

Title 9 Health Services
Chapter 10 Health Care Institutions: Licensing
Article 7 Behavioral Health Outpatient Clinics

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

R9-10-1003 B 7 a Administrators of large programs do not have a current *requirement to be on each premise*. According to the definitions a Chief Administrator is appointed by the Governing Authority. If you appoint a Site Manager, they are not appointed by the Governing Authority.

R9-10-1003 C 3 *Designate in writing an individual who is on premises when the administrator is not present*. Present on the OPC premises or at the administrative office? How often do they have to be present? These questions are only designed to find out whose name needs to go on the license application.

R9-10-1003 E Per ADHS/BHS Policy there are exceptions for repeated frivolous complaints that have been fully investigated in the past. Continually reporting these to the Police, CPS or APS has angered some of these agencies. We recommend adding a phrase that allows an exemption under these circumstances. We are not advocating for ignoring these repeated complaints but rather for a rational approach to this issue. Filing an incident report and an internal review should be sufficient to ensure safety.

R9-10-1005 Contracted Services *List & description of contracted services provided*. Per definitions, “contracted services” would include MOU services. Does contracted services include transportation & interpretation? Currently in some areas of the state the RBHAs and not the provider holds contracts for these services.

R9-10-1006 Transport: Transfer

The definition of Transport (10-101) states: “*sending an individual to another licensed facility for outpatient services*”. When you combine the terms Transport and Transfer as it is in this section it becomes confusing since there is no specific rule for OPC that describes the requirements for Transport alone at an OPC. OPC’s provide transport to individuals to a number of settings. Does this only apply to licensed facilities and licensed services (e.g. behavioral health counseling, medical)? What about vocational services, peer services via a CSA, grocery shopping or social/rec outings? Is transport to these sites/events considered “transport” and subject to these standards (medical record, informed consent on risks/benefits)? It was our understanding at the open meetings that transport to appointments and other service locations would not have to meet these requirements. Transport: Transfer on the other hand means that the person does not return to the original facility and the rule requirements apply. Is this a correct interpretation?

R9-10-1006 A.1.a. – *Establish and implement policies that specify the process by which personnel members coordinate the transport and the services provided to protect patient health*

& safety If the transportation agency (e.g. Taxis, Dial a Ride, etc.) is not contracted by the OPC, how do we ensure the agency conforms w/ health and safety standards?

R9-10-1006 A.1.f. – *Specify how a staff member explains risks & benefits based on mode of transport* How is this accomplished by taxi or RBHA contracted transportation agencies?

R9-10-1006 B.1.c – “at the time of transport” Should be “transfer”

R9-10-1007 2 b *A personnel members skills and knowledge are verified at least once every 12 months.* What specific skills need to be verified and by whom? All professionals require CEU or CME's to maintain their licenses and we believe that this should be sufficient for BHP's and BHMP's. For other personnel, we are not sure what skills and knowledge are included. We recommend using the employee performance evaluation process as the verification of knowledge and skills.

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

R9-10-1009 Medical Records C.8. – “Medical record contains an interval note” An “Interval note” is defined in 10-101 as documentation updating a person's medical condition or behavioral health issue following an assessment. This suggests the single assessment document may not be all-inclusive of person's current status. We do not believe an Interval note is necessary when a full document is also present. We also believe that a “progress note”, a term used in behavioral health, is essentially the same as an “interval note” unless you have created a distinction.

R9-10-1010 Medication Services

A.1.b – *Procedures for preventing, responding to and reporting a medication error.*

A.2.a – *Specify a process for QM review of a “medication administration error” (this is defined in 101 as “provision or application of a medication by a medical practitioner or nurse”)*

There is no definition of “*medication error*”. Is this to be defined by the licensed agency in its policies? Under definitions it appears to relate only to errors in provision or application by a BHMP or nurse.

C.1. *If the OPC provides assistance with self administration (ASA), the administrator shall ensure patient's medication is stored by the OPC.*

The definitions states ASA means restricting a person's access to the medication and providing support while the person takes the medication. This suggests ASA only occurs for medication the OPC controls (e.g. brings to the person at their home, etc.) and not to services that provide only medication observation/prompting/support where the person controls their medication. Is this true?

