA) and Certified Medication Assistant (CMA) Training Programs

1. Authorization

This rule is specifically authorized by A.R.S § §32-1606 (B) (1) and (B) (2), and (B) (11) and implements provisions of A.R.S. § 32-1649, 32-1650.01, 32-1666 (B) and 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

2. Objective

This rule serves to inform current and potential nursing assistant programs of the standards that must be met to obtain Board approval.

3. Proposed Course of Action

The AZBN, if approved, plans to submit to the Governor's Office a request for exemption from the Rulemaking Moratorium to make technical amendments this section header only, to clarify that the training programs are for the "nursing assistant" rather than "certified nursing assistant", i.e. both CNAs and LNAs, not just CNAs. This is consistent with the body of the rule that refers to "NA", i.e., "nursing assistant".

R4-19-802. CNA Program Requirements

1. Authorization

This rule is specifically authorized by A.R.S § §32-1606 (B) (1) and (B) (2), and (B) (11) and implements provisions of A.R.S. § 32-1666 (B). It is also consistent with 42 C.F.R. 483.152.

2. Objective

This rule provides detailed information regarding the curricular requirements of an approved nursing assistant program.

3. Proposed Course of Action

Similar to R4-19-801, above, the AZBN, if approved, plans to submit to the Governor's Office a request for exemption from the Rulemaking Moratorium to make technical amendments this section header only, to clarify that the training programs are for the "nursing assistant" rather than "certified nursing assistant", i.e. both CNAs and LNAs, not just CNAs. This is consistent with the body of the rule that refers to "nursing assistant", rather than CNA.

R4-19-803. Certified Medication Assistant Program Requirements

1. Authorization

This rule is specifically authorized by A.R.S § §32-1606 (B) (1) and (B) (2), and implements provisions of A.R.S. § 32-1650.01.

2. Objective

This rule establishes the criteria that a medication assistant program provider must meet in order to be approved by the Board.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-804. Initial Approval and Re-Approval Training Programs

1. Authorization

This rule is specifically authorized by A.R.S § §32-1606 (B) (1) and (B) (2), and (B) (11) and implements provisions of A.R.S. § 32-1650.01, 32-1666 (B) and 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

2. Objective

This rule establishes the criteria and conditions for initial renewing approval of a nursing and medication assistant training programs.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-805. Deficiencies and Rescission of Program Approval, Unprofessional Program Conduct, Voluntary Termination, Disciplinary Action, and Reinstatement.

1. Authorization

This rule is specifically authorized by A.R.S § §32-1606 (B) (1) and (B) (2), and (B) (11) and implements provisions of A.R.S. §§ 32-1601 (12), (26), and 32-1650.01, 32-1666 (B) and 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

2. Objective

This rule establishes the grounds for rescission, disciplinary action and reinstatement for a nursing assistant training program, and further defines unprofessional program conduct. It also establishes the process for reinstatement of a previously terminated nursing assistant training program.

3. Proposed course of action

There is no proposed action for this rule at this time.

R4-19-806. Initial Nursing Assistant Licensure (LNA) and Medication Assistant Certification

1. Authorization

This rule is specifically authorized by A.R.S § § 32-1605.01 (B) (3) and (B) (4) and 32-1606 (B) (11), and 32-1650, 32-1650.02-07, and implements provisions of A.R.S. §§ 32-1643, 32-1645, 32-1646, 32-1666 (B), 41-1080, and 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

2. Objective

This rule establishes procedures for obtaining nursing and medication assistant certification.

3. Proposed course of action

There is no proposed action for this rule at this time.

R4-19-807. Nursing Assistant Licensure and Medication Assistant Certification by Endorsement

1. Authorization

This rule is specifically authorized by A.R.S § §32-1605.01 (B) (3) and (B) (4) and 32-1606 (B) (11), 32-1650, 32-1650.02-07, and implements provisions of A.R.S. §§ 32-1643, 32-1645, 32-1666 (B) and 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

2. Objective

This rule establishes the process for nursing and medication assistants from other states to endorse into Arizona.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-808. Fees Related to Certified Medication Assistant

1. Authorization

This rule is authorized by A.R.S § § 32-1606 (B) (1), and implements A.R.S. §§ 32-1650, 32-1650.02-07, and 44-6852.

2. Objective

This rule establishes the fees and related payment process for obtaining a Certified Medication Assistant certificate.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-809. Nursing Assistant Licensure and Medication Assistant Certificate Renewal

1. Authorization

This rule is specifically authorized by A.R.S § §32-1605.01 (B) (3) and 32-1606 (B) (11) and implements provisions of A.R.S. §§ 32-1645, 32-1650, 32-1650.02-07, 32-1666 (B) 32-1663.01 and 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

2. Objective

This rule establishes standards for renewal of nursing and medication assistant certification.

3. Proposed Course of Action

No substantive changes are anticipated, but some technical edits are part of a proposed rules package that has been submitted to the Governor's Office for a request for exemption from the Rulemaking Moratorium.

R4-19-810. Certified Nursing Assistant Register; Licensed Nursing Assistant Register

1. Authorization

This rule is specifically authorized by A.R.S § 32-1606 (B) (11) and implements provisions of A.R.S. §§ 32-1645 and 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

2. Objective

The rule implements the federal requirements for the nursing assistant register.

3. Proposed Course of Action

Allowing nursing assistants to renew registry status even if they have only performed volunteer work (not for compensation) is part of a proposed rules package that has been submitted to the Governor's Office for a request for exemption from the Rulemaking Moratorium, along with elimination of a requirement to report findings to Arizona Department of Health Services due to a change in statute.

R4-19-811. Application for Duplicate License or Certificate

1. Authorization

This rule is specifically authorized by the Boards general rulemaking authority under A.R.S §32-1606 (A) (1) and implements provisions of A.R.S. § 32-1643.

2. Objective

This rule establishes the process obtaining a duplicate certificate if the person's certificate is lost or stolen.

9. Proposed Course of Action

The AZBN is in the process of converting to a paperless system regarding issuance of licenses and certificate. After obtaining permission from the Department of Library, Archives and Public Records, this rule will become obsolete, and the AZBN, upon approval, intends to seek its repeal.

R4-19-812. Change of Name or Address

1. Authorization

This rule is authorized by general rulemaking authority of the Board A.R.S § 32-1606(A) (1) and implements provisions of A.R.S. § 32-1609.

2. Objective

This rule establishes the process for changing the name or address of a licensee or certificate holder.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-813. Performance of Nursing Assistant Tasks; Performance of Medication Assistant Tasks

1. Authorization

This rule is authorized by general rulemaking authority of the Board A.R.S § 32-1606 (A) (1) and implements provisions of §§ 32-1650, 32-1650.01-07, 32-1646, 42 CFR 483.150, 483.151, 483.152, 483.154, 483.156 and 483.158.

2. Objective

This rule establishes the activities and conditions under which a nursing assistant and medication assistant may practice. It serves to inform both the nursing or medication assistant, and the delegating nurse, about the range of acceptable tasks a nursing or medication assistant may perform.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-814. Standards of Conduct for Licensed Nursing Assistants and Certified Medication Assistants

1. Authorization

This rule is specifically authorized by A.R.S §§ 32-1645, 32-1646, 32-1650, 32-1650.02-07, and implements provisions of A.R.S. §§ 32-1601 (26), 32-1606(B)(10), 32-1663 and 32-1664.

2. Objective

This rule clarifies 32-1601 (26) (d) as it applies to licensed nursing assistant or medication assistant conduct. It serves to notify the public of actions by nursing or medication assistants that the Board considers unprofessional conduct.

3. Proposed Course of Action

There is no proposed action for this rule at this time.

R4-19-815. Reinstatement or Subsequent Issuance of a Nursing Assistant License or Medication Assistant Certificate

1. Authorization

This provision is authorized by the Board's general rulemaking authority under A.R.S. §32-1606 (A) (1) and 32-1664 (P) and implements provisions of A.R.S. §§ 32-1601, 32-1650, 32-1650.02-07, and 32-1663.

2. Objective

This rule establishes the conditions under which a previously denied, revoked, or voluntarily surrendered nursing assistant license or medication certificate may be reinstated or reissued.

3. Proposed Course of Action

Some technical and substantive changes to this Section are part of a proposed rules package that has been submitted to the Governor's Office for a request for exemption from the Rulemaking Moratorium. The changes include a clarification that re-issuance may be granted with conditions and/or limitations, and other changes modeled after existing Rule 4-19-404, which is the re-issuance rule for nurses.

ARTICLE 3. LICENSURE

R4-19-301. Licensure by Examination

- A.** An applicant for licensure by examination shall:
1. Submit a verified application to the Board on a form furnished by the Board that provides the following information about the applicant:
 - a. Full legal name and all former names used by the applicant;
 - b. Mailing address, including declared primary state of residence, e-mail address, and telephone number;
 - c. Place and date of birth;
 - d. Ethnic category and marital status, at the applicant's discretion;
 - e. Social Security number for an applicant who lives or works in the United States;
 - f. Post-secondary education, including the names and locations of all schools attended, graduation dates, and degrees received, if applicable;
 - g. Current employer or practice setting, including address, position, and dates of service, if employed or practicing in nursing or health care;
 - h. Information regarding the applicant's compliance with the practice or education requirements in R4-19-312;
 - i. Any state, territory, or country in which the applicant holds or has held a registered or practical nursing license and the license number and status of the license, including original state of licensure, if applicable;
 - j. The date the applicant previously filed an application for licensure in Arizona, if applicable;
 - k. Responses to questions regarding the applicant's background on the following subjects:
 - i. Current investigation or pending disciplinary action by a nursing regulatory agency in the United States or its territories;
 - ii. Action taken on a nursing license by any other state;
 - iii. Undesignated offenses, felony charges, convictions and plea agreements, including deferred prosecution;
 - iv. Misdemeanor charges, convictions and plea agreements, including deferred prosecution, that are required to be reported under A.R. S. § 32-3208;
 - v. Unprofessional conduct as defined in A.R.S. § 32-1601;
 - vi. Substance use disorder within the last 5 years;
 - vii. Current participation in an alternative to discipline program in any other state;
 - l. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background; and
 - m. Certification in nursing including category, specialty, name of certifying body, date of certification, and expiration date.
 2. Submit proof of United States citizenship or alien status as specified in A.R.S. § 41-1080;
 3. Submit a completed fingerprint card on a form provided by the Board or prints for the purpose of obtaining a criminal history report under A.R.S. § 32-1606 if the applicant has not submitted a fingerprint card or prints to the Board within the last two years; and
 4. Pay the applicable fees.
- B.** If an applicant is a graduate of a pre-licensure nursing program in the United States that has been assigned a program code by the National Council of State Boards of Nursing during the period of the applicant's attendance, the applicant shall submit one of the following:
1. If the program is an Arizona-approved program, the transcript required in subsection (B)(2) or a statement signed by a nursing program administrator or designee verifying that:
 - a. The applicant graduated from or is eligible to graduate from a registered nursing program for a registered nurse applicant; or
 - b. The applicant graduated from or is eligible to graduate from a practical nursing program or graduated from a registered nursing program and completed Board-prescribed role delineation education for a practical nurse applicant; or
 2. If the program is located either in Arizona or in another state or territory and meets educational standards that are substantially comparable to Board standards for educational programs under Article 2 when the applicant completed the program, an official transcript sent directly from one of the following as:
 - a. Evidence of graduation or eligibility for graduation from a diploma registered nursing program, associate degree registered nursing program, or baccalaureate or higher degree registered nursing program for a registered nurse applicant.
 - b. Evidence of graduation or eligibility for graduation of a practical nursing program, associate degree registered nursing program, or baccalaureate or higher degree registered nursing program for a practical nurse applicant.
 - C. If an applicant is a graduate of a pre-licensure international nursing program and lacks items required in subsection (B), the applicant shall comply with subsection (A), submit a self report on the status of any international nursing license, and submit the following:
 1. To demonstrate nursing program equivalency, one of the following:
 - a. If the applicant graduated from a Canadian nursing program, evidence of a passing score on the English language version of either the Canadian Nurses' Association Testing Service, the Canadian Registered Nurse Examination, NCLEX or an equivalent examination;
 - b. A Certificate or Visa Screen Certificate issued by the Commission on Graduates of Foreign Nursing Schools (CGFNS), or a report from CGFNS that indicates an applicant's program is substantially comparable to a U.S. program; or
 - c. A report from any other credential evaluation service (CES) approved by the Board.
 2. If a graduate of an international pre-licensure nursing program subsequently obtains a degree in nursing from an accredited U.S. nursing program, the requirement for a CES equivalency report may be waived by the Board, however the applicant is not eligible for a multi-state compact license.
 3. If an applicant's pre-licensure nursing program provided classroom instruction, textbooks, or clinical experiences in a language other than English, a test of written, oral, and spoken English is required. Clinical experiences are deemed to have been provided in a language other than English if the principal or official language of the country or region where the clinical experience occurred is a language other than English, according to the United States Department of State.

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4. An applicant who is required to demonstrate English language proficiency shall ensure that one of the following is submitted to the Board directly from the testing or certifying agency:
- a. Evidence of a minimum score of 84 with a minimum speaking score of 26 on the Internet-based Test of English as a Foreign Language (TOEFL),
 - b. Evidence of a minimum score of 6.5 overall with minimum of 6.0 on each module of the Academic Exam of the International English Language Test Service (IELTS) Examination,
 - c. Evidence of a minimum score of 55 overall with a minimum score of 50 on each section of the Pearson Test of English Academic exam.
 - d. A Visa Screen Certificate from CGFNS,
 - e. A CGFNS Certificate,
 - f. Evidence of a similar minimum score on another written and spoken English proficiency exam determined by the Board to be equivalent to the other exams in this subsection, or
 - g. Evidence of employment for a minimum of 960 hours within the past five years as a nurse in a country or territory where the principal language is English, according to the United States Department of State.
- D. An applicant for a registered nurse license shall attain one of the following:
1. A passing score on the NCLEX-RN;
 2. A score of 1600 on the NCLEX-RN, if the examination was taken before July 1988; or
 3. A score of not less than 350 on each part of the SBTPE for registered nurses.
- E. An applicant for a practical nurse license shall attain:
1. A passing score on the NCLEX-PN;
 2. A score of not less than 350 on the NCLEX-PN, if the examination was taken before October 1988; or
 3. A score of not less than 350 on the SBTPE for practical nurses.
- F. The Board shall grant a license to practice as a registered or practical nurse to any applicant who meets the criteria established in statute and this Article. An applicant who is denied a license by examination may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the license. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.
- G. If the Board receives an application from a graduate of a nursing program and the program's approval was rescinded under R4-19-212 at any time during the applicant's nursing education, the Board shall ensure that the applicant has completed a basic curriculum that is equivalent to that of a Board-approved nursing program and may do any of the following:
1. Grant licensure, if the program's approval was reinstated during the applicant's period of enrollment and the program provides evidence that the applicant completed a curriculum equivalent to that of a Board-approved nursing program;
 2. By order, require successful completion of remedial education while enrolled in a Board approved nursing program which may include clinical experiences, before granting licensure; or
 3. Return or deny the application if the education was not equivalent and no remediation is possible.

Historical Note

Former Section II, Part I; Amended effective January 20, 1975 (Supp. 75-1). Amended effective December 7, 1976

(Supp. 76-5). Former Section R4-19-24 repealed, new Section R4-19-24 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-24 repealed, new Section R4-19-24 adopted effective May 9, 1984 (Supp. 84-3). Former Section R4-19-24 renumbered as Section R4-19-301 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 1483, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2).

R4-19-302. Licensure by Endorsement

- A. An applicant for a license by endorsement shall submit all of the information required in R4-19-301(A).
- B. In addition to the information required in subsection (A), an applicant for a license by endorsement shall:
1. Submit evidence of a passing examination score in accordance with:
 - a. R4-19-301(E) for a registered nurse applicant, or
 - b. R4-19-301(F) for a practical nurse applicant.
 2. Submit the following:
 - a. Evidence of previous or current license in another state or territory of the United States,
 - b. Information related to the nurse's practice for the purpose of collecting nursing workforce data, and
 - c. One of the following:
 - i. Completion of a pre-licensure nursing program that has been assigned a nursing program code by the National Council of State Boards of Nursing (NCSBN) at the time of program completion and the program meets educational standards substantially comparable to Board standards for educational programs in Article 2;
 - ii. If the applicant completed a pre-licensure nursing program that has been assigned a program code by the NCSBN but the program's approval was rescinded under A.R.S. § 32-1606(B)(8) or removed from the list of approved programs under A.R.S. § 32-1644(D) or R4-19-212 during the applicant's enrollment in the program, proof of completion of the program and completion of any remedial education required by the Board to mitigate the deficiencies in the applicant's initial nursing program;
 - iii. If the applicant graduated from a U.S. nursing program before 1986 and the applicant was issued an initial license in another state or territory of the United States without being required to obtain additional education or experience, proof both of program completion and initial licensure without additional educational or experiential requirements;
 - iv. If the applicant graduated from an international nursing program, proof of meeting the requirements in R4-19-301.
 - v. If the Board finds that the documentation submitted by the applicant does not fulfill one of the requirements in (B)(2)(b)(i) through (iv), but the applicant has submitted verified employer evaluations demonstrating applicant's safe practice as a registered or practical nurse in another state for a minimum of two

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- years full-time during the past three years and applicant otherwise meets licensure requirements, the Board may grant a single-state only license if the Board determines that licensure is in the best interest of the public.
- C. The Board shall grant a license to practice as a registered or practical nurse to any applicant who meets the criteria established in statute and this Article. An applicant who is denied a license by endorsement may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the license. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Former Section II, Part II; Amended effective December 7, 1976 (Supp. 76-5). Former Section R4-19-25 repealed, new Section R4-19-25 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-25 repealed, new Section R4-19-25 adopted effective May 9, 1984 (Supp. 84-3). Former Section R4-19-25 renumbered and amended as Section R4-19-302 effective February 21, 1986 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 1483, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

R4-19-303. Requirements for Credential Evaluation Service

- A. A CES seeking Board approval shall submit documentation to the Board demonstrating that it:
1. Provides a credential evaluation to determine comparability of registered nurse or practical nurse programs in other countries to nursing education in the United States;
 2. Evaluates original source documents;
 3. Has five or more years of experience in evaluating nursing educational programs or employs personnel that have this experience;
 4. Employs staff with expertise in evaluating nursing programs;
 5. Has access to resources pertinent to the field of nursing education and the evaluation of nursing programs;
 6. Issues a report on each applicant, and supplies the Board with a sample of such a report, regarding the comparability of the applicant's nursing educational program to nursing education in the United States that includes:
 - a. The current name of the applicant including any names formerly used by the applicant;
 - b. Source and description of the documents evaluated;
 - c. Name and nature of the nursing education program, including status of the parent institution;
 - d. Dates applicant attended;
 - e. References consulted;
 - f. A seal or some other security measure;
 - g. Notification of any falsification or misrepresentation of documents by the applicant;
 - h. A report on licensure examination results for the applicant, if an exam was required for licensure in the international jurisdiction; and
 - i. The status of any international nursing licenses held by the applicant.
 7. Has a quality control program that includes at a minimum:
 - a. Standards regarding the use of original documents;
 - b. Verification of authenticity of documents and translations;
 - c. Processes and procedures to prevent and detect fraud;
 - d. Policies for maintaining confidentiality of applicant educational records;
 - e. Responsiveness to applicants, including ensuring that reports are issued no later than eight weeks from the receipt of an applicant's documents; and
 - f. Tracking of and notification to the Board of any trends in falsification or misrepresentation of documents;
 8. Follows or exceeds the standards of the National Association of Credentialing Services (NACES) or an equivalent organization;
 9. Responds to Board requests for information in a timely and thorough manner; and
 10. Agrees to notify the Board before any changes in any of the above criteria.
- B. If a CES fails to comply with the provisions of subsection (A), the Board may rescind its approval of the CES.
- C. The Board shall approve a credential evaluation service that meets the criteria established in this Section. A CES applicant who is denied approval or whose approval is revoked may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Former Section II, Part III; Former Section R4-19-26 repealed, new Section R4-19-26 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-26 renumbered and amended as Section R4-19-27, new Section R4-19-26 adopted effective May 9, 1984 (Supp. 84-3). Former Section R4-19-27 renumbered as Section R4-19-303 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 5 A.A.R. 1802, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-303 renumbered to R4-19-304; new Section R4-19-303 made by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

R4-19-304. Temporary License

- A. Subject to subsection (B), the Board shall issue a temporary license if:
1. An applicant:
 - a. Is qualified under:
 - i. A.R.S. § 32-1635 and applies for a temporary registered nursing license, or is qualified under A.R.S. § 32-1640 and applies for a temporary practical nursing license; and
 - ii. R4-19-301 for applicants for licensure by examination, or is qualified under R4-19-302 for applicants for licensure by endorsement; and
 - b. Submits an application for a temporary license with the applicable fee required under A.R.S. § 32-1643(A)(9); and
 - c. Submits an application for a license by endorsement or examination with the applicable fee required under A.R.S. § 32-1643(A).

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2. An applicant is seeking a license by examination, meets the requirements of R4-19-312(D), and the Board receives a report from the Arizona Department of Public Safety (DPS), verifying that DPS has no criminal history record information, as defined in A.R.S. § 41-1701, relating to the applicant or that any criminal history reported has been reviewed by the executive director or the director's designee and determined not to pose a threat to public health, safety, or welfare; or
 3. An applicant is seeking a license by endorsement, meets the requirements in R4-19-312(B), and the applicant submits evidence that the applicant has a current license in good standing in another state or territory of the United States or, if no current license, a previous license in good standing that was not the subject of an investigation or pending discipline; or
 4. An applicant who does not meet the practice requirements in R4-19-312(B) or (D), but provides evidence that the applicant has applied for enrollment in a refresher or other competency program approved by the Board, may practice nursing under a temporary license during the clinical portion of the program only.
- B.** An applicant who has a criminal history, a history of disciplinary action by a regulatory agency, a pending complaint before the Board, or answers affirmatively to any criminal background or disciplinary question in the application is not eligible for a temporary license or extension of a temporary license without Board approval.
- C.** A temporary license is valid for a maximum of 12 months unless extended for good cause under subsection (D) of this Section.
- D.** An applicant with a temporary license may apply for and the Board, the Executive Director or the Executive Director's designee may grant an extension of the temporary license period for good cause. Good cause means reasons beyond the control of the temporary licensee, such as unavoidable delays in obtaining information required for licensure.
- E.** An applicant who receives a temporary license but does not meet the criteria for a regular license within the established period under subsections (C) and (D) is no longer eligible for a temporary license except for the purpose of completing a refresher or other competency program under subsection (A)(4) of this Section.

Historical Note

Former Section II, Part IV; Amended effective January 20, 1975 (Supp. 75-1). Former Section R4-19-27 repealed, new Section R4-19-27 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-27 renumbered and amended as Section R4-19-28. Former Section R4-19-26 renumbered and amended as Section R4-19-27 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-27 renumbered and amended as Section R4-19-304 effective February 21, 1986 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-304 renumbered to R4-19-305; new Section R4-19-304 renumbered from R4-19-303 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Chapter Section references updated under subsections (A)(2) and (A)(4) under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number

R16-186 (Supp. 16-3).

R4-19-305. License Renewal

- A. An applicant for renewal of a registered or practical nursing license shall:
 1. Submit a verified application to the Board on a form furnished by the Board that provides all of the following information about the applicant:
 - a. Full legal name, mailing address, e-mail address, telephone number and declared primary state of residence;
 - b. A listing of all states in which the applicant is currently licensed, or, since the last renewal, was previously licensed or has been denied licensure;
 - c. Marital status and ethnic category, at the applicant's discretion;
 - d. Information regarding qualifications, including:
 - i. Educational background;
 - ii. Employment status;
 - iii. Practice setting; and
 - iv. Other information related to the nurse's practice for the purpose of collecting nursing workforce data.
 - e. Responses to questions regarding the applicant's background on the following subjects:
 - i. Criminal convictions for offenses involving drugs or alcohol since the time of last renewal;
 - ii. Undesignated offenses and felony charges, convictions and plea agreements including deferred prosecution;
 - iii. Misdemeanor charges, convictions and plea agreements, including deferred prosecution, that are required to be reported under A.R.S. § 32-3208;
 - iv. Unprofessional conduct as defined in A.R.S. § 32-1601 since the time of last renewal;
 - v. Substance use disorder within the last five years;
 - vi. Current participation in an alternative to discipline program in any other state; and
 - vii. Disciplinary action or investigation related to the applicant's nursing license by any other state nursing regulatory agency since the last renewal.
 - f. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
 - g. Information related to the applicant's current or most recent nursing practice setting, including position, address, telephone number, and dates of practice;
 - h. Information regarding the applicant's compliance with the practice or education requirements in R4-19-312;
 - i. National certification in nursing including specialty, name of certifying body, date of certification, certification number, and expiration date, if applicable; and for an applicant certified as a registered nurse practitioner or clinical nurse specialist the patient population of the certification; and
 2. Pay fees for renewal authorized by A.R.S. § 32-1643 (A)(6); and
 3. Pay an additional fee for late renewal authorized by A.R.S. § 32-1643(A)(7) if the application for renewal is submitted after May 1 of the year of renewal.

B. A license expires on August 1 of the year of renewal indicated on the license.

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- C. A licensee who fails to submit a renewal application before expiration of a license shall not practice nursing until the Board issues a renewal license.
- D. If the applicant holds a license or certificate that has been or is currently revoked, surrendered, denied, suspended or placed on probation in another jurisdiction, the applicant is not eligible to renew or reactivate a license until a review or investigation has been completed and a decision regarding eligibility for renewal or reactivation is made by the Board.
- E. The Board shall renew the license of any registered or practical nurse applicant who meets the criteria established in statute and this Article. An applicant who is denied renewal of a license may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying renewal of the license. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Former Section II, Part V; Repealed effective January 20, 1975 (Supp. 75-1). New Section R4-19-28 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-28 renumbered and amended as Section R4-19-29. Former Section R4-19-27 renumbered and amended as Section R4-19-28 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-28 renumbered and repealed as Section R4-19-305 effective February 21, 1986 (Supp. 86-1). New Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-305 renumbered to R4-19-306; new Section R4-19-305 renumbered from R4-19-304 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2).

R4-19-306. Inactive License

- A. A licensee in good standing may submit to the Board either as a separate written document or as part of the renewal application, a request to transfer to inactive status, or retirement status under A.R.S. §§ 32-1606(A)(10) and 32-1636(E).
- B. The Board shall send a written notice to the licensee granting inactive or retirement status or denying the request. A licensee denied a request for transfer to inactive or retirement status may request a hearing by filing a written request with the Board within 30 days of service of the denial of the request. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Former Section II, Part VI; Amended effective January 20, 1975 (Supp. 75-1). Amended effective December 7, 1976 (Supp. 76-5). Former Section R4-19-29 repealed, new Section R4-19-29 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-29 renumbered and amended as Section R4-19-30 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-28 renumbered and amended as Section R4-19-29 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-29 renumbered as Section R4-19-306 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-306 renumbered to R4-19-307; new Section R4-19-306 renumbered from R4-19-305 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

1308, effective July 6, 2013 (Supp. 13-2).

R4-19-307. Application for a Duplicate License

- A. A licensee shall report a lost or stolen license to the Board, in writing or electronically through the Board website, within 30 days of the loss.
- B. A licensee requesting a duplicate license shall file an application on a form provided by the Board for a duplicate license and pay the applicable fee under A.R.S. § 32-1643(A)(14).

Historical Note

Former Section II, Part VII; Former Section R4-19-30 renumbered and amended as Section R4-19-45, new Section R4-19-30 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-30 renumbered and amended as Section R4-19-31. Former Section R4-19-29 renumbered and amended as R4-19-30 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-29 renumbered and amended as Section R4-19-307 effective February 21, 1986 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-307 renumbered to R4-19-308; new Section R4-19-307 renumbered from R4-19-306 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

R4-19-308. Change of Name or Address

- A. A licensee or applicant shall notify the Board, in writing or electronically through the Board website, of any legal change in name within 30 days of the change, and submit a copy of the official document verifying the name change.
- B. A licensee or applicant shall notify the Board in writing or electronically through the Board website of any change in mailing address within 30 days.

Historical Note

Former Section II, Part VII; Former Section R4-19-31 repealed, new Section R4-19-31 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-31 renumbered and amended as Section R4-19-32. Former Section R4-19-30 renumbered and amended as Section R4-19-31 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-31 renumbered as Section R4-19-308 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended effective December 3, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-308 renumbered to R4-19-309; new Section R4-19-308 renumbered from R4-19-307 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

R4-19-309. School Nurse Certification Requirements

- A. An applicant for initial school nurse certification shall:
 - 1. Hold a current license in good standing or multistate privilege to practice as a registered nurse in Arizona.
 - 2. Submit a verified application to the Board on a form furnished by the Board that provides the following information about the applicant:
 - a. Full legal name and any former names used by the applicant;
 - b. Mailing address and telephone number;
 - c. Registered nurse license number;

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- d. Social security number;
 - e. A description of the applicant's educational background, including the number and location of schools attended, the number of years attended, the date of graduation, the type of degree or certificate awarded, and if applicable, evidence that the applicant has satisfied the requirements specified in subsection (B), (C) or (D);
 - f. Current employer, including address, telephone number, position type, dates of employment, and previous employer if the current employment is less than 12 months;
 - g. The name of any national certifying organization, specialty area, certification number and date of certification, if applicable; and for an applicant certified in as a nurse practitioner or clinical nurse specialist, the population of the certification;
 - h. Responses to questions regarding the applicant's background on the following subjects:
 - i. Current investigation or pending disciplinary action by a nursing regulatory agency in the United States or its territories or current investigation in another state or territory of the United States;
 - ii. Action taken on a nursing license by any other state;
 - iii. Undesignated offenses, felony charges, convictions and plea agreements, including deferred prosecution;
 - iv. Misdemeanor charges, convictions and plea agreements, including deferred prosecution, that are required to be reported under A.R.S. § 32-3208;
 - v. Unprofessional conduct as defined in A.R.S. § 32-1601;
 - vi. Substance use disorder within the last five years; and
 - vii. Current participation in an alternative to discipline program in any other state;
 - i. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background; and
 - j. E-mail address, ethnic category and marital status at the applicant's discretion.
3. Pay applicable fees.
- B.** National certification. In addition to the requirements of subsection (A), if an applicant provides evidence of current national certification as a school nurse or school nurse practitioner from an organization that meets the requirements of R4-19-310, the applicant qualifies for Arizona school nurse certification without meeting the requirements in subsection (C) for as long as the national certification remains current. The nurse shall provide evidence of continuing certification upon each renewal under subsection (D).
- C. Initial certification**
1. In addition to the requirements in subsection (A), the registered nurse applicant shall provide evidence of completion of all the following:
 - a. Three semester hours in school nurse practice course work;
 - b. Three semester hours in physical assessment of the school-aged child course work unless the applicant provides evidence of current national certification from an organization that meets the requirements of R4-19-310 as a pediatric nurse practitioner, family
- nurse practitioner, or pediatric clinical nurse specialist; and
 - c. Three semester hours in nursing care of the child with special needs.
2. An initial certificate expires six years after the issue date on the certificate.
- D. Renewal of certification.**
1. If the initial certificate of a school nurse has expired and the applicant, has met the requirements in subsections (B) or (C)(1) of this Section, the applicant is eligible to apply for re-certification. Within the application, the applicant shall provide evidence of completion of one of the following for renewal of certification:
 - a. Current national certification as a school nurse as specified in subsection (B),
 - b. A bachelor of science or graduate degree in nursing earned from an accredited institution as specified in R4-19-201(A) within the last six years, or
 - c. Evidence of completion of a minimum of 90 contact hours of continuing education activity, as defined in R4-19-101, related to school nursing practice and completed within the last six years.
 2. Renewal of certification expires six years after the issue date on the certificate.
- E.** The Board shall grant a school nurse certificate to any applicant who meets the criteria established in statute and this Article. An applicant who is denied a school nurse certificate may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the certificate. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Former Section II, Part IX; Repealed effective February 20, 1980 (Supp. 80-1). Former Section R4-19-31 renumbered and amended as Section R4-19-32 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-32 renumbered as Section R4-19-309 (Supp. 86-1). Repealed effective July 19, 1995 (Supp. 95-3). New Section made by final rulemaking at 8 A.A.R. 1813, effective March 20, 2002 (Supp. 02-1). Former Section R4-19-309 renumbered to R4-19-311; new Section R4-19-309 renumbered from R4-19-308 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

R4-19-310. Certified Registered Nurse

A registered nurse who has been certified by a nursing certification organization accredited by the Accreditation Board for Specialty Nursing Certification, the National Commission for Certifying Agencies, or an equivalent accrediting agency as determined by the Board is deemed certified for the purposes of A.R.S. § 32-1601(5).

Historical Note

New Section made by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). A.R.S. Section reference updated under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3).

R4-19-311. Nurse Licensure Compact

The Board shall implement A.R.S. §§ 32-1668 and 32-1669 according to the provisions of the Nurse Licensure Compact Model Rules and Regulations for RNs and LPN/VNs, published by the National Council of State Boards of Nursing, Inc., 111 E. Wacker Dr., Suite 2900, Chicago, IL 60601, www.ncsbn.org, November 13, 2012, and

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no later amendments or editions, which is incorporated by reference and on file with the Board.

Historical Note

New Section renumbered from R4-19-309 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 18 A.A.R. 2485, effective September 11, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 2852, effective September 11, 2013 (Supp. 13-3).

R4-19-312. Practice Requirement

- A. The Board shall not issue a license or renew the license of an applicant who does not meet the applicable requirements in subsections (B), (C), and (D).
- B. An applicant for licensure by endorsement or renewal shall either have completed a post-licensure nursing program or practiced nursing at the applicable level of licensure for a minimum of 960 hours in the five years before the date on which the application is received. This requirement is satisfied if the applicant verifies that the applicant has:
 - 1. Completed a post-licensure nursing education program at a school that is accredited under R4-19-201(A) and obtained a degree, or an advanced practice certificate in nursing within the past five years; or
 - 2. Practiced for a minimum of 960 hours within the past five years where the nurse:
 - a. Worked for compensation or as a volunteer, as a licensed nurse in the United States or an international jurisdiction, and performed one or more acts under A.R.S. § 32-1601(21) as an RN if applying for RN renewal or licensure or A.R.S. § 32-1601(17) as an LPN if applying for LPN renewal or licensure; or
 - b. Held a position for compensation or as a volunteer in the United States or an international jurisdiction that required or recommended, in the job description, the level of licensure being sought or renewed; or
 - c. Engaged in clinical practice as part of an RN-to-Bachelor of Science in Nursing, Masters, Doctoral or Nurse Practitioner program.
- C. Care of family members does not meet the requirements of subsection (B)(2) unless the applicant submits evidence:
 - 1. That the applicant is providing care as part of a medical foster home; or
 - 2. That the specific care provided by the applicant was:
 - a. Ordered by another health care provider who is authorized to prescribe and was responsible for the care of the patient,
 - b. The type of care would typically be authorized by a third-party payer, and
 - c. The care was documented and reviewed by the health care provider.
- D. An applicant for licensure by either examination or endorsement, who does not meet the requirements of subsection (B), shall have completed the clinical portion of a pre-licensure nursing program within two years of the date of licensure.
- E. A licensee or applicant who fails to satisfy the requirements of subsection (B) or (D), shall submit evidence of satisfactory completion of a Board-approved refresher or competency program. The Board may issue a temporary license stamped "for refresher course only" to any applicant who meets all requirements of this Article except subsection (B) or (D) and provides evidence of applying for enrollment in a Board-approved refresher or competency program.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Pursuant to author-

ity of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citations in subsection (B)(2)(a) were updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). A.R.S. Section references updated under subsection (B)(2)(a) under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2).

R4-19-313. Background

- A. All applicants convicted of a sexual offense involving a minor or performing a sexual act against the will of another person shall be subject to a Board order under A.R.S. § 32-1664(F) and R4-19-405 unless the individual is precluded from licensure under A.R.S. § 32-1606(B)(17). If the evaluation identifies sexual behaviors of a predatory nature, the Board shall deny licensure or renewal of licensure.
- B. All individuals reporting a substance use disorder in the last five years may be subject to a Board order for an evaluation under A.R.S. § 32-1664(F) and R4-19-405 to determine safety to practice.
- C. The Board may order the evaluation of other individuals on a case-by-case basis under A.R.S. § 32-1664(F) and R4-19-405.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

ARTICLE 4. REGULATION**R4-19-401. Standards Related to Licensed Practical Nurse Scope of Practice**

- A. A licensed practical nurse shall engage in practical nursing as defined in A.R.S. § 32-1601 only under the supervision of a registered nurse or licensed physician.
- B. A LPN's nursing practice is limited to those activities for which the LPN has been prepared through basic practical nursing education in accordance with A.R.S. § 32-1637(1) and those additional skills that are obtained through subsequent nursing education and within the scope of practice of a LPN as determined by the Board.
- C. A LPN shall:
 - 1. Practice within the legal boundaries of practical nursing within the scope of practice authorized by A.R.S. Title 32, Chapter 15 and 4 A.A.C.19;
 - 2. Demonstrate honesty and integrity;
 - 3. Base nursing decisions on nursing knowledge and skills, the needs of clients, and licensed practical nursing standards;
 - 4. Accept responsibility for individual nursing actions, decisions, and behavior in the course of practical nursing practice.
 - 5. Maintain competence through ongoing learning and application of knowledge in practical nursing practice.
 - 6. Protect confidential information unless obligated by law to disclose the information;
 - 7. Report unprofessional conduct, as defined in A.R.S. § 32-1601(24) and further specified in R4-19-403 and R4-19-814, to the Board;
 - 8. Respect a client's rights, concerns, decisions, and dignity;
 - 9. Maintain professional boundaries; and
 - 10. Respect a client's property and the property of others.
- D. In participating in the nursing process and implementing client care across the lifespan, a LPN shall:

June 3, 2003 (Supp. 03-2).

R4-19-706. Renumbered**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4).
Renumbered to R4-19-705 by final rulemaking at 9
A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

ARTICLE 8. CERTIFIED AND LICENSED NURSING ASSISTANTS AND CERTIFIED MEDICATION ASSISTANTS**R4-19-801. Common Standards for Certified Nursing Assistant (CNA) and Certified Medication Assistant (CMA) Training Programs****A. Program Administrative Responsibilities**

1. Any person or entity offering a training program under this Article shall, before accepting tuition from prospective students, and at all times thereafter, provide program personnel including a coordinator and instructors, as applicable, who meet the requirements of this Article.
2. If at any time, a person or entity offering a training program cannot provide a qualified instructor for its students, it shall immediately cease instruction and, if the training program cannot provide a qualified instructor within 5 business days, the training program shall offer all enrolled students a refund of all tuition and fees the students have paid to the program.
3. A training program shall obtain and maintain Board approval or re-approval as specified in this Article and A.R.S. § 32-1650.01(B) before advertising the program, accepting any tuition, fees, or other funds from prospective students, or enrolling students.
4. A training program that uses external clinical facilities shall execute a written agreement with each external clinical facility.
5. A training program that requires students to pay tuition for the program shall:
 - a. Make all program costs readily accessible on the school's website with effective dates,
 - b. Publicly post any increases in costs on the school's website 30 days in advance of the increase;
 - c. Include in the cost calculation and public posting, all fees directly paid to the program including but not limited to tuition, lab fee, clinical fee, enrollment fee, insurance, books, uniform, health screening, credit card fee and state competency exam fee; and
 - d. Provide a description of all program costs to the student that are not directly paid to the program.
6. Before collecting any tuition or fees from a student, a training program shall notify each prospective student of Board requirements for certification and licensure including:
 - a. Legal presence in the United States; and
 - b. For licensure, criminal background check requirements, and ineligibility under A.R.S. § 32-1606(B)(15) and (16).
7. Within the first 14 days of the program and before 50% of program instruction occurs, a training program shall transmit to the Board-approved test vendor, accurate and complete information regarding each enrolled student for the purposes of tracking program enrollment, attrition and completion. Upon receipt of accurate completion information, the vendor shall issue a certificate of completion to the program for each successful graduate.
8. A training program shall provide the Board, or its designee, access to all training program records, students and staff at any time, including during an announced or unan-

nounced visit. A program's refusal to provide such access is grounds for withdrawal of Board approval.

9. A training program shall provide each student with an opportunity to anonymously and confidentially evaluate the course instructor, curriculum, classroom environment, clinical instructor, clinical setting, textbook and resources of the program.
10. A training program shall provide and implement a plan to evaluate the program that includes the frequency of evaluation, the person responsible, the evaluative criteria, the results of the evaluation and actions taken to improve the program. The program shall evaluate the following elements at a minimum every two years:
 - a. Student evaluations consistent with subsection (A)(9);
 - b. First-time pass rates on the written and manual skills certification exams for each admission cohort;
 - c. Student attrition rates for each admission cohort;
 - d. Resolution of student complaints and grievances in the past two years; and
 - e. Review and revision of program policies.
11. A training program shall submit written documentation and information to the Board regarding the following program changes within 30 days of instituting the change:
 - a. For a change or addition of an instructor or coordinator, the name, RN license number, and documentation that the coordinator or instructor meets the applicable requirements of R4-19-802(B) and (C) for NA programs and R4-19-803(B) for CMA programs;
 - b. For a change in classroom location, the previous and new location, and a description of the new classroom;
 - c. For a change in a clinical facility, the name and address of the new facility and a copy of the signed clinical contract;
 - d. For a change in the name or ownership of the training program, the former name or owners and the new name or owners; and
 - e. For a decrease in hours of the program, a written revised curriculum document that clearly highlights new content, strikes out deleted content and includes revised hours of instruction, as applicable.

B. Policies and Procedures

1. A training program shall promulgate and enforce written policies and procedures that comply with state and federal requirements, and are consistent with the policies and procedures of the parent institution, if any. The program shall provide effective and review dates for each policy or procedure.
2. A training program shall provide a copy of its policies and procedures to each student on or before the first day the student begins the program.
3. The program shall promulgate and enforce the following policies with accompanying procedures:
 - a. Admission requirements including:
 - i. Criminal background, health and drug screening either required by the program or necessary to place a student in a clinical agency; and
 - ii. English language, reading and math skills necessary to comprehend course materials and perform duties safely.
 - b. Student attendance policy, ensuring that a student receives the hours and types of instruction as reported to the Board in the program's most recent application to the Board and as required in this Article.

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- cle. If absences are permitted, the program shall ensure that each absence is remediated by providing and requiring the student to complete learning activities that are equivalent to the missed curriculum topics, clinical experience or skill both in substance and in classroom or clinical time.
- c. A final examination policy that includes the following provisions;
- i. Require that its students score a minimum 75% correct answers on a comprehensive secure final examination with no more than one re-take. The program may allow an additional re-take following documented, focused remediation based on past test performance. Any re-take examination must contain different items than the failed exam, address all course competencies, and be documented with score, date administered and proctor in the student record; and
 - ii. Require that each student demonstrate, to program faculty, satisfactory performance of each practical skill as prescribed in the curriculum before performance of that skill on patients or residents without the instructor's presence, direct observation, and supervision;
- d. Student record maintenance policies consistent with subsection (D) including the retention period, the location of records and the procedure for students to access to their records.
- e. Clinical supervision policies consistent with clinical supervision provisions of this Section, and:
- i. R4-19-802(C) and (D) for NA programs, or
 - ii. R4-19-803(B) and (C) for CMA programs;
- f. Student conduct policies for expected and unacceptable conduct in both classroom and clinical settings;
- g. Dismissal and withdrawal policies;
- h. Student grievance policy that includes a chain of command for grade disputes and ensures that students have the right to contest program actions and provide evidence in support of their best interests including the right to a third party review by a person or committee that has no stake in the outcome of the grievance;
- i. Program progression and completion criteria.
- C. Classroom and clinical instruction
1. During clinical training sessions, a training program shall ensure that each student is identified as a student by a name badge or another means readily observable to staff, patients, and residents.
 2. A training program shall not utilize, or allow the clinical facility to utilize, students as staff during clinical training sessions.
 3. A training program shall provide a clean, comfortable, distraction-free learning environment for didactic teaching and skill practice.
 4. A training program shall provide, in either electronic or paper format, a written curriculum to each student on or before the first day of class that includes a course description, course hours including times of instruction and total course hours, instructor information, passing requirements, course goals, and a topical schedule containing date, time and topic for each class session.
 5. For each unit or class session the program shall provide, to its students, written:
 - a. Measurable learner-centered objectives,
 - b. An outline of the material to be taught, and
6. c. The learning activities or reading assignment.
6. A training program shall utilize an electronic or paper textbook corresponding to the course curriculum that has been published within the previous five years. Unless granted specific permission by the publisher, a training program shall not utilize copies of published materials in lieu of an actual textbook.
7. A training program shall provide, to all program instructors and enrolled students, access to the following instructional and educational resources:
- a. Reference materials, corresponding to the level of the curriculum; and
 - b. Equipment and supplies necessary to practice skills.
8. A training program instructor shall:
- a. Plan each learning experience;
 - b. Ensure that the curriculum meets the requirements of this Section;
 - c. Prepare written course goals, lesson objectives, class content and learning activities;
 - d. Schedule and achieve course goals and objectives by the end of the course; and
 - e. Require satisfactory performance of all critical elements of each skill under R4-19-802(H) for nursing assistant and R4-19-803(D)(4) for medication assistant before allowing a student to perform the skill on a patient or resident without the instructor's presence at the bedside.
9. A qualified RN instructor shall be present at all times and during all scheduled classroom, skills laboratory and clinical sessions. In no instance shall a nursing assistant or other unqualified person provide any instruction, reinforcement, evaluation or independent activities in the classroom or skills laboratory.
10. A qualified RN instructor shall supervise any student who provides care to patients or residents by:
- a. Remaining in the clinical facility and focusing attention on student learning needs during all student clinical experiences;
 - b. Providing the instructor's current and valid contact information to students and facility staff during the instructor's scheduled teaching periods;
 - c. Observing each student performing tasks taught in the training program;
 - d. Documenting each student's performance each day, consistent with course skills and clinical objectives;
 - e. During the clinical session, engaging exclusively in activities related to the supervision of students; and
 - f. Reviewing all student documentation.
- D. Records
1. A training program shall maintain the following program records either electronically or in paper form for a minimum of three years for NA programs and five years for CMA programs:
 - a. Curriculum and course schedule for each admission cohort;
 - b. Results of state-approved written and manual skills testing;
 - c. Documentation of program evaluation under subsection (A)(10);
 - d. A copy of any Board reports, applications, or correspondence, related to the program; and
 - e. A copy of all clinical contracts, if using outside clinical agencies.
 2. A training program shall maintain the following student records either electronically or in paper form for a mini-

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- mum of three years for NA programs and five years for CMA programs:
- a. A record of each student's legal name, date of birth, address, telephone number, e-mail address and Social Security number, if available;
 - b. A completed skill checklist containing documentation of student level of competency performing the skills in R4-19-802(F) for nursing assistant, and in R4-19-803(D)(4) for medication assistants;
 - c. An accurate attendance record, which describes any make-up class sessions and reflects whether the student completed the required number of hours in the course; and
 - d. Scores for each test, quiz, or exam and whether such test, quiz, or exam was retaken.
 - e. For NA programs only, a copy of a document providing proof of legal presence in the United States as specified in A.R.S. § 41-1080 to be remitted to the Board's designated testing vendor in order to facilitate timely placement of program graduates on a nursing assistant registry.
- E. Certifying Exam Passing Standard:** A training program and each site of a consolidated program under R4-19-802(E) shall attain, at a minimum, an annual first-time passing rate on the manual skill and written certifying examinations that is equal to the Arizona average pass rate for all candidates on each examination minus 20 percentage points. The Board may waive this requirement for programs with less than five students taking the exam during the year. The Board shall issue a notice of deficiency under A.A.C. R4-19-805 to any program with five or more students taking the exam that fails to achieve the minimum passing standard in any calendar year.
- F. Distance Learning; Innovative Programs**
1. A training program may be offered using real-time interactive distance technologies such as interactive television and web based conferencing if the program meets the requirements of this Article.
 2. Before a training program may offer, advertise, or recruit students for an on-line, innovative or other non-traditional program, the program shall submit an application for innovative applications in education under R4-19-214 and receive Board approval.
- G. Site visits:** A training program shall permit the Board, and its designee, including another state agency, to conduct an onsite scheduled evaluation for initial Board approval and renewal of approval in accordance with R4-19-804 and announced or unannounced site visits at any other time the Board deems necessary.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). A.R.S. Section reference updated under subsection (A)(6), under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2).

R4-19-802. CNA Program Requirements**A. Organization and Administration**

1. A nursing assistant program may be offered by:

- a. An educational institution licensed by the State Board for Private Postsecondary Education,
 - b. A public educational institution or a program funded by a local, state or federal governmental agency,
 - c. A health care institution licensed by the Arizona Department of Health Services or a federally authorized health care institution,
 - d. A private business that meets the requirements of this Article and all other legal requirements to operate a business in Arizona.
2. If a nursing assistant program is offered by a private business, the program shall meet the following requirements.
 - a. Hold insurance covering any potential or future claims for damages resulting from any aspect of the program or a hold a surety bond from a surety company with a financial strength rating of "A minus" or better by Best's Credit Ratings, Moody's Investors Service, Standard and Poor's rating service or another comparable rating service as determined by the Board in the amount of a minimum of \$15,000. The program shall ensure that:
 - i. Bond or insurance distributions are limited to students or former students with a valid claim for instructional or program deficiencies;
 - ii. The amount of the bond or insurance is sufficient to reimburse the full amount of collected tuition and fees for all students during all enrollment periods of the program; and
 - iii. The bond or insurance is maintained for an additional 24 months after program closure; and
 - b. Upon initial use and remodeling, provide the Board with a fire inspection report from the Office of the State Fire Marshal or the local authority with jurisdiction, indicating that each program classroom and skill lab location is in compliance with the applicable fire code.
 3. Programs approved by the Board before the effective date of this Section shall comply with subsection (A)(2) within one year of the effective date. If a program does not charge tuition or fees, the bond requirement is waived.
 4. A Medicare or Medicaid certified long-term care facility-based nursing assistant program shall not require a student to pay a fee for any portion of the program including the initial attempt on the state competency exam.
 5. In addition to the policies required in R4-19-801(B), the Board may approve a nursing assistant program to offer an advanced placement option to a student with a background in health care. A nursing assistant program wishing to offer an advance placement option shall submit their advanced placement policy to the Board and receive approval before implementing the policy. The program shall include, at a minimum, the following provisions in its policy:
 - a. Advanced placement is limited to students with at least one year full-time employment in the direct provision of health care within the past five years or students who have successfully completed course work that included direct patient care experiences in allied health, medicine or nursing in the past five years.
 - b. The program, at a minimum, shall require an advanced placement student to meet the same outcomes as regular students on all examinations and skill performance demonstrations.
 - c. The program shall require an advanced placement student to successfully accomplish all clinical objec-

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- tives during a minimum of 16 hours of clinical practice under the direct supervision and observation of a qualified instructor and in a long-term care facility.
- d. Upon successful completion of advanced placement and any other program requirements, the program shall credit the graduate with the same number of didactic, laboratory and clinical hours as the regular graduate.
- B. Program coordinator qualifications and responsibilities**
1. Program coordinator qualifications include:
 - a. Holding a current, registered nurse license that is active and in good standing or multistate privilege to practice as an RN under A.R.S. Title 32, Chapter 15; and
 - b. Possessing at least two years of nursing experience at least one year of which is in the provision of long-term care facility services.
 2. A director of nursing in a health care facility may assume the role of a program coordinator for a nursing assistant training program that is housed in the facility but shall not function as a program instructor.
 3. A program coordinator's responsibilities include:
 - a. Supervising and evaluating the program;
 - b. Ensuring that instructors meet Board qualifications and there are sufficient instructors to provide for a clinical ratio not to exceed 10 students per instructor;
 - c. Ensuring that the program meets the requirements of this Article; and
 - d. Ensuring that the program meets federal requirements regarding clinical facilities under 42 CFR 483.151.
 4. Other than the director of nursing in a long-term care facility, a program coordinator may also serve as a program instructor.
- C. Program instructor qualifications and duties**
1. Program instructor qualifications include:
 - a. Holding a current, registered nurse license that is active and in good standing under A.R.S. Title 32, Chapter 15 and provide documentation of a minimum of one year full time or 1500 hours employment providing direct care as a registered nurse in any setting; and
 - b. At a minimum, one of the following:
 - i. Successful completion of a three semester credit course on adult teaching and learning concepts offered by an accredited post-secondary educational institution,
 - ii. Completion of a 40 hour continuing education program in adult teaching and learning concepts that was awarded continuing education credit by an accredited organization,
 - iii. One year of full-time or 1500 hours experience teaching adults as a faculty member or clinical educator, or
 - iv. One year of full time or 1500 hours experience supervising nursing assistants, either in addition to or concurrent with the one year of experience required in subsection (C)(1)(a).
 2. In addition to the program instruction requirements in R4-19-801(C), a nursing assistant program instructor shall provide on-site supervision for each student placed in a health care facility not to exceed 10 students per instructor;
- D. Clinical and classroom hour requirements and resources**
1. A nursing assistant training program shall ensure each graduate receives a minimum of 120 hours of total instruction consisting of:
 - a. Instructor-led teaching in a classroom setting for a minimum of 40 hours;
 - b. Instructor-supervised skills practice and testing in a laboratory setting for a minimum of 20 hours; and
 - c. Instructor-supervised clinical experiences for a minimum of 40 hours, consistent with the goals of the program. Clinical requirements include the following:
 - i. The program shall provide students with clinical orientation to any clinical setting utilized.
 - ii. The program shall provide a minimum of 20 hours of direct resident care in a long-term care facility licensed by the Department of Health Services, except as provided in subsection (iv). Direct resident care does not include orientation and clinical pre and post conferences.
 - iii. If another health care facility is used for additional required hours, the program shall ensure that the facility provides opportunities for students to apply nursing assistant skills similar to those provided to long-term care residents.
 - iv. If a long-term care facility licensed by the Department of Health Services is not available within 50 miles of the training program's classroom, the program may provide the required clinical hours in a facility or unit that cares for residents or patients similar to those residing in a long-term care facility.
 - d. To meet the 120 hour minimum program hour requirement, a NA program shall designate an additional 20 hours to classroom, skill or clinical instruction based upon the educational needs of the program's students and program resources.
 2. A nursing assistant training program shall ensure that equipment and supplies are in functional condition and sufficient in number for each enrolled student to practice required skills. At a minimum, the program shall provide:
 - a. Hospital-type bed, over-bed table, linens, linen protectors, pillows, privacy curtain, call-light and nightstand;
 - b. Thermometers, stethoscopes, including a teaching stethoscope, aneroid blood pressure cuffs, and a scale;
 - c. Realistic skill training equipment, such as a manikin or model, that provides opportunity for practice and demonstration of perineal care;
 - d. Personal care supplies including wash basin, towels, washcloths, emesis basin, rinse-free wash, tooth brushes, disposable toothettes, dentures, razor, shaving cream, emery board, orange stick, comb, shampoo, hair brush, and lotion;
 - e. Clothes for dressing residents including undergarments, socks, hospital gowns, shirts, pants and shoes or non-skid slippers;
 - f. Elimination equipment including fracture bed pans, bed pans, urinals, ostomy supplies, adult briefs, specimen cups, graduate cylinder, and catheter supplies;
 - g. Aseptic and protective equipment including running water, sink, soap, paper towels, clean disposable gloves, surgical masks, particulate respirator mask for demonstration purposes, gowns, hair protectors and shoe protectors;

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- h. Restorative equipment including wheelchair, gait belt, walker, anti-embolic hose, adaptive equipment, and cane;
 - i. Feeding supplies including cups, glasses, dishes, straws, standard utensils, adaptive utensils and clothing protectors;
 - j. Clean dressings, bandages and binders; and
 - k. Documentation forms.
- E. Consolidated Programs**
- 1. A nursing assistant program may request, in writing, to consolidate more than one site of a program under one program approval for convenience of administration. The site of a program is where didactic instruction occurs. The Board may approve the request for a consolidated program if all the following conditions are met:
 - a. The program is not based in a long-term care facility;
 - b. The program does not offer an innovative program as defined in R4-19-214 at any consolidated site;
 - c. A single RN administrator has authority and responsibility for all sites including hiring, retention and evaluation of all program personnel;
 - d. Curriculum and policies are identical for all sites;
 - e. Instructional delivery methods are substantially similar at all sites;
 - f. Didactic, lab practice and clinical hours are identical for all sites;
 - g. The program presents sufficient evidence that all sites have comparable resources, including classroom, skill lab, clinical facilities and staff. Evidence may include pictures, videos, documentation of equipment purchase and instructor resumes;
 - h. The program provides an application to the Board a minimum of 30 days before consolidation of the program or use of the new site;
 - i. The site is fully staffed before accepting students;
 - j. The program evaluates each site separately under R4-19-801(A)(9);
 - k. The program arranges for the test vendor to provide a separate program number for each site;
 - 2. There have been no substantiated complaints against the program or failure to follow the provisions of this Article in the past two years.
 - 3. The program shall notify the Board if a site is closed or has not been used in two years.
 - 4. A program that has been Board-approved as a consolidated program may request to add additional sites 30 days in advance of site utilization. The Board may approve the new site if the site meets the criteria in subsection (E)(1).
 - 5. The Board may deny a request to consolidate programs or add a site if the requirements of this section are not met. Denial of such a request is not a disciplinary action and does not affect the program's approval status.
 - 6. The Board shall not renew or visit any site that was not used in the previous approval period.
- F. Curriculum:** a nursing assistant training program shall provide classroom and clinical instruction regarding each of the following subjects:
- 1. Communication, interpersonal skills, and documentation;
 - 2. Infection control;
 - 3. Safety and emergency procedures, including abdominal thrusts for foreign body airway obstruction and cardio-pulmonary resuscitation;
 - 4. Patient or resident independence;
 - 5. Patient or resident rights, including the right to:
 - a. Confidentiality;
- b. Privacy;
 - c. Be free from abuse, mistreatment, and neglect;
 - d. Make personal choices;
 - e. Obtain assistance in resolving grievances and disputes;
 - f. Security of a patient's or resident's personal property; and
 - g. Be free from restraints;
6. Recognizing and reporting abuse, mistreatment or neglect to a supervisor;
7. Basic nursing assistant skills, including:
 - a. Taking vital signs, height, and weight using standing, wheelchair and bed scales;
 - b. Maintaining a patient's or resident's environment;
 - c. Observing and reporting pain;
 - d. Assisting with diagnostic tests including obtaining specimens;
 - e. Providing care for patients or residents with drains and tubes including catheters and feeding tubes;
 - f. Recognizing and reporting abnormal patient or resident physical, psychological, or mental changes to a supervisor;
 - g. Applying clean bandages;
 - h. Providing peri-operative care; and
 - i. Assisting in admitting, transferring, or discharging patients or residents.
8. Personal care skills, including:
 - a. Bathing, skin care, and dressing;
 - b. Oral and denture care;
 - c. Shampoo and hair care;
 - d. Fingernail care;
 - e. Toileting, perineal, and ostomy care;
 - f. Feeding and hydration, including proper feeding techniques and use of assistive devices in feeding; and
9. Age specific, mental health, and social service needs, including:
 - a. Modifying the nursing assistant's behavior in response to patient or resident behavior;
 - b. Demonstrating an awareness of the developmental tasks and physiologic changes associated with the aging process,
 - c. Responding to patient or resident behavior,
 - d. Allowing the resident or patient to make personal choices and providing and reinforcing other behavior consistent with the individual's dignity,
 - e. Providing culturally sensitive care,
 - f. Caring for the dying patient or resident, and
 - g. Using the patient's or resident's family as a source of emotional support for the resident or patient;
10. Care of the cognitively impaired patient or resident including:
 - a. Understanding and addressing the unique needs and behaviors of patients or residents with dementia or other cognitive impairment,
 - b. Communicating with cognitively impaired patients or residents,
 - c. Reducing the effects of cognitive impairment, and
 - d. Appropriate responses to the behavior of cognitively impaired individuals.
11. Skills for basic restorative services, including:
 - a. Body mechanics;
 - b. Resident self-care;
 - c. Assistive devices used in transferring, ambulating and dressing;
 - d. Range of motion exercises;

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- e. Bowel and bladder training;
- f. Care and use of prosthetic and orthotic devices; and
- g. Turning and positioning a resident in bed, transferring a resident between bed and chair and positioning a resident in a chair.
- 12. Health care team member skills including the role of the nursing assistant and others on the health care team, time management and prioritizing work; and
- 13. Legal aspects of nursing assistant practice, including:
 - a. Requirements for licensure and registry placement and renewal,
 - b. Delegation of nursing tasks,
 - c. Ethics,
 - d. Advance directives and do-not-resuscitate orders, and
 - e. Standards of conduct under R4-19-814.
- 14. Body structure and function, together with common diseases and conditions.
- G. Curriculum sequence: A nursing assistant training program shall provide a student with a minimum of 16 hours instruction in the subjects identified in subsections (F)(1) through (F)(6) before allowing a student to care for patients or residents.
- H. Skills: A nursing assistant instructor shall verify and document that the following skills are satisfactorily performed by each student before allowing the student to perform the skill on a patient or resident without the instructor present:
 - 1. Hand hygiene, gloving and gowning; and
 - 2. Skills in subsection (F)(7), (8) and (11)(a), (c), (d), (f), and (g).
- I. One-year approval: following receipt and review of a complete initial application as specified in R4-19-804 the Board may approve the program for a period that does not exceed one year, if requirements are met, without a site visit.
- J. A Medicare or Medicaid certified long-term care facility-based program shall provide in its initial and each renewal application, a signed, sworn, and notarized document, executed by the program coordinator, affirming that the program does not require a nursing assistant student to pay a fee for any portion of the program including the initial attempt on the state competency exam.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2).

R4-19-803. Certified Medication Assistant Program Requirements

- A. Organization and Administration: A certified medication assistant (CMA) program may only be offered by those entities identified in A.R.S. § 32-1650.01(A).
- B. Instructor qualifications and duties
 - 1. A medication assistant program instructor shall:
 - a. Hold a current, registered nurse license that is active and in good standing or multistate privilege to practice as an RN under A.R.S. Title 32, Chapter 15;
 - b. Possess at least two years or 3,000 hours of direct care nursing experience; and
 - c. Have administered medications to residents of a long-term care facility for a minimum of 40 hours.
 - 2. Duties of a medication assistant instructor include, but are not limited to:
 - a. Ensuring that the program meets the requirements of this Article;
 - b. Planning each learning experience;
 - c. Teaching a curriculum that meets the requirements of this Section;
 - d. Implementing student and program evaluation policies that meet or exceed the requirements R4-19-801(A)(9) and (10);
 - e. Administering not less than three secure unit examinations and one comprehensive final exam consistent with the course curriculum and the requirements of R4-19-801(B)(3)(c) and;
 - f. Requiring each student to demonstrate satisfactory performance of all critical elements of each skill in subsection (D)(4) before allowing a student to perform the skill on a patient or resident without the instructor's presence and direct observation;
 - g. Being physically present and attentive to students in the classroom and clinical setting at all times during all sessions;
 - 3. A program instructor shall supervise only one student for the first 12 hours of each student's clinical experience; no more than three students for the next 12 hours of each student's clinical experience; and no more than five students for the next 16 hours of each student's clinical experience;
- C. Clinical and classroom hour requirements and resources
 - 1. A medication assistant training program shall ensure each graduate received a minimum of 100 hours of total instruction consisting of:
 - a. Instructor-led didactic instruction for a minimum of 45 hours;
 - b. Instructor supervised skill practice and testing for a minimum of 15 hours;
 - c. Instructor supervised medication administration for a minimum of 40 hours in a long-term care facility licensed by the Department of Health Services.
 - 2. A medication assistant program shall ensure that equipment and supplies are in functional condition and sufficient in number for each enrolled student to practice required skills in subsection (D)(3) and (D)(4). At a minimum, the program shall provide the following:
 - a. A medication cart similar to one used in the clinical practice facility;
 - b. Simulated medications and packaging consistent with resident medications;
 - c. Pill crushers, pill splitters, medication cups and hand hygiene supplies;
 - d. Medication administration record forms; and
 - e. Current drug references, calculator and any other equipment used to administer medications safely.
- D. Curriculum: a medication assistant training program shall provide classroom and clinical instruction in each of the following subjects.
 - 1. Role of certified medication assistant (CMA) in Arizona including allowable acts, conditions, delegation and restrictions;
 - 2. Principles of medication administration including:
 - a. Terminology,
 - b. Laws affecting drug administration,
 - c. Drug references,
 - d. Medication action,
 - e. Medication administration across the human life-span,

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- f. Dosage calculation,
 - g. Medication safety,
 - h. Asepsis, and
 - i. Documentation.
3. Medication properties, uses, adverse effects, administration and care implications for the following types of medications:
- a. Vitamins, minerals, and herbs,
 - b. Antimicrobials,
 - c. Eye and ear medications,
 - d. Skin medications,
 - e. Cardiovascular medications,
 - f. Respiratory medications,
 - g. Gastrointestinal medications,
 - h. Urinary system medications and medications to attain fluid balance,
 - i. Endocrine/reproductive medications,
 - j. Musculoskeletal medications,
 - k. Nervous system/sensory system medications and
 - l. Psychotropic medications.
4. Medication administration theory and skill practice in administration of:
- a. Oral tablets, capsules, and solutions;
 - b. Ear drops, eye drops and eye ointments;
 - c. Topical lotions, ointments and solutions;
 - d. Rectal suppositories; and
 - e. Nasal drops and sprays.
5. Any other topics deemed by the program or the Board as necessary and pertinent to the safe administration of medications.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3).

R4-19-804. Initial Approval and Re-Approval Training Programs

- A. An applicant for initial training program approval shall submit an application packet to the Board at least 90 days before the expected starting date of the program. An applicant shall submit application documents that are unbound, typed or word processed, single-sided, and on white, letter-size paper plus one electronic copy of the entire packet. The Board does not accept notebooks, spiral bound documents, manuals or books.
- B. The Board may impose disciplinary action including denial on any training program that has advertised, conducted classes, recruited or collected money from potential students before receiving Board approval or after expiration of approval except for completing instruction to students who enrolled before the expiration date.
- C. A program applying for initial approval shall include all of the following in their application packet:
1. Name, address, web address, telephone number, e-mail address and fax number of the program;
 2. Identity of all program owners or sponsoring institutions;
 3. Name, license number, telephone number, e-mail address and qualifications of the program coordinator as required in R4-19-802;
 4. Name, license number, telephone number, e-mail address and qualifications of each program instructor including clinical instructors as required in either R4-19-802 for NA programs or R4-19-803 for CMA programs;

5. Name, telephone number, e-mail address and qualifications any person with administrative oversight of the training program, such as an owner, supervisor or director;
6. Accreditation status of the training program, if any, including the name of the accrediting body and date of last review;
7. Name, address, telephone number and contact person, for all health care institutions which will be clinical sites for the program;
8. Medicare certification status of all clinical sites, if any;
9. Evidence of program compliance with this Article including all of the following:
- a. Program description that includes the length of the program, number of hours of clinical, laboratory and classroom instruction, and program goals consistent with federal, state, and if applicable, private postsecondary requirements;
 - b. A list and description of classroom facilities, equipment, and instructional tools the program will provide;
 - c. Written curriculum and course schedule according to the provisions of this Article;
 - d. A copy of the documentation that the program will use to verify student attendance, instructor presence and skills;
 - e. Copy of signed, current clinical contracts;
 - f. The title, author, name, year of publication, and publisher of all textbooks the program will require students to use;
 - g. A copy of course policies and any other materials that demonstrate compliance with this Article and the statutory requirements in Title 32, Chapter 15;
 - h. A plan to evaluate the program that meets requirements in R4-19-801(A)(10);
 - i. An implementation plan including start date and a description of how the program will provide oversight to ensure all requirements of this Article are met;
 - j. A self-assessment checklist of the application contents and their location in the application, on a form provided by the Board; and
 - k. Other requirements as requested consistent with R4-19-802 for nursing assistant programs and R4-19-803 for medication assistant programs.

D. Re-approval of Training Programs

1. A training program applying for re-approval shall submit a paper and electronic application and accompanying materials to the Board before expiration of the current approval. The applicant program shall ensure that all documents submitted are unbound, typed or word processed, single-sided, and on white, letter-size paper. The Board does not accept notebooks, spiral bound documents, manuals or books. A program or site of a consolidated program that did not hold any classes in the previous approval period is not eligible for renewal of approval.
2. The program shall include the following with the renewal application:
 - a. A program description and course goals;
 - b. Name, license number, and qualifications of current program personnel
 - c. A copy of the current curriculum which meets the applicable requirements in either R4-19-802 or R4-19-803;
 - d. The dates of each program offering, number of students who have completed the program, and the

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- results of the state-approved written and manual skills tests, including first-time pass rates since the last program review;
- e. A copy of current program policies, consistent with R4-19-801;
 - f. Any change in resources, contracts, or clinical facilities since the previous approval or changes that were not previously reported to the Board;
 - g. The program evaluation plan with findings regarding required evaluation elements under R4-19-801(A)(10);
 - h. The title, author, year of publication, and publisher of the textbook used by the program;
 - i. Copies of the redacted records of one program graduate;
 - j. The total number of enrolled students and graduates for each year since the last approval;
 - k. The total number of persons taking the state-approved exam in the past two years; if the number is less than 10, a comprehensive plan to increase program enrollment;
 - l. A self-assessment checklist of the application contents and their location in the application, on a form provided by the Board; and
 - m. Other requirements as requested consistent with R4-19-802 for nursing assistant programs and R4-19-803 for medication assistant programs.
- E.** Upon determination of administrative completeness of either an initial or renewal application, the Board, through its authorized representative, shall schedule and conduct a site visit of a NA program, unless one year only approval is granted on an initial application. The Board may conduct a site visit of a CMA program. Site visits are for the purpose of verifying compliance with this Article. Site visits may be conducted in person or through the use of distance technology.
- F.** Following an evaluation of the program application and a site visit, if applicable, the Board may approve or renew the approval of the program for two years for a nursing assistant program and up to four years for a medication assistant program, if the program renewal application and site visit findings, as applicable, meet the requirements of this Article, and A.R.S. Title 32, Chapter 15 and renewal is in the best interest of the public. If the program does not meet these requirements, the Board may issue a notice of deficiency under R4-19-805 or take disciplinary action.
- G.** A program may request an administrative hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for program approval or renewal of approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.
- H.** The owner, operator, administrator or coordinator of a program that is denied approval or renewal of approval shall not be eligible to conduct, own or operate a new or existing program for a period of two years from the date of denial.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

R4-19-805. Deficiencies and Rescission of Program**Approval, Unprofessional Program Conduct, Voluntary Termination, Disciplinary Action, and Reinstatement****A. Deficiencies**

1. Upon determining that a training program has not complied with this Article, the Board s may issue a written notice of deficiency to the program. The Board shall establish a reasonable period of time, based upon the number and severity of deficiencies, for correction of the deficiencies. Under no circumstances, however, shall the period for correction of deficiencies exceed six months.
 - a. Within ten days from the date that the notice of deficiency is served, the program shall submit a plan of correction to the Board.
 - b. The Board, through its authorized representative, may approve the plan of correction or require modifications to the plan if the plan does not adequately address the deficiencies.
 - c. The Board may conduct periodic evaluations and site visits during the period of correction to ascertain the program's progress toward correcting the deficiencies.
 - d. The Board shall evaluate the program's compliance, at a regularly scheduled Board meeting following the period of correction to determine whether the program has corrected the deficiencies.
 2. The Board may rescind the approval of a training program or take other disciplinary action under A.R.S. § 32-1663, based on the number and severity of violations if the program engages in any of the following:
 - a. Failure to submit a plan of correction to the Board within ten days of service of a notice of deficiency.
 - b. Failure to comply with the requirements of this Article within the period set by the Board in the notice of deficiency;
 - c. Noncompliance with federal, state, or, if applicable, private postsecondary requirements;
 - d. Failure to permit a scheduled or unannounced Board site visit or failure to allow a Board representative access to program documents, staff or students during a site visit or investigation;
 - e. Loaning or transferring Board program approval to another entity or facility, including a facility with the same ownership;
 - f. Offering, advertising, recruiting, or enrolling students in a training program before Board approval is granted;
 - g. Conducting a training program after expiration of Board approval without filing an application for renewal of approval before the expiration date;
 - h. For a long-term care based nursing assistant program, charging for any portion of the program;
 - i. Committing an act of unprofessional program conduct.
- B. Unprofessional program conduct.** A notice of deficiency or a disciplinary action including denial of approval or rescission of approval may be issued against a training program for any of the following acts of unprofessional conduct:
1. Failing to maintain minimum standards of acceptable and prevailing educational practice;
 2. Any violation of this Article;
 3. Utilization of students as labor rather than for educational purposes in a health care facility;
 4. Failing to follow the program's or parent institution's mission or goals, program design, objectives, or policies;

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- 5. Failing to provide the classroom, laboratory or clinical teaching hours required by this Article or described in the program description;
 - 6. Enrolling students in a program without adequate faculty, facilities, or clinical experiences, as required by this Article;
 - 7. Permitting unqualified persons to supervise teaching-learning experiences in any portion of the program;
 - 8. Failing to comply with Board requirements within designated timeframes;
 - 9. Engaging in fraud, misrepresentation or deceit in advertising, recruiting, promoting or implementing the program;
 - 10. Making a false, inaccurate or misleading statement to the Board or the Board's designee in the course of an investigation, or on any application or information submitted to the Board or on the program's public website;
 - 11. Failing to supervise students in the clinical setting in accordance with this Article or allowing more than the maximum students per clinical instructor prescribed in this Article;
 - 12. Engaging in any other conduct that gives the Board reasonable cause to believe the program's conduct may be a threat to the safety or welfare of students, faculty, patients or the public.
 - 13. Failing to:
 - a. Furnish in writing a full and complete explanation of a matter reported pursuant to A.R.S. § 32-1664, or
 - b. Respond to a subpoena issued by the Board;
 - 14. Failing to take appropriate action to safeguard a patient's or resident's welfare or follow policies and procedures of the program or clinical site designed to safeguard the patient or resident;
 - 15. Failing to promptly provide make-up classroom, laboratory, or clinical hours, with adequate notice to students, equivalent educational content, and reasonable scheduling, when shortages of hours were caused by the program or program instructors;
 - 16. Failing to promptly remove, or adequately discipline or train, program instructors whose conduct violates this Article or may be a threat to the safety or welfare of students, patients, residents, or the public.
 - 17. Engaging in retaliatory, threatening, or intimidating conduct toward current, prospective or former program students, instructors, other staff, or the public, who make complaints about any aspect of the program to program staff or the Board.
- C. Disciplinary Action.** If the Board issues disciplinary action against the approval of a nursing assistant or medication assistant training program, the program may request a hearing by filing a written request with the Board within 30 days of service of the Board's order. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10, and 4 A.A.C. 19, Article 6.
- D. Voluntary termination**
1. If a training program is voluntarily terminating before renewal, the program shall submit a written notice of termination to the Board.
 2. The program coordinator shall continue the training program, including retaining necessary instructors, until the last student is transferred or has completed the training program.
 3. Within 15 days after the termination of a training program, the administrator or a program representative shall notify the Board in writing of the permanent location and availability of all program records.
- 4. A program that fails to renew its approval with the Board shall be considered voluntarily terminated unless there is a complaint against the program.
- E. Re-issuance of approval**
1. If the Board revokes the approval of a training program, the owner, administrator or coordinator of the revoked program may apply for re-issuance of program approval after a period of two years by complying with the requirements of this Article. The owner, administrator and coordinator of a program that had its approval revoked shall not own, administer or coordinate a training program for a period of two years from the date of program revocation.
 2. If the Board, in lieu of revocation, accepts a voluntarily surrender of a program's approval, the program's owner, administrator or coordinator may apply for reissuance of the program's approval after a period of two years. The owner, administrator and coordinator of a program that voluntarily surrendered its approval shall not own, administer or coordinate a training program for a period of two years from the date of the surrender of approval.
 3. A training program owner, administrator or coordinator whose program approval was voluntarily surrendered or that had its approval rescinded or revoked shall submit a complete reissuance application packet in writing that contains all of the information and documentation required of programs applying for initial approval. In addition, the program shall provide substantial evidence that the basis for revocation or voluntary surrender no longer exist and that reissuance of program approval is in the best interest of the public.
 4. The Board may reissue approval to a training program that meets the requirements of this Article. A program that is denied reissuance of approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying reissuance. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3).

R4-19-806. Initial Nursing Assistant Licensure (LNA) and Medication Assistant Certification

- A.** An applicant for initial licensed nursing assistant (LNA) licensure or CMA certification shall submit the following to the Board:
1. A verified application on a form furnished by the Board that provides the following information about the applicant:
 - a. Full legal name and any and all former names used by the applicant;
 - b. Current mailing address, including county of residence, e-mail address and telephone number;
 - c. Place and date of birth;
 - d. Social Security number;
 - e. Ethnic category and marital status at the applicant's discretion;
 - f. Educational background, including the name of the training program attended, and date of graduation and for medication assistant, proof of high school or

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- equivalent education completion as required in A.R.S. § 32-1650-02(A)(4);
- g. Current employer, including address and telephone number, type of position, and dates of employment, if employed in health care;
- h. A list of all states in which the applicant is or has been included on a nursing assistant registry or been licensed or certified as a nursing or medication assistant and the license or certificate number, if any;
- i. For medication assistant, proof of LNA licensure and 960 hours or 6 months full time employment as a CNA or LNA in the past year, as required in A.R.S. § 32-1650.02;
- j. Responses to questions regarding the applicant's background on the following subjects:
- i. Current investigation or pending disciplinary action by a nursing, nursing assistant or medication assistant regulatory agency in the United States or its territories;
 - ii. Action taken on a nursing assistant or medication assistant license, certification or registry designation in any other state;
 - iii. Felony conviction or conviction of an undesignated or other similar offense and the date of absolute discharge of sentence;
 - iv. Unprofessional conduct as defined in A.R.S. § 32-1601;
 - v. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
2. Proof of satisfactory completion of a nursing assistant or medication assistant training program that meets the requirements of this Article;
3. Proof of United States citizenship or alien status as specified in A.R.S. § 41-1080;
4. For LNA applicants, one or more fingerprint cards or fingerprints
5. For CMA applicants, one or more fingerprint cards or fingerprints, as required by A.R.S. § 32-1606(B)(15) if a fingerprint background report has not been received by the Board in the past two years; and
6. Applicable fees under A.R.S. § 32-1643 and R4-19-808.
- B.** An applicant for licensure as a nursing assistant shall submit a passing score on a Board-approved nursing assistant examination and provide one of the following criteria:
1. Proof that the applicant has completed a Board-approved nursing assistant training program within the past two years;
 2. Proof that the applicant has completed a nursing assistant training program approved in another state or territory of the United States consisting of at least 120 hours within the past two years;
 3. Proof that the applicant has completed a nursing assistant program approved in another state or territory of the United States of at least 75 hours of instruction in the past two years and proof of working as a nursing assistant for an additional number of hours in the past two years that together with the hours of instruction, equal at least 120 hours;
 4. Proof that the applicant either holds a nursing license in good standing in the U.S. or territories, has graduated from an approved nursing program, or otherwise meets educational requirements for a registered or practical nursing license in Arizona;
 5. Documentation sent directly from the program that the applicant successfully completed a nursing course or courses as part of an RN or LPN program approved in either this or another state in the last 2 years that included:
 - a. Didactic content regarding long-term care clients; and
 - b. Forty hours of instructor-supervised direct patient care in a long-term care or comparable facility; or
6. Documentation of a minimum of 100 hours of military health care training, as evidenced by military records, and proof of working in health care within the past 2 years.
- C.** An applicant for medication assistant shall meet the qualifications of A.R.S. §§ 32-1650.02 and 32-1650.03. An applicant who wishes to use part of a nursing program in lieu of completion of a Board approved medication assistant training program under A.R.S. § 32-1650.02 shall submit the following:
1. An official transcript from a Board approved nursing program showing a grade of C or higher in a 45 hour or 3 semester credit, or equivalent, pharmacology course; and
 2. A document signed by both the applicant's clinical instructor and the nursing program administrator verifying that the applicant completed 40 hours of supervised medication administration in a long-term care facility.
- D. Certifying Exam**
1. A LNA applicant shall take and pass both portions of the certifying exam within 2 years:
 - a. Of program completion for graduates of nursing assistant programs approved in Arizona or another state, or
 - b. Of the date of the first test for all other applicants.
 2. A CMA applicant shall take and pass both portions of the certifying exam within one year:
 - a. Of program completion for graduates of Board-approved programs, or
 - b. Of the date of the first test for all other applicants.
 3. An applicant may re-take the failed portion or portions of a certifying exam, under conditions prescribed in written policy by the exam vendor, until a passing score is achieved or their time expires under subsections (D)(1) or (2).
- E.** An applicant who does not take or pass an examination within the time period specified in subsection (D) shall enroll in and successfully complete a Board approved training program in the certification category before being permitted to retake an examination.
- F.** The Board may license a nursing assistant or certify a medication assistant applicant who meets the applicable criteria in this Article and A.R.S. Title 32, Chapter 15 if licensure or certification is in the best interest of the public.
- G.** An applicant who is denied licensure or certification may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.
- H.** Medication assistant certification expires when nursing assistant licensure expires.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

R4-19-807. Nursing Assistant Licensure and Medication

Assistant Certification by Endorsement

- A. An applicant for LNA or CMA by endorsement shall submit all of the information, documentation, and fees required in R4-19-806.
- B. An applicant who has been employed for less than one year shall list all employers during the past two years.
- C. An applicant for nursing assistant licensure by endorsement shall meet the training program criteria in R4-19-806(B). An applicant for medication assistant endorsement shall, in addition, provide evidence satisfactory completion of a training program that meets the requirements of A.R.S. § 32-1650.04 and pass a competency examination as prescribed in A.R.S. § 32-1650.03.
- D. In addition to the other requirements of this Section, an applicant for licensure or certification by endorsement shall provide evidence that the applicant:
 - 1. Is or has been, within the last 2 years, listed as active on a nursing assistant register or a substantially equivalent register by another state or territory of the United States with no substantiated complaints or discipline; and
 - 2. For nursing assistant, meets one or more of the following criteria:
 - a. Regardless of job title or description, performed nursing assistant activities for a minimum of 160 hours for an employer or as part of a nursing or allied health program in the past two years; or
 - b. Has completed a nursing assistant training program and passed the required examination within the past two years.
 - 3. In addition to the above requirements, for medication assistant certification, meets the practice requirements of A.R.S. § 32-1650.04 and pays applicable fees under R4-19-808.
- E. The Board may license a nursing assistant or certify a medication assistant applicant who meets the applicable criteria in this Article if certification is in the best interest of the public.
- F. An applicant who is denied licensure or certification may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for licensure or certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

R4-19-808. Fees Related to Certified Medication Assistant

- A. The Board shall collect the following fees related medication assistant certification:
 - 1. Initial application for certification by exam, \$50.00.
 - 2. Fingerprint processing, \$50.00.
 - 3. Application for certification by endorsement, \$50.00.
- B. If an individual or entity submits a dishonored check, draft order or note, the Board may collect, from the provider of the instrument, the amount allowed under A.R.S. § 44-6852.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 5004, effective November 15, 2002 (Supp. 02-4). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005

(Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

R4-19-809. Nursing Assistant Licensure and Medication Assistant Certificate Renewal

- A. An applicant for renewal of a LNA license or a CMA certificate shall:
 - 1. Submit a verified application to the Board on a form furnished by the Board that provides all of the following information about the applicant:
 - a. Full legal name, mailing address including county of residence, e-mail address and telephone number;
 - b. Marital status and ethnicity at the applicant's discretion;
 - c. Current health care employer including name, address, telephone number, dates of employment and type of setting;
 - d. If the applicant fails to meet the practice requirements in subsections (A)(2) for nursing assistant or (A)(3) for medication assistant renewal, documentation that the applicant has completed a Board-approved training program for the licensure or certification sought and passed both the written and manual skills portions of the competency examination within the past two years;
 - e. Responses to questions that address the applicant's background:
 - i. Any investigation or disciplinary action by a nursing regulatory agency or nursing assistant regulatory agency in the United States or its territories not previously disclosed by the applicant to the Board;
 - ii. Felony conviction or conviction of undesignated offense and date of absolute discharge of sentence since certified or last renewed, and
 - iii. Unprofessional conduct committed by the applicant as defined in A.R.S. § 32-1601 since the time of last renewal and not previously disclosed by the applicant to the Board;
 - iv. Any disciplinary action or investigation related to the applicant's nursing license or nursing assistant or medication assistant license, certificate or registry listing by any other state regulatory agency since the last renewal and not previously disclosed to the Board.
 - v. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
 - 2. For LNA renewal, employment as a nursing assistant, performing nursing assistant tasks for an employer or the applicant's performance of nursing assistant activities as part of a nursing or allied health program for a minimum of 160 hours every two years since the last license or certificate was issued, or
 - 3. For CMA renewal, employment as a medication assistant for a minimum of 160 hours within the last 2 years, and
 - 4. Applicable fees under A.R.S. § 32-1643 and R4-19-808.
 - B. A nursing assistant license and a medication assistant certificate expire simultaneously every 2 years on the last day of the licensee's birth date month. If a licensee fails to timely renew the license or certificate, the licensee shall;

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1. Not work or practice as a LNA until the Board issues a renewal license and shall not practice as a CMA until the Board issues a renewal certificate; and
 2. Pay any late fee imposed by the Board.
- C. If an applicant holds a license or held a license or certificate that has been or is currently revoked, surrendered, denied, suspended or placed on probation in another jurisdiction, the applicant is not eligible to renew or reactivate the applicant's Arizona license or certificate until a review or investigation has been completed and a decision made by the Board.
- D. The Board may renew an LNA license and CMA certificate of an applicant who meets the criteria established in statute and this Article. An applicant who is denied renewal of a license or certificate may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying renewal of the license or certificate. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

R4-19-810. Certified Nursing Assistant Register; Licensed Nursing Assistant Register

- A. The Board shall maintain a Certified Nursing Assistant (CNA) Registry and a Licensed Nursing Assistant (LNA) Registry. All individuals listed in either Registry shall provide proof to the Board, either directly or through the Board's test vendor, of legal presence in the United States as specified in A.R.S. § 41-1080. Both Registries meet the requirements of A.R.S. § 32-1601(B)(11).

1. To be placed on the CNA Registry, the applicant shall either:
 - a. Have successfully completed an approved nursing assistant training program and passed the nursing assistant written and manual skills competency evaluation within the past two years; or
 - b. For endorsement, be listed on another state's nursing assistant registry.
2. To renew CNA Registry status under A.R.S. § 32-1642 (E), an applicant shall submit an application that includes verified statements of:
 - a. Whether applicant has performed nursing assistant or nursing related services for compensation for at least eight hours within the past 24 months, and
 - b. Whether the applicant's listing on any registry in any other state includes documented findings of abuse, neglect or misappropriation of property.
3. The Executive Director shall include the following information in the CNA Register for each registered individual:
 - a. Full legal name and any other names used;
 - b. Address of record;
 - c. County of residence;
 - d. The date of initial placement on the register;
 - e. Dates and results of both the written and manual skills portions of the nursing assistant competency examination;
4. Date of expiration of registration, if applicable;
5. Any substantiated complaints of abuse, neglect or misappropriation of funds; and

8. Registry status such as active or expired, as applicable.
- B. An applicant who meets qualifications under subsection (A)(1) and the licensure requirements of this Article shall be placed on an LNA Registry. The Executive Director shall include the following information in the Licensed Nursing Assistant Register for each licensed individual:
1. Information contained in subsection (A)(3);
 2. Existence of pending investigation, if applicable;
 3. Status of the license and any Board actions on the license, such as active, denied, expired, or revoked, as applicable.
- C. The Executive Director shall include the following information in the applicable Register for an individual if the Board, or the United States Department of Health and Human Services (HHS), or the Arizona Department of Health Services finds that the individual has violated relevant law:
1. For a finding by the Board or HHS, the Executive Director shall include:
 - a. The finding, including the date of the decision, and a reference to each statute, rule, or regulation violated; and
 - b. The sanction, if any, including the date of action and the duration of action, if time-limited.
 2. For a finding by the Arizona Department of Health Services, the Executive Director shall include:
 - a. The allegation;
 - b. Documentation of the investigation, including the:
 - i. Nature of allegation, and
 - ii. Description of evidence supporting the finding;
 - c. Date of hearing, if any, or the date that the complaint was substantiated;
 - d. Statement disputing the allegation, if any;
 - e. The finding, including the date of the decision and a reference to each statute or rule violated; and
 - f. The sanction, including the dates of action and the duration of the sanction, if time-limited.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

R4-19-811. Application for Duplicate License or Certificate

- A. A licensee or CMA certificate holder shall report a lost or stolen license or certificate to the Board in writing or electronically through the Board's website, within 30 days of discovery of the loss.
- B. An individual requesting a duplicate license or certificate shall file an application on a form provided by the Board and pay the applicable fee under A.R.S. § 32-1643(A)(14).

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

R4-19-812. Change of Name or Address

- A. An applicant, CNA, LNA, or CMA certificate holder shall notify the Board, in writing or electronically through the Board's website of any legal name change within 30 days of the change, and submit a copy of the official document verifying the name change.

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- B. An applicant, CNA, LNA, or CMA certificate holder shall notify the Board in writing or electronically through the Board's website of any change of address within 30 days of the address change.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

R4-19-813. Performance of Nursing Assistant Tasks; Performance of Medication Assistant Tasks

- A. A CNA or LNA may perform the following tasks as delegated by a licensed nurse:
1. Tasks for which the nursing assistant has been trained through the curriculum identified in R4-19-802, and
 2. Tasks learned through inservice or educational training if the task meets the following criteria and the nursing assistant has demonstrated competence performing the task:
 - a. The task can be safely performed according to clear, exact, and unchanging directions;
 - b. The task poses minimal risk to the patient or resident and the consequences of performing the task improperly are not life-threatening or irreversible;
 - c. The results of the task are reasonably predictable; and
 - d. Assessment, interpretation, or decision-making is not required during the performance or at the completion of the task.
- B. A licensed nursing assistant who is also certified as a medication assistant under A.R.S. § 32-1650.02 may administer medications under the conditions imposed by A.R.S. §§ 32-1650 through 32-1650.07.
- C. A licensed nursing assistant under this Article shall:
1. Recognize the limits of the licensee's personal knowledge, skills, and abilities;
 2. No change
 3. Inform the registered nurse, licensed practical nurse, or another person authorized to delegate the task about the licensee's ability to perform the task before accepting the assignment;
 4. Accept delegation, instruction, and supervision from a licensed nurse or another person authorized to delegate a task;
 5. Not perform any task that requires a judgment based on nursing knowledge;
 6. Acknowledge responsibility for personal actions necessary to complete an accepted assigned task;
 7. Follow the plan of care, if available;
 8. Observe, report, and record signs, symptoms, and changes in the patient or resident's condition in an ongoing and timely manner; and
 9. Retain responsibility for all assigned tasks without delegating any tasks to another person.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R.

1900, effective July 1, 2016 (Supp. 16-2).

R4-19-814. Standards of Conduct for Licensed Nursing Assistants and Certified Medication Assistants

For purposes of A.R.S. § 32-1601(24)(d), a practice or conduct that is or might be harmful or dangerous to the health of a patient or the public and constitutes a basis for disciplinary action on a LNA license and a CMA certificate includes the following:

1. Failing to maintain professional boundaries or engaging in a dual relationship with a patient, resident, or any member of the patient's or resident's family;
2. Engaging in sexual conduct with a patient, resident, or any member of the patient's or resident's family who does not have a pre-existing relationship with the licensee or any conduct while on duty or in the presence of a patient or resident that a reasonable person would interpret as sexual;
3. Leaving an assignment or abandoning a patient or resident who requires care without properly notifying the immediate supervisor;
4. Failing to accurately and timely document care and treatment provided to a patient or resident, including, for a CMA, medications administered or not administered;
5. Falsifying or making a materially incorrect entry in a health care record;
6. Failing to follow an employer's policies and procedures, designed to safeguard the patient or resident;
7. Failing to take action to protect a patient or resident whose safety or welfare is at risk from potential or actual incompetent health care practice, or to report the practice to the immediate supervisor or a facility administrator;
8. Failing to report signs, symptoms, and changes in patient or resident conditions to the immediate supervisor in an ongoing and timely manner;
9. Violating the rights or dignity of a patient or resident;
10. Violating a patient or resident's right of privacy by disclosing confidential information or knowledge concerning the patient or resident, unless disclosure is otherwise required by law;
11. Neglecting or abusing a patient or resident physically, verbally, emotionally, or financially;
12. Failing to immediately report to a supervisor and the Board any observed or suspected abuse or neglect, including a resident or patient's report of abuse or neglect;
13. Soliciting, or borrowing, property or money from a patient or resident, or any member of the patient's or resident's family, or the patient's or resident's guardian;
14. Soliciting or engaging in the sale of goods or services unrelated to the licensee's health care assignment with a patient or resident, or any member of the patient or resident's immediate family, or guardians;
15. Removing, without authorization, any money, property, or personal possessions, or requesting payment for services not performed from a patient, resident, employer, co-worker, or member of the public.
16. Repeated use or being under the influence of alcohol, medication, or any other substance to the extent that judgment may be impaired and practice detrimentally affected or while on duty in any work setting;
17. Accepting or performing patient or resident care tasks that the licensee lacks the education, competence or legal authority to perform;
18. Removing, without authorization, narcotics, drugs, supplies, equipment, or medical records from any work setting;

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19. Obtaining, possessing, using, or selling any narcotic, controlled substance, or illegal drug in violation of any employer policy or any federal or state law;
20. Permitting or assisting another person to use the licensee's license or CMA certificate holder's certificate or identity for any purpose;
21. Making untruthful or misleading statements in advertisements of the individual's practice as a licensed nursing assistant or certified medication assistant;
22. Offering or providing licensed nursing assistant or certified medication assistant services for compensation without a designated registered nurse supervisor;
23. Threatening, harassing, or exploiting an individual;
24. Using violent or abusive behavior in any work setting;
25. Failing to cooperate with the Board during an investigation by:
 - a. Not furnishing in writing a complete explanation of a matter reported under A.R.S. § 32-1664;
 - b. Not responding to a subpoena or written request for information issued by the Board;
 - c. Not completing and returning a Board-issued questionnaire within 30 days; or
 - d. Not informing the Board of a change of address or phone number within 10 days of each change;
26. Cheating on the competency exam or providing false information on an initial or renewal application for licensure or certification;
27. Making a false or inaccurate statement to the Board or the Board's designee during the course of an investigation;
28. Making a false or misleading statement on a nursing assistant, medication assistant or health care related employment or credential application;
29. If an applicant, licensee or CMA certificate holder is charged with a felony or a misdemeanor, involving conduct that may affect patient safety, failing to notify the Board, in writing, within 10 working days of being charged under A.R.S. § 32-3208. The applicant, licensee or CMA certificate holder shall include the following in the notification:
 - a. Name, current address, telephone number, Social Security number, and license and certificate number, if applicable;
 - b. Date of the charge; and
 - c. Nature of the offense;
30. Failing to notify the Board, in writing, of a conviction for a felony or an undesignated offense within 10 days of the conviction. The applicant, licensee or CMA certificate holder shall include the following in the notification:
 - a. Name, current address, telephone number, Social Security number, and license and CMA certificate number, if applicable;
 - b. Date of the conviction;
 - c. Nature of the offense;
31. For a medication assistant, performance of any acts associated with medication administration not specifically authorized by A.R.S. § 32-1650 et.seq; and
32. Practicing in any other manner that gives the Board reasonable cause to believe that the health of a patient, resident, or the public may be harmed.
33. Violation of any other state or federal laws, rules or regulations.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R.

757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4). Antiquated statute reference in opening subsection revised at the request of Board under A.R.S. § 41-1011(C), Office File No. M11-189, filed May 16, 2011 (Supp. 11-2). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citation in the opening subsection was updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). A.R.S. Section reference updated under subsection under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3).

R4-19-815. Reissuance or Subsequent Issuance of a Nursing Assistant License or Medication Assistant Certificate

An applicant whose application is denied or a licensee or CMA certificate holder whose certificate or license is revoked in accordance with A.R.S. § 32-1663, may reapply to the Board after a period of five years from the date the license, certificate or application is revoked or denied. A licensee or CMA certificate holder who voluntarily surrenders a certificate may reapply to the Board after no less than three years from the date the certificate is surrendered. The Board may issue or re-issue a nursing assistant license or medication assistant certificate under the following terms and conditions:

1. An applicant shall submit documentation showing that the basis for denial, revocation or voluntary surrender has been removed and that the issuance or re-issuance of licensure or CMA certification will no longer constitute a threat to the public health or safety. The Board may require an applicant to be tested for competency, or retake and successfully complete a Board approved training program and pass the required examination, all at the applicant's expense.
2. The Board shall consider the application, and may designate a time for the applicant to address the Board at a regularly scheduled meeting.
3. After considering the application, the Board may:
 - a. Grant certification, or
 - b. Deny the application.
4. An applicant who is denied issuance or reinstatement of licensure or CMA certification may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying issuance or reinstatement of nursing assistant licensure or medication assistant certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

32-1606. Powers and duties of board

A. The board may:

1. Adopt and revise rules necessary to carry into effect this chapter.
2. Publish advisory opinions regarding registered and practical nursing practice and nursing education.
3. Issue limited licenses or certificates if it determines that an applicant or licensee cannot function safely in a specific setting or within the full scope of practice.
4. Refer criminal violations of this chapter to the appropriate law enforcement agency.
5. Establish a confidential program for the monitoring of licensees who are chemically dependent and who enroll in rehabilitation programs that meet the criteria established by the board. The board may take further action if the licensee refuses to enter into a stipulated agreement or fails to comply with its terms. In order to protect the public health and safety, the confidentiality requirements of this paragraph do not apply if the licensee does not comply with the stipulated agreement.
6. On the applicant's or regulated party's request, establish a payment schedule with the applicant or regulated party.
7. Provide education regarding board functions.
8. Collect or assist in the collection of workforce data.
9. Adopt rules for conducting pilot programs consistent with public safety for innovative applications in nursing practice, education and regulation.
10. Grant retirement status on request to retired nurses who are or were licensed under this chapter, who have no open complaint or investigation pending against them and who are not subject to discipline.
11. Accept and spend federal monies and private grants, gifts, contributions and devises to assist in carrying out the purposes of this chapter. These monies do not revert to the state general fund at the end of the fiscal year.

B. The board shall:

1. Approve regulated training and educational programs that meet the requirements of this chapter and rules adopted by the board.
2. By rule, establish approval and reapproval processes for nursing and nursing assistant training programs that meet the requirements of this chapter and board rules.
3. Prepare and maintain a list of approved nursing programs for the preparation of registered and practical nurses whose graduates are eligible for licensing under this chapter as registered nurses or as practical nurses if they satisfy the other requirements of this chapter and board rules.
4. Examine qualified registered and practical nurse applicants.
5. License and renew the licenses of qualified registered and practical nurse applicants and licensed nursing assistants who are not qualified to be licensed by the executive director.
6. Adopt a seal, which the executive director shall keep.
7. Keep a record of all proceedings.
8. For proper cause, deny or rescind approval of a regulated training or educational program for failure to comply with this chapter or the rules of the board.

9. Adopt rules for the approval of credential evaluation services that evaluate the qualifications of applicants who graduated from an international nursing program.
10. Determine and administer appropriate disciplinary action against all regulated parties who are found guilty of violating this chapter or rules adopted by the board.
11. Perform functions necessary to carry out the requirements of nursing assistant and nurse aide training and competency evaluation program as set forth in the omnibus budget reconciliation act of 1987 (P.L. 100-203; 101 Stat. 1330), as amended by the medicare catastrophic coverage act of 1988 (P.L. 100-360; 102 Stat. 683). These functions shall include:
 - (a) Testing and registration of certified nursing assistants.
 - (b) Testing and licensing of licensed nursing assistants.
 - (c) Maintaining a list of board-approved training programs.
 - (d) Maintaining a registry of nursing assistants for all certified nursing assistants and licensed nursing assistants.
 - (e) Assessing fees.
12. Adopt rules establishing those acts that may be performed by a registered nurse practitioner or certified nurse midwife, except that the board does not have authority to decide scope of practice relating to abortion as defined in section 36-2151.
13. Adopt rules that prohibit registered nurse practitioners or certified nurse midwives from dispensing a schedule II controlled substance that is an opioid, except for an implantable device or an opioid that is for medication-assisted treatment for substance use disorders.
14. Adopt rules establishing educational requirements for the certification of school nurses.
15. Publish copies of board rules and distribute these copies on request.
16. Require each applicant for initial licensure or certification to submit a full set of fingerprints to the board for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.
17. Except for a licensee who has been convicted of a felony that has been designated a misdemeanor pursuant to section 13-604, revoke a license of a person, revoke the multistate licensure privilege of a person pursuant to section 32-1669 or not issue a license or renewal to an applicant who has one or more felony convictions and who has not received an absolute discharge from the sentences for all felony convictions three or more years before the date of filing an application pursuant to this chapter.
18. Establish standards for approving and reapproving nurse practitioner and clinical nurse specialist programs and provide for surveys of nurse practitioner and clinical nurse specialist programs as it deems necessary.
19. Provide the licensing authorities of health care institutions, facilities and homes any information the board receives regarding practices that place a patient's health at risk.
20. Limit the multistate licensure privilege of any person who holds or applies for a license in this state pursuant to section 32-1668.
21. Adopt rules to establish competency standards for obtaining and maintaining a license.
22. Adopt rules for the qualification and certification of clinical nurse specialists.
23. Adopt rules for approval and reapproval of refresher courses for nurses who are not currently practicing.

24. Maintain a list of approved medication assistant training programs.
25. Test and certify medication assistants.
26. Maintain a registry and disciplinary record of medication assistants who are certified pursuant to this chapter.
 - C. The board may conduct an investigation on receipt of information that indicates that a person or regulated party may have violated this chapter or a rule adopted pursuant to this chapter. Following the investigation, the board may take disciplinary action pursuant to this chapter.
 - D. The board may limit, revoke or suspend the privilege of a nurse to practice in this state granted pursuant to section 32-1668.
 - E. Failure to comply with any final order of the board, including an order of censure or probation, is cause for suspension or revocation of a license or a certificate.
 - F. The president or a member of the board designated by the president may administer oaths in transacting the business of the board.

32-1664. Investigation; hearing; notice

- A. In connection with an investigation, the board or its duly authorized agents or employees may obtain any documents, reports, records, papers, books and materials, including hospital records, medical staff records and medical staff review committee records, or any other physical evidence that indicates that a person or regulated party may have violated this chapter or a rule adopted pursuant to this chapter:
 1. By entering the premises, at any reasonable time, and inspecting and copying materials in the possession of a regulated party that relate to nursing competence, unprofessional conduct or mental or physical ability of a licensee to safely practice nursing.
 2. By issuing a subpoena under the board's seal to require the attendance and testimony of witnesses or to demand the production for examination or copying of documents or any other physical evidence. Within five days after a person is served with a subpoena, that person may petition the board to revoke, limit or modify the subpoena. The board shall do so if in its opinion the evidence required does not relate to unlawful practices covered by this chapter, is not relevant to the charge that is the subject matter of the hearing or investigation or does not describe with sufficient particularity the physical evidence whose production is required.
 3. By submitting a written request for the information.
 4. In the case of an applicant's or a regulated party's personal medical records, as defined in section 12-2291, by any means permitted by this section if the board either:
 - (a) Obtains from the applicant or regulated party, or the health care decision maker of the applicant or regulated party, a written authorization that satisfies the requirements of title 12, chapter 13, article 7.1.
 - (b) Reasonably believes that the records relate to information already in the board's possession regarding the competence, unprofessional conduct or mental or physical ability of the applicant or regulated party as it pertains to safe practice. If the board adopts a substantive policy statement pursuant to section 41-1091, it may authorize the executive director, or a designee in the absence of the executive director, to make the determination of reasonable belief.

B. A regulated party and a health care institution as defined in section 36-401 shall, and any other person may, report to the board any information the licensee, certificate holder, health care institution or individual may have that appears to show that a regulated party or applicant is, was or may be a threat to the public health or safety.

C. The board retains jurisdiction to proceed with an investigation or a disciplinary proceeding against a regulated party whose license or certificate expired not more than five years before the board initiates the investigation.

D. Any regulated party, health care institution or other person that reports or provides information to the board in good faith is not subject to civil liability. If requested the board shall not disclose the name of the reporter unless the information is essential to proceedings conducted pursuant to this section.

E. Any regulated party or person who is subject to an investigation may obtain representation by counsel.

F. On determination of reasonable cause, the board, or if delegated by the board the executive director, may require a licensee, certificate holder or applicant to undergo at the expense of the licensee, certificate holder or applicant any combination of mental, physical or psychological examinations, assessments or skills evaluations necessary to determine the person's competence or ability to practice safely. These examinations may include bodily fluid testing and other examinations known to detect the presence of alcohol or drugs. If the executive director orders the licensee, applicant or certificate holder to undertake an examination, assessment or evaluation pursuant to this subsection, and the licensee, certificate holder or applicant fails to affirm to the board in writing within fifteen days after receipt of the notice of the order that the licensee, certificate holder or applicant intends to comply with the order, the executive director shall refer the matter to the board to permit the board to determine whether to issue an order pursuant to this subsection. At each regular meeting of the board the executive director shall report to the board data concerning orders issued by the executive director pursuant to this subsection since the last regular meeting of the board and any other data requested by the board.

G. The board shall provide the investigative report if requested pursuant to section 32-3206.

H. If after completing its investigation the board finds that the information provided pursuant to this section is not of sufficient seriousness to merit disciplinary action against the regulated party or applicant, it may take either of the following actions:

1. Dismiss if in the opinion of the board the information is without merit.
2. File a letter of concern if in the opinion of the board there is insufficient evidence to support disciplinary action against the regulated party or applicant but sufficient evidence for the board to notify the regulated party or applicant of its concern.

I. Except as provided pursuant to section 32-1663, subsection F and subsection J of this section, if the investigation in the opinion of the board reveals reasonable grounds to support the charge, the regulated party is entitled to an administrative hearing pursuant to title 41, chapter 6, article 10. If notice of the hearing is served by certified mail, service is complete on the date the notice is placed in the mail.

J. A regulated party shall respond in writing to the board within thirty days after notice of the hearing is served as prescribed in subsection I of this section. The board may consider a

regulated party's failure to respond within this time as an admission by default to the allegations stated in the complaint. The board may then take disciplinary actions allowed by this chapter without conducting a hearing.

K. An administrative law judge or a panel of board members may conduct hearings pursuant to this section.

L. In any matters pending before it, the board may issue subpoenas under its seal to compel the attendance of witnesses.

M. Patient records, including clinical records, medical reports, laboratory statements and reports, any file, film, other report or oral statement relating to diagnostic findings or treatment of patients, any information from which a patient or a patient's family might be identified or information received and records kept by the board as a result of the investigation procedure outlined in this chapter are not available to the public and are not subject to discovery in civil or criminal proceedings.

N. Hospital records, medical staff records, medical staff review committee records, testimony concerning these records and proceedings related to the creation of these records shall not be available to the public. They shall be kept confidential by the board and shall be subject to the same provisions concerning discovery and use in legal actions as are the original records in the possession and control of hospitals, their medical staffs and their medical staff review committees. The board shall use these records and testimony during the course of investigations and proceedings pursuant to this chapter.

O. If the regulated party is found to have committed an act of unprofessional conduct or to have violated this chapter or a rule adopted pursuant to this chapter, the board may take disciplinary action.

P. The board may subsequently issue a denied license or certificate and may reissue a revoked or voluntarily surrendered license or certificate.

Q. On application by the board to any superior court judge, a person who without just cause fails to comply with a subpoena issued pursuant to this section may be ordered by the judge to comply with the subpoena and punished by the court for failing to comply. Subpoenas shall be served by regular or certified mail or in the manner required by the Arizona rules of civil procedure.

R. The board may share investigative information that is confidential under subsections M and N of this section with other state, federal and international health care agencies and with state, federal and international law enforcement authorities if the recipient is subject to confidentiality requirements similar to those established by this section. A disclosure made by the board pursuant to this subsection is not a waiver of the confidentiality requirements established by this section.

BOARD OF OCCUPATIONAL THERAPY (F-18-1003)

Title 4, Chapter 43, Article 1, General Provisions; Article 2, Licensure; Article 3, Hearings; Article 4, Regulatory Provisions

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM – FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-3

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE : September 18, 2018

SUBJECT: BOARD OF OCCUPATIONAL THERAPY EXAMINERS (F-18-1003)

Title 4, Chapter 43, Article 1, General Provisions; Article 2, Licensure; Article 3, Hearings, Article 4, Regulatory Provisions

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Board of Occupational Therapy Examiners (Board) is to “promote the safe and professional practice of occupational therapy.” Laws 2008, Ch. 15, § 3. This report covers 16 rules in A.A.C. Title 4, Chapter 43, Articles 1 through 4.

Article 1 contains three rules, which address general provisions, including definitions specific to occupational therapy, fees charged for applications and licenses, and the proper method by which the Board may serve notice of a process. Article 2 contains five rules related to initial application and renewal requirements, continuing education requirements, and the procedures for processing license applications. Article 3 contains two rules, which relate to hearing procedures and rehearing or review of a decision. Article 4 contains six rules addressing supervision of occupational therapy assistants, occupational therapy aides, and other unlicensed personnel, authorized titles for unlicensed persons working in occupational therapy, requirements for the display of a licensee’s certificate, and requirements for notifying the Board when a name or address change occurs.

The Board indicates that none of the revisions proposed in past five-year-review reports have been implemented. In the 2008 five-year review report, The Board indicated it would amend three rules identified in the 2003 five-year review report in June 2008 and amend an additional 13 rules in June 2009. Shortly thereafter, the Governor issued a rules moratorium, and the Board did not seek an exemption. From April 2007 to June 2010, the Board had four different Executive Directors. During that period, draft rules were attempted but never completed due to the lack of continuity in Executive Directors. The 2013 five-year-review report resulted in

the Council approving six rule changes. In January 2014, the Governor issued a rulemaking moratorium. The Board directed the Executive Director to request an exemption, but it is unclear if the exemption was ever requested. Several of the amendments currently proposed were proposed and accepted in the 2013 Five-Year-Review Report.

Proposed Action

The Board indicates that it plans to submit a rulemaking to the Council by June 2019. In the meantime, the Board indicates that it plans to amend its current rules based on legislation passed since its last two five-year-review reports. The Board plans to:

- **R4-43-101:** Update definition of “supervision” to align with SB 1105 and add definitions for “military,” “military spouses,” and “veterans.”
- **R4-43-102:** Change “Limited Permit” to “Limited License” in subsection (A)(1)(b). Update rule to offer reduced initial application fees for members of the military, military spouses, and veterans.
- **R4-43-103:** Update the statute citation referenced.
- **R4-43-201:** Change “Limited Permit” to “Limited License” in subsections (D) and (D)(5). Updated references to the National Board For Certification in Occupational Therapy, Inc. Add language to clarify application requirements when applying for a license by endorsement. Add “valid email address” to the list of information required on an initial application. Amend the fingerprint requirement for all applicants by allowing fingerprint requirement to be met upon submission of a copy of a fingerprint clearance card. The Board will work with the Governor’s policy advisors and Legislature in the fifty-fourth Legislature - First Regular Session to bring about the statutory change necessary to change the fingerprint requirement.
- **R4-43-202:** Add “valid email address” to the list of information required on renewal applications. Add a fingerprint clearance requirement for all renewal applications and require an unexpired fingerprint clearance card to be on file at all times. The Board will work with the Governor’s policy advisors and Legislature in the fifty-fourth Legislature - First Regular Session to bring about the statutory change necessary to change the fingerprint requirement.
- **R4-43-203:** Update the continuing education requirement to allow an occupational therapist’s supervision of a student’s fieldwork to count as continuing education and increase an occupational therapist’s continuing education requirement to 24 hours. Add language requiring all licensees to complete a course on the Arizona Board of Occupational Therapy rules and statutes. Add language allowing for random audits of continuing education.
- **R4-43-204:** Change “Limited Permit” to “Limited License” in subsection (A).
- **R4-43-402:** Update the rule to address the change from non-licensed employees and volunteers to unlicensed personnel and students to match A.R.S. § 32-3441.
- **R4-43-403:** Change “Limited Permit” to “Limited License” in subsection (1).
- **R4-43-404:** Change term “Limited Permit” to “Limited License” to match A.R.S. § 32-3428.

- **R4-43-405:** Add the requirement of carrying a “wallet sized card” if a facility is not available to display the license pursuant to A.R.S. § 32-3441.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. The Board has general authority requiring it to “adopt rules necessary to carry out [A.R.S. Title 32, Chapter 34, Occupational Therapy].” A.R.S. § 32-3404(A). The Board also must “administer, coordinate and enforce this chapter.” *Id.*

The Board has specific authority to “establish and collect fees” for licensure, initial issuance, renewal, reinstatement; a limited license; a duplicate license; and renewal of an inactive status license. A.R.S. § 32-3427.

The Board has specific authority to evaluate applicant’s qualifications, prescribed examination requirements for licensure, and prescribe educational programs required for licensure. *Id.* The Board has specific authority to require certain qualifications of initial applicants and to “establish by rule additional requirements for license renewal to require the successful completion of a prescribed number of continuing education as a condition of licensure renewal.” A.R.S. §§ 32-3423 and 32-2426(C).

Finally, The Board has specific authority to adopt rules “reasonably related to sound client care governing an occupational therapist’s supervision of licensed occupational therapy assistants or unlicensed personnel or students working with the occupational therapist” and to “take disciplinary action against the occupational therapist or occupational therapy assistant.” A.R.S. § 32-3441.

2. Summary of the agency’s economic impact comparison and identification of stakeholders:

The Board estimates that the economic impact of these rules is generally minimal. Due to statutory mandates to switch from annual licensing to biennial licensing, the Board experienced significant declines in revenue from license renewals. The reduction in revenue for the Board was not anticipated in prior economic, small business, and consumer impact statements.

Key stakeholders include the Board, the Board’s licensees, and patients of the Board’s licensees. The Board currently licenses 2,537 occupational therapists and 1,223 occupational therapy assistants. This is an increase of 38% over 2013’s licensee count of 1,949 occupational therapists and 774 occupational therapy assistants.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and cost to those who are regulated?

Yes. Once the deficiencies identified in this report are addressed, the Board believes that the rules will impose the least burden and costs to those regulated by the rules.

4. Has the agency received any written criticisms of the rules over the last five years?

Yes. In an October 2017 stakeholder survey, over 30 respondents felt that R4-43-201(A) related to initial license application and R4-43-202(A) related to renewal of license were overly burdensome and that license approval should not have to wait for Board approval. The Board responded by indicating that it will seek a change in the relevant statute to delegate the authority to approve licenses to the Board's executive director.

In the same survey, 17 respondents stated that R4-43-202(A) related to renewal of license was overly burdensome, and suggested that the Board convert to online renewals, randomly conduct continuing education audits, and change the renewal cycle to every three years instead of every two years. The Board implemented online licensing in May 2018. The Board has also proposed an amendment to include random audits of continuing education. The Board indicates that converting to a three-year renewal cycle without increasing renewal fees would lead to a fund deficit.

In the same survey, over 30 respondents felt that the rules in R4-42-401(C) related to supervision of occupational therapy assistants sion should be changed. The Board responded that it is seeking approval to amend rules related to supervision (See "Proposed Action" section above).

In the same survey, ten respondents stated that displaying an 8.5 inch by 11 inch certificate, as required by R4-43-405, is not realistic. The Board responded that it is seeking to amend this rule to allow wallet sized cards, as required in A.R.S. § 32-3441.

5. Has the agency analyzed the rules clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. The Board indicates that the rules are effective in achieving their objectives, but are not clear, concise, understandable, or consistent with other rules and statutes. The Board has proposed changes to address the issues with the rules.

6. Has the agency analyzed the current enforcement status of the rules?

Yes. The Board indicates that two rules are not enforced as written. Currently, R4-43-201 and R4-43-202 do not list "valid email address" on the list of information required for an initial application and renewal of license, respectively. The new eLicensing system used by the Board requires an email address. The Board has proposed amendments so that both rules include "valid email address" in the list of information required for licensure.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements?

Not applicable. The Board indicates that there are no corresponding federal laws.

8. For rules adopted after July 29, 2010, does the rules require a permit or licenses and, if so, does the agency comply with A.R.S. § 41-1037?

Not applicable. The rules were adopted before July 29, 2010.

9. Conclusion

The Board indicates that it plans to submit a rulemaking to the Council by June 2019. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval.

DOUGLAS A. DUCEY
Governor

KAREN WHITEFORD
Executive Director

QUENTON McCALLISTER
Chair



ARIZONA BOARD OF OCCUPATIONAL THERAPY EXAMINERS
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July 27, 2018

Ms. Nicole Ong Colyer, Chairwoman
Governor's Regulatory Review Council
100 North Fifteenth Avenue, Suite 305
Phoenix, AZ 85007

Re: Five-Year-Review Report Title 4, Chapter 43, Articles 1 through 4

Dear Ms. Ong:

In compliance with A.R.S. § 41-1056, the Arizona Board of Occupational Therapy Examiners submits a report of its five-year review of Title 4, Chapter 43, Articles 1 through 4 of the Arizona Administrative Code.

The Arizona Board of Occupational Therapy Examiners is in compliance with A.R.S. § 41-1091. A binder containing a directory summarizing all currently applicable rules and substantive policy statements, a complete copy of rules, and substantive policy statements is available for public inspection in the Board office at all times.

No rules have been omitted from review with the intention of letting them expire.

If you have any questions regarding this five-year report or you need more information prior to the Council meeting when the report will be considered, please contact Karen Whiteford, Executive Director, at (602)589-8353. I will be present at the Council meeting to answer any questions that the Council members may have about this five-year review report.

Best Regards,

Karen Whiteford
Executive Director

Enclosures

Arizona Board of Occupational Therapy Examiners

Five-Year-Review Report

2018

1. Authorization of the rule by existing statutes

General Statutory Authority:

A.R.S. § 32-3404 - Provides general authority for the rules

Specific Statutory Authority:

Rule	Specific Statutory Authority
R4-43-101	A.R.S. § 32-3404
R4-43-102	A.R.S. § 32-3427
R4-43-103	A.R.S. § 41-1092
R4-43-201	A.R.S. § 32-3423, A.R.S. § 41-1080
R4-43-202	A.R.S. § 32-3426
R4-43-203	A.R.S. § 32-3426
R4-43-204	A.R.S. § 32-3426
R4-43-205	Title 41, Chapter 6, Article 7.1
R4-43-301	Title 41, Chapter 6
R4-43-302	A.R.S. § 41-1092.09
R4-43-401	A.R.S. § 32-3441
R4-43-402	A.R.S. § 32-3441
R4-43-403	A.R.S. § 32-3404
R4-43-404	A.R.S. § 32-3428
R4-43-405	A.R.S. § 32-3404
R4-43-406	A.R.S. § 32-3426

2. The objective of each rule:

Rule	Objective
R4-43-101 Definitions	R4-43-101 was adopted to provide the definitions relating to the policies and procedures of the Board for administering the issuance and renewal of licenses, for receiving, investigating, and resolving complaints, and for responding to the protected and the regulated public regarding the license status of occupational therapy practitioners.
R4-43-102 Fees	R4-43-102 was adopted to provide the regulated public with the various fees for licensure and the forms of acceptable payment.
R4-43-201 Initial Application	R4-43-201 was adopted to provide potential applicants with the steps and requirements necessary to apply for a license as an occupational therapist or an occupational therapy assistant.

R4-43-202 Renewal License	R4-43-202 was adopted to provide licensees with the steps and requirements necessary to apply for the renewal of a license as an occupational therapist or an occupational therapy assistant as provided for in ARS § 32-3426 (A)(1).
R4-43-203 Continuing Education for Renewal of License	R4-43-203 was adopted to provide licensees with the steps and requirements necessary to complete continuing education units required in to apply for a renewal license as provided for in ARS § 32-3426 (C).
R4-43-204 Inactive License	R4-43-204 was adopted to provide licensees with a mechanism to inactivate a license and provide licensees with the steps required to reactivate an inactive license.
R4-43-205 Procedures for Processing License Applications	R4-43-205 was adopted to inform applicants of the steps involved and time frames required in processing a license.
R4-43-301 Hearing Procedures	R4-43-301 was adopted to inform licensees and the public of the statutory authorities by which the Board will conduct hearings.
R4-43-302 Rehearing or Review of Decision	R4-43-302 was adopted to inform licensees and the public of the statutory authorities by which the Board will rehear or review a previous decision, provide the process of requesting a rehearing and the reasons why the Board may review a decision.
R4-43-401 Supervision of Occupational Therapy Assistants	R4-43-401 was adopted to inform licensees that only a licensed occupational therapist may supervise an occupational therapy assistant and advise licensees of the required levels of supervision based on the occupational therapy assistants experience level.
R4-43-402 Supervision of Occupational Therapy Aides and Other Unlicensed Personnel.	R4-43-402 was adopted to inform licensees that an occupational therapy aide may not provide occupational therapy services and that an occupational therapy aide shall receive continuous supervision.
R4-43-403 Designation of Title	R4-43-403 was adopted to inform the public of the titles that unlicensed personnel and students shall use.
R4-43-404 Limited Permit Practice	R4-43-404 was adopted to set out the Board's requirements for a limited permit and inform licensees as to who is qualified for a limited permit.
R4-43-405 Display of License Certificate	R4-43-405 was adopted to inform licensees and the public of the requirement to display valid licenses at the treatment facility.

R4-43-406 Change of Name or Address	R4-43-406 was adopted to inform licensees of the requirement to keep name and address changes up-to-date so that the Board can contact them when necessary.
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3. **Are the rules effective in achieving their objectives?** Yes X No

If not, please identify the rule(s) that is not effective and provide an explanation for why the rule(s) is not effective.

Rule	Explanation
N/A	

4. **Are the rules consistent with other rules and statutes?** Yes No X

If not, please identify the rule(s) that is not consistent. Also, provide an explanation and identify the provisions that are not consistent with the rule.

Rule	Explanation
R4-43-101 Definitions	SB 1128 passed in 2008 and SB 1105 passed in 2013, modified several definitions and added a few new ones. The changes to the statute, brought about by passage of these two pieces of legislation, require changes to this rule. Specifically, SB 1128 revised the definitions of consultation, occupational therapist, occupational therapy, occupational therapy assistant occupational services and unprofessional conduct. SB 1128 removed the definition for direct supervision and added definitions for letter of concern and supervision. SB 1125 modified the definition of supervision and added to definition of unprofessional conduct.
R4-43-402 Supervision of Occupational Therapy Aides and Other Unlicensed Personnel	SB 1105 passed in 2013, revised A.R.S. § 32-3441 and may require rule revisions to address the change from non-licensed employees and volunteers to unlicensed personnel and students.
R4-43-404 Limited Permit Practice	SB 1128 passed in 2008, revised in A.R.S. §32-3428 the term Limited Permit to Limited License. A revision will be required for consistency.
R4-43-405 Display of License Certificate	SB 1105 passed in 2013, revised A.R.S. § 32-3441 by adding the carrying of a wallet sized card as an additional requirement. A revision will be required to add a wallet sized card to the rule for consistency.

5. **Are the rules enforced as written?** Yes No X

If not, please identify the rule(s) that is not enforced as written and provide an explanation of the issues with enforcement. In addition, include the agency's proposal for resolving the issue.

Rule	Explanation
R4-43-201 Initial Application	The current rule does not list “valid email address” on the list of information required on the initial application. The new eLicensing system requires email addresses for log in and for communication with applicants. The Board requests the addition of “valid email address” to the list of information required on an initial application.
R4-43-202 Renewal of License	The current rule does not list “valid email address” on the list of information required on the renewal application. The new eLicensing system requires email addresses for log in and for communication with applicants. The Board requests the addition of “valid email address” to the list of information required on a renewal application.

6. Are the rules clear, concise, and understandable?

Yes No X

If not, please identify the rule(s) that is not clear, concise, or understandable and provide an explanation as to how the agency plans to amend the rule(s) to improve clarity, conciseness, and understandability.

Rule	Explanation
R4-43-103 Service by the Board	A revision is required to update the statute citation referenced.
R4-43-201 Initial Application	The rule does not specifically state the requirements for licensure by endorsement. The Board desires to add language to clarify the application requirements when applying for a license by endorsement. The intention of clarifying the requirements is to provide a consistent, less cumbersome process for experienced occupational therapists and occupational therapy assistants to obtain a license.
R4-43-201 Initial Application	Current statute and rule requires that applicants submit a full set of fingerprints for the purpose of obtaining a state and federal criminal records check. This is a point of confusion for many applicants, as they often assume submitting a fingerprint card with ABOTE will result in receipt of a fingerprint clearance card. In a survey conducted in July 2018, 71% of the 1,031 respondents stated that their employer requires a fingerprint clearance card issued by the Arizona Department of Public Safety. In order to streamline the application process while continuing to protect the safety of the public, the Board wishes to change the fingerprint requirement for all applicants. A change to the fingerprint requirements first requires change to statute before changing the rule.
R4-43-102 Fees	Executive Order 2018-02 required the Board to investigate ways to ease the financial burden of obtaining a license for military members, their spouses, and veterans. The Board would like to offer reduced initial application fees for members of the military, military spouses, and veterans. This would require additions to R4-43-101 to include definitions of military, military spouses, and veterans as well.

R4-43-202 Renewal of License	Current statute and rule requires that applicants for an initial license submit a full set of fingerprints for the purpose of obtaining a state and federal criminal records check. However, they are not required to submit fingerprints at regular intervals. There is also much confusion regarding A.R.S. § 32-3208 and the requirements for reporting criminal charges. The Board wishes to change statute and rule to require licensees to maintain a fingerprint clearance card. This will not be a financial burden, as a survey conducted in July 2018, showed that 71% of the 1,031 respondents were required by their employer to hold a fingerprint clearance card issued by the Arizona Department of Public Safety. A change to the fingerprint requirements first requires change to statute before changing the rule.
R4-43-203 Continuing Education for Renewal of License	Licensees often do not understand that, according to rule, fieldwork supervision is not accepted for continuing education. To maintain consistency with national certification requirements, the Board desires revisions to allow an occupational therapist's supervision of a student's fieldwork to count as continuing education. The Board also wishes to increase the continuing education requirement for occupational therapists to 24 to ensure they are maintaining their knowledge, skills and abilities in the profession, and to add language requiring all licensees to complete a course on the Arizona Board of Occupational Therapy rules and statutes.
R4-43-203 Continuing Education for Renewal of License	Board staff currently audits 100% of continuing education certificates. With a 43% increase in the number of applications processed since fiscal year 2012, it is difficult for Board staff to review 100% of continuing education without working overtime. The Board does not wish to increase fees in order to hire additional staff. The Board desires to add language to allow for random audits of continuing education.

7. Has the agency received written criticisms of the rules within the last five years? Yes X No _____

If yes, please fill out the table below:

Commenter	Comment	Agency's Response
October 2017 Stakeholder Survey Respondents (14)	R4-43-201.A. Initial Application and R4-43-202.A. Renewal of License – In a survey conducted in 2017, over 30 respondents felt that this rule was overly burdensome and that license approval should not have to wait for Board approval.	The Board will seek change to statute to delegate authority to approve licenses to the Board's executive director. Board staff will work with the Governor's advisors and the Legislature to bring about this administrative change to statute in the Fifty-fourth Legislature - First Regular Session.

October 2017 Stakeholder Survey Respondents (17)	R4-43-202.A. Renewal of License – 17 respondents felt this rule was overly burdensome. Their suggestions included converting to online renewals, doing random continuing audits, and changing the renewal cycle to every three years instead of two.	The Board implemented online licensing in May 2018. The Board is proposing (question 6) an amendment to this rule to include random audits of continuing education. Converting to a three-year renewal cycle without increasing renewal fees would cause a fund deficit long-term.
October 2017 Stakeholder Survey Respondents (6)	R4-43-401.C. Supervision of Occupational Therapy Assistants – Over 30 respondents felt that rules regarding supervision should be changed.	The Board is seeking approval to modify rules related to supervision (question 4).
October 2017 Stakeholder Survey Respondents (10)	R4-43-405. Display of License Certificate – 10 respondents stated that displaying an 8.5x11 certificate is not realistic.	The Board is seeking to change this rule to allow wallet cards, as required in A.R.S. § 32-3441.

8. Economic, small business, and consumer impact comparison:

The Economic impact of the 2000 rulemaking was as anticipated for the four rules covered, except that changes are now necessary in R4-43-101, R4-43-402, R4-43-404, and R4-43-405 to account for statutory changes. The economic impact of the remaining rules is to provide the procedures necessary to regulate the OTs and OTAs. The rule provides all of the requirements necessary for the Board to enforce the statute and rule, including discipline of the licensees. Overall, the rules have a minimal to moderate economic impact on the licensed professionals and the public. The economic impact of the rules on the public is to protect the public from the licensure of persons who may harm them in the course of receiving occupational therapy services.

The Board, in 2003, reported in its economic impact statement (EIS) that fee increases proposed at that time would increase license renewal fees by 34%. The Board further reported that the need for increasing fees came about due to a legislated mandate to go from annual licensing to bi-annual licensing. The EIS stated that the Board's revenues had dropped significantly as a result.

The Board's last Five-Year-Review Report was approved in 2008; The Board reported that the revenue disparity reported in 2003 would be dealt with in a rule amendment to be filed later that year. The rules

were never amended. However, adjustments were made to the fee structure to cover the Board's operating expenses.

When the current executive director discovered the discrepancy between the fees published in rules and what the agency was charging, the fee amounts were immediately reverted to those published in rules.

In 2013, the Board licensed 1,949 occupational therapists and 774 occupational therapy assistants. Currently, 2,537 occupational therapists and 1,223 occupational therapy assistants are licensed by the Board or a 38% increase from 2013 to 2018. Additionally, the Board's budget in 2013 was roughly \$162,700 compared to the Board's current budget of \$180,300, or an 11% increase from 2013.

Approximately 9% of the increase can be attributed to the cost of licenses and support for the new eLicensing (online) system.

The Board will submit a rulemaking in June 2019 to be consistent with statutory revisions made in 2008 and 2013, and to streamline administrative functions as identified as a result of Executive Order 2018-02. These revisions will not have an economic impact on applicants, consumers, or small businesses.

The Board should experience moderate costs to write and implement the proposed rules, and the related economic, small business, and consumer impact statement.

9. Has the agency received any business competitiveness analyses of the rules? Yes No X

10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?

Please state what the previous course of action was and if the agency did not complete the action, please explain why not.

The previous five-year-reviews have resulted in proposed rule revisions. However, none of these rule revisions was implemented.

It was noted in the 2008 Five-Year-Review Report that the Board would amend three rules identified in the 2003 the Five-Year-Review Report. The report stated that a docket had been opened in January of 2008 and proposed rule revisions for June of 2008.

The Board further proposed that thirteen additional rules would be amended in June of 2009 pending the passing of legislation. Soon after the docket opening, the Governor issued a rules moratorium and the

proposed rules were never amended. In a recent review of the Board's past minutes from January of 2008 through September 2013, it was determined that the subject of requesting an exemption from the Governor's rules moratorium was never discussed. It should also be noted that from April of 2007 until June of 2010 the Board went through four Executive Directors. During that period, draft rules were attempted but never fully completed due to the lack of continuity.

The most recent rule review resulted in the Council approving six changes to the agency's rules. The Board held multiple meetings to obtain public input, with the last meeting held in December of 2014. In January of 2014, the Governor issued a rulemaking moratorium. The Board directed the Executive Director to request an exemption. It is unclear if that exemption was ever requested.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Board believes that with the proposed changes the rules will impose the least burden and costs to the community regulated by the rules. The Board is making every effort to ensure the policies, procedures, paperwork and compliance costs effectively work for the regulated community, but that they are also efficient, cost effective and necessary to achieving the regulatory objectives for the Board.

12. **Are the rules more stringent than corresponding federal laws?** Yes No X

Please provide a citation for the federal law(s). And if the rule(s) is more stringent, is there statutory authority to exceed the requirements of federal law(s)?

There are no applicable federal laws with which to compare the stringency of the rules.

13. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

The rules were not adopted after July 29, 2010. Therefore, analysis related to general permits is not required for the rules in this report.

14. **Proposed course of action**

If possible, please identify a month and year by which the agency plans to complete the course of action.

The Board plans to submit a rulemaking to Council by June 2019. The Board plans to amend its current rules based on legislation passed since its last two Five-Year-Review Reports. Specifically, the Board plans to amend the following rules:

R4-43-101 Definitions - SB 1105 passed in 2013 and revised the definition of supervision. The definition of supervision in this rule must be modified to align with the definition in statute.

R4-43-102 Fees - SB 1128 revised in A.R.S. §32-3428 the term Limited Permit to Limited License. A revision will be required in R4-43-102(A)(1)(b) for consistency. The Board would like to offer reduced initial application fees for members of the military, military spouses, and veterans. This would also require additions to R4-43-101 to include definitions of military, military spouses, and veterans as well.

R4-43-103 Service by the Board - A revision is required to update the statute citation referenced.

R4-43-201 Initial Application - SB 1128 revised in A.R.S. §32-3428 the term Limited Permit to Limited License. A revision to R4-43-201(D) and R4-43-201(D)(5) will be required for consistency.

A revision to R4-43-201(C)(2)(a), changing “National Board For Certification in Occupational Therapy, Incorporated” to “National Board for Certification in Occupational Therapy, Inc.” is required for consistency.

A revision to R4-43-201(C)(3)(c), changing “National Board For Certification in Occupational Therapy” to “National Board for Certification in Occupational Therapy, Inc.” is required for consistency.

The Board desires to add language to clarify the application requirements when applying for a license by endorsement. The intention of clarifying the requirements is to provide a consistent, less cumbersome process for experienced occupational therapists and occupational therapy assistants to obtain a license.

The Board also requests the addition of “valid email address” to the list of information required on an initial application. The new eLicensing system requires email addresses for log in and for communication with applicants.

In order to streamline the application process while continuing to protect the safety of the public, the Board wishes to change the fingerprint requirement for all applicants. Current statute requires that applicants submit a full set of fingerprints for the purpose of obtaining a state and federal criminal records check. In a survey conducted in July 2018, 71% of the 1,031 respondents stated that a

fingerprint clearance card issued by the Arizona Department of Public Safety is required by their employer. The Board's criminal records check requirement could more easily be met by applicants submitting a copy of a fingerprint clearance card. A change to the fingerprint requirements first requires change to statute. Board staff will work with the Governor's advisors and the Legislature to bring about this administrative change to statute in the Fifty-fourth Legislature - First Regular Session.

R4-43-202 Renewal of License - The Board wishes to add "valid email address" to the list of information required on renewal applications. The new eLicensing system requires email addresses for log in and for communication with applicants.

In order to effectively protect the public, the Board wishes add a fingerprint clearance requirement for all renewal applications. Current statute requires that applicants submit a full set of fingerprints for the purpose of obtaining a state and federal criminal records check as part of the initial application. Once a person is licensed, they are not required to submit fingerprints again, and are required by A.R.S. 32-3208 to report criminal charges within ten working days. In many cases, licensees are not aware of this requirement. Requiring an unexpired fingerprint clearance card on file at all times would help the Board be more informed of criminal charges against licensees. This would not be a burden to a majority of the licensees. In a survey conducted in July 2018, 71% of the 1,031 respondents stated that a fingerprint clearance card issued by the Arizona Department of Public Safety is required by their employer. The Board's criminal records check requirement could more easily be met by applicants submitting a copy of a fingerprint clearance card. A change to the fingerprint requirements first requires change to Arizona Revised Statute 32-3430. Board staff will work with the Governor's advisors and the Legislature to bring about this administrative change to statute in the Fifty-fourth Legislature - First Regular Session.

R4-43-203 Continuing Education for Renewal of License - To maintain consistency with national certification requirements, the Board desires revisions to allow an occupational therapist's supervision of a student's fieldwork to count as continuing education. The Board also wishes to increase the continuing education requirement for occupational therapists to 24 to ensure they are maintaining their knowledge, skills and abilities in the profession, and to add language requiring all licensees to complete a course on the Arizona Board of Occupational Therapy rules and statutes.

In addition, the Board desires to add language to allow for random audits of continuing education. Board staff currently audits 100% of continuing education certificates. With a 43% increase in the

number of applications processed since fiscal year 2012, it is difficult for Board staff to review 100% of continuing education without working overtime.

R4-43-205. Procedures for Processing License Applications - SB 1128 revised in A.R.S. §32-3428 the term Limited Permit to Limited License. A revision to R4-43-205(A), R4-43-205(A)(1), R4-43-205(A)(3), R4-43-205(A)(4), R4-43-205(A)(5) and R4-43-205(A)(9) will be required for consistency.

R4-43-402 Supervision of Occupational Therapy Aides and Other Unlicensed Personnel - SB1105 made revisions to A.R.S. § 32-3441 that may require rule revisions to address the change from non-licensed employees and volunteers to unlicensed personnel and students.

R4-43-403 Designation of Title – SB 1128 revised in A.R.S. §32-3428 the term Limited Permit to Limited License. A revision to R4-43-403(1) will be required for consistency.

R4-43-404 Limited Permit Practice - SB 1128 revised in A.R.S. §32-3428 the term Limited Permit to Limited License. A revision will be required for consistency.

R4-43-405 Display of License Certificate - SB 1105 revised A.R.S. § 32-3441 by adding the carrying of a wallet sized card as an additional requirement. A revision will be required to add a wallet sized card to the rule for consistency.

The Board will continue to work with the public to ensure that these rules not only meet the objectives of the Board, but also consider the needs of the licensees who are required licenses to carry out the practice of occupational therapy.

TITLE 4. PROFESSIONS AND OCCUPATIONS**CHAPTER 43. BOARD OF OCCUPATIONAL THERAPY EXAMINERS**

(Authority: A.R.S. § 32-3401 et seq.)

ARTICLE 1. GENERAL PROVISIONS

Article 1, consisting of Sections R4-43-101 through R4-43-103, adopted effective October 14, 1992 (Supp. 92-4).

Article 1, consisting of Sections R4-43-101 through R4-43-103, adopted again by emergency action effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

Article 1, consisting of Sections R4-43-101 through R4-43-103, adopted again by emergency action effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

Article 1, consisting of Sections R4-43-101 through R4-43-103, adopted again by emergency action effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 1, consisting of Sections R4-43-101 through R4-43-103, adopted by emergency action effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4).

Section

R4-43-101. Definitions

R4-43-102. Fees

R4-43-103. Service by the Board

ARTICLE 2. LICENSURE

Article 2, consisting of Sections R4-43-201 through R4-43-205, adopted effective October 14, 1992 (Supp. 92-4).

Article 2, consisting of Sections R4-43-201 through R4-43-204, adopted again by emergency action effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

Article 2, consisting of Sections R4-43-201 through R4-43-204, adopted again by emergency action effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

Article 2, consisting of Sections R4-43-201 through R4-43-204, adopted again by emergency action effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 2, consisting of Sections R4-43-201 through R4-43-204, adopted by emergency action effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4).

Section

R4-43-201. Initial Application

R4-43-202. Renewal of License

R4-43-203. Continuing Education for Renewal of License

R4-43-204. Inactive License

R4-43-205. Procedures for Processing License Applications

R4-43-206. Renumbered

ARTICLE 3. HEARINGS

Article 3, consisting of Sections R4-43-301 and R4-43-302, adopted effective October 14, 1992 (Supp. 92-4).

Article 3, consisting of Sections R4-43-301 and R4-43-302, adopted again by emergency action effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

Article 3, consisting of Sections R4-43-301 and R4-43-302, adopted again by emergency action effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

Article 3, consisting of Sections R4-43-301 and R4-43-302, adopted again by emergency action effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 3, consisting of Sections R4-43-301 and R4-43-302, adopted by emergency action effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4).

Section

R4-43-301. Hearing Procedures

R4-43-302. Rehearing or Review of Decision

ARTICLE 4. REGULATORY PROVISIONS

Article 4, consisting of Sections R4-43-401 through R4-43-406, adopted effective October 14, 1992 (Supp. 92-4).

Article 4, consisting of Sections R4-43-401 through R4-43-406, adopted again by emergency action effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

Article 4, consisting of Sections R4-43-401 through R4-43-406, adopted again by emergency action effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

Article 4, consisting of Sections R4-43-401 through R4-43-406, adopted again by emergency action effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 4, consisting of Sections R4-43-401 through R4-43-406, adopted by emergency action effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4).

Section

R4-43-401. Supervision of Occupational Therapy Assistants

R4-43-402. Supervision of Occupational Therapy Aides and Other Unlicensed Personnel

R4-43-403. Designation of Title

R4-43-404. Limited Permit Practice

R4-43-405. Display of License Certificate

R4-43-406. Change of Name or Address

ARTICLE 1. GENERAL PROVISIONS**R4-43-101. Definitions**

In addition to the definitions at A.R.S. § 32-3401, in this Chapter:

1. “Facility of Practice” means the principal location of an agency or organization where an occupational therapist or occupational therapy assistant practices occupational therapy.
2. “Good Moral Character” means an applicant has not been convicted of a felony or a misdemeanor within 5 years before application and never been convicted of a felony or misdemeanor involving moral turpitude.
3. “Health Care Professional” means a person certified as an Occupational Therapist or an Occupational Therapy Assistant by the American Occupational Therapy Certification Board or the National Board for Certification in Occupational Therapy, Inc. or any medical professional licensed by A.R.S. Title 32 or the equivalent if licensed outside of Arizona.
4. “Immediate area” means an occupational therapist is on the same floor and within 80 feet of an occupational therapy aide providing services to an occupational therapy patient.
5. “Immorality or misconduct that tends to discredit the occupational therapy profession” means:
 - a. Engaging in false advertising of occupational therapy services.

- b. Engaging in assault and battery of a patient, client, or other person with whom the licensee has a professional relationship.
 - c. Falsifying patient or client documentation or reports.
 - d. Failing to provide appropriate supervision of an occupational therapy assistant or unlicensed personnel performing occupational therapy.
 - e. Failing to provide a comprehensive occupational therapy service compatible with current research within ethical and professional standards, or failing to provide services based upon an evaluation of the patient or client needs and appropriate treatment procedures.
 - f. Failing to document or maintain patient treatment records, or failing to prepare patient or client reports within 30 days of service or treatment.
 - g. Failing to renew a license while continuing to practice occupational therapy.
 - h. Falsely claiming to have performed a professional service, charging for a service not rendered, or representing a service as the licensee's own when the licensee has not rendered the service or assumed supervisory responsibility for the service.
 - i. Obtaining a fee, a referral fee, or other compensation by fraud or misrepresentation.
 - j. Sexually inappropriate conduct with a client or patient, or with a former client or patient within 6 months after the termination of treatment.
 - k. Signing a blank, undated, or unprepared prescription form.
 - l. Using fraud, misrepresentation, or deception in assisting another person to obtain or attempt to obtain an occupational therapist or occupational therapy assistant license.
 - m. Violating any federal law, state law, administrative rules, or regulations concerning the practice of occupational therapy.
 - n. Violating rules or statutes concerning the training of unlicensed occupational therapy personnel or requiring an unlicensed person to provide occupational therapy services without proper training.
6. "Licensee" means a person licensed in Arizona as an occupational therapist or an occupational therapy assistant.
7. "Occupational therapy aide," "unlicensed personnel," and "occupational therapy technician" mean a person who is not licensed as an occupational therapist or occupational therapy assistant, working under the continuous supervision of a licensed occupational therapist.
8. "Physically present" means a supervising occupational therapist is present to observe the practice of occupational therapy.
9. "Premises" means the building and the surrounding property in which the occupational therapy is practiced.
10. "Person" means the same as in A.R.S. § 41-1001.
11. "Supervision" means a collaborative process for the responsible periodic review and inspection of all aspects of occupational therapy services. The following levels of supervision are minimal. An occupational therapist may assign an increased level of supervision if necessary for the safety of a patient or client. The levels of supervision are:
- a. "Close supervision" means the supervising occupational therapist provides initial direction to the occupational therapy assistant and daily contact while on the premises.
 - b. "Continuous supervision" means the supervising occupational therapist is in the immediate area of the occupational therapy aide performing supportive services.
 - c. "General supervision" means the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 30-calendar days on a per patient or client basis while on the premises, with the supervising occupational therapist available by telephone or by written communication.
 - d. "Minimal supervision" means the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 30-calendar days while on the premises.
 - e. "Routine supervision" means the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 15-calendar days on a per patient or client basis while on the premises, with the supervising occupational therapist available by telephone or by written communication.
12. "Supportive Services" means clerical and maintenance activities, preparation of work area or equipment, and delegated, routine aspects of an intervention session with a patient or client that require no adaptations by an occupational therapy aide.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Amended effective November 6, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2). Amended by final rulemaking at 6 A.A.R. 707, effective January 25, 2000 (Supp. 00-1).

R4-43-102. Fees

- A. The Board shall charge the following fees:
 - 1. An applicant for licensure:
 - a. Application fee: \$100. This fee is in addition to the initial license fee.
 - b. Limited permit fee: \$35. Upon full licensure, the Board shall subtract \$35 from the initial licensure fee.
 - 2. A licensee:
 - a. Reinstatement fee: \$75. This reinstatement fee is in addition to the appropriate license renewal fee.
 - b. Duplicate license fee: \$10.
 - 3. An occupational therapist:
 - a. Initial license fee: \$135.
 - b. Renewal license fee: \$135.
 - c. Inactive status renewal fee: \$25.
 - 4. An occupational therapy assistant:
 - a. Initial license fee: \$70.
 - b. Renewal license fee: \$70.
 - c. Inactive status renewal fee: \$15.
- B. All fees set forth in subsection (A) are nonrefundable except as provided in A.R.S. § 41-1077.

Board of Occupational Therapy Examiners

1. Initial application, initial licensure, limited permit, and returned or insufficient fund replacement checks shall be remitted in cash, cashier's check, or money order.
2. Renewal, duplicate license, and reinstatement fees shall be remitted in cash, cashier's check, money order, or personal check.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired.

Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Amended effective September 15, 1994 (Supp. 94-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-103. Service by the Board

Pursuant to A.R.S. § 41-1063(A), service may be made by, for and on behalf of the Board of any decision, order, subpoena, notice or other process by personal service or by mailing a copy by certified mail. Service by certified mail shall be made to the last address of record filed with the Board. Service upon an attorney who has appeared on behalf of a party constitutes service upon the party. If service is by certified mail, service is complete upon deposit in the United States mail.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired.

Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4).

ARTICLE 2. LICENSURE**R4-43-201. Initial Application**

- A. An applicant for an initial license to practice as an occupational therapist or an occupational therapy assistant shall submit an application form provided by the Board to the Board's office. The application and all supporting documentation shall be received by the Board at least 7 days before a Board meeting to be considered at that Board meeting.
- B. The initial application form shall be signed by an applicant and include the following information on the applicant:
 1. Applicant's last name, 1st name, and middle name;
 2. How applicant's name is to be shown on the licensure certificate;
 3. Other names used;
 4. Social security number;
 5. Residence address;
 6. Alternate mailing address if the residential address is to remain confidential;
 7. The type of license for which applying;
 8. The amount of the application and license fee to be submitted;
 9. Applicant's American Occupational Therapy Certifica-

tion Board or National Board for Certification in Occupational Therapy, Inc. certification number, date of certification, and the number of times the applicant has taken the national examination;

10. Education;
 11. Professional experience, field work, or both within the last 5 years;
 12. Employer's name, address, and telephone number;
 13. Current and previous occupational therapy or other professional license or certification numbers from other states and foreign countries and the status of the license or certification;
 14. Current and previous disciplinary actions;
 15. Affidavit of applicant.
- C. An applicant shall submit or cause to be submitted on the applicant's behalf the following:
1. Application fee;
 2. Written verification received from:
 - a. The National Board For Certification In Occupational Therapy, Incorporated or the American Occupational Therapy Certification Board of a passing score on the examination administered by these entities; or
 - b. Certified letters of good standing issued by each state that has previously issued the applicant an occupational therapy license, provided at least 1 of the states requires standards for licensure equivalent to the requirements for licensure in this Chapter and A.R.S. §§ 32-3401 et seq.
 3. Recommendation of good moral character from 2 health care professionals on a form that shall include the following:
 - a. Applicant's last name, 1st name, and middle initial, and other names used by applicant;
 - b. Applicant's mailing address;
 - c. Applicant's American Occupational Therapy Certification Board or the National Board For Certification In Occupational Therapy certification number;
 - d. Period of time the health care professional has known the applicant;
 - e. Period of time the health care professional has worked with the applicant;
 - f. A statement that the health care professional considers the applicant to be of good moral character;
 - g. Address, city, state, and zip code where the health care professional worked with the applicant;
 - h. A description of the professional relationship or professional experience with the applicant and why the health care professional recommends the applicant for an occupational therapy license;
 - i. Name, address, and telephone number of the health care professional;
 - j. The professional license or certification number and issuing agency of the health care professional;
 - k. The health care professional's signature and date.