R9-10-1011 A 3 b This provision is not relevant as there are very few, if any, Nurses, Physician Assistants and Behavioral Health Professionals who are *between the ages of 18-21*. The request from the Providers was to allow peer support staff who are 18 and above to work with young adults. This age group is particularly influenced by their peer group and we have found it very beneficial to have peers who have recovered work with this population in our Community Service Agencies (CSA) where the minimal age for an employee is set at 18.

R9-10-1011 A 5 There are numerous services that paraprofessionals and behavior health technicians can perform that are not "*under the practice*" of behavior health professionals. In fact, the majority of paraprofessional and technicians time is spent delivery services such as peer support, skill development, personal assistance, case management, etc which do require professional oversight. Our assumption is that in these cases "*clinical oversight*" by a behavior health professional is not required unless the services falls under the professional skill set of services. Stated another way, "*clinical oversight*" would be required if the paraprofessional or technician performs assessment, service planning or counseling but not for the time they spend performing other services.

R9-10-1011 A If a behavioral health technician provides counseling to a client can any independently licensed behavioral health professional with demonstrated knowledge, skills and competencies in counseling provide clinical oversight or would the counseling oversight be restricted to independently licensed professional counselors?

R9-10-1011 B 8 We agree that the person needs to be involved in their assessment and if they are not, then there is a problem; however, requiring documentation of the "*request for participation*" in the person's assessment is unnecessary as the assessments indicate who was involved.

R9-10-1011 5 b-vi According to this rule, supervision will have to provided once per week instead the previous requirement of 1 hour for every 40 hours the person worked. This provision is not practical as individuals schedules vary based on days off, illness, holidays, training, etc. The prior requirement is much more manageable and achieves the same goal.

R9-10-1011 B -16 According to this rule Respite under the auspices of an Outpatient Clinic is limited to the "patient's residence" or up to "8 hours in the community". Longer term respite in the community cannot be provided for longer than 8 continuous hours under an OPC license unless it is in the person's home? Is this correct?

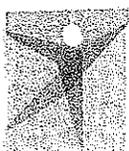
R9-10 1014 Clinical Lab Services *Administrator ensure if lab services are provided by contracted services at another location, the lab holds a certificate, etc* The current practice is that the RBHA holds the lab contract. The OPC would not be in a position to "verify" certification.

R9 10 1015 Crisis Services *Comply with requirements in 1013 (court ordered treatment* Should be more specific about what parts of 1013 apply to agencies delivering unscheduled crisis services.

R9-10-1018 A 5 Psychiatric Nurse Practitioners (PNP) are independently licensed and do not require physician supervision. We are wondering why a physician would have to be on call if a PNP is on duty.

R9-10-1018 A 10 While it is certainly important that each person has a place to sit in a Observation/Stabilization program, the use of the term "*observation chair*" has an archaic and non-recovery oriented connotation. We are suggesting a more recovery oriented term such as Relaxation Chair.

R9-10-1018 A 21-22 There should be no artificial time limit on when a person can be readmitted as long as it is clinically necessary as stated in 22 c. The proposed rule may place police officers in potential conflict with treating personnel.



THE
Crossroads
PUTTING LIVES TOGETHER. ONE PERSON AT A TIME

RECEIVED
13 MAY 10 PM 1:59
ADHS
DIRECTORS OFFICE

May 9, 2013

Mr. Will Humble
AZ Department of Health Services
150 N. 18th Street
Phoenix, AZ 85007

Dear Mr. Humble,

I want to once again thank you for considering our issues with the new proposed rules, which will eliminate Transitional Level IV housing as a licensed category. Please bear with me while I briefly list our most significant concerns with what has been proposed:

1. Spatial Requirement-A high percentage of our facility rooms are unable to comply and would cost us tens, possibly hundreds of thousands of dollars to comply.
2. Assessment Notes-This would require us to hire a medical professional full time, greatly affecting our costs.
3. Treatment Plans-This also would require us to hire a medical professional
4. Discharge Notes-more of the same
5. File Notes-more requirements for medical personnel.
6. Food Dietician-our kitchens are already inspected by the county, and the VA, and we comply with dietary requirements.

Again, Crossroads has operated safely, following rules, and helping anyone in need of substance abuse recovery. We continue to hope for your help in allowing us to operate with the same requirements and high standards we have for decades.