- D. An applicant applying for a limited permit shall submit the application and information listed in subsections (B), (C), and this subsection. An Arizona licensed occupational therapist assuming the professional and legal responsibility for supervision of a limited permit applicant shall complete and sign a Direct Supervision Agreement for a Limited Permit form with the Board. The occupational therapist shall file the Direct Supervision Agreement for a Limited Permit form with the Board before the Board shall issue a limited permit. The Direct Supervision Agreement for a Limited Permit form shall contain the following:

1. Applicant's last name, 1st name, middle name, and other names used by the applicant;
 2. Date the form is completed and signed by the supervising occupational therapist;
 3. Name of the supervising occupational therapist;
 4. Arizona license number of the supervising occupational therapist;
 5. Limited permittee's employment address;
 6. Supervisor's mailing address;
 7. Supervisor's employment address and employment telephone number;
 8. Description of supervision;
 9. Signature of the supervising occupational therapist.
- E.** The Board shall retain the application and documents filed in support of the application.
- F.** If the Board denies an application, the applicant may, within 30 days of service of the notice of denial, make a written request for a hearing to review the Board's decision. The hearing shall be conducted under A.R.S. Title 41, Chapter 6, Article 10.
- G.** In a hearing conducted on a denial of a license, the applicant has the burden of proof.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Amended effective September 15, 1994 (Supp. 94-3). Amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-202. Renewal of License

- A.** A licensee shall renew a license by submitting to the Board a renewal application, proof of completion of the continuing education requirements in R4-43-203, and paying the renewal fee within 2 years of initial licensure or last license renewal date.
- B.** The renewal application form provided by the Board shall include the following:
1. Applicant's last name, first name, middle initial, and other names used by the applicant;
 2. How applicant's name is to be shown on the renewal license;
 3. Residence address;
 4. Alternate mailing address if the residential address is to remain confidential;
 5. Current Arizona Board of Occupational Therapy Examiners license number;
 6. Type of renewal license for which applying;
 7. The amount of the renewal fee;
 8. Disciplinary actions since initial licensure;
 9. Hours and titles of continuing education completed;
 10. Total hours of continuing education completed;
 11. Social security number;
 12. Employer's name, address, and telephone number;
 13. Signature and date.
- C.** Unless otherwise required by A.R.S. § 32-3202, a license that is not renewed within 2 years of the date of issuance expires by operation of law. A licensee may reinstate within 180 calendar days of the expiration date upon payment of the required

renewal fee, a reinstatement fee under R4-43-102(A)(2)(a) and submittal of proof of completion of the continuing education requirements in R4-43-203.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Former Section R4-43-202 repealed; new Section R4-43-202 renumbered from R4-43-203 and amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-203. Continuing Education for Renewal of License

- A.** A licensee shall complete continuing education for renewal of a license as follows:
1. Occupational Therapist, 20 clock-hours for renewal of a 2-year license; and
 2. Occupational Therapy Assistant, 12 clock-hours for renewal of a 2-year license.
- B.** A licensee shall complete the continuing education clock hours in subsection (A) within the 2-year period before the date the licensee's license expires, or if requesting a return to active status license, within the 2-year period before the date the licensee submits the return to active status request to the Board.
- C.** Continuing education shall contribute to professional competency and the practice of occupational therapy. The Board shall determine if continuing education hours contribute directly to the professional competency and if the continued education hours relate to the clinical practice of occupational therapy.
- D.** A licensee may fulfill the licensee's continuing education requirement by completing any of the following:
1. A professional workshop, seminar, or conference and submitting proof of attendance as follows:
 - a. The American and Arizona Occupational Therapy Association's original check-in sheet displaying the organization's name, official stamp, hours, and licensee's name; or
 - b. Photocopy of a signed certificate or letter issued by the sponsoring organization or instructor displaying the clock-hours, date of attendance, name of the workshop, seminar, or conference, licensee's name, and information necessary to contact the sponsoring organization or instructor for verification of attendance;
 2. Self-study or formal study through course work and submitting a photocopy of a signed certificate or letter issued by the sponsoring organization or instructor displaying the clock hours, dates of attendance, name of the study or course work, licensee's name, and information necessary to contact the sponsoring organization or instructor for verification of attendance;
 3. Viewing a taped video presentation and submitting a photocopy of a signed certificate or letter issued by the sponsoring organization or instructor displaying the clock-hours, dates of attendance, name of the study or course work, licensee's name, and information necessary to contact the sponsoring organization or instructor for verification of attendance;

- tion of attendance;
4. Undergraduate, graduate college, or university course work of a grade "C" or better and submitting a course completion notification sheet and a statement describing how the course extends the licensee's professional skill and knowledge;
 5. Publishing:
 - a. A book, for a maximum credit of 10 clock-hours, and submitting a copy of the book;
 - b. An article, for a maximum credit of 4 clock-hours, and submitting a copy of the article;
 - c. A chapter of a book, for a maximum of 5 clock-hours, and submitting a copy of the chapter or book;
 - d. A film, for a maximum of 6 clock-hours, and submitting a copy of the film; or
 - e. A videotape, for a maximum of 6 clock-hours, and submitting a copy of videotape;
 6. Presenting a program, workshop, seminar, or conference of not less than 1.5 hours in duration for a maximum of 4 clock-hours and submitting a brochure, agenda, or similar printed material describing:
 - a. The content of the presentation, workshop, seminar, or conference;
 - b. The date, duration, and location of the presentation conference, workshop, or seminar; and
 - c. The name of the presenting licensee or a signed certificate or letter from the program organizer if other than the presenting licensee; or
 7. In-service training related to clinical occupational therapy services excluding safety, fire evacuation, and cardiopulmonary resuscitation (CPR), for a maximum of 4 clock-hours and submitting:
 - a. A letter from the supervising occupational therapist or other immediate supervisor; and
 - b. A licensee's statement consisting of:
 - i. Specific topics,
 - ii. Presenters,
 - iii. Dates,
 - iv. Times,
 - v. Location, and
 - vi. How the training or in-service relates to the clinical practice of occupational therapy or contributes to professional competency.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Amended effective September 15, 1994 (Supp. 94-3). Former Section R4-43-203 renumbered to R4-43-202; new Section R4-43-203 renumbered from R4-43-204 and amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-204. Inactive License

- A licensee may transfer an active license into inactive status if the licensee's license is current and in good standing.
- The licensee shall not practice during the time the license is inactive.

- C. A licensee may renew or reactivate an inactive license by:
 1. Submitting a renewal application under R4-43-202;
 2. Paying the licensure renewal fee under R4-43-102 or, if reactivating an inactive license, paying the renewal fee less the last inactive status fee paid by the applicant; and
 3. Meeting the continuing education requirements under R4-43-203.

Historical Note

R4-43-204 adopted by emergency effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Section R4-43-204 adopted by emergency action permanently adopted as R4-43-205, new Section R4-43-204 adopted effective October 14, 1992 (Supp. 92-4). Amended effective September 15, 1994 (Supp. 94-3). Amended effective December 5, 1997 (Supp. 97-4). Former Section R4-43-204 renumbered to R4-43-203; new Section R4-43-204 renumbered from R4-43-205 and amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-205. Procedures for Processing License Applications

- A. Initial application for a license or permit.
 1. Within 60 calendar days after receipt of an initial application for a license or permit, the Board shall perform an administrative completeness review and notify the applicant in writing that the application is either complete or incomplete. If the application is incomplete, the notice shall specify what documentation or information is missing.
 2. If the Board has notified an applicant that an application is incomplete within the 60-day administrative completeness review timeframe, the timeframe is suspended from the date of the notice.
 3. An applicant with an incomplete application shall submit all missing documentation and information within 60 days from the date of the notice. If the applicant fails to do so for an initial license or permit, the Board may close the applicant's file. An applicant whose file has been closed and who later wishes to become licensed, shall apply anew.
 4. Except for a limited permit application, an application is not complete until the applicant has fully complied with the application requirements of A.R.S. Title 32, Chapter 34 and this Article. A limited permit application is complete when the Board receives all of the information required in R4-43-201(D) except for the exam score in R4-43-201(C)(2)(a).
 5. If an applicant for an initial license or permit cannot submit all missing documentation or information within 60 days from the date of the notice, the applicant may request an extension by submitting a written request to the Board post marked or delivered not later than 60 days from the date of the notice. The written request for an extension shall explain the reasons for the applicant's inability to meet the 60-day deadline.
 6. Under A.R.S. § 32-3403(A), the Executive Director's duties shall include review of requests for an extension. The Executive Director shall grant an extension request, if the extension will enable the applicant to submit the

- missing documentation or information, but shall not grant an extension of more than 60 days. The Executive Director shall notify the applicant in writing of the decision to grant or deny the request for an extension.
7. If the applicant fails to submit all missing documentation and information within the extension period, the Board may close the applicant's file. An applicant whose file has been closed and who later wishes to become licensed, shall apply anew.
 8. After receipt of all missing documentation or information within the administrative completeness timeframe specified in this Section, the Board shall notify the applicant in writing that the application is complete.
 9. The Board shall perform the substantive review and issue or deny the license or permit no later than 60 days after receipt of a complete application. For this subsection, the date of receipt is the date of the notice advising the applicant that the application is complete.
- B.** Renewal license application, request to transfer into inactive status, or application to return to active status.
1. Within 60 calendar days after receipt of an application described in subsection (B)(2), the Board shall perform an administrative completeness review and notify the applicant in writing that the application is complete or incomplete.
 2. The following applications are governed by this subsection:
 - a. A renewal license application;
 - b. A request to transfer into inactive status by a licensee with an unexpired license; and
 - c. A renewal application to return to active status.
 3. If the Board has notified an applicant that an application is incomplete within the 60-day administrative completeness review timeframe, the timeframe is suspended from the date of the notice.
 4. An application is not complete until the applicant has fully complied with all of the application requirements of A.R.S. Title 32, Chapter 34 and this Article.
 5. After receipt of all missing documentation and information within the administrative completeness timeframe specified in this Section, the Board shall notify the applicant that the application is complete.
 6. The substantive review timeframe runs from the date of the Board's notice advising the applicant that the application is complete until the Board grants or denies the renewal or transfer. The substantive review timeframe is 60 days.
 7. A timely submittal renewal application causes the license to remain in effect until further notice by the Board.
 8. If a licensee fails to submit a renewal application before the expiration date, the applicant may seek reinstatement under R4-43-202(C) if applicable or reapply under R4-43-201.
- C.** For the purposes of A.R.S. § 41-1073, the Board establishes the following timeframes for any license or permit it issues:
1. Administrative completeness review timeframe: 60 days.
 2. Substantive review timeframe: 60 days.
 3. Overall timeframe: 120 days.

Historical Note

R4-43-204 adopted by emergency effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency

expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Former R4-43-204 now adopted as R4-43-205 effective October 14, 1992 (Supp. 92-4). Amended effective September 15, 1994 (Supp. 94-3). Former Section R4-43-205 renumbered to R4-43-204; new Section R4-43-205 renumbered from R4-43-206 and amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-206. Renumbered

Historical Note

Adopted effective October 21, 1997 (Supp. 97-4). Section R4-43-206 renumbered to R4-43-205 by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

ARTICLE 3. HEARINGS

R4-43-301. Hearing Procedures

The Board shall conduct all hearings held under A.R.S. § 32-3442 et seq. in accordance with A.R.S. Title 41, Chapter 6, Article 10 and rules issued by the Office of Administrative Hearings.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted without change effective October 14, 1992 (Supp. 92-4). Amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-302. Rehearing or Review of Decision

- A. The Board shall provide for a rehearing and review of its decisions under A.R.S. Title 41, Chapter 6, Article 10 and rules established by the Office of Administrative Hearings.
- B. A party is required to file a motion for rehearing or review of a decision of the Board to exhaust the party's administrative remedies.
- C. A party may amend a motion for rehearing or review at any time before the Board rules on the motion.
- D. The Board may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
 1. Irregularity in the proceedings of the Board, or any order or abuse of discretion, that deprived the moving party of a fair hearing;
 2. Misconduct of the Board, its staff, an administrative law judge, or the prevailing party;
 3. Accident or surprise that could not have been prevented by ordinary prudence;
 4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
 5. Excessive penalty;
 6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings;
 7. That the Board's decision is a result of passion or prejudice; or
 8. That the findings of fact or decision is not justified by the evidence or is contrary to law.

- E.** The Board may affirm or modify a decision or grant a rehearing to all or any of the parties on all or part of the issues for any of the reasons in subsection (D). An order modifying a decision or granting a rehearing shall specify with particularity the grounds for the order.
- F.** When a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. The Board may extend this period for a maximum of 20 days, for good cause as described in subsection (I).
- G.** Not later than 10 days after the date of a decision, after giving parties notice and an opportunity to be heard, the Board may grant a rehearing or review on its own initiative for any reason for which it might have granted relief on motion of a party. The Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion.
- H.** If a rehearing is granted, the Board shall hold the rehearing within 60 days after the issue date on the order granting the rehearing.
- I.** The Board may extend all time limits listed in this Section upon a showing of good cause. A party demonstrates good cause by showing that the grounds for the party's motion or other action could not have been known in time, using reasonable diligence, and:
 - 1. A ruling on the motion will further administrative convenience, expedition, or economy; or
 - 2. A ruling on the motion will avoid undue prejudice to any party.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Amended by final rulemaking at 5 A.A.R. 1614, effective May 6, 1999 (Supp. 99-2).

ARTICLE 4. REGULATORY PROVISIONS

- R4-43-401. Supervision of Occupational Therapy Assistants**
 - A.** Only a licensed occupational therapist shall:
 - 1. Prepare an initial treatment plan, initiate or re-evaluate a client or patient's treatment plan, or authorize in writing a change of a treatment plan;
 - 2. Delegate duties to a licensed occupational therapy assistant, designate an assistant's duties, and assign a level of supervision; and
 - 3. Authorize a patient discharge.
 - B.** A licensed occupational therapy assistant shall not:
 - 1. Evaluate or develop a treatment plan independently;
 - 2. Initiate a treatment plan before a client or patient is evaluated and a treatment plan is prepared by an occupational therapist;
 - 3. Continue a treatment procedure appearing harmful to a patient or client until the procedure is reevaluated by an occupational therapist; or
 - 4. Continue or discontinue occupational therapy services unless the treatment plan is approved or re-approved by a supervising occupational therapist.
 - C.** A supervising occupational therapist shall supervise a licensed occupational therapy assistant as follows:
 - 1. Not less than routine supervision if the occupational ther-

- apy assistant has less than 12 months work experience in a particular practice setting or with a particular skill.
- 2. Not less than general supervision if the occupational therapy assistant has more than 12 months but less than 24 months of experience in a particular practice setting or with a particular skill.
- 3. Not less than minimal supervision if an occupational therapy assistant has more than 24 months of experience in a particular practice setting or with a particular skill.
- 4. Increased level of supervision, if necessary, for the safety of a patient or client.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Amended by final rulemaking at 6 A.A.R. 707, effective January 25, 2000 (Supp. 00-1).

R4-43-402. Supervision of Occupational Therapy Aides and Other Unlicensed Personnel

- A.** An occupational therapy aide shall not provide occupational therapy services in any setting. However, an occupational therapy aide may provide supportive services assigned by an occupational therapist or occupational therapy assistant after the aide is specifically trained to provide the supportive services by an occupational therapist.
- B.** An occupational therapy aide shall receive continuous supervision.
- C.** An occupational therapy aide shall not act independently.
- D.** An occupational therapy aide shall not perform the following tasks:
 - 1. Evaluate a client or patient;
 - 2. Prepare a treatment plan;
 - 3. Make entries in client or patient record regarding client or patient status;
 - 4. Develop, plan, adjust, or modify treatment procedures;
 - 5. Interpret referrals or prescriptions for occupational therapy services;
 - 6. Continue a task if there is a change in the client's or patient's condition;
 - 7. Perform any task without adequate training or skills; and
 - 8. Perform any task requiring licensure under A.R.S. § 32-3401-3445.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Amended by final rulemaking at 6 A.A.R. 707, effective January 25, 2000 (Supp. 00-1).

R4-43-403. Designation of Title

An unlicensed person who works in a facility of practice shall use 1

of the following titles:

1. A person practicing under a limited permit shall use the term "Limited Permit" following the person's name.
2. An occupational therapy aide shall use the term "OT Aide" following the occupational therapy aide's name.
3. An occupational therapy student enrolled in an accredited program in occupational therapy shall use the term "OT Student" following the student's name.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted without change effective October 14, 1992 (Supp. 92-4). Amended by final rulemaking at 6 A.A.R. 707, effective January 25, 2000 (Supp. 00-1).

R4-43-404. Limited Permit Practice

- A. Any change or addition of a supervising occupational therapist requires the filing of a new Direct Supervision Agreement for a Limited Permit form by the supervisor under R4-43-201(D). The supervisor shall submit the Direct Supervision Agreement for a Limited Permit form within 7 days of any change or addition of a supervising occupational therapist.
- B. The supervising occupational therapist shall co-sign all patient records documenting patient treatment and progress.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective Octo-

ber 14, 1992 (Supp. 92-4). Amended effective September 15, 1994 (Supp. 94-3). Amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-405. Display of License Certificate

Each licensee shall display a current license certificate issued by the Board in a prominent place in each facility of practice. A licensee may use a copy of the license certificate to satisfy this requirement.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 8, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted with changes effective October 14, 1992 (Supp. 92-4). Amended effective September 15, 1994 (Supp. 94-3). Amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

R4-43-406. Change of Name or Address

- A. A licensee shall notify the Board in writing within 30 days of a legal name change. A copy of the official document evidencing the name change shall be included. The Board shall issue a duplicate license certificate reflecting the name change.
- B. A licensee shall notify the Board in writing within 30 days of a change in mailing address.

Historical Note

Emergency rule adopted effective December 12, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 11, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective June 5, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Adopted without change effective October 14, 1992 (Supp. 92-4). Amended effective September 15, 1994 (Supp. 94-3). Amended by final rulemaking at 5 A.A.R. 1427, effective April 22, 1999 (Supp. 99-2).

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32-3401. Definitions

In this chapter, unless the context otherwise requires:

1. "Board" means the board of occupational therapy examiners.
2. "Consultation" means the act or procedure of exchanging ideas or information or providing professional advice to another professional or responsible party regarding the provision of occupational therapy services.
3. "Evaluation" means an occupational therapist's assessment of treatment needs within the scope of practice of occupational therapy. Evaluation does not include making a medical diagnosis.
4. "Letter of concern" means a non-disciplinary advisory letter to notify a licensee that, while there is insufficient evidence to support disciplinary action, the licensee should modify or eliminate certain practices and that continuation of the activities that led to the information being submitted to the board may result in future action against the licensee's license.
5. "Occupational therapist" means a person who is licensed pursuant to this chapter to practice occupational therapy and who is a graduate of an accredited occupational therapy education program, completes the approved fieldwork and passes the examination as required by the board pursuant to section 32-3424.
6. "Occupational therapy" means the use of therapeutic activities or modalities to promote engagement in activities with individuals who are limited by physical or cognitive injury or illness, psychosocial dysfunction, developmental or learning disabilities, sensory processing or modulation deficits or the aging process in order to achieve optimum functional performance, maximize independence, prevent disability and maintain health. Occupational therapy includes evaluation, treatment and consultation based on the client's temporal, spiritual and cultural values and needs.
7. "Occupational therapy assistant" means a person who is licensed pursuant to this chapter, who is a graduate of an accredited occupational therapy assistant education program, who assists in the practice of occupational therapy and who performs delegated procedures commensurate with the person's education and training.
8. "Occupational therapy services" includes the following:
 - (a) Developing an intervention and training plan that is based on the occupational therapist's evaluation of the client's occupational history and experiences, including the client's daily living activities, development, activity demands, values and needs.
 - (b) Evaluating and facilitating developmental, perceptual-motor, communication, neuromuscular and sensory processing function, psychosocial skills and systemic functioning, including wound, lymphatic and cardiac functioning.
 - (c) Enhancing functional achievement, prevocational skills and work capabilities through the use of therapeutic activities and modalities that are based on anatomy, physiology and kinesiology, growth and development, disabilities, technology and analysis of human behavioral and occupational performance.

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- (d) Evaluating, designing, fabricating and training the individual in the use of selective orthotics, prosthetics, adaptive devices, assistive technology and durable medical equipment as appropriate.
 - (e) Administering and interpreting standardized and non-standardized tests that are performed within the practice of occupational therapy, including manual muscle, sensory processing, range of motion, cognition, developmental and psychosocial tests.
 - (f) Assessing and adapting environments for individuals with disabilities or who are at risk for dysfunction.
9. "Supervision" means the giving of instructions by the supervising occupational therapist or the occupational therapy assistant that are adequate to ensure the safety of clients during the provision of occupational therapy services and that take into consideration at least the following factors:
- (a) Skill level.
 - (b) Competency.
 - (c) Experience.
 - (d) Work setting demands.
 - (e) Client population.
10. "Unprofessional conduct" includes the following:
- (a) Habitual intemperance in the use of alcohol.
 - (b) Habitual use of narcotic or hypnotic drugs.
 - (c) Gross incompetence, repeated incompetence or incompetence resulting in injury to a client.
 - (d) Having professional connection with or lending the name of the licensee to an unlicensed occupational therapist.
 - (e) Practicing or offering to practice occupational therapy beyond the scope of the practice of occupational therapy.
 - (f) Obtaining or attempting to obtain a license by fraud or misrepresentation or assisting a person to obtain or to attempt to obtain a license by fraud or misrepresentation.
 - (g) Failing to provide supervision according to this chapter and rules adopted pursuant to this chapter.
 - (h) Making misleading, deceptive, untrue or fraudulent representations in violation of this chapter.
 - (i) Having been adjudged mentally incompetent by a court of competent jurisdiction.
 - (j) Knowingly aiding a person who is not licensed in this state and who directly or indirectly performs activities requiring a license.
 - (k) Failing to report to the board any act or omission of a licensee or applicant or of any other person who violates this chapter.
 - (l) Engaging in the performance of substandard care by a licensee due to a deliberate or negligent act or failure to act, regardless of whether actual injury to the person receiving occupational therapy services is established.

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- (m) Failing to refer a client whose condition is beyond the training or ability of the occupational therapist to another professional qualified to provide such service.
- (n) Censure of a licensee or refusal, revocation, suspension or restriction of a license to practice occupational therapy by any other state, territory, district or country, unless the applicant or licensee can demonstrate that the disciplinary action is not related to the ability to safely and skillfully practice occupational therapy or to any act of unprofessional conduct prescribed in this paragraph.
- (o) Any conduct or practice that violates recognized standards of ethics of the occupational therapy profession, any conduct or practice that does or might constitute a danger to the health, welfare or safety of the client or the public or any conduct, practice or condition that does or might impair the licensee's ability to safely and skillfully practice occupational therapy.
- (p) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate this chapter.
- (q) Falsely claiming to have performed a professional service, billing for a service not rendered or charging or collecting an excessive fee for services not performed.
- (r) Sexually inappropriate conduct with a client. For the purposes of this subdivision, "sexually inappropriate conduct" includes:
 - (i) Engaging in or soliciting a sexual relationship, whether consensual or nonconsensual, with a current client or with a former client within three months after termination of occupational therapy services.
 - (ii) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or inappropriate physical contact of a sexual nature with a person treated by an occupational therapist or occupational therapy assistant.
 - (iii) Intentionally viewing a completely or partially disrobed client in the course of treatment if the viewing is not related to treatment under current practice standards.
- (s) Knowingly making a false or misleading statement to the board on a license application or renewal form required by the board or any other verbal or written communications directed to the board or its staff.
- (t) Conviction of a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case conviction by a court of competent jurisdiction is conclusive evidence of the commission and the board may take disciplinary action after the time for appeal has lapsed, when judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order. For the purposes of this subdivision, "conviction" means a plea or verdict of guilty or a conviction following a plea of nolo contendere.
- (u) Violating any federal law, state law, rule or regulation directly related to the practice of occupational therapy.
- (v) Engaging in false advertising of occupational therapy services.
- (w) Engaging in the assault or battery of a client.
- (x) Falsifying client documents or reports.

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- (y) Failing to document or maintain client treatment records or failing to prepare client reports within thirty days of service or treatment.
- (z) Failing to renew a license while continuing to practice occupational therapy.
- (aa) Signing a blank, undated or unprepared prescription form.
- (bb) Entering into a financial relationship other than a normal billing process that leads to embezzlement or violates recognized ethical standards.
- (cc) Failing to maintain client confidentiality without written consent of the client or unless otherwise required by law.
- (dd) Promoting or providing treatment, intervention or a device or service that is unwarranted for the condition of the client beyond the point of reasonable benefit.

32-3402. Board of occupational therapy examiners; members; qualifications; terms; compensation; civil immunity

A. The board of occupational therapy examiners is established and consists of five members appointed by the governor. Each board member shall be a resident of the state at the time of appointment. The governor shall appoint two persons who are not engaged, directly or indirectly, in the provision of health care services to serve as public members. The other three members shall have at least three years of experience in occupational therapy or teaching in an accredited occupational therapy education program in this state immediately before appointment and shall be licensed under this chapter. The governor may select board members from a list of licensees submitted by the Arizona occupational therapy association, inc. or any other appropriate organization.

B. The term of office of board members is three years to begin and end on the third Monday in January. A member shall not serve more than two consecutive terms.

C. The board, at its first regular meeting after the start of each calendar year and as necessary, shall elect a chairperson and other officers from among its members. The board shall meet at least once each quarter in compliance with the open meeting requirements of title 38, chapter 3, article 3.1 and shall keep an official record of these meetings. Other meetings may be convened at the call of the chairperson or the written request of any two board members. A majority of the members of the board shall constitute a quorum.

D. Each member of the board is eligible to receive compensation in the amount of one hundred dollars for each regular or special board meeting the member attends and is eligible for reimbursement for all expenses necessarily and properly incurred in attending board meetings.

E. A board member is immune from civil liability for any actions that are within the scope of the board member's duties if they are taken without malice and in the reasonable belief that they are warranted by law.

32-3403. Executive director; personnel; duties; compensation

A. Subject to title 41, chapter 4, article 4, the board may employ and discharge an executive director and other officers and employees as it deems necessary and

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designate their duties. Board personnel are eligible to receive compensation as determined pursuant to section 38-611.

B. The executive director shall:

1. Issue and document licenses approved by the board.
2. Keep a record of the status of licenses and licensees.
3. Keep a record of the status of applicants, including those whose applications are denied.
4. Perform tasks and duties assigned by the board.
5. Collect fees and maintain accounting records according to generally accepted accounting principles.

32-3404. Powers and duties; commissioners; committees

A. The board shall:

1. Administer, coordinate and enforce this chapter.
2. Evaluate the qualifications of applicants.
3. Prescribe examination requirements for licensure.
4. Adopt rules necessary to carry out this chapter.
5. Conduct informal meetings, formal interviews and hearings and keep records and minutes necessary to carry out its functions.
6. Prescribe educational programs required for licensure pursuant to this chapter.

B. The board may:

1. Appoint commissioners to assist in the performance of its duties.
2. Report any violations of this chapter or rules adopted pursuant to this chapter to a county attorney, the attorney general, a federal agency or a state or national organization.
3. Establish committees to assist in carrying out its duties for a time prescribed by the board. The board may require a committee appointed pursuant to this paragraph to make regular reports to the board.

C. Commissioners appointed pursuant to subsection B, paragraph 1 of this section shall receive no compensation for their services but shall be reimbursed for actual and necessary expenses that they incur in the performance of their duties.

32-3405. Occupational therapy fund; deposit of receipts by board

A. The occupational therapy fund is established. Pursuant to sections 35-146 and 35-147, civil penalties imposed under section 32-3442, subsection K shall be deposited in the state general fund. The board shall deposit ten per cent of all other monies collected under this chapter in the state general fund and deposit the remaining ninety per cent in the occupational therapy fund. Monies in the occupational therapy fund may be used by the board for payment of all necessary board expenses, including compensation and expenses of board members and board staff on claims approved by the board.

B. Monies deposited in the occupational therapy fund are subject to section 35-143.01.

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32-3421. Practicing without a license; prohibition; use of titles

- A. Except as provided by section 32-3422, a person shall not do any of the following in this state unless licensed pursuant to this chapter:
1. Practice or assist in the practice of occupational therapy.
 2. Claim to be an occupational therapist, an occupational therapy assistant or a provider of occupational therapy services.
 3. Render occupational therapy services.
- B. A person shall not use any of the following titles, or any letters, abbreviations or insignia of these titles, in connection with that person's name or place of business unless the person is licensed pursuant to this chapter:
1. Occupational therapist.
 2. Licensed occupational therapist.
 3. Occupational therapist registered.
 4. Occupational therapy assistant.
 5. Licensed occupational therapy assistant.
 6. Certified occupational therapy assistant.

32-3422. Persons and practices not required to be licensed

This chapter does not prevent or restrict the practice, services or activities of:

1. A person engaging in the practice of that person's profession if the service is not practiced as or represented to be occupational therapy.
2. A person licensed in this state from engaging in the profession or occupation for which the person is licensed.
3. A person employed as an occupational therapist or occupational therapy assistant by the United States or any agency of the United States, if that person provides occupational therapy solely under the direction or control of the agency that employs that person.
4. A person pursuing a supervised course of study leading to a degree or certificate in occupational therapy at an accredited or approved educational program pursuant to section 32-3404, if the person is designated by a title that clearly indicates the person's status as a student or trainee.
5. A person fulfilling the supervised fieldwork experience requirements of section 32-3423, if the experience constitutes a part of the fieldwork experience necessary to meet the requirements of section 32-3423.
6. A person performing occupational therapy services in this state for purposes of continuing education, consultation or training, if these services are performed for no more than a cumulative total of sixty days in a calendar year in association with an occupational therapist licensed under this chapter, if either of the following is true:
 - (a) The person is licensed as an occupational therapist or occupational therapy assistant in good standing in another state.
 - (b) The person is certified by the national board for certification in occupational therapy, incorporated.

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7. A person employed by a health care provider licensed pursuant to another chapter of this title if the person does not claim to be an occupational therapist or occupational therapy assistant and the services or activities constitute a part of the person's job duties.

32-3423. Application for licensure; qualifications

A. An applicant for licensure as an occupational therapist or as an occupational therapy assistant shall:

1. Be of good moral character.
 2. Successfully complete the academic and fieldwork requirements of an educational program subject to board review and standards prescribed by the board. The board shall require:
 - (a) For an occupational therapist, a minimum of nine hundred twenty-eight hours of supervised fieldwork experience as determined by the supervising institution, organization or sponsor.
 - (b) For an occupational therapy assistant, a minimum of six hundred eight hours of supervised fieldwork experience as determined by the supervising institution, organization or sponsor.
 3. Pass an examination administered pursuant to section 32-3424.
 4. Complete the application process and pay all fees required pursuant to this chapter.
- B. The board may deny a license to an applicant who:
1. Commits a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case conviction by a court of competent jurisdiction is conclusive evidence of the commission.
 2. Engages in any conduct that violates section 32-3401.
- C. An applicant who is denied a license may request a hearing pursuant to title 41, chapter 6, article 10.

32-3424. Examination for licensure of occupational therapists and occupational therapy assistants

A. An applicant for licensure shall take a written examination approved and administered by the national board for certification in occupational therapy, incorporated. The examination shall test an applicant's knowledge of the basic and clinical services relating to providing occupational therapy services, techniques and methods.

B. The applicant shall arrange for the examination following successful completion of the academic and fieldwork requirements of section 32-3423 and submit evidence of successful completion of the examination.

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32-3425. Licensure by endorsement

- A. The board shall grant a license to any person certified before July 1, 1990 as a registered occupational therapist or a certified occupational therapy assistant by the American occupational therapy certification board, incorporated.
- B. The board may waive the examination, education or experience requirements and grant a license to an applicant who presents proof of current licensure as an occupational therapist or occupational therapy assistant in another state, the District of Columbia or a territory of the United States that requires standards for licensure considered by the board to be equivalent to the requirements of this chapter for licensure.
- C. The board shall issue a license to a person who meets the requirements of this chapter on payment of all prescribed fees.

32-3426. Renewal of license; inactive status; notice of address or name change

- A. Except as provided in section 32-4301, a license issued under this chapter is subject to renewal every two years and expires unless renewed. The board may reinstate an expired license if the licensee:
 1. Complies with board rules for renewal of licenses.
 2. Is not in violation of this chapter or board rules or orders.
 3. Pays the fees prescribed pursuant to section 32-3427.
- B. A licensee may request and the board may grant inactive status to a licensee who ceases to practice as an occupational therapist or occupational therapy assistant.
- C. The board may establish by rule additional requirements for license renewal to require the successful completion of a prescribed number of hours of continuing education as a condition of licensure renewal.
- D. A licensee must report to the board in writing a name change and any change in business or home address within thirty days after the change.

32-3427. Fees

- A. The board by rule, shall establish and collect fees not to exceed:
 1. One hundred dollars for application for a license.
 2. Three hundred dollars for an initial license.
 3. Three hundred dollars for renewal of a license.
 4. Three hundred dollars for an application for reinstatement.
 5. Seventy-five dollars for a limited license.
 6. Fifty dollars for a duplicate license.
- B. The board, by rule, shall establish and collect fees for renewal of an inactive status license.

32-3428. Limited license

- A. The board may grant a limited license to a person who has not taken the licensure examination if that person was trained in this country and has completed the academic and fieldwork requirements of this chapter.

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- B. The board may grant a limited license to a foreign-trained person who has completed the academic and fieldwork requirements of this chapter if that person has not taken the licensure examination but submits proof of acceptance to take the licensure examination.
- C. The holder of a limited license may practice occupational therapy only under the supervision of a licensed occupational therapist.
- D. A limited license is valid for four months and becomes void if a person fails the examination. The limited license expires if a person passes the examination and is issued a license under section 32-3425, subsection C.
- E. The board may reissue a limited license once.

32-3429. Foreign trained applicants

Foreign trained occupational therapists and occupational therapy assistants shall:

1. Satisfy the examination requirements of section 32-3424.
2. Provide proof of good moral character.
3. Complete the academic and supervised fieldwork requirements, substantially equal to those contained in section 32-3423 before taking the examination.
4. Submit a completed application as prescribed by the board.
5. Pay all applicable fees prescribed pursuant to section 32-3427.

32-3430. Fingerprinting

A. Each applicant for original licensure, license renewal, license reinstatement or a limited license pursuant to this chapter who has not previously done so shall submit a full set of fingerprints to the board at the applicant's or licensee's expense for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

B. If the board does not have any evidence or reasonable suspicion that the applicant has a criminal history and the applicant otherwise satisfies the requirements of section 32-3423, the board may issue a license or a limited license before it receives the results of a criminal records check.

C. The board shall suspend a license or a limited license of a person who submits an unreadable set of fingerprints and does not submit a new readable set of fingerprints within twenty days after being notified by the board.

D. This section does not affect the board's authority to otherwise issue, deny, cancel, terminate, suspend or revoke a license or a limited license.

32-3441. Proper use of title or designation of occupational therapists; license display; supervision; responsibilities

A. A person who is licensed pursuant to this chapter to practice as an occupational therapist and who is in good standing may use the title of licensed occupational therapist and the abbreviation "O.T.", "O.T./L.", "O.T.R." or "O.T.R./L.". A person who is licensed pursuant to this chapter to practice as a licensed occupational

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therapy assistant and who is in good standing may use the title of licensed occupational therapy assistant and the abbreviation "O.T.A.", "O.T.A./L.", "C.O.T.A." or "C.O.T.A./L.".

B. Each occupational therapist and occupational therapy assistant shall display the person's current license in each facility in which the person practices occupational therapy. If a facility is not available for the display of the license, the occupational therapist or the occupational therapy assistant must carry a board-issued wallet-sized license card during working hours.

C. The board may adopt rules reasonably related to sound client care governing an occupational therapist's supervision of licensed occupational therapy assistants or unlicensed personnel or students working with the occupational therapist.

D. An occupational therapist and an occupational therapy assistant are professionally and legally responsible for supervising client care given by unlicensed personnel or students. If an occupational therapist or occupational therapy assistant fails to adequately supervise client care given by unlicensed personnel or students, the board may take disciplinary action against the occupational therapist or occupational therapy assistant.

E. In all settings in which occupational therapy services are provided, an occupational therapist, during evaluation, intervention and outcome and discharge planning:

1. Must sign all clinical documentation performed by students.
2. Must be the primary clinical supervisor for level II occupational therapist and occupational therapy assistant students, including level II doctoral students. The occupational therapist's supervision of the student must initially be direct and subsequently may be decreased to less direct supervision as appropriate to the setting, the client's needs and the student's ability.

F. In all settings in which occupational therapy services are provided, an occupational therapy assistant, during evaluation, intervention and outcome and discharge planning:

1. Must sign all clinical documentation performed by students.
2. Must be under the direction of an occupational therapist.
3. May be the primary clinical educator for level I occupational therapist and occupational therapy assistant students and level II occupational therapy assistant students. The occupational therapy assistant's supervision of the student must initially be direct and subsequently may be decreased to less direct supervision as appropriate to the setting, the client's needs and the student's ability.

32-3442. Disciplinary action; informal meetings; formal interviews; hearings; penalties; reinstatement of license

A. The board may:

1. Receive written complaints filed against licensees and conduct investigations.
2. Conduct an investigation at any time on its own initiative without receipt of a written complaint if the board has reason to believe:

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(a) That there may be a violation of this chapter, a rule adopted pursuant to this chapter or a written board order.

(b) That a licensee is or may be guilty of unprofessional conduct or is or may be acting outside the scope of practice.

(c) That a licensee is or may be incompetent.

B. Any occupational therapist, occupational therapy assistant or health care institution as defined in section 36-401 shall report to the board any information the occupational therapist, occupational therapy assistant, health care institution or individual may have that appears to show that an occupational therapist or an occupational therapy assistant is or may be guilty of unprofessional conduct or is or may be incompetent.

C. A person who provides information to the board in good faith pursuant to subsection A or B of this section is not subject to an action in civil damages as a result of providing the information.

D. Within sixty days of receipt of a written complaint pursuant to subsection A of this section or information pursuant to subsection B of this section, the board shall notify the licensee about whom information has been received as to the content of the complaint or information.

E. The board may request an informal meeting or a formal interview with the licensee or any other person to further its investigation or to resolve a complaint.

F. If a licensee refuses the board's request for an informal meeting or a formal interview, or in place of holding an informal meeting or a formal interview, the board shall hold a hearing pursuant to title 41, chapter 6, article 10.

G. If the results of an informal meeting or a formal interview indicate that suspension or revocation of the licensee's license or a civil penalty might be appropriate, the board shall notify the licensee of the time and place for a hearing pursuant to title 41, chapter 6, article 10.

H. If at the informal meeting or formal interview the board finds a violation of this chapter, but the violation is not of sufficient seriousness to merit a civil penalty or suspension or revocation of a license, it may take one or more of the following actions:

1. Issue a decree of censure.

2. Establish length and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the licensee. Probation may include:

(a) Submission of the licensee to examinations to determine the mental or physical condition or professional competence of the licensee at the licensee's expense.

(b) Occupational therapy training or education that the board believes to be necessary to correct deficiencies.

(c) Review or supervision of the licensee's practice that the board finds necessary to identify and correct deficiencies in the practice, including a requirement that the licensee regularly report to the board on matters related to the licensee's probationary requirements.

(d) Restrictions on the nature and scope of practice to ensure that the licensee does not practice beyond the limits of the licensee's capabilities.

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3. Issue a letter of concern.
4. Issue a non-disciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of practice standards for licensees including current developments, skills, procedures or treatment interventions.
5. Dismiss the complaint.
 - I. In addition to the terms of probation described in subsection H, paragraph 2 of this section, probation may also include temporary suspension or restriction of the licensee's license to practice. A licensee's failure to comply with probation or any other board order is cause for a hearing pursuant to title 41, chapter 6, article 10.
 - J. At the licensee's expense the board may require any combination of a physical, mental or occupational therapy competence examination as part of a board investigation, including, if necessary, the taking of depositions as may be required to fully inform itself with respect to the allegations presented by the complaint. These examinations may include biological fluid testing.
 - K. Any licensee who, after a hearing, is found guilty of unprofessional conduct or incompetence is subject to the following:
 1. A decree of censure.
 2. Probation as provided in this section.
 3. Suspension or revocation of the license.
 4. Imposition of a civil penalty of not less than two hundred fifty dollars nor more than ten thousand dollars for each violation of this chapter.
 5. Any combination of these sanctions for a period of time or permanently and under conditions as the board deems appropriate for the protection of the public health and safety.
 - L. A licensee shall return to the board a revoked or suspended license within fifteen days after it is revoked or suspended.
 - M. The board may reinstate a person's license that has been suspended for less than two years pursuant to this section if the person pays a renewal fee and a reinstatement fee as prescribed by the board by rule and completes the reapplication process as prescribed by the board.
 - N. The board may reinstate a person's license that has been suspended for more than two years pursuant to this section if the person does all of the following:
 1. Reapplies for a license pursuant to section 32-3423.
 2. To the board's satisfaction, demonstrates competency to practice.
 3. Completes any other requirements prescribed by the board.

32-3443. Hearings and investigations; subpoenas

- A. The board may issue subpoenas to compel attendance of witnesses and production of documents and administer oaths, take testimony, hear offers of proof and receive exhibits in evidence in connection with a board investigation or hearing. If a board subpoena is disobeyed, the board may invoke the aid of any court in this

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state in requiring the attendance and testimony of witnesses and the production of documentary evidence.

B. Any person appearing before the board may be represented by counsel.
C. The board may investigate any person to the extent necessary to determine if the person is engaged in the unlawful practice of occupational therapy. If an investigation indicates that a person may be practicing occupational therapy unlawfully, the board shall inform the person of the alleged violation. If the person does not immediately cease the unlawful practice of occupational therapy, the board may refer the matter for criminal prosecution pursuant to section 32-3445.

32-3444. Judicial review

Except as provided in section 41-1092.08, subsection H, final decisions of the board are subject to judicial review pursuant to title 12, chapter 7, article 6.

32-3445. Violations; classification

A person is guilty of a class 1 misdemeanor who:

1. Obtains a license by fraud, by misrepresentation or in any manner other than that prescribed in this chapter.
2. Practices or assists in the practice of occupational therapy and is not licensed or exempt from the requirements of licensure pursuant to this chapter.
3. Violates any provision of this chapter.

32-3446. Substance abuse recovery program; consent agreement

In lieu of a disciplinary proceeding prescribed by this article, the board may permit a licensee to actively participate in a board-approved substance abuse recovery program if:

1. The board has evidence that the licensee is an impaired professional.
2. The licensee has not been convicted of a felony relating to a controlled substance in a court of competent jurisdiction.
3. The licensee enters into a consent agreement and complies with all of the terms of the agreement, including making satisfactory progress in the program and adhering to any limitations on the licensee's practice imposed by the board to protect the public. If a licensee does not enter into a consent agreement, the board may begin an investigation and disciplinary proceedings.
4. As part of the agreement between the licensee and the board, the licensee signs a waiver that allows the substance abuse recovery program to release information to the board if the licensee does not comply with the requirements of this section or is unable to practice with reasonable skill or safety.

DEPARTMENT OF HEALTH SERVICES (F-18-1005)

Title 9, Chapter 10, Article 8, Assisted Living Facilities

GOVERNOR'S REGULATORY REVIEW COUNCIL
STAFF MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-4

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: DEPARTMENT OF HEALTH SERVICES (F-18-1005)
Title 9, Chapter 10, Article 8, Assisted Living Facilities

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report:

This five-year review report, from the Department of Health Services (Department), covers 20 rules in A.A.C. Title 9, Chapter 10, Article 8. The rules in Article 8 establish requirements related to licensing of assisted living facilities. In particular, the rules specify licensing application requirements, establish policies and procedures to protect the health and safety of a resident, establish requirements for quality management program, personnel and personnel records, residency agreements, service plans, and services provided at assisted living facilities.

This is the first five-year review report on the new rules adopted via exempt rulemaking in 2013, and the rules were last amended in 2014.

Proposed Action

The Department intends to amend the rules, to address the issues identified throughout the report, by July 2019.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. The Department cites to both general and specific authority. A.R.S. § 36-136(G) states that the director of the Department “may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.” Additionally, A.R.S. § 36-405(A), authorizes the director to “adopt rules to establish minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to ensure the public health, safety and welfare.”

2. Summary of the agency's economic impact comparison and identification of stakeholders:

The rules in Article 8 were made as part of an exempt rulemaking, so no economic, small business, and consumer impact statement was prepared. As of July 1, 2018, there were 2,097 licensed assisted living facilities in Arizona.

Key stakeholders include the Department, assisted living facilities, residents of assisted living facilities, their families, and the general public.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

Yes. The Department determines that the rules will be the least intrusive and least costly method of achieving the regulatory objective once the rules are revised.

4. Has the agency received any written criticisms of the rules over the last five years?

Yes. The Department received two public comments from Gaile Dixon, owner of Dream Catcher Assisted Living Home, and Bill Kuhaneck, registered nurse at Hope Springs Memory Care. The comments, along with the Department's responses, are summarized on pages 5 and 6 of the report. The Department plans to incorporate some of the suggestions in the upcoming rulemaking.

5. Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. The Department has identified that the following rules could be made more clear, concise, and understandable, consistent with other rules and statutes, and more effective:

- Section 801: Subsection (3) should be amended to clarify that “assisted living services” include behavioral health care rather than behavioral health services. Also, it should be made clear that behavioral health services are provided only if authorized.
- Section 802: References to “respite care services” should be added in a new subsection (2)(c). In addition, the term “initial” should be removed to make the rule consistent with A.R.S. § 36-405.
- Section 803: Subsection (C)(1)(j)(ii) should be made consistent with Section 811(C)(17). In addition, the title of the “State Long-Term Care Ombudsman” should be amended to “Long Term Care Ombudsman” to be consistent with the Long Term Care Ombudsman program provided by the Department of Economic Security. In addition, subsection (C) should contain a policy or procedure to cover a method by which an assisted living facility manager may be aware of a residents whereabouts.

- Section 806: Reference to “Board of Examiners” should be changed to “Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers.” The rule should also be amended to include a requirement for a daily staffing schedule and a policy or procedure that requires facility personnel to be a backup when a caregiver or manager is not available.
- Section 807: In subsections (C)(2) and (C)(3), the requirements for “assisted living services” should be updated to remove “assisted living,” to be consistent with Laws 2011, Ch. 96. The rule should also be amended to clarify that a licensed assisted living facility does not accept individuals who do not have difficulty with daily living activities.
- Section 808: Subsection (E)(4) should be amended to “multiple media sources are provided to residents to maintain a resident’s continued awareness of current news, social events, and other noteworthy information,”
- Section 810: The terms “admission” and “admitted” should be changed to be consistent with Section 801(1).
- Section 811: The rule should clarify that a resident’s primary diagnosis by the resident’s primary care physician is a physical health diagnosis and not a behavioral health diagnosis.
- Section 814: In subsection (F)(4), reference to subsection (B)(2)(b) should be changed to (B)(2)(b)(iii).
- Section 815: The rule should be amended to remove “in the Uniform Building Code” and state the specific subsection in R9-1-412 that contain the requirements for special egress-control devices.
- Section 817: References to the webpage for dietary guidelines should be updated.
- Section 818: The term “renewal” should be removed to make the rule consistent with A.R.S. § 36-405.
- Section 820: The terms used to define the types of accommodations provided to a resident should be amended to be consistent with A.R.S. § 36-401.

6. Has the agency analyzed the current enforcement status of the rules?

Yes. The Department indicates that the rules are enforced as written.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

No. The Department indicates that no federal laws apply to the rules.

8. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

Yes. The Department indicates that the rules require a specific agency authorization, which is authorized by A.R.S. § 36-405.

9. Conclusion

As noted above, the Department plans to amend the rules by July 2019. This report complies with A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval of this report.



ARIZONA DEPARTMENT OF HEALTH SERVICES

POLICY & INTERGOVERNMENTAL AFFAIRS

July 27, 2018

Nicole O. Colyer, Esq., Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: Report for A.A.C. Title 9, Chapter 10, Article 8 Assisted Living Facilities

Dear Ms. Colyer:

According to the five-year-review report schedule of the Governor's Regulatory Review Council (Council), a report for A.A.C. Title 9, Chapter 10, Article 8 is due to the Council no later than July 31, 2018. The Arizona Department of Health Services (Department) has reviewed 9 A.A.C. 10, Article 8 and is enclosing a report to the Council for this rule.

The Department believes that this report complies with the requirements of A.R.S. § 41-1056. The report contains a summary of the Department's review for all the rules and is in the format of the Council's report template. Included in the package are the rules reviewed, the general and specific authority, and written criticisms. As described in the report, the Department plans to amend the rules in 9 A.A.C. 10, Article 8 in an expedited rulemaking and as applicable, the Department plans to address some rule changes through a regular rulemaking for 9 A.A.C. 10 to comply with Laws 2017, Ch. 122.

The Department certifies that it is in compliance with A.R.S. § 41-1091.

If you need any further information, please contact me at (602) 542-1020.

Sincerely,

A blue ink signature of Robert Lane, Director's Designee.

Robert Lane
Director's Designee

RL:tk
Enclosures

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

Arizona Department of Health Services

Five-Year-Review Report

Title 9. Health Services

Chapter 10. Department of Health Services

Health Care Institutions: Licensing

Article 8. Assisted Living Facilities

July 2018

1. Authorization of the rule by existing statutes

Authorizing statutes: A.R.S. §§ 36-132(A)(1) and (A)(17) and 36-136(G)

Implementing statutes: A.R.S. §§ 36-405 and 36-406

2. The objective of each rule:

Rule	Objective
R9-10-801	The objective of the rule is to define terms used in the Article to enable readers to better understand the requirements and to allow for consistent interpretation of the terms.
R9-10-802	The objective of the rule is to provide additional application requirements specific to an assisted living facility.
R9-10-803	The objective of the rule is to establish minimum requirements for an assisted living facility's governing authority and administrator, including specific administrative policies and procedures to protect the health and safety of a resident.
R9-10-804	The objective of the rule is to establish minimum requirements for an assisted living facility's quality management program.
R9-10-805	The objective of the rule is to establish minimum requirements for a person who contracts with the licensee to provide assisted living facility services.
R9-10-806	The objective of the rule is to establish minimum requirements for an assisted living facility personnel and personnel records.
R9-10-807	The objective of the rule is to establish minimum requirements for residency and residency agreements.
R9-10-808	The objective of the rule is to establish requirements for residence service plans.
R9-10-809	The objective of the rule is to establish minimum requirements for the transport and transfer of a resident to ensure that the resident's health and safety are not compromised as a result of the resident's transport or transfer.

R9-10-810	The objective of the rule is to establish minimum requirements for resident rights.
R9-10-811	The objective of the rule is to establish minimum requirements for resident's medical records.
R9-10-812	The objective of the rule is to establish minimum requirements for behavioral care provided in an assisted living facility.
R9-10-813	The objective of the rule is to establish minimum requirements for behavioral health services provided in an assisted living facility.
R9-10-814	The objective of the rule is to establish minimum requirements for personal care services provided in an assisted living facility.
R9-10-815	The objective of the rule is to establish minimum requirements for directed care services provided in an assisted living facility.
R9-10-816	The objective of the rule is to establish minimum requirements for medication services provided in an assisted living facility.
R9-10-817	The objective of the rule is to establish minimum standards for food services.
R9-10-818	The objective of the rule is to establish a minimum emergency and safety standards to ensure that an assisted living facility is prepared for an emergency, including how to respond to a resident who has an accident, emergency, or injury that requires the resident receive medical services.
R9-10-819	The objective of the rule is to establish minimum environmental standards.
R9-10-820	The objective of the rule is to establish minimum physical plant standards.

3. Are the rules effective in achieving their objectives?

Yes ✓

No

If not, please identify the rule(s) that is not effective and provide an explanation for why the rule(s) is not effective.

Rule	Explanation
Article 8	The rules in Article 8 would be more effective if the rules in paragraphs 4 and 6 were changed to resolve the matters as mentioned.
R9-10-803	The rule would be more effective if in subsection (C) a policy and procedure were required to cover a method by which an assisted living facility manager may be aware of the whereabouts of a resident, including whether a resident is physically on the premises.
R9-10-806	The rule would be more effective if in subsection (A) an assisted living facility manager were required to have a policy and procedure that covers having other personnel as backup when a caregiver or manager is ill or otherwise not available.

4. Are the rules consistent with other rules and statutes?Yes No

If not, please identify the rule(s) that is not consistent. Also, provide an explanation and identify the provisions that are not consistent with the rule.

Rule	Explanation
R9-10-802	The rules are mostly consistent with other rules and statutes, except for Laws 2017, Ch.122 that amended A.R.S. § 36-405 and changed the types of licensure (application) for health care institutions. The amended statutes no longer specify “initial” and “renewal” licensure. The rules would be more consistent with statutes if the words “initial” and “renewal” were deleted from R9-10-802 and R9-10-818, respectively.
R9-10-818(E)(3)	

5. Are the rules enforced as written?Yes No

If not, please identify the rule(s) that is not enforced as written and provide an explanation of the issues with enforcement.

In addition, include the agency’s proposal for resolving the issue.

Rule	Explanation

6. Are the rules clear, concise, and understandable?Yes No

If not, please identify the rule(s) that is not clear, concise, or understandable and provide an explanation as to how the agency plans to amend the rule(s) to improve clarity, conciseness, and understandability.

Rule	Explanation
R9-10-801	The rule would be clearer if subsection (3) were revised to clarify that “assisted living services” includes “behavioral health care” rather than “behavioral health services” and if required “behavioral health services” are provided “only if authorized.”
R9-10-802	The rule would be clearer if the reference to “respite care services” in R9-10-801(1)(b) were also clarified in R9-10-802(2). “Respite care services” would be added in R9-10-802 as new subsection (2)(c).
R9-10-803	The rule would be clearer if R9-10-803(C)(1)(j)(ii), “making vaccination for influenza available to residents according to A.R.S. 36-406((1)(d),” were consistent with R9-10-811(C)(17), “Documentation of notification of the resident of the availability of vaccination for influenza and pneumonia, according to A.R.S. 36-406((1)(d).”
R9-10-803(D)(3)(c) R9-10-807(H)	The rules would be clearer if the title of the “State Long-Term Care Ombudsman” were amended to “Long Term Care Ombudsman” to make the rules consistent with the Long Term Care Ombudsman program provided by the Department of Economic Security.

R9-10-806	The rule would be clearer if the reference to “Board of Examiners,” identified in subsection (A)(1)(b)(iv)(1), was changed to reference “Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers.”
R9-10-806	The rule would be clearer if a requirement for a daily staffing schedule were added, and the effectiveness of the rule would also increase by allowing managers to determine whether there are adequate personnel to meet the needs of the residents and to ensure their health and safety according to R9-10-806(A)(5)(b) and (c).
R9-10-807	The rule would be clearer if the requirement for “assisted living services” in subsections R9-10-807(C)(2) and (C)(3) were updated to remove “assisted living.” This change is consistent with Laws 2011, Ch. 96.
R9-10-807	The rule would be clearer if the rule clarified that a licensed assisted living facility does not accept individuals who do not have difficulty with daily living activities, also known as “independent living.” Independent living centers provide for individuals who still live independently yet have access to services such as housekeeping, meals, and laundry. The clarification will improve the rule and could be added as new R9-10-807(K) stating “A licensed assisted living facility shall not accept individuals who do not require assisted living services, adult day health care services, or respite care service.”
R9-10-808	The rule could be clearer if in R9-10-808(E)(4) antiquated language “daily newspapers, current magazines, and a variety of reading materials” were changed to “multiple media sources are provided to residents to maintain a resident’s continued awareness of current news, social events, and other noteworthy information.”
R9-10-810	The rule would be clearer if the word “admission” in subsection (A) and the word “admitted” in subsection (B)(3)(b) were changed to be consistent with definition R9-10-801(1).
R9-10-811	The rule would be clearer if the rule in R9-10-811 clarified that “a resident’s primary diagnosis by the resident’s primary care provider is a physical health diagnosis,” since an assisted living facility may not accept a resident whose primary diagnosis is a behavioral health diagnosis.
R9-10-814 R9-10-815	The rule would be clearer if the rule in R9-10-814(F)(4) were changed to include an additional subsection level to reference (B)(2)(b) as (B)(2)(b)(iii). Likewise R9-10-815(C)(2) would be clearer if the rule were changed to include an additional subsection to reference (B)(2)(b) as (B)(2)(b)(iii).
R9-10-815(F)(2)(c)	The rule would be clearer if the language “Special Egress-Control Devices provisions in the Uniform Building Code incorporated by reference” was changed to remove “in

	Uniform Building Code" and state the specific subsection in R9-1-412 that contains the requirements for special egress-control devices.
R9-10-817	The rule would be clearer if the reference to the webpage for dietary guidelines in R9-10-817(A)(5)(a) were updated to http://www.health.gov/dietaryguidelines .
R9-10-820	The rule would be clearer if the terms used to define the types of accommodations provided to a resident were revised or added, and if the terms identified the areas or spaces within each type and clarified how the area/space is used, such as living, sleeping, bathroom, or kitchen. The terms "resident rooms," "resident beds," and "residential units" are defined or used in A.R.S. § 36-401. In the rules "bedrooms," "beds," "sleeping space," "resident's bedroom," "residential unit," "rooms," "sleeping area," "living space," and "kitchen area" are used, but not defined. Clarifying these terms will eliminate confusion when the rules are compared to related definition in A.R.S. § 36-401. Additionally, the confusion among licensees, architects, and inspectors, who are having difficulties agreeing on the types of accommodations and what space or areas each may include, would be significantly reduced. These changes would decrease burdens for all affected persons. Lastly, subsection (A) could be clearer if the incorporation by reference clarified that the International Building Code (IBC) required for an assisted living facility providing personal care service (IBC 308.3) and differs from that required for an assisted living facility providing directed care services (IBC 308.4).

7. Has the agency received written criticisms of the rules within the last five years? Yes ✓ No
If yes, please fill out the table below:

Commenter 1:	Gaile Perry Dixon, Owner-Manager, Dream Catcher Assisted Living Home
Comment:	<p>The commenter expressed concern that:</p> <ol style="list-style-type: none"> There is no provision in the rules for a family to leave a facility if the needs for the resident are not met. Commenter stated the rules require a facility to make policies and procedures for termination of residency and appears standard policy for residency termination is to give a 30-day notice. Commenter clarified that a family must wait 30 days while the services they pay for are not being provided. Commenter requested that a 14-day notice be reinstated for failure of the facility to provide service. They did not see termination protocol for dealing with abuse, neglect, or exploitation. The commenter stated that the pre-2014 rules allowed for immediate termination of the residency agreement, if the abuse, neglect or exploitation is substantiated. And thinks that such a protocol protects resident's safety and prevents unexpected burden for not having to, at the same time, pay for 30 days of service to the contracted facility and 30 days of service to the new facility.

Agency Response:	<p>The Department has reviewed the commenter's concerns and provides the following:</p> <ol style="list-style-type: none"> 1. In R9-10-807, Residency and Residency Agreements, subsection (D) provides a requirement that "Before or at the time of an individual's acceptance by an assisted living facility, a manager shall ensure that there is a documented residency agreement with the assisted living facility that includes:" and in subsection (D)(7), requires "a policy and procedure for a resident to terminate residency, including terminating residency because services were not provided to the resident according to the resident's service plan." The Department has determined to review the rules in R9-10-807 and R9-10-803 to ensure that the rules clearly address policies and procedures for resident agreements and may add or amend the rules to clarify how a resident, whose physical and behavioral health needs are not being met, may terminate a residency agreement and may clarify an assisted living facility's obligation to return fees to a resident for physical and behavioral health care services not received. 2. The Department did remove the rule that a resident may terminate residency for neglect, abuse, or exploitation if substantiated because the Department determined that the rule does not protect a resident's health and safety. The Department believes that the requirement in R9-10-803 (J) regarding neglect, abuse, and exploitation better protects a resident's health and safety. The rules in R9-10-803(J) requires a manager with a reasonable basis to believe abuse, neglect, or exploitation to take immediate action to stop the suspected abuse, neglect, and exploitation and to immediately report the suspected abuse, neglect, and exploitation to a peace officer or to a protective services worker, according to A.R.S. § 46-454. Additionally, the manager is required to document the suspected abuse, neglect, and exploitation, as well as investigate and document actions taken to prevent the abuse, neglect, and exploitation from occurring in the future. <p>The Department believes that the new Article 8 rules are more effective, clearer, concise, and understandable than the pre-2014 rules. In the previous five years, the Department has not received any complaints from residents, residents' agents, or members of the public.</p>
Commenter 2:	Bill Kuhaneck, RN, Hope Springs Memory Care, LLC
Comment:	The commenter recommends that "Licensed nurses, EMT's, and trained healthcare professionals, should be exempt from the rule of first aid card requirement, as this is already part of their daily services, their initial licensure and their recertification. This is already part of the training curriculum for these credentials, and is not currently a state requirement for those that have undergone the training in these areas for licensure."
Agency Response:	The Department has review the rule in R9-10-806(A)(9) that requires "...a manager or caregiver provides current documentation of first aid training and cardiopulmonary resuscitation training certification specific to adults." The Department agrees that the rule could be clearer. The Department will consider how the rule may be changed to make it clearer that a licensed health professional performing duties as a caregiver are exempt from first aid training requirement.

8. Economic, small business, and consumer impact comparison:

The rules in 9 A.A.C. 10, Article 8 were made new in 2013 as part of an exempt rulemaking of 9 A.A.C. 10 and 9 A.A.C. 20 to comply with Laws 2011, Ch. 96 that required the Department to adopt rules for health care institutions to reduce monetary or regulatory costs on person or individuals and facilitate licensing of "integrated health programs that provide both behavioral and physical health services." In 2014, the rules in Article 8 were further revised to comply with Laws 2013, Ch. 10 that extended Laws 2011, Ch. 96 exempt rulemaking time period until April 30, 2014. A.R.S. § 36-401(8) defines "assisted living facility" as a residential care institution, including an adult foster care home, that provides or contracts to provide supervisory care services, personal care services or directed care services on a continuous basis. The Department currently licenses and regulates adult foster care homes according to the assisted living facility rules. No economic, small business and consumer impact statements were prepared as a part of the exempt rulemakings. The Department believes persons who are directly affected by, bear the costs of, or directly benefit from the rules are: the Department, assisted living facilities, residents and their families, and the general public. Annual costs and revenues are designated as minimal when more than \$0 and less than \$5,000, moderate when \$5,000 and less than \$20,000, and substantial when \$20,000 or greater. A cost or benefit is designated as significant when meaningful or important but not readily subject to quantification.

As of July 1, 2018, the Department reported that 2,097 licensed assisted living facilities were operating in the state. In calendar year 2017, 294 assisted living facilities elected to close, 176 initial applications and 1,861 renewal applications were approved, two initial applications were denied, and 46 licenses were amended. The Department completed 1,626 compliance surveys and 621 complaint investigations surveys. The Department also completed 1,546 enforcement actions and as a result of the enforcement actions, the Department assessed \$653,455 for civil money penalties.

In the 2013 exempt rulemaking, the new Article 8, Assisted Living Facilities, consists of 20 Sections and were previously located in Chapter 10, Article 7. The old Article 7, Assisted Living Facilities, contained 22 Sections that were consolidated into 15 Sections in new Article 8 and five new Sections were added. The new Sections added to Article 8 include quality management, contracted services, transport/transfer, behavioral care, and behavioral health services. All of the Sections in Article 8, except the five new Sections, were simplified and minor language changes were made to make the rules clearer. In addition, citations were updated and references were corrected. The old R9-10-701, Definitions, contained 110 definitions. One hundred definitions were deleted as no longer needed, already defined in A.R.S. § 36-401, or moved to A.A.C. R9-10-101. Definitions in new R9-10-801 consist of three new definitions (assistant caregiver, assisted living services, and behavioral care) and ten definitions from old R9-10-701. The Department believes the reference to other definitions added to new R9-10-801 and adding or keeping only the definitions related to the Article improves the effectiveness and understandability of the rules. The Department believes new R9-10-801 provides a significant benefit to the Department, assisted living facilities, and residents and their families by eliminating confusion, providing more

effective rules, and increasing consistency for all Articles in 9 A.A.C. 10.

Parts of old R9-10-702 related to sub-classify according to size, requesting a change the level of service, and time-frames were moved to Chapter 10, Article 1. Other requirements in old R9-10-702 related to physical plant and emergency and safety standards were moved to new R9-10-814, R9-10-818, and R9-10-820. The remaining requirements in R9-10-702 related to types of services were move to new R9-10-802 and new R9-10-802 added a list of other services an assisted living facility may request and provide. Most of the requirements in old R9-10-703, Administration, were moved to new R9-10-803. The requirement for notifying the Department of a change of ownership, facility name, resident records, and termination of operations were move to Chapter 10, Article 1; and for keeping pets and reporting an accident, incident, or injury were moved to new R9-10-819 and R9-10-803, respectively. The new R9-10-803 added requirements to adopt a quality management program and for an assisted living facility to post a copy of the Department inspection report and any plan of correction. Additionally, the requirements in old R9-10-704 for abuse, neglect, and exploitation were simplified and moved to new R9-10-803 and the requirements in R9-10-705 for limitation on resident's level of services were clarified and moved to new R9-10-807. The Department believes that consolidating the rules, adding an additional requirement for a quality management program, and clarifying resident's level of services would most likely not increase costs, and rather, provide increased benefits to affected parties. The five new Sections added to Article 8 include R9-10-804, Quality Management; R9-10-805, Contracted Services; R9-10-809, Transport/Transfer; R9-10-812, Behavioral Care; and R9-10-813, Behavioral Health Services. In the new rules, the Department provides minimum requirements and standards to protect the public health and safety of Arizona citizens and the objective of each new rule is listed in paragraph 2. Additionally, the new rules added are consistent with other Chapter 10 Articles. The Department believes that residents may experience a significant benefit for being able to stay at an assisted living facility longer as the resident's health needs change and assisted living facilities may also experience a significant benefit resulting from increased revenues. The Department believes assisted living facilities will experience additional benefits for having requirements that provide clarification for the differences between transfer and transport and how to correctly document a resident's medical record.

The new R9-10-806, Personnel, rule includes previous R9-10-706 and parts of R9-10-708. The rule was changed to clarify what information in a personnel record is required and added how long the personnel records are to be maintained. The tuberculosis, fingerprinting, first aid training, and cardiopulmonary resuscitation training requirements were updated, as were the requirements related to personnel qualifications, skills, and knowledge, instead of just requiring "sufficient personnel." Also, in addition to assisted living services provided by caregivers and assistant caregiver, behavioral health services and behavioral care services were added. Old R9-10-707 was clarified is now in new R9-10-803 as policies and procedures established, documented, and implemented by an assisted living facility manager. Rules in new R9-10-807, previous R9-10-709, requirements specific to Arizona Long Term Care System and Life Care Contract were deleted and behavioral health services

were added. The rule was also reorganized, updated citations and reference, and simplified to make the rule clear, concise, and understandable. The following old rules moved to new Article 8 were simplified; antiquated terms removed, outdated citations and references updated, and other changes were made as indicated:

<u>Old Rules</u>	<u>New Rules</u>	<u>Changes</u>
R9-10-711, R9-10-712	R9-10-808 Service Plan	New requirements for behavioral care and respite service were added.
R9-10-710	R9-10-810 Resident Rights	A requirement specific to the type of behaviors a resident should not be subjected too was changed to include coercion, manipulation, and sexual abuse and assault; requirements for consent to be photographed and a resident's right to receive a referral to another health care institution were added.
R9-10-714	R9-10-811 Medical Records	A requirement for resident's social security number was deleted and a requirement for safeguards to prevent unauthorized access to a resident's electronic medical record was added. Also, added were requirements to include in a resident's medical record documentation of a resident's refusal of a medication and a determination that a resident requires behavioral care or behavioral health services.
R9-10-722	R9-10-814 Personal Care Services	R9-10-722 requirements for how treatment for a resident receiving personal care services should be administered were not moved to R9-10-814. Rather information regarding "verbal orders" was added to R9-10-811, Medical Records.
R9-10-723	R9-10-815 Directed Care Services	A requirement for a manager to provide a resident access to an outside area and controls or alerts employees of the egress of a resident from the facility was added.
R9-10-713	R9-10-816 Medication Services	A requirement for a drug reference guide was deleted and a requirement for reporting a medication error was added. A requirement for a separate medical record was moved to R9-10-811.
R9-10-715	R9-10-817 Food Services	A requirement for a licensee to ensure three meals a day are served was deleted. A requirement for a resident who requires assistance to eat be provided assistance was added. And a requirement for an assisted living facility obtain a license as a food establishment under 9 A.A.C. 8, Article 1 was added.

R9-10-717	R9-10-818 Emergency and Safety Standards	A requirement from R9-10-718 for a first-aid kit was added. A fire alarm system requirement and a fire extinguisher and smoke detector requirement were added for an assisted living center and an assisted living home, respectively.
R9-10-718	R9-10-819 Environmental Standards	Requirements from R9-10-703 for pets and animals and swimming pools were updated to current standards and added.
R9-10-716	R9-10-820 Physical Plant Standards	In addition to R9-10-716 rules, resident sleeping area requirements from R9-10-720 were added. Also, a standard for number of toilet, sink, and bathtub or shower for every eight residents was added.

The Department believes that consolidating the rules should not result in increased costs, and rather, provide increased benefits to affected parties.

In the 2014 exempt rulemaking, all of the Sections were changed to increase clarity and consistency of the rules with other Articles in Chapter 10. Additionally, changes were made to add, update, or correct references and citations. Technical changes were also made to increase effectiveness and understandability of the rules. In R9-10-801 two definitions (behavioral care and resident's representative) were moved to Chapter 10, Article 1. In R9-10-802, clarification was added for a supplemental application to be in a Department-provided format. In R9-10-803, a requirement was added to review and evaluate the quality management program and requirements for additional policies and procedures were added for covering patient safety reporting and non-retaliation and for covering how a caregiver will respond to a resident's sudden, intense, or out-of-control behavior. A requirement to obtain documentation of fingerprint clearance was deleted, as was a requirement to submit an investigation report to the Department within 10 working days after submitting the report according to A.R.S. § 46-454. Rules regarding home health agency or hospice service agency in R9-10-815 were moved to R9-10-803 and a new requirement for a manager of an assisted living home to establish policies and procedures for a caregiver to obtain and provide documentation of cardiopulmonary resuscitation training. Changes to R9-10-806 include adding a requirement that a manager or caregiver is present and awake, when a resident is present in the assisted living home, and clarifies what is required during nighttime hours.

A requirement to have a resident or representative's signature on a documented residency agreement was added in R9-10-807. In R9-10-808, a requirement for a medical practitioner to provide a determination that a resident is exempt from an evacuation drill based on harm to the resident; and an exception to R9-10-807(A) for a resident staying for no more than seven calendar days were added. Additionally, exceptions in R9-10-809 were added for when transport and transfer requirements do not apply. A medical records requirement in R9-10-811 was changed to clarify a resident's representative information and a requirement for including documentation of

an action taken to control a resident's behavior. A requirement in R9-10-814 for a written medication order for a resident allowed to receive assistance in the self-administration of medication was deleted, since written orders are required to be contained in the resident's medical record. In R9-10-815, a rule was added to require documenting a patient's weight. In R9-10-804, R9-10-805, R9-10-810, R9-10-812, R9-10-813, R9-10-816, R9-10-817, R9-10-818, R9-10-819, and R9-10-820 changes were made to update outdated citations and references, correct typographical errors, remove antiquated terms, and clarify and consolidate requirements to increase effectiveness of the rules.

Overall, the Department believes that the changes made to the rules may have created a minimal increase in costs, but believes that the benefit for having more effective and understandable rules outweighs any costs incurred. Through the exempt rulemakings, the Department reduced monetary or regulatory cost on persons or individuals and simplified licensing of integrated health programs that provide both behavioral and physical health services. The Department believes that the benefits of the rules for all affected persons are far greater than the costs incurred.

9. Has the agency received any business competitiveness analyses of the rules? Yes No ✓

10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?

Please state what the previous course of action was and if the agency did not complete the action, please explain why not.

This is the first five-year-review of the new rules adopted by exempt rulemaking in 2013 and amended in 2014.

11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:

The Department has determined that the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

12. Are the rules more stringent than corresponding federal laws? Yes No ✓

Please provide a citation for the federal law(s). And if the rule(s) is more stringent, is there statutory authority to exceed the requirements of federal law(s)?

The rules are not related to federal laws.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

A general permit is not applicable. The rules require the issuance of a specific agency authorization, which is authorized

by A.R.S. § 36-405.

14. Proposed course of action

If possible, please identify a month and year by which the agency plans to complete the course of action.

The Department plans to amend the rules in 9 A.A.C. 10, Article 8 to address the matters identified in this five-year-review report in a regular rulemaking for 9 A.A.C. 10 necessary to comply with Laws 2017, Ch. 122. The Department plans to submit a Notice of Final Rulemaking to the Council by July 2019.

9 A.C. 10, ART 8 - ATTACHMENT C

WRITTEN CRITICISM

#1.

Teresa Koehler

From: Robert Lane
Sent: Monday, June 4, 2018 9:03 AM
To: Teresa Koehler
Subject: FW: Rules Revisions

Please see the below comment, which I believe relates to a 5 Year Review you are working on. Thanks.

Rob

From: Harmony Duport
Sent: Monday, June 4, 2018 8:05 AM
To: Robert Lane; Ruthann Smejkal; Kathryn McCanna
Subject: Fwd: Rules Revisions

Hi,

Please see the written comment/criticism below that I received about Article 8 in anticipation of the SYRR.

Thank you,
Harmony Duport, R.S.
Bureau Chief, Residential Facilities Licensing
Arizona Department of Health Services
150 North 18th Avenue, Suite 420, Phoenix, AZ 85007
Direct 602-364-2632
Email harmony.duport@azdhs.gov
Health and Wellness for all Arizonans

Begin forwarded message:

From: Gaile Dixon <gailep@cox.net>
Date: June 1, 2018 at 4:24:31 PM MST
To: 'Harmony Duport' <Harmony.Duport@azdhs.gov>
Subject: Rules Revisions

Dear Harmony,

I understand there may be an opportunity to request modifications in Article 8 to better protect residents and families.

There is no provision in the rules for a family to leave a facility if the needs of the resident are not being met. It is currently up to the facility to make policies and procedures for termination of residency. If the policy is simply to give 30-day notice, which appears to be the default notice, a family must wait 30 days while the services they pay for are not being provided.

I would suggest a 14-day notice be reinstated for failure of the facility to provide services: "*The resident or representative may terminate this agreement with a 14-day written notice to the licensee for documented failure to comply with the resident's service plan or residency agreement.*"

I also did not see termination protocol for dealing with abuse, neglect, or exploitation. The pre-2014 rules allowed for immediate termination of the residency agreement, if the abuse, neglect or

exploitation is substantiated. I think this is good protocol to protect the resident from having to stay in a facility or pay the facility if the facility is suspected of abusing, neglecting or exploiting the resident. Many families cannot afford to pay 30 days, and then pay another 30 days for a new facility. Further, the resident could well be fearful of remaining in a facility and risk retribution for thinking he/she was abused. I think the pre-2014 rules covered these situations better than the new Article 8 rules.

If there is an opportunity to review the 2014 rules, I would appreciate these considerations be made.

Respectfully,

Gaile Perry Dixon
Owner, Manager
Dream Catcher Assisted Living Home

From: Harmony Duport
Sent: Friday, June 29, 2018 7:38 AM
To: Teresa Koehler
Cc: Kathryn McCanna
Subject: Fwd: Provider proposing change to Article 8?

Hi Teresa,

Please see the email below in red from one of our providers. This includes comments about the First Aid training requirement for personnel that work in AL facilities.

Thank you,

Harmony Duport, R.S.

Bureau Chief, Residential Facilities Licensing
Arizona Department of Health Services
150 North 18th Avenue, Suite 420, Phoenix, AZ 85007
Direct 602-364-2632
Email harmony.duport@azdhs.gov
Health and Wellness for all Arizonans

Begin forwarded message:

From: Bob Ohlfest <Bob.Ohlfest@azdhs.gov>
Date: June 29, 2018 at 7:26:51 AM MST
To: Harmony Duport <Harmony.Duport@azdhs.gov>, Jewela West <Jewela.West@azdhs.gov>
Cc: Seth Mackey <Seth.Mackey@azdhs.gov>
Subject: FW: Provider proposing change to Article 8?

In the past, we gave credit for RN's to be exempt from the First Aid requirement. However, it is not clear in the rule so I believe the suggestion is a legitimate one. Thanks.

From: Seth Mackey
Sent: Thursday, June 28, 2018 4:34 PM
To: Bob Ohlfest
Subject: RE: Provider proposing change to Article 8?

Hi Bob,

This is what they sent me:

Hello Seth,
Thank- you for all of your assistance in this process, it is greatly appreciated. As far as the input we had discussed for the upcoming changes, here are some suggestions I would recommend. Licensed nurses, EMT's, and trained healthcare professionals, should be exempt from the rule of first aid card requirement, as this is already part of their daily services, their initial licensure and their recertification. This is already part of the training curriculum for these credentials, and is not currently a state requirement for those that have undergone the training in these areas for licensure.

Thank-you again for all you have done, and I appreciate the opportunity to help improve systems in the future.

Bill Kuhaneck, RN
Hope Springs Memory Care, LLC

From: Bob Ohlfest
Sent: Tuesday, June 19, 2018 1:15 PM
To: Seth Mackey
Subject: RE: Provider proposing change to Article 8?

Have him send an e mail to us and we will forward his recommendations to Harmony for the next rule review go-round.

From: Seth Mackey
Sent: Tuesday, June 19, 2018 12:24 PM
To: Bob Ohlfest
Subject: Provider proposing change to Article 8?

Hi Bob,

I have a provider (the RN who does not think first aid requirements are meaningful) who would like to provide input regarding changes to article 8 he would like to see considered. I told him I did not know the submission process but I would find out.

Do you know who he would contact?

Thanks,

Seth Mackey
Bureau of Residential Facilities Licensing
Arizona Department of Health Services
400 W. Congress St., Suite 116,
Tucson, Arizona 85701
Direct: 520-628-6739
Fax: 520-628-6991
Email Seth.Mackey@azdhs.gov
Health and Wellness for all Arizonans

ARTICLE 8. ASSISTED LIVING FACILITIES

Article 8 (Sections R9-10-801 through R9-10-812) adopted as permanent rules effective October 30, 1989.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective July 31, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective April 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

New Article 8, consisting of Sections R9-10-801 through R9-10-812, adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Former Article 8, consisting of Sections R9-10-801 through R9-10-867, repealed effective October 20, 1982.

Section

- R9-10-801. Definitions
- R9-10-802. Supplemental Application Requirements
- R9-10-803. Administration
- R9-10-804. Quality Management
- R9-10-805. Contracted Services
- R9-10-806. Personnel
- R9-10-807. Residency and Residency Agreements
- R9-10-808. Service Plans
- R9-10-809. Transport; Transfer
- R9-10-810. Resident Rights
- R9-10-811. Medical Records
- R9-10-812. Behavioral Care
- R9-10-813. Behavioral Health Services
- R9-10-814. Personal Care Services
- R9-10-815. Directed Care Services
- R9-10-816. Medication Services
- R9-10-817. Food Services
- R9-10-818. Emergency and Safety Standards

R9-10-819. Environmental Standards

R9-10-820. Physical Plant Standards

ARTICLE 8. ASSISTED LIVING FACILITIES

R9-10-801. Definitions

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following definitions apply in this Article, unless the context otherwise requires:

1. “Accept” or “acceptance” means:
 - a. An individual begins living in and receiving assisted living services from an assisted living facility; or
 - b. An individual begins receiving adult day health care services or respite care services from an assisted living facility.
2. “Assistant caregiver” means an employee or volunteer who helps a manager or caregiver provide supervisory care services, personal care services, or directed care services to a resident, and does not include a family member of the resident.
3. “Assisted living services” means supervisory care services, personal care services, directed care services, behavioral health services, or ancillary services provided to a resident by or on behalf of an assisted living facility.
4. “Caregiver” means an individual who provides supervisory care services, personal care services, or directed care services to a resident, and does not include a family member of the resident.
5. “Manager” means an individual designated by a governing authority to act on behalf of the governing authority in the onsite management of the assisted living facility.
6. “Medication organizer” means a container that is designed to hold doses of medication and is divided according to date or time increments.
7. “Primary care provider” means a physician, a physician’s assistant, or registered nurse practitioner who directs a resident’s medical services.
8. “Residency agreement” means a document signed by a resident or the resident’s representative and a manager, detailing the terms of residency.
9. “Service plan” means a written description of a resident’s need for supervisory care services, personal care services, directed care services, ancillary services, or behavioral health services and the specific assisted living services to be provided to the resident.
10. “Termination of residency” or “terminate residency” means a resident is no longer living

in and receiving assisted living services from an assisted living facility.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-802. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for an initial license as an assisted living facility shall include in a Department-provided format:

1. Which of the following levels of assisted living services the applicant is requesting authorization to provide:
 - a. Supervisory care services,
 - b. Personal care services, or
 - c. Directed care services; and
2. Whether the applicant is requesting authorization to provide:
 - a. Adult day health care services, or
 - b. Behavioral health services other than behavioral care.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-803. Administration

A. A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and

- administration of an assisted living facility;
2. Establish, in writing, an assisted living facility's scope of services;
 3. Designate, in writing, a manager who:
 - a. Is 21 years of age or older; and
 - b. Except for the manager of an adult foster care home, has either a:
 - i. Certificate as an assisted living facility manager issued under A.R.S. § 36-446.04(C), or
 - ii. A temporary certificate as an assisted living facility manager issued under A.R.S. § 36-446.06;
 4. Adopt a quality management program that complies with R9-10-804;
 5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
 6. Designate, in writing, an acting manager who has the qualifications established in subsection (A)(3), if the manager is:
 - a. Expected not to be present on the assisted living facility's premises for more than 30 calendar days, or
 - b. Not present on the assisted living facility's premises for more than 30 calendar days;
 7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the manager and identify the name and qualifications of the new manager;
 8. Ensure that a manager or caregiver who is able to read, write, understand, and communicate in English is on an assisted living facility's premises; and
 9. Ensure compliance with A.R.S. § 36-411.

B. A manager:

1. Is directly accountable to the governing authority of an assisted living facility for the daily operation of the assisted living facility and all services provided by or at the assisted living facility;
2. Has the authority and responsibility to manage the assisted living facility; and
3. Except as provided in subsection (A)(6), designates, in writing, a caregiver who is:
 - a. At least 21 years of age, and
 - b. Present on the assisted living facility's premises and accountable for the assisted living facility when the manager is not present on the assisted living facility premises.

C. A manager shall ensure that policies and procedures are:

1. Established, documented, and implemented to protect the health and safety of a resident that:
 - a. Cover job descriptions, duties, and qualifications, including required skills and knowledge, education, and experience for employees and volunteers;
 - b. Cover orientation and in-service education for employees and volunteers;
 - c. Include how an employee may submit a complaint related to resident care;
 - d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Except as provided in subsection (M), cover cardiopulmonary resuscitation training for applicable employees and volunteers, including:
 - i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the employee's or volunteer's ability to perform cardiopulmonary resuscitation;
 - ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
 - iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
 - iv. The documentation that verifies that the employee or volunteer has received cardiopulmonary resuscitation training;
 - f. Cover first aid training;
 - g. Cover how a caregiver will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
 - h. Cover staffing and recordkeeping;
 - i. Cover resident acceptance, resident rights, and termination of residency;
 - j. Cover the provision of assisted living services, including:
 - i. Coordinating the provision of assisted living services,
 - ii. Making vaccination for influenza available to residents according to A.R.S. § 36-406(1)(d), and
 - iii. Obtaining resident preferences for food and the provision of assisted living services;
 - k. Cover the provision of respite services or adult day health services, if applicable;
 - l. Cover resident medical records, including electronic medical records;
 - m. Cover personal funds accounts, if applicable;
 - n. Cover specific steps for:

- i. A resident to file a complaint, and
 - ii. The assisted living facility to respond to a resident's complaint;
 - o. Cover health care directives;
 - p. Cover assistance in the self-administration of medication, and medication administration;
 - q. Cover food services;
 - r. Cover contracted services;
 - s. Cover equipment inspection and maintenance, if applicable;
 - t. Cover infection control; and
 - u. Cover a quality management program, including incident report and supporting documentation;
2. Available to employees and volunteers of the assisted living facility; and
 3. Reviewed at least once every three years and updated as needed.
- D.** A manager shall ensure that the following are conspicuously posted:
1. A list of resident rights;
 2. The assisted living facility's license;
 3. Current phone numbers of:
 - a. The unit in the Department responsible for licensing and monitoring the assisted living facility,
 - b. Adult Protective Services in the Department of Economic Security,
 - c. The State Long-Term Care Ombudsman, and
 - d. The Arizona Center for Disability Law; and
 4. The location at which a copy of the most recent Department inspection report and any plan of correction resulting from the Department inspection may be viewed.
- E.** A manager shall ensure that, unless otherwise stated:
1. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 2. When documentation or information is required by this Chapter to be submitted on behalf of an assisted living facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the assisted living facility.
- F.** If a requirement in this Article states that a manager shall ensure an action or condition or sign a document:

1. A governing authority or licensee may ensure the action or condition or sign the document and retain the responsibility to ensure compliance with the requirement in this Article;
2. The manager may delegate ensuring the action or condition or signing the document to another individual, but the manager retains the responsibility to ensure compliance with the requirement in the Article; and
3. If the manager delegates ensuring an action or condition or signing a document, the delegation is documented and the documentation includes the name of the individual to whom the action, condition, or signing is delegated and the effective date of the delegation.

G. A manager shall:

1. Not act as a resident's representative and not allow an employee or a family member of an employee to act as a resident's representative for a resident who is not a family member of the employee;
2. If the assisted living facility administers personal funds accounts for residents and is authorized in writing by a resident or the resident's representative to administer a personal funds account for the resident:
 - a. Ensure that the resident's personal funds account does not exceed \$2,000;
 - b. Maintain a separate record for each resident's personal funds account, including receipts and expenditures;
 - c. Maintain the resident's personal funds account separate from any account of the assisted living facility; and
 - d. Provide a copy of the record of the resident's personal funds account to the resident or the resident's representative at least once every three months;
3. Notify the resident's representative, family member, public fiduciary, or trust officer if the manager determines that a resident is incapable of handling financial affairs; and
4. Except when a resident's need for assisted living services changes, as documented in the resident's service plan, ensure that a resident receives at least 30 calendar days written notice before any increase in a fee or charge.

H. A manager shall permit the Department to interview an employee, a volunteer, or a resident as part of a compliance survey or a complaint investigation.

I. If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was accepted or while the resident is not on the premises and not receiving

services from an assisted living facility's manager, caregiver, or assistant caregiver, the manager shall report the alleged or suspected abuse, neglect, or exploitation of the resident according to A.R.S. § 46-454.

- J.** If a manager has a reasonable basis, according to A.R.S. § 46-454, to believe abuse, neglect or exploitation has occurred on the premises or while a resident is receiving services from an assisted living facility's manager, caregiver, or assistant caregiver, the manager shall:
 - 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 - 2. Report the suspected abuse, neglect, or exploitation of the resident according to A.R.S. § 46-454;
 - 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (J)(1); and
 - c. The report in subsection (J)(2);
 - 4. Maintain the documentation in subsection (J)(3) for at least 12 months after the date of the report in subsection(J)(2);
 - 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (J) (2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the manager to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 - 6. Maintain a copy of the documented information required in subsection (J)(5) for at least 12 months after the date the investigation was initiated.
- K.** A manager shall provide written notification to the Department of a resident's:
 - 1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
 - 2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency services provider.
- L.** If a resident is receiving services from a home health agency or hospice service agency, a

manager shall ensure that:

1. The resident's medical record contains:
 - a. The name, address, and contact individual, including contact information, of the home health agency or hospice service agency;
 - b. Any information provided by the home health agency or hospice service agency; and
 - c. A copy of resident follow-up instructions provided to the resident by the home health agency or hospice service agency; and
2. Any care instructions for a resident provided to the assisted living facility by the home health agency or hospice service agency are:
 - a. Within the assisted living facility's scope of services,
 - b. Communicated to a caregiver, and
 - c. Documented in the resident's service plan.

M. A manager of an assisted living home may establish, in policies and procedures, requirements that a caregiver obtains and provides documentation of cardiopulmonary resuscitation training specific to adults, which includes a demonstration of the caregiver's ability to perform cardiopulmonary resuscitation, from one of the following organizations:

1. American Red Cross,
2. American Heart Association, or
3. National Safety Council.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Former Section R9-10-803 renumbered to R9-10-804; new Section R9-10-803 made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-804. Quality Management

A manager shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:

- a. A method to identify, document, and evaluate incidents;
 - b. A method to collect data to evaluate services provided to residents;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident care;
 - d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to resident care; and
 - e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
 - a. An identification of each concern about the delivery of services related to resident care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed; new Section R9-10-804 renumbered from R9-10-803 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-805. Contracted Services

A manager shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days

(Supp. 88-4). Emergency expired. Readopted as an emergency and (A)(1)(a)(i)(1) amended effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-806. Personnel

A. A manager shall ensure that:

1. A caregiver:
 - a. Is 18 years of age or older; and
 - b. Provides documentation of:
 - i. Completion of a caregiver training program approved by the Department or the Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers;
 - ii. For supervisory care services, employment as a manager or caregiver of a supervisory care home before November 1, 1998;
 - iii. For supervisory care services or personal care services, employment as a manager or caregiver of a supportive residential living center before November 1, 1998; or
 - iv. For supervisory care services, personal care services, or directed services, one of the following:
 - (1) A nursing care institution administrator's license issued by the Board of Examiners;
 - (2) A nurse's license issued to the individual under A.R.S. Title 32, Chapter 15;
 - (3) Documentation of employment as a manager or caregiver of an unclassified residential care institution before November 1, 1998; or
 - (4) Documentation of sponsorship of or employment as a caregiver in an adult foster care home before November 1, 1998;
2. An assistant caregiver:
 - a. Is 16 years of age or older, and
 - b. Interacts with residents under the supervision of a manager or caregiver;

3. The qualifications, skills, and knowledge required for a caregiver or assistant caregiver:
 - a. Are based on:
 - i. The type of assisted living services, behavioral health services, or behavioral care expected to be provided by the caregiver or assistant caregiver according to the established job description; and
 - ii. The acuity of the residents receiving assisted living services, behavioral health services, or behavioral care from the caregiver or assistant caregiver according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services, or behavioral care listed in the established job description;
 - ii. The type and duration of education that may allow the caregiver or assistant caregiver to have acquired the specific skills and knowledge for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services, or behavioral care listed in the established job description; and
 - iii. The type and duration of experience that may allow the caregiver or assistant caregiver to have acquired the specific skills and knowledge for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services or behavioral care listed in the established job description;
4. A caregiver's or assistant caregiver's skills and knowledge are verified and documented:
 - a. Before the caregiver or assistant caregiver provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
5. An assisted living facility has a manager, caregivers, and assistant caregivers with the qualifications, experience, skills, and knowledge necessary to:
 - a. Provide the assisted living services, behavioral health services, behavioral care, and ancillary services in the assisted living facility's scope of services;
 - b. Meet the needs of a resident; and
 - c. Ensure the health and safety of a resident;
6. At least one manager or caregiver is present and awake at an assisted living center when a resident is on the premises;
7. A manager, a caregiver, and an assistant caregiver, or an employee or a volunteer who

- has or is expected to have more than eight hours per week of direct interaction with residents, provides evidence of freedom from infectious tuberculosis:
- a. On or before the date the individual begins providing services at or on behalf of the assisted living facility, and
 - b. As specified in R9-10-113;
8. Before providing assisted living services to a resident, a caregiver or an assistant caregiver receives orientation that is specific to the duties to be performed by the caregiver or assistant caregiver; and
 9. Before providing assisted living services to a resident, a manager or caregiver provides current documentation of first aid training and cardiopulmonary resuscitation training certification specific to adults.

B. A manager of an assisted living home shall ensure that:

1. An individual residing in an assisted living home, who is not a resident, a manager, a caregiver, or an assistant caregiver:
 - a. Either:
 - i. Complies with the fingerprinting requirements in A.R.S. § 36-411, or
 - ii. Interacts with residents only under the supervision of an individual who has a valid fingerprint clearance card; and
 - b. If the individual is 12 years of age or older, provides evidence of freedom from infectious tuberculosis as specified in R9-10-113;
2. Documentation of compliance with the requirements in subsection (B)(1)(a) and evidence of freedom from infectious tuberculosis, if required under subsection (B)(1)(b), is maintained for an individual residing in the assisted living home who is not a resident, a manager, a caregiver, or an assistant caregiver; and
3. At least the manager or a caregiver is present at an assisted living home when a resident is present in the assisted living home and:
 - a. Except for nighttime hours, the manager or caregiver is awake; and
 - b. If the manager or caregiver is not awake during nighttime hours:
 - i. The manager or caregiver can hear and respond to a resident needing assistance; and
 - ii. If the assisted living home is authorized to provide directed care services, policies and procedures are developed, documented, and implemented to establish a process for checking on a resident receiving directed care services

during nighttime hours to ensure the resident's health and safety.

C. A manager shall ensure that a personnel record for each employee or volunteer:

1. Includes:
 - a. The individual's name, date of birth, and contact telephone number;
 - b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 - c. Documentation of:
 - i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - ii. The individual's education and experience applicable to the individual's job duties;
 - iii. The individual's completed orientation and in-service education required by policies and procedures;
 - iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or in policies and procedures;
 - v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - vi. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(7);
 - vii. Cardiopulmonary resuscitation training, if required for the individual in this Article or policies and procedures;
 - viii First aid training, if required for the individual in this Article or policies and procedures; and
 - ix. Documentation of compliance with the requirements in A.R.S. § 36-411(A) and (C);
2. Is maintained:
 - a. Throughout the individual's period of providing services in or for the assisted living facility, and
 - b. For at least 24 months after the last date the individual provided services in or for the assisted living facility; and
3. For a manager, a caregiver, or an assistant caregiver who has not provided physical health services or behavioral health services at or for the assisted living facility during the previous 12 months, is provided to the Department within 72 hours after the Department's request.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-807. Residency and Residency Agreements

- A.** Except as provided in R9-10-808(B)(2), a manager shall ensure that a resident provides evidence of freedom from infectious tuberculosis:
 - 1. Before or within seven calendar days after the resident's date of occupancy, and
 - 2. As specified in R9-10-113.
- B.** A manager shall ensure that before or at the time of acceptance of an individual, the individual submits documentation that is dated within 90 calendar days before the individual is accepted by an assisted living facility and:
 - 1. If an individual is requesting or is expected to receive supervisory care services, personal care services, or directed care services:
 - a. Includes whether the individual requires:
 - i. Continuous medical services,
 - ii. Continuous or intermittent nursing services, or
 - iii. Restraints; and
 - b. Is dated and signed by a:
 - i. Physician,
 - ii. Registered nurse practitioner,
 - iii. Registered nurse, or
 - iv. Physician assistant; and
 - 2. If an individual is requesting or is expected to receive behavioral health services, other than behavioral care, in addition to supervisory care services, personal care services, or directed care services from an assisted living facility:
 - a. Includes whether the individual requires continuous behavioral health services, and

- b. Is signed and dated by a behavioral health professional.
- C. A manager shall not accept or retain an individual if:
 - 1. The individual requires continuous:
 - a. Medical services;
 - b. Nursing services, unless the assisted living facility complies with A.R.S. § 36-401(C); or
 - c. Behavioral health services;
 - 2. The assisted living services needed by the individual are not within the assisted living facility's scope of services;
 - 3. The assisted living facility does not have the ability to provide the assisted living services needed by the individual; or
 - 4. The individual requires restraints, including the use of bedrails.
- D. Before or at the time of an individual's acceptance by an assisted living facility, a manager shall ensure that there is a documented residency agreement with the assisted living facility that includes:
 - 1. The individual's name;
 - 2. Terms of occupancy, including:
 - a. Date of occupancy or expected date of occupancy,
 - b. Resident responsibilities, and
 - c. Responsibilities of the assisted living facility;
 - 3. A list of the services to be provided by the assisted living facility to the resident;
 - 4. A list of the services available from the assisted living facility at an additional fee or charge;
 - 5. For an assisted living home, whether the manager or a caregiver is awake during nighttime hours;
 - 6. The policy for refunding fees, charges, or deposits;
 - 7. The policy and procedure for a resident to terminate residency, including terminating residency because services were not provided to the resident according to the resident's service plan;
 - 8. The policy and procedure for an assisted living facility to terminate residency;
 - 9. The complaint process; and
 - 10. The manager's signature and date signed.
- E. Before or within five working days after a resident's acceptance by an assisted living facility,

a manager shall obtain on the documented agreement, required in subsection (D), the signature of one of the following individuals:

1. The resident,
2. The resident's representative,
3. The resident's legal guardian, or
4. Another individual who has been designated by the individual under A.R.S. § 36-3221 to make health care decisions on the individual's behalf.

F. A manager shall:

1. Before or at the time of an individual's acceptance by an assisted living facility, provide to the resident or resident's representative a copy of:
 - a. The residency agreement in subsection (D),
 - b. Resident's rights, and
 - c. The policy and procedure on health care directives; and
2. Maintain the original of the residency agreement in subsection (D) in the resident's medical record.

G. A manager may terminate residency of a resident as follows:

1. Without notice, if the resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individuals in an assisted living facility;
2. With a 14 calendar day written notice of termination of residency:
 - a. For nonpayment of fees, charges, or deposit; or
 - b. Under any of the conditions in subsection (C); or
3. With a 30 calendar day written notice of termination of residency, for any other reason.

H. A manager shall ensure that a written notice of termination of residency includes:

1. The date of notice;
2. The reason for termination;
3. The policy for refunding fees, charges, or deposits;
4. The deposition of a resident's fees, charges, and deposits; and
5. Contact information for the State Long-Term Care Ombudsman.

I. A manager shall provide the following to a resident when the manager provides a written notice of termination of residency:

1. A copy of the resident's current service plan, and
2. Documentation of the resident's freedom from infectious tuberculosis.

J. If an assisted living facility issues a written notice of termination of residency to a resident or

the resident's representative because the resident needs services the assisted living facility is either not licensed to provide or is licensed to provide but not able to provide, a manager shall ensure that the written notice of termination of residency includes a description of the specific services that the resident needs that the assisted living facility is either not licensed to provide or is licensed to provide but not able to provide.

Historical Note

Adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-808. Service Plans

- A. Except as required in subsection (B), a manager shall ensure that a resident has a written service plan that:
 1. Is completed no later than 14 calendar days after the resident's date of acceptance;
 2. Is developed with assistance and review from:
 - a. The resident or resident's representative,
 - b. The manager, and
 - c. Any individual requested by the resident or the resident's representative;
 3. Includes the following:
 - a. A description of the resident's medical or health problems, including physical, behavioral, cognitive, or functional conditions or impairments;
 - b. The level of service the resident is expected to receive;
 - c. The amount, type, and frequency of assisted living services being provided to the resident, including medication administration or assistance in the self-administration of medication;
 - d. For a resident who requires intermittent nursing services or medication administration, review by a nurse or medical practitioner;
 - e. For a resident who requires behavioral care:

- i. Any of the following that is necessary to provide assistance with the resident's psychosocial interactions to manage the resident's behavior:
 - (1) The psychosocial interactions or behaviors for which the resident requires assistance,
 - (2) Psychotropic medications ordered for the resident,
 - (3) Planned strategies and actions for changing the resident's psychosocial interactions or behaviors, and
 - (4) Goals for changes in the resident's psychosocial interactions or behaviors; and
 - ii. Review by a medical practitioner or behavioral health professional; and
 - f. For a resident who will be storing medication in the resident's bedroom or residential unit, how the medication will be stored and controlled;
4. Is reviewed and updated based on changes in the requirements in subsections (A)(3)(a) through (f):
 - a. No later than 14 calendar days after a significant change in the resident's physical, cognitive, or functional condition; and
 - b. As follows:
 - i. At least once every 12 months for a resident receiving supervisory care services,
 - ii. At least once every six months for a resident receiving personal care services, and
 - iii. At least once every three months for a resident receiving directed care services; and
 5. When initially developed and when updated, is signed and dated by:
 - a. The resident or resident's representative;
 - b. The manager;
 - c. If a review is required in subsection (A)(3)(d), the nurse or medical practitioner who reviewed the service plan; and
 - d. If a review is required in subsection (A)(3)(e)(ii), the medical practitioner or behavioral health professional who reviewed the service plan.
- B.** For a resident receiving respite care services, a manager shall ensure that:
1. A written service plan is:
 - a. Based on a determination of the resident's current needs and:
 - i. Is completed no later than three working days after the resident's date of

- acceptance; or
- ii. If the resident has a service plan in the resident's medical record that was developed within the previous 12 months, is reviewed and updated based on changes in the requirements in subsections (A)(3)(a) through (f) within three working days after the resident's date of acceptance; and
 - b. If a significant change in the resident's physical, cognitive, or functional condition occurs while the resident is receiving respite care services, updated based on changes in the requirements in subsections (A)(3)(a) through (f) within three working days after the significant change occurs; and
2. If the resident is not expected to be present in the assisted living facility for more than seven calendar days, the resident is not required to comply with the requirements in R9-10-807(A).
- C.** A manager shall ensure that:
1. A caregiver or an assistant caregiver:
 - a. Provides a resident with the assisted living services in the resident's service plan;
 - b. Is only assigned to provide the assisted living services the caregiver or assistant caregiver has the documented skills and knowledge to perform;
 - c. Provides assistance with activities of daily living according to the resident's service plan;
 - d. If applicable, suggests techniques a resident may use to maintain or improve the resident's independence in performing activities of daily living;
 - e. Provides assistance with, supervises, or directs a resident's personal hygiene according to the resident's service plan;
 - f. Encourages a resident to participate in activities planned according to subsection (E); and
 - g. Documents the services provided in the resident's medical record; and
 2. A volunteer or an assistant caregiver who is 16 or 17 years of age does not provide:
 - a. Assistance to a resident for:
 - i. Bathing,
 - ii. Toileting, or
 - iii. Moving the resident's body from one surface to another surface;
 - b. Assistance in the self-administration of medication;
 - c. Medication administration; or

- d. Nursing services.
- D. A manager of an assisted living facility that is authorized to provide adult day health services shall ensure that the adult day health care services are provided as specified in R9-10-1113.
- E. A manager shall ensure that:
 - 1. Daily social, recreational, or rehabilitative activities are planned according to residents' preferences, needs, and abilities;
 - 2. A calendar of planned activities is:
 - a. Prepared at least one week in advance of the date the activity is provided,
 - b. Posted in a location that is easily seen by residents,
 - c. Updated as necessary to reflect substitutions in the activities provided, and
 - d. Maintained for at least 12 months after the last scheduled activity;
 - 3. Equipment and supplies are available and accessible to accommodate a resident who chooses to participate in a planned activity; and
 - 4. Daily newspapers, current magazines, and a variety of reading materials are available and accessible to a resident.
- F. If a resident is not receiving assistance with the resident's psychosocial interactions under the direction of a behavioral health professional or any other behavioral health services at an assisted living facility, the resident is not considered to be receiving behavioral care or behavioral health services from the assisted living facility if the resident:
 - 1. Is prescribed a psychotropic medication, or
 - 2. Is receiving directed care services and has a primary diagnosis of:
 - a. Dementia,
 - b. Alzheimer's disease-related dementia, or
 - c. Traumatic brain injury.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015,

effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-809. Transport; Transfer

A. Except as provided in subsection (B), a manager shall ensure that:

1. A caregiver or employee coordinates the transport and the services provided to the resident;
2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before and after the transport, and
 - b. Information from the resident's medical record is provided to a receiving health care institution; and
3. Documentation includes:
 - a. If applicable, any communication with an individual at a receiving health care institution;
 - b. The date and time of the transport; and
 - c. If applicable, the name of the caregiver accompanying the resident during a transport.

B. Subsection (A) does not apply to:

1. Transportation to a location other than a licensed health care institution,
2. Transportation provided for a resident by the resident or the resident's representative,
3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or
4. A transport to another licensed health care institution in an emergency.

C. Except for a transfer of a resident due to an emergency, a manager shall ensure that:

1. A caregiver coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before the transfer;
 - b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A caregiver explains risks and benefits of the transfer to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;

- c. The mode of transportation; and
- d. If applicable, the name of the caregiver accompanying the resident during a transfer.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Former Section R9-10-809 renumbered to R9-10-812; new Section R9-10-809 made by final rulemaking at 9 A.A.R. 319, effective March 31, 2003 (Supp. 03-1). R9-10-809(E) reflects a corrected reference to Article 14 from Article 4 (05-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-810. Resident Rights

- A. A manager shall ensure that, at the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (C).
- B. A manager shall ensure that:
 - 1. A resident is treated with dignity, respect, and consideration;
 - 2. A resident is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by the assisted living facility's manager, caregivers, assistant caregivers, employees, or volunteers; and
 - 3. A resident or the resident's representative:

- a. Is informed of the following:
 - i. The policy on health care directives, and
 - ii. The resident complaint process;
- b. Consents to photographs of the resident before the resident is photographed, except that a resident may be photographed when admitted to an assisted living facility for identification and administrative purposes;
- c. Except as otherwise permitted by law, provides written consent before the release of information in the resident's:
 - i. Medical record, or
 - ii. Financial records;
- d. May:
 - i. Request or consent to relocation within the assisted living facility; and
 - ii. Except when relocation is necessary based on a change in the resident's condition as documented in the resident's service plan, refuse relocation within the assisted living facility;
- e. Has access to the resident's records during normal business hours or at a time agreed upon by the resident or resident's representative and the manager; and
- f. Is informed of:
 - i. The rates and charges for services before the services are initiated;
 - ii. A change in rates or charges at least 30 calendar days before the change is implemented, unless the change in rates or charges results from a change in services; and
 - iii. A change in services at least 30 calendar days before the change is implemented, unless the resident's service plan changes.

C. A resident has the following rights:

- 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- 2. To receive assisted living services that support and respect the resident's individuality, choices, strengths, and abilities;
- 3. To receive privacy in:
 - a. Care for personal needs;
 - b. Correspondence, communications, and visitation; and
 - c. Financial and personal affairs;

4. To maintain, use, and display personal items unless the personal items constitute a hazard;
5. To choose to participate or refuse to participate in social, recreational, rehabilitative, religious, political, or community activities;
6. To review, upon written request, the resident's own medical record;
7. To receive a referral to another health care institution if the assisted living facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
8. To choose to access services from a health care provider, health care institution, or pharmacy other than the assisted living facility where the resident is residing and receiving services or a health care provider, health care institution, or pharmacy recommended by the assisted living facility;
9. To participate or have the resident's representative participate in the development of, or decisions concerning, the resident's service plan; and
10. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Former Section R9-10-810 renumbered to R9-10-813; new Section R9-10-810 made by final rulemaking at 9 A.A.R. 319, effective March 31, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-811. Medical Records

A. A manager shall ensure that:

1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a resident's medical record is:
 - a. Only recorded by an individual authorized by policies and procedures to make the entry;

- b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
 - 3. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - 4. A resident's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the resident's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the resident or the resident's representative; or
 - c. As permitted by law; and
 - 5. A resident's medical record is protected from loss, damage, or unauthorized use.
- B.** If an assisted living facility maintains residents' medical records electronically, a manager shall ensure that:
- 1. Safeguards exist to prevent unauthorized access, and
 - 2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.
- C.** A manager shall ensure that a resident's medical record contains:
- 1. Resident information that includes:
 - a. The resident's name, and
 - b. The resident's date of birth;
 - 2. The names, addresses, and telephone numbers of:
 - a. The resident's primary care provider;
 - b. Other persons, such as a home health agency or hospice service agency, involved in the care of the resident; and
 - c. An individual to be contacted in the event of emergency, significant change in the resident's condition, or termination of residency;
 - 3. If applicable, the name and contact information of the resident's representative and:
 - a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
 - b. If the resident's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of

- the health care power of attorney or mental health care power of attorney; or
- ii. Is a legal guardian, a copy of the court order establishing guardianship;
4. The date of acceptance and, if applicable, date of termination of residency;
 5. Documentation of the resident's needs required in R9-10-807(B);
 6. Documentation of general consent and informed consent, if applicable;
 7. Except as allowed in R9-10-808(B)(2), documentation of freedom from infectious tuberculosis as required in R9-10-807(A);
 8. A copy of resident's health care directive, if applicable;
 9. The resident's signed residency agreement and any amendments;
 10. Resident's service plan and updates;
 11. Documentation of assisted living services provided to the resident;
 12. A medication order from a medical practitioner for each medication that is administered to the resident or for which the resident receives assistance in the self-administration of the medication;
 13. Documentation of medication administered to the resident or for which the resident received assistance in the self-administration of medication that includes:
 - a. The date and time of administration or assistance;
 - b. The name, strength, dosage, and route of administration;
 - c. The name and signature of the individual administering or providing assistance in the self-administration of medication; and
 - d. An unexpected reaction the resident has to the medication;
 14. Documentation of the resident's refusal of a medication, if applicable;
 15. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
 16. If applicable, documentation of a determination by a medical practitioner that evacuation from the assisted living facility during an evacuation drill would cause harm to the resident;
 17. Documentation of notification of the resident of the availability of vaccination for influenza and pneumonia, according to A.R.S. § 36-406(1)(d);
 18. Documentation of the resident's orientation to exits from the assisted living facility required in R9-10-818(B);
 19. If a resident is receiving behavioral health services other than behavioral care, documentation of the determination in R9-10-813(3);

20. If a resident is receiving behavioral care, documentation of the determination in R9-10-812(3);
21. If applicable, for a resident who is unable to direct self-care, the information required in R9-10-815(F);
22. Documentation of any significant change in a resident's behavior, physical, cognitive, or functional condition and the action taken by a manager or caregiver to address the resident's changing needs;
23. Documentation of the notification required in R9-10-803(G) if the resident is incapable of handling financial affairs; and
24. If the resident no longer resides and receives assisted living services from the assisted living facility:
 - a. A written notice of termination of residency; or
 - b. If the resident terminated residency, the date the resident terminated residency.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Former Section R9-10-811 renumbered to R9-10-814; new Section R9-10-811 made by final rulemaking at 9 A.A.R. 319, effective March 31, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-812. Behavioral Care

A manager shall ensure that for a resident who requests or receives behavioral care from the assisted living facility, a behavioral health professional or medical practitioner:

1. Evaluates the resident:
 - a. Within 30 calendar days before acceptance of the resident or before the resident begins receiving behavioral care, and
 - b. At least once every six months throughout the duration of the resident's need for behavioral care;
2. Reviews the assisted living facility's scope of services; and
3. Signs and dates a determination stating that the resident's need for behavioral care can be

met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989 (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989 (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed; new Section R9-10-812 renumbered from R9-10-809 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-813. Behavioral Health Services

If an assisted living facility is authorized to provide behavioral health services other than behavioral care, a manager shall ensure that:

1. Policies and procedures are established, documented, and implemented that cover when general consent and informed consent are required and by whom general consent and informed consent may be given;
2. The behavioral health services:
 - a. Are provided under the direction of a behavioral health professional; and
 - b. Comply with the requirements:
 - i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115; and
 - ii. For an assessment, in R9-10-1011(B); and
3. For a resident who requests or receives behavioral health services from the assisted living facility, a behavioral health professional:
 - a. Evaluates the resident within 30 calendar days before acceptance of the resident and at least once every six months throughout the duration of the resident's need for behavioral health services;
 - b. Reviews the assisted living facility's scope of services; and
 - c. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility.

Historical Note

New Section renumbered from R9-10-810 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-814. Personal Care Services

- A.** A manager of an assisted living facility authorized to provide personal care services shall not accept or retain a resident who:
 - 1. Is unable to direct self-care;
 - 2. Except as specified in subsection (B), is confined to a bed or chair because of an inability to ambulate even with assistance; or
 - 3. Except as specified in subsection (C), has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner.
- B.** A manager of an assisted living facility authorized to provide personal care services may accept or retain a resident who is confined to a bed or chair because of an inability to ambulate even with assistance if:
 - 1. The condition is a result of a short-term illness or injury; or
 - 2. The following requirements are met at the onset of the condition or when the resident is accepted by the assisted living facility:
 - a. The resident or resident's representative requests that the resident be accepted by or remain in the assisted living facility;
 - b. The resident's primary care provider or other medical practitioner:
 - i. Examines the resident at the onset of the condition, or within 30 calendar days before acceptance, and at least once every six months throughout the duration of the resident's condition;
 - ii. Reviews the assisted living facility's scope of services; and
 - iii. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility; and
 - c. The resident's service plan includes the resident's increased need for personal care services.
 - C.** A manager of an assisted living facility authorized to provide personal care services may

accept or retain a resident who has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner, if the requirements in subsection (B)(2) are met.

- D. A manager of an assisted living facility authorized to provide personal care services may accept or retain a resident who:
 - 1. Is receiving nursing services from a home health agency or a hospice service agency; or
 - 2. Requires intermittent nursing services if:
 - a. The resident's condition for which nursing services are required is a result of a short-term illness or injury, and
 - b. The requirements of subsection (B)(2) are met.
- E. A manager shall ensure that a bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies is available and accessible in a bedroom or residential unit being used by a resident receiving personal care services.
- F. In addition to the requirements in R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving personal care services includes:
 - 1. Skin maintenance to prevent and treat bruises, injuries, pressure sores, and infections;
 - 2. Offering sufficient fluids to maintain hydration;
 - 3. Incontinence care that ensures that a resident maintains the highest practicable level of independence when toileting; and
 - 4. If applicable, the determination in subsection (B)(2)(b).
- G. A manager shall ensure that an employee does not provide non-prescription medication to a resident receiving personal care services unless the resident has an order from the resident's primary care provider or another medical practitioner for the non-prescription medication.

Historical Note

New Section renumbered from R9-10-811 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-815. Directed Care Services

- A. A manager shall ensure that a resident's representative is designated for a resident who is unable to direct self-care.
- B. A manager of an assisted living facility authorized to provide directed care services shall not accept or retain a resident who, except as provided in R9-10-814(B)(2):
 - 1. Is confined to a bed or chair because of an inability to ambulate even with assistance; or

2. Has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner.
- C. In addition to the requirements in R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving directed care services includes:
 1. The requirements in R9-10-814(F)(1) through (3);
 2. If applicable, the determination in R9-10-814(B)(2)(b);
 3. Cognitive stimulation and activities to maximize functioning;
 4. Strategies to ensure a resident's personal safety;
 5. Encouragement to eat meals and snacks;
 6. Documentation:
 - a. Of the resident's weight, or
 - b. From a medical practitioner stating that weighing the resident is contraindicated; and
 7. Coordination of communications with the resident's representative, family members, and, if applicable, other individuals identified in the resident's service plan.
- D. A manager shall ensure that an employee does not provide non-prescription medication to a resident receiving directed care services unless the resident has an order from a medical practitioner for the non-prescription medication.
- E. A manager shall ensure that:
 1. A bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies is available in a bedroom being used by a resident receiving directed care services; or
 2. An assisted living facility has implemented another means to alert a caregiver or assistant caregiver to a resident's needs or emergencies.
- F. A manager of an assisted living facility authorized to provide directed care services shall ensure that:
 1. Policies and procedures are established, documented, and implemented that ensure the safety of a resident who may wander;
 2. There is a means of exiting the facility for a resident who does not have a key, special knowledge for egress, or the ability to expend increased physical effort that meets one of the following:
 - a. Provides access to an outside area that:
 - i. Allows the resident to be at least 30 feet away from the facility, and
 - ii. Controls or alerts employees of the egress of a resident from the facility;

- b. Provides access to an outside area:
 - i. From which a resident may exit to a location at least 30 feet away from the facility, and
 - ii. Controls or alerts employees of the egress of a resident from the facility; or
 - c. Uses a mechanism that meets the Special Egress-Control Devices provisions in the Uniform Building Code incorporated by reference in A.A.C. R9-1-412; and
3. A caregiver or an assistant caregiver complies with the requirements for incidents in R9-10-804 when a resident who is unable to direct self-care wanders into an area not designated by the governing authority for use by the resident.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-816. Medication Services

- A. A manager shall ensure that:
 1. Policies and procedures for medication services include:
 - a. Procedures for preventing, responding to, and reporting a medication error;
 - b. Procedures for responding to and reporting an unexpected reaction to a medication;
 - c. Procedures to ensure that a resident's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;
 - d. Procedures for:
 - i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and
 - ii. Monitoring a resident who self-administers medication;
 - e. Procedures for assisting a resident in procuring medication; and
 - f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
 2. If a verbal order for a resident's medication is received from a medical practitioner by the assisted living facility:
 - a. The manager or a caregiver takes the verbal order from the medical practitioner,
 - b. The verbal order is documented in the resident's medical record, and

- c. A written order verifying the verbal order is obtained from the medical practitioner within 14 calendar days after receiving the verbal order.
- B.** If an assisted living facility provides medication administration, a manager shall ensure that:
- 1. Medication is stored by the assisted living facility;
 - 2. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner, registered nurse, or pharmacist;
 - b. Include a process for documenting an individual, authorized, according to the definition of “administer” in A.R.S. § 32-1901, by a medical practitioner to administer medication under the direction of the medical practitioner;
 - c. Ensure that medication is administered to a resident only as prescribed; and
 - d. Cover the documentation of a resident’s refusal to take prescribed medication in the resident’s medical record; and
 - 3. A medication administered to a resident:
 - a. Is administered by an individual under direction of a medical practitioner;
 - b. Is administered in compliance with a medication order, and
 - c. Is documented in the resident’s medical record.
- C.** If an assisted living facility provides assistance in the self-administration of medication, a manager shall ensure that:
- 1. A resident’s medication is stored by the assisted living facility;
 - 2. The following assistance is provided to a resident:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container or medication organizer for the resident;
 - c. Observing the resident while the resident removes the medication from the container or medication organizer;
 - d. Except when a resident uses a medication organizer, verifying that the medication is taken as ordered by the resident’s medical practitioner by confirming that:
 - i. The resident taking the medication is the individual stated on the medication container label,
 - ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
 - iii. The resident is taking the medication at the time stated on the medication

- container label or according to an order from a medical practitioner dated later than the date on the medication container label;
- e. For a resident using a medication organizer, verifying that the resident is taking the medication in the medication organizer according to the schedule specified on the medical practitioner's order; or
 - f. Observing the resident while the resident takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or nurse; and
 4. Assistance in the self-administration of medication provided to a resident:
 - a. Is in compliance with an order, and
 - b. Is documented in the resident's medical record.
- D.** A manager shall ensure that:
1. A current drug reference guide is available for use by personnel members, and
 2. A current toxicology reference guide is available for use by personnel members.
- E.** A manager shall ensure that a resident's medication organizer is only filled by:
1. The resident;
 2. The resident's representative;
 3. A family member of the resident;
 4. A personnel member of a home health agency or hospice service agency; or
 5. The manager or a caregiver who has been designated and is under the direction of a medical practitioner, according to subsection (B)(2)(b).
- F.** When medication is stored by an assisted living facility, a manager shall ensure that:
1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
 2. Medication is stored according to the instructions on the medication container; and
 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of residents who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.

- G.** A manager shall ensure that a caregiver immediately reports a medication error or a resident's unexpected reaction to a medication to the medical practitioner who ordered the medication or, if the medical practitioner who ordered the medication is not available, another medical practitioner.
- H.** If medication is stored by a resident in the resident's bedroom or residential unit, a manager shall ensure that:
1. The medication is stored according to the resident's service plan; or
 2. If the medication is not being stored according to the resident's service plan, the resident's service plan is updated to include how the medication is being stored by the resident.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-817. Food Services

- A.** A manager shall ensure that:
1. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served each day,
 - c. Is conspicuously posted at least one calendar day before the first meal on the food menu is served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
 2. Meals and snacks provided by the assisted living facility are served according to posted menus;
 3. If the assisted living facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the assisted living facility, a copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the assisted living facility;

4. The assisted living facility is able to store, refrigerate, and reheat food to meet the dietary needs of a resident;
 5. Meals and snacks for each day are planned using the applicable guidelines in <http://www.health.gov/dietaryguidelines/2010.asp>;
 6. A resident is provided a diet that meets the resident's nutritional needs as specified in the resident's service plan;
 7. Water is available and accessible to residents at all times, unless otherwise stated in a medical practitioner's order; and
 8. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the provision of adaptive eating equipment or utensils, such as a plate guard, rocking fork, or assistive hand device, if not provided by the resident.
- B.** If the assisted living facility offers therapeutic diets, a manager shall ensure that:
1. A current therapeutic diet manual is available for use by employees, and
 2. The therapeutic diet is provided to a resident according to a written order from the resident's primary care provider or another medical practitioner.
- C.** A manager shall ensure that food is obtained, prepared, served, and stored as follows:
1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
 2. Food is protected from potential contamination;
 3. Food is prepared:
 - a. Using methods that conserve nutritional value, flavor, and appearance; and
 - b. In a form to meet the needs of a resident, such as cut, chopped, ground, pureed, or thickened;
 4. Potentially hazardous food is maintained as follows:
 - a. Foods requiring refrigeration are maintained at 41° F or below; and
 - b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
 - i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at

- least 155° F;
- iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155 °F;
 - v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
 - vi. Leftovers are reheated to a temperature of at least 165° F;
5. A refrigerator used by an assisted living facility to store food or medication contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
 6. Frozen foods are stored at a temperature of 0° F or below; and
 7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.
- D.** A manager of an assisted living center shall ensure that:
1. The assisted living center has a license or permit as a food establishment under 9 A.A.C. 8, Article 1; and
 2. A copy of the assisted living center's food establishment license or permit is maintained.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-818. Emergency and Safety Standards

- A.** A manager shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to caregivers and assistant caregivers, and, if necessary, implemented that includes:
 - a. When, how, and where residents will be relocated;
 - b. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
 - c. A plan to ensure each resident's medication will be available to administer to the resident during a disaster; and
 - d. A plan for obtaining food and water for individuals present in the assisted living facility or the assisted living facility's relocation site during a disaster;
 2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;

3. Documentation of the disaster plan review required in subsection (A)(2) includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each employee or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
5. An evacuation drill for employees and residents:
 - a. Is conducted at least once every six months; and
 - b. Includes all individuals on the premises except for:
 - i. A resident whose medical record contains documentation that evacuation from the assisted living facility would cause harm to the resident, and
 - ii. Sufficient caregivers to ensure the health and safety of residents not evacuated according to subsection (A)(5)(b)(i);
6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees and residents to evacuate the assisted living facility;
 - c. If applicable:
 - i. An identification of residents needing assistance for evacuation, and
 - ii. An identification of residents who were not evacuated;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted in each hallway of each floor of the assisted living facility.

B. A manager shall ensure that:

1. A resident receives orientation to the exits from the assisted living facility and the route to be used when evacuating the assisted living facility within 24 hours after the resident's acceptance by the assisted living facility, and
 2. The resident's orientation is documented.
- C. A manager shall ensure that a first-aid kit is maintained in the assisted living facility in a location accessible to caregivers and assistant caregivers.**

D. When a resident has an accident, emergency, or injury that results in the resident needing medical services, a manager shall ensure that a caregiver or an assistant caregiver:

1. Immediately notifies the resident's emergency contact and primary care provider; and
2. Documents the following:
 - a. The date and time of the accident, emergency, or injury;
 - b. A description of the accident, emergency, or injury;
 - c. The names of individuals who observed the accident, emergency, or injury;
 - d. The actions taken by the caregiver or assistant caregiver;
 - e. The individuals notified by the caregiver or assistant caregiver; and
 - f. Any action taken to prevent the accident, emergency, or injury from occurring in the future.

E. A manager of an assisted living center shall ensure that:

1. Unless the assisted living center has documentation of having received an exception from the Department before October 1, 2013, in the areas of the assisted living center providing personal care services or directed care services:
 - a. A fire alarm system is installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in A.A.C. R9-1-412, and is in working order; and
 - b. A sprinkler system is installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in A.A.C. R9-1-412, and is in working order;
2. For the areas of the assisted living center providing only supervisory care services:
 - a. A fire alarm system and a sprinkler system meeting the requirements in subsection (E)(1) are installed and in working order, or
 - b. The assisted living center complies with the requirements in subsection (F);
3. A fire inspection is conducted by a local fire department or the State Fire Marshal before initial licensing and according to the time-frame established by the local fire department or the State Fire Marshal;
4. Any repairs or corrections stated on the fire inspection report are made; and
5. Documentation of a current fire inspection is maintained.

F. A manager of an assisted living home shall ensure that:

1. A fire extinguisher that is labeled as rated at least 2A-10-BC by the Underwriters Laboratories is mounted and maintained in the assisted living home;

2. A disposable fire extinguisher is replaced when its indicator reaches the red zone;
3. A rechargeable fire extinguisher:
 - a. Is serviced at least once every 12 months, and
 - b. Has a tag attached to the fire extinguisher that specifies the date of the last servicing and the identification of the person who serviced the fire extinguisher;
4. Except as provided in subsection (G):
 - a. A smoke detector is:
 - i. Installed in each bedroom, hallway that adjoins a bedroom, storage room, laundry room, attached garage, and room or hallway adjacent to the kitchen, and other places recommended by the manufacturer;
 - ii. Either battery operated or, if hard-wired into the electrical system of the assisted living home, has a back-up battery;
 - iii. In working order; and
 - iv. Tested at least once a month; and
 - b. Documentation of the test required in subsection (F)(4)(a)(iv) is maintained for at least 12 months after the date of the test;
5. An appliance, light, or other device with a frayed or spliced electrical cord is not used at the assisted living home; and
6. An electrical cord, including an extension cord, is not run under a rug or carpeting, over a nail, or from one room to another at the assisted living home.

G. A manager of an assisted living home may use a fire alarm system and a sprinkler system to ensure the safety of residents if the fire alarm system and sprinkler system:

1. Are installed and in working order, and
2. Meet the requirements in subsection (E)(1).

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-819. Environmental Standards

A. A manager shall ensure that:

1. The premises and equipment used at the assisted living facility are:
 - a. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and

- b. Free from a condition or situation that may cause a resident or other individual to suffer physical injury;
- 2. A pest control program is implemented and documented;
- 3. Garbage and refuse are:
 - a. Stored in covered containers lined with plastic bags, and
 - b. Removed from the premises at least once a week;
- 4. Heating and cooling systems maintain the assisted living facility at a temperature between 70° F and 84° F at all times, unless individually controlled by a resident;
- 5. Common areas:
 - a. Are lighted to ensure the safety of residents, and
 - b. Have lighting sufficient to allow caregivers and assistant caregivers to monitor resident activity;
- 6. Hot water temperatures are maintained between 95° F and 120° F in areas of an assisted living facility used by residents;
- 7. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
- 8. A resident has access to a laundry service or a washing machine and dryer in the assisted living facility;
- 9. Soiled linen and soiled clothing stored by the assisted living facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
- 10. Oxygen containers are secured in an upright position;
- 11. Poisonous or toxic materials stored by the assisted living facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents;
- 12. Combustible or flammable liquids and hazardous materials stored by the assisted living facility are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
- 13. Equipment used at the assisted living facility is:
 - a. Maintained in working order;
 - b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
 - c. Used according to the manufacturer's recommendations;

14. If pets or animals are allowed in the assisted living facility, pets or animals are:
 - a. Controlled to prevent endangering the residents and to maintain sanitation;
 - b. Licensed consistent with local ordinances; and
 - c. For a dog or cat, vaccinated against rabies;
 15. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
 16. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to applicable state laws and rules.
- B.** If a swimming pool is located on the premises, a manager shall ensure that:
1. On a day that a resident uses the swimming pool, an employee:
 - a. Tests the swimming pool's water quality at least once for compliance with one of the following chemical disinfection standards:
 - i. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test;
 - ii. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test; or
 - iii. An oxidation-reduction potential equal to or greater than 650 millivolts; and
 - b. Records the results of the water quality tests in a log that includes the date tested and test result;
 2. Documentation of the water quality test is maintained for at least 12 months after the date of the test; and
 3. A swimming pool is not used by a resident if a water quality test shows that the swimming pool water does not comply with subsection (B)(1)(a).

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-820. Physical Plant Standards

- A. A manager shall ensure that an assisted living center complies with the applicable physical plant health and safety codes and standards, incorporated by reference in A.A.C. R9-1-412, in effect on the date the assisted living facility submitted architectural plans and specifications to the Department for approval, according to R9-10-104.
- B. A manager shall ensure that:
 - 1. The premises and equipment are sufficient to accommodate:
 - a. The services stated in the assisted living facility's scope of services, and
 - b. An individual accepted as a resident by the assisted living facility;
 - 2. A common area for use by residents is provided that has sufficient space and furniture to accommodate the recreational and socialization needs of residents;
 - 3. A dining area has sufficient space and tables and chairs to accommodate the needs of the residents;
 - 4. At least one bathroom is accessible from a common area and:
 - a. May be used by residents and visitors;
 - b. Provides privacy when in use; and
 - c. Contains the following:
 - i. At least one working sink with running water,
 - ii. At least one working toilet that flushes and has a seat,
 - iii. Toilet tissue for each toilet,
 - iv. Soap in a dispenser accessible from each sink,
 - v. Paper towels in a dispenser or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A window that opens or another means of ventilation;
 - 5. An outside activity space is provided and available that:
 - a. Is on the premises,
 - b. Has a hard-surfaced section for wheelchairs, and
 - c. Has an available shaded area;
 - 6. Exterior doors are equipped with ramps or other devices to allow use by a resident using a wheelchair or other assistive device; and
 - 7. The key to the door of a lockable bathroom, bedroom, or residential unit is available to a manager, caregiver, and assistant caregiver.
- C. A manager shall ensure that:

1. For every eight residents there is at least one working toilet that flushes and has a seat and one sink with running water;
2. For every eight residents there is at least one working bathtub or shower; and
3. A resident bathroom provides privacy when in use and contains:
 - a. A mirror;
 - b. Toilet tissue for each toilet;
 - c. Soap accessible from each sink;
 - d. Paper towels in a dispenser or a mechanical air hand dryer for a bathroom that is not in a residential unit and used by more than one resident;
 - e. A window that opens or another means of ventilation;
 - f. Grab bars for the toilet and, if applicable, the bathtub or shower and other assistive devices, if required to provide for resident safety; and
 - g. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers.

D. A manager shall ensure that:

1. Each resident is provided with a sleeping area in a residential unit or a bedroom;
2. For an assisted living home, a resident's sleeping area is on the ground floor of the assisted living home unless:
 - a. The resident is able to direct self-care;
 - b. The resident is ambulatory without assistance; and
 - c. There are at least two unobstructed, usable exits to the outside from the sleeping area that the resident is capable of using;
3. Except as provided in subsection (E), no more than two individuals reside in a residential unit or bedroom;
4. A resident's sleeping area:
 - a. Is not used as a common area;
 - b. Is not used as a passageway to a common area, another sleeping area, or common bathroom unless the resident's sleeping area:
 - i. Was used as a passageway to a common area, another sleeping area, or common bathroom before October 1, 2013; and
 - ii. Written consent is obtained from the resident or the resident's representative;
 - c. Is constructed and furnished to provide unimpeded access to the door;
 - d. Has floor-to-ceiling walls with at least one door;

- e. Has access to natural light through a window or a glass door to the outside; and
 - f. Has a window or door that can be used for direct egress to outside the building;
5. If a resident's sleeping area is in a bedroom, the bedroom has:
 - a. For a private bedroom, at least 80 square feet of floor space, not including a closet or bathroom;
 - b. For a shared bedroom, at least 60 square feet of floor space for each individual occupying the shared bedroom, not including a closet or bathroom; and
 - c. A door that opens into a hallway, common area, or outdoors;
 6. If a resident's sleeping area is in a residential unit, the residential unit has:
 - a. Except as provided in subsection (E)(2), at least 220 square feet of floor space, not including a closet or bathroom, for one individual residing in the residential unit and an additional 100 square feet of floor space, not including a closet or bathroom, for each additional individual residing in the residential unit;
 - b. An individually keyed entry door;
 - c. A bathroom that provides privacy when in use and contains:
 - i. A working toilet that flushes and has a seat;
 - ii. A working sink with running water;
 - iii. A working bathtub or shower;
 - iv. Lighting;
 - v. A mirror;
 - vi. A window that opens or another means of ventilation;
 - vii. Grab bars for the toilet and, if applicable, the bathtub or shower and other assistive devices, if required to provide for resident safety; and
 - viii. Nonporous surfaces for shower enclosures and slip-resistant surfaces in bathtubs and showers;
 - d. A resident-controlled thermostat for heating and cooling;
 - e. A kitchen area equipped with:
 - i. A working sink and refrigerator,
 - ii. A cooking appliance that can be removed or disconnected,
 - iii. Space for food preparation, and
 - iv. Storage for utensils and supplies; and
 - f. If not furnished by a resident:
 - i. An armchair, and

- ii. A table where a resident may eat a meal; and
 - 7. If not furnished by a resident, each sleeping area has:
 - a. A bed, at least 36 inches in width and 72 inches in length, consisting of at least a frame and mattress that is clean and in good repair;
 - b. Clean linen, including a mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, a bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for the resident;
 - c. Sufficient light for reading;
 - d. Storage space for clothing;
 - e. Individual storage space for personal effects; and
 - f. Adjustable window covers that provide resident privacy.
- E.** A manager may allow more than two individuals to reside in a residential unit or bedroom if:
- 1. There is at least 60 square feet for each individual living in the bedroom;
 - 2. There is at least 100 square feet for each individual living in the residential unit; and
 - 3. The manager has documentation that the assisted living facility has been operating since before November 1, 1998, with more than two individuals living in the residential unit or bedroom.
- F.** If there is a swimming pool on the premises of the assisted living facility, a manager shall ensure that:
- 1. Unless the assisted living facility has documentation of having received an exception from the Department before October 1, 2013, the swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (F)(1)(e);
 - d. Is not chain-link;
 - e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and
 - f. Has a self-closing, self-latching gate that:
 - i. Opens away from the swimming pool,
 - ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use;
 - 2. A life preserver or shepherd's crook is available and accessible in the swimming pool

area; and

3. Pool safety requirements are conspicuously posted in the swimming pool area.

G. A manager shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (F)(1) is covered and locked when not in use.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

Statutory Authority

36-132. Department of health services; functions; contracts

A. The department shall, in addition to other powers and duties vested in it by law:

1. Protect the health of the people of the state.
2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.
3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of the state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with the provisions of chapter 3 of this title, and sections 36-693, 36-694 and 39-122.
4. Operate such sanitariums, hospitals or other facilities assigned to the department by law or by the governor.
5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information for the promotion of good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of education of children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.
6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.
7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.
8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of school children, including special fields such as the prevention of blindness and conservation of sight and hearing.
9. Encourage and aid in the coordination of local programs concerning nutrition of the people

of the state.

10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.
11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.
12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection H, paragraph 10.
13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.
14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in the enforcement of the federal food, drug and cosmetic act of 1938 (52 Stat. 1040; 21 United States Code sections 1 through 905).
15. Recruit and train personnel for state, local and district health departments.
16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.
17. License and regulate health care institutions according to chapter 4 of this title.
18. Issue or direct the issuance of licenses and permits required by law.
19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.
20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:
 - (a) Screening in early pregnancy for detecting high risk conditions.

- (b) Comprehensive prenatal health care.
- (c) Maternity, delivery and postpartum care.
- (d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.
- (e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.

21. License and regulate the health and safety of group homes for persons with developmental disabilities. The department shall issue a license to an accredited facility for a period of the accreditation, except that no licensing period shall be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.

B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.

C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. Powers and duties of director; compensation of personnel; rules; definition

A. The director shall:

- 1. Be the executive officer of the department of health services and the state registrar of vital

statistics but shall not receive compensation for services as registrar.

2. Perform all duties necessary to carry out the functions and responsibilities of the department.
 3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.
 4. Administer and enforce the laws relating to health and sanitation and the rules of the department.
 5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.
 6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.
 7. Prepare sanitary and public health rules.
 8. Perform other duties prescribed by law.
- B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.
- C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals.

The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing

and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.
3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.
4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:
 - (a) Served at a noncommercial social event such as a potluck.
 - (b) Prepared at a cooking school that is conducted in an owner-occupied home.
 - (c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.
 - (d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fund-raising or an employee social event.
 - (e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for

immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) Baked and confectionary goods that are not potentially hazardous and that are prepared in a kitchen of a private home for commercial purposes if packaged with a label that clearly states the address of the maker, includes contact information for the maker, lists all the ingredients in the product and discloses that the product was prepared in a home. The label must be given to the final consumer of the product. If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must obtain a food handler's card or certificate if one is issued by the local county and must register with an online registry established by the department pursuant to paragraph 13 of this subsection. For the purposes of this subdivision, "potentially hazardous" means baked and confectionary goods that meet the requirements of the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for the preservation or storage of food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing

of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparation of food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.

13. Establish an online registry of food preparers that are authorized to prepare food for

commercial purposes pursuant to paragraph 4 of this subsection.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".

J. The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph

14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. For the purposes of this section, "fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.

36-405. Powers and duties of the director

A. The director shall adopt rules to establish minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to ensure the public health, safety and welfare. The standards and requirements shall relate to the construction, equipment, sanitation, staffing for medical, nursing and personal care services, and recordkeeping pertaining to the administration of medical, nursing, behavioral health and personal care services, in accordance with generally accepted practices of health care. The director shall use the current standards adopted by the joint commission on accreditation of hospitals and the commission on accreditation of the American osteopathic association or those adopted by any recognized accreditation organization approved by the department as guidelines in prescribing minimum standards and requirements under this section.

B. The director, by rule, may:

1. Classify and subclassify health care institutions according to character, size, range of services provided, medical or dental specialty offered, duration of care and standard of patient care required for the purposes of licensure. Classes of health care institutions may include hospitals, infirmaries, outpatient treatment centers, health screening services centers and residential care facilities. Whenever the director reasonably deems distinctions in rules and standards to be appropriate among different classes or subclasses of health care institutions, the director may make such distinctions.
2. Prescribe standards for determining a health care institution's substantial compliance with licensure requirements.
3. Prescribe the criteria for the licensure inspection process.
4. Prescribe standards for the selection of health care-related demonstration projects.
5. Establish nonrefundable application and licensing fees for health care institutions, including a grace period and a fee for the late payment of licensing fees, and fees for architectural plans and specifications reviews.
6. Establish a process for the department to notify a licensee of the licensee's licensing fee due date.
7. Establish a process for a licensee to request a different licensing fee due date, including

any limits on the number of requests by the licensee.

C. The director, by rule, shall adopt licensing provisions that facilitate the colocation and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services consistent with article 3.1 of this chapter.

D. Ninety percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the health services licensing fund established by section 36-414 and ten percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.

E. Subsection B, paragraph 5 of this section does not apply to a health care institution operated by a state agency pursuant to state or federal law or to adult foster care residential settings.

36-406. Powers and duties of the department

In addition to its other powers and duties:

1. The department shall:

- (a) Administer and enforce this chapter and the rules, regulations and standards adopted pursuant thereto.
- (b) Review, and may approve, plans and specifications for construction or modification or additions to health care institutions regulated by this chapter.
- (c) Have access to books, records, accounts and any other information of any health care institution reasonably necessary for the purposes of this chapter.
- (d) Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe the manner by which the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of that vaccination in this state as determined by the director.

2. The department may:

- (a) Make or cause to be made inspections consistent with standard medical practice of every part of the premises of health care institutions which are subject to the provisions of this chapter as well as those which apply for or hold a license required by this chapter.
- (b) Make studies and investigations of conditions and problems in health care institutions, or any class or subclass thereof, as they relate to compliance with this chapter and rules, regulations and standards adopted pursuant thereto.

(c) Develop manuals and guides relating to any of the several aspects of physical facilities and operations of health care institutions or any class or subclass thereof for distribution to the governing authorities of health care institutions and to the general public.

36-422. Application for license; notification of proposed change in status; joint licenses; definitions

A. A person who wishes to apply for a license to operate a health care institution pursuant to this chapter shall submit to the department all of the following:

1. An application on a written or electronic form that is prescribed, prepared and furnished by the department that contains all of the following:

(a) The name and location of the health care institution.

(b) Whether the health care institution is to be operated as a proprietary or nonproprietary institution.

(c) The name of the governing authority. The applicant shall be the governing authority having the operative ownership of, or the governmental agency charged with the administration of, the health care institution sought to be licensed. If the applicant is a partnership that is not a limited partnership, the partners shall apply jointly, and the partners are jointly the governing authority for purposes of this article.

(d) The name and business or residential address of each controlling person and an affirmation that none of the controlling persons has been denied a license or certificate by a health profession regulatory board pursuant to title 32 or by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution in this state or another state or has had a license or certificate issued by a health profession regulatory board pursuant to title 32 or issued by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution revoked. If a controlling person has been denied a license or certificate by a health profession regulatory board pursuant to title 32 or by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution in this state or another state or has had a health care professional license or a license to operate a health care institution revoked, the controlling person shall include in the application a comprehensive description of the circumstances for the denial or the revocation.

(e) The class or subclass of health care institution to be established or operated.

(f) The types and extent of the health care services to be provided, including emergency services, community health services and services to indigent patients.

(g) The name and qualifications of the chief administrative officer implementing direction in that specific health care institution.

(h) Other pertinent information required by the department for the proper administration of this chapter and department rules.

2. The architectural plans and specifications or the department's approval of the architectural plans and specifications required by section 36-421, subsection A.

3. The applicable application fee.
- B. An application filed pursuant to this section shall contain the written or electronic signature of:
1. If the applicant is an individual, the owner of the health care institution.
 2. If the applicant is a partnership, limited liability company or corporation, two of the officers of the corporation or managing members of the partnership or limited liability company or the sole member of the limited liability company if it has only one member.
 3. If the applicant is a governmental unit, the head of the governmental unit.
- C. An application for licensure shall be submitted at least sixty but not more than one hundred twenty days before the anticipated operation or the expiration date of the current license. An application for a substantial compliance survey submitted pursuant to section 36-425, subsection G shall be filed at least thirty days before the date on which the substantial compliance survey is requested.
- D. If a current licensee intends to terminate the operation of a licensed health care institution or if a change of ownership is planned either during or at the expiration of the term of the license, the current licensee shall notify the director in writing at least thirty days before the termination of operation or change in ownership is to take place. The current licensee is responsible for preventing any interruption of services required to sustain the life, health and safety of the patients or residents. A new owner shall not begin operating the health care institution until the director issues a license.
- E. A licensed health care institution for which operations have not been terminated for more than thirty days may be relicensed pursuant to the standards that were applicable under its most recent license.
- F. If a person operates a hospital in a county with a population of more than five hundred thousand persons in a setting that includes satellite facilities of the hospital that are located separately from the main hospital building, the department at the request of the applicant or licensee shall issue a single group license to the hospital and its designated satellite facilities located within one-half mile of the main hospital building if all of the facilities meet or exceed department licensure requirements for the designated facilities. At the request of the applicant or licensee, the department shall also issue a single group license that includes the hospital and not more than ten of its designated satellite facilities that are located farther than one-half mile from the main hospital building if all of these facilities meet or exceed applicable department licensure requirements. Each facility included under a single group license is subject to the department's licensure requirements that are applicable to that category of facility. Subject to compliance with applicable licensure or accreditation requirements, the department shall reissue individual licenses for the facility of a hospital located in separate buildings from the main hospital building when requested by the hospital. This subsection does not apply to nursing care institutions and residential care institutions. The department is not limited in conducting inspections of an accredited health care institution to ensure that the institution meets department licensure requirements. If a person operates a hospital in a county with a population of five hundred thousand persons or less in a setting that includes satellite facilities of the hospital that are located separately from the

main hospital building, the department at the request of the applicant or licensee shall issue a single group license to the hospital and its designated satellite facilities located within thirty-five miles of the main hospital building if all of the facilities meet or exceed department licensure requirements for the designated facilities. At the request of the applicant or licensee, the department shall also issue a single group license that includes the hospital and not more than ten of its designated satellite facilities that are located farther than thirty-five miles from the main hospital building if all of these facilities meet or exceed applicable department licensure requirements.

G. If a county with a population of more than one million persons or a special health care district in a county with a population of more than one million persons operates an accredited hospital that includes the hospital's accredited facilities that are located separately from the main hospital building and the accrediting body's standards as applied to all facilities meet or exceed the department's licensure requirements, the department shall issue a single license to the hospital and its facilities if requested to do so by the hospital. If a hospital complies with applicable licensure or accreditation requirements, the department shall reissue individual licenses for each hospital facility that is located in a separate building from the main hospital building if requested to do so by the hospital. This subsection does not limit the department's duty to inspect a health care institution to determine its compliance with department licensure standards. This subsection does not apply to nursing care institutions and residential care institutions.

H. An applicant or licensee must notify the department within thirty days after any change regarding a controlling person and provide the information and affirmation required pursuant to subsection A, paragraph 4 of this section.

I. This section does not limit the application of federal laws and regulations to an applicant or licensee certified as a medicare or an Arizona health care cost containment system provider under federal law.

J. Except for an outpatient treatment center providing dialysis services or abortion procedures, a person wishing to begin operating an outpatient treatment center before an initial licensing inspection is completed shall submit all of the following:

1. The initial license application required pursuant to this section.

2. All applicable application and license fees.

3. A written request for a temporary license that includes:

(a) The anticipated date of operation.

(b) An attestation signed by the applicant that the applicant and the facility comply with and will continue to comply with the applicable licensing statutes and rules.

K. Within seven days of the department's receipt of the items required in subsection J of this section, but not before the anticipated operation date submitted in subsection C of this section, the department shall issue a temporary license that includes:

1. The name of the facility.
2. The name of the licensee.
3. The facility's class or subclass.
4. The temporary license's effective date.
5. The location of the licensed premises.

L. A facility may begin operating on the effective date of the temporary license.

M. The director may cease the issuance of temporary licenses at any time if the director believes that public health and safety is endangered.

N. For the purposes of this section:

1. "Accredited" means accredited by a nationally recognized accreditation organization.
2. "Satellite facility" means an outpatient facility at which the hospital provides outpatient medical services.

DEPARTMENT OF HEALTH SERVICES (F-18-1006)

Title 9, Chapter 10, Article 10, Outpatient Treatment Centers

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-5

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: DEPARTMENT OF HEALTH SERVICES (F-18-1006)
Title 9, Chapter 10, Article 10, Outpatient Treatment Centers

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report:

This five-year review report, from the Department of Health Services (Department), covers 31 rules in A.A.C. Title 9, Chapter 10, Article 10. The rules in Article 10 establish requirements related to licensing of outpatient treatment centers. Specifically, the rules establish licensing application requirements, administrative policies and procedures to protect patient health and safety, requirements for quality management program, personnel and personnel records, patient rights, and requirements for all the different services provided by the treatment centers.

This is the first five-year review report on the new rules adopted via exempt rulemaking in 2013, and the rules were last amended at various times between 2013 and 2016.

Proposed Action

The Department intends to amend the rules, to address the issues identified throughout the report, by submitting a Notice of Final Expedited Rulemaking to the Council by June 2019.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. The Department cites to both general and specific authority. A.R.S. § 36-136(G) states that the director of the Department “may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.” Additionally, A.R.S. § 36-405(A), authorizes the director to “adopt rules to establish minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to ensure the public health, safety and welfare.”

2. Summary of the agency's economic impact comparison and identification of stakeholders:

The Department indicates that no economic, small business, and consumer impact statement was prepared for the rulemakings on 9 A.A.C. 10 and 9 A.A.C. 20. In this review however, the Department believes that while the rules may have increased costs for some stakeholders, the benefits from the rules outweigh the costs.

The Department notes that patients benefit by having more health services available through outpatient treatment centers. The Department believes increased access to services could lower costs for patients who would otherwise have to visit hospitals. The Department also notes that outpatient treatment centers benefit from the increased business opportunities provided by offering more services.

Other changes throughout the rulemaking included improved language clarity; improved explanation of patients' rights; improved regulation of patient medical records; and the addition and revision of sections specifying the additional types of health services outpatient treatment centers may provide if they submit a supplemental application to the Department.

The stakeholders include the Department, outpatient treatment centers, physicians, other health care providers, patients, and the general public. The Department reported that in 2017, there were 2,483 licensed outpatient treatment centers operating in the state: 9 outpatient treatment centers elected to close. Additionally, 330 initial applications and 1,684 renewal applications were approved.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

Yes. The Department determines that the rules impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

4. Has the agency received any written criticisms of the rules over the last five years?

Yes. In April 2014, the Department received a written criticism from Jack Confer, Executive Director for the Arizona State Board of Respiratory Care. Mr. Confer expressed concern that Section 1026 excluded respiratory therapists from doing sleep studies in a licensed sleep center and recommended that the Department add "a licensed respiratory therapist" to the rule. After reviewing the respiratory care statutes, the Department concluded that a respiratory therapist should be allowed to perform sleep studies and therefore, added "respiratory therapist" to the rule in June 2014.

5. Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. The Department has identified that the following rules could be made more clear, concise, and understandable, consistent with other rules and statutes, and more effective:

- Section 1002: In subsection (A), the term “initial” should be removed to make the rule consistent with A.R.S. § 36-405.
- Section 1003: The word “immediate” should be added before the word “notify” in subsection (B)(7).
- Section 1031: Citation to A.R.S. § 36-425.03 should be changed to A.R.S. Title 36, Chapter 5, Article 4.
- Section 1014: Citation to A.R.S. Title 36, Chapter 5, Article 4 should be changed to A.R.S. Title 36, Chapter 5, Article 5.
- Section 1017: Citation to 12 A.A.C. 1 should be changed to 9 A.A.C. 7, Article 1.
- Section 1018: References in subsections (M) and (N) should be updated to reflect the current standards adopted by the Association for the Advancement of Medical Instrumentation.
- Section 1019: Reference to subsection (12) should be changed to subsection (11).
- Section 1020: The outdated term “opioid addiction” should be changed to “substance use disorder.”

6. Has the agency analyzed the current enforcement status of the rules?

Yes. The Department indicates that the rules are enforced as written.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

No. The Department indicates that no federal laws apply to the rules.

8. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

Yes. The Department indicates that the rules requires a specific agency authorization, which is authorized by A.R.S. § 36-405.

9. Conclusion

As noted above, the Department plans to amend the rules by June 2019. This report complies with A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval of this report.



ARIZONA DEPARTMENT OF HEALTH SERVICES

POLICY & INTERGOVERNMENTAL AFFAIRS

July 27, 2018

Nicole O. Colyer, Esq., Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: Report for A.A.C. Title 9, Chapter 10, Article 10 Outpatient Treatment Centers

Dear Ms. Colyer:

According to the five-year-review report schedule of the Governor's Regulatory Review Council (Council), a report for A.A.C. Title 9, Chapter 10, Article 10 is due to the Council no later than July 31, 2018. The Arizona Department of Health Services (Department) has reviewed 9 A.A.C. 10, Article 10 and is enclosing a report to the Council for this rule.

The Department believes that this report complies with the requirements of A.R.S. § 41-1056. The report contains a summary of the Department's review for all the rules and is in the format of the Council's report template. Included in the package are the rules reviewed, the general and specific authority, and written criticism. As described in the report, the Department plans to amend the rules in 9 A.A.C. 10, Article 10 in an expedited rulemaking.

The Department certifies that it is in compliance with A.R.S. § 41-1091.

If you need any further information, please contact me at (602) 542-1020.

Sincerely,

A blue ink signature of Robert Lane.