Sincerely,

Lee Pioske, MS LISAC
Executive Director, Crossroads

cc: Heather Carter
Kate Brophy McGee
Steve Pierce

CHAPTER 10 – ARTICLE 7

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 68 99 84 80**Response Started:** Sunday, May 5, 2013 6:33:52 PM**Response Modified:** Sunday, May 5, 2013 8:05:55 PM**1. What parts of the draft rules do you believe are effective?**

Please note that the Office of Human Rights (OHR) is the unit of Arizona Department of Health Services/Division of Behavioral Health Services that provides advocacy to individuals with a Serious Mental Illness (SMI) in Arizona's public behavioral health system. To further our mission – providing advocacy to individuals with a SMI to help them understand, protect and exercise their rights, facilitate self-advocacy through education and obtain access to behavioral health services in the public behavioral system in Arizona – OHR reviews and submits comments on proposed changes to rules, regulations, policies, etc. that affect individuals with a SMI. We are pleased to see the merging of LII and LIII residential and the recognition built in that some individuals will need long-term assistance from such facilities for purposes of maintaining or enhancing ability to function independently. Ideally, this will limit the "need" to move individuals from LII type settings to LIII type settings as the new residential will focus the level of services needed on the person's individual needs, addressing them specifically in the treatment plan. R9-10-706 I contains important language about staffing levels. R9-10-707 9 a v emphasizes the need to address whether a person is under a guardianship during the assessment and that is absolutely crucial to ensure informed and general consent during the person's admission and stay.

2. How can the draft rules be improved?

In general, the use of the word "patient" is not preferred to "client" or even "person" or "individual." R9-10-701 contains a definition for "emergency safety response." We strongly support eliminating this or at least limiting it to children's facilities. The reason for this is the federal regulations classify anything that involves physically "holding" an adult as a restraint and it is difficult to imagine any behavioral health residential facilities that will be exempt from federal rules applying as all receive federal funding/reimbursement of some sort through Medicaid. Another approach is to qualify the use of ESRs with language like "only if consistent with existing laws" so as to clearly indicate that the facility must comply with not only these regulations but any other state or federal law that applies. R9-10-702 3 a & b notes "or" between the types of services – does this mean a facility cannot do both? In R9-10-703 C 2 n, we suggest adding a requirement that the resident be informed prior to a fee being charged. In the same subsection under r, we strongly support the inclusion of the word "imminent" to the phrase "prevent harm" so as to focus on truly emergent situations. R9-10-703 K contains guidelines for when a facility handles the resident's money. We are quite concerned about this and believe further safeguards should be put into place, such as offering the resident other options – including if the resident is required to have a payee, local options for payees other than the facility, offering budgeting support and information so that the person is able to handle their own funds, etc. Additionally, this section should require a regular accounting (every quarter?) to the resident as well as the resident being able to receive an accounting upon request. R9-10-708 A discusses treatment plan requirements but leave the important requirements about inviting and participation of the person and any representative in treatment planning until subsection B. We strongly support moving these important requirements into A to place the appropriate emphasis on the importance. R9-10-709.C notes when a resident must be discharged from a residential yet it is unclear about who determines "when the treatment needs are not consistent with the services" and makes no reference to ensuring participation of the resident/any representative when this comes into question or notice/appeal rights. Subsection F addresses discharge to anything other than an HCI, but then there is no mention of what type of coordination must happen when discharged to an HCI – wouldn't the individual still need a copy of the discharge instructions, as well as the receiving HCI? In Resident Outings subsection A 3.e.ii we suggest adding "imminent" before "threat" to ensure focus on serious situations. Resident Time Out R9-10-712 - this section is troubling in the adult residential setting as it borders on being seclusion, particularly under the SMI definition of seclusion. In order to safeguard against misuse and/or misunderstanding, subsection 5 should be reworded to replace "discuss with" to "encourage" the resident to consider when ready to leave time out and that it is ultimately the resident's decision, not the staff's! This also seems to be missing a requirement for 15 minute checks and documenting details, also, to ensure safety of the resident and a clear understanding that the time out is voluntary and ends when the resident chooses. Rights R9-10-713 covers individual rights but it fails to under A 2 make a reference to sharing SMI rights and specifically R9-21-101, et seq with individuals who are identified as SMI. This section also omits a significant number of rights that is contained in the current licensure rules – which