Robert Lane
Director's Designee

RL:tk
Enclosures

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

Arizona Department of Health Services

Five-Year-Review Report

Title 9. Health Services

Chapter 10. Department of Health Services Health Care Institutions: Licensing

Article 10. Outpatient Treatment Centers

July 2018

1. Authorization of the rule by existing statutes

Authorizing statutes: A.R.S. §§ 36-104(3), 36-132(A)(1) and (A)(17), and 36-136(G)

Implementing statutes: A.R.S. §§ 36-405 through 36-407, 36-425, and 36-439.01 through 36-439.04

2. The objective of each rule:

Rule	Objective
R9-10-1001	The objective of the rule is to define terms used in the Article to enable readers to better understand the requirements and to allow for consistent interpretation of the terms.
R9-10-1002	The objective of the rule is to provide additional application requirements specific to an outpatient treatment center.
R9-10-1003	The objective of the rule is to establish minimum requirements for an outpatient treatment center's governing authority and administrator, including specific administrative policies and procedures to protect patient health and safety.
R9-10-1004	The objective of the rule is to establish minimum requirements for an outpatient treatment center's quality management program.
R9-10-1005	The objective of the rule is to establish minimum requirements for a person who contracts with the licensee to provide outpatient treatment center services.
R9-10-1006	The objective of the rule is to establish minimum requirements for outpatient treatment center personnel and personnel records.
R9-10-1007	The objective of the rule is to establish minimum requirements for the transport and transfer of a patient to ensure that the health and safety of the patient are not compromised as a result of the patient's transport or transfer.
R9-10-1008	The objective of the rule is to establish minimum requirements for patient rights.
R9-10-1009	The objective of the rule is to establish minimum requirements for patient medical records.

R9-10-1010	The objective of the rule is to establish minimum requirements for medication services in an outpatient treatment center.
R9-10-1011	The objective of the rule is to establish minimum requirements for behavioral health services in an outpatient treatment center.
R9-10-1012	The objective of the rule is to establish minimum requirements for behavioral health observation and stabilization services in an outpatient treatment center.
R9-10-1013	The objective of the rule is to establish a minimum requirement for an outpatient treatment center's administrator to provide a court-ordered evaluation.
R9-10-1014	The objective of the rule is to establish a minimum requirement for an outpatient treatment center's administrator to provide a court-ordered treatment.
R9-10-1015	The objective of the rule is to establish a minimum requirement for clinical laboratory services in an outpatient treatment center.
R9-10-1016	The objective of the rule is to establish a minimum requirement for crisis services in an outpatient treatment center.
R9-10-1017	The objective of the rule is to establish a minimum requirement for diagnostic imaging services in an outpatient treatment center.
R9-10-1018	The objective of the rule is to establish a minimum requirement for dialysis services in an outpatient treatment center.
R9-10-1019	The objective of the rule is to establish a minimum requirement for emergency room services in an outpatient treatment center.
R9-10-1020	The objective of the rule is to establish minimum requirements for opioid treatment services.
R9-10-1021	The objective of the rule is to establish minimum requirements for pain management services.
R9-10-1022	The objective of the rule is to establish minimum requirements for physical health services.
R9-10-1023	The objective of the rule is to establish minimum requirements for pre-petition screening.
R9-10-1024	The objective of the rule is to establish minimum requirements for rehabilitation services.
R9-10-1025	The objective of the rule is to establish minimum requirements for respite services.
R9-10-1026	The objective of the rule is to establish minimum requirements for sleeping disorder services.

R9-10-1027	The objective of the rule is to establish minimum requirements for urgent care services provided in a freestanding urgent care setting.
R9-10-1028	The objective of the rule is to establish minimum standards for infection control in an outpatient treatment center.
R9-10-1029	The objective of the rule is to establish a minimum emergency and safety standards.
R9-10-1030	The objective of the rule is to establish a minimum physical plant, environmental services, and equipment standards.
R9-10-1031	The objective of the rule is to establish minimum colocation requirements for collaborating outpatient treatment centers.

3. Are the rules effective in achieving their objectives?

Yes No

If not, please identify the rule(s) that is not effective and provide an explanation for why the rule(s) is not effective.

Rule	Explanation
Article 10	The rules in Article 10 would be more effective if the rules cited in paragraph 4 and 6 were changed as indicated below.

4. Are the rules consistent with other rules and statutes?

Yes No

If not, please identify the rule(s) that is not consistent. Also, provide an explanation and identify the provisions that are not consistent with the rule.

Rule	Explanation
R9-10-1002	The rules are mostly consistent with other rules and statutes, except for Laws 2017,
R9-10-1031	Ch.122 which amended A.R.S. § 36-405 and changed the types of licensure for health care institutions. The amended statutes no longer specify “initial” and “renewal” licensure. The rules would be more consistent with statutes if the words “initial” and “renewal” were deleted from R9-10-1002(A) and R9-10-1031.

5. Are the rules enforced as written?

Yes No

If not, please identify the rule(s) that is not enforced as written and provide an explanation of the issues with enforcement.

In addition, include the agency’s proposal for resolving the issue.

Rule	Explanation

6. Are the rules clear, concise, and understandable?

Yes No

If not, please identify the rule(s) that is not clear, concise, or understandable and provide an explanation as to how the agency plans to amend the rule(s) to improve clarity, conciseness, and understandability.

Rule	Explanation
R9-10-1003(B)(7)	The rule is clear, concise, and understandable, although if the word “immediate” were added before the word “notify,” the rules would be clear and a reader would not have to refer to A.R.S. § 36-425(I) to know when to notify the Department.
R9-10-1013	The rule is clear, concise, and understandable, although the rule would be clearer if the citation to A.R.S. § 36-425.03 were changed to A.R.S. Title 36, Chapter 5, Article 4.
R9-10-1014	The rule is clear, concise, and understandable, although the rule would be clearer if the citation to A.R.S. Title 36, Chapter 5, Article 4 were changed A.R.S. Title 36, Chapter 5, Article 5.
R9-10-1017	The rule is clear, concise, and understandable, although in subsection (A) the rule cites 12 A.A.C. 1 which has been repealed. The rule would be clearer if 12 A.A.C. 1 were changed to 9 A.A.C. 7, Article 1.
R9-10-1018	The rule is clear, concise, and understandable, although the rule would be clearer if the references in subsections (M) and (N) were updated to current standards adopted by ANSI/AAMI. Subsection (M) should reference ANSI/AAMI RD47: 2008/(R)2013 -Reprocessing of Hemodialyzers and subsection (N) should reference ANSI/AAMI RD62 – Water Treatment Equipment for Hemodialysis Applications.
R9-10-1019(12)	The rule is clear, concise, and understandable, although the rule would be clearer if the reference to subsection (12) were changes to (11).
R9-10-1020(C)(3)	The rule is clear, concise, and understandable, although the rule would be clearer if the outdated term “opioid addiction” were changed to “substance use disorder” that is consistent with current medical terms.

7. Has the agency received written criticisms of the rules within the last five years? Yes No ✓

If yes, please fill out the table below:

Commenter	Jack Confer, Executive Director, Arizona State Board of Respiratory Care (April 2014)
Comment	The commenter expressed concern that the rule in R9-10-1026 excluded respiratory therapist from doing sleep studies in a licensed sleep center and recommended that the Department add “a licensed respiratory therapist” to rule in R9-10-1026(2).
Agency Response	The Department reviewed the respiratory care statutes in A.R.S. Title 32, Chapter 35 and determined that a “respiratory therapist” is educated, trained, and allowed to perform tests

	related to the sleep disorder services in R9-10-1026. The Department added “respiratory therapist” to the rule in Notice of Exempt Rulemaking at 20 A.A.R. 1597.
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8. Economic, small business, and consumer impact comparison:

The rules in 9 A.A.C. 10, Article 10 were made new in their entirety in 2013 as part of an exempt rulemaking of 9 A.A.C. 10 and 9 A.A.C. 20 to comply with Laws 2011, Ch. 96 that required the Department to adopt rules for health care institutions to reduce monetary or regulatory costs on person or individuals and facilitate licensing of "integrated health programs that provide both behavioral and physical health services." In 2014, the rules in Article 10 were further revised to comply with Laws 2013, Ch. 10 that extended Laws 2011, Ch. 96 exempt rulemaking time period until April 30, 2014. In addition in 2016, three of the rules were revised to allow for an outpatient treatment center to provide respite care for children receiving behavioral health services and a new rule was added to allow for integrated services to occur at the same physical outpatient treatment center location under multiple licenses (colocation). No economic, small business, and consumer impact statements were prepared as a part of the exempt rulemakings. The Department believes persons who are directly affected by, bear the costs of, or directly benefit from the rules are: the Department, outpatient treatment centers, physicians and other health care providers, patients, and the general public. Annual costs and revenues are designated as minimal when more than \$0 and less than \$5,000, moderate when \$5,000 and less than \$20,000, and substantial when \$20,000 or greater. A cost or benefit is designated as significant when meaningful or important but not readily subject to quantification.

In 2017, the Department reported that 2,483 licensed outpatient treatment centers were operating in the state and 9 outpatient treatment centers elected to close. Additionally, 330 initial applications and 1,684 renewal applications were approved. No amended applications were received, and no other applications were denied. The Department completed 2,174 initial and re-licensure surveys and completed 177 complaint investigation surveys. The Department also completed 358 enforcement actions of which 49 were related to surveys and 169 related to late renewal applications. And as a result of the enforcement actions, the Department collected \$149,760.00 in civil money penalties.

In the 2013 exempt rulemaking, eight Sections were renamed or moved and 17 new Sections were added. In new R9-10-1001 definitions were deleted as no longer needed and already defined in A.R.S. § 36-401 or moved to A.A.C. R9-10-101. Thirteen of the definitions specific to dialysis services were moved to R9-10-1018, Dialysis Services. In new R9-10-1001 rule, one definition for “emergency room services” was added. The Department believes the reference to other definitions added to new R9-10-1001 and definitions moved to R9-10-1018 improves the effectiveness and understandability of the rules. The Department believes new rules in R9-10-1001 and R9-10-1018 provide a significant benefit to the Department, outpatient treatment centers, physicians and other health care providers by eliminating confusion, providing more effective rules, and

increasing consistency for all Articles in 9 A.A.C. 10. In new R9-10-1002, the list of health services that an outpatient treatment center may provide was expanded to include services for behavioral health, diagnostic imaging, clinical laboratory, emergency, pain management, physical health, rehabilitation, sleep disorder, urgent care services, and counseling. Most of rules in R9-10-1003 were not affected by this exempt rulemaking. The changes made to new R9-10-1003 rules deleted requirements for: tuberculosis reporting, control, and screening; governing authority to appoint an administrator who is a registered nurse, including specific education and employment qualifications, and a staff member work schedule be provided to the Department within four hours after requested. Other changes to new R9-10-1003 included adding requirements to establish policies and procedures for first aid training, cardiopulmonary resuscitation training, smoking, and telemedicine. The rules were also changed to clarify and make clearer requirements for abuse, neglect, or exploitation of a patient. The Department believes the changes increase benefits for patients by having more health services available through an outpatient treatment center, and most likely, at a cost lower than if provided at a hospital. Outpatient treatment centers are also expected to see benefits as a result of providing more health services. The Department believes that if more health services are provided, an outpatient treatment center's revenue will increase. The Department believes that outpatient treatment centers providing more health services may provide a benefit to the public, who prior to the new rules, would have had to travel out of their community to visit a hospital emergency room for care.

In R9-10-1004, R9-10-1005, and R9-10-1008 the rules were simplified and minor language changes were made to make the rules clearer. In addition, the rules R9-10-1008 were changed to clarify that personnel members' qualifications, skills and knowledge are to be based on the type of physical and behavioral health services expected to be provided by the personnel member. Requirements for patient rights were changed to clarify the types of conduct a patient should not be subjected too, such as coercion and manipulation, and clarified other conduct and rights a patient should receive, such as the choice to participate or refuse to participate in research or experimental treatment. The change to R9-10-1009, Medical Records, was made to require that a patient's order provide by a medical practitioner or behavioral health professional, and other types of documents, be kept in the patient's medical record. Fourteen definitions, thirteen from old R9-10-1001, were added to new R9-10-1018 rules and requirements for appointing a chief clinical officer, standards for an outpatient treatment center's premises where dialysis service are provided, and list of information a patient receiving dialysis should have in the patient's medical record were added. The new rules in R9-10-1028 and R9-10-1029 remain much the same; however, some changes were made to remove antique terms, update references, and clarify language for an evacuation drill. The new R9-10-1030 rules were changed to provide general requirements for premises, physical plant, environmental services, and equipment standards, rather than providing requirements for physical plant health and safety codes and standards based on the types of health services provided: dialysis, medical, and nursing. The Department believes outpatient treatment centers, physicians, other health care providers, and

patients may have experienced significant benefits from having: personnel members who are qualified and trained to perform health services provided to patients, and patient rights that better protect patients, outpatient treatment centers, physicians, and other health care providers. The Department does not believe the changes made through the 2013 exempt rulemaking imposed substantial costs on affected persons.

The 17 new Sections are specific to additional types of health services that an outpatient treatment center may provide and require an outpatient treatment center to submit a supplemental application to the Department. The new Sections include: R9-10-1007, Transport and Transfer; R9-10-1011, Behavioral Health Services; R9-10-1012, Behavioral Health Observation/Stabilization Services; R9-10-1013, Court-ordered Evaluation; R9-10-1014, Court-ordered Treatment; R9-10-1015, Clinical Laboratory; R9-10-1016, Crisis Services; R9-10-1017, Diagnostic Imaging Services; R9-10-1019, Emergency Room Services; R9-10-1020, Opioid Treatment Services; R9-10-1021, Pain Management Services; R9-10-1022, Physical Health Services; R9-10-1023, Pre-petition Screening; R9-10-1024, Rehabilitation Services; R9-10-1025, Respite Services; R9-10-1026, Sleep Disorder Services; and R9-10-1027, Urgent Care Services Provided in a Freestanding Urgent Care Setting. In the new rules, the Department provides minimum requirements and standards to protect the public health and safety of Arizona citizens and the objective of each new rule is listed in paragraph 2. Additionally, the new rules for added health services are consistent with other Chapter 10 Articles. The Department believes for outpatient treatment centers that choose to add additional health services an initial moderate-to-substantial increase in costs could occur, depending on which health services and how many health services are added.

In the 2014 exempt rulemaking, changes to R9-10-1001, as in most other Sections, include minor language changes and clarifications to make the rules clearer and more effective. Also, changes to rules in R9-10-1003, as in 13 other Sections, include updating citations and correcting references. In R9-10-1003, requirements were added for policies and procedures that cover patient safety reporting and non-retaliation and prescribing a controlled substance. Other changes included changing the policies and procedures review period to three years from two years and requirements for abuse, neglect, or exploitation of a patient were clarified and increased the time period for initiating an investigation from 48 hours to five working days. In new R9-10-1007, a requirement for patient transport and transfer was changed to clarify medical record information and a new subsection that identifies under what circumstances the transport and transfer requirements do not apply was added. For example, the requirements do not apply to a patient being transported to a location other than a licensed health care institution. A change in R9-10-1008 was made to clarify a requirement for restraints and seclusion that a patient should not be subjected too. In addition, requirements in R9-10-1009, Medical Records, were added for obtaining contact information for patient's representative; copies of health care or mental health care power of attorney; and a copy of a court order establishing guardianship. The Department believes that outpatient treatment centers should experience a significant benefit for having more time to complete policies and procedures review and initiate an

investigation required in R9-10-1003. The Department believes that patients should experience a significant benefit for having clearer abuse, neglect, or exploitation and restraint and seclusion rules that increase patients' health and safety. The Department does not believe that the rules in these Sections will lead to cost increases for affected persons.

In R9-10-1010, a requirement that a patient's medical record contain pain management documentation was deleted since the documentation is included in R9-10-1009 and a change for medication storage was made to clarify where medication is stored. Also, other professionals that may provide health services to a patient were added in R9-10-1011 and R9-10-1016, a registered nurse; R9-10-1018, a social worker; and R9-10-1026, a respiratory therapist. Further, other changes to R9-10-1011 included moving requirements for respite services to R9-10-1025. In R9-10-1012, Behavioral Health Observation/Stabilization Services, a requirement for a "room used for seclusion" to comply with requirements in R9-10-316 was added and in R9-10-1019, a policy and procedure requirement for emergency room services was added. In R9-10-1020, the definitions "opioid treatment service" and opioid agonist treatment medication" were moved to Chapter 10, Article 1. Contagious disease and communicable disease reporting requirements were deleted from R9-10-1028. And in R9-10-1029, national standards were updated and an exception for outpatient treatment centers build before October 2013 and have a corridor less than 44 inches was added. Lastly, in R9-10-1030, the rule was changed to clarify the types of bathroom located on the premises and the Department added requirements for bathrooms maintenance. The Department believes that outpatient treatment centers, physician, other personnel members, and patients will most likely benefit from the new rules, especially the addition of other professionals who may provide health services to a patient, as included in R9-10-1011, R9-10-1016, R9-10-1018, and R9-10-1026. The Department believes that the changes made through the 2014 exempt rulemaking moderately benefit affected persons and have not increased costs.

As part of the 2016 exempt rulemaking, changes in R9-10-1002 added children's behavioral health services to the list of services that an outpatient treatment center may provide. In R9-10-1025, Respite Services, definitions for "outing," "parent," and "respite capacity" were added. In addition, in R9-10-1025 for children receiving respite services requirements were added that include continuous hours of care and supervision; personnel member providing respite services; modified fire, evacuation, and emergency safety procedures; children's medical records; indoor and outdoor activities; napping; meals and snacks; laundry and bathrooms; and maintaining premises and furniture in a manner that is sanitary and safe for children. A requirement in R9-10-1030 was changed to require provision of a bathroom specifically for use by children who are on the premises and receiving respite services. Lastly, new requirements and standards were added in R9-10-1031 for integrated services to occur at the same physical outpatient treatment center location under multiple licenses, known as colocation. The Department believes that most outpatient treatment centers who choose to add respite services for children will initially incur minimal-to-moderate costs for making the premises compliant with rule and adding

personnel to supervise and care for the children. The Department also believes that outpatient treatment centers, children, and parents will experience a significant benefit that outweighs the costs as a result of providing and having alternative respite service resources for children who need respite services. Likewise, the Department believes that outpatient treatment centers that meet the requirements in R9-10-1030 and enter into an agreement with an associated licensed provider may incur minimal-to-moderate cost increases. However, over time they may experience an increase in revenues as a result of an expanded scope of services for their patients. And for patients, who receive services from collaborators, the Department believes patients may experience a significant benefit as a result of additional options for health services and providers.

Overall, the Department believes the changes made to the rules may have created a minimal increase in costs, but the benefits of more effective and understandable rules outweigh any costs. Through the exempt rulemakings, the Department reduced regulatory cost on persons or individuals and simplified licensing of integrated health programs that provide both behavioral and physical health services; integrated services to occur at the same physical outpatient treatment center location under multiple licenses; and provided provision for respite care on the premises of an outpatient treatment center for children receiving behavioral health services. The Department believes that the benefits of the rules for affected persons are far greater than the costs.

9. Has the agency received any business competitiveness analyses of the rules? Yes No

10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?

Please state what the previous course of action was and if the agency did not complete the action, please explain why not.

This is the first five-year-review of the new rules adopted by exempt rulemaking in 2013 and amended in 2014.

11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:

The Department has determined that the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

12. Are the rules more stringent than corresponding federal laws? Yes No

Please provide a citation for the federal law(s). And if the rule(s) is more stringent, is there statutory authority to exceed the requirements of federal law(s)?

The rules are not related to federal laws.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

A general permit is not applicable. The rules require the issuance of a specific agency authorization, which is authorized by A.R.S. § 36-405.

14. Proposed course of action

If possible, please identify a month and year by which the agency plans to complete the course of action.

The Department plans to amend the rules in 9 A.A.C. 10, Article 10 to address issues identified in this five-year-review report in an expedited rulemakings. The Department plans to submit a Notice of Final Expedited Rulemaking to the Council by June 2019.

Teresa Koehler

From: Valerie Grina
Sent: Monday, April 7, 2014 8:14 AM
To: Teresa Koehler; Patti Cordova; Ruthann Smejkal
Subject: FW: Rule recommendation R9-10-226

Please put on the agenda

From: Connie Belden
Sent: Thursday, April 03, 2014 6:22 PM
To: Valerie Grina
Cc: Cara Christ; Kathryn McCanna
Subject: Rule recommendation R9-10-226

Sleep Disorder Services

Current Rule:

R9-10-1026.2. A polysomnographic technician certified by the Board of Registered Polysomnographic Technologists (BRPT) or accepted by BRPT to sit for the BRPT certification examination is present on the premise of the outpatient treatment center;

Recommendation for Rule Change:

A polysomnographic technician certified by the Board of Registered Polysomnographic Technologists (BRPT) or accepted by BRPT to sit for the BRPT certification examination or a **licensed Respiratory Therapist** is present on the premise of the outpatient treatment center;

Background: BMFL met with the Executive Director of the Respiratory Therapy Board today. They were concerned that our rule excluded them from doing Sleep studies in a licensed Sleep Center. We explained the rule did not exclude an RT from doing the procedure but the rule did require a Polysom to be present on the premise.

In review of the RT Statutes at ARS 32-3501 through 3558, it appears that they are educated and trained and allowed to do these tests.

Mr. Jack Confer, Executive Director, is available if further clarification is required. The RTs educational program includes sleep study process according to the Director of the Board.

I do know that there are many RTs staffing these centers and many of the centers will staff with only one staff member during the study.

Thank you for your consideration to a last minute rule change.

9 A.A.C. 8, ARTICLE 10 - ATTACHMENT A – OTC RULES

ARTICLE 10. OUTPATIENT TREATMENT CENTERS

R9-10-1001. Definitions

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

“Emergency room services” means medical services provided to a patient in an emergency.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1002. Supplemental Application Requirements

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

1. The days and hours of clinical operation and, if different from the days and hours of clinical operation, the days and hours of administrative operation; and
2. A request to provide one or more of the following services:
 - a. Behavioral health services and, if applicable;
 - i. Behavioral health observation/stabilization services,
 - ii. Children’s behavioral health services,
 - iii. Court-ordered evaluation,
 - iv. Court-ordered treatment,
 - v. Counseling,
 - vi. Crisis services,
 - vii. Opioid treatment services,
 - viii. Pre-petition screening,
 - ix. Respite services,
 - x. Respite services for children on the premises,
 - xi. DUI education,
 - xii. DUI screening,
 - xiii. DUI treatment, or
 - xiv. Misdemeanor domestic violence offender treatment;
 - b. Diagnostic imaging services;
 - c. Clinical laboratory services;

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- d. Dialysis services;
 - e. Emergency room services;
 - f. Pain management services;
 - g. Physical health services;
 - h. Rehabilitation services;
 - i. Sleep disorder services; or
 - j. Urgent care services provided in a freestanding urgent care center setting.
- B.** In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority of an:
- 1. Affiliated outpatient treatment center, as defined in R9-10-1901, applying for an initial or renewal license for the affiliated outpatient treatment center shall submit, in a format provided by the Department, the following information for each counseling facility for which the affiliated outpatient treatment center is providing administrative support:
 - a. Name, and
 - b. Either:
 - i. The license number assigned to the counseling facility by the Department; or
 - ii. If the counseling facility is not currently licensed, the:
 - (1) Counseling facility's street address, and
 - (2) Date the counseling facility submitted to the Department an application for an initial health care institution license; and
 - 2. Outpatient treatment center, applying for an initial or renewal license that includes a request for authorization to provide respite services for children on the premises, shall include the requested respite capacity, as defined in R9-10-1025(A).

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2).

R9-10-1003. Administration

- A.** If an outpatient treatment center is operating under a single group license issued to a hospital according to A.R.S. § 36-422(F) or (G), the hospital's governing authority is the governing authority for the outpatient treatment center.

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B. A governing authority shall:

1. Consist of one or more individuals accountable for the organization, operation, and administration of an outpatient treatment center;
2. Establish, in writing:
 - a. An outpatient treatment center's scope of services, and
 - b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (B)(2)(b);
4. Adopt a quality management program according to R9-10-1004;
5. Review and evaluate the effectiveness of the quality management program in R9-10-1004 at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (B)(2)(b) if the administrator is:
 - a. Expected not to be present on an outpatient treatment center's premises for more than 30 calendar days, or
 - b. Not present on an outpatient treatment center's premises for more than 30 calendar days; and
7. Except as provided in subsection (B)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in an administrator and identify the name and qualifications of the new administrator.

C. An administrator:

1. Is directly accountable to the governing authority for the daily operation of the outpatient treatment center and all services provided by or at the outpatient treatment center;
2. Has the authority and responsibility to manage the outpatient treatment center; and
3. Except as provided in subsection (B)(6), designates, in writing, an individual who is present on the outpatient treatment center's premises and accountable for the outpatient treatment center when the administrator is not available.

D. An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to services provided to a patient;
 - d. Cover the requirements in Title 36, Chapter 4, Article 11;
 - e. Cover cardiopulmonary resuscitation training including:

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- i. The method and content of cardiopulmonary resuscitation training which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
 - ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
 - iii. The time-frame for renewal of cardiopulmonary resuscitation training, and
 - iv. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;
 - f. Cover first aid training;
 - g. Include a method to identify a patient to ensure the patient receives the services ordered for the patient;
 - h. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
 - i. Cover health care directives;
 - j. Cover medical records, including electronic medical records;
 - k. Cover quality management, including incident report and supporting documentation; and
 - l. Cover contracted services;
2. Policies and procedures for services provided at or by an outpatient treatment center are established, documented, and implemented to protect the health and safety of a patient that:
- a. Cover patient screening, admission, assessment, transport, transfer, discharge plan, and discharge;
 - b. Cover the provision of medical services, nursing services, health-related services, and ancillary services;
 - c. Include when general consent and informed consent are required;
 - d. Cover obtaining, administering, storing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;
 - e. Cover prescribing a controlled substance to minimize substance abuse by a patient;
 - f. Cover infection control;
 - g. Cover telemedicine, if applicable;
 - h. Cover environmental services that affect patient care;
 - i. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. An outpatient treatment center to respond to a complaint;
 - j. Cover smoking tobacco products on an outpatient treatment center's premises; and
 - k. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
3. Outpatient treatment center policies and procedures are:
- a. Reviewed at least once every three years and updated as needed, and
 - b. Available to personnel members and employees;

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4. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of an outpatient treatment center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the outpatient treatment center;
5. The following are conspicuously posted:
 - a. The current license for the outpatient treatment center issued by the Department;
 - b. The name, address, and telephone number of the Department;
 - c. A notice that a patient may file a complaint with the Department about the outpatient treatment center;
 - d. One of the following:
 - i. A schedule of rates according to A.R.S. § 36-436.01(C), or
 - ii. A notice that the schedule of rates required in A.R.S. § 36-436.01(C) is available for review upon request;
 - e. A list of patient rights;
 - f. A map for evacuating the facility; and
 - g. A notice identifying the location on the premises where current license inspection reports required in A.R.S. § 36-425(D), with patient information redacted, are available; and
6. Patient follow-up instructions are:
 - a. Provided, orally or in written form, to a patient or the patient's representative before the patient leaves the outpatient treatment center unless the patient leaves against a personnel member's advice; and
 - b. Documented in the patient's medical record.
- E. If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from an outpatient treatment center's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:
 1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
 2. For a patient under 18 years of age, according to A.R.S. § 13-3620.
- F. If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from an outpatient treatment center's employee or personnel member, an administrator shall:
 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 2. Report the suspected abuse, neglect, or exploitation of the patient as follows:
 - a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or

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- b. For a patient under 18 years of age, according to A.R.S. § 13-3620;
 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (F)(1); and
 - c. The report in subsection (F)(2);
 4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- G.** If an outpatient treatment center is an affiliated outpatient treatment center as defined in R9-10-1901, an administrator shall ensure that the outpatient treatment center complies with the requirements for an affiliated outpatient treatment center in 9 A.A.C. 10, Article 19.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

R9-10-1004. Quality Management

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
 - a. A method to identify, document, and evaluate incidents;
 - b. A method to collect data to evaluate services provided to patients;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;

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- d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
 - e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
 - a. An identification of each concern about the delivery of services related to patient care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1005. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1006. Personnel

An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
 - b. Include:

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- i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description;
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
 3. Sufficient personnel members are present on an outpatient treatment center's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the outpatient treatment center's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient;
 4. A personnel member only provides physical health services or behavioral health services the personnel member is qualified to provide;
 5. A plan is developed, documented, and implemented to provide orientation specific to the duties of personnel members, employees, volunteers, and students;
 6. A personnel member completes orientation before providing medical services, nursing services or health-related services to a patient;
 7. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 8. A plan is developed, documented, and implemented to provide in-service education specific to the duties of a personnel member;
 9. A personnel member's in-service education is documented, to include:
 - a. The personnel member's name,
 - b. The date of the in-service education, and
 - c. The subject or topics covered in the in-service education;

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10. A personnel member who is a behavioral health technician or behavioral health paraprofessional complies with the applicable requirements in R9-10-115;
11. A record for a personnel member, an employee, a volunteer, or a student is maintained that includes:
 - a. The individual's name, date of birth, and contact telephone number;
 - b. The individual's starting date of employment or volunteer service, and if applicable, the ending date;
 - c. Documentation of:
 - i. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
 - ii. The individual's education and experience applicable to the individual's job duties;
 - iii. The individual's completed orientation and in-service education as required by policies and procedures;
 - iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - vi. The individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03, if applicable; and
 - vii. Cardiopulmonary resuscitation training, if the individual is required to have cardiopulmonary resuscitation training according to this Article or policies and procedures; and
12. The record in subsection (A)(11) is:
 - a. Maintained while an individual provides services for or at the outpatient treatment center and for at least 24 months after the last date the employee or volunteer provided services for or at the outpatient treatment center; and
 - b. If the ending date of employment or volunteer service was 12 or more months before the date of the Department's request, provided to the Department within 72 hours after the Department's request.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1007. Transport; Transfer

- A. Except as provided in subsection (B), an administrator shall ensure that:
 1. A personnel member coordinates the transport and the services provided to the patient;
 2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before and after the transport;
 - b. Information from the patient's medical record is provided to a receiving health care institution,

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- c. A personnel member explains risks and benefits of the transport to the patient or the patient's representative; and
 - d. A personnel member communicates or documents why the personnel member did not communicate with an individual at a receiving health care institution;
3. The patient's medical record includes documentation of:
- a. Communication or lack of communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transport.
- B.** Subsection (A) does not apply to:
- 1. Transportation to a location other than a licensed health care institution,
 - 2. Transportation provided for a patient by the patient or the patient's representative,
 - 3. Transportation provided by an outside entity that was arranged for a patient by the patient or the patient's representative, or
 - 4. A transport to another licensed health care institution in an emergency.
- C.** Except for a transfer of a patient due to an emergency, an administrator shall ensure that:
- 1. A personnel member coordinates the transfer and the services provided to the patient;
 - 2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before the transfer;
 - b. Information from the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
 - 3. Documentation in the patient's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transfer.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1008. Patient Rights

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A. An administrator shall ensure that:

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
 - b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Except as allowed in R9-10-1012(B), restraint or seclusion;
 - i. Retaliation for submitting a complaint to the Department or another entity; or
 - j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
 - d. Is informed of the following:
 - i. The outpatient treatment center's policy on health care directives, and
 - ii. The patient complaint process;

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- e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
- f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records.

C. A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1009. Medical Records

A. An administrator shall ensure that:

1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
 - a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
3. An order is:

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- a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
 - c. As permitted by law;
 6. Policies and procedures include the maximum time-frame to retrieve a patient's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and
 7. A patient's medical record is protected from loss, damage, or unauthorized use.
- B.** If an outpatient treatment center maintains patients' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a medical record is recorded by the computer's internal clock.
- C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
 - a. Except as specified in A.A.C. R9-6-1005, the patient's name and address;
 - b. The patient's date of birth; and
 - c. Any known allergies, including medication allergies;
 2. A diagnosis or reason for outpatient treatment center services;
 3. Documentation of general consent and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
 4. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:

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- i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
5. Documentation of medical history and, if applicable, results of a physical examination;
 6. Orders;
 7. Assessment;
 8. Treatment plans;
 9. Interval notes;
 10. Progress notes;
 11. Documentation of outpatient treatment center services provided to the patient;
 12. The name of each individual providing treatment or a diagnostic procedure;
 13. Disposition of the patient upon discharge;
 14. Documentation of the patient's follow-up instructions provided to the patient;
 15. A discharge summary;
 16. If applicable:
 - a. Laboratory reports,
 - b. Radiologic reports,
 - c. Sleep disorder reports,
 - d. Diagnostic reports, and
 - e. Consultation reports;
 17. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual, other than actions taken while providing behavioral health observation/stabilization services; and
 18. Documentation of a medication administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;

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- e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication;
- f. Any adverse reaction a patient has to the medication; and
- g. For prepacked or sample medication provided to the patient for self-administration, the name, strength, dosage, amount, route of administration, and expiration date.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1010. Medication Services

- A.** If an outpatient treatment center provides medication administration or assistance in the self-administration of medication, an administrator shall ensure that policies and procedures for medication services:
 1. Include:
 - a. A process for providing information to a patient about medication prescribed for the patient including:
 - i. The prescribed medication's anticipated results,
 - ii. The prescribed medication's potential adverse reactions,
 - iii. The prescribed medication's potential side effects, and
 - iv. Potential adverse reactions that could result from not taking the medication as prescribed;
 - b. Procedures for preventing, responding to, and reporting:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner and meets the patient's needs;
 - d. Procedures for documenting medication administration and assistance in the self-administration of medication;
 - e. Procedures for assisting a patient in obtaining medication; and
 - f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
 2. Specify a process for review through the quality management program of:
 - a. A medication administration error, and
 - b. An adverse reaction to a medication.
- B.** If an outpatient treatment center provides medication administration, an administrator shall ensure that:

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1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a patient only as prescribed; and
 - d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
 3. A medication administered to a patient is:
 - a. Administered in compliance with an order, and
 - b. Documented in the patient's medical record.
- C. If an outpatient treatment center provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A patient's medication is stored by the outpatient treatment center;
 2. The following assistance is provided to a patient:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the patient;
 - c. Observing the patient while the patient removes the medication from the container;
 - d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:
 - i. The patient taking the medication is the individual stated on the medication container label,
 - ii. The patient is taking the dosage of the medication stated on the medication container label, and
 - iii. The patient is taking the medication at the time stated on the medication container label; or
 - e. Observing the patient while the patient takes the medication;
 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
 4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,

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- ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
 - 5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
 - 6. Assistance in the self-administration of medication provided to a patient is:
 - a. In compliance with an order, and
 - b. Documented in the patient's medical record.
- D.** An administrator shall ensure that:
- 1. A current drug reference guide is available for use by personnel members;
 - 2. A current toxicology reference guide is available for use by personnel members;
 - 3. If pharmaceutical services are provided:
 - a. The pharmaceutical services are provided under the direction of a pharmacist;
 - b. The pharmaceutical services comply with ARS Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
 - c. A copy of the pharmacy license is provided to the Department upon request.
- E.** When medication is stored at an outpatient treatment center, an administrator shall ensure that:
- 1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 - 2. Medication is stored according to the instructions on the medication container; and
 - 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of patients who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.
- F.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the outpatient treatment center's clinical director.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

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R9-10-1011. Behavioral Health Services

- A.** An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that:
1. The outpatient treatment center does not provide a behavioral health service the outpatient treatment center is not authorized to provide;
 2. The behavioral health services provided by or at the outpatient treatment center:
 - a. Are provided under the direction of a behavioral health professional; and
 - b. Comply with the requirements:
 - i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115, and
 - ii. For an assessment, in subsection (B);
 3. A personnel member who provides behavioral health services is:
 - a. At least 21 years of age; or
 - b. At least 18 years of age and is licensed or certified under A.R.S. Title 32 and providing services within the personnel member's scope of practice; and
 4. If an outpatient treatment center provides behavioral health services to a patient who is less than 18 years of age, the owner and an employee or a volunteer comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.
- B.** An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that:
1. Except as provided in subsection (B)(2), a behavioral health assessment for a patient is completed before treatment for the patient is initiated;
 2. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the outpatient treatment center or the outpatient treatment center has a medical record for the patient that contains an assessment that was completed within 12 months before the date of the patient's current admission:
 - a. The patient's assessment information is reviewed and updated if additional information that affects the patient's assessment is identified, and
 - b. The review and update of the patient's assessment information is documented in the patient's medical record within 48 hours after the review is completed;
 3. If a behavioral health assessment is conducted by a:
 - a. Behavioral health technician or a registered nurse, within 72 hours a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient reviews and signs the behavioral

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- health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the patient; or
- b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the behavioral health services needed by the patient;
4. A behavioral health assessment:
- a. Documents a patient's:
- i. Presenting issue;
- ii. Substance abuse history;
- iii. Co-occurring disorder;
- iv. Medical condition and history;
- v. Legal history, including:
- (1) Custody,
- (2) Guardianship, and
- (3) Pending litigation;
- vi. Criminal justice record;
- vii. Family history;
- viii. Behavioral health treatment history; and
- ix. Symptoms reported by the patient and referrals needed by the patient, if any;
- b. Includes:
- i. Recommendations for further assessment or examination of the patient's needs;
- ii. The behavioral health services, physical health services, or ancillary services that will be provided to the patient; and
- iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and
- c. Is documented in patient's medical record;
5. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;
6. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;
7. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;

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8. Documentation of the request in subsection (B)(6) and the opportunity in subsection (B)(7) is in the patient's medical record;
 9. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;
 10. If information in subsection (B)(4)(a) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;
 11. Counseling is:
 - a. Offered as described in the outpatient treatment center's scope of services,
 - b. Provided according to the frequency and number of hours identified in the patient's assessment, and
 - c. Provided by a behavioral health professional or a behavioral health technician;
 12. A personnel member providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and
 13. Each counseling session is documented in the patient's medical record to include:
 - a. The date of the counseling session;
 - b. The amount of time spent in the counseling session;
 - c. Whether the counseling was individual counseling, family counseling, or group counseling;
 - d. The treatment goals addressed in the counseling session; and
 - e. The signature of the personnel member who provided the counseling and the date signed.
- C. An administrator of an outpatient treatment center authorized to provide behavioral health services may request to provide any of the following to individuals required to attend by a referring court:
1. DUI screening,
 2. DUI education,
 3. DUI treatment, or
 4. Misdemeanor domestic violence offender treatment.
- D. An administrator of an outpatient treatment center authorized to provide the services in subsection (C):
1. Shall comply with the requirements for the specific service in 9 A.A.C. 20, and
 2. May have a behavioral health technician who has the appropriate skills and knowledge established in policies and procedures provide the services.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1011 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995

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(Supp. 95-3). The proposed summary action repealing R9-10-1011 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1012. Behavioral Health Observation/Stabilization Services

- A. An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall ensure that:
 1. Behavioral health observation/stabilization services are available 24 hours a day, every calendar day;
 2. Behavioral health observation/stabilization services are provided in a designated area that:
 - a. Is used exclusively for behavioral health observation/stabilization services;
 - b. Has the space for a patient to receive privacy in treatment and care for personal needs; and
 - c. For every 15 observation chairs or less, has at least one bathroom that contains:
 - i. A working sink with running water,
 - ii. A working toilet that flushes and has a seat,
 - iii. Toilet tissue,
 - iv. Soap for hand washing,
 - v. Paper towels or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A means of ventilation;
 3. If the outpatient treatment center is authorized to provide behavioral health observation/stabilization services to individuals under 18 years of age:
 - a. There is a separate designated area for providing behavioral health observation/stabilization services to individuals under 18 years of age that:
 - i. Meets the requirements in subsection (B)(2), and
 - ii. Has floor to ceiling walls that separate the designated area from other areas of the outpatient treatment center;
 - b. A registered nurse is present in the separate designated area; and
 - c. A patient under 18 years of age does not share any space, participate in any activity or treatment, or have verbal or visual interaction with a patient 18 years of age or older;
 4. A medical practitioner is available;

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5. If the medical practitioner present at the outpatient treatment center is a registered nurse practitioner or a physician assistant, a physician is on-call;
6. A registered nurse is present and provides direction for behavioral health observation/stabilization services in the designated area;
7. A nurse monitors each patient at the intervals determined according to subsection (A)(12) and documents the monitoring in the patient's medical record;
8. An individual who arrives at the designated area for behavioral health observation/stabilization services in the outpatient treatment center is screened within 30 minutes after entering the designated area to determine whether the individual is in need of immediate physical health services;
9. If a screening indicates that an individual needs immediate physical health services that the outpatient treatment center is:
 - a. Able to provide according to the outpatient treatment center's scope of services, the individual is examined by a medical practitioner within 30 minutes after being screened; or
 - b. Not able to provide, the individual is transferred to a health care institution capable of meeting the individual's immediate physical health needs;
10. If a screening indicates that an individual needs behavioral health observation/stabilization services and the outpatient treatment center has the capabilities to provide the behavioral health observation/stabilization services, the individual is admitted to the designated area for behavioral health observation/stabilization services and may remain in the designated area and receive observation/stabilization services for up to 23 hours and 59 minutes;
11. Before a patient is discharged from the designated area for behavioral health observation/stabilization services, a medical practitioner determines whether the patient will be:
 - a. If the behavioral health observation/stabilization services are provided in a health care institution that also provides inpatient services and is capable of meeting the patient's needs, admitted to the health care institution as an inpatient;
 - b. Transferred to another health care institution capable of meeting the patient's needs;
 - c. Provided a referral to another entity capable of meeting the patient's needs; or
 - d. Discharged and provided patient follow-up instructions;
12. When a patient is admitted to a designated area for behavioral health observation/stabilization services, an assessment of the patient includes the interval for monitoring the patient based on the patient's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the patient;
13. If a patient is not being admitted as an inpatient to a health care institution, before discharging the patient from a designated area for behavioral health observation/stabilization services, a personnel member:

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- a. Identifies the specific needs of the patient after discharge necessary to assist the patient to function independently;
 - b. Identifies any resources, including family members, community social services, peer support services, and Regional Behavioral Health Agency staff, that may be available to assist the patient; and
 - c. Documents the information in subsection (A)(13)(a) and the resources in subsection (A)(13)(b) in the patient's medical record;
14. When a patient is discharged from a designated area for behavioral health observation/stabilization services, a personnel member:
- a. Provides the patient with discharge information that includes:
 - i. The identified specific needs of the patient after discharge, and
 - ii. Resources that may be available for the patient; and
 - b. Contacts any resources identified as required in subsection (A)(13)(b);
15. Except as provided in subsection (A)(16), a patient is not re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the patient's discharge from a designated area for behavioral health observation/stabilization services;
16. A patient may be re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the patient's discharge if:
- a. It is at least one hour since the time of the patient's discharge;
 - b. A law enforcement officer or the patient's case manager accompanies the patient to the outpatient treatment center;
 - c. Based on a screening of the patient, it is determined that re-admission for behavioral health observation/stabilization is necessary for the patient; and
 - d. The name of the law enforcement officer or the patient's case manager and the reasons for the determination in subsection (A)(16)(c) are documented in the patient's medical record;
17. A patient admitted for behavioral health observation/stabilization services is provided:
- a. An observation chair; or
 - b. A separate piece of equipment for the patient to use to sit or recline that:
 - i. Is at least 12 inches from the floor; and
 - ii. Has sufficient space around the piece of equipment to allow a personnel member to provide behavioral health services and physical health services, including emergency services, to the patient;
18. If an individual is not admitted for behavioral health observation/stabilization services because there is not an observation chair available for the individual's use, a personnel member provides support to the individual to access the services or resources necessary for the individual's health and safety, which may include:

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- a. Admitting the individual to the outpatient treatment center to provide behavioral health services other than behavioral health observation/stabilization services;
 - b. Establishing a method to notify the individual when there is an observation chair available;
 - c. Referring or providing transportation to the individual to another health care institution;
 - d. Assisting the individual to contact the individual's support system; and
 - e. If the individual is enrolled with a Regional Behavioral Health Authority, contacting the appropriate person to request assistance for the individual;
19. Personnel members establish a log of individuals who were not admitted because there was not an observation chair available and document the individual's name, actions taken to provide support to the individual to access the services or resources necessary for the individual's health and safety, and date and time the actions were taken;
20. The log required in subsection (A)(19) is maintained for at least 12 months after the date of documentation in the log;
21. An observation chair or, as provided in subsection (A)(17)(b), a piece of equipment used by a patient to sit or recline is visible to a personnel member;
22. Except as provided in subsection (A)(23), a patient admitted to receive behavioral health observation/stabilization services is visible to a personnel member;
23. A patient admitted to receive behavioral health observation/stabilization services may use the bathroom and not be visible to a personnel member, if the personnel member:
- a. Determines that the patient is capable of using the bathroom unsupervised,
 - b. Is aware of the patient's location, and
 - c. Is able to intervene in the patient's actions to ensure the patient's health and safety; and
24. An observation chair:
- a. Effective until July 1, 2015, has space around the observation chair that allows a personnel member to provide behavioral health services and physical health services, including emergency services, to a patient in the observation chair; and
 - b. Effective on July 1, 2015, has at least three feet of clear floor space:
 - i. On at least two sides of the observation chair, and
 - ii. Between the observation chair and any other observation chair.
- B. An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall:
- 1. Have a room used for seclusion that complies with requirements for seclusion rooms in R9-10-316, and
 - 2. Comply with the requirements for restraint and seclusion in R9-10-316.

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- C. An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover the process for:
 - i. Evaluating a patient previously admitted to the designated area to determine whether the patient is ready for admission to an inpatient setting or discharge, including when to implement the process;
 - ii. Contacting other health care institutions that provide behavioral health observation/stabilization services to determine if the patient could be admitted for behavioral health observation/stabilization services in another health care institution, including when to implement the process; and
 - iii. Ensuring that sufficient personnel members, space, and equipment are available to provide behavioral health observation/stabilization services to patients admitted to receive behavioral health observation/stabilization services; and
 - b. Establish a maximum capacity of the number of patients for whom the outpatient treatment center is capable of providing behavioral health observation/stabilization services;
 2. The outpatient treatment center does not:
 - a. Exceed the maximum capacity established by the outpatient treatment center in subsection (C)(1)(b); or
 - b. Admit an individual if the outpatient treatment center does not have personnel members, space, and equipment available to provide behavioral health observation/stabilization services to the individual; and
 3. Effective on July 1, 2015:
 - a. If an admission of an individual causes the outpatient treatment center to exceed the outpatient treatment center's licensed occupancy, the individual is only admitted for behavioral health observation/stabilization services after:
 - (i.) A behavioral health professional reviews the individual's screening and determines the admission is an emergency; and
 - (ii.) Documents the determination in the individual's medical record; and
 - b. The outpatient treatment center's quality management program's plan, required in R9-10-1004(1), includes a method to identify and document each occurrence of exceeding licensed occupancy, to evaluate the occurrences of exceeding licensed occupancy, and to review the actions taken to reduce future occurrences of exceeding licensed occupancy.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1012 adopted as an emergency now adopted and amended as a permanent rule

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effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1012 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1013. Court-ordered Evaluation

An administrator of an outpatient treatment center that is authorized to provide court-ordered evaluation shall comply with the requirements for court-ordered evaluation in A.R.S. § 36-425.03.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1013 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1013 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1014. Court-ordered Treatment

An administrator of an outpatient treatment center that is authorized to provide court-ordered treatment shall comply with the requirements for court-ordered treatment in A.R.S. Title 36, Chapter 5, Article 4.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1014 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1014 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222,

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effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1015. Clinical Laboratory Services

An administrator of an outpatient treatment center that is authorized to provide clinical laboratory services shall ensure that:

1. If clinical laboratory services are provided on the premises or at another location, the clinical laboratory services are provided by a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the U.S. Department of Health and Human Services under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. 263a, as amended by Public Law 100-578, October 31, 1988; and
2. A clinical laboratory test result is documented in a patient's medical record including:
 - a. The name of the clinical laboratory test;
 - b. The patient's name;
 - c. The date of the clinical laboratory test;
 - d. The results of the clinical laboratory test; and
 - e. If applicable, any adverse reaction related to or as a result of the clinical laboratory test.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1015 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1015 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1016. Crisis Services

- A. An administrator of an outpatient treatment center that is authorized to provide crisis services shall comply with the requirements for behavioral health services in R9-10-1011.
- B. An administrator of an outpatient treatment center that is authorized to provide crisis services shall ensure that:

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1. Crisis services are available during clinical hours of operation;
2. A behavioral health technician, qualified to provide crisis services according to the outpatient treatment center's policies and procedures, is present in the outpatient treatment center during clinical hours of operation; and
3. The following individuals, qualified to provide crisis services according to policies and procedures, are available during clinical hours of operation:
 - a. A behavioral health professional,
 - b. A medical practitioner, and
 - c. A registered nurse.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1016 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1016 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1017. Diagnostic Imaging Services

An administrator of an outpatient treatment center that is authorized to provide diagnostic imaging services shall:

1. Designate an individual to provide direction for diagnostic imaging services who is a:
 - a. Radiologic technologist certified under A.R.S. Title 32, Chapter 28, Article 2 who has at least 12 months experience in an outpatient treatment center;
 - b. Physician; or
 - c. Radiologist; and
2. Ensure that:
 - a. Diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and 12 A.A.C. 1;
 - b. A copy of a certificate documenting compliance with subsection (2)(a) is maintained;
 - c. Diagnostic imaging services are provided to a patient according to an order that includes:
 - i. The patient's name,
 - ii. The name of the ordering individual,

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- iii. The diagnostic imaging procedure ordered, and
- iv. The reason for the diagnostic imaging procedure;
- d. A physician or radiologist interprets the diagnostic image; and
- e. A diagnostic imaging patient report is completed that includes:
 - i. The patient's name,
 - ii. The date of the procedure, and
 - iii. A physician's or radiologist's interpretation of the diagnostic image.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1017 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1017 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1018. Dialysis Services

- A. In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-1001, the following definitions apply in this Section:
- 1. “Caregiver” means an individual designated by a patient or a patient's representative to perform self-dialysis in the patient's stead.
 - 2. “Chief clinical officer” means a physician appointed to provide direction for dialysis services provided by an outpatient treatment center.
 - 3. “Long-term care plan” means a written plan of action for a patient with kidney failure that is developed to achieve long-term optimum patient outcome.
 - 4. “Modality” means a method of treatment for kidney failure, including transplant, hemodialysis, and peritoneal dialysis.
 - 5. “Nutritional assessment” means an analysis of a patient's weight, height, lifestyle, medication, mobility, food and fluid intake, and diagnostic procedures to identify conditions and behaviors that indicate whether the patient's nutritional needs are being met.

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6. “Patient care plan” means a written document for a patient receiving dialysis that identifies the patient’s needs for medical services, nursing services, and health-related services and the process by which the medical services, nursing services, or health-related services will be provided to the patient.
 7. “Peritoneal dialysis” means the process of using the peritoneal cavity for removing waste products by fluid exchange.
 8. “Psychosocial evaluation” means an analysis of an individual’s mental and social conditions to determine the individual’s need for social work services.
 9. “Reprocessing” means cleaning and sterilizing a dialyzer previously used by a patient so that the dialyzer can be reused by the same patient.
 10. “Self-dialysis” means dialysis performed by a patient or a caregiver on the patient’s body.
 11. “Social worker” means an individual licensed according to A.R.S. Title 32, Chapter 33 to engage in the “practice of social work” as defined in A.R.S. § 32-3251.
 12. “Stable means” that a patient’s blood pressure, temperature, pulse, respirations, and diagnostic procedure results are within medically recognized acceptable ranges or consistent with the patient’s usual medical condition so that medical intervention is not indicated.
 13. “Transplant surgeon” means a physician who:
 - a. Is board eligible or board certified in general surgery or urology by a professional credentialing board, and
 - b. Has at least 12 months of training or experience performing renal transplants and providing care for patients with renal transplants.
- B.** A governing authority of an outpatient treatment center that is authorized to provide dialysis services shall:
1. Ensure that the administrator appointed as required in R9-10-1003(B)(3) has at least 12 months of experience in an outpatient treatment center providing dialysis services; and
 2. Appoint a chief clinical officer to direct the dialysis services provided by or at the outpatient treatment center who is a physician who:
 - a. Is board eligible or board certified in internal medicine or pediatrics by a professional credentialing board, and
 - b. Has at least 12 months of experience or training in providing dialysis services.
- C.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that:
1. In addition to the policies and procedures required in R9-10-1003(D), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. Long-term care plans and patient care plans,
 - b. Assigning a patient an identification number,
 - c. Personnel members’ response to a patient’s adverse reaction during dialysis, and
 - d. Personnel members’ response to an equipment malfunction during dialysis;

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2. A personnel member complies with the requirements in A.R.S. § 36-423 and R9-10-114 for hemodialysis technicians and hemodialysis technician trainees, if applicable;
 3. A personnel member completes basic cardiopulmonary resuscitation training specific to the age of the patients receiving dialysis from the outpatient treatment center:
 - a. Before providing dialysis services, and
 - b. At least once every 12 months after the initial date of employment or volunteer service;
 4. A personnel member wears a name badge that displays the individual's first name, job title, and professional license or certification; and
 5. At least one registered nurse or medical practitioner is on the premises while a patient receiving dialysis services is on the premises.
- D.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that:
1. The premises of the outpatient treatment center where dialysis services are provided complies with the applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in A.A.C. R9-1-412, that were in effect on the date listed on the building permit or zoning clearance submitted, as required by R9-10-104, as part of the application for approval of the architectural plans and specifications submitted before initial approval of the inclusion of dialysis services in the outpatient treatment center's scope of services;
 2. Before a modification of the premises of an outpatient treatment center where dialysis services are provided is made, an application for approval of the architectural plans and specifications of the outpatient treatment center required in R9-10-104(A):
 - a. Is submitted to the Department; and
 - b. Demonstrates compliance with the applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in A.A.C. R9-1-412, in effect on the date:
 - i. Listed on the building permit or zoning clearance submitted as part of the application for approval of the architectural plans and specifications for the modification, or
 - ii. The application for approval of the architectural plans and specifications of the modification of the outpatient treatment center required in R9-10-104(A) is submitted to the Department; and
 3. A modification of the outpatient treatment center complies with applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in A.A.C. R9-1-412 in effect on the date:
 - a. Listed on the building permit or zoning clearance submitted as part of the application for approval of the architectural plans and specifications for the modification, or

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- b. The application for approval of the architectural plans and specifications required in R9-10-104(A) is submitted to the Department.
- E. An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that for a patient receiving dialysis services:
- 1. The dialysis services provided to the patient meet the needs of the patient;
 - 2. A physician:
 - a. Performs a medical history and physical examination on the patient within 30 calendar days before admission or within 48 hours after admission, and
 - b. Documents the medical history and physical examination in the patient's medical record within 48 hours after admission;
 - 3. If the patient's medical history and physical examination required in subsection (E)(2) is not performed by the patient's nephrologist, the patient's nephrologist, within 30 calendar days after the date of the medical history and physical examination:
 - a. Reviews and authenticates the patient's medical history and physical examination, documents concurrence with the medical history and physical examination, and includes information specific to nephrology; or
 - b. Performs a medical history and physical examination that includes information specific to nephrology;
 - 4. The patient's nephrologist or the nephrologist's designee:
 - a. Performs a medical history and physical examination on the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center, and
 - b. Documents monthly notes related to the patient's progress in the patient's medical record;
 - 5. A registered nurse responsible for the nursing services provided to the patient receiving dialysis services:
 - a. Reviews with the patient the results of any diagnostic tests performed on the patient;
 - b. Assesses the patient's medical condition before the patient begins receiving hemodialysis and after the patient has received hemodialysis;
 - c. If the patient returns to another health care institution after receiving dialysis services at the outpatient treatment center, provides an oral or written notice of information related to the patient's medical condition to the registered nurse responsible for the nursing services provided to the patient at the health care institution or, if there is not a registered nurse responsible, the individual responsible for the medical services, nursing services, or health-related services provided to the patient at the health care institution;
 - d. Informs the patient's nephrologist of any changes in the patient's medical condition or needs; and
 - e. Documents in the patient's medical record:
 - i. Any notice provided as required in subsection (E)(5)(c), and
 - ii. Monthly notes related to the patient's progress;

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6. If the patient is not stable, before dialysis is provided to the patient, a nephrologist is notified of the patient's medical condition and dialysis is not provided until the nephrologist provides direction;
7. The patient:
 - a. Is under the care of a nephrologist;
 - b. Is assigned a patient identification number according to the policy and procedure in subsection (C)(1)(b);
 - c. Is identified by a personnel member before beginning dialysis;
 - d. Receives the dialysis services ordered for the patient by a medical practitioner;
 - e. Is monitored by a personnel member while receiving dialysis at least once every 30 minutes; and
 - f. If the outpatient treatment center reprocesses and reuses dialyzers, is informed that the outpatient treatment center reprocesses and reuses dialyzers before beginning hemodialysis;
8. Equipment used for hemodialysis is inspected and tested according to the manufacturer's recommendations or the outpatient treatment center's policies and procedures before being used to provide hemodialysis to a patient;
9. The equipment inspection and testing required in subsection (E)(8) is documented in the patient's medical record;
10. Supplies and equipment used for dialysis services for the patient are used, stored, and discarded according to manufacturer's recommendations;
11. If hemodialysis is provided to the patient, a personnel member:
 - a. Inspects the dialyzer before use to ensure that the:
 - i. External surface of the dialyzer is clean;
 - ii. Dialyzer label is intact and legible;
 - iii. Dialyzer, blood port, and dialysate port are free from leaks and cracks or other structural damage; and
 - iv. Dialyzer is free of visible blood and other foreign material;
 - b. Verifies the order for the dialyzer to ensure the correct dialyzer is used for the correct patient;
 - c. Verifies the duration of dialyzer storage based on the type of germicide used or method of sterilization or disinfection used;
 - d. If the dialyzer has been reprocessed and is being reused, verifies that the label on the dialyzer includes:
 - i. The patient's name and the patient's identification number,
 - ii. The number of times the dialyzer has been used in patient treatments,
 - iii. The date of the last use of the dialyzer by the patient, and
 - iv. The date of the last reprocessing of the dialyzer;
 - e. If the patient's name is similar to the name of another patient receiving dialysis in the same outpatient treatment center, informs other personnel members, employees, and volunteers, of the similar names to ensure that the name or other identifying information on the label corresponds to the correct patient; and
 - f. Ensures that a patient's vascular access is visible to a personnel member during dialysis;

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12. A patient receiving dialysis is visible to a nurse at a location used by nurses to coordinate patients and treatment;
 13. If the patient has an adverse reaction during dialysis, a personnel member responds by implementing the policy and procedure required in subsection (C)(1)(c);
 14. If the equipment used during the patient's dialysis malfunctions, a personnel member responds by implementing the policy and procedure required in subsection (C)(1)(d); and
 15. After a patient's discharge from an outpatient treatment center, the nephrologist responsible for the dialysis services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
 - a. A description of the patient's medical condition and the dialysis services provided to the patient, and
 - b. The signature of the nephrologist.
- F.** If an outpatient treatment center provides support for self-dialysis services, an administrator shall ensure that:
1. A patient or the patient's caregiver is:
 - a. Instructed to use the equipment to perform self-dialysis by a personnel member trained to provide the instruction, and
 - b. Monitored in the patient's home to assess the patient's or patient caregiver's ability to use the equipment to perform self-dialysis;
 2. Instruction provided to a patient as required in subsection (F)(1)(a) and monitoring in the patient's home as required in subsection (F)(1)(b) is documented in the patient's medical record;
 3. All supplies for self-dialysis necessary to meet the needs of the patient are provided to the patient;
 4. All equipment necessary to meet the needs of the patient's self-dialysis is provided for the patient and maintained by the outpatient treatment center according to the manufacturer's recommendations;
 5. The water used for hemodialysis is tested and treated according to the requirements in subsection (N);
 6. Documentation of the self-dialysis maintained by the patient or the patient's caregiver is:
 - a. Reviewed to ensure that the patient is receiving continuity of care, and
 - b. Placed in the patient's medical record; and
 7. If a patient uses self-dialysis and self-administers medication:
 - a. The medical practitioner responsible for the dialysis services provided to the patient reviews the patient's diagnostic laboratory tests;
 - b. The patient and the patient's caregiver are informed of any potential:
 - i. Side effects of the medication; and
 - ii. Hazard to a child having access to the medication and, if applicable, a syringe used to inject the medication; and
 - c. The patient or the patient's caregiver is:

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- i. Taught the route and technique of administration and is able to administer the medication, including injecting the medication;
- ii. Taught and able to perform sterile techniques if the patient or the patient's caregiver will be injecting the medication;
- iii. Provided with instructions for the administration of the medication, including the specific route and technique the patient or the patient's caregiver has been taught to use;
- iv. Able to read and understand the directions for using the medication;
- v. Taught and able to self-monitor the patient's blood pressure; and
- vi. Informed how to store the medication according to the manufacturer's instructions.

G. An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a social worker is employed by the outpatient treatment center to meet the needs of a patient receiving dialysis services including:

1. Conducting an initial psychosocial evaluation of the patient within 30 calendar days after the patient's admission to the outpatient treatment center;
2. Participating in reviewing the patient's need for social work services;
3. Recommending changes in treatment based on the patient's psychosocial evaluation;
4. Assisting the patient and the patient's representative in obtaining and understanding information for making decisions about the medical services provided to the patient;
5. Identifying community agencies and resources and assisting the patient and the patient's representative to utilize the community agencies and resources;
6. Documenting monthly notes related to the patient's progress in the patient's medical record; and
7. Conducting a follow-up psychosocial evaluation of the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center.

H. An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a registered dietitian is employed by the outpatient treatment center to assist a patient receiving dialysis services to meet the patient's nutritional and dietetic needs including:

1. Conducting an initial nutritional assessment of the patient within 30 calendar days after the patient's admission to the outpatient treatment center;
2. Consulting with the patient's nephrologist and recommending a diet to meet the patient's nutritional needs;
3. Providing advice to the patient and the patient's representative regarding a diet prescribed by the patient's nephrologist;
4. Monitoring the patient's adherence and response to a prescribed diet;

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5. Reviewing with the patient any diagnostic test performed on the patient that is related to the patient's nutritional or dietetic needs;
 6. Documenting monthly notes related to the patient's progress in the patient's medical record; and
 7. Conducting a follow-up nutritional assessment of the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center.
- I.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a long-term care plan for each patient:
1. Is developed by a team that includes at least:
 - a. The chief clinical officer of the outpatient treatment center;
 - b. If the chief clinical officer is not a nephrologist, the patient's nephrologist;
 - c. A transplant surgeon or the transplant surgeon's designee;
 - d. A registered nurse responsible for nursing services provided to the patient;
 - e. A social worker;
 - f. A registered dietitian; and
 - g. The patient or patient's representative, if the patient or patient's representative chooses to participate in the development of the long-term care plan;
 2. Identifies the modality of treatment and dialysis services to be provided to the patient;
 3. Is reviewed and approved by the chief clinical officer;
 4. Is signed and dated by each personnel member participating in the development of the long-term care plan;
 5. Includes documentation signed by the patient or the patient's representative that the patient or the patient's representative was provided an opportunity to participate in the development of the long-term care plan;
 6. Is signed and dated by the patient or the patient's representative; and
 7. Is reviewed at least once every 12 months by the team in subsection (I)(1) and updated according to the patient's needs.
- J.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a patient care plan for each patient:
1. Is developed by a team that includes at least:
 - a. The patient's nephrologist;
 - b. A registered nurse responsible for nursing services provided to the patient;
 - c. A social worker;
 - d. A registered dietitian; and
 - e. The patient or the patient's representative, if the patient or patient's representative chooses to participate in the development of the patient care plan;

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2. Includes an assessment of the patient's need for dialysis services;
 3. Identifies treatment and treatment goals;
 4. Is signed and dated by each personnel member participating in the development of the patient care plan;
 5. Includes documentation signed by the patient or the patient's representative that the patient or the patient's representative was provided an opportunity to participate in the development of the patient care plan;
 6. Is signed and dated by the patient or the patient's representative;
 7. Is implemented;
 8. Is evaluated by:
 - a. The registered nurse responsible for the dialysis services provided to the patient,
 - b. The registered dietitian providing services to the patient related to the patient's nutritional or dietetic needs, and
 - c. The social worker providing services to the patient related to the patient's psychosocial needs;
 9. Includes documentation of interventions, resolutions, and outcomes related to treatment goals; and
 10. Is reviewed and updated according to the needs of the patient:
 - a. At least once every six months for a patient whose medical condition is stable, and
 - b. At least once every 30 calendar days for a patient whose medical condition is not stable.
- K.** In addition to the requirements in R9-10-1009(C), an administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a medical record for each patient contains:
1. An annual medical history;
 2. An annual physical examination;
 3. Monthly notes related to the patient's progress by a medical practitioner, registered dietitian, social worker, and registered nurse;
 4. If applicable, documentation of:
 - a. The equipment inspection and testing required in subsection (E)(9), and
 - b. The self-dialysis required in subsection (F)(2); and
 5. If applicable, documentation of the patient's discharge.
- L.** For a patient who received dialysis services, an administrator shall ensure that after the patient's discharge from an outpatient treatment center that is authorized to provide dialysis services, the nephrologist responsible for the dialysis services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
1. A description of the patient's medical condition and the dialysis services provided to the patient, and
 2. The signature of the nephrologist.