should not be omitted. We are shocked to see that subsection B 1.a permits the "intentional infliction of physical, mental or emotional pain" that is related to the "patient's condition." How can this be? We strongly support removal of the qualifier about relation to the individual's condition. We also strongly suggest that a section noting the word "abuse" is also inserted – as that would cover instances of negligence that would not fall under "intentional." In the same subsection under f & g, we note concern that the term "sexual abuse" is used and then two references to Arizona criminal law are made – is this sufficient to cover such, as not all acts may fall under a criminal definition yet still should be prohibited. Additionally, subsection 2.a is missing a reference to receiving telephone calls. Subsection C (& D) addresses when a person's activity (rights in B 2) can be limited under certain circumstances. This could be clarified and more individual rights-focused by adding a subsection 3 that notes that individual must be informed about what needs to occur to have the restriction lifted, a subsection 4 that specifies that a timeframe for review of the restriction must be set and changing the existing #3 to #5. Resident Records Subsection C of R9-10-714 should note a requirement that when a resident has a representative, proof of the legal authority of the representative must also be stored in the records. This makes it clear who holds the power to give consent and also supports appropriate communication with the representative. Behavioral Health Services R9-10-716 covers behavioral health services and it contains a reference in subsection A.1 to "continuous protective oversight." It is unclear what this entails and raises some concerns about the resident's ability to come and go from an outpatient residential setting. We suggest that more guidelines be included to explain this and to protect individual rights. Subsection D.2.a notes that the facility must ensure another individual at the facility does not subject others receiving treatment to "threats, ridicule, verbal harassment, punishment or abuse." It seems more practical language would emphasize that others receiving treatment should be free from and the facility should protect them from such negative interactions from other patients. What is a possible result of leaving the draft language as is – perhaps that the individuals with the most difficult behaviors and issues will be discharged suddenly (or perhaps worse, subjected to inappropriate law enforcement involvement) because the facility cannot always meet this standard? It seems there must be a balance between the facility's obligation to treat individuals (no matter how acute or how difficult the behavior) in an inpatient setting while also keeping others safe in that setting. Subsection E contains a discussion of emergency safety response. As noted above, we strongly support eliminating this option for adult facilities. At a minimum, if this remains in the final rules, a reference to ensuring use of ESRs is in compliance with existing laws will make it a bit clearer that such interventions are likely viewed as restraints and not allowed under federal law – which applies when facilities receive/encounter for federal funds. Subsection F references "safe use" of an ESR – which is conclusory and inaccurate language that does not belong in the rules. It is arguably not possible to safely administer ESRs because they involve physical contact in volatile situations. We strongly support the removal of the word "safe." Physical Plant Standards Subsection R9-10-722 B 8 g ii notes that eight individuals can share the same bedroom! This seems incredibly high, despite the square footage per resident. In fact, most adult behavioral health residential settings often contain at most eight residents total. We strongly support reconsidering this and lowering the maximum occupancy per room.

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

The rules are missing a reference to the SMI regulations – R9-21-101 et seq. The current rules contain such a reference which is essential to ensure facilities are reminded of and abide by the additional requirements in the SMI rules. Under subsection R9-10-703 H adding a reference to the SMI rules in subsection 1 would be appropriate; in subsection 4, a reference to "receive" phone calls is missing. Section R9-10-718 covers medication services but no reference is made to the facility coordinating medication/knowledge of current medication prescribed with any outpatient service provider already in place and/or primary care provider or other provider who has prescribed medication to the individual. This addition would be beneficial to individuals to ensure stronger coordination of prescribed medications.

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 24 251 153 14**Response Started:** Sunday, May 5, 2013 2:38:33 PM**Response Modified:** Sunday, May 5, 2013 2:39:18 PM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

Under Food Services Section - a The applicable meal planning guides in http://www.fns.usda.gov/cnd/Care/ProgramBasics/Meals/Meal_Pattern.htm; and ADD to this - A registered dietitian: a Reviews a food menu before the food menu is used to ensure that a resident's nutritional needs are being met, b. Documents the review of a food menu, and Thank you

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

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 206.80.197.45

Response Started: Tuesday, April 30, 2013 1:43:30 PM

Response Modified: Tuesday, April 30, 2013 1:45:46 PM

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

2. How can the draft rules be improved?

Area of concern with OBHL Licensure Regulations R9-10-703 We have multiple sites with professional staff interacting with non-professionals in the group homes daily Our Administrator and our designated Acting Administrator are not in each home monthly We have a Team Supervisor that is assigned to one home or in some cases two homes however they are not "on the behavioral health premises" 24/7 for seven days a week but are available for the services provided by the behavioral residential facility when the administrator is not present on the behavioral health residential facility's premises There is always managerial staff on-call and available to go to the home to provide for needed services Issue: Once staff read the definitions associated with the "administrator" they are apprehensive about the interactions with governing board, development of P&P, quality management programs etc. The term for the designee as "acting administrator" for the designated responsible party for the site is causing anxiety Could this be titled differently i.e. designated responsible party for daily operations or something other than acting administrator? Caregiver Training Since behavioral health programming has now been included in Licensure for Assisted Living Facilities, does a caregiver providing personal care services in a behavioral health program have to complete the Assisted Living Facility Caregiver Training Program (136 hours) The cost for the provision of this training is estimated to be in excess of \$2,000 per staff member. In our case, we have 102 staff members

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

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 184 183 31 18

Response Started: Monday, April 29, 2013 1:51:18 PM

Response Modified: Monday, April 29, 2013 3:00:34 PM

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

Abandoning the truly needy.

2. How can the draft rules be improved?

Allow level 4's to continue to operate.

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

Fairness

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 97.226.163.7

Response Started: Saturday, April 27, 2013 3:51:32 PM

Response Modified: Saturday, April 27, 2013 3:59:35 PM

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

I don't believe any of them are effective

2. How can the draft rules be improved?

they can't be improved upon

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

things just need to stay the way they are had not been for crossroads West mens transitional living facility and then letting me in with a hundred dollars and no job prospect I might have died with a needle in my arm today I'm two years sober! have a job at the electrical Union

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 184 183 31 18

Response Started: Thursday, April 25, 2013 9:52:24 AM

Response Modified: Thursday, April 25, 2013 9:57:50 AM

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

The only effective portion I see is the weeding out of level 4's

2 How can the draft rules be improved?

Allow level 4's to continue to operate and if there's no evidence based criteria re: spacial requirements, dont impose any

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

The less fortunate people who want help

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 70 167 199 28

Response Started: Tuesday, April 23, 2013 11:44:02 AM

Response Modified: Tuesday, April 23, 2013 11:53:50 AM

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

The draft rules appear appropriate for treatment centers that are currently licensed. The fact that currently licensed Transitional Living Centers have been eliminated or overlooked is devastating for these facilities, the residents served, and agencies served. By eliminating Transitional Living Centers as a licensed category, the department has obliterated a clean, beneficial, regulated low cost option for the many people who can't afford expensive substance abuse treatment. The effects of this decision will be that many low or no income clients will receive worse care . . . if any care at all

2. How can the draft rules be improved?

Responsibly address Transitional Living Centers with appropriate standards. There is a solution other than leaving them out of the new rules and licensing

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

Yes. You have left out licensed Transitional Living Centers, and therefore have disenfranchised thousands of behavioral health clients who will no longer be able to live in a behavioral health licensed facility. Instead of increasing standards for these clients you have effectively decreased them. Where will they go? Who in the department is thinking about their well being?

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[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 184.183.31.18**Response Started:** Monday, April 22, 2013 10:59:58 AM**Response Modified:** Monday, April 22, 2013 11:03:07 AM**1. What parts of the draft rules do you believe are effective?**

Not much has changed in the way of effectiveness. I think the new rules limit who gets help and is prejudice to those serving them.

2. How can the draft rules be improved?

The spacial requirements are ridiculous. Only a major hospital or corporate America could manage these requirements.

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

The working poor, homeless, left for dead, no one will take a chance on clients

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[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 68 71 101 188**Response Started:** Monday, April 22, 2013 10:24:16 AM**Response Modified:** Monday, April 22, 2013 10:31:26 AM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?Provide clarification to R9-10-703 F 3-6: Please clarify where OBHL would expect the report to be maintained.