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- M.** If an outpatient treatment center reuses dialyzers or other dialysis supplies, an administrator shall ensure that the outpatient treatment center complies with the guidelines adopted by the Association for the Advancement of Medical Instrumentation in Reuse of Hemodialyzers, ANSI/AAMI RD47:2002 & RD47:2002/A1:2003, incorporated by reference, on file with the Department, and including no future editions or amendments. Copies may be purchased from the Association for the Advancement of Medical Instrumentation, 1110 N. Glebe Road, Suite 220, Arlington, VA 22201-4795.
- N.** A chief clinical officer shall ensure that the quality of water used in dialysis conforms to the guidelines adopted by the Association for the Advancement of Medical Instrumentation in Hemodialysis systems, ANSI/AAMI RD5:2003, incorporated by reference, on file with the Department, and including no future editions or amendments. Copies may be purchased from the Association for the Advancement of Medical Instrumentation, 1110 N. Glebe Road, Suite 220, Arlington, VA 22201-4795.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1018 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1018 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1019. Emergency Room Services

An administrator of an outpatient treatment center that is authorized to provide emergency room services shall ensure that:

1. Emergency room services are:
 - a. Available on the premises:
 - i. At all times, and
 - ii. To stabilize an individual's emergency medical condition; and
 - b. Provided:
 - i. In a designated area, and
 - ii. Under the direction of a physician;
2. Clinical laboratory services are available on the premises;
3. Diagnostic imaging services are available on the premises;

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4. An area designated for emergency room services complies with the physical plant codes and standards for a freestanding emergency care facility in R9-1-412;
5. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that specify requirements for the use of a seclusion room;
6. A physician is present in an area designated for emergency room services;
7. A registered nurse is present in an area designated for emergency room services and provides direction for nursing services in the designated area;
8. The outpatient treatment center has a documented transfer agreement with a general hospital;
9. Emergency room services are provided to an individual, including a woman in active labor, requesting medical services in an emergency;
10. If emergency room services cannot be provided at the outpatient treatment center, measures and procedures are implemented to minimize the risk to the patient until the patient is transferred to the general hospital with which the outpatient treatment center has a transfer agreement as required in subsection (8);
11. There is a chronological log of emergency room services provided to a patient that includes:
 - a. The patient's name;
 - b. The date, time, and mode of arrival; and
 - c. The disposition of the patient, including discharge or transfer; and
12. The chronological log required in subsection (11) is maintained:
 - a. In the designated area for emergency room services for at least 12 months after the date the emergency room services were provided; and
 - b. By the outpatient treatment center for a total of at least 24 months after the date the emergency room services were provided.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1019 adopted as an emergency now adopted as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1019 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1020. Opioid Treatment Services

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- A.** A governing authority of an outpatient treatment center that is authorized to provide opioid treatment services shall:
 - 1. Ensure that the outpatient treatment center obtains certification by the Substance Abuse and Mental Health Services Administration before providing opioid treatment;
 - 2. Maintain a current Substance Abuse and Mental Health Services Administration certificate for the outpatient treatment center on the premises, and
 - 3. Ensure that the administrator appointed as required in R9-10-1003(B)(3) is named on the Substance Abuse and Mental Health Services Administration certificate as the individual responsible for the opioid treatment services provided by or at the outpatient treatment center.
- B.** An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that:
 - 1. In addition to the policies and procedures required in R9-10-1003(D), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Include the criteria for receiving opioid treatment services and address:
 - i. Comprehensive maintenance treatment consisting of dispensing or administering an opioid agonist treatment medication at stable dosage levels to a patient for a period in excess of 21 calendar days and providing medical and health-related services to the patient, and
 - ii. Detoxification treatment that occurs over a continuous period of more than 30 calendar days;
 - b. Include the criteria and procedures for discontinuing opioid treatment services;
 - c. Address the needs of specific groups of patients, such as patients who:
 - i. Are pregnant;
 - ii. Are children;
 - iii. Have chronic or acute medical conditions such as HIV infection, hepatitis, diabetes, tuberculosis, or cardiovascular disease;
 - iv. Have a mental disorder;
 - v. Abuse alcohol or other drugs; or
 - vi. Are incarcerated or detained;
 - d. Contain a method of patient identification to ensure the patient receives the opioid treatment services ordered;
 - e. Contain methods to assess whether a patient is receiving concurrent opioid treatment services from more than one health care institution;
 - f. Contain methods to ensure that the opioid treatment services provided to a patient by or at the outpatient treatment center meet the patient's needs;
 - g. Include relapse prevention procedures;
 - h. Include for laboratory testing:

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- i. Criteria for the assessment of a patient's opioid agonist blood levels;
 - ii. Procedures for specimen collection and processing to reduce the risk of fraudulent results, and
 - iii. Procedures for conducting random drug testing of patients receiving an opioid agonist treatment medication;
 - i. Include procedures for the response of personnel members to a patient's adverse reaction during opioid treatment; and
 - j. Include criteria for dispensing one or more doses of an opioid agonist treatment medication to a patient for use off the premises and address:
 - i. Who may authorize dispensing,
 - ii. Restrictions on dispensing, and
 - iii. Information to be provided to a patient or the patient's representative before dispensing;
2. A physician provides direction for the opioid treatment services provided at the outpatient treatment center;
 3. If a patient requires administration of an opioid agonist treatment medication as a result of chronic pain, the patient:
 - a. Receives consultation with or a referral for consultation with a physician or registered nurse practitioner who specializes in chronic pain management, and
 - b. Is not admitted for opioid treatment services:
 - i. Unless the patient is physically addicted to an opioid drug, as manifested by the symptoms of withdrawal in the absence of the opioid drug; and
 - ii. A medical practitioner at the outpatient treatment center coordinates with the physician or registered nurse practitioner who is providing chronic pain management to the patient; and
 4. In addition to the requirements in R9-10-1009(C), a medical record for each patient contains:
 - a. If applicable, documentation of the dispensing of doses of an opioid agonist treatment medication to the patient for use off the premises; and
 - b. If applicable, documentation of the patient's discharge from receiving opioid treatment services.
- C. An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that for a patient receiving opioid treatment services:
1. The opioid treatment services provided to the patient meet the needs of the patient;
 2. A physician or a medical practitioner under the direction of a physician:
 - a. Performs a medical history and physical examination on the patient within 30 calendar days before admission or within 48 hours after admission, and
 - b. Documents the medical history and physical examination in the patient's medical record within 48 hours after admission;

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3. Before receiving opioid treatment, the patient is informed of the following:
 - a. The progression of opioid addiction and the patient's apparent stage of opioid addiction;
 - b. The goal and benefits of opioid treatment;
 - c. The signs and symptoms of overdose and when to seek emergency assistance;
 - d. The characteristics of opioid agonist treatment medication, including common side-effects and potential interaction effects with other drugs;
 - e. The requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law;
 - f. Confidentiality requirements;
 - g. Drug screening and urinalysis procedures;
 - h. Requirements for dispensing to a patient one or more doses of an opioid agonist treatment medication for use by the patient off the premises;
 - i. Testing and treatment available for HIV and other communicable diseases; and
 - j. The patient complaint process;
 4. Documentation of the provision of the information specified in subsection (C)(3) is included in the patient's medical record;
 5. The patient receives a dose of an opioid agonist treatment medication only on the order of a medical practitioner;
 6. The patient begins detoxification treatment only at the request of the patient or according to the outpatient treatment center's policy and procedure for discontinuing opioid treatment services required in subsection (B)(1)(b);
 7. If the patient has an adverse reaction during opioid treatment, a personnel member and, if appropriate, a medical practitioner responds by implementing the policy and procedure required in subsection (B)(1)(i);
 8. Before the patient's discharge from opioid treatment services, the patient is provided with patient follow-up instructions that:
 - a. Include information that may reduce the risk of relapse; and
 - b. May include a referral for counseling, support groups, or medication for depression or sleep disorders; and
 9. After the patient's discharge from opioid treatment services provided by or at the outpatient treatment center, the medical practitioner responsible for the opioid treatment services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
 - a. A description of the patient's medical condition and the opioid treatment services provided to the patient, and
 - b. The signature of the medical practitioner.
- D.** An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that an assessment for each patient receiving opioid treatment services:

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1. Includes, in addition to the information in R9-10-1010(B):
 - a. An assessment of the patient's need for opioid treatment services,
 - b. An assessment of the patient's medical conditions that may be affected by opioid treatment,
 - c. An assessment of other medications being taken by the patient and conditions that may be affected by opioid treatment, and
 - d. A plan to prevent relapse;
2. Identifies the treatment to be provided to the patient and treatment goals; and
3. Specifies whether the patient may receive an opioid agonist treatment medication for use off the premises and, if so, the number of doses that may be dispensed.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1020 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1020 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1021. Pain Management Services

An administrator of an outpatient treatment center that is authorized to provide pain management services shall ensure that:

1. Pain management services are provided under the direction of a physician;
2. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise;
3. If a controlled substance is used to provide pain management services:
 - a. A medical practitioner discusses the risks and benefits of using a controlled substance with a patient; and
 - b. The following information is included in a patient's medical record:
 - i. The patient's history or alcohol and substance abuse,
 - ii. Documentation of the discussion in subsection (3)(a),
 - iii. The nature and intensity of the patient's pain, and
 - iv. The objectives used to determine whether the patient is being successfully treated; and
4. If an injection or a nerve block is used to provide pain management services:

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- a. Before the injection or nerve block is initially used on a patient, an evaluation of the patient is performed by a physician or nurse anesthetist;
- b. An injection or nerve block is administered by a physician or nurse anesthetist; and
- c. The following information is included in a patient's medical record:
 - i. The evaluation of the patient required in subsection (4)(a),
 - ii. A record of the administration of the injection or nerve block, and
 - iii. Any resuscitation measures taken.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1021 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1021 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1022. Physical Health Services

An administrator of an outpatient treatment center that is authorized to provide physical health services shall ensure that:

1. Medical services provided at or by the outpatient treatment center are provided under the direction of a physician or a registered nurse practitioner,
2. Nursing services provided at or by the outpatient treatment center are provided under the direction of a registered nurse, and
3. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1022 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1022 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222,

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effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1023. Pre-petition Screening

An administrator of an outpatient treatment center that is authorized to provide pre-petition screening shall comply with the requirements for pre-petition screening in A.R.S. Title 36, Chapter 5, Article 4.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1023 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1023 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1024. Rehabilitation Services

An administrator shall ensure that if an outpatient treatment center is authorized to provide:

1. Occupational therapy services, an occupational therapist provides direction for the occupational therapy services provided at or by the outpatient treatment center;
2. Physical therapy services, a physical therapist provides direction for the physical therapy services provided at or by the outpatient treatment center; or
3. Speech-language pathology services, a speech-language pathologist provides direction for the speech-language pathology services provided at or by the outpatient treatment center.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). New Section R9-10-1024 adopted as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1024 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by

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exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1025. Respite Services

- A. In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-1001, the following definitions apply in this Section:
1. “Emergency safety response” has the same meaning as in R9-10-701.
 2. “Outing” means travel by a child, who is receiving respite services provided by an outpatient treatment center, to a location away from the outpatient treatment center premises or, if applicable, the child’s residence for a specific activity.
 3. “Parent” means a child’s:
 - a. Mother or father, or
 - b. Legal guardian.
 4. “Respite capacity” means the total number of children for whom an outpatient treatment center is authorized by the Department to provide respite services on the outpatient treatment center’s premises.
- B. An administrator of an outpatient treatment center that is authorized to provide respite services shall ensure that:
1. Respite services are not provided in a personnel member’s residence unless the personnel member’s residence is licensed as a behavioral health respite home;
 2. Except for an outpatient treatment center that is authorized to provide respite services for children on the premises, respite services are provided:
 - a. In a patient’s residence; or
 - b. Up to 10 continuous hours in a 24-hour time period while the individual who is receiving the respite services is:
 - i. Supervised by a personnel member;
 - ii. Awake;
 - iii. Except as stated in subsection (B)(3), provided food;
 - iv. Allowed to rest;
 - v. Provided an opportunity to use the toilet and meet the individual’s hygiene needs; and
 - vi. Participating in activities in the community but is not in a licensed health care institution or child care facility; and
 3. If a child is provided respite services according to subsection (B)(2)(b), the child is provided the appropriate meals or snacks in subsection (J)(1) for the amount of time the child is receiving respite services from the outpatient treatment center.
- C. If an outpatient treatment center that is authorized to provide respite services for children includes outings in the outpatient treatment center’s scope of services, an administrator shall ensure that:

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1. Before a personnel member takes a child receiving respite services on an outing, written permission is obtained from the child's parent that includes:
 - a. The child's name;
 - b. A description of the outing;
 - c. The name of the outing destination, if applicable;
 - d. The street address and, if available, the telephone number of the outing destination;
 - e. Either:
 - i. The date or dates of the outing; or
 - ii. The time period, not to exceed 12 months, during which the permission is given;
 - f. The projected time of departure from the outpatient treatment center or, if applicable, the child's residence;
 - g. The projected time of arrival back at the outpatient treatment center or, if applicable, the child's residence; and
 - h. The dated signature of the child's parent;
2. Each motor vehicle used on an outing by a personnel member for a child receiving respite services from the outpatient treatment center:
 - a. Is maintained in a mechanically safe condition;
 - b. Is free from hazards;
 - c. Has an operational heating system;
 - d. Has an operational air-conditioning system; and
 - e. Is equipped with:
 - i. A first-aid kit that meets the requirements in subsection (S)(1), and
 - ii. Two large, clean towels or blankets;
3. On an outing, a child does not ride in a truck bed, camper, or trailer attached to a motor vehicle;
4. The Department is notified within 24 hours after a motor vehicle accident that involves a child who is receiving respite services while riding in the motor vehicle on an outing; and
5. A personnel member who drives a motor vehicle with children receiving respite services from the outpatient treatment center in the motor vehicle:
 - a. Requires that each door be locked before the motor vehicle is set in motion and keeps the doors locked while the motor vehicle is in motion;
 - b. Does not permit a child to be seated in front of a motor vehicle's air bag;
 - c. Requires that a child remain seated and entirely inside the motor vehicle while the motor vehicle is in motion;
 - d. Requires that a child is secured, as required in A.R.S. § 28-907 or 28-909, before the motor vehicle is set in motion and while the motor vehicle is in motion;

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- e. Assists a child into or out of the motor vehicle away from moving traffic at curbside or in a driveway, parking lot, or other location designated for this purpose;
 - f. Carries drinking water in an amount sufficient to meet the needs of each child on the outing and a sufficient number of cups or other drinking receptacles so that each child can drink from a different cup or receptacle; and
 - g. Accounts for each child while on the outing.
- D. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
- 1. Respite services are only provided on the premises for up to 10 continuous hours per day between the hours of 6:00 a.m. and 10:00 p.m.;
 - 2. The specific 10 continuous hours per day during which the outpatient treatment center provides respite services on the premises is stated in the outpatient treatment center's hours of operation that is submitted as part of the outpatient treatment center's initial or renewal license application;
 - 3. A personnel member, who is expected to provide respite services eight or more hours a week, complies with the requirements for tuberculosis screening in R9-10-113;
 - 4. At least one personnel member who has current training in first aid and cardiopulmonary resuscitation is available on the premises when a child is receiving respite services on the premises;
 - 5. At least one personnel member who has completed training in crisis intervention according to R9-10-716(F) is available on the premises when a child is receiving respite services on the premises;
 - 6. A personnel member does not use or possess any of the following items when a child receiving respite services is on the premises:
 - a. A controlled substance as listed in A.R.S. Title 36, Chapter 27, Article 2, except where used as a prescription medication in the manner prescribed;
 - b. A dangerous drug as defined in A.R.S. § 13-3401, except where used as a prescription medication in the manner prescribed;
 - c. A prescription medication as defined in A.R.S. § 32-1901, except where used in the manner prescribed; or
 - d. A firearm as defined in A.R.S. § 13-105;
 - 7. An unannounced fire and emergency evacuation drill is conducted at least once a month, and at different times of the day, and each personnel member providing respite services for children on the premises and each child receiving respite services on the premises participates in the fire and emergency evacuation drill;
 - 8. Each fire and emergency evacuation drill is documented, and the documentation is maintained for at least 12 months after the date of the fire and emergency evacuation drill;

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9. Before a child receives respite services on the premises of the outpatient treatment center, in addition to the requirements in R9-10-1009, the following information is obtained and maintained in the child's medical record;
 - a. The name, home address, city, state, zip code, and contact telephone number of each parent of the child;
 - b. The name and contact telephone number of at least two additional individuals authorized by the child's parent to collect the child from the outpatient treatment center;
 - c. The name and contact telephone number of the child's health care provider;
 - d. The written authorization for emergency medical care of the child when the parent cannot be contacted at the time of an emergency;
 - e. The name of the individual to be contacted in case of injury or sudden illness of the child;
 - f. If applicable, a description of any dietary restrictions or needs due to a medical condition or diagnosed food sensitivity or allergy;
 - g. A written record completed by the child's parent or health care provider noting the child's susceptibility to illness, physical conditions of which a personnel member should be aware, and any specific requirements for health maintenance; and
10. Documentation is obtained and maintained in the child's medical record each time the child receives respite services on the premises that includes:
 - a. The date and time of each admission to and discharge from receiving respite services; and
 - b. A signature, which contains at least a first initial of a first name and the last name of the child's parent or other individual designated by the child's parent, each time the child is admitted or discharged from receiving respite services on the premises;
11. Policies and procedures are developed, documented, and implemented to ensure that the identity of an individual is known to a personnel member or is verified with picture identification before the personnel member discharges a child to the individual;
12. A child is not discharged to an individual other than the child's parent or other individual designated according to subsection (D)(9)(b), except:
 - a. When the child's parent authorizes the administrator by telephone or electronic means to release the child to an individual not so designated, and
 - b. The administrator can verify the telephone or electronic authorization using a means of verification that has been agreed to by the administrator and the child's parent and documented in the child's medical record; and
13. The number of personnel members providing respite services for children on the premises is determined by the needs of the children present, with a minimum of at least:
 - a. One personnel member providing supervision for every five children receiving respite services on the premises; and

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- b. Two personnel members on the premises when a child is receiving respite services on the premises.
- E. If swimming activities are conducted at a swimming pool for a child receiving respite services on the premises of an outpatient treatment center, an administrator shall ensure that there is an individual at the swimming pool on the premises who has current lifeguard certification that includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation. If the individual is a personnel member, the personnel member cannot be counted in the personnel member-to-children ratio required by subsection (D)(13).
- F. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that in each area designated for providing respite services:
 - 1. Drinking water is provided sufficient for the needs of and accessible to each child in both indoor and outdoor areas;
 - 2. Indoor areas used by children are decorated with age-appropriate articles such as bulletin boards, pictures, and posters;
 - 3. Storage space is provided for indoor and outdoor toys, materials, and equipment in areas accessible to children;
 - 4. Clean clothing is available to a child when the child needs a change of clothing;
 - 5. At least one indoor area in the outpatient treatment center where respite services are provided for children is equipped with at least one cot or mat, a sheet, and a blanket, where a child can rest quietly away from the other children;
 - 6. Except as provided in subsection (AA)(2)(a), outdoor or large muscle development activities are scheduled to allow not less than 75 square feet for each child occupying the outdoor area or indoor area substituted for outdoor area at any time;
 - 7. The premises, including the buildings, are maintained free from hazards;
 - 8. Toys and play equipment, required in this Section, are maintained:
 - a. Free from hazards, and
 - b. In a condition that allows the toy or play equipment to be used for the original purpose of the toy or play equipment;
 - 9. Temperatures are maintained between 70° F and 84° F in each room or indoor area used by children;
 - 10. Except when a child is napping or sleeping or for a child who has a sensory issue documented in the child's behavioral health assessment, each room or area used by a child is maintained at a minimum of 30 foot candles of illumination;
 - 11. When a child is napping or sleeping in a room, the room is maintained at a minimum of five foot candles of illumination;

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12. Each child's toothbrush, comb, washcloth, and cloth towel that are provided for the child's use by the child's parent are maintained in a clean condition and stored in an identified space separate from those of other children;
 13. Except as provided in subsection (F)(14), the following are stored separate from food storage areas and are inaccessible to a child:
 - a. All materials and chemicals labeled as a toxic or flammable substance;
 - b. All substances that have a child warning label and may be a hazard to a child; and
 - c. Lawn mowers, ladders, toilet brushes, plungers, and other equipment that may be a hazard to a child;
 14. Hand sanitizers:
 - a. When being stored, are stored separate from food storage areas and are inaccessible to children; and
 - b. When being provided for use, are accessible to children; and
 15. Except when used as part of an activity, the following are stored in an area inaccessible to a child:
 - a. Garden tools, such as a rake, trowel, and shovel; and
 - b. Cleaning equipment and supplies, such as a mop and mop bucket.
- G.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that a personnel member:
1. Supervises each child at all times;
 2. Does not smoke or use tobacco:
 - a. In any area where respite services may be provided for a child, or
 - b. When transporting or transferring a child;
 3. Except for a child who can change the child's own clothing, changes a child's clothing when wet or soiled;
 4. Empties clothing soiled with feces into a toilet without rinsing;
 5. Places a child's soiled clothing in a plastic bag labeled with the child's name, stores the clothing in a container used for this purpose, and sends the clothing home with the child's parent;
 6. Prepares and posts in each indoor area, before the first child arrives to receive respite services that day, a current schedule of age-appropriate activities that meet the needs of the children receiving respite services that day, including the times the following are provided:
 - a. Meals and snacks,
 - b. Naps,
 - c. Indoor activities,
 - d. Outdoor or large muscle development activities,
 - e. Quiet and active activities,
 - f. Personnel member-directed activities,
 - g. Self-directed activities, and

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- h. Activities that develop small muscles;
7. Provides activities and opportunities, consistent with a child's behavioral health assessment, for each child to:
 - a. Gain a positive self-concept;
 - b. Develop and practice social skills;
 - c. Acquire communication skills;
 - d. Participate in large muscle physical activity;
 - e. Develop habits that meet health, safety, and nutritional needs;
 - f. Express creativity;
 - g. Learn to respect cultural diversity of children and staff;
 - h. Learn self-help skills; and
 - i. Develop a sense of responsibility and independence;
8. Implements the schedule in subsection (G)(6);
9. If an activity on the schedule in subsection (G)(6) is not implemented, writes on the schedule the activity that was not implemented and what activity was substituted;
10. Ensures that each indoor area has a supply of age-appropriate toys, materials, and equipment, necessary to implement the schedule required in subsection (G)(6), in a quantity sufficient for the number of children receiving respite services at the outpatient treatment center that day, including:
 - a. Art and crafts supplies;
 - b. Books;
 - c. Balls;
 - d. Puzzles, blocks, and toys to enhance manipulative skills;
 - e. Creative play toys;
 - f. Musical instruments; and
 - g. Indoor and outdoor equipment to enhance large muscle development;
11. Does the following when a parent permits or asks a personnel member to apply personal products, such as petroleum jelly, diaper rash ointments, sun screen or sun block preparations, toothpaste, and baby diapering preparations on the parent's child:
 - a. Obtains the child's personal products and written approval for use of the personal products from the child's parent;
 - b. Labels the personal products with the child's name; and
 - c. Keeps the personal products inaccessible to children; and
12. Monitors a child for overheating or overexposure to the sun.

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H. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises and includes in the outpatient treatment center's scope of respite services for children wearing diapers shall ensure that there is a diaper changing space in the area designated for providing respite services for children that contains:

1. A nonabsorbent, sanitizable diaper changing surface that is:
 - a. Seamless and smooth, and
 - b. Kept clear of items not required for diaper changing;
2. A hand-washing sink adjacent to the diaper changing surface, for a personnel member's use when changing diapers and for washing a child during or after diapering, that provides:
 - a. Running water,
 - b. Soap from a dispenser, and
 - c. Single-use paper hand towels from a dispenser;
3. At least one waterproof, sanitizable container with a waterproof liner and a tight-fitting lid for soiled diapers; and
4. At least one waterproof, sanitizable container with a waterproof liner and a tight-fitting lid for soiled clothing.

I. In a diaper changing space, an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:

1. A diaper changing procedure is established, documented, and implemented that states that a child's diaper is changed as soon as it is soiled and that a personnel member when diapering:
 - a. Washes and dries the child, using a separate wash cloth and towel only once for each child;
 - b. If applicable, applies the child's individual personal products labeled with the child's name;
 - c. Uses single-use non-porous gloves;
 - d. Washes the personnel member's own hands with soap and running water according to the requirements in R9-10-1028(5);
 - e. Washes each child's hands with soap and running water after each diaper change; and
 - f. Cleans, sanitizes, and dries the diaper changing surface following each diaper change; and
2. A personnel member:
 - a. Removes disposable diapers and disposable training pants from a diaper changing space as needed or at least twice every 24 hours to a waste receptacle outside the building; and
 - b. Does not:
 - i. Permit a bottle, formula, food, eating utensil, or food preparation in a diaper changing space;
 - ii. Draw water for human consumption from the hand-washing sink adjacent to a diaper changing surface, required in subsection (H)(2); or

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- iii. If responsible for food preparation, change diapers until food preparation duties have been completed for the day.
- J.** Except as provided in subsection (K)(3), an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:
1. Serve the following meals or snacks to a child receiving respite services on the premises:
 - a. For the following periods of time:
 - i. Two to four hours, one or more snacks;
 - ii. Four to eight hours, one or more snacks and one or more meals; and
 - iii. More than eight hours, two snacks and one or more meals;
 - b. Make breakfast available to a child receiving respite services on the premises before 8:00 a.m.;
 - c. Serve lunch to a child who is receiving respite services on the premises between 11:00 a.m. through 1:00 p.m.; and
 - d. Serve dinner to a child who is receiving respite services on the premises from 5:00 p.m. through 7:00 p.m. and who will remain on the premises after 7:00 p.m.;
 2. Ensure that a meal or snack provided by the outpatient treatment center meets the meal pattern requirements in Table 10.1; and
 3. If the outpatient treatment center provides a meal or snack to a child:
 - a. Make a second serving of a food component of a provided snack or meal available to a child who requests a second serving, and
 - b. Substitute a food that is equivalent to a specific food component if a requested second serving of a specific food component is not available.
- K.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises:
1. May serve food provided for a child by the child's parent;
 2. If a child's parent does not provide a sufficient number of meals or snacks to meet the requirements in subsection (J)(1), shall supplement, according to the requirements in Table 10.1, the meals or snacks provided by the child's parent; and
 3. If applicable, shall serve food to a child at the times and in quantities consistent with the information documented according to subsection (D)(9)(f) for the child and the child's behavioral health assessment, to meet the child's dietary and nutritional needs.
- L.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises that has a respite capacity of more than 10 shall obtain a food establishment license or permit according to

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the requirements in 9 A.A.C. 8, Article 1, and, if applicable, maintain documentation of the current food establishment license or permit.

- M. If an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises serves food to a child receiving respite services on the premises that is not prepared by the outpatient treatment center or provided by the child's parent, the administrator shall ensure that the food was prepared by a food establishment, as defined according to A.A.C. R9-8-101.
- N. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
 1. Children, except infants and children who cannot wash their own hands, wash their hands with soap and running water before and after handling or eating food;
 2. A personnel member:
 - a. Washes the hands of an infant or a child who cannot wash the child's own hands before and after the infant or child handles or eats food, using:
 - i. A washcloth,
 - ii. A single-use paper towel, or
 - iii. Soap and running water; and
 - b. If using a washcloth, uses each washcloth on only one child and only one time before it is laundered or discarded;
 3. Non-single-use utensils and equipment used in preparing, eating, or drinking food are:
 - a. After each use:
 - i. Washed in an automatic dishwasher and air dried or heat dried; or
 - ii. Washed in hot soapy water, rinsed in clean water, sanitized, and air dried or heat dried; and
 - b. Stored in a clean area protected from contamination;
 4. Single-use utensils and equipment are disposed of after being used;
 5. Perishable foods are covered and stored in a refrigerator at a temperature of 41° F or less;
 6. A refrigerator at the outpatient treatment center maintains a temperature of 41° F or less, as shown by a thermometer kept in the refrigerator at all times;
 7. A freezer at the outpatient treatment center maintains a temperature of 0° F or less, as shown by a thermometer kept in the freezer at all times; and
 8. Foods are prepared as close as possible to serving time and, if prepared in advance, are either:
 - a. Cold held at a temperature of 45° F or less or hot held at a temperature of 130° F or more until served, or
 - b. Cold held at a temperature of 45° F or less and then reheated to a temperature of at least 165° F before being served.

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- O.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises:
1. May allow a personnel member to separate a child who is receiving respite services on the premises from other children for unacceptable behavior for no longer than three minutes after the child has regained self-control, but not more than 10 minutes without the personnel member interacting with the child, consistent with the child's behavioral health assessment;
 2. Shall ensure that:
 - a. A personnel member, consistent with the child's behavioral health assessment:
 - i. Defines and maintains consistent and reasonable guidelines and limitations for a child's behavior;
 - ii. Teaches, models, and encourages orderly conduct, personal control, and age-appropriate behavior; and
 - iii. Explains to a child why a particular behavior is not allowed, suggests an alternative, and assists the child to become engaged in an alternative activity;
 - b. An emergency safety response is:
 - i. Only used:
 - (1) By a personnel member trained according to R9-10-716(F)(1) to use an emergency safety response,
 - (2) For the management of a child's violent or self-destructive behavior, and
 - (3) When less restrictive interventions have been determined to be ineffective; and
 - ii. Discontinued at the earliest possible time, but no longer than five minutes after the emergency safety response is initiated;
 - c. If an emergency safety response was used for a child, a personnel member, when the child is discharged to the child's parent:
 - i. Notifies the child's parent of the use of the emergency safety response for the child and the behavior, event, or environmental factor that caused the need for the emergency safety response; and
 - ii. Documents in the child's medical record that the child's parent was notified of the use of the emergency safety response;
 - d. Within 24 hours after an emergency safety response is used for a child receiving respite services on the premises, the following information is entered into the child's medical record:
 - i. The date and time the emergency safety response was used;
 - ii. The name of each personnel member who used an emergency safety response;
 - iii. The specific emergency safety response used;
 - iv. The behavior, event, or environmental factor that caused the need for the emergency safety response; and
 - v. Any injury that resulted from the use of the emergency safety response;

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- e. Within 10 working days after an emergency safety response is used for a child receiving respite services on the premises, a behavioral health professional reviews the information in subsection (O)(2)(d) and documents the review in the child's medical record;
 - f. After the review required in subsection (O)(2)(e), the following information is entered into the child's medical record:
 - i. Actions taken or planned to prevent the need for a subsequent use of an emergency safety response for the child,
 - ii. A determination of whether the child is appropriately placed at the outpatient treatment center providing respite services for children on the premises, and
 - iii. Whether the child's treatment plan was reviewed or needs to be reviewed and amended to ensure that the child's treatment plan is meeting the child's treatment needs;
 - g. Emergency safety response training is documented according to the requirements in R9-10-716(F)(2); and
 - h. Materials used for emergency safety response training are maintained according to the requirements in R9-10-716(F)(3); and
3. A personnel member does not use or permit:
- a. A method of discipline that could cause harm to the health, safety, or welfare of a child;
 - b. Corporal punishment;
 - c. Abusive language;
 - d. Discipline associated with:
 - i. Eating, napping, sleeping, or toileting;
 - ii. Medication; or
 - iii. Mechanical restraint; or
 - e. Discipline administered to any child by another child.
- P. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:
- 1. Provide each child who naps or sleeps on the premises with a separate cot or mat and ensure that:
 - a. A cot or mat used by the child accommodates the child's height and weight;
 - b. A personnel member covers each cot or mat with a clean sheet that is laundered when soiled, or at least once every seven days and before use by a different child;
 - c. A clean blanket or sheet is available for each child;
 - d. A rug, carpet, blanket, or towel is not used as a mat; and
 - e. Each cot or mat is maintained in a clean and repaired condition;
 - 2. Not use bunk beds or waterbed mattresses for a child receiving respite services;

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3. Provide an unobstructed passageway at least 18 inches wide between each row of cots or mats to allow a personnel member access to each child;
 4. Ensure that if a child naps or sleeps while receiving respite services at the outpatient treatment center, the administrator:
 - a. Does not permit the child to lie in direct contact with the floor while napping or sleeping;
 - b. Prohibits the operation of a television in a room where the child is napping or sleeping; and
 - c. Requires that a personnel member remain awake while supervising the napping or sleeping child; and
 5. Ensure that storage space is provided on the premises for cots, mats, sheets, and blankets, that is:
 - a. Accessible to an area used for napping or sleeping; and
 - b. Separate from food service and preparation areas, toilet rooms, and laundry rooms.
- Q.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall, in the area of the premises where the respite services are provided:
1. Maintain the premises and furnishings:
 - a. Free of insects and vermin,
 - b. In a clean condition, and
 - c. Free from odor; and
 2. Ensure that:
 - a. Floor coverings are:
 - i. Clean; and
 - ii. Free from:
 - (1) Dampness,
 - (2) Odors, and
 - (3) Hazards;
 - b. Toilet bowls, lavatory fixtures, and floors in toilet rooms and kitchens are cleaned and sanitized as often as necessary to maintain them in a clean and sanitized condition or at least once every 24 hours;
 - c. Each toilet room used by children receiving respite services on the premises contains, within easy reach of children:
 - i. Mounted toilet tissue;
 - ii. A sink with running water;
 - iii. Soap contained in a dispenser; and
 - iv. Disposable, single-use paper towels, in a mounted dispenser, or a mechanical hand dryer;
 - d. Personnel members wash their hands with soap and running water after toileting;
 - e. A child's hands are washed with soap and running water after toileting;

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- f. Except for a cup or receptacle used only for water, food waste is stored in a covered container and the container is clean and lined with a plastic bag;
 - g. Food waste and other refuse is removed from the area of the premises where respite services are provided for children at least once every 24 hours or more often as necessary to maintain a clean condition and avoid odors;
 - h. A personnel member or a child does not draw water for human consumption from a toilet room hand-washing sink;
 - i. Toys, materials, and equipment are maintained in a clean condition;
 - j. Plumbing fixtures are maintained in a clean and working condition; and
 - k. Chipped or cracked sinks and toilets are replaced or repaired.
- R.** If laundry belonging to an outpatient treatment center providing respite services for children on the premises is done on the premises, an administrator shall:
- 1. Not use a kitchen or food storage area for sorting, handling, washing, or drying laundry;
 - 2. Locate the laundry equipment in an area that is separate from areas used by children and inaccessible to children;
 - 3. Not permit a child to be in a laundry room or use a laundry area as a passageway for children; and
 - 4. Ensure that laundry soiled by vomitus, urine, feces, blood, or other body fluid is stored, cleaned, and sanitized separately from other laundry.
- S.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that there is a first aid kit in the designated area of the outpatient treatment center where respite services are provided that:
- 1. Contains first aid supplies in a quantity sufficient to meet the needs of the children receiving respite services, including the following:
 - a. Sterile bandages including:
 - i. Self-adhering bandages of assorted sizes,
 - ii. Sterile gauze pads, and
 - iii. Sterile gauze rolls;
 - b. Antiseptic solution or sealed antiseptic wipes;
 - c. A pair of scissors;
 - d. Self-adhering tape;
 - e. Single-use, non-porous gloves; and
 - f. Reclosable plastic bags of at least one-gallon size; and
 - 2. Is accessible to personnel members but inaccessible to children receiving respite services on the premises.

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- T.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:
1. Prepare and date a written fire and emergency plan that contains:
 - a. The location of the first aid kit;
 - b. The names of personnel members who have first aid training;
 - c. The names of personnel members who have cardiopulmonary resuscitation training;
 - d. The directions for:
 - i. Initiating notification of a child's parent by telephone or other equally expeditious means within 60 minutes after a fire or emergency; and
 - ii. Providing written notification to the child's parent within 24 hours after a fire or emergency; and
 2. Maintain the plan required in subsection (T)(1) in the area designated for providing respite services;
 3. Post the plan required in subsection (T)(1) in any indoor area where respite services are provided that does not have an operable telephone service or two-way voice communication system that connects the indoor area where respite services are provided with an individual who has direct access to an in-and-out operable telephone services; and
 4. Update the plan in subsection (T)(1) at least once every 12 months after the date of initial preparation of the plan or when any information changes.
- U.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall in the area designated for providing respite services:
1. Post, near a room's designated exit, a building evacuation plan that details the designated exits from the room and the facility where the outpatient treatment center is located; and
 2. Maintain and use a communication system that contains:
 - a. A direct-access, in-and-out, operating telephone service in the area where respite services are provided; or
 - b. A two-way voice communication system that connects the area where respite services are provided with an individual who has direct access to an in-and-out, operating telephone service.
- V.** If, while receiving respite services at an outpatient treatment center authorized to provide respite services for children on the premises, a child has an accident, injury, or emergency that, based on an evaluation by a personnel member, requires medical treatment by a health care provider, an administrator shall ensure that a personnel member:
1. Notifies the child's parent immediately after the accident, injury, or emergency;
 2. Documents:

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- a. A description of the accident, injury, or emergency, including the date, time, and location of the accident, injury, or emergency;
 - b. The method used to notify the child's parent; and
 - c. The time the child's parent was notified; and
3. Maintains the documentation required in subsection (V)(2) for at least 12 months after the date the child last received respite services on the outpatient treatment center's premises.
- W.** If a parent of a child who received respite services at an outpatient treatment center authorized to provide respite services for children on the premises informs a personnel member that the child's parent obtained medical treatment for the child from a health care provider for an accident, injury, or emergency the child had while on the premises, an administrator shall ensure that a personnel member:
1. Documents any information about the child's accident, injury, or emergency received from the child's parent; and
 2. Maintains the documentation required in subsection (W)(1) for at least 12 months after the date the child last received respite services on the outpatient treatment center's premises.
- X.** If a child exhibits signs of illness or infestation at an outpatient treatment center authorized to provide respite services for children on the premises, an administrator shall ensure that a personnel member:
1. Immediately separates the child from other children,
 2. Immediately notifies the child's parent by telephone or other expeditious means to arrange for the child's discharge from the outpatient treatment center,
 3. Documents the notification required in subsection (X)(2), and
 4. Maintains documentation of the notification required in subsection (X)(3) for at least 12 months after the date of the notification.
- Y.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall comply with the following physical plant requirements:
1. Toilets and hand-washing sinks are available to children in the area designated for providing respite services or on the premises as follows:
 - a. At least one flush toilet and one hand-washing sink for 10 or fewer children;
 - b. At least two flush toilets and two hand-washing sinks for 11 to 25 children; and
 - c. At least one flush toilet and one hand-washing sink for each additional 20 children;
 2. A hand-washing sink provides running water with a drain connected to a sanitary sewer as defined in A.R.S. § 45-101;
 3. A glass mirror, window, or other glass surface that is located within 36 inches of the floor is made of safety glass that has been manufactured, fabricated, or treated to prevent the glass from shattering or flying when struck or broken, or is shielded by a barrier to prevent impact by or physical injury to a child; and

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4. There is at least 30 square feet of unobstructed indoor space for each child who may be receiving respite services on the premises, which excludes floor space occupied by:
 - a. The interior walls;
 - b. A kitchen, a bathroom, a closet, a hallway, a stair, an entryway, an office, an area designated for isolating a child from other children, a storage room, or a room or floor space designated for the sole use of personnel members;
 - c. Room space occupied by desks, file cabinets, storage cabinets, or hand-washing sinks for a personnel member's use; or
 - d. Indoor area that is substituted for required outdoor area.
- Z. An administrator of an outpatient treatment center authorized to provide respite services for children on the premises shall ensure that, in addition to the policies and procedures required in this Article, policies and procedures are established, documented, and implemented for the children's use of a toilet and hand-washing sink that ensure the children's health and safety and include:
 1. Supervision requirements for children using the toilet, based on a child's age, gender, and behavioral health issue; and
 2. If the outpatient treatment center does not have a toilet and hand-washing sink available for the exclusive use of children receiving respite services, a method to ensure that an individual, other than a child receiving respite services or a personnel member providing respite services, is not present in the toilet and hand-washing sink area when a child receiving respite services is present in the toilet and hand-washing sink area.
- AA. To provide activities that develop large muscles and an opportunity to participate in structured large muscle physical activities, an administrator of an outpatient treatment center authorized to provide respite services for children on the premises shall:
 1. Provide at least 75 square feet of outdoor area per child for at least 50% of the outpatient treatment center's respite capacity; or
 2. Comply with one of the following:
 - a. If no child receives respite services on the premises for more than four hours per day, provide at least 50 square feet of indoor area for each child, based on the outpatient treatment center's respite capacity;
 - b. If a child receives respite services on the premises for more than four hours but less than six hours per day, provide at least 75 square feet of indoor area per child for at least 50% of the outpatient treatment center's respite capacity, in addition to the indoor area required in subsection (Y)(4); or
 - c. Provide at least 37.5 square feet of outdoor area and 37.5 square feet of indoor area per child for at least 50% of the outpatient treatment center's respite capacity, in addition to the activity area required in subsection (Y)(4).

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BB. If an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises is substituting indoor area for outdoor area, the administrator shall:

1. Designate, on the site plan and the floor plan submitted with the license application or a request for an intended change or modification, the indoor area that is being substituted for an outdoor area; and
2. In the indoor area substituted for outdoor area, install and maintain a mat or pad designed to provide impact protection in the fall zone of indoor swings and climbing equipment.

CC. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:

1. An outdoor area used by children receiving respite services:
 - a. Is enclosed by a fence:
 - i. A minimum of 4.0 feet high,
 - ii. Secured to the ground, and
 - iii. With either vertical or horizontal open spaces on the fence or gate that do not exceed 4.0 inches;
 - b. Is maintained free from hazards, such as exposed concrete footings and broken toys; and
 - c. Has gates that are kept closed while a child is in the outdoor area;
2. The following is provided and maintained within the fall zones of swings and climbing equipment in an outdoor area:
 - a. A shock-absorbing unitary surfacing material manufactured for such use in outdoor activity areas; or
 - b. A minimum depth of 6.0 inches of a nonhazardous, resilient material such as fine loose sand or wood chips;
3. Hard surfacing material such as asphalt or concrete is not installed or used under swings or climbing equipment unless used as a base for shock-absorbing unitary surfacing material;
4. A swing or climbing equipment is not located in the fall zone of another swing or climbing equipment; and
5. A shaded area for each child occupying an outdoor area at any time of the day is provided.

DD. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall install and maintain a portable, pressurized fire extinguisher that meets, at a minimum, a 2A-10-BC rating of the Underwriters Laboratories in an outpatient treatment center's kitchen and any other location required for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, incorporated by reference in A.A.C. R9-1-412.

EE. In addition to the requirements in R9-10-1029(F), an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:

1. Combustible material, such as paper, boxes, or rags, is not permitted to accumulate inside or outside the premises;
2. An unvented or open-flame space heater or portable heater is not used on the premises;
3. A gas valve on an unused gas outlet is removed and capped where it emerges from the wall or floor;

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4. Heating and cooling equipment is inaccessible to a child;
5. Fans are mounted and inaccessible to a child;
6. Toilet rooms are ventilated to the outside of the building, either by a screened window open to the outside air or by an exhaust fan and duct system that is operated when the toilet room is in use;
7. A toilet room with a door that opens to the exterior of a building is equipped with a self-closing device that keeps the door closed except when an individual is entering or exiting; and
8. A toilet room door does not open into a kitchen or laundry.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1025 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1025 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Sequential numbering corrections made under subsection R9-10-1025(G) at the request of the Department of Health Services on June 27, 2016; file number M16-185 (Supp. 16-3).

Table 10.1 Meal Pattern Requirements for Children

Meal Pattern Requirements for Children

Food Components	Ages 1 through 2 years	Ages 3 through 5 years	Ages 6 and older
Breakfast:			
1. Milk, fluid	1/2 cup	3/4 cup	1 cup
2. Vegetable, fruit, or full-strength juice	1/4 cup	1/2 cup	1/2 cup
3. Bread and bread alternates (whole grain or enriched):	1/2 slice	1/2 slice	1 slice
Bread	1/2 serving	1/2 serving	1 serving
or cornbread, rolls, muffins, or biscuits	1/4 cup	1/3 cup	3/4 cup
	1/4 cup	1/4 cup	1/2 cup

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or cold dry cereal (volume or weight, whichever is less) or cooked cereal, pasta, noodle products, or cereal grains			
Lunch or Supper:			
1. Milk, fluid	1/2 cup	3/4 cup	1 cup
2. Vegetable and/or fruit (2 or more kinds)	1/4 cup total	1/2 cup total	3/4 cup total
3. Bread and bread alternates (whole grain or enriched):	1/2 slice	1/2 slice	1 slice
Bread	1/2 serving	1/2 serving	1 serving
or cornbread, rolls, muffins, or biscuits	1/4 cup	1/3 cup	3/4 cup
or cold dry cereal (volume or weight, whichever is less)	1/4 cup	1/4 cup	1/2 cup
or cooked cereal, pasta, noodle products, or cereal grains	1 oz.	1 1/2 oz.	2 oz.
4. Meat or meat alternates:	1/2 egg	3/4 egg	1 egg
Lean meat, fish, or poultry (edible portion as served)	1/4 cup	3/8 cup	1/2 cup
2 tbsp.**	2 tbsp.**	3 tbsp.**	4 tbsp.**
or cheese			
or egg	1/2 oz.**	3/4 oz.**	1 oz.**
or cooked dry beans or peas*			
or peanut butter, soy nut butter, or other nut or seed	4 oz.	6 oz.	8 oz.
butters			
or peanuts, soy nuts, tree nuts, or seeds			
or an equivalent quantity of any combination of the			
above meat/meat alternates			
or yogurt			

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Snack: (select 2 of these 4 components)***					
1.	Milk, fluid	1/2 cup	1/2 cup	1 cup	
2.	Vegetable, fruit, or full-strength juice	1/2 cup	1/2 cup	3/4 cup	
3.	Bread and bread alternates (whole grain or enriched):	1/2 slice Bread or cornbread, rolls, muffins, or biscuits or cold dry cereal (volume or weight, whichever is less) or cooked cereal, pasta, noodle products, or cereal grains	1/2 slice 1/2 serving 1/4 cup 1/4 cup	1/2 slice 1/2 serving 1/3 cup 1/4 cup	1 slice 1 serving 3/4 cup 1/2 cup
4.	Meat or meat alternates:	1/2 egg Lean meat, fish, or poultry (edible portion as served) or cheese or egg or cooked dry beans or peas* or peanut butter, soy nut butter, or other nut or seed butters or peanuts, soy nuts, tree nuts, or seeds or an equivalent quantity of any combination of the above meat/meat alternates or yogurt	1/2 egg 1/8 cup 1 tbsp. 1/2 oz.	1/2 egg 1/8 cup 1 tbsp. 1/2 oz.	1/2 egg 1/4 cup 2 tbsp. 1 oz. 1 oz.
<p>* In the same meal service, dried beans or dried peas may be used as a meat alternate or as a vegetable; however, such use does not satisfy the requirement for both components.</p> <p>** At lunch and supper, no more than 50% of the requirement shall be met with nuts, seeds, or nut butters. Nuts, seeds, or nut butters shall be combined with another meat or meat alternative to fulfill the requirement. Two tablespoons of nut butter or one ounce of nuts or seeds equals one ounce of meat.</p>					

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*** Juice may not be served when milk is served as the only other component.

Historical Note

Table 10.1 made by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2).

R9-10-1026. Sleep Disorder Services

An administrator of an outpatient treatment center that is authorized to provide sleep disorder services shall ensure that:

1. A physician provides direction for the sleep disorder services provided by the outpatient treatment center;
2. At least one of the following is present on the premise of the outpatient treatment center:
 - a. A polysomnographic technician certified by the Board of Registered Polysomnographic Technologists (BRPT),
 - b. A polysomnographic technician accepted by the BRPT to sit for the BRPT certification examination, or
 - c. A respiratory therapist;
3. There is at least one patient testing room having a minimum of 140 square feet and no dimension less than 10 feet;
4. There is a bathroom available for use by a patient that contains:
 - a. A working sink with running water,
 - b. A working toilet that flushes and has a seat,
 - c. Toilet tissue,
 - d. Soap for hand washing,
 - e. Paper towels or a mechanical air hand dryer,
 - f. Lighting, and
 - g. A means of ventilation;
5. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise; and
6. Equipment for the delivery of continuous positive airway pressure and bi-level positive airway pressure, including remote control of the airway pressure, is available on the premises of the outpatient treatment center.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1026 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1026 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the

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proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1027. Urgent Care Services Provided in a Freestanding Urgent Care Setting

An administrator of an outpatient treatment center that is authorized to provide urgent care services in a freestanding urgent care setting shall ensure that:

1. In addition to the policies and procedures required in R9-10-1003(D)(1), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover basic life support training and pediatric basic life support training including:
 - a. Method and content of training,
 - b. Qualifications of individuals providing the training, and
 - c. Documentation that verifies a medical practitioner has received the training;
2. A medical practitioner is on the premises during hours of clinical operation to provide the medical services, nursing services, and health-related services included in the outpatient treatment center's scope of services;
3. If a physician is not on the premises during hours of operation, a notice stating this fact is conspicuously posted in the waiting room according to A.R.S. § 36-432;
4. If a patient's death occurs at the outpatient treatment center, a written report is submitted to the Department as required in A.R.S. § 36-445.04;
5. A medical practitioner completes basic life support training and pediatric basic life support training:
 - a. Before providing medical services, nursing services, or health-related services at the outpatient treatment center, and
 - b. At least once every 24 months after the initial date of employment;
6. Except as provided in subsection (5), a personnel member completes basic adult and pediatric cardiopulmonary resuscitation training:
 - a. Before providing medical services, nursing services, or health-related services at the outpatient treatment center; and
 - b. At least once every 24 months after the initial date of employment or volunteer service; and
7. In addition to the requirements in R9-10-1006(11), a medical practitioner's record includes documentation of completion of basic life support training and pediatric basic life support training.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1027 adopted as an emergency now adopted and amended as a permanent rule

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effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1027 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1028. Infection Control

An administrator shall ensure that:

1. An infection control program is established, under the direction of an individual qualified according to the outpatient treatment center's policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
 - a. A method to identify and document infections occurring at the outpatient treatment center;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the outpatient treatment center;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the outpatient treatment center; and
 - d. Documentation of infection control activities including:
 - i. The collection and analysis of infection control data,
 - ii. The actions taken related to infections and communicable diseases, and
 - iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. If applicable:
 - i. Handling and disposal of biohazardous medical waste;
 - ii. Isolation of a patient;
 - iii. Sterilization and disinfection of medical equipment and supplies;
 - iv. Use of personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable; and
 - v. Collection, storage, and cleaning of soiled linens and clothing;
 - b. Cleaning an individual's hands when the individual's hands are visibly soiled;
 - c. Training of personnel members, employees, and volunteers in infection control practices; and

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- d. Work restrictions for a personnel member, employee, or volunteer with a communicable disease or infected skin lesion;
- 4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures; and
- 5. A personnel member, employee, or volunteer washes his or her hands with soap and water or uses a hand disinfection product before and after each patient contact and after handling soiled linen, soiled clothing, or a potentially infectious material.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1028 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1028 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1029. Emergency and Safety Standards

- A. An administrator shall ensure that policies and procedures for providing emergency treatment are established, documented, and implemented that protect the health and safety of patients and include:
 - 1. A list of the medications, supplies, and equipment required on the premises for the emergency treatment provided by the outpatient treatment center;
 - 2. A system to ensure medications, supplies, and equipment are available, have not been tampered with, and, if applicable, have not expired;
 - 3. A requirement that a cart or a container is available for emergency treatment that contains the medication, supplies, and equipment specified in the outpatient treatment center's policies and procedures; and
 - 4. A method to verify and document that the contents of the cart or container are available for emergency treatment.
- B. An administrator shall ensure that emergency treatment is provided to a patient admitted to the outpatient treatment center according to the outpatient treatment center's policies and procedures.
- C. An administrator shall ensure that:
 - 1. A disaster plan is developed, documented, maintained in a location accessible to personnel members, and, if necessary, implemented that includes:
 - a. Procedures for protecting the health and safety of patients and other individuals on the premises;

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- b. Assigned responsibilities for each personnel member, employee, or volunteer;
 - c. Instructions for the evacuation of patients and other individuals on the premises; and
 - d. Arrangements to provide medical services, nursing services, and health-related services to meet patients' needs;
2. The disaster plan required in subsection (C)(1) is reviewed at least once every 12 months;
 3. An evacuation drill is conducted on each shift at least once every 12 months;
 4. A disaster plan review required in subsection (C)(2) or an evacuation drill required in subsection (C)(3) is documented as follows:
 - a. The date and time of the evacuation drill or disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the evacuation drill or disaster plan review;
 - c. A critique of the evacuation drill or disaster plan review; and
 - d. If applicable, recommendations for improvement;
 5. Documentation required in subsection (C)(4) is maintained for at least 12 months after the date of the evacuation drill or disaster plan review; and
 6. An evacuation path is conspicuously posted on each hallway of each floor of the outpatient treatment center.
- D.** An administrator shall ensure that an outpatient treatment center has either:
1. Both of the following that are tested and serviced at least once every 12 months:
 - a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in A.A.C. R9-1-412, that is in working order; and
 - b. A sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in A.A.C. R9-1-412, that is in working order; or
 2. The following:
 - a. A smoke detector installed in each hallway of the outpatient treatment center that is:
 - i. Maintained in an operable condition;
 - ii. Either battery operated or, if hard-wired into the electrical system of the outpatient treatment center, has a back-up battery; and
 - iii. Tested monthly; and
 - b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that:
 - i. Is available at the outpatient treatment center;

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- ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;
 - iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and
 - iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person.
- E.** An administrator shall ensure that documentation of a test required in subsection (D) is maintained for at least 12 months after the date of the test.
- F.** An administrator shall ensure that:
- 1. Exit signs are illuminated, if the local fire jurisdiction requires illuminated exit signs;
 - 2. Except as provided in subsection (G), a corridor in the outpatient treatment center is at least 44 inches wide;
 - 3. Corridors and exits are kept clear of any obstructions;
 - 4. A patient can exit through any exit during hours of operation;
 - 5. An extension cord is not used instead of permanent electrical wiring;
 - 6. Each electrical outlet and electrical switch has a cover plate that is in good repair;
 - 7. If applicable, a sign is placed at the entrance of a room or an area indicating that oxygen is in use; and
 - 8. Oxygen and medical gas containers:
 - a. Are maintained in a secured, upright position; and
 - b. Are stored in a room with a door:
 - i. In a building with sprinklers, at least five feet from any combustible materials; or
 - ii. In a building without sprinklers, at least 20 feet from any combustible materials.

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Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1029 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1029 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1030. Physical Plant, Environmental Services, and Equipment Standards

- A. An administrator shall ensure that:
 1. An outpatient treatment center's premises are:
 - a. Sufficient to provide the outpatient treatment center's scope of services;
 - b. Cleaned and disinfected according to the outpatient treatment center's policies and procedures to prevent, minimize, and control illness and infection; and
 - c. Free from a condition or situation that may cause an individual to suffer physical injury;
 2. If an outpatient treatment center collects urine or stool specimens from a patient, except as provided in subsection (B), or is authorized to provide respite services for children on the premises, the outpatient treatment center has at least one bathroom on the premises that:
 - a. Contains:
 - i. A working sink with running water,
 - ii. A working toilet that flushes and has a seat,
 - iii. Toilet tissue,
 - iv. Soap for hand washing,
 - v. Paper towels or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A means of ventilation; and
 - b. Is for the exclusive use of the outpatient treatment center;
 3. A pest control program is implemented and documented;
 4. A tobacco smoke-free environment is maintained on the premises;
 5. A refrigerator used to store a medication is:
 - a. Maintained in working order, and

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- b. Only used to store medications;
 - 6. Equipment at the outpatient treatment center is:
 - a. Sufficient to provide the outpatient treatment center's scope of services;
 - b. Maintained in working condition;
 - c. Used according to the manufacturer's recommendations; and
 - d. If applicable, tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
 - 7. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of testing, calibration, or repair.
- B.** An outpatient treatment center may have a bathroom used for the collection of a patient's urine or stool that is not for the exclusive use of the outpatient treatment center if:
- 1. The bathroom is located in the same contiguous building as the outpatient treatment center's premises,
 - 2. The bathroom is of a sufficient size to support the outpatient treatment center's scope of services, and
 - 3. There is a documented agreement between the licensee and the owner of the building stating that the bathroom complies with the requirements in this Section and allowing the Department access to the bathroom to verify compliance.
- C.** If an outpatient treatment center has a bathroom that is not for the exclusive use of the outpatient treatment center as allowed in subsection (B), an administrator shall ensure that:
- 1. Policies and procedures are established, documented, and implemented to:
 - a. Protect the health and safety of an individual using the bathroom; and
 - b. Ensure that the bathroom is cleaned and sanitized to prevent, minimize, and control illness and infection;
 - 2. Documented instructions are provided to a patient that cover:
 - a. Infection control measures when a patient uses the bathroom, and
 - b. The safe return of a urine or stool specimen to the outpatient treatment center;
 - 3. The bathroom complies with the requirements in subsection (A)(2)(a); and
 - 4. The bathroom is free from a condition or situation that may cause an individual using the bathroom to suffer a physical injury.

Historical Note

Adopted effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective

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October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2).

R9-10-1031. Colocation Requirements

A. In addition to the definitions in A.R.S. §§ 36-401 and 36-439 and R9-10-101 and R9-10-1001, the following definition applies in this Section:

“Patient” means an individual who enters the premises of a collaborating outpatient treatment center to obtain physical health services or behavioral health services from the collaborating outpatient treatment center or a colocator that shares common areas with the collaborating outpatient treatment center.

B. Only one outpatient treatment center in a facility may be designated as a collaborating outpatient treatment center for the facility.

C. The following health care institutions are not permitted to be a collaborating outpatient treatment center or a colocator in a collaborating outpatient treatment center:

1. An affiliated counseling facility, as defined in R9-10-1901;
2. An outpatient treatment center authorized by the Department to provide dialysis services according to R9-10-1018;
3. An outpatient treatment center authorized by the Department to provide emergency room services according to R9-10-1019; or
4. An outpatient treatment center operating under a single group license according to A.R.S. § 36-422 (F) or (G).

D. In addition to the requirements for an initial license application in R9-10-105, renewal license application in R9-10-107, or, if part of a license change or modification, the supplemental application requirements in R9-10-1002, a governing authority of an outpatient treatment center requesting authorization to operate or continue to operate as a collaborating outpatient treatment center shall submit, in a Department-provided format:

1. The following information for each proposed colocator that may share a common area and nontreatment personnel at the collaborating outpatient treatment center:
 - a. For each proposed associated licensed provider:
 - i. Name,
 - ii. The associated licensed provider’s license number or the date the associated licensed provider submitted to the Department an initial license application for an outpatient treatment center or a counseling facility license,
 - iii. Proposed scope of services, and
 - iv. A copy of the written agreement with the collaborating outpatient treatment center required in subsection (E); and

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- b. For each exempt health care provider:
 - i. Name,
 - ii. Current health care professional license number,
 - iii. Proposed scope of services, and
 - iv. A copy of the written agreement required in subsection (F) with the collaborating outpatient treatment center; and
 - 2. In addition to the requirements in R9-10-105(A)(5)(b)(v), a floor plan that shows:
 - a. Each colocator's proposed treatment area, and
 - b. The common areas of the collaborating outpatient treatment center.
- E. An administrator of a collaborating outpatient treatment center shall have a written agreement with each associated licensed provider that includes:
- 1. In a Department-provided format:
 - a. The associated licensed provider's name;
 - b. The name of the associated licensed provider's governing authority;
 - c. Whether the associated licensed provider plans to share medical records with the collaborating outpatient treatment center;
 - d. If the associated licensed provider plans to share medical records with the collaborating outpatient treatment center, specific information about which party will obtain a patient's:
 - i. General consent or informed consent, as applicable;
 - ii. Consent to allow a colocator access to the patient's medical record; and
 - iii. Advance directives;
 - e. How the associated licensed provider will transport or transfer a patient to another colocator within the collaborating outpatient treatment center;
 - f. How the associated licensed provider will ensure controlled substances stored in the associated licensed provider's licensed premises are not diverted;
 - g. How the associated licensed provider will ensure environmental services in the associated licensed provider's licensed premises will not affect patient care in the collaborating outpatient treatment center;
 - h. How the associated licensed provider's personnel members will respond to a patient's sudden, intense, or out-of-control behavior, in the associated licensed provider's treatment area, to prevent harm to the patient or another individual in the collaborating outpatient treatment center;
 - i. A statement that, if any of the collocators include children's behavioral health services in the colocator's scope of services, the associated licensed provider will ensure that all employees and personnel members of the associated licensed provider comply the fingerprint clearance card requirements in A.R.S. § 36-425.03;

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- j. A statement that the associated licensed provider will:
 - i. Document the following each time another colocator provides emergency health care services in the associated licensed provider's treatment area:
 - (1) The name of colocator;
 - (2) If different from the name of the colocator, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
 - (3) A description of the emergency health care services provided; and
 - (4) The date and time the emergency health care services were provided;
 - ii. Maintain the documentation in subsection (E)(1)(j)(i) for at least 12 months after the emergency health care services were provided; and
 - iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
 - k. A statement that the associated licensed provider will:
 - i. Document the following each time the associated licensed provider provides emergency health care services in another colocator's treatment area:
 - (1) If different from the name of the associated licensed provider, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
 - (2) The name of colocator;
 - (3) A description of the emergency health care services provided; and
 - (4) The date and time the emergency health care services were provided;
 - ii. Maintain the documentation in subsection (E)(1)(k)(i) for at least 12 months after the emergency health care services were provided; and
 - iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
 - l. An attestation that the associated licensed provider will comply with the written agreement;
 - m. The signature of the associated licensed provider's governing authority according to A.R.S. § 36-422(B) and the date signed; and
 - n. The signature of the collaborating outpatient treatment center's governing authority according to A.R.S. § 36-422(B) and the date signed; and
2. A copy of the associated licensed provider's scope of services, including whether the associated licensed provider plans to provide behavioral health services for children.

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- F. An administrator of a collaborating outpatient treatment center shall have a written agreement with each exempt health care provider that includes:
1. In a Department-provided format:
 - a. The exempt health care provider's name;
 - b. The exempt health care provider license type and license number;
 - c. Whether the exempt health care provider plans to share medical records with the collaborating outpatient treatment center;
 - d. If the exempt health care provider plans to share medical records with the collaborating outpatient treatment center, specific information about which party will obtain a patient's:
 - i. General consent or informed consent, as applicable;
 - ii. Consent to allow a colocator access to the patient's medical record; and
 - iii. Advance directives;
 - e. How the exempt health care provider will transport or transfer a patient to another colocator within the collaborating outpatient treatment center;
 - f. How the exempt health care provider will ensure controlled substances stored in the exempt health care provider's designated premises are not diverted;
 - g. How the exempt health care provider will ensure environmental services in the exempt health care provider's licensed premises will not affect patient care in the collaborating outpatient treatment center;
 - h. How the exempt health care provider and any staff of the exempt health care provider will respond to a patient's sudden, intense, or out-of-control behavior, in the exempt health care provider's treatment area, to prevent harm to the patient or another individual in the collaborating outpatient treatment center;
 - i. A statement that, if any of the colocators include children's behavioral health services in the colocator's statement of services, the exempt health care provider will ensure that all employees and staff of the exempt health care provider comply with the fingerprint clearance card requirements A.R.S. § 36-425.03;
 - j. A statement that the exempt health care provider will:
 - i. Document the following each time another colocator provides emergency health care services in the exempt health care provider's treatment area:
 - (1) The name of colocator;
 - (2) If different from the name of the colocator, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
 - (3) A description of the emergency health care services provided; and
 - (4) The date and time the emergency health care services were provided;

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- ii. Maintain the documentation in subsection (F)(1)(j)(i) for at least 12 months after the emergency health care services were provided; and
 - iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
- k. A statement that the exempt health care provider will:
- i. Document the following each time the exempt health care provider provides emergency health care services in another colocator's treatment area:
 - (1) If different from the name of the exempt health care provider, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
 - (2) The name of colocator;
 - (3) A description of the emergency health care services provided; and
 - (4) The date and time the emergency health care services were provided;
 - ii. Maintain the documentation in subsection (F)(1)(k)(i) for at least 12 months after the emergency health care services were provided; and
 - iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
- l. An attestation that the exempt health care provider will comply with the written agreement;
- m. The signature of the exempt health care provider and the date signed; and
- n. The signature of the collaborating outpatient treatment center's governing authority according to A.R.S. § 36-422(B) and the date signed; and
2. A copy of the exempt health care provider's scope of services, including whether the exempt health care provider plans to provide behavioral health services for children.
- G.** As part of the policies and procedures required in this Article, an administrator of a collaborating outpatient treatment center shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient based on the scopes of services of all colocators that:
- 1. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for nontreatment personnel who may provide services in the common areas of the collaborating outpatient treatment center;
 - 2. Cover orientation and in-service education for nontreatment personnel who may provide services in the common areas of the collaborating outpatient treatment center;
 - 3. Cover cardiopulmonary resuscitation training, including:

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- a. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
 - b. The qualifications for an individual to provide cardiopulmonary resuscitation training;
 - c. The time-frame for renewal of cardiopulmonary resuscitation training; and
 - d. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;
4. Cover first aid training;
 5. Cover patient screening, including a method to ensure that, if a patient identifies a specific colocator, the patient is directed to the identified colocator;
 6. Cover the provision of emergency treatment to protect the health and safety of a patient or individual present in a common area according to the requirements for emergency treatment policies and procedures in R9-10-1029(A);
 7. If medication is stored in the collaborating outpatient treatment center's common areas, cover obtaining, storing, accessing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;
 8. Cover biohazardous wastes, if applicable;
 9. Cover environmental services in the common area that affect patient care; and
 10. Cover how personnel members and nontreatment personnel will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual in the collaborating outpatient treatment center's common areas.
- H.** An administrator of a collaborating outpatient treatment center shall ensure that:
1. An outpatient treatment center's common areas are:
 - a. Sufficient to accommodate the outpatient treatment center's and any colocators' scopes of services;
 - b. Cleaned and disinfected according to the outpatient treatment center's policies and procedures to prevent, minimize, and control illness and infection; and
 - c. Free from a condition or situation that may cause an individual to suffer physical injury;
 2. A written log is maintained that documents the date, time, and circumstances each time a colocator provides emergency health care services in another colocator's designated treatment area; and
 3. The documentation in the written log required in subsection (H)(2) is maintained for at least 12 months after the date the colocator provides emergency health care services in another colocator's designated treatment area.
- I.** If any colocator at a collaborating outpatient treatment center includes children's behavioral health services as part of the colocator's scope of services, an administrator of the collaborating outpatient treatment center shall ensure that the governing authority, employees, personnel members, nontreatment personnel, and volunteers of the collaborating outpatient treatment center comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.

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Historical Note

New Section made by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2).

h. 10, § 13; effective July 1, 2014 (Supp. 14-2).

9 A.A.C. 8, ARTICLE 10 - ATTACHMENT B

Statutory Authority

36-104. Powers and duties

This section is not to be construed as a statement of the department's organization. This section is intended to be a statement of powers and duties in addition to the powers and duties granted by section 36-103. The director shall:

1. Administer the following services:

(a) Administrative services, which shall include at a minimum the functions of accounting, personnel, standards certification, electronic data processing, vital statistics and the development, operation and maintenance of buildings and grounds utilized by the department.

(b) Public health support services, which shall include at a minimum:

(i) Consumer health protection programs that include at least the functions of community water supplies, general sanitation, vector control and food and drugs.

(ii) Epidemiology and disease control programs that include at least the functions of chronic disease, accident and injury control, communicable diseases, tuberculosis, venereal disease and others.

(iii) Laboratory services programs.

(iv) Health education and training programs.

(v) Disposition of human bodies programs.

(c) Community health services, which shall include at a minimum:

(i) Medical services programs that include at least the functions of maternal and child health, preschool health screening, family planning, public health nursing, premature and newborn program, immunizations, nutrition, dental care prevention and migrant health.

(ii) Dependency health care services programs that include at least the functions of need determination, availability of health resources to medically dependent individuals, quality control, utilization control and industry monitoring.

(iii) Children with physical disabilities services programs.

(iv) Programs for the prevention and early detection of an intellectual disability.

(d) Program planning, which shall include at least the following:

(i) An organizational unit for comprehensive health planning programs.

(ii) Program coordination, evaluation and development.

(iii) Need determination programs.

(iv) Health information programs.

2. Include and administer, within the office of the director, staff services, which shall include at a minimum budget preparation, public information, appeals, hearings, legislative and federal government liaison, grant development and management and departmental and interagency coordination.

3. Make rules and regulations for the organization and proper and efficient operation of the department.

4. Determine when a health care emergency or medical emergency situation exists or occurs within the state that cannot be satisfactorily controlled, corrected or treated by the health care delivery systems and facilities available. When such a situation is determined to exist, the director shall immediately report that situation to the legislature and the governor. The report shall include information on the scope of the emergency, recommendations for solution of the emergency and estimates of costs involved.

5. Provide a system of unified and coordinated health services and programs between the state and county governmental health units at all levels of government.

6. Formulate policies, plans and programs to effectuate the missions and purposes of the department.

7. Make contracts and incur obligations within the general scope of the department's activities and operations subject to the availability of funds.

8. Be designated as the single state agency for the purposes of administering and in furtherance of each federally supported state plan.

9. Provide information and advice on request by local, state and federal agencies and by private citizens, business enterprises and community organizations on matters within the scope of the department's duties subject to the departmental rules and regulations on the confidentiality of information.

10. Establish and maintain separate financial accounts as required by federal law or regulations.

11. Advise with and make recommendations to the governor and the legislature on all matters concerning the department's objectives.

12. Take appropriate steps to reduce or contain costs in the field of health services.

13. Encourage and assist in the adoption of practical methods of improving systems of comprehensive planning, of program planning, of priority setting and of allocating resources.

14. Encourage an effective use of available federal resources in this state.
15. Research, recommend, advise and assist in the establishment of community or area health facilities, both public and private, and encourage the integration of planning, services and programs for the development of the state's health delivery capability.
16. Promote the effective utilization of health manpower and health facilities that provide health care for the citizens of this state.
17. Take appropriate steps to provide health care services to the medically dependent citizens of this state.
18. Certify training on the nature of sudden infant death syndrome, which shall include information on the investigation and handling of cases involving sudden and unexplained infant death for use by law enforcement officers as part of their basic training requirement.
19. Adopt protocols on the manner in which an autopsy shall be conducted under section 11-597, subsection D in cases of sudden and unexplained infant death.
20. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities in this state to collect data and conduct projects in the United States and Mexico on issues that are within the scope of the department's duties and that relate to quality of life, trade and economic development in this state in a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of this state and of the Arizona-Mexico region.
21. Administer the federal family violence prevention and services act grants, and the department is designated as this state's recipient of federal family violence prevention and services act grants.
22. Accept and spend private grants of monies, gifts and devises for the purposes of methamphetamine education. The department shall disburse these monies to local prosecutorial or law enforcement agencies with existing programs, faith based organizations and nonprofit entities that are qualified under section 501(c)(3) of the United States internal revenue code, including nonprofit entities providing services to women with a history of dual diagnosis disorders, and that provide educational programs on the repercussions of methamphetamine use. State general fund monies shall not be spent for the purposes of this paragraph. If the director does not receive sufficient monies from private sources to carry out the purposes of this paragraph, the director shall not provide the educational programs prescribed in this paragraph. Grant monies received pursuant to this paragraph are non-lapsing and do not revert to the state general fund at the close of the fiscal year.
23. Identify successful methamphetamine prevention programs in other states that may be implemented in this state.
24. Pursuant to chapter 13, article 8 of this title, coordinate all public health and risk assessment issues associated with a chemical or other toxic fire event if a request for the event is received from the incident commander, the emergency response commission or the department of public safety and if funding is available. Coordination of public health issues shall include general environmental health consultation and risk assessment services consistent with chapter 13, article 8 of this title and, in consultation with the Arizona poison control system, informing the public as to potential

public health risks from the environmental exposure. Pursuant to chapter 13, article 8 of this title, the department of health services shall also prepare a report, in consultation with appropriate state, federal and local governmental agencies, that evaluates the public health risks from the environmental exposure. The department of health services' report shall include any department of environmental quality report and map of smoke dispersion from the fire, the results of any environmental samples taken by the department of environmental quality and the toxicological implications and public health risks of the environmental exposure. The department of health services shall consult with the Arizona poison control system regarding toxicology issues and shall prepare and produce its report for the public as soon as practicable after the event. The department of health services shall not use any monies pursuant to section 49-282, subsection E to implement this paragraph.

36-132. Department of health services; functions; contracts

A. The department shall, in addition to other powers and duties vested in it by law:

1. Protect the health of the people of the state.
2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.
3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of the state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with the provisions of chapter 3 of this title, and sections 36-693, 36-694 and 39-122.
4. Operate such sanitariums, hospitals or other facilities assigned to the department by law or by the governor.
5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information for the promotion of good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of education of children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.
6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.

7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.
8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of school children, including special fields such as the prevention of blindness and conservation of sight and hearing.
9. Encourage and aid in the coordination of local programs concerning nutrition of the people of the state.
10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.
11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.
12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection H, paragraph 10.
13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.
14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in the enforcement of the federal food, drug and cosmetic act of 1938 (52 Stat. 1040; 21 United States Code sections 1 through 905).
15. Recruit and train personnel for state, local and district health departments.
16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.
17. License and regulate health care institutions according to chapter 4 of this title.
18. Issue or direct the issuance of licenses and permits required by law.

19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.
 20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:
 - (a) Screening in early pregnancy for detecting high risk conditions.
 - (b) Comprehensive prenatal health care.
 - (c) Maternity, delivery and postpartum care.
 - (d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.
 - (e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.
21. License and regulate the health and safety of group homes for persons with developmental disabilities. The department shall issue a license to an accredited facility for a period of the accreditation, except that no licensing period shall be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.
- B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.
- C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.
- D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. Powers and duties of director; compensation of personnel; rules; definition

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.
2. Perform all duties necessary to carry out the functions and responsibilities of the department.
3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.
4. Administer and enforce the laws relating to health and sanitation and the rules of the department.
5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.
6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.
7. Prepare sanitary and public health rules.
8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property

related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar

as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

(a) Served at a noncommercial social event such as a potluck.

(b) Prepared at a cooking school that is conducted in an owner-occupied home.

(c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.

(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fund-raising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) Baked and confectionary goods that are not potentially hazardous and that are prepared in a kitchen of a private home for commercial purposes if packaged with a label that clearly states the address of the maker, includes contact information for the maker, lists all the ingredients in the

product and discloses that the product was prepared in a home. The label must be given to the final consumer of the product. If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must obtain a food handler's card or certificate if one is issued by the local county and must register with an online registry established by the department pursuant to paragraph 13 of this subsection. For the purposes of this subdivision, "potentially hazardous" means baked and confectionary goods that meet the requirements of the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for the preservation or storage of food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparation of food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political

subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.

13. Establish an online registry of food preparers that are authorized to prepare food for commercial purposes pursuant to paragraph 4 of this subsection.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".

J. The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat

products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. For the purposes of this section, "fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.

36-405. Powers and duties of the director

A. The director shall adopt rules to establish minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to ensure the public health, safety and welfare. The standards and requirements shall relate to the construction, equipment, sanitation, staffing for medical, nursing and personal care services, and recordkeeping pertaining to the administration of medical, nursing, behavioral health and personal care services, in accordance with generally accepted practices of health care. The director shall use the current standards adopted by the joint commission on accreditation of hospitals and the commission on accreditation of the American osteopathic association or those adopted by any recognized accreditation organization approved by the department as guidelines in prescribing minimum standards and requirements under this section.

B. The director, by rule, may:

1. Classify and subclassify health care institutions according to character, size, range of services provided, medical or dental specialty offered, duration of care and standard of patient care required for the purposes of licensure. Classes of health care institutions may include hospitals, infirmaries, outpatient treatment centers, health screening services centers and residential care facilities. Whenever the director reasonably deems distinctions in rules and standards to be appropriate among different classes or subclasses of health care institutions, the director may make such distinctions.
2. Prescribe standards for determining a health care institution's substantial compliance with licensure requirements.
3. Prescribe the criteria for the licensure inspection process.
4. Prescribe standards for the selection of health care-related demonstration projects.
5. Establish nonrefundable application and licensing fees for health care institutions, including a grace period and a fee for the late payment of licensing fees, and fees for architectural plans and specifications reviews.
6. Establish a process for the department to notify a licensee of the licensee's licensing fee due date.
7. Establish a process for a licensee to request a different licensing fee due date, including any limits on the number of requests by the licensee.

C. The director, by rule, shall adopt licensing provisions that facilitate the colocation and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services consistent with article 3.1 of this chapter.

D. Ninety percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the health services licensing fund established by section 36-414 and ten percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.

E. Subsection B, paragraph 5 of this section does not apply to a health care institution operated by a state agency pursuant to state or federal law or to adult foster care residential settings.

36-406. Powers and duties of the department

In addition to its other powers and duties:

1. The department shall:

(a) Administer and enforce this chapter and the rules, regulations and standards adopted pursuant thereto.

(b) Review, and may approve, plans and specifications for construction or modification or additions to health care institutions regulated by this chapter.

(c) Have access to books, records, accounts and any other information of any health care institution reasonably necessary for the purposes of this chapter.

(d) Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe the manner by which the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of that vaccination in this state as determined by the director.

2. The department may:

(a) Make or cause to be made inspections consistent with standard medical practice of every part of the premises of health care institutions which are subject to the provisions of this chapter as well as those which apply for or hold a license required by this chapter.

(b) Make studies and investigations of conditions and problems in health care institutions, or any class or subclass thereof, as they relate to compliance with this chapter and rules, regulations and standards adopted pursuant thereto.

(c) Develop manuals and guides relating to any of the several aspects of physical facilities and operations of health care institutions or any class or subclass thereof for distribution to the governing authorities of health care institutions and to the general public.

36-407. Prohibited acts

A. A person shall not establish, conduct or maintain in this state a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the department specifying the class or subclass of health care institution the person is establishing, conducting or maintaining. The license is valid only for the establishment, operation and maintenance of the class or subclass of health care institution, the type of services and, except for emergency admissions as prescribed by the director by rule, the licensed capacity specified by the license.

B. The licensee shall not imply by advertising, directory listing or otherwise that the licensee is authorized to perform services more specialized or of a higher degree of care than is authorized by this chapter and the underlying rules for the particular class or subclass of health care institution within which the licensee is licensed.

C. The licensee may not transfer or assign the license. A license is valid only for the premises occupied by the institution at the time of its issuance.

D. The licensee shall not personally or through an agent offer or imply an offer of rebate or fee splitting to any person regulated by title 32 or chapter 17 of this title.

E. The licensee shall submit an itemized statement of charges to each pa

36-425. Inspections; issuance of license; posting requirements; provisional license; denial of license

A. On receipt of a properly completed application for a health care institution license, the director shall conduct an inspection of the health care institution as prescribed by this chapter. If an application for a license is submitted due to a planned change of ownership, the director shall determine the need for an inspection of the health care institution. Based on the results of the inspection and after the submission of the applicable licensing fee, the director shall either deny the license or issue a regular or provisional license. A license issued by the department shall be posted in a conspicuous location in the reception area of that institution.

B. The director shall issue a license if the director determines that an applicant and the health care institution for which the license is sought substantially comply with the requirements of this chapter and rules adopted pursuant to this chapter and the applicant agrees to carry out a plan acceptable to the director to eliminate any deficiencies. The director shall not require a health care institution that was designated as a critical access hospital to make any modifications required by this chapter or rules adopted pursuant to this chapter in order to obtain an amended license with the same licensed capacity the health care institution had before it was designated as a critical access hospital if all of the following are true:

1. The health care institution has subsequently terminated its critical access hospital designation.
2. The licensed capacity of the health care institution does not exceed its licensed capacity before its designation as a critical access hospital.
3. The health care institution remains in compliance with the applicable codes and standards that were in effect at the time the facility was originally licensed with the higher licensed capacity.

C. A health care institution license does not expire and remains valid unless:

1. The department subsequently revokes or suspends the license.
2. The license is considered void because the licensee did not pay the licensing fee before the licensing fee due date.

D. Except as provided in section 36-424, subsection B and subsection E of this section, the department shall conduct a compliance inspection of a health care institution to determine compliance with this chapter and rules adopted pursuant to this chapter at least once annually.

E. If the department determines a facility to be deficiency free on a compliance survey, the department shall not conduct a compliance survey of that facility for twenty-four months after the date of the deficiency free survey. This subsection does not prohibit the department from enforcing licensing requirements as authorized by section 36-424.

F. A hospital licensed as a rural general hospital may provide intensive care services.

G. The director shall issue a provisional license for a period of not more than one year if an inspection or investigation of a currently licensed health care institution or a health care institution for which an applicant is seeking a license reveals that the institution is not in substantial compliance with department licensure requirements and the director believes that the immediate interests of the patients and the general public are best served if the institution is given an opportunity to correct deficiencies. The applicant or licensee shall agree to carry out a plan to eliminate deficiencies that is acceptable to the director. The director shall not issue consecutive provisional licenses to a single health care institution. The director shall not issue a license to the current licensee or a successor applicant before the expiration of the provisional license unless the health care institution submits an application for a substantial compliance survey and is found to be in substantial compliance. The director may issue a license only if the director determines that the institution is in substantial compliance with the licensure requirements of the department and this chapter. This subsection does not prevent the director from taking action to protect the safety of patients pursuant to section 36-427.

H. Subject to the confidentiality requirements of articles 4 and 5 of this chapter, title 12, chapter 13, article 7.1 and section 12-2235, the licensee shall keep current department inspection reports at the health care institution. Unless federal law requires otherwise, the licensee shall post in a conspicuous location a notice that identifies the location at that institution where the inspection reports are available for review.

I. A health care institution shall immediately notify the department in writing when there is a change of the chief administrative officer specified in section 36-422, subsection A, paragraph 1, subdivision (g).

J. When the department issues an original license or an original provisional license to a health care institution, it shall notify the owners and lessees of any agricultural land within one-fourth mile of the health care institution. The health care institution shall provide the department with the names and addresses of owners or lessees of agricultural land within one-fourth mile of the proposed health care institution.

K. In addition to the grounds for denial of licensure prescribed pursuant to subsection A of this section, the director may deny a license because an applicant or anyone in a business relationship with the applicant, including stockholders and controlling persons, has had a license to operate a health care institution denied, revoked or suspended or a license or certificate issued by a health profession regulatory board pursuant to title 32 or issued by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title denied, revoked or suspended or has a licensing history of recent serious violations occurring in this state or in another state that posed a direct risk to the life, health or safety of patients or residents.

L. In addition to the requirements of this chapter, the director may prescribe by rule other licensure requirements.

36-439.01. Colocation of licensees

Notwithstanding any other provision of this chapter, one or more outpatient treatment center licensees that provide medical, nursing and health-related services may collocate or colocate with one or more licensees that provide behavioral health services or with one or more licensed

counseling facilities and may share common areas at the collaborating outpatient treatment center premises and share nontreatment personnel pursuant to the requirements of this article.

36-439.02. Colocators; collaborating outpatient treatment centers; requirements

In addition to any other requirements of this chapter, colocators at a collaborating outpatient treatment center shall:

1. Designate which outpatient treatment center will act as the collaborating outpatient treatment center and be liable and responsible for the health, safety, cleanliness and maintenance of all common areas and the supervision and training of all shared nontreatment personnel pursuant to written policies of the collaborating outpatient treatment center.
2. Designate which areas are considered common areas and which personnel are designated as shared nontreatment personnel.
3. Designate the associated licensed providers.
4. Ensure that medical records that are located in common areas or shared by colocators are maintained pursuant to all federal and state confidentiality laws. A colocator may have access to a patient's medical records only if the patient has consented.

36-439.03. Use of treatment areas

Colocators shall solely maintain and use treatment areas that are designated pursuant to each of their respective licenses and may not use another colocator's treatment areas except as follows:

1. For the provision of emergency health care services.
2. During hours of operation by a colocator that are clearly identified by signage to the public and notice to the department.

36-439.04. Colocation; outpatient treatment centers; health care providers

- A. The governing authority of a licensed collaborating outpatient treatment center, by agreement, may share common areas and may share nontreatment personnel with one or more exempt health care providers or one or more licensed counseling facilities pursuant to section 36-439.02.
- B. Treatment areas that are licensed under an outpatient treatment center may also be used by an exempt health care provider if the provider's treatment areas and hours of operation are clearly identified by signage to the public and notice to the department.
- C. Notwithstanding subsections A and B of this section, an outpatient treatment center may contract with or employ an exempt health care provider to provide health care services to the outpatient treatment center's patients.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-18-1007)
Title 9, Chapter 22, Article 11, Civil Monetary Penalties and Assessments

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM – FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-6

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE : September 18, 2018

SUBJECT: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-18-1007)**
Title 9, Chapter 22, Article 11, Civil Monetary Penalties and Assessments

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Arizona Health Care Cost Containment System Administration (AHCCCS or Administration) is “to promote a comprehensive health care system to eligible citizens of this state.” Laws 2013, Ch. 10, § 53. The Director of AHCCCS (Director) has the authority to adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. See A.R.S. § 36.2957.