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

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 68.71.101.188**Response Started:** Friday, April 19, 2013 1:49:40 PM**Response Modified:** Friday, April 19, 2013 2:12:35 PM**1. What parts of the draft rules do you believe are effective?**No Response

2. How can the draft rules be improved?

R9-10-703.C 1 c - "Include how a personnel member may submit a complaint relating to services provided to a resident" - Please clarify Submit complaint to whom? Regarding ethical conduct of another staff member with respect to services provided? Definition of "personnel" versus "employee" is confusing and usage is not consistent. Please clarify

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

"Respite Services" , R9-10-702 4 is NOT defined in R9-10-Article 7, nor in R9-10 Article 1, or R9-10 Article 3. "Ethical Behavior" (formerly R9-20-201 B 2 c) is not addressed -- It SHOULD be addressed "Sentinel Event" Management is not mentioned; it is "alluded" to in R9-10-303 & R9-10-703 but language should be added back specifically in the rules.

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 184 183 31 18

Response Started: Thursday, April 18, 2013 1:02:46 PM

Response Modified: Thursday, April 18, 2013 1:48:10 PM

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

All parts are effective The new rules just will not allow the average person to afford quality recovery.

2. How can the draft rules be improved?

Allow level 4's to exist Some have been in the valley for over 50 years and have licensed as such Why the sudden change Who is pulling the strings?

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

Dignity

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 209 234 144 197

Response Started: Thursday April 18, 2013 1:05:43 PM

Response Modified: Thursday, April 18, 2013 1:16:34 PM

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

Several parts are good but the question should be which are not effective Specifically as the rules apply to operations formerly licensed as Transitional Living Centers such as Crossroads My experience with Crossroads reaching back several decades is that there have never been rule violation issues and they as they presently operate serve thousands of people in need. This service would be adversely affected by the new rules and thus adversely affect our economy and those in need

2 How can the draft rules be improved?

Put TLC back in the rules Don't let the desire to make new rules adversely affect a program that benefits the state, does not cost the state or any other government entity any funds and helps thousands This is truly government shooting itself in the foot and the tax payers as well as those in need Why?

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

Yes TLC are left out By making these rule changes it will put hundreds of people looking for help out on the street All for want of some one to actually look at the affect of the rules as compared to just making them with out thought as to the real affect. With all the issues with our representaitives and the way things are run at then governmental level won't anyone have the courage to look at this in real time as it affects real people?

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 184.183.31.18

Response Started: Thursday, April 18, 2013 1:02:46 PM

Response Modified: Thursday, April 18, 2013 1:48:10 PM

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

All parts are effective The new rules just will not allow the average person to afford quality recovery

2. How can the draft rules be improved?

Allow level 4's to exist Some have been in the valley for over 50 years and have licensed as such Why the sudden change Who is pulling the strings?

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

Dignity

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[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 159 36 0 199**Response Started:** Thursday, April 18, 2013 8:54:15 AM**Response Modified:** Thursday, April 18, 2013 8:57:35 AM**1. What parts of the draft rules do you believe are effective?**

All of them.

2. How can the draft rules be improved?

Add some alternate or additional requirements dealing with the training of staff to meet the needs of unique populations such as the deaf, developmentally disabled, and children who have been removed from their home environments due to issues arising from their parents' behaviors (as opposed to their own)

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

Alternate methods for meeting the clinical director requirements when the population substantially unique such as with the developmentally disabled (cognitive deficits, specifically).

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 184 183 31 18

Response Started: Tuesday, April 16 2013 1:55:15 PM

Response Modified: Tuesday April 16 2013 2:06:07 PM

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

Everyone at the Veterans Administration are flabbergasted that you are eliminating Level IV Transitional Living We have contracted for YEARS with this entity They have provided clean safe LICENSED bed space, as well as medication services, food, and beds Our contracts require licensure What are you thinking about? WE provide treatment to our clients who live there

2. How can the draft rules be improved?

Just restore the original rules with Transitional Living Centers You have made a bad mistake and you need to correct it

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

Just tell us where you want our homeless veterans to go please where they get food beds medication services, and a place licensed by the OBHL for \$40/day Wait until the taxpayers hear about this one!

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[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 184 183 31 18**Response Started:** Monday, April 15, 2013 2:45:37 PM**Response Modified:** Monday April 15, 2013 2:47:53 PM**1 What parts of the draft rules do you believe are effective?**

There effective if your trying to limit the quality of care people get EVERYONE should have the opportunity to live in a liscensed facility

2. How can the draft rules be improved?

Allow level 4's to continue to exist

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

Fairness