This five-year review report covers ten rules regarding civil monetary penalties and assessments in A.A.C. Title 9, Chapter 22, Article 11. The rules relate to grounds for imposing civil monetary penalties and assessments, methods for determining the proper dollar amount, mitigating and aggravating circumstances to consider in making a determination, and notice and hearing requirements and procedures.

In the previous five-year review report on these rules, AHCCCS did not propose any changes be made to the rule.

Proposed Action

AHCCCS indicates that it plans to begin the expedited rulemaking process to address clarity issues within 180 days of the Council’s approval of this report. AHCCCS plans to:

- **R9-22-1101**
 - Update subsection (C)(7) to read “‘Reason to know’ or ‘had reason to know’ means that a person acts in deliberate ignorance of the truth or falsity of information or with reckless disregard of the truth or falsity of information. ...”
- **R9-22-1104**
 - Change "a claim" to "each claim" to match R9-22-1105; and
 - Update subsection (2)(a) to read "Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present a claim for the service."
- **R9-22-1105**
 - Update subsection (1)(a) to read "A person has forged, altered, recreated, destroyed, or failed to maintain records;" ;
 - Update subsection (1)(c) to read "The services are of multiple billing code types,";
 - Update subsection (1)(d) to read “All the dates of services occurred in a period of greater than six months,”;
 - Update subsection (2) to read "The degree of culpability of a person who resents or causes to present each claim is an aggravating circumstance, including but not limited to, if:";
 - Add new subsection (2)(d) to read "The person knows or had reason to know that the payment would violate state or federal law."; and
 - Update subsection (4) to read “The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim is an aggravating circumstance.”
- **R9-22-1108**
 - Update subsection (B)(2) to read "To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision. A failure to respond to the Notice of Compromise Decision will lead to the decision being upheld."
- **R9-22-1109**
 - Update to read “If a person fails to respond to the Notice of Intent within the time period stated on the Notice...”
- **R9-22-1110**
 - Update subsection (B) to read: “AHCCCS shall mail a Notice of Hearing within the time frame specified in A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.”
- **R9-22-1111**
 - Update subsection (A) to read: “... a person shall bear the burden of proving by a preponderance of evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment and any mitigating circumstance under R9-22-1104.”

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. AHCCCS cites to both general and specific authority for the rules. A.R.S. §§ 37-2918 and 37-2957 relate to prohibited acts and corresponding penalties and assessments that may be imposed. Under these statutes, the Director or the Director's designees shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. A.R.S. § 37-2918(C). Further, the Director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. A.R.S. § 37-2957(C).

2. Summary of the agency's economic impact comparison and identification of stakeholders:

AHCCCS has determined that the economic impact of the rules included in Title 9, Chapter 22, Article 11 does not differ significantly from what was originally determined by the economic impact statement submitted in fiscal year (FY) 2011. The stakeholders include AHCCCS, AHCCCS contracted providers, AHCCCS non-contracting providers, AHCCCS members, and taxpayers.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and cost to those who are regulated?

Yes. AHCCCS has determined that the rules under review provide the least intrusive and least costly method of achieving the regulatory objective, which is to clearly and concisely set out the rules specifying the procedures and penalties applied when AHCCCS providers (contracted and non-contracted) are found to have submitted fraudulent claims. Only those providers that do not adhere to AHCCCS' regulations and fail to conduct business in an ethical manner bear the costs of these rules.

4. Has the agency received any written criticisms of the rules over the last five years?

No. AHCCCS indicates that it has not received any written criticisms of the rules over the past five years.

5. Has the agency analyzed the rules clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. AHCCCS indicates that the rules are effective in achieving their objectives and are consistent with other rules and statutes. AHCCCS further indicates that the rules are not clear, concise, and understandable. AHCCCS has proposed amendments to the rules to address these issues.

6. Has the agency analyzed the current enforcement status of the rules?

Yes. AHCCCS indicates that the rules are enforced as written.

7. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements?**

No. AHCCCS indicates that the rules are not more stringent than 31 U.S.C. 3729-3733, which describe civil actions for false claims made to the federal government and allow for the imposition of civil penalties for such claims.

8. **For rules adopted after July 29, 2010, does the rules require a permit or licenses and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules were adopted before July 29, 2010.

9. **Conclusion**

AHCCCS indicates that it plans to file a Notice of Expedited Rulemaking to make the changes identified in the report within 180 days of the Council's approval of the report. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval.

July 30, 2018

Ms. Nicole Colyer, Chair
Governor's Regulatory Review Council
100 N. 15th Ave, Suite 402
Phoenix, AZ 85007

Dear Ms. Colyer:

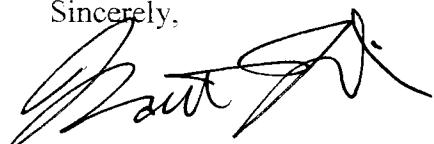
Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 22, Article 11. The report includes all of the documentation required by R1-6-301 (C) and (D).

No rules were left out of this 5-Year Review Report to be expired under A.R.S. § 41-1056 (J). Similarly, there were no rules subject to rescheduling.

As required by A.R.S. § 41-1056, the Administration certifies that the agency is in compliance with A.R.S. § 41-1091.

If you have any questions or comments regarding this report, please contact Nicole Fries, Associate General Counsel, Office of Administrative Legal Services at (602)-417-4232.

Sincerely,



Matthew Devlin
Assistant Director

Attachment

Arizona Health Care Cost Containment System

(AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 11

July 2018

1. Authorization of the rule by existing statutes

General Statutory Authority: A.R.S. § 36-2918.

Specific Statutory Authority: A.R.S. § 36-2957.

2. The objective of each rule:

Rule	Objective
R9-22-1101	Provides definitions and general requirements for Civil Monetary Penalties.
R9-22-1102	Provides requirements of how to determine the amount of a penalty.
R9-22-1104	Provides mitigating circumstances considered when determining a penalty.
R9-22-1105	Provides aggravating circumstances considered when determining a penalty.
R9-22-1106	Describes the notice requirements for Civil Monetary Penalties.
R9-22-1108	Describes how to request a compromise with AHCCCS.
R9-22-1109	Describes what occurs due to a failure to respond to the Notice of Intent.
R9-22-1110	Describes how to request a state fair hearing.
R9-22-1111	Describes the Burden of Proof in a state fair hearing.
R9-22-1112	Provides AHCCCS's right to withdraw or seek a continuance.

3. Are the rules effective in achieving their objectives? Yes X No

4. Are the rules consistent with other rules and statutes? Yes X No

5. Are the rules enforced as written? Yes X No

6. Are the rules clear, concise, and understandable? Yes No X

Rule	Explanation
R9-22-1101	Change to read: "Reason to know" or "had reason to know" means that a person acts in deliberate ignorance of the truth or falsity of information or with reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

R9-22-1104	<p>Change “a claim” to “each claim” to match R9-22-1105.</p> <p>Change 2.a. to read “Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present a claim for the service,”</p>
R9-22-1105	<p>Change 1.a. to read “A person has forged, altered, recreated, destroyed, or failed to maintain records;”</p> <p>Change 1.c. to read “The services are of multiple billing code types,”</p> <p>Change 1.d. to read “All the dates of services occurred in a period of greater than six months,”</p> <p>Change 2. To read “The degree of culpability of a person who presents or causes to present each claim is an aggravating circumstance, including but not limited to, if:”</p> <p>Add 2.d. “The person knows or had reason to know that the payment would violate state or federal law.”</p> <p>Change 4. To read: The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim is an aggravating circumstance.</p>
R9-22-1108	Change B.2. to read “To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision. A failure to respond to the Notice of Compromise Decision will lead to the decision being upheld.
R9-22-1109	Change to read: If a person fails to respond to the Notice of Intent within the time period stated on the Notice...
R9-22-1110	Change B. to read: AHCCCS shall mail a Notice of Hearing within the time frame specified in A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.
R9-22-1111	Change A. to read: a person shall bear the burden of proving by a preponderance of evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment and any mitigating circumstances under R9-22-1104.

7. Has the agency received written criticisms of the rules within the last five years? Yes No X

8. Economic, small business, and consumer impact comparison:

None of the changes proposed in this 5YRR have any effect on the economic impact of this chapter. Substantive and procedural rights of members are not affected, nor are any of the programs of the Administration. These

proposed changes are merely clarifying; therefore the economic impact of this chapter remains the same as the prior 5YRR.

9. **Has the agency received any business competitiveness analyses of the rules?** Yes No
10. **Has the agency completed the course of action indicated in the agency's previous five-year-review report?**
The prior 5YRR did not find any need to revise the rules, therefore there was no proposed course of action.
11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**
The changes that are proposed in this 5YRR are meant for clarifying purposes and do not impose any additional burdens or costs to regulated persons. In addition they are they impost the least burden and cost to achieve the same benefits as the Article currently provides to regulated persons.
12. **Are the rules more stringent than corresponding federal laws?** Yes No
The rules are not more stringent than 31 U.S.C. 3729-3733.
13. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**
Not applicable.
14. **Proposed course of action**
The Administration intends to request from the Governor's office to begin an expedited rulemaking within 180 days of GRRC's approval of this report in order to make these changes and update the cross references for the ease of use of AHCCCS's members.

Arizona Health Care Cost Containment System - Administration

Historical Note

New Section made by final rulemaking at 10 A.A.R.
1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1006. AHCCCS Monitoring Responsibilities

AHCCCS shall monitor first- or third-party liability payments to a provider or noncontracting provider, which include but are not limited to payments by or for:

1. Private health insurance;
2. Employment-related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute from recovery;
5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption-related payment; or
11. A tortfeasor.

Historical Note

New Section made by final rulemaking at 10 A.A.R.
1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1007. Notification for Perfection, Recording, and Assignment of AHCCCS Liens

- A.** Hospital requirements. A hospital providing medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall within 30 days after a member's discharge:
1. Notify AHCCCS via facsimile or mail under R9-22-1008, or
 2. Mail AHCCCS a copy of the lien the hospital proposes to record or has recorded under A.R.S. § 33-932.
- B.** Provider and noncontracting provider requirements. A provider or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall notify AHCCCS via facsimile or mail under R9-22-1008 within 30 days after providing the service.

Historical Note

New Section made by final rulemaking at 10 A.A.R.
1146, effective May 1, 2004 (Supp. 04-1). Amended by
final rulemaking at 15 A.A.R. 179, effective March 7,
2009 (Supp. 09-1).

R9-22-1008. Notification Information for Liens

- A.** Except as provided in subsection (B), a hospital, provider, and noncontracting provider identified in R9-22-1007 shall provide the following information to AHCCCS in writing:
1. Name of the hospital, provider or noncontracting provider;
 2. Address of the hospital, provider or noncontracting provider;
 3. Name of member;
 4. Member's Social Security Number or AHCCCS identification number;
 5. Address of member;
 6. Date of member's admission or date service is provided;
 7. Amount estimated to be due for care of member;
 8. Date of discharge, if member has been discharged;
 9. Name of county in which injuries were sustained; and

10. Name and address of all persons, firms, and corporations and their insurance carriers identified by the member or legal representative as being liable for damages.

- B.** If the date of discharge is not known at the time the information in subsection (A) is provided, a party identified in subsection (A) shall notify AHCCCS of the date of discharge within 30 days after the member has been discharged.

Historical Note

New Section made by final rulemaking at 10 A.A.R.
1146, effective May 1, 2004 (Supp. 04-1). Amended by
final rulemaking at 15 A.A.R. 179, effective March 7,
2009 (Supp. 09-1).

R9-22-1009. Notification of Health Insurance Information

A provider or noncontracting provider shall notify AHCCCS, in writing, of the following health insurance information within 10 days of receipt of the health insurance information:

1. Name of member,
2. Member's Social Security Number or AHCCCS identification number,
3. Insurance carrier name,
4. Insurance carrier address,
5. Policy number or insurance holder's Social Security Number,
6. Policy begin and end dates, and
7. Insurance holder's name.

Historical Note

New Section made by final rulemaking at 10 A.A.R.
1146, effective May 1, 2004 (Supp. 04-1).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions**

- A.** Scope. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).
- B.** Purpose. This Article describes the circumstances AHCCCS considers and the process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and time-frames used by a person to request a State Fair Hearing.
- C.** Definitions. The following definitions apply to this Article:
1. "Assessment" means a monetary amount that does not exceed twice the dollar amount claimed by the person for each service.
 2. "Claim" means a request for payment submitted by a person for payment for a service or line item of service, including a submission of an encounter.
 3. "Day" means calendar day unless otherwise specified.
 4. "File" means the date that AHCCCS receives a written acceptance, request for compromise, request for a counter proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.
 5. "Penalty" means a monetary amount, based on the number of items of service claimed or reported, that does not exceed \$2,000 times the number of line items of service.
 6. "Person" means an individual or entity as described under A.R.S. § 1-215.
 7. "Reason to know" or "had reason to know" means that a person, acts in deliberate ignorance of the truth or falsity

Arizona Health Care Cost Containment System - Administration

of, or with reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2). Amended by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1102. Determining the Amount of a Penalty and an Assessment

- A. AHCCCS shall determine the amount of a penalty and assessment according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.
- B. AHCCCS shall include in the amount of the penalty and assessment the cost incurred by AHCCCS for conducting the following;
 - 1. An investigation,
 - 2. Audit, or
 - 3. Inquiry.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1103. Repealed**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Section repealed by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1104. Mitigating Circumstances

AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of a claim. The following are mitigating circumstances:
 - a. All the services are of the same type,
 - b. All the dates of services occurred within six months or less,
 - c. The number of claims submitted is less than 25,
 - d. The nature and circumstances do not indicate a pattern of inappropriate claims for the services, and
 - e. The total amount claimed for the services is less than \$1,000.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim is a mitigating circumstance if:
 - a. Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present the service,
 - b. Corrective steps were taken promptly by the person after the error was discovered, and

- c. The person had a fraud and abuse control plan that was operating effectively at the time each claim was presented or caused to be presented.
3. Financial condition. The financial condition of a person who presents or causes to present a claim is a mitigating circumstance if the imposition of a penalty, assessment, or penalty and assessment without reduction will render the provider incapable to continue providing services. AHCCCS shall consider the resources available to the person when determining the amount of the penalty, assessment, or penalty and assessment.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice, the circumstances require a reduction of the penalty, assessment, or penalty and assessment.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1105. Aggravating Circumstances

AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of each claim. The nature and circumstances of each claim and the circumstances under which the claim is presented or caused to be presented are aggravating circumstances if:
 - a. A person has forged, altered, recreated, or destroyed records;
 - b. The person refuses to provide pertinent documentation to AHCCCS for a claim or refuses to cooperate with investigators;
 - c. The services are of several types;
 - d. All the dates of services did not occur within six months or less;
 - e. The number of claims submitted is greater than 25;
 - f. The nature and circumstances indicate a pattern of inappropriate claims for the services; and
 - g. The total amount claimed for the services is \$5,000 or greater.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim is an aggravating circumstance if:
 - a. The person knows or had reason to know that each service was not provided as claimed,
 - b. The person knows or had reason to know that no payment could be made because the person had been excluded from reimbursement by AHCCCS, or
 - c. The person knows or had reason to know that the payment would violate the terms of an agreement between the person and AHCCCS system.
3. Prior offenses. The prior offenses of a person who presents or causes to present each claim are an aggravating circumstance if:
 - a. At any time before the submittal of the claim the person was held criminally or civilly liable for any act, or
 - b. The person had received an administrative sanction in connection with:
 - i. A Medicaid program,
 - ii. A Medicare program, or

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- iii. Any other public or private program of reimbursement for medical services.
- 4. Effect on patient care. The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim.
- 5. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice, the circumstances require an increase of the penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1106. Notice of Intent

If AHCCCS imposes a penalty, assessment, or a penalty and assessment, AHCCCS shall hand deliver or send by certified mail return receipt requested or Federal Express to the person, a written Notice of Intent to impose a penalty, assessment, or a penalty and assessment. The Notice of Intent shall include:

1. The statutory basis for the penalty, assessment, or the penalty and assessment;
2. Identification of the state or federal regulation and state or federal law that AHCCCS alleges has been violated;
3. The factual basis for AHCCCS' determination that the penalty, assessment, or the penalty and assessment should be imposed;
4. The amount of the penalty, assessment, or penalty and assessment;
5. The process for the person to accept or request a compromise of the penalty, assessment, or penalty and assessment; and
6. The process for requesting a State Fair Hearing.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1107. Reserved**R9-22-1108. Request for a Compromise**

- A. To request a compromise, the person shall file a written request with AHCCCS within 30 days from the date of receipt of the Notice of Intent. The written request for compromise shall contain the person's reasons for the reduction or modification of the penalty, assessment, or penalty and assessment.
- B. Within 30 days from the date of receipt of the request for compromise from the person, AHCCCS shall send a Notice of Compromise Decision that accepts, denies, or offers a counter proposal to the person's request for compromise. If AHCCCS offers a counter proposal the amount of the counter proposal shall represent the penalty, assessment, or penalty and assessment.
 1. If AHCCCS does not withdraw the Notice of Intent under R9-22-1112 or denies the request for compromise the original penalty, assessment, or penalty and assessment is upheld.
 2. To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1109. Failure to Respond to the Notice of Intent

If a person fails to respond timely to the Notice of Intent, AHCCCS shall uphold the original penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1110. Request for State Fair Hearing

- A. To request a State Fair Hearing regarding a dispute concerning a penalty, assessment, or penalty and assessment, the person shall file a written request for a State Fair Hearing with AHCCCS within 60 days from the date of the receipt of the Notice of Intent under R9-22-1106 or within 30 days from the date of receipt of the Notice of Compromise Decision under R9-22-1108, if applicable.
- B. AHCCCS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.
- C. AHCCCS shall mail a Director's Decision to the person no later than 30 days after the date the Administrative Law Judge sends the decision of the Office of Administrative Hearings (OAH) to AHCCCS.
- D. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092 et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092 et seq., a person may withdraw the hearing request only by sending a written request for withdrawal to OAH.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1111. Issues and Burden of Proof

- A. Preponderance of evidence. In any State Fair Hearing conducted under R9-22-1110, AHCCCS shall prove by a preponderance of the evidence that a person presented or caused to be presented each claim in violation of this Article and any aggravating circumstances under R9-22-1105. A person shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment.
- B. Statistical sampling.
 1. In meeting the burden of proof described in subsection (A), AHCCCS may introduce the results of a statistical sampling study as evidence of the number and amount of claims that were presented or caused to be presented by the person. A statistical sampling study constitutes *prima facie* evidence of the number and amount of claims if computed by valid statistical methods.
 2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once AHCCCS has made a *prima facie* case as described in subsection (B)(1). AHCCCS shall be given the opportunity to rebut this evidence.

Arizona Health Care Cost Containment System - Administration

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1112. Withdrawal and Continuances

AHCCCS may withdraw the Notice of Intent at any time. Prior to referring a matter to the Office of Administrative Hearings the parties may mutually agree to a continuance.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES**R9-22-1201. Definitions**

Definitions. The following definitions apply to this Article:

“Adult behavioral health therapeutic home” as defined in 9 A.A.C. 10, Article 1.

“Agency” for the purposes of this Article means a behavioral health facility, a classification of a health care institution, including a mental health treatment agency defined in A.R.S. § 36-501, that is licensed to provide behavioral health services according to A.R.S. Title 36, Chapter 4.

“Assessment” means an analysis of a patient’s need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.

“Behavior management services” means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.

“Behavioral health therapeutic home care services” means interactions that teach the client living, social, and communication skills to maximize the client’s ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client’s treatment plan, as appropriate.

“Behavioral health services” means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s behavioral health issue.

“Behavioral health technician” means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

Are provided with clinical oversight by a behavioral health professional.

“Case management” for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.

“Certified psychiatric nurse practitioner” means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).

“Clinical oversight” means as described under 9 A.A.C. 10.

“Cost avoid” means to avoid payment of a third-party liability claim when the probable existence of third-party liability has been established under 42 CFR 433.139(b).

“Court-ordered evaluation” has the same meaning as “evaluation” in A.R.S. § 36-501.

“Court-ordered pre-petition screening” has the same meaning as “pre-petition screening” in A.R.S. § 36-501.

“Court-ordered treatment” means treatment provided according to A.R.S. Title 36, Chapter 5.

“Crisis services” means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.

“Direct supervision” has the same meaning as “supervision” in A.R.S. § 36-401.

“Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.

“Health care institution” has the same meaning as defined in A.R.S. § 36-401.

“Health care practitioner” means a:

Physician;

Physician assistant;

Nurse practitioner; or

Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

“Licensee” means the same as in 9 A.A.C. 10, Article 1.

“Medical practitioner” means a physician, physician assistant, or nurse practitioner.

“Partial care” means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.

“Physician assistant” means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.

“Psychiatrist” means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.

“Psychologist” means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.

“Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-22-1206.

“Respite” means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.

“TRBHA” or “Tribal Regional Behavioral Health Authority” means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.

36-2918. Prohibited acts; penalties; subpoena power

A. A person may not present or cause to be presented to this state or to a contractor:

1. A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed.

2. A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent.

3. A claim for payment that the person knows or has reason to know may not be made by the system because:

(a) The person was terminated or suspended from participation in the program on the date for which the claim is being made.

(b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.

(c) The patient was not a member on the date for which the claim is being made.

4. A claim for a physician's service or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:

(a) Was not licensed as a physician.

(b) Obtained the license through a misrepresentation of material fact.

(c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified.

5. A request for payment that the person knows or has reason to know is in violation of an agreement between the person and this state or the administration.

B. A person who violates a provision of subsection A of this section is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty of not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.

C. The director or the director's designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or the director's designee in accordance with criteria established in rules. The director or director's designee may make this determination in the same proceeding to exclude the person from system participation.

D. A person who is adversely affected by a determination of the director or the director's designee under this section may appeal that decision in accordance with provider grievance provisions set forth in rule. The final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.

E. Amounts recovered under this section shall be deposited in the state general fund. The amount of such penalty or assessment may be deducted from any amount then or later owing by the administration or this state to the person against whom the penalty or assessment has been imposed.

F. If a civil penalty or assessment imposed pursuant to subsection C of this section is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa

county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented, except that the time to file a collection action is tolled either:

1. After any administrative action arising out of or referencing the wrongful acts is commenced and until the action's final resolution, including any legal challenges to the action.
2. While the state and the administration did not know, and with the exercise of reasonable diligence, should not have known, that a claim was false, fraudulent or not provided as claimed.

G. Pursuant to an investigation of prohibited acts or fraud and abuse involving the system, the director, and any person designated by the director in writing, may examine any person under oath and issue a subpoena to any person to compel the attendance of a witness. The administration by subpoena may compel the production of any record in any form necessary to support an investigation or an audit. The administration shall serve the subpoenas in the same manner as subpoenas in a civil action. If the subpoenaed person does not appear or does not produce the record, the director or the director's designee by affidavit may apply to the superior court in the county in which the controversy occurred and the court in that county shall proceed as though the failure to comply with the subpoena had occurred in an action in the court in that county.

36-2957. Prohibited acts; penalties

- A. No person may present or cause to be presented to the administration or to a program contractor:
1. A claim for an item or service that the person knows or has reason to know was not provided as claimed.
 2. A claim for an item or service that the person knows or has reason to know is false or fraudulent.
 3. A claim for payment which the person knows or has reason to know may not be made by the system because:
 - (a) The person was not a member on the date for which the claim is being made.
 - (b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of care.
 4. A claim for a physician's service, or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:
 - (a) Was not licensed as a physician.
 - (b) Obtained a license through a misrepresentation of material fact.
 - (c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the person was not certified.
 5. A request for payment which the person knows or has reason to know is in violation of an agreement between the person and the administration or the program contractor.
- B. A person who violates a provision of subsection A is subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.
- C. The director or his designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or his designee in accordance with criteria established in rules. The director or his designee may make a determination in the same proceeding to exclude the person from system participation.
- D. A person adversely affected by a determination of the director or his designee under this section may appeal that decision in accordance with grievance provisions set forth in rule. The final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.
- E. Amounts recovered under this section shall be deposited in the Arizona long-term care system fund. The amount of such penalty or assessment may be deducted from any amount then or later owing by the administration to the person against whom the penalty or assessment has been imposed.
- F. If a civil penalty or assessment imposed pursuant to subsection C is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-18-1008)
Title 9, Chapter 28, Article 10, Civil Monetary Penalties and Assessments

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM – FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-7

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE : September 18, 2018

SUBJECT: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-18-1008)**
Title 9, Chapter 28, Article 10, Civil Monetary Penalties and Assessments

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Arizona Health Care Cost Containment System Administration (AHCCCS) is “to promote a comprehensive health care system to eligible citizens of this state.” Laws 2013, Ch. 10, § 53. The Director of AHCCCS (Director) has the authority to adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. See A.R.S. § 36.2957.

This five-year review report covers one rule regarding civil monetary penalties and assessments in A.A.C. Title 9, Chapter 28, Article 10. R9-28-1001, Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims, requires use of the provisions located in 9 A.A.C. 22, Article 11 for determining and collecting penalties and assessments, whether imposed separately or collectively, for persons submitting improper claims for services provided under the 9 A.A.C. 28, Arizona Long-Term Care System (ALTCS).

In the previous five-year review report covering this rule, AHCCCS did not propose any changes be made to the rule.

Proposed Action

AHCCCS does not plan to amend the rule at this time.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. AHCCCS cites to both general and specific statutory authority for the rules. A.R.S. §§ 37-2918 and 37-2957 relate to prohibited acts and corresponding penalties and assessments that may be imposed. Under these statutes, the Director or the Director's designees shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. A.R.S. § 37-2918(C). Further, the Director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. A.R.S. § 37-2957(C).

2. Summary of the agency's economic impact comparison and identification of stakeholders:

AHCCCS has determined that the economic impact of the rule does not differ significantly from what was originally determined by the economic impact statement. The stakeholders include AHCCCS, AHCCCS contracted providers, AHCCCS non-contracting providers, AHCCCS members, and taxpayers.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and cost to those who are regulated?

Yes. AHCCCS has determined that the rule provides the least intrusive and least costly method of achieving the regulatory objective.

4. Has the agency received any written criticisms of the rules over the last five years?

No. AHCCCS indicates that it has not received any written criticisms of the rule over the last five years.

5. Has the agency analyzed the rules clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. AHCCCS indicates that the rule is clear, concise, understandable, consistent with other rules and statutes, and effective in achieving its objective.

6. Has the agency analyzed the current enforcement status of the rules?

Yes. AHCCCS indicates that the rule is enforced as written.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements?

No. AHCCCS indicates that the rule is not more stringent than 31 U.S.C. § 3729-3733, which describe civil actions for false claims made to the federal government and allow for the imposition of civil penalties for such claims.

8. For rules adopted after July 29, 2010, does the rules require a permit or licenses and, if so, does the agency comply with A.R.S. § 41-1037?

Not applicable. The rule was adopted before July 29, 2010.

9. Conclusion

AHCCCS states that it does not plan to amend the rule at this time. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval.

July 30, 2018

Ms. Nicole Colyer, Chair
Governor's Regulatory Review Council
100 N. 15th Ave, Suite 402
Phoenix, AZ 85007

Dear Ms. Colyer:

Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 28, Article 10. The report includes all of the documentation required by R1-6-301 (C) and (D).

No rules were left out of this 5-Year Review Report to be expired under A.R.S. § 41-1056 (J). Similarly, there were no rules subject to rescheduling.

As required by A.R.S. § 41-1056, the Administration certifies that the agency is in compliance with A.R.S. § 41-1091.

If you have any questions or comments regarding this report, please contact Nicole Fries, Associate General Counsel, Office of Administrative Legal Services at (602)-417-4232.

Sincerely,



Matthew Devlin
Assistant Director

Attachment

Arizona Health Care Cost Containment System

(AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 10

July 2018

1. Authorization of the rule by existing statutes

General Statutory Authority: A.R.S. § 36-2918.

Specific Statutory Authority: A.R.S. § 36-2957.

2. The objective of each rule:

Rule	Objective
R9-28-1001	Provides a cross-reference to R9-22-Article 11.

3. Are the rules effective in achieving their objectives? Yes X No __

4. Are the rules consistent with other rules and statutes? Yes X No __

5. Are the rules enforced as written? Yes X No __

6. Are the rules clear, concise, and understandable? Yes X No __

7. Has the agency received written criticisms of the rules within the last five years? Yes __ No X

8. Economic, small business, and consumer impact comparison:

No changes to the rule are proposed so substantive and procedural rights of members are not affected, nor are any of the programs of the Administration. Therefore the economic impact of this chapter remains the same as the prior 5YRR.

9. Has the agency received any business competitiveness analyses of the rules? Yes __ No X

10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?

The prior 5YRR did not find any need to revise the rules, therefore there was no proposed course of action.

11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:

The current rule still creates the least burden and cost for regulated persons.

12. Are the rules more stringent than corresponding federal laws? Yes No X

The rules are not more stringent than 31 U.S.C. 3729-3733.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

Not applicable.

14. Proposed course of action

No changes are proposed.

Arizona Health Care Cost Containment System - Arizona Long-term Care System

- E. AHCCCS shall exempt the following income, resources, and property of Native Americans (NA) and Alaska Natives (AN) from estate recovery:
1. Income and resources from tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission or U.S. Claims Court;
 2. Ownership interest in trust or non-trust property;
 3. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources;
 4. Any other ownership interests or rights in a property that has unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom; and
 5. Income left as a remainder in an estate derived from any property listed in subsection (E)(1) through (4), that was either collected by a NA, or by a Tribe or Tribal organization and distributed to a NA.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-912. Partial Recovery

AHCCCS shall use the following factors in determining whether to seek a partial recovery of funds when an heir or devisee does not meet the requirements of R9-28-911 and requests a partial recovery:

1. Financial and medical hardship to the heir or devisee;
2. Income of the heir or devisee and whether the heir or devisee's household gross annual income is less than 100 percent of the FPL;
3. Resources of the heir or devisee;
4. Value and type of assets;
5. Amount of AHCCCS' claim against the estate; and
6. Whether other creditors have filed claims against the estate or have foreclosed on the property.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-913. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-914. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-915. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-916. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-917. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-918. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-919. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS**R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims**

AHCCCS shall use the provisions in 9 A.A.C. 22, Article 11 for the determination and collection of penalties, assessments, and penalties and assessments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective June 9, 1998 (Supp. 98-2). Amended by final rulemaking at 10 A.A.R. 3065, effective September 11, 2004 (Supp. 04-3).

R9-28-1002. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1003. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1004. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Repealed effective June 9, 1998 (Supp. 98-2).

ARTICLE 11. BEHAVIORAL HEALTH SERVICES**R9-28-1101. General Requirements**

General requirements. The following general requirements apply to behavioral health services provided under this Article, and Chapter 22 subject to all exclusions and limitations.

36-2918. Prohibited acts; penalties; subpoena power

A. A person may not present or cause to be presented to this state or to a contractor:

1. A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed.

2. A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent.

3. A claim for payment that the person knows or has reason to know may not be made by the system because:

(a) The person was terminated or suspended from participation in the program on the date for which the claim is being made.

(b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.

(c) The patient was not a member on the date for which the claim is being made.

4. A claim for a physician's service or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:

(a) Was not licensed as a physician.

(b) Obtained the license through a misrepresentation of material fact.

(c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified.

5. A request for payment that the person knows or has reason to know is in violation of an agreement between the person and this state or the administration.

B. A person who violates a provision of subsection A of this section is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty of not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.

C. The director or the director's designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or the director's designee in accordance with criteria established in rules. The director or director's designee may make this determination in the same proceeding to exclude the person from system participation.

D. A person who is adversely affected by a determination of the director or the director's designee under this section may appeal that decision in accordance with provider grievance provisions set forth in rule. The final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.

E. Amounts recovered under this section shall be deposited in the state general fund. The amount of such penalty or assessment may be deducted from any amount then or later owing by the administration or this state to the person against whom the penalty or assessment has been imposed.

F. If a civil penalty or assessment imposed pursuant to subsection C of this section is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa

county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented, except that the time to file a collection action is tolled either:

1. After any administrative action arising out of or referencing the wrongful acts is commenced and until the action's final resolution, including any legal challenges to the action.
2. While the state and the administration did not know, and with the exercise of reasonable diligence, should not have known, that a claim was false, fraudulent or not provided as claimed.

G. Pursuant to an investigation of prohibited acts or fraud and abuse involving the system, the director, and any person designated by the director in writing, may examine any person under oath and issue a subpoena to any person to compel the attendance of a witness. The administration by subpoena may compel the production of any record in any form necessary to support an investigation or an audit. The administration shall serve the subpoenas in the same manner as subpoenas in a civil action. If the subpoenaed person does not appear or does not produce the record, the director or the director's designee by affidavit may apply to the superior court in the county in which the controversy occurred and the court in that county shall proceed as though the failure to comply with the subpoena had occurred in an action in the court in that county.

36-2957. Prohibited acts; penalties

- A. No person may present or cause to be presented to the administration or to a program contractor:
1. A claim for an item or service that the person knows or has reason to know was not provided as claimed.
 2. A claim for an item or service that the person knows or has reason to know is false or fraudulent.
 3. A claim for payment which the person knows or has reason to know may not be made by the system because:
 - (a) The person was not a member on the date for which the claim is being made.
 - (b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of care.
 4. A claim for a physician's service, or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:
 - (a) Was not licensed as a physician.
 - (b) Obtained a license through a misrepresentation of material fact.
 - (c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the person was not certified.
 5. A request for payment which the person knows or has reason to know is in violation of an agreement between the person and the administration or the program contractor.
- B. A person who violates a provision of subsection A is subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.
- C. The director or his designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or his designee in accordance with criteria established in rules. The director or his designee may make a determination in the same proceeding to exclude the person from system participation.
- D. A person adversely affected by a determination of the director or his designee under this section may appeal that decision in accordance with grievance provisions set forth in rule. The final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.
- E. Amounts recovered under this section shall be deposited in the Arizona long-term care system fund. The amount of such penalty or assessment may be deducted from any amount then or later owing by the administration to the person against whom the penalty or assessment has been imposed.
- F. If a civil penalty or assessment imposed pursuant to subsection C is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-18-1009)
Title 9, Chapter 31, Article 11, Civil Monetary Penalties and Assessments

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM – FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-8

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE : September 18, 2018

SUBJECT: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-18-1009)**
Title 9, Chapter 22, Article 11, Civil Monetary Penalties and Assessments

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Arizona Health Care Cost Containment System Administration (AHCCCS) is “to promote a comprehensive health care system to eligible citizens of this state.” Laws 2013, Ch. 10, § 53. The Director of AHCCCS (Director) has the authority to adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. See A.R.S. § 36.2957.

This five-year review report from AHCCCS covers one rule regarding civil monetary penalties and assessments in A.A.C. Title 9, Chapter 22, Article 11. R9-31-1101 requires use of the provisions located in 9 A.A.C. 22, Article 11 for determining and collecting penalties and assessments, whether imposed separately or collectively, for persons submitting improper claims for services provided under the KidsCare program (9 A.A.C. 31, Children’s Health Insurance Program)

In the previous five-year review report covering this rule, AHCCCS did not propose any changes be made to the rule.

Proposed Action

AHCCCS does not plan to amend the rule at this time.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. AHCCCS cites to both general and specific statutory authority for the rules. A.R.S. §§ 37-2918 and 37-2957 relate to prohibited acts and corresponding penalties and assessments that may be imposed. Under these statutes, the Director or the Director's designees shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. A.R.S. § 37-2918(C). Further, the Director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. A.R.S. § 37-2957(C).

2. Summary of the agency's economic impact comparison and identification of stakeholders:

AHCCCS has determined that the economic impact of the rule does not differ significantly from what was originally determined by the economic impact statement. The stakeholders include AHCCCS, AHCCCS contracted providers, AHCCCS non-contracting providers, AHCCCS members, and taxpayers.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and cost to those who are regulated?

Yes. AHCCCS has determined that the rule provides the least intrusive and least costly method of achieving the regulatory objective.

4. Has the agency received any written criticisms of the rules over the last five years?

No. AHCCCS indicates that it has not received any written criticisms of the rule over the past five years.

5. Has the agency analyzed the rules clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. AHCCCS indicates that the rule is clear, concise, understandable, consistent with other rules and statutes, and effective in achieving their objectives.

6. Has the agency analyzed the current enforcement status of the rules?

Yes. AHCCCS indicates that the rule is enforced as written.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements?

No. AHCCCS indicates that the rule is not more stringent than 31 U.S.C. § 3729-3733, which describe civil actions for false claims made to the federal government and allow for the imposition of civil penalties for such claims.

8. For rules adopted after July 29, 2010, does the rules require a permit or licenses and, if so, does the agency comply with A.R.S. § 41-1037?

Not applicable. The rule was adopted before July 29, 2010.

9. Conclusion

AHCCCS states that it does not plan to amend the rule at this time. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval.

July 30, 2018

Ms. Nicole Colyer, Chair
Governor's Regulatory Review Council
100 N. 15th Ave, Suite 402
Phoenix, AZ 85007

Dear Ms. Colyer:

Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 31, Article 11. The report includes all of the documentation required by R1-6-301 (C) and (D).

No rules were left out of this 5-Year Review Report to be expired under A.R.S. § 41-1056 (J). Similarly, there were no rules subject to rescheduling.

As required by A.R.S. § 41-1056, the Administration certifies that the agency is in compliance with A.R.S. § 41-1091.

If you have any questions or comments regarding this report, please contact Nicole Fries, Associate General Counsel, Office of Administrative Legal Services at (602)-417-4232.

Sincerely,



Matthew Devlin
Assistant Director

Attachment

Arizona Health Care Cost Containment System

(AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 31, Article 11

July 2018

1. Authorization of the rule by existing statutes

General Statutory Authority: A.R.S. § 36-2918.

Specific Statutory Authority: A.R.S. § 36-2957.

2. The objective of each rule:

Rule	Objective
R9-31-1101	Provides a cross-reference to R9-22-Article 11.

3. Are the rules effective in achieving their objectives? Yes X No __

4. Are the rules consistent with other rules and statutes? Yes X No __

5. Are the rules enforced as written? Yes X No __

6. Are the rules clear, concise, and understandable? Yes X No __

7. Has the agency received written criticisms of the rules within the last five years? Yes __ No X

8. Economic, small business, and consumer impact comparison:

No changes to the rule are proposed so substantive and procedural rights of members are not affected, nor are any of the programs of the Administration. Therefore the economic impact of this chapter remains the same as the prior 5YRR.

9. Has the agency received any business competitiveness analyses of the rules? Yes __ No X

10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?

The prior 5YRR did not find any need to revise the rules, therefore there was no proposed course of action.

11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:

The current rule still creates the least burden and cost for regulated persons.

12. Are the rules more stringent than corresponding federal laws? Yes No X

The rules are not more stringent than 31 U.S.C. 3729-3733.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

Not applicable.

14. Proposed course of action

No changes are proposed.

repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

ARTICLE 9. REPEALED**R9-31-901. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 12 A.A.R. 4494, effective January 6, 2007 (Supp. 06-4).

ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**R9-31-1001. Definitions**

The definitions in A.R.S. § 36-2981, A.A.C. R9-22-1001, and A.A.C. R9-31-101 apply to this Article.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1002. General Provisions

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1003. Cost Avoidance

The provisions in A.A.C. R9-22-1003 apply to this Section except:

1. Replace the reference to “Article 2,” with 9 A.A.C. 31, Article 2; and
2. This Section applies to Title XXI covered services.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1004. Member Participation

The provisions in A.A.C. R9-22-1004 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1005. Collections

The provisions in A.A.C. R9-22-1005 apply to this Section except:

1. Replace the reference to “Article 2,” with 9 A.A.C. 31, Article 2;
2. This Section applies to Title XXI fee-for-service and reinsurance payments.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1006. AHCCCS Monitoring Responsibilities

With the exception of long-term care insurance, the provisions in A.A.C. R9-22-1006 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1007. Notification for Perfection, Recording, and Assignment of Title XXI liens

The provisions in A.A.C. R9-22-1007 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1008. Notification Information for Liens

The provisions in A.A.C. R9-22-1008 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1009. Notification of Health Insurance Information

The provisions in A.A.C. R9-22-1009 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims**

AHCCCS shall use the provisions in 9 A.A.C. 22, Article 11 for the determination and collection of penalties, assessments, and penalties and assessments.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1102. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1103. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1104. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES**R9-31-1201. Requirements**

The requirements, services and definitions under Chapter 22, Article 2 and Article 12 apply to behavioral health services provided under this Article.

36-2918. Prohibited acts; penalties; subpoena power

A. A person may not present or cause to be presented to this state or to a contractor:

1. A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed.

2. A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent.

3. A claim for payment that the person knows or has reason to know may not be made by the system because:

(a) The person was terminated or suspended from participation in the program on the date for which the claim is being made.

(b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.

(c) The patient was not a member on the date for which the claim is being made.

4. A claim for a physician's service or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:

(a) Was not licensed as a physician.

(b) Obtained the license through a misrepresentation of material fact.

(c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified.

5. A request for payment that the person knows or has reason to know is in violation of an agreement between the person and this state or the administration.

B. A person who violates a provision of subsection A of this section is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty of not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.

C. The director or the director's designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or the director's designee in accordance with criteria established in rules. The director or director's designee may make this determination in the same proceeding to exclude the person from system participation.

D. A person who is adversely affected by a determination of the director or the director's designee under this section may appeal that decision in accordance with provider grievance provisions set forth in rule. The final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.

E. Amounts recovered under this section shall be deposited in the state general fund. The amount of such penalty or assessment may be deducted from any amount then or later owing by the administration or this state to the person against whom the penalty or assessment has been imposed.

F. If a civil penalty or assessment imposed pursuant to subsection C of this section is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa

county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented, except that the time to file a collection action is tolled either:

1. After any administrative action arising out of or referencing the wrongful acts is commenced and until the action's final resolution, including any legal challenges to the action.
2. While the state and the administration did not know, and with the exercise of reasonable diligence, should not have known, that a claim was false, fraudulent or not provided as claimed.

G. Pursuant to an investigation of prohibited acts or fraud and abuse involving the system, the director, and any person designated by the director in writing, may examine any person under oath and issue a subpoena to any person to compel the attendance of a witness. The administration by subpoena may compel the production of any record in any form necessary to support an investigation or an audit. The administration shall serve the subpoenas in the same manner as subpoenas in a civil action. If the subpoenaed person does not appear or does not produce the record, the director or the director's designee by affidavit may apply to the superior court in the county in which the controversy occurred and the court in that county shall proceed as though the failure to comply with the subpoena had occurred in an action in the court in that county.

36-2957. Prohibited acts; penalties

- A. No person may present or cause to be presented to the administration or to a program contractor:
1. A claim for an item or service that the person knows or has reason to know was not provided as claimed.
 2. A claim for an item or service that the person knows or has reason to know is false or fraudulent.
 3. A claim for payment which the person knows or has reason to know may not be made by the system because:
 - (a) The person was not a member on the date for which the claim is being made.
 - (b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of care.
 4. A claim for a physician's service, or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:
 - (a) Was not licensed as a physician.
 - (b) Obtained a license through a misrepresentation of material fact.
 - (c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the person was not certified.
 5. A request for payment which the person knows or has reason to know is in violation of an agreement between the person and the administration or the program contractor.
- B. A person who violates a provision of subsection A is subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.
- C. The director or his designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or his designee in accordance with criteria established in rules. The director or his designee may make a determination in the same proceeding to exclude the person from system participation.
- D. A person adversely affected by a determination of the director or his designee under this section may appeal that decision in accordance with grievance provisions set forth in rule. The final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.
- E. Amounts recovered under this section shall be deposited in the Arizona long-term care system fund. The amount of such penalty or assessment may be deducted from any amount then or later owing by the administration to the person against whom the penalty or assessment has been imposed.
- F. If a civil penalty or assessment imposed pursuant to subsection C is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-18-1009)
Title 9, Chapter 31, Article 11, Civil Monetary Penalties and Assessments

GOVERNOR'S REGULATORY REVIEW COUNCIL

STAFF MEMORANDUM – FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-8

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE : September 18, 2018

SUBJECT: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-18-1009)**
Title 9, Chapter 22, Article 11, Civil Monetary Penalties and Assessments

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Arizona Health Care Cost Containment System Administration (AHCCCS) is “to promote a comprehensive health care system to eligible citizens of this state.” Laws 2013, Ch. 10, § 53. The Director of AHCCCS (Director) has the authority to adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. See A.R.S. § 36.2957.

This five-year review report from AHCCCS covers one rule regarding civil monetary penalties and assessments in A.A.C. Title 9, Chapter 22, Article 11. R9-31-1101 requires use of the provisions located in 9 A.A.C. 22, Article 11 for determining and collecting penalties and assessments, whether imposed separately or collectively, for persons submitting improper claims for services provided under the KidsCare program (9 A.A.C. 31, Children’s Health Insurance Program)

In the previous five-year review report covering this rule, AHCCCS did not propose any changes be made to the rule.

Proposed Action

AHCCCS does not plan to amend the rule at this time.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. AHCCCS cites to both general and specific statutory authority for the rules. A.R.S. §§ 37-2918 and 37-2957 relate to prohibited acts and corresponding penalties and assessments that may be imposed. Under these statutes, the Director or the Director's designees shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. A.R.S. § 37-2918(C). Further, the Director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. A.R.S. § 37-2957(C).

2. Summary of the agency's economic impact comparison and identification of stakeholders:

AHCCCS has determined that the economic impact of the rule does not differ significantly from what was originally determined by the economic impact statement. The stakeholders include AHCCCS, AHCCCS contracted providers, AHCCCS non-contracting providers, AHCCCS members, and taxpayers.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and cost to those who are regulated?

Yes. AHCCCS has determined that the rule provides the least intrusive and least costly method of achieving the regulatory objective.

4. Has the agency received any written criticisms of the rules over the last five years?

No. AHCCCS indicates that it has not received any written criticisms of the rule over the past five years.

5. Has the agency analyzed the rules clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. AHCCCS indicates that the rule is clear, concise, understandable, consistent with other rules and statutes, and effective in achieving their objectives.

6. Has the agency analyzed the current enforcement status of the rules?

Yes. AHCCCS indicates that the rule is enforced as written.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements?

No. AHCCCS indicates that the rule is not more stringent than 31 U.S.C. § 3729-3733, which describe civil actions for false claims made to the federal government and allow for the imposition of civil penalties for such claims.

8. For rules adopted after July 29, 2010, does the rules require a permit or licenses and, if so, does the agency comply with A.R.S. § 41-1037?

Not applicable. The rule was adopted before July 29, 2010.

9. Conclusion

AHCCCS states that it does not plan to amend the rule at this time. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval.

July 30, 2018

Ms. Nicole Colyer, Chair
Governor's Regulatory Review Council
100 N. 15th Ave, Suite 402
Phoenix, AZ 85007

Dear Ms. Colyer:

Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 31, Article 11. The report includes all of the documentation required by R1-6-301 (C) and (D).

No rules were left out of this 5-Year Review Report to be expired under A.R.S. § 41-1056 (J). Similarly, there were no rules subject to rescheduling.

As required by A.R.S. § 41-1056, the Administration certifies that the agency is in compliance with A.R.S. § 41-1091.

If you have any questions or comments regarding this report, please contact Nicole Fries, Associate General Counsel, Office of Administrative Legal Services at (602)-417-4232.

Sincerely,



Matthew Devlin
Assistant Director

Attachment

Arizona Health Care Cost Containment System

(AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 31, Article 11

July 2018

1. Authorization of the rule by existing statutes

General Statutory Authority: A.R.S. § 36-2918.

Specific Statutory Authority: A.R.S. § 36-2957.

2. The objective of each rule:

Rule	Objective
R9-31-1101	Provides a cross-reference to R9-22-Article 11.

3. Are the rules effective in achieving their objectives? Yes X No __

4. Are the rules consistent with other rules and statutes? Yes X No __

5. Are the rules enforced as written? Yes X No __

6. Are the rules clear, concise, and understandable? Yes X No __

7. Has the agency received written criticisms of the rules within the last five years? Yes __ No X

8. Economic, small business, and consumer impact comparison:

No changes to the rule are proposed so substantive and procedural rights of members are not affected, nor are any of the programs of the Administration. Therefore the economic impact of this chapter remains the same as the prior 5YRR.

9. Has the agency received any business competitiveness analyses of the rules? Yes __ No X

10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?

The prior 5YRR did not find any need to revise the rules, therefore there was no proposed course of action.

11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:

The current rule still creates the least burden and cost for regulated persons.

12. Are the rules more stringent than corresponding federal laws? Yes No X

The rules are not more stringent than 31 U.S.C. 3729-3733.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

Not applicable.

14. Proposed course of action

No changes are proposed.

repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

ARTICLE 9. REPEALED**R9-31-901. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 12 A.A.R. 4494, effective January 6, 2007 (Supp. 06-4).

ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**R9-31-1001. Definitions**

The definitions in A.R.S. § 36-2981, A.A.C. R9-22-1001, and A.A.C. R9-31-101 apply to this Article.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1002. General Provisions

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1003. Cost Avoidance

The provisions in A.A.C. R9-22-1003 apply to this Section except:

1. Replace the reference to “Article 2,” with 9 A.A.C. 31, Article 2; and
2. This Section applies to Title XXI covered services.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1004. Member Participation

The provisions in A.A.C. R9-22-1004 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1005. Collections

The provisions in A.A.C. R9-22-1005 apply to this Section except:

1. Replace the reference to “Article 2,” with 9 A.A.C. 31, Article 2;
2. This Section applies to Title XXI fee-for-service and reinsurance payments.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1006. AHCCCS Monitoring Responsibilities

With the exception of long-term care insurance, the provisions in A.A.C. R9-22-1006 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1007. Notification for Perfection, Recording, and Assignment of Title XXI liens

The provisions in A.A.C. R9-22-1007 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1008. Notification Information for Liens

The provisions in A.A.C. R9-22-1008 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1009. Notification of Health Insurance Information

The provisions in A.A.C. R9-22-1009 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims**

AHCCCS shall use the provisions in 9 A.A.C. 22, Article 11 for the determination and collection of penalties, assessments, and penalties and assessments.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1102. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1103. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1104. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES**R9-31-1201. Requirements**

The requirements, services and definitions under Chapter 22, Article 2 and Article 12 apply to behavioral health services provided under this Article.

36-2918. Prohibited acts; penalties; subpoena power

A. A person may not present or cause to be presented to this state or to a contractor:

1. A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed.

2. A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent.

3. A claim for payment that the person knows or has reason to know may not be made by the system because:

(a) The person was terminated or suspended from participation in the program on the date for which the claim is being made.

(b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.

(c) The patient was not a member on the date for which the claim is being made.

4. A claim for a physician's service or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:

(a) Was not licensed as a physician.

(b) Obtained the license through a misrepresentation of material fact.

(c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified.

5. A request for payment that the person knows or has reason to know is in violation of an agreement between the person and this state or the administration.

B. A person who violates a provision of subsection A of this section is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty of not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.

C. The director or the director's designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or the director's designee in accordance with criteria established in rules. The director or director's designee may make this determination in the same proceeding to exclude the person from system participation.

D. A person who is adversely affected by a determination of the director or the director's designee under this section may appeal that decision in accordance with provider grievance provisions set forth in rule. The final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.

E. Amounts recovered under this section shall be deposited in the state general fund. The amount of such penalty or assessment may be deducted from any amount then or later owing by the administration or this state to the person against whom the penalty or assessment has been imposed.

F. If a civil penalty or assessment imposed pursuant to subsection C of this section is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa

county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented, except that the time to file a collection action is tolled either:

1. After any administrative action arising out of or referencing the wrongful acts is commenced and until the action's final resolution, including any legal challenges to the action.
2. While the state and the administration did not know, and with the exercise of reasonable diligence, should not have known, that a claim was false, fraudulent or not provided as claimed.

G. Pursuant to an investigation of prohibited acts or fraud and abuse involving the system, the director, and any person designated by the director in writing, may examine any person under oath and issue a subpoena to any person to compel the attendance of a witness. The administration by subpoena may compel the production of any record in any form necessary to support an investigation or an audit. The administration shall serve the subpoenas in the same manner as subpoenas in a civil action. If the subpoenaed person does not appear or does not produce the record, the director or the director's designee by affidavit may apply to the superior court in the county in which the controversy occurred and the court in that county shall proceed as though the failure to comply with the subpoena had occurred in an action in the court in that county.

36-2957. Prohibited acts; penalties

- A. No person may present or cause to be presented to the administration or to a program contractor:
1. A claim for an item or service that the person knows or has reason to know was not provided as claimed.
 2. A claim for an item or service that the person knows or has reason to know is false or fraudulent.
 3. A claim for payment which the person knows or has reason to know may not be made by the system because:
 - (a) The person was not a member on the date for which the claim is being made.
 - (b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of care.
 4. A claim for a physician's service, or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:
 - (a) Was not licensed as a physician.
 - (b) Obtained a license through a misrepresentation of material fact.
 - (c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the person was not certified.
 5. A request for payment which the person knows or has reason to know is in violation of an agreement between the person and the administration or the program contractor.
- B. A person who violates a provision of subsection A is subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.
- C. The director or his designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or his designee in accordance with criteria established in rules. The director or his designee may make a determination in the same proceeding to exclude the person from system participation.
- D. A person adversely affected by a determination of the director or his designee under this section may appeal that decision in accordance with grievance provisions set forth in rule. The final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.
- E. Amounts recovered under this section shall be deposited in the Arizona long-term care system fund. The amount of such penalty or assessment may be deducted from any amount then or later owing by the administration to the person against whom the penalty or assessment has been imposed.
- F. If a civil penalty or assessment imposed pursuant to subsection C is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented.

E-10

DEPARTMENT OF HEALTH SERVICES (F-18-1013)

Title 9, Chapter 10, Article 7, Behavioral Health Residential Facilities

GOVERNOR'S REGULATORY REVIEW COUNCIL
STAFF MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE: October 2, 2018

AGENDA ITEM: E-10

TO: Members of the Governor's Regulatory Review Council (Council)

FROM: Council Staff

DATE: September 18, 2018

SUBJECT: DEPARTMENT OF HEALTH SERVICES (F-18-1013)
Title 9, Chapter 10, Article 7, Behavioral Health Residential Facilities

COMMENTS ON THE FIVE-YEAR REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report:

This five-year review report, from the Department of Health Services (Department), covers 22 rules in A.A.C. Title 9, Chapter 10, Article 7. The rules in Article 7 establish requirements related to licensing of behavioral health residential facilities. Among other things, the rules specify licensing application requirements, establish requirements for quality management program, admission, treatment plans, discharge procedures, medical records, transportation, and services provided by the facility to the residents.

This is the first five-year review report on the new rules adopted via exempt rulemaking in 2013, and the rules were last amended at various times between 2013 and 2016.

Proposed Action

The Department intends to amend the rules, to address the issues identified throughout the report, by July 2019.

1. Has the agency analyzed whether the rules are authorized by statute?

Yes. The Department cites to both general and specific authority. A.R.S. § 36-136(G) states that the director of the Department “may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.” Additionally, A.R.S. § 36-405(A), authorizes the director to “adopt rules to establish minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to ensure the public health, safety and welfare.”

2. Summary of the agency's economic impact comparison and identification of stakeholders:

The Department indicates that the economic impact of the 2013 and 2014 rulemakings for Article 7 reduced the monetary and regulatory costs for participants and made the rules consistent with practices within health care institution licensing rules.

The stakeholders include the Department, Arizona behavioral health residential facilities, health care providers (including behavioral health professionals), social workers, residents, their families, and the general public. As of August 2018, there were 546 licensed behavioral health residential facilities in Arizona.

3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?

Yes. The Department believes the rules impose the least burden and costs to stakeholders necessary to achieve the underlying regulatory objective except for the rules identified in section 5 of this memo.

4. Has the agency received any written criticisms of the rules over the last five years?

No. The Department indicates that it did not receive any written criticism of the rules over the last five years.

5. Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?

Yes. The Department has identified that the following rules could be made more clear, concise, and understandable, consistent with other rules and statutes, and more effective:

- Section 702: Remove requirements for initial licenses and renewal licenses as license renewal applications will no longer be required once the rule is amended to comply with Laws 2017, Ch. 122. In addition, the rule should be revised to include a request for authorization to provide recidivism reduction services.
- Section 703: Subsection (C)(2)(h) should be amended to clarify that the policies and procedures include respite services for individuals spending up to 30 days as a resident of the behavioral health residential facility, as well as individuals receiving respite services for a few hours. The reference in subsection (I)(5)(a) should be to Articles 3, 4, or 5 in A.R.S. Title 36, Chapter 5, rather than Articles 1, 2, or 3. Subsection (I)(8) should be removed since it is duplicative of subsection (I)(7). Grammatical errors should also be corrected.
- Section 706: Subsection (G)(3) should include documentation of all requirements for fingerprinting and background checks.
- Section 707: In subsection (A), “resident’s presenting behavioral health issue” should be clarified to indicate that the resident’s principal diagnosis, for which the individual was

admitted as a resident, was a behavioral health issue. Cross-references should be updated. In subsection (A)(5), the time period, between admission and when a medical history and physical exam or a nursing assessment is performed, should be shortened.

- Section 708: References should be updated and grammatical error should be corrected.
- Section 711: Subsection (B)(3) should be amended to read “representative, a resident is allowed to.” In addition, the rule could be more clear if subsection (B)(4)(b) included further subsections, rather than all the exceptions being lumped together.
- Section 712: Clarifying change should be made in subsection (C)(16).
- Section 713: Grammatical errors should be corrected.
- Section 714: Clarifying change should be made.
- Section 715: Cross reference in subsection (2) should be R9-10-804(A), (D), (E), and (F).
- Section 716: In subsection (A)(1), “personnel care services” should be changed to “personal care services.” Subsection (E)(2)(e) should be amended to “Any injury that resulted from the use of the emergency safety response.”
- Section 717: Reference to the webpage for dietary guidelines should be updated in subsection (B)(4).
- Section 718: Clarifying changes should be made throughout the rule.
- Section 719: Reference to the webpage for dietary guidelines should be updated in subsection (B)(4).
- Section 720: Typographical error should be corrected.
- Section 721: Reference to R3-8-201(C)(4) should be added.
- Section 722: Subsection (A)(2) should be amended to use “admitted” rather than “accepted.”

6. Has the agency analyzed the current enforcement status of the rules?

Yes. The Department indicates that the rules are enforced as written.

7. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?

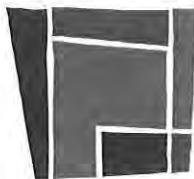
No. The Department indicates that no federal laws directly apply to the rules.

8. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

Yes. The Department indicates that the rules require a specific agency authorization, which is authorized by A.R.S. § 36-405.

9. Conclusion

As noted above, the Department plans to amend the rules by July 2019. This report complies with A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval of this report.



ARIZONA DEPARTMENT OF HEALTH SERVICES

POLICY & INTERGOVERNMENTAL AFFAIRS

August 17, 2018

Nicole O. Colyer, Esq., Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: Report for A.A.C. Title 9, Chapter 10, Article 7 Health Care Institutions: Licensing – Behavioral Health Residential Facilities

Dear Ms. Colyer:

According to the five-year-review report schedule of the Governor's Regulatory Review Council (Council), a report for A.A.C. Title 9, Chapter 10, Article 7 is due to the Council no later than October 31, 2018. The Arizona Department of Health Services (Department) has reviewed 9 A.A.C. 10, Article 7 and is enclosing a report to the Council for this rule.

The Department believes that this report complies with the requirements of A.R.S. § 41-1056. The five-year-review report, the rules reviewed, and the general and specific authority for the rules are included in the package. As described in the report, the Department plans to amend the rules in 9 A.A.C. 10, Article 7 by July 2019.

The Department certifies that it is in compliance with A.R.S. § 41-1091.

If you need any further information, please contact me at (602) 542-1020.

Sincerely,

A handwritten signature in black ink, appearing to read "RL".

Robert Lane
Director's Designee

RL:rms
Enclosures

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director



Arizona Department of Health Services

Five-Year-Review Report

Title 9. Health Services

Chapter 10. Department of Health Services

Health Care Institutions: Licensing

Article 7. Behavioral Health Residential Facilities

August 2018

1. Authorization of the rule by existing statutes

General Statutory Authority: A.R.S. §§ 36-132(A)(1) and (17) and 36-136(G)

Specific Statutory Authority: A.R.S. §§ 36-405 through 36-407, and 36-502

In addition, the following rules have additional specific statutory authority:

Rule	Statutory Authority
R9-10-702	A.R.S. § 36-422
R9-10-706	A.R.S. §§ 36-411, 36-411.01, and 36-425.03
R9-10-717	A.R.S. § 434

2. The objective of each rule:

The purpose of the rules is to establish requirements related to the licensing of behavioral health residential facilities to protect public health and safety.

Rule	Objective
R9-10-701	To define terms used in the Article so that a reader can consistently interpret requirements.
R9-10-702	To specify license application requirements, in addition to those in A.R.S. § 36-422 and R9-10-105 that are specific to behavioral health residential facilities.
R9-10-703	To establish minimum requirements and responsibilities for a behavioral health residential facility's governing authority and administrator.
R9-10-704	To establish minimum requirements for a behavioral health residential facility's quality management program.
R9-10-705	To establish minimum requirements for persons who contracts with the licensee to provide behavioral health residential facility services.
R9-10-706	To establish minimum standards for behavioral health residential facility personnel and minimum standards for documentation of personnel member qualifications.
R9-10-707	To establish minimum requirements for admission and assessment.
R9-10-708	To establish minimum requirements for developing and implementing a treatment plan for a resident.

R9-10-709	To establish minimum requirements for discharge of a resident.
R9-10-710	To establish minimum requirements for transport and transfer to ensure that a resident's health and safety are not compromised as a result of a transport or transfer.
R9-10-711	To establish minimum standards for resident rights.
R9-10-712	To establish minimum requirements for resident medical records.
R9-10-713	To establish minimum requirements for transportation and resident outings.
R9-10-714	To establish minimum requirements for a resident time-out.
R9-10-715	To establish minimum requirements for physical health services provided by a behavioral health residential facility.
R9-10-716	To establish minimum requirements for behavioral health services provided by a behavioral health residential facility.
R9-10-717	To establish minimum requirements for an outdoor behavioral health program provided by a behavioral health residential facility.
R9-10-718	To establish minimum requirements for medication services provided by a behavioral health residential facility.
R9-10-719	To establish minimum requirements for food services provided by a behavioral health residential facility.
R9-10-720	To establish minimum emergency and safety standards for a behavioral health residential facility.
R9-10-721	To establish minimum environmental standards for a behavioral health residential facility.
R9-10-722	To establish minimum physical plant standards for a behavioral health residential facility.

3. **Are the rules effective in achieving their objectives?** Yes X No

If not, please identify the rule(s) that is not effective and provide an explanation for why the rule(s) is not effective.

Rule	Explanation
Multiple	The rules are effective, but they would be more effective if the issues identified in paragraphs 4 and 6 were addressed.
R9-10-703	The rule would be more effective if subsection (C)(1) included a requirement for policies and procedures related to fingerprinting/background checks, including, as applicable, requirements in A.R.S. §§ 36-411, 36-411.01, and 36-425.03. The effectiveness of the rules in the Article would also be improved by requiring an individual who understands English to be on the facility's premises to allow better communication with Department staff.
R9-10-707	The rule would be more effective in protecting the health and safety of residents if the time period, specified in subsection (A)(5), between admission and when a medical history and physical exam or a nursing assessment is performed were shortened. The rules may also be more effective if requirements for providing respite services were grouped together in one Section.

4. **Are the rules consistent with other rules and statutes?** Yes No X

If not, please identify the rule(s) that is not consistent. Also, provide an explanation and identify the provisions that are not consistent with the rule.

Rule	Explanation
R9-10-702	The rule is inconsistent with A.R.S. § 36-425 as amended by Laws 2017, Ch. 122, because of references to “initial” and “renewal” licenses.
Multiple, including: R9-10-702, R9-10-703, R9-10-706	The rule does not address requirements relevant to a behavioral health residential facility that provides recidivism reduction services, as added to the statutes in A.R.S. Title 9, Chapter 4, Article 1 by Laws 2017, Ch. 134.
R9-10-703	The reference in subsection (I)(5)(a) should be to Articles “3, 4, or 5” in A.R.S. Title 36, Chapter 5, rather than to Articles “1, 2, or 3.” The cross-reference in subsection (L)(2) should be to “subsection (L)(1)” rather than to “subsection (L)(1)(a).”
R9-10-706	The rule does not address requirements relevant to requirements for fingerprinting/background checks in A.R. S. §§ 36-411 or 36-411.01, as well as the requirement in subsection (G)(3)(e) to demonstrate compliance with A.R.S. § 36-425.03.
R9-10-715	The cross-references in subsection (2) should be to R9-10-814(A), (D), (E), and (F).

5. **Are the rules enforced as written?**

Yes No

If not, please identify the rule(s) that is not enforced as written and provide an explanation of the issues with enforcement. In addition, include the agency’s proposal for resolving the issue.

Rule	Explanation

6. **Are the rules clear, concise, and understandable?**

Yes No

If not, please identify the rule(s) that is not clear, concise, or understandable and provide an explanation as to how the agency plans to amend the rule(s) to improve clarity, conciseness, and understandability.

Rule	Explanation
R9-10-702	Since license renewal applications will no longer be required once the rules have been changed to comply with Laws 2017, Ch. 122, the rule would be more understandable if requirements for “initial licenses” and “renewal licenses” were removed and the rule were retitled to include documentation that will need to be submitted along with annual fees. The rule would also be clearer if subsection (A)(1) were revised to include a request for authorization to provide recidivism reduction services and to break out the populations (child/adult) for whom respite services are provided.
R9-10-703	The rule would be more understandable if subsection (C)(2)(h) were clarified to specify that the policies and procedures include respite services for, as applicable, individuals spending up to 30 calendar days as a resident of the behavioral health residential facility, as well as individuals receiving respite services for a few hours but not staying overnight. Subsection (I) would be more concise if subsection (I)(8) were removed since it duplicates the requirement in subsection (I)(7). The rule would also be improved if grammatical/typographical errors in subsections (C)(2)(k) and (o)(ii) were corrected.

R9-10-706	The rule would be clearer if subsection (G)(3) included documentation of all requirements for fingerprinting/background checks in A.R. S. §§ 36-411, 36-411.01, and 36-425.03, as applicable.
R9-10-707	The rule would be improved if the “resident’s presenting behavioral health issue” in subsection (A) were clarified to indicate that the resident’s principal diagnosis, which caused the individual to be admitted as a resident, was a behavioral health issue. The timing of the review of a pre-existing behavioral health assessment in subsection (A)(9) would be clearer if subsection (A)(8) were referenced. The rule would be clearer if subsection (D) specified that an administrator ensures that an interval note is documented. The rule would also be clearer if the exception to the requirement for tuberculosis screening in subsection (E)(1)(d) were clarified as to whether the exclusion referred to a resident present for seven consecutive days or any seven days within some time period.
R9-10-708	The rule would be clearer if subsection (A)(1) read “or (E)(1)(a) and” rather than “or (E)(1) and” and a grammatical error in subsection (A)(4)(c) were corrected.
R9-10-711	The rule would be clearer if subsection (B)(3) were revised to read “representative, a resident is allowed to.” The rule would also be more understandable if subsection (B)(4)(b) were revised to include further subsections, rather than all the exceptions being lumped together.
R9-10-712	The rule would be clearer if a typographical error in subsection (C)(16) were corrected.
R9-10-713	The rule would be clearer if grammatical errors in subsections (A)(2) and (B)(6)(d) were corrected.
R9-10-714	The rule would be clearer if typographical errors in the Section were corrected.
R9-10-716	The rule would be clearer if the wording of subsections (A)(1), (2), (4)(b), and (5)(b) were simplified and if the typographical error of “personnel care services” in subsection (A)(1) were corrected to “personal care services.” Subsection (E)(2)(e) should read “Any injury that resulted from the use of the emergency safety response.” Subsection (E)(4) should include by whom the information required in subsections (E)(4)(a) through (c) is entered.
R9-10-717	The rule would be clearer if the reference to the webpage for dietary guidelines in subsection (B)(4) were updated to http://www.health.gov/dietaryguidelines .
R9-10-718	The rule would be more understandable if subsection (B)(1)(c) read “medication is administered to a resident only as ordered,” subsection (C)(2)(d) read “the medication is taken as prescribed by the resident’s medical practitioner,” and subsection (F) read “to the medical practitioner who ordered or prescribed the medication.” The rule would be clearer if a typographical error in subsection (C) were corrected.
R9-10-719	The rule would be clearer if the reference to the webpage for dietary guidelines in subsection (B)(4) were updated to http://www.health.gov/dietaryguidelines . The rule would also be clearer if a typographical error in subsection (A)(2) were corrected.
R9-10-720	The rule would be clearer if a typographical error in subsection (A)(1) were corrected.
R9-10-721	The rule would be clearer if subsection (A)(2) included a reference to A.A.C. R3-8-201(C)(4), which was adopted in A.A.C. Title 3 in 2017, and states that “An individual may not provide pest management services at a school, child care facility, health care institution, or food-handling establishment unless the individual is a certified applicator in the certification category for which services are being provided.”
R9-10-722	The rule would be clearer if subsection (A)(2) used “admitted” rather than “accepted.”

7. **Has the agency received written criticisms of the rules within the last five years?** Yes _____ No X

If yes, please fill out the table below:

Rule	Explanation

8. Economic, small business, and consumer impact comparison:

There were 546 licensed behavioral health residential facilities in Arizona as of August 1, 2018. The Department received 443 renewal applications and 91 initial applications in 2017. In 2017, the Department also conducted 100 complaint surveys and 313 compliance surveys and received \$70,675.00 in monetary penalties as a result of 66 late applications and 72 survey enforcements. There were 84 behavioral health residential facilities that closed in 2017.

Prior to 2013, the rules for facilities now licensed as behavioral health residential facilities had been adopted in 9 A.A.C. 20. In 2013, the rules in 9 A.A.C. 20 for level 2 and level 3 residential treatment centers were revised in their entirety, integrated with other health care institution licensure rules, and moved to 9 A.A.C. 10, Article 7, as part of an exempt rulemaking to comply with Laws 2011, Ch. 96. Laws 2013, Ch. 10, § 13, amended Laws 2011, Ch. 96 to extend the time for the Department to further revise the rules in 9 A.A.C. 10 under exempt rulemaking authority to April 30, 2014, during which time another exempt rulemaking of 9 A.A.C. 10 further revised all the rules in Article 7 except R9-10-704. Stakeholders for these rulemakings include the Department, Arizona behavioral health residential facilities, health care providers (including behavioral health professionals), social workers, residents and their families, and the general public.

The 2013 exempt rulemaking changed some requirements for behavioral health residential facilities when it created 9 A.A.C. 10, Article 7. It added more specific requirements for governing authorities and administrators, added requirements for quality management, and added contracted services requirements. It also made minor changes to personnel requirements, including additional requirements related to personnel qualifications. The Department separated requirements for assessment and treatment plan into separate Sections, combined admission and assessment into one Section, and added Sections for “Transport; Transfers,” “Medical Records,” “Physical Health Services,” “Behavioral Health Services,” “Outdoor Behavioral Health Care Programs,” “Food Services,” Emergency and Safety Standards,” and “Physical Plant Standards.” It also combined the old “Transportation” Section and the old “Outings” Section into one “Resident Outings” Section and removed a few transportation and outing requirements. The rulemaking also altered admission and assessment requirements and made minor changes to required time frames for updating resident medical records. The rulemaking added several requirements for discharge. It also included components of the client rights Section in 9 A.A.C. 20 into a “Resident Rights” Section and moved several other components that had been part of client rights to other Sections, adding a few additional requirements, and removing a few items. The “Environmental Standards” Section was significantly rearranged and altered and some items were moved to the new “Physical Plant Standards” Section, although several new items were also added to the “Physical Plant Standards” Section. These changes integrated the licensing of health care institutions that provide both behavioral and physical health services and made the rules more effective and easier to understand.

The 2014 exempt rulemaking made changes to almost all of the Sections. It removed definitions that were also included in R9-10-101 and changed the requirements for an applicant to indicate what services they are requesting authorization to provide. The rulemaking added items that must be included in policies and procedures, clarified requirements related to investigating abuse, neglect, or exploitation of a resident, and clarified when an individual, who is accountable to the governing authority of a behavioral health residential facility when an administrator is not present, must be present on the premises. Requirements for tuberculosis screening of residents and personnel members and for providing personnel records of personnel members who are no longer providing services at the behavioral health residential facility were reduced, and requirements for direct supervision of other personnel members were clarified. Requirements for a behavioral health assessment conducted by a behavioral health technician, a registered nurse, or a behavioral health paraprofessional were clarified, as were requirements for treatment plans and for discharge. The difference between providing transportation to a resident and a transport, as defined in R9-10-101, was clarified, as were requirements for each. The ability of a behavioral health residential facility to use restraint on a resident was removed since the facility could use an emergency safety response in its place. The rulemaking clarified requirements for release of information in a resident's medical or financial records and for the items included in a resident's medical record. It also added a number of items that must be included in resident medical records and clarified requirements for medication services. To protect health and safety of residents, the rulemaking added requirements for the review of a disaster plan and for a disaster drill. Environmental standards were clarified and simplified, including requirements related to pet vaccinations and to the use of tobacco products. Requirements for bathrooms and sleeping areas were also clarified. These changes from the 2014 rulemaking further improved the integration of health care institutions that provide both behavioral and physical health services and made the rules even more effective and easier to understand.

The changes in both the 2013 exempt rulemaking and the 2014 exempt rulemaking were intended to reduce monetary and regulatory costs and facilitate licensing of "integrated health programs that provide both behavioral and physical health services." The changes also made the rules more consistent with practices and increased consistency within health care institution licensing rules.

9. Has the agency received any business competitiveness analyses of the rules? Yes No X
10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?
Please state what the previous course of action was and if the agency did not complete the action, please explain why not.
This is the first five-year-review of the new rules adopted by exempt rulemaking in 2013 and amended in 2014.
11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:

The changes in both the 2013 exempt rulemaking and the 2014 exempt rulemaking were intended to reduce monetary and regulatory costs. Except as noted in paragraphs 4 and 6, the Department believes that the rules impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

12. Are the rules more stringent than corresponding federal laws? Yes No X

Please provide a citation for the federal law(s). And if the rule(s) is more stringent, is there statutory authority to exceed the requirements of federal law(s)?

Federal laws are not applicable to the rules in 9 A.A.C. 10, Article 7.

13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

The rules require the issuance of a specific agency authorization, which is authorized by A.R.S. § 36-405, so a general permit is not applicable.

14. Proposed course of action

If possible, please identify a month and year by which the agency plans to complete the course of action.

The Department plans to amend the rules in 9 A.A.C. 10, Article 7 to address issues identified in this five- year-review report by July 2019.

Current Rules in 9 A.A.C. 10, Article 7

ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

R9-10-701. Definitions

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

“Emergency safety response” means physically holding a resident to manage the resident’s sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual.

R9-10-702. Supplemental Application Requirements

- A. In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for an initial license as a behavioral health residential facility shall include on the application:
1. Whether the applicant is requesting authorization to provide:
 - a. Behavioral health services to individuals under 18 years of age, including the licensed capacity requested;
 - b. Behavioral health services to individuals 18 years of age and older, including the licensed capacity requested; or
 - c. Respite services;
 2. Whether the applicant is requesting authorization to provide an outdoor behavioral health care program, including:
 - a. The requested licensed capacity for providing the outdoor behavioral health care program to individuals 12 to 17 years of age, and
 - b. The requested licensed capacity for providing the outdoor behavioral health care program to individuals 18 to 24 years of age;
 3. Whether the applicant is requesting authorization to provide:
 - a. Residential services to individuals 18 years of age or older whose behavioral health issue limits the individuals’ ability to function independently, or
 - b. Personal care services;
 4. For a behavioral health residential facility requesting authorization to provide respite services, the requested number of individuals the behavioral health residential facility plans to admit for respite services who do not stay overnight in the behavioral health residential facility; and
 5. For an outdoor behavioral health care program, a copy of the outdoor behavioral health care program’s current accreditation report.
- B. In addition to the renewal license application requirements in A.R.S. § 36-422 and R9-10-107, an administrator of an outdoor behavioral health care program shall submit with a renewal

application, a copy of the outdoor behavioral health care program's current accreditation report.

R9-10-703. Administration

A. A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of a behavioral health residential facility;
2. Establish, in writing:
 - a. A behavioral health residential facility's scope of services, and
 - b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-704;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b), if the administrator is:
 - a. Expected not to be present on the behavioral health residential facility's premises for more than 30 calendar days, or
 - b. Not present on the behavioral health residential facility's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

B. An administrator:

1. Is directly accountable to the governing authority of a behavioral health residential facility for the daily operation of the behavioral health residential facility and all services provided by or at the behavioral health residential facility;
2. Has the authority and responsibility to manage the behavioral health residential facility; and
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the behavioral health residential facility's premises and accountable for the behavioral health residential facility when the administrator is not present on the behavioral health residential facility's premises.

C. An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees,

- volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to services provided to a resident;
 - d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Cover cardiopulmonary resuscitation training including:
 - i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
 - ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
 - iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
 - iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
 - f. Cover first aid training;
 - g. Include a method to identify a resident to ensure the resident receives physical health services and behavioral health services as ordered;
 - h. Cover resident rights, including assisting a resident who does not speak English or who has a physical or other disability to become aware of resident rights;
 - i. Cover specific steps for:
 - i. A resident to file a complaint, and
 - ii. The behavioral health residential facility to respond to a resident complaint;
 - j. Cover health care directives;
 - k. Cover medical records, including electronic medical records;
 - l. Cover a quality management program, including incident reports and supporting documentation;
 - m. Cover contracted services; and
 - n. Cover when an individual may visit a resident in a behavioral health residential facility;
2. Policies and procedures for behavioral health services and physical health services are established, documented, and implemented to protect the health and safety of a resident that:
- a. Cover resident screening, admission, assessment, treatment plan, transport, transfer, discharge planning, and discharge;
 - b. Cover the provision of behavioral health services and physical health services;
 - c. Include when general consent and informed consent are required;

- d. Cover emergency safety responses;
 - e. Cover a resident's personal funds account;
 - f. Cover dispensing medication, administering medication, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
 - g. Cover prescribing a controlled substance to minimize substance abuse by a resident;
 - h. Cover respite services;
 - i. Cover services provided by an outdoor behavioral health care program, if applicable;
 - j. Cover infection control;
 - k. Cover resident time out;
 - l. Cover resident outings;
 - m. Cover environmental services that affect resident care;
 - n. Cover whether pets and other animals are allowed on the premises, including procedures to ensure that any pets or other animals allowed on the premises do not endanger the health or safety of residents or the public;
 - o. If animals are used as part of a therapeutic program, cover:
 - i. Inoculation/vaccination requirements, and
 - ii. Methods to minimize risks to resident's health and safety;
 - p. Cover the process for receiving a fee from a resident and refunding a fee to a resident;
 - q. Cover the process for obtaining resident preferences for social, recreational, or rehabilitative activities and meals and snacks;
 - r. Cover the security of a resident's possessions that are allowed on the premises;
 - s. Cover smoking and the use of tobacco products on the premises; and
 - t. Cover how the behavioral health residential facility will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
- 3. Policies and procedures are reviewed at least once every three years and updated as needed;
 - 4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
 - 5. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health residential facility, the documentation or information is provided to the unit in the Department that is responsible for

licensing and monitoring the behavioral health residential facility.

- D.** If an applicant requests or a behavioral health residential facility has a licensed capacity of 10 or more residents, an administrator shall designate a clinical director who:
 - 1. Provides direction for the behavioral health services provided by or at the behavioral health residential facility;
 - 2. Is a behavioral health professional; and
 - 3. May be the same individual as the administrator, if the individual meets the qualifications in subsections (A)(2)(b) and (D)(1) and (2).
- E.** Except for respite services, an administrator shall ensure that medical services, nursing services, health-related services, or ancillary services provided by a behavioral health residential facility are only provided to a resident who is expected to be present in the behavioral health residential facility for more than 24 hours.
- F.** An administrator shall provide written notification to the Department of a resident's:
 - 1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
 - 2. Self-injury, within two working days after the resident inflicts a self-injury or has an accident that requires immediate intervention by an emergency medical services provider.
- G.** If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from a behavioral health residential facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
 - 1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - 2. For a resident under 18 years of age, according to A.R.S. § 13-3620.
- H.** If an administrator has a reasonable basis, according to A.R.S. §§ 13-3620 or 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from a behavioral health residential facility's employee or personnel member, the administrator shall:
 - 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 - 2. Report the suspected abuse, neglect, or exploitation of the resident:
 - a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
 - 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (H)(1); and
 - c. The report in subsection (H)(2);
 - 4. Maintain the documentation in subsection (H)(3) for at least 12 months after the date of the report in subsection (H)(2);

5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in (H)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (H)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

I. An administrator shall:

1. Establish and document requirements regarding residents, personnel members, employees, and other individuals entering and exiting the premises;
2. Establish and document guidelines for meeting the needs of an individual residing at a behavioral health residential facility with a resident, such as a child accompanying a parent in treatment, if applicable;
3. If children under the age of 12, who are not admitted to a behavioral health residential facility, are residing at the behavioral health residential facility and being cared for by employees or personnel members, ensure that:
 - a. An employee or personnel member caring for children has current cardiopulmonary resuscitation and first aid training specific to the ages of children being cared for; and
 - b. The staff-to-children ratios in A.A.C. R9-5-404(A) are maintained, based on the age of the youngest child in the group;
4. Establish and document the process for responding to a resident's need for immediate and unscheduled behavioral health services or physical health services;
5. Establish and document the criteria for determining when a resident's absence is unauthorized, including criteria for a resident who:
 - a. Was admitted under A.R.S. Title 36, Chapter 5, Articles 1, 2, or 3;
 - b. Is absent against medical advice; or
 - c. Is under the age of 18;
6. If a resident's absence is unauthorized as determined according to the criteria in subsection (I)(5), within an hour after determining that the resident's absence is unauthorized, notify:
 - a. For a resident who is under 18 years of age, the resident's parent or legal guardian; and

- b. For a resident who is under a court's jurisdiction, the appropriate court;
- 7. Maintain a written log of unauthorized absences for at least 12 months after the date of a resident's absence that includes the:
 - a. Name of a resident absent without authorization,
 - b. Name of the individual to whom the report required in subsection (I)(6) was submitted, and
 - c. Date of the report;
- 8. Document the notification in subsection (I)(6) and the written log required in subsection (I)(7); and
- 9. Evaluate and take action related to unauthorized absences under the quality management program in R9-10-704.

J. An administrator shall ensure that the following information or documents are conspicuously posted on the premises and are available upon request to a personnel member, employee, resident, or a resident's representative:

- 1. The behavioral health residential facility's current license,
- 2. The location at which inspection reports required in R9-10-720(C) are available for review or can be made available for review, and
- 3. The calendar days and times when a resident may accept visitors or make telephone calls.

K. An administrator shall ensure that:

- 1. Labor performed by a resident for the behavioral health residential facility is consistent with A.R.S. § 36-510;
- 2. A resident who is a child is only released to the child's custodial parent, guardian, or custodian or as authorized in writing by the child's custodial parent, guardian, or custodian;
- 3. The administrator obtains documentation of the identity of the parent, guardian, custodian, or family member authorized to act on behalf of a resident who is a child; and
- 4. A resident, who is an incapacitated person according to A.R.S. § 14-5101 or who is gravely disabled, is assisted in obtaining a resident's representative to act on the resident's behalf.

L. If an administrator determines that a resident is incapable of handling the resident's financial affairs, the administrator shall:

- 1. Notify the resident's representative or contact a public fiduciary or a trust officer to take responsibility of the resident's financial affairs, and
- 2. Maintain documentation of the notification required in subsection (L)(1)(a) in the resident's medical record for at least 12 months after the date of the notification.

M. If an administrator manages a resident's money through a personal funds account, the administrator shall ensure that:

- 1. Policies and procedure are established, developed, and implemented for:

- a. Using resident's funds in a personal funds account,
 - b. Protecting resident's funds in a personal funds account,
 - c. Investigating a complaint about the use of resident's funds in a personal funds account and ensuring that the complaint is investigated by an individual who does not manage the personal funds account,
 - d. Processing each deposit into and withdrawal from a personal funds account, and
 - e. Maintaining a record for each deposit into and withdrawal from a personal funds account; and
2. The personal funds account is only initiated after receiving a written request that:
 - a. Is provided:
 - i. Voluntarily by the resident,
 - ii. By the resident's representative, or
 - iii. By a court of competent jurisdiction;
 - b. May be withdrawn at any time; and
 - c. Is maintained in the resident's record.

R9-10-704. Quality Management

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
 - a. A method to identify, document, and evaluate incidents;
 - b. A method to collect data to evaluate services provided to residents;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident care;
 - d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to resident care; and
 - e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
 - a. An identification of each concern about the delivery of services related to resident care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

R9-10-705. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

R9-10-706. Personnel

A. An administrator shall ensure that:

1. A personnel member is:
 - a. At least 21 years old, or
 - b. Licensed or certified under A.R.S. Title 32 and providing services within the personnel member's scope of practice;
2. An employee is at least 18 years old;
3. A student is at least 18 years old; and
4. A volunteer is at least 21 years old.

B. An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of behavioral health services or physical health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the residents receiving behavioral health services or physical health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:

- a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures; and
 - 3. Sufficient personnel members are present on a behavioral health residential facility's premises with the qualifications, experience, skills, and knowledge necessary to:
 - a. Provide the services in the behavioral health residential facility's scope of services,
 - b. Meet the needs of a resident, and
 - c. Ensure the health and safety of a resident.
- C. An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.
- D. An administrator shall ensure that an individual who is licensed under A.R.S. Title 32, Chapter 33 as a baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor is under direct supervision, as defined in A.A.C. R4-6-101.
- E. An administrator shall ensure that:
- 1. A plan to provide orientation, specific to the duties of a personnel member, an employee, a volunteer, or a student, is developed, documented, and implemented;
 - 2. A personnel member completes orientation before providing behavioral health services or physical health services;
 - 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 - 4. A written plan is developed and implemented to provide in-service education specific to the duties of a personnel member; and
 - 5. A personnel member's in-service education is documented, to include:
 - a. The personnel member's name,
 - b. The date of the training, and
 - c. The subject or topics covered in the training.
- F. An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with residents, provides evidence of freedom from infectious tuberculosis:
- 1. On or before the date the individual begins providing services at or on behalf of the behavioral health residential facility, and
 - 2. As specified in R9-10-113.
- G. An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:

1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
 - a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - e. If the behavioral health residential facility is authorized to provide services to children, the individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03;
 - f. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - g. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-703(C)(1)(e);
 - h. First aid training, if required for the individual according to this Article or policies and procedures; and
 - i. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).

H. An administrator shall ensure that personnel records are:

1. Maintained:
 - a. Throughout an individual's period of providing services in or for the behavioral health residential facility, and
 - b. For at least 24 months after the last date the individual provided services in or for the behavioral health residential facility; and
2. For a personnel member who has not provided physical health services or behavioral health services at or for the behavioral health residential facility during the previous 12 months, provided to the Department within 72 hours after the Department's request.

I. An administrator shall ensure that the following personnel members have first-aid and cardiopulmonary resuscitation training specific to the populations served by the behavioral health residential facility:

1. At least one personnel member who is present at the behavioral health residential facility during hours of operation of the behavioral health residential facility, and
2. Each personnel member participating in an outing.

J. An administrator shall ensure that:

1. At least one personnel member is present and awake at the behavioral health residential facility when a resident is on the premises;
2. In addition to the personnel member in subsection (J)(1), at least one personnel member is on-call and available to come to the behavioral health residential facility if needed;
3. There is a daily staffing schedule that:
 - a. Indicates the date, scheduled work hours, and name of each employee assigned to work, including on-call personnel members;
 - b. Includes documentation of the employees who work each calendar day and the hours worked by each employee; and
 - c. Is maintained for at least 12 months after the last date on the documentation;
4. A behavioral health professional is present at the behavioral health residential facility or on-call;
5. A registered nurse is present at the behavioral health residential facility or on-call; and
6. If a resident requires services that the behavioral health residential facility is not authorized or not able to provide, a personnel member arranges for the resident to be transported to a hospital or another health care institution where the services can be provided.

R9-10-707. Admission; Assessment

A. An administrator shall ensure that:

1. A resident is admitted based upon the resident's presenting behavioral health issue and treatment needs and the behavioral health residential facility's scope of services;
2. A behavioral health professional, authorized by policies and procedures to accept a resident for admission, is available;
3. General consent is obtained from:
 - a. An adult resident or the resident's representative before or at the time of admission, or
 - b. A resident's representative, if the resident is not an adult;
4. The general consent obtained in subsection (A)(3) is documented in the resident's medical record;
5. Except as provided in subsection (E)(1)(a), a medical practitioner performs a medical history and physical examination or a registered nurse performs a nursing assessment on a resident within 30 calendar days before admission or within seven calendar days after admission and documents the medical history and physical examination or nursing assessment in the resident's medical record within seven calendar days after admission;
6. If a medical practitioner performs a medical history and physical examination or a nurse performs a nursing assessment on a resident before admission, the medical practitioner

- enters an interval note or the nurse enters a progress note in the resident's medical record within seven calendar days after admission;
7. If a behavioral health assessment is conducted by a:
 - a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the resident; or
 - b. Behavioral health paraprofessional, a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, supervises the behavioral health paraprofessional during the completion of the assessment and signs the assessment to ensure that the assessment identifies the behavioral health services needed by the resident;
 8. Except as provided in subsection (A)(9), a behavioral health assessment for a resident is completed before treatment for the resident is initiated;
 9. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the behavioral health residential facility or if the behavioral health residential facility has a medical record for the resident that contains a behavioral health assessment that was completed within 12 months before the date of the resident's current admission:
 - a. The resident's assessment information is reviewed and updated if additional information that affects the resident's assessment is identified, and
 - b. The review and update of the resident's assessment information is documented in the resident's medical record within 48 hours after the review is completed;
 10. A behavioral health assessment:
 - a. Documents a resident's:
 - i. Presenting issue;
 - ii. Substance abuse history;
 - iii. Co-occurring disorder;
 - iv. Legal history, including:
 - (1) Custody,
 - (2) Guardianship, and
 - (3) Pending litigation;
 - v. Criminal justice record;
 - vi. Family history;
 - vii. Behavioral health treatment history;
 - viii. Symptoms reported by the resident; and

- ix. Referrals needed by the resident, if any;
 - b. Includes:
 - i. Recommendations for further assessment or examination of the resident's needs,
 - ii. The physical health services or ancillary services that will be provided to the resident until the resident's treatment plan is completed, and
 - iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and
 - c. Is documented in resident's medical record;
11. A resident is referred to a medical practitioner if a determination is made that the resident requires immediate physical health services or the resident's behavioral health issue may be related to the resident's medical condition; and
12. Except as provided in subsection (E)(1)(d), a resident provides evidence of freedom from infectious tuberculosis:
- a. Before or within seven calendar days after the resident's admission, and
 - b. As specified in R9-10-113.

B. An administrator shall ensure that:

- 1. A request for participation in a resident's behavioral health assessment is made to the resident or the resident's representative,
- 2. An opportunity for participation in the resident's behavioral health assessment is provided to the resident or the resident's representative, and
- 3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.

C. An administrator shall ensure that a resident's behavioral health assessment information is documented in the medical record within 48 hours after completing the behavioral health assessment.

D. If information in subsection (A)(10) is obtained about a resident after the resident's behavioral health assessment is completed, an interval note, including the information, is documented in the resident's medical record within 48 hours after the information is obtained.

E. If a behavioral health residential facility is authorized to provide respite services, an administrator shall ensure that:

- 1. Upon admission of a resident for respite services:
 - a. Except as provided in subsection (F), a medical history and physical examination of the resident:
 - i. Is performed; or
 - ii. Dated within the previous 12 months, is available in the resident's medical record from a previous admission to the behavioral health residential

- facility;
- b. A treatment plan that meets the requirements in R9-10-708:
 - i. Is developed; or
 - ii. Dated within the previous 12 months, is available in the resident's medical record from a previous admission to the behavioral health residential facility;
 - c. If a treatment plan, dated within the previous 12 months, is available, the treatment plan is reviewed, updated, and documented in the resident's medical record; and
 - d. If the resident is not expected to be present in the behavioral health residential facility for more than seven days, the resident is not required to comply with the requirements in subsection (A)(12);
2. The common area required in R9-10-722(B)(1)(b) provides at least 25 square feet for each resident, including residents who do not stay overnight; and
 3. In addition to the requirements in R9-10-722(B)(3), toilets and hand-washing sinks are available to residents, including residents who do not stay overnight, as follows:
 - a. There is at least one working toilet that flushes and has a seat and one sink with running water for every 10 residents,
 - b. There are at least two working toilets that flush and have seats and two sinks with running water if there are 11 to 25 residents, and
 - c. There is at least one additional working toilet that flushes and has a seat and one additional sink with running water for each additional 20 residents.

- F. A medical history and physical examination is not required for a child who is admitted or expected to be admitted to a residential behavioral health facility for less than 10 days in a 90-consecutive-day period.

R9-10-708. Treatment Plan

- A. An administrator shall ensure that a treatment plan is developed and implemented for each resident that:
1. Is based on the medical history and physical examination or nursing assessment required in R9-10-707(A)(5) or (E)(1) and the behavioral health assessment required in R9-10-707(A)(8) or (9) and on-going changes to the behavioral health assessment of the resident;
 2. Is completed:
 - a. By a behavioral health professional or a behavioral health technician under the clinical oversight of a behavioral health professional, and
 - b. Before the resident receives physical health services or behavioral health services or within 48 hours after the assessment is completed;

3. Is documented in the resident's medical record within 48 hours after the resident first receives physical health services or behavioral health services;
4. Includes:
 - a. The resident's presenting issue;
 - b. The physical health services or behavioral health services to be provided to the resident;
 - c. The signature of the resident or the resident's representative, and date signed, or documentation of the refusal to sign;
 - d. The date when the resident's treatment plan will be reviewed;
 - e. If a discharge date has been determined, the treatment needed after discharge; and
 - f. The signature of the personnel member who developed the treatment plan and the date signed;
5. If the treatment plan was completed by a behavioral health technician, is reviewed and signed by a behavioral health professional within 24 hours after the completion of the treatment plan to ensure that the treatment plan is complete and accurate and meets the resident's treatment needs; and
6. Is reviewed and updated on an on-going basis:
 - a. According to the review date specified in the treatment plan,
 - b. When a treatment goal is accomplished or changed,
 - c. When additional information that affects the resident's behavioral health assessment is identified, and
 - d. When a resident has a significant change in condition or experiences an event that affects treatment.

B. An administrator shall ensure that:

1. A request for participation in developing a resident's treatment plan is made to the resident or the resident's representative,
2. An opportunity for participation in developing the resident's treatment plan is provided to the resident or the resident's representative, and
3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.

R9-10-709. Discharge

A. An administrator shall ensure that a discharge plan for a resident is:

1. Developed that:
 - a. Identifies any specific needs of the resident after discharge,
 - b. Is completed before discharge occurs, and
 - c. Includes a description of the level of care that may meet the resident's assessed and

- anticipated needs after discharge;
2. Documented in the resident's medical record within 48 hours after the discharge plan is completed; and
 3. Provided to the resident or the resident's representative before the discharge occurs.
- B.** An administrator shall ensure that:
1. A request for participation in developing a resident's discharge plan is made to the resident or the resident's representative,
 2. An opportunity for participation in developing the resident's discharge plan is provided to the resident or the resident's representative, and
 3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.
- C.** An administrator shall ensure that a resident is discharged from a behavioral health residential facility when the resident's treatment needs are not consistent with the services that the behavioral health residential facility is authorized and able to provide.
- D.** An administrator shall ensure that there is a documented discharge order by a medical practitioner or behavioral health professional before a resident is discharged unless the resident leaves the behavioral health residential facility against a medical practitioner's or behavioral health professional's advice.
- E.** An administrator shall ensure that, at the time of discharge, a resident receives a referral for treatment or ancillary services that the resident may need after discharge, if applicable.
- F.** If a resident is discharged to any location other than a health care institution, an administrator shall ensure that:
1. Discharge instructions are documented, and
 2. The resident or the resident's representative is provided with a copy of the discharge instructions.
- G.** An administrator shall ensure that a discharge summary for a resident:
1. Is entered into the resident's medical record within 10 working days after a resident's discharge; and
 2. Includes:
 - a. The following information authenticated by a medical practitioner or behavioral health professional:
 - i. The resident's presenting issue and other physical health and behavioral health issues identified in the resident's treatment plan;
 - ii. A summary of the treatment provided to the resident;
 - iii. The resident's progress in meeting treatment goals, including treatment goals that were and were not achieved; and
 - iv. The name, dosage, and frequency of each medication ordered for the resident

by a medical practitioner at the behavioral health residential facility at the time of the resident's discharge; and

- b. A description of the disposition of the resident's possessions, funds, or medications brought to the behavioral health residential facility by the resident.

- H. An administrator shall ensure that a resident who is dependent upon a prescribed medication is offered a written referral to detoxification services or opioid treatment before the resident is discharged from the behavioral health residential facility if a medical practitioner for the behavioral health residential facility will not be prescribing the medication for the resident at or after discharge.

R9-10-710. Transport; Transfer

- A. Except as provided in subsection (B), an administrator shall ensure that:

1. A personnel member coordinates the transport and the services provided to the resident;
2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before and after the transport;
 - b. Information from the resident's medical record is provided to a receiving health care institution, and
 - c. A personnel member explains risks and benefits of the transport to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transport.

- B. Subsection (A) does not apply to:

1. Transportation to a location other than a licensed health care institution,
2. Transportation provided for a resident by the resident or the resident's representative,
3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or
4. A transport to another licensed health care institution in an emergency.

- C. Except for a transfer of a resident due to an emergency, an administrator shall ensure that:

1. A personnel member coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before the transfer;
 - b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and

- c. A personnel member explains risks and benefits of the transfer to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transfer.

R9-10-711. Resident Rights

- A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the resident rights in subsection (E) are conspicuously posted on the premises;
 2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (E); and
 3. Policies and procedures include:
 - a. How and when a resident or the resident's representative is informed of the resident rights in subsection (E), and
 - b. Where resident rights are posted as required in subsection (A)(1).
- B.** An administrator shall ensure that:
1. A resident is treated with dignity, respect, and consideration;
 2. A resident is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity;
 - k. Misappropriation of personal and private property by the behavioral health residential facility's personnel members, employees, volunteers, or students;
 - l. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the resident's treatment needs, except as established in a fee agreement signed by the resident or the resident's representative; or

- m. Treatment that involves the denial of:
 - i. Food,
 - ii. The opportunity to sleep, or
 - iii. The opportunity to use the toilet;
 - 3. Except as provided in subsection (C) or (D), and unless restricted by the resident's representative, is allowed to:
 - a. Associate with individuals of the resident's choice, receive visitors, and make telephone calls during the hours established by the behavioral health residential facility;
 - b. Have privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and
 - c. Unless restricted by a court order, send and receive uncensored and unopened mail; and
 - 4. A resident or the resident's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5 or A.R.S. 8-341.01; is necessary to save the resident's life or physical health; or is provided according to A.R.S. § 36-512;
 - c. Except in an emergency, is informed of proposed treatment alternatives, associated risks, and possible complications;
 - d. Is informed of the following:
 - i. The behavioral health residential facility's policy on health care directives, and
 - ii. The resident complaint process; and
 - e. Except as otherwise permitted by law, provides written consent to the release of information in the resident's:
 - i. Medical record, or
 - ii. Financial records.
- C. For a behavioral health residential facility with licensed capacity of less than 10 residents, if a behavioral health professional determines that a resident's treatment requires the behavioral health residential facility to restrict the resident's ability to participate in the activities in subsection (B)(3), the behavioral health professional shall:
1. Document a specific treatment purpose in the resident's medical record that justifies restricting the resident from the activity,
 2. Inform the resident or resident's representative of the reason why the activity is being restricted, and

3. Inform the resident or resident's representative of the resident's right to file a complaint and the procedure for filing a complaint.

D. For a behavioral health residential facility with a licensed capacity of 10 or more residents, if a clinical director determines that a resident's treatment requires the behavioral health residential facility to restrict the resident's ability to participate in the activities in subsection (B)(3), the clinical director shall comply with the requirements in subsections (C)(1) through (3).

E. A resident has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that:
 - a. Supports and respects the resident's individuality, choices, strengths, and abilities;
 - b. Supports the resident's personal liberty and only restricts the resident's personal liberty according to a court order, by the resident's or the resident's representative's general consent, or as permitted in this Chapter; and
 - c. Is provided in the least restrictive environment that meets the resident's treatment needs;
3. To receive privacy in treatment and care for personal needs, including the right not to be fingerprinted, photographed, or recorded without consent, except:
 - a. A resident may be photographed when admitted to a behavioral health residential facility for identification and administrative purposes;
 - b. For a resident receiving treatment according to A.R.S. Title 36, Chapter 37; or
 - c. For video recordings used for security purposes that are maintained only on a temporary basis;
4. Not to be prevented or impeded from exercising the resident's civil rights unless the resident has been adjudicated incompetent or a court of competent jurisdiction has found that the resident is not able to exercise a specific right or category of rights;
5. To review, upon written request, the resident's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
6. To be provided locked storage space for the resident's belongings while the resident receives treatment;
7. To have opportunities for social contact and daily social, recreational, or rehabilitative activities;
8. To be informed of the requirements necessary for the resident's discharge or transfer to a less restrictive physical environment;
9. To receive a referral to another health care institution if the behavioral health residential facility is not authorized or not able to provide physical health services or behavioral health services needed by the resident;

10. To participate or have the resident's representative participate in the development of a treatment plan or decisions concerning treatment;
11. To participate or refuse to participate in research or experimental treatment; and
12. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

R9-10-712. Medical Records

A. An administrator shall ensure that:

1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a resident's medical record is:
 - a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
3. An order is:
 - a. Dated when the order is entered in the resident's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A resident's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the resident's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the resident or the resident's representative; or
 - c. As permitted by law;
6. Policies and procedures include the maximum time-frame to retrieve a resident's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and
7. A resident's medical record is protected from loss, damage, or unauthorized use.

B. If a behavioral health residential facility maintains residents' medical records electronically, an administrator shall ensure that:

1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.

C. An administrator shall ensure that a resident's medical record contains:

1. Resident information that includes:
 - a. The resident's name;
 - b. The resident's address;
 - c. The resident's date of birth; and
 - d. Any known allergies, including medication allergies;
2. The name of the admitting medical practitioner or behavioral health professional;
3. An admitting diagnosis or presenting behavioral health issues;
4. The date of admission and, if applicable, date of discharge;
5. If applicable, the name and contact information of the resident's representative and:
 - a. If the resident is 18 years of age or older or an emancipated minor, the document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
 - b. If the resident's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
6. If applicable, documented general consent and informed consent for treatment by the resident or the resident's representative;
7. Documentation of medical history and results of a physical examination;
8. A copy of resident's health care directive, if applicable;
9. Orders;
10. Assessment;
11. Treatment plans;
12. Interval notes;
13. Progress notes;
14. Documentation of behavioral health services and physical health services provided to the resident;
15. If applicable, documentation of the use of an emergency safety response;
16. If applicable, documentation of time out required in R9-10-714(6);
17. Except as allowed in R9-10-707(E)(1)(d), documentation of freedom from infectious tuberculosis required in R9-10-707(A)(12);

18. The disposition of the resident after discharge;
19. The discharge plan;
20. The discharge summary, if applicable;
21. If applicable:
 - a. Laboratory reports,
 - b. Radiologic reports,
 - c. Diagnostic reports, and
 - d. Consultation reports; and
22. Documentation of medication administered to the resident that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain, when administered initially or on a PRN basis:
 - i. An assessment of the resident's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication, when administered initially or on a PRN basis:
 - i. An assessment of the resident's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering or providing assistance in the self-administration of the medication; and
 - f. Any adverse reaction a resident has to the medication.

R9-10-713. Transportation; Resident Outings

- A. An administrator of a behavioral health residential facility that uses a vehicle owned or leased by the behavioral health residential facility to provide transportation to a resident shall ensure that:
1. The vehicle:
 - a. Is safe and in good repair,
 - b. Contains a first aid kit,
 - c. Contains drinking water sufficient to meet the needs of each resident present in the vehicle, and
 - d. Contains a working heating and air conditioning system;
 2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle is maintained;
 3. A driver of the vehicle:

- a. Is 21 years of age or older;
 - b. Has a valid driver license;
 - c. Operates the vehicle in a manner that does not endanger a resident in the vehicle;
 - d. Does not leave in the vehicle unattended:
 - i. Child,
 - ii. Resident who may be a threat to the health or safety of the resident or another individual, or
 - iii. Resident who is incapable of independent exit from the vehicle; and
4. Transportation safety is maintained as follows:
 - a. Each individual in the vehicle is sitting in a seat and wearing a working seat belt while the vehicle is in motion, and
 - b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a resident's body.

B. An administrator shall ensure that:

1. An outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each resident participating in the outing;
2. At least two personnel members are present on an outing;
3. In addition to the personnel members required in subsection (B)(2), a sufficient number of personnel members are present to ensure each resident's health and safety on the outing;
4. Documentation is developed before an outing that includes:
 - a. The name of each resident participating in the outing;
 - b. A description of the outing;
 - c. The date of the outing;
 - d. The anticipated departure and return times;
 - e. The name, address, and, if available, telephone number of the outing destination; and
 - f. If applicable, the license plate number of each vehicle used to transport a resident;
5. The documentation described in subsection (B)(4) is updated to include the actual departure and return times and is maintained for at least 12 months after the date of the outing; and
6. Emergency information for each resident participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for the outing and includes:
 - a. The resident's name;
 - b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the resident during the anticipated duration of the outing;
 - c. The resident's allergies; and

- d. The name and telephone number of a designated individual, to notify in case of an emergency, who is present on the behavioral health residential facility's premises.

R9-10-714. Resident Time Out

An administrator shall ensure that a time out:

1. Is provided to a resident who voluntarily decides to go in a time out;
2. Takes place in an area that is unlocked, lighted, quiet, and private;
3. Is time-limited and does not exceed the amount of time as determined by the resident;
4. Does not result in a resident missing a meal if the resident is in time out at mealtime;
5. Includes monitoring of the resident by a personnel member at least once every 15 minutes to ensure the resident's health and safety and to discuss with the resident if the resident is ready to leave time out; and
6. Is documented in the resident's medical record, to include:
 - a. The date of the time out,
 - b. The reason for the time out,
 - c. The duration of the time out, and
 - d. The action planned and taken by the administrator to prevent the use of time out in the future.

R9-10-715. Physical Health Services

An administrator of a behavioral health residential facility that provides personal care services shall ensure that:

1. Personnel members who provide personal care services have documentation of completion of a caregiver training program that complies with A.A.C. R4-33-702(A)(5);
2. Residents receive personal care services according to the requirements in R9-10-814(A), (C), (D), and (E); and
3. A resident who has a stage 3 or stage 4 pressure sore is not admitted to the behavioral health residential facility.

R9-10-716. Behavioral Health Services

A. An administrator shall ensure that:

1. If a behavioral health residential facility is licensed to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently, in addition to behavioral health services and personnel care services as indicated in the resident's treatment plan, receives continuous

- protective oversight;
2. A resident admitted to the behavioral health residential facility who needs behavioral health services to maintain or enhance the resident's ability to function independently, in addition to receiving behavioral health services, and, if indicated in the resident's treatment plan, personal care services, is provided an opportunity to participate in activities designed to maintain or enhance the resident's ability to function independently while caring for the resident's health, safety, or personal hygiene or performing homemaking functions;
 3. Behavioral health services are provided to meet the needs of a resident and are consistent with a behavioral health residential facility's scope of services;
 4. Behavioral health services:
 - a. Listed in the behavioral health residential facility's scope of services are provided on the premises; and
 - b. When provided in a setting or activity with more than one resident participating, before a resident participates, the diagnoses, treatment needs, developmental levels, social skills, verbal skills, and personal histories, including any history of physical or sexual abuse, of the residents participating are reviewed to ensure that the:
 - i. Health and safety of each resident is protected, and
 - ii. Treatment needs of each resident participating are being met; and
 5. A resident does not:
 - a. Use or have access to any materials, furnishings, or equipment or participate in any activity or treatment that may present a threat to the resident's health or safety based on the resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, or personal history; or
 - b. Share any space, participate in any activity or treatment, or verbally or physically interact with any other resident that may present a threat to the resident's health or safety based on the other resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, and personal history.

B. An administrator shall ensure that counseling is:

1. Offered as described in the behavioral health residential facility's scope of services,
2. Provided according to the frequency and number of hours identified in the resident's treatment plan, and
3. Provided by a behavioral health professional or a behavioral health technician.

C. An administrator shall ensure that:

1. A personnel member providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the

- specific type of behavioral health issue; and
2. Each counseling session is documented in a resident's medical record to include:
 - a. The date of the counseling session;
 - b. The amount of time spent in the counseling session;
 - c. Whether the counseling was individual counseling, family counseling, or group counseling;
 - d. The treatment goals addressed in the counseling session; and
 - e. The signature of the personnel member who provided the counseling and the date signed.
- D.** An administrator of a behavioral health residential facility authorized to provide behavioral health residential services to individuals under 18 years of age:
1. May continue to provide behavioral health services to a resident who is 18 years of age or older:
 - a. If the resident:
 - i. Was admitted to the behavioral health residential facility before the resident's 18th birthday;
 - ii. Is not 21 years of age or older; and
 - iii. Is:
 - (1) Attending classes or completing coursework to obtain a high school or a high school equivalency diploma, or
 - (2) Participating in a job training program; or
 - b. Through the last calendar day of the month of the resident's 18th birthday; and
 2. Shall ensure that:
 - a. A resident does not receive the following from other residents at the behavioral health residential facility:
 - i. Threats,
 - ii. Ridicule,
 - iii. Verbal harassment,
 - iv. Punishment, or
 - v. Abuse;
 - b. The interior of the behavioral health residential facility has furnishings and decorations appropriate to the ages of the residents receiving services at the behavioral health residential facility;
 - c. A resident older than three years of age does not sleep in a crib;
 - d. Clean and non-hazardous toys, educational materials, and physical activity equipment are available and accessible to residents on the premises in a quantity sufficient to meet each resident's needs and are appropriate to each resident's age,

developmental level, and treatment needs; and

- e. A resident's educational needs are met, including providing or arranging for transportation:
 - i. By establishing and providing an educational component, approved in writing by the Arizona Department of Education; or
 - ii. As arranged and documented by the administrator through the local school district.

E. An administrator shall ensure that:

1. An emergency safety response is:
 - a. Only used:
 - i. By a personnel member trained to use an emergency safety response,
 - ii. For the management of a resident's violent or self-destructive behavior, and
 - iii. When less restrictive interventions have been determined to be ineffective; and
 - b. Discontinued at the earliest possible time, but no longer than five minutes after the emergency safety response is initiated;
2. Within 24 hours after an emergency safety response is used for a resident, the following information is entered into the resident medical record:
 - a. The date and time the emergency safety response was used;
 - b. The name of each personnel member who used an emergency safety response;
 - c. The specific emergency safety response used;
 - d. The personnel member or resident behavior, event, or environmental factor that caused the need for the emergency safety response; and
 - e. Any injury that resulted from the emergency safety response;
3. Within 10 working days after an emergency safety response is used for a resident, the administrator or clinical director reviews the information in subsection (E)(2); and
4. After the review required in subsection (E)(3), the following information is entered into the resident's medical record:
 - a. Actions taken or planned actions to prevent the need for the use of an emergency safety response for the resident,
 - b. A determination of whether the resident is appropriately placed at the behavioral health residential facility, and
 - c. Whether the resident's treatment plan was reviewed or needs to be reviewed and amended to ensure that the resident's treatment plan is meeting the resident's treatment needs.

F. An administrator shall ensure that:

1. A personnel member whose job description includes the ability to use an emergency safety

response:

- a. Completes training in crisis intervention that includes:
 - i. Techniques to identify personnel member and resident behaviors, events, and environmental factors that may trigger the need for the use of an emergency safety response;
 - ii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods; and
 - iii. The safe use of an emergency safety response including the ability to recognize and respond to signs of physical distress in a client who is receiving an emergency safety response; and
 - b. Completes training required in subsection (F)(1)(a):
 - i. Before providing behavioral health services, and
 - ii. At least once every 12 months after the date the personnel member completed the initial training;
2. Documentation of the completed training in subsection (F)(1)(a) includes:
 - a. The name and credentials of the individual providing the training,
 - b. Date of the training, and
 - c. Verification of a personnel member's ability to use the training; and
 3. The materials used to provide the completed training in crisis intervention, including handbooks, electronic presentations, and skills verification worksheets, are maintained for at least 12 months after each personnel member who received training using the materials no longer provides services at the behavioral health residential facility.

R9-10-717. Outdoor Behavioral Health Care Programs

- A. An administrator of a behavioral health residential facility providing an outdoor behavioral health care program shall ensure that:
1. Behavioral health services are provided to a resident participating in the outdoor behavioral health care program consistent with the age, developmental level, physical ability, medical condition, and treatment needs of the resident;
 2. Continuous protective oversight is provided to a resident;
 3. Transportation is provided to a resident from the behavioral health residential facility's administrative office for the outdoor behavioral health care program to the location where the outdoor behavioral health care program is provided and from the location where the outdoor behavioral health care program is provided to the behavioral health residential facility's administrative office for the outdoor behavioral health care program; and
 4. Communication is available between the outdoor behavioral health care program personnel

and:

- a. A behavioral health professional,
- b. A registered nurse,
- c. An emergency medical response team, and
- d. The behavioral health residential facility's administrative office for the outdoor behavioral health care program.

B. An administrator of a behavioral health residential facility providing an outdoor behavioral health care program shall ensure that:

1. Food is prepared:
 - a. Using methods that conserve nutritional value, flavor, and appearance; and
 - b. In a form to meet the needs of a resident such as cut, chopped, ground, pureed, or thickened;
2. A food menu is prepared based on the number of calendar days scheduled for the behavioral health care program;
3. Meals and snacks provided by the behavioral health care program are served according to menus;
4. Meals and snacks for each day are planned using the applicable guidelines in <http://www.health.gov/dietaryguidelines/2010.asp>;
5. A resident is provided:
 - a. A diet that meets the resident's nutritional needs as specified in the resident's assessment or treatment plan;
 - b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(5)(d);
 - c. The option to have a daily evening snack or other snack; and
 - d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if the resident agrees;
6. Water is available and accessible to residents unless otherwise stated in a resident's treatment plan;
7. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
8. Food is protected from potential contamination; and
9. Food being maintained in coolers containing ice is not in direct contact with ice or water if water may enter the food because of the nature of the food's packaging, wrapping, or container or the positioning of the food in the ice or water.

C. An administrator of a behavioral health residential facility providing an outdoor behavioral health care program shall ensure that:

1. The location and, if applicable, equipment used by the outdoor behavioral health care program are sufficient to accommodate the activities, treatment, and ancillary services

- required by the residents participating in the behavioral health care program;
2. The location and equipment are maintained in a condition that allows the location and equipment to be used for the original purpose of the location and equipment;
 3. Garbage and refuse are:
 - a. Stored in plastic bags in covered containers, and
 - b. Removed from the location used by the outdoor behavioral health care program at least once a week;
 4. Common areas:
 - a. Are lighted when in use to assure the safety of residents, and
 - b. Have sufficient lighting to allow personnel members to monitor resident activity;
 5. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
 6. Soiled clothing is stored in closed containers away from food storage, medications, and eating areas;
 7. Poisonous or toxic materials are maintained in labeled containers, secured, and separate from food preparation and storage, eating areas, and medications and inaccessible to residents;
 8. Combustible or flammable liquids and hazardous materials are stored in the original labeled containers or safety containers, secured, and inaccessible to residents;
 9. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
 10. Smoking or the use of tobacco products may be permitted away from the residents.

R9-10-718. Medication Services

- A. An administrator shall ensure that policies and procedures for medication services:
1. Include:
 - a. A process for providing information to a resident about medication prescribed for the resident including:
 - i. The prescribed medication's anticipated results,
 - ii. The prescribed medication's potential adverse reactions,
 - iii. The prescribed medication's potential side effects, and
 - iv. Potential adverse reactions that could result from not taking the medication as prescribed;

- b. Procedures for preventing, responding to, and reporting:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a resident's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;
 - d. Procedures for documenting, as applicable, medication administration and assistance in the self-administration of medication;
 - e. A process for monitoring a resident who self-administers medication;
 - f. Procedures for assisting a resident in obtaining medication; and
 - g. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. Specify a process for review through the quality management program of:
 - a. A medication administration error, and
 - b. An adverse reaction to a medication.

B. If a behavioral health residential facility provides medication administration, an administrator shall ensure that:

1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a resident only as prescribed; and
 - d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a resident:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the resident's medical record.

C. If behavioral health residential facility provides assistance in the self-administration of medication, an administrator shall ensure that:

1. A resident's medication is stored by the behavioral health residential facility;
2. The following assistance is provided to a resident:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the resident;
 - c. Observing the resident while the resident removes the medication from the container;

- d. Verifying that the medication is taken as ordered by the resident's medical practitioner by confirming that:
 - i. The resident taking the medication is the individual stated on the medication container label,
 - ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
 - iii. The resident is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
 - e. Observing the resident while the resident takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
 4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
 5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
 6. Assistance in the self-administration of medication provided to a resident:
 - a. Is in compliance with an order, and
 - b. Is documented in the resident's medical record.

D. An administrator shall ensure that:

1. A current drug reference guide is available for use by personnel members;
2. A current toxicology reference guide is available for use by personnel members; and
3. If pharmaceutical services are provided on the premises:
 - a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
 - i. Develop a drug formulary,

- ii. Update the drug formulary at least once every 12 months;
 - iii. Develop medication usage and medication substitution policies and procedures, and
 - iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical practitioner specifically orders otherwise;
- b. The pharmaceutical services are provided under the direction of a pharmacist;
 - c. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
 - d. A copy of the pharmacy license is provided to the Department upon request.

E. When medication is stored at a behavioral health residential facility, an administrator shall ensure that:

- 1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
- 2. Medication is stored according to the instructions on the medication container; and
- 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of residents who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.

F. An administrator shall ensure that a personnel member immediately reports a medication error or a resident's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the behavioral health residential facility's clinical director.

R9-10-719. Food Services

- A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:
- 1. For a behavioral health residential facility that has a licensed capacity of more than 10 residents:
 - a. The behavioral health residential facility obtains a license or permit as a food establishment under 9 A.A.C. 8, Article 1; and
 - b. A copy of the behavioral health residential facility's food establishment license or permit is maintained;
 - 2. If a behavioral health residential facility contracts with food establishment, as established in 9

A.A.C. 8, Article 1, to prepare and deliver food to the behavioral health residential facility, a copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the behavioral health residential facility;

3. Food is stored, refrigerated, and reheated to meet the dietary needs of a resident;
 4. A registered dietitian is employed full-time, part-time, or as a consultant; and
 5. If a registered dietitian is not employed full-time, an individual is designated as a director of food services who consults with a registered dietitian as often as necessary to meet the nutritional needs of the residents.
- B.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, a registered dietitian or director of food services shall ensure that:
1. Food is prepared:
 - a. Using methods that conserve nutritional value, flavor, and appearance; and
 - b. In a form to meet the needs of a resident, such as cut, chopped, ground, pureed, or thickened;
 2. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served each day,
 - c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
 3. Meals and snacks provided by the behavioral health residential facility are served according to posted menus;
 4. Meals and snacks for each day are planned using the applicable guidelines in <http://www.health.gov/dietaryguidelines/2010.asp>;
 5. A resident is provided:
 - a. A diet that meets the resident's nutritional needs as specified in the resident's assessment or treatment plan;
 - b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(5)(d);
 - c. The option to have a daily evening snack identified in subsection (B)(5)(d)(ii) or other snack; and
 - d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
 - i. The resident agrees; and

- ii. The resident is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
 - 6. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
 - 7. Water is available and accessible to residents unless otherwise stated in a resident's treatment plan.
- C. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that food is obtained, prepared, served, and stored as follows:
- 1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
 - 2. Food is protected from potential contamination;
 - 3. Potentially hazardous food is maintained as follows:
 - a. Foods requiring refrigeration are maintained at 41° F or below; and
 - b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
 - i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
 - iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155 °F;
 - v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
 - vi. Leftovers are reheated to a temperature of at least 165° F;
 - 4. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
 - 5. Frozen foods are stored at a temperature of 0° F or below; and
 - 6. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

R9-10-720. Emergency and Safety Standards

- A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that a behavioral health residential facility has:

1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in A.A.C. R9-1-412, and a sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in A.A.C. R9-1-412, that are in working order; or
 2. An alternative method to ensure resident's safety that is documented and approved by the local jurisdiction.
- B. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:
 1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. When, how, and where residents will be relocated;
 - b. How each resident's medical record will be available to individuals providing services to the resident during a disaster;
 - c. A plan to ensure each resident's medication will be available to administer to the resident during a disaster; and
 - d. A plan for obtaining food and water for individuals present in the behavioral health residential facility, under the care and supervision of personnel members, or in the behavioral health residential facility's relocation site during a disaster;
 2. The disaster plan required in subsection (B)(1) is reviewed at least once every 12 months;
 3. Documentation of a disaster plan review required in subsection (B)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
 4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
 5. An evacuation drill for employees and residents on the premises is conducted at least once every six months on each shift;
 6. Documentation of each evacuation drill is created, is maintained for 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for all employees and residents to evacuate the behavioral health residential facility;
 - c. Names of employees participating in the evacuation drill;

- d. An identification of residents needing assistance for evacuation;
 - e. Any problems encountered in conducting the evacuation drill; and
 - f. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health residential facility.

C. An administrator shall:

1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

R9-10-721. Environmental Standards

- A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:
1. The premises and equipment are:
 - a. Maintained in a condition that allows the premises and equipment to be used for the original purpose of the premises and equipment;
 - b. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
 - c. Free from a condition or situation that may cause a resident or other individual to suffer physical injury;
 2. A pest control program is implemented and documented;
 3. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
 4. Equipment used at the behavioral health residential facility is:
 - a. Maintained in working order;
 - b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
 5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
 6. Garbage and refuse are:
 - a. Stored in covered containers lined with plastic bags, and
 - b. Removed from the premises at least once a week;
 7. Heating and cooling systems maintain the behavioral health residential facility at a temperature between 70° F and 84° F;

8. A space heater is not used;
9. Common areas:
 - a. Are lighted to assure the safety of residents, and
 - b. Have lighting sufficient to allow personnel members to monitor resident activity;
10. Hot water temperatures are maintained between 95° F and 120° F in the areas of the behavioral health residential facility used by residents;
11. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
12. Soiled linen and soiled clothing stored by the behavioral health residential facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
13. Oxygen containers are secured in an upright position;
14. Poisonous or toxic materials stored by the behavioral health residential facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents;
15. Combustible or flammable liquids and hazardous materials stored by a behavioral health residential facility are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
16. If pets or animals are allowed in the behavioral health residential facility, pets or animals are:
 - a. Controlled to prevent endangering the residents and to maintain sanitation;
 - b. Licensed consistent with local ordinances; and
 - c. For a dog or cat, vaccinated against rabies;
17. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
18. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to all applicable state laws and rules.

B. An administrator shall ensure that:

1. Smoking tobacco products is not permitted within a behavioral health residential facility; and
2. Smoking tobacco products may be permitted on the premises outside a behavioral health residential facility if:
 - a. Signs designating smoking areas are conspicuously posted, and
 - b. Smoking is prohibited in areas where combustible materials are stored or in use.

C. If a swimming pool is located on the premises, an administrator shall ensure that:

1. On each day that a resident uses the swimming pool, an employee:
 - a. Tests the swimming pool's water quality at least once for compliance with one of the following chemical disinfection standards:
 - i. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test;
 - ii. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test; or
 - iii. An oxidation-reduction potential equal to or greater than 650 millivolts; and
 - b. Records the results of the water quality tests in a log that includes each testing date and test result;
2. Documentation of the water quality test is maintained for at least 12 months after the date of the test;
3. A swimming pool is not used by a resident if a water quality test shows that the swimming pool water does not comply with subsection (C)(1)(a);
4. At least one personnel member, with cardiopulmonary resuscitation training that meets the requirements in R9-10-703(C)(1)(e), is present in the pool area when a resident is in the pool area; and
5. At least two personnel members are present in the pool area if two or more residents are in the pool area.

R9-10-722. Physical Plant Standards

A. Except for a behavioral health outdoor program, an administrator shall ensure that the premises and equipment are sufficient to accommodate:

1. The services in the behavioral health residential facility's scope of services, and
2. An individual accepted as a resident by the behavioral health residential facility.

B. An administrator shall ensure that:

1. A behavioral health residential facility has a:
 - a. Room that provides privacy for a resident to receive treatment or visitors; and
 - b. Common area and a dining area that contain furniture and materials to accommodate the recreational and socialization needs of the residents and other individuals in the behavioral health residential facility;
2. At least one bathroom is accessible from a common area that:
 - a. May be used by residents and visitors;
 - b. Provides privacy when in use; and
 - c. Contains the following:
 - i. At least one working sink with running water,

- ii. At least one working toilet that flushes and has a seat,
 - iii. Toilet tissue for each toilet,
 - iv. Soap in a dispenser accessible from each sink,
 - v. Paper towels in a dispenser or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A window that opens or another means of ventilation;
- 3. For every six residents who stay overnight at the behavioral health residential facility, there is at least one working toilet that flushes and has a seat, and one sink with running water;
- 4. For every eight residents who stay overnight at the behavioral health residential facility, there is at least one working bathtub or shower;
- 5. A resident bathroom provides privacy when in use and contains:
 - a. A shatter-proof mirror, unless the resident's treatment plan allows for otherwise;
 - b. A window that opens or another means of ventilation; and
 - c. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers;
- 6. If a resident bathroom door locks from the inside, an employee has a key and access to the bathroom;
- 7. Each resident is provided a sleeping area that is in a bedroom; and
- 8. A resident bedroom complies with the following:
 - a. Is not used as a common area;
 - b. Is not used as a passageway to another bedroom or bathroom unless the bathroom is for the exclusive use of an individual occupying the bedroom;
 - c. Contains a door that opens into a hallway, common area, or outdoors;
 - d. Is constructed and furnished to provide unimpeded access to the door;
 - e. Has window or door covers that provide resident privacy;
 - f. Has floor to ceiling walls;
 - g. Is a:
 - i. Private bedroom that contains at least 60 square feet of floor space, not including the closet; or
 - ii. Shared bedroom that:
 - (1) Is shared by no more than eight residents;
 - (2) Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the shared bedroom; and
 - (3) Provides at least three feet of floor space between beds or bunk beds;
 - h. Contains for each resident occupying the bedroom:

- i. A bed that is at least 36 inches wide and at least 72 inches long, and consists of at least a frame and mattress and linens; and
 - ii. Individual storage space for personal effects and clothing such as shelves, a dresser, or chest of drawers;
- i. Has clean linen for each bed including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each resident;
 - j. Has sufficient lighting for a resident occupying the bedroom to read; and
 - k. Has a clothing rod or hook in the bedroom designed to minimize the opportunity for a resident to cause self-injury.
- C. A behavioral health residential facility that was licensed as a Level 4 transitional agency before October 1, 2013 may continue to use a shared bedroom that provides at least 40 square feet of floor space, not including a closet, for each individual occupying the shared bedroom. If there is a modification to the shared bedroom, the behavioral health residential facility shall comply with the requirement in subsection (B)(8)(g).
- D. If a swimming pool is located on the premises, an administrator shall ensure that:
- 1. The swimming pool is equipped with the following:
 - a. An operational water circulation system that clarifies and disinfects the swimming pool water continuously and that includes at least:
 - i. A removable strainer,
 - ii. Two swimming pool inlets located on opposite sides of the swimming pool, and
 - iii. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed without using tools; and
 - b. An operational vacuum cleaning system;
 - 2. The swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (D)(2)(e);
 - d. Is not chain-link;
 - e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and
 - f. Has a self-closing, self-latching gate that:
 - i. Opens away from the swimming pool,
 - ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use; and
 - 3. A life preserver or shepherd's crook is available and accessible in the pool area.

E. An administrator shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (D)(2) is covered and locked when not in use.

Statutory Authority for 9 A.A.C. 10, Article 7

36-132. Department of health services; functions; contracts

A. The department, in addition to other powers and duties vested in it by law, shall:

1. Protect the health of the people of the state.
2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.
3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of this state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with chapter 3 of this title and sections 36-693, 36-694 and 39-122.
4. Operate such sanitariums, hospitals or other facilities assigned to the department by law or by the governor.
5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information for the promotion of good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of education of children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.
6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.
7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.
8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of schoolchildren, including special fields such as the prevention of blindness and conservation of sight and hearing.
9. Encourage and aid in the coordination of local programs concerning nutrition of the people of this state.

10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.
11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.
12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection I, paragraph 10.
13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.
14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in the enforcement of the federal food, drug, and cosmetic act (52 Stat. 1040; 21 United States Code sections 1 through 905).
15. Recruit and train personnel for state, local and district health departments.
16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.
17. License and regulate health care institutions according to chapter 4 of this title.
18. Issue or direct the issuance of licenses and permits required by law.
19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.
20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:
 - (a) Screening in early pregnancy for detecting high-risk conditions.
 - (b) Comprehensive prenatal health care.
 - (c) Maternity, delivery and postpartum care.

(d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.

(e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.

21. License and regulate the health and safety of group homes for persons with developmental disabilities. The department shall issue a license to an accredited facility for a period of the accreditation, except that no licensing period shall be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.

B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.

C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end-stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. Powers and duties of director; compensation of personnel; rules; definition

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.

2. Perform all duties necessary to carry out the functions and responsibilities of the department.

3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.
4. Administer and enforce the laws relating to health and sanitation and the rules of the department.
5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.
6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.
7. Prepare sanitary and public health rules.
8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

(a) Served at a noncommercial social event such as a potluck.

(b) Prepared at a cooking school that is conducted in an owner-occupied home.

(c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.

(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fund-raising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) Baked and confectionary goods that are not potentially hazardous and that are prepared in a kitchen of a private home for commercial purposes if packaged with a label that clearly states the address of the maker, includes contact information for the maker, lists all the ingredients in the product and discloses that the product was prepared in a home. The label must be given to the final consumer of the product. If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must obtain a food handler's card or certificate if one is issued by the local county and must register with an online registry established by the department pursuant to paragraph 13 of this subsection. For the purposes of this subdivision, "potentially hazardous" means baked and confectionary goods that meet the requirements of

the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for the preservation or storage of food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

36-405. Powers and duties of the director

A. The director shall adopt rules to establish minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to ensure the public health, safety and welfare. The standards and requirements shall relate to the construction, equipment, sanitation, staffing for medical, nursing and personal care services, and recordkeeping pertaining to the administration of medical, nursing, behavioral health and personal care services, in accordance with generally accepted practices of health care. The director shall use the current standards adopted by the joint commission on accreditation of hospitals and the commission on accreditation of the American osteopathic association or those adopted by any recognized accreditation organization approved by the department as guidelines in prescribing minimum standards and requirements under this section.

B. The director, by rule, may:

1. Classify and subclassify health care institutions according to character, size, range of services provided, medical or dental specialty offered, duration of care and standard of patient care required for the purposes of licensure. Classes of health care institutions may include hospitals, infirmaries, outpatient treatment centers, health screening services centers and residential care facilities. Whenever the director reasonably deems distinctions in rules and standards to be appropriate among different classes or subclasses of health care institutions, the director may make such distinctions.
 2. Prescribe standards for determining a health care institution's substantial compliance with licensure requirements.
 3. Prescribe the criteria for the licensure inspection process.
 4. Prescribe standards for the selection of health care-related demonstration projects.
 5. Establish nonrefundable application and licensing fees for health care institutions, including a grace period and a fee for the late payment of licensing fees, and fees for architectural plans and specifications reviews.
 6. Establish a process for the department to notify a licensee of the licensee's licensing fee due date.
 7. Establish a process for a licensee to request a different licensing fee due date, including any limits on the number of requests by the licensee.
- C. The director, by rule, shall adopt licensing provisions that facilitate the colocation and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services consistent with article 3.1 of this chapter.
- D. Ninety percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the health services licensing fund established by section 36-414 and ten percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.
- E. Subsection B, paragraph 5 of this section does not apply to a health care institution operated by a state agency pursuant to state or federal law or to adult foster care residential settings.

36-406. Powers and duties of the department

In addition to its other powers and duties:

1. The department shall:
 - (a) Administer and enforce this chapter and the rules, regulations and standards adopted pursuant thereto.
 - (b) Review, and may approve, plans and specifications for construction or modification or additions to health care institutions regulated by this chapter.

- (c) Have access to books, records, accounts and any other information of any health care institution reasonably necessary for the purposes of this chapter.
- (d) Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe the manner by which the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of that vaccination in this state as determined by the director.
2. The department may:
- (a) Make or cause to be made inspections consistent with standard medical practice of every part of the premises of health care institutions which are subject to the provisions of this chapter as well as those which apply for or hold a license required by this chapter.
- (b) Make studies and investigations of conditions and problems in health care institutions, or any class or subclass thereof, as they relate to compliance with this chapter and rules, regulations and standards adopted pursuant thereto.
- (c) Develop manuals and guides relating to any of the several aspects of physical facilities and operations of health care institutions or any class or subclass thereof for distribution to the governing authorities of health care institutions and to the general public.
- 36-407. Prohibited acts**
- A. A person shall not establish, conduct or maintain in this state a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the department specifying the class or subclass of health care institution the person is establishing, conducting or maintaining. The license is valid only for the establishment, operation and maintenance of the class or subclass of health care institution, the type of services and, except for emergency admissions as prescribed by the director by rule, the licensed capacity specified by the license.
- B. The licensee shall not imply by advertising, directory listing or otherwise that the licensee is authorized to perform services more specialized or of a higher degree of care than is authorized by this chapter and the underlying rules for the particular class or subclass of health care institution within which the licensee is licensed.
- C. The licensee may not transfer or assign the license. A license is valid only for the premises occupied by the institution at the time of its issuance.
- D. The licensee shall not personally or through an agent offer or imply an offer of rebate or fee splitting to any person regulated by title 32 or chapter 17 of this title.

E. The licensee shall submit an itemized statement of charges to each patient.

36-411. Residential care institutions; nursing care institutions; home health agencies; fingerprinting requirements; exemptions; definitions

A. Except as provided in subsections F, G, H and I of this section, as a condition of licensure or continued licensure of a residential care institution, a nursing care institution or a home health agency and as a condition of employment in a residential care institution, a nursing care institution or a home health agency, employees and owners of residential care institutions, nursing care institutions or home health agencies or contracted persons or volunteers who provide medical services, nursing services, behavioral health services, health-related services, home health services or supportive services and who have not been subject to the fingerprinting requirements of a health professional's regulatory board pursuant to title 32 shall have valid fingerprint clearance cards that are issued pursuant to title 41, chapter 12, article 3.1 or shall apply for a fingerprint clearance card within twenty working days of employment or beginning volunteer work.

B. A health professional who has complied with the fingerprinting requirements of the health professional's regulatory board as a condition of licensure or certification pursuant to title 32 is not required to submit an additional set of fingerprints to the department of public safety pursuant to this section.

C. Owners shall make documented, good faith efforts to:

1. Contact previous employers to obtain information or recommendations that may be relevant to a person's fitness to work in a residential care institution, nursing care institution or home health agency.
2. Verify the current status of a person's fingerprint clearance card.

D. An employee, an owner, a contracted person or a volunteer or a facility on behalf of the employee, the owner, the contracted person or the volunteer shall submit a completed application that is provided by the department of public safety within twenty days after the date the person begins work or volunteer service.

E. Except as provided in subsection F of this section, a residential care institution, nursing care institution or home health agency shall not allow an employee to continue employment or a contracted person to continue to provide medical services, nursing services, behavioral health services, health-related services, home health services or supportive services if the person has been denied a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1 or has been denied approval pursuant to this section before May 7, 2001.

F. An employee or contractor who is eligible pursuant to section 41-1758.07, subsection C to petition the board of fingerprinting for a good cause exception and who provides documentation of having applied for a good cause exception pursuant to section 41-619.55 but who has not yet received a decision is exempt from the fingerprinting requirements of this section if the person provides services to residents or patients while under the direct visual supervision of an owner or employee who has a valid fingerprint clearance card.

G. A residential care institution, nursing care institution or home health agency shall require that an owner or employee who has a valid fingerprint clearance card provide direct visual supervision of a volunteer who provides services to residents or patients unless the volunteer has a valid fingerprint clearance card.

H. Notwithstanding the requirements of section 41-1758.02, subsection B, an employee of a residential care institution, home health agency or nursing care institution, after meeting the fingerprinting and criminal records check requirements of this section, is not required to meet the fingerprint and criminal records check requirements of this section again if that person remains employed by the same employer or changes employment within two years after satisfying the requirements of this section. For the purposes of this subsection, if the employer changes through sale, lease or operation of law, a person is deemed to be employed by the same employer if that person remains employed by the new employer.

I. Notwithstanding the requirements of section 41-1758.02, subsection B, a person who has received approval pursuant to this section before May 7, 2001 and who remains employed by the same employer is not required to apply for a fingerprint clearance card.

J. If a person's employment record contains a six-month or longer time frame during which the person was not employed by any employer, a completed application with a new set of fingerprints shall be submitted to the department of public safety.

K. For the purposes of this section:

1. "Direct visual supervision" means continuous visual oversight of the supervised person that does not require the supervisor to be in a superior organizational role to the person being supervised.
2. "Home health services" has the same meaning prescribed in section 36-151.
3. "Supportive services" has the same meaning prescribed in section 36-151.

36-411.01. Adult residential care institutions; recidivism reduction services; rules

A. An adult residential care institution subclass that is authorized to provide recidivism reduction services may employ recidivism reduction staff who are exempt from the requirements of section 36-411, subsection E to assist in the delivery of recidivism reduction services.

B. An applicant for employment is exempt from the requirements of section 36-411, subsection E if the applicant does both of the following:

1. Successfully completes treatment for recidivism reduction as prescribed by rule.
2. Passes a background and screening evaluation conducted by the adult residential care institution as prescribed by rule that demonstrates that the individual is not a threat to the health or safety of staff or residents of the adult residential care institution.

C. As prescribed by rule, only adult residents of an adult residential care institution who have been referred to receive recidivism reduction services may receive services from recidivism reduction staff.

D. An adult resident of an adult residential care institution may be referred for recidivism reduction services if the adult resident is one or more of the following:

1. Charged with or convicted of one or more criminal offenses.

2. Referred by a court, prosecutor or probation officer.

3. Approved for placement at the adult residential care institution by a health care professional who is licensed pursuant to title 32 and whose scope of practice includes recidivism reduction services.

36-422. Application for license; notification of proposed change in status; joint licenses; definitions

A. A person who wishes to apply for a license to operate a health care institution pursuant to this chapter shall submit to the department all of the following:

1. An application on a written or electronic form that is prescribed, prepared and furnished by the department that contains all of the following:

(a) The name and location of the health care institution.

(b) Whether the health care institution is to be operated as a proprietary or nonproprietary institution.

(c) The name of the governing authority. The applicant shall be the governing authority having the operative ownership of, or the governmental agency charged with the administration of, the health care institution sought to be licensed. If the applicant is a partnership that is not a limited partnership, the partners shall apply jointly, and the partners are jointly the governing authority for purposes of this article.

(d) The name and business or residential address of each controlling person and an affirmation that none of the controlling persons has been denied a license or certificate by a health profession regulatory board pursuant to title 32 or by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution in this state or another state or has had a license or certificate issued by a health profession regulatory board pursuant to title 32 or issued by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution revoked. If a controlling person has been denied a license or certificate by a health profession regulatory board pursuant to title 32 or by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution in this state or another state or has had a health care professional license or a license to operate a health care institution revoked, the controlling person shall include in the application a comprehensive description of the circumstances for the denial or the revocation.

(e) The class or subclass of health care institution to be established or operated.

- (f) The types and extent of the health care services to be provided, including emergency services, community health services and services to indigent patients.
 - (g) The name and qualifications of the chief administrative officer implementing direction in that specific health care institution.
 - (h) Other pertinent information required by the department for the proper administration of this chapter and department rules.
2. The architectural plans and specifications or the department's approval of the architectural plans and specifications required by section 36-421, subsection A.
 3. The applicable application fee.
- B. An application submitted pursuant to this section shall contain the written or electronic signature of:
1. If the applicant is an individual, the owner of the health care institution.
 2. If the applicant is a partnership, limited liability company or corporation, two of the officers of the corporation or managing members of the partnership or limited liability company or the sole member of the limited liability company if it has only one member.
 3. If the applicant is a governmental unit, the head of the governmental unit.
- C. An application for licensure shall be submitted at least sixty but not more than one hundred twenty days before the anticipated date of operation. An application for a substantial compliance survey submitted pursuant to section 36-425, subsection G shall be submitted at least thirty days before the date on which the substantial compliance survey is requested.
- D. If a current licensee intends to terminate the operation of a licensed health care institution or if a change of ownership is planned, the current licensee shall notify the director in writing at least thirty days before the termination of operation or change in ownership is to take place. The current licensee is responsible for preventing any interruption of services required to sustain the life, health and safety of the patients or residents. A new owner shall not begin operating the health care institution until the director issues a license to the new owner.
- E. A licensed health care institution for which operations have not been terminated for more than thirty days may be relicensed pursuant to the codes and standards for architectural plans and specifications that were applicable under its most recent license.
- F. If a person operates a hospital in a county with a population of more than five hundred thousand persons in a setting that includes satellite facilities of the hospital that are located separately from the main hospital building, the department at the request of the applicant or licensee shall issue a single group license to the hospital and its designated satellite facilities located within one-half mile of the main hospital building if all of the facilities meet or exceed department licensure requirements for the designated facilities. At the request of the applicant or licensee, the department shall also issue a single

group license that includes the hospital and not more than ten of its designated satellite facilities that are located farther than one-half mile from the main hospital building if all of these facilities meet or exceed applicable department licensure requirements. Each facility included under a single group license is subject to the department's licensure requirements that are applicable to that category of facility. Subject to compliance with applicable licensure or accreditation requirements, the department shall reissue individual licenses for the facility of a hospital located in separate buildings from the main hospital building when requested by the hospital. This subsection does not apply to nursing care institutions and residential care institutions. The department is not limited in conducting inspections of an accredited health care institution to ensure that the institution meets department licensure requirements. If a person operates a hospital in a county with a population of five hundred thousand persons or less in a setting that includes satellite facilities of the hospital that are located separately from the main hospital building, the department at the request of the applicant or licensee shall issue a single group license to the hospital and its designated satellite facilities located within thirty-five miles of the main hospital building if all of the facilities meet or exceed department licensure requirements for the designated facilities. At the request of the applicant or licensee, the department shall also issue a single group license that includes the hospital and not more than ten of its designated satellite facilities that are located farther than thirty-five miles from the main hospital building if all of these facilities meet or exceed applicable department licensure requirements.

G. If a county with a population of more than one million persons or a special health care district in a county with a population of more than one million persons operates an accredited hospital that includes the hospital's accredited facilities that are located separately from the main hospital building and the accrediting body's standards as applied to all facilities meet or exceed the department's licensure requirements, the department shall issue a single license to the hospital and its facilities if requested to do so by the hospital. If a hospital complies with applicable licensure or accreditation requirements, the department shall reissue individual licenses for each hospital facility that is located in a separate building from the main hospital building if requested to do so by the hospital. This subsection does not limit the department's duty to inspect a health care institution to determine its compliance with department licensure standards. This subsection does not apply to nursing care institutions and residential care institutions.

H. An applicant or licensee must notify the department within thirty days after any change regarding a controlling person and provide the information and affirmation required pursuant to subsection A, paragraph 1, subdivision (d) of this section.

I. This section does not limit the application of federal laws and regulations to an applicant or licensee that is certified as a medicare or an Arizona health care cost containment system provider under federal law.

J. Except for an outpatient treatment center providing dialysis services or abortion procedures, a person wishing to begin operating an outpatient treatment center before a licensing inspection is completed shall submit all of the following:

1. The license application required pursuant to this section.
2. All applicable application and license fees.

3. A written request for a temporary license that includes:

(a) The anticipated date of operation.

(b) An attestation signed by the applicant that the applicant and the facility comply with and will continue to comply with the applicable licensing statutes and rules.

K. Within seven days after the department's receipt of the items required in subsection J of this section, but not before the anticipated operation date submitted pursuant to subsection C of this section, the department shall issue a temporary license that includes:

1. The name of the facility.

2. The name of the licensee.

3. The facility's class or subclass.

4. The temporary license's effective date.

5. The location of the licensed premises.

L. A facility may begin operating on the effective date of the temporary license.

M. The director may cease the issuance of temporary licenses at any time if the director believes that public health and safety is endangered.

N. For the purposes of this section:

1. "Accredited" means accredited by a nationally recognized accreditation organization.

2. "Satellite facility" means an outpatient facility at which the hospital provides outpatient medical services.

36-425.03. Children's behavioral health programs; personnel; fingerprinting requirements; exemptions; definitions

A. Except as provided in subsections B, C and D of this section, children's behavioral health program personnel, including volunteers, shall submit the form prescribed in subsection E of this section to the employer and shall have a valid fingerprint clearance card issued pursuant to title 41, chapter 12, article 3.1 or, within seven working days after employment or beginning volunteer work, shall apply for a fingerprint clearance card.

B. The following persons are exempt from the fingerprinting requirements of this section:

1. When under the direct visual supervision and in the presence of children's behavioral health program personnel who have a valid fingerprint clearance card:

(a) Except as provided in subsection C of this section, parents, foster parents, kinship foster care parents and guardians who participate in group activities that include their children who are receiving behavioral health services from a children's behavioral health program if they are not employees of the children's behavioral health program.

(b) A volunteer who provides services to children receiving behavioral health services.

(c) An employee or contractor who is eligible pursuant to section 41-1758.07, subsection C to petition the board of fingerprinting for a good cause exception and who provides documentation of having applied for a good cause exception pursuant to section 41-619.55 but who has not yet received a decision.

(d) A person who is not providing medical services, nursing services, behavioral health services, health-related services, home health services or supportive services and who is either not an employee or contractor or not on the premises on a regular basis.

2. Hospital medical staff members, employees, contractors and volunteers who are not present in an area of the hospital authorized by the department for providing children's behavioral health services.

C. A parent, foster parent, kinship foster care parent or guardian of a child who is receiving behavioral health services from a children's behavioral health program is not required to be fingerprinted or supervised for purposes of this section if the person is in the presence of or participating with only the person's own child.

D. Applicants and employees who are fingerprinted pursuant to section 15-512 or 15-534 are exempt from the fingerprinting requirements of subsection A of this section.

E. Children's behavioral health program personnel shall certify on forms that are provided by the department and notarized that they are not awaiting trial on or have never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction.

F. Forms submitted pursuant to subsection E of this section are confidential.

G. Employers of children's behavioral health program personnel shall make documented, good faith efforts to contact previous employers of children's behavioral health program personnel to obtain information or recommendations that may be relevant to an individual's fitness for employment in a children's behavioral health program.

H. A person who is awaiting trial on or who has been convicted of or who has admitted in open court or pursuant to a plea agreement to committing a criminal offense listed in section 41-1758.03, subsection B is prohibited from working in any capacity in a children's behavioral health program that requires or allows contact with children.

I. A person who is awaiting trial on or who has been convicted of or who has admitted in open court or pursuant to a plea agreement to committing a criminal offense listed in section 41-1758.03, subsection C shall not work in a children's behavioral health program in any capacity that requires or allows the employee to provide direct services to children unless the person has applied for and received the required fingerprint clearance card pursuant to title 41, chapter 12, article 3.1.

J. The department of health services shall accept a certification submitted by a United States military base or a federally recognized Indian tribe that either:

1. Personnel who are employed or who will be employed and who provide services directly to children have not been convicted of, have not admitted committing or are not awaiting trial on any offense prescribed in subsection H of this section.
2. Personnel who are employed or who will be employed to provide services directly to children have been convicted of, have admitted committing or are awaiting trial on any offense prescribed in subsection I of this section if the personnel provide these services while under direct visual supervision.

K. The employer shall notify the department of public safety if the employer receives credible evidence that a person who possesses a valid fingerprint clearance card either:

1. Is arrested for or charged with an offense listed in section 41-1758.03, subsection B.
2. Falsified information on the form required by subsection E of this section.

L. For the purposes of this section:

1. "Children's behavioral health program" means a program provided in a health care institution that is licensed by the department to provide children's behavioral health services.
2. "Children's behavioral health program personnel" means an owner, employee or volunteer who works at a children's behavioral health program.
3. "Direct visual supervision" means continuous visual oversight of the supervised person that does not require the supervisor to be in a superior organizational role to the person being supervised.

36-434. Outdoor behavioral health care programs; licensing requirements; inspections

A. An outdoor behavioral health care program shall:

1. Comply with the requirements for a level 2 behavioral health residential agency, as established by the department by rule except as provided in subsection C of this section.
2. Obtain and maintain national accreditation as an outdoor behavioral health care program.

3. Ensure that the outdoor behavioral health program's personnel comply with the requirements of section 36-425.03.

B. In addition to the standards adopted pursuant to section 36-405, subsection A, the department may adopt rules to establish facility, equipment and sanitation standards for outdoor behavioral health care programs.

C. An outdoor behavioral health care program that does not use facilities is exempt from any facility standards applicable to a behavioral health service agency.

D. If the director determines that there is reasonable cause to believe an outdoor behavioral health care program is not adhering to the licensing requirements of this chapter, the director and any duly designated employee or agent of the director, including county health representatives and county or municipal fire inspectors, may enter on and into any area used by the outdoor behavioral health care program at any reasonable time to determine, consistent with standard medical practices or behavioral health practices, compliance with this chapter, rules adopted pursuant to this chapter and local fire ordinances or rules.

E. An application for licensure under this chapter constitutes permission for and complete acquiescence in any entry or inspection of any area used by the outdoor behavioral health care program during the pendency of the application and, if licensed, during the term of the license.

F. If an inspection reveals that the outdoor behavioral health care program is not adhering to the licensing requirements prescribed pursuant to this chapter, the director may take action authorized by this chapter.

G. An outdoor behavioral health care program whose license has been suspended or revoked pursuant to this section is subject to inspection on application for re licensure or reinstatement of license.