NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES –

HEALTH CARE INSTITUTIONS: LICENSING

PREAMBLE

1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039 by the governor on:

April 17, 2024

2. Article, Part, or Section Affected (as applicable)	**Rulemaking Action**
R9-10-1201	Amend
R9-10-1203	Amend
R9-10-1207	Amend
R9-10-1209	Amend
R9-10-1210	Amend

3. 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) and 17, and 36-136(G)

Implementing statute: A.R.S. §§ 36-151 through 36-160, 36-405, 36-406, and 36-411

4. The effective date of the rule:

This rule shall become effective 60 days after a certified original and preamble are filed in the Office of the Secretary of State pursuant to A.R.S. § 41-1032(A). The effective date is (to be filled in by *Register* editor).

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 the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable

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 the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable

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

Notice of Rulemaking Docket Opening: 30 A.A.R. 934, May 10, 2024, 19, [R24-78]

Notice of Proposed Rulemaking: 30 A.A.R. 2531, August 9, 2024, 32, File number: [R24-145]

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

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or

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Division: Policy and Intergovernmental Affairs

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) require the Arizona Department of Health Services (Department) to protect the health of the people in Arizona, and license and regulate health care institutions. The Department, in its 2023 Home Health Agencies Five Year Review Report (Report), identified matters that if addressed would improve the effectiveness of the rules. The matters identified in the Report include aligning the rules with standards set forth by the Centers for Medicare and Medicaid Services and amending the rules necessary for the proper administration and enforcement of the laws relating to public health to promote continuity and improve patient outcomes. The purpose of this rulemaking is to amend the rules to address the matters identified and to complete the proposed course of action stated in the Report. The Governor's Regulatory Review Council approved the Report on April 2, 2024, and the Department received rulemaking approval from the governor's office, pursuant to § 41-1039(A) on April 17, 2024.

8. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not 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:

Not applicable

9. 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

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

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) require the Arizona Department of Health Services (Department) to protect the health of the people in Arizona, and license and regulate health care institutions. The rules in 9 A.A.C. 10, Article 12 were established in 2013 to comply with Laws 2011, Ch. 96, which required the Department to adopt rules for health care institutions to reduce costs and facilitate licensing of integrated health programs. This rulemaking focuses on aligning rules with standards set by the Centers for Medicare and Medicaid Services and amending the rules to ensure proper administration and enforcement of public health laws, and improve patient outcomes. By making these changes, the Department aims to enhance the

effectiveness of our regulations, promote continuity in care, and improve patient outcomes. This analysis covers the costs and benefits associated with the rule changes related to addressing issues identified in recent five-year review reports and amending rules related to public health and safety. The annual cost and revenue changes are designated as minimal when $1,000 or less, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues. Costs are listed as significant when meaningful or important, but not readily subject to quantification. The Department expects that the individuals who will be directly affected by, bear the costs of, or directly benefit from the rules include the Department, home health agencies, health care providers, patients and their families, and the general public.

The Department is proposing several rule changes to enhance the administration and oversight of home health agencies. Amendments in R9-10-1203 will limit the number of agencies an administrator can serve to five, aiming to improve oversight and focus on patient care services. Since administrators are responsible for 87.6% of a facility's duties, the new rule changes are expected to provide a significant benefit to administrators for having more manageable workloads, leading to better patient outcomes. Administrators who oversee more than five home health agencies may incur moderate costs from the new rules. Furthermore, the changes in R9-10-1207 require timely development and regular review of patient care plans are expected to increase transparency and collaboration in patient care plans, with minimal costs for home health agencies. Amendments to R9-10-1209 clarify medical record documentation, adding protection for healthcare providers without additional costs. Lastly, updates to R9-10-1210 will allow physician assistants to sign orders and include licensed health aides in the workforce, expanding service capabilities and benefiting home health agencies. Overall, these rule changes aim to improve management, patient outcomes, and operational efficiency in home health agencies. The Department estimates that the new changes in the rules may cause home health agencies to incur minimal to no costs, and home health agencies and the patients at a home health agency will receive a significant benefit from increased transparency and collaboration.

The Department expects that limiting the number of facilities an administrator can oversee will enhance oversight and provide more focused services, benefiting healthcare providers, patients, and their families. Additionally, new requirements in R9-10-1207 for documenting and responding to referrals within 48 hours aim to improve patient outcomes by ensuring quicker responses. Also, a new requirement in R9-10-1207 mandates that the care plan be established & implemented within five days. This new requirement may impose minimal costs on home health agencies, but since home health agencies that accept patients will have to implement the care plan, the new requirement clarifies the timeframe that the care plan must be implemented. While this may pose a minimal administrative burden, the Department believes the benefits will outweigh the costs, leading to better collaboration in care plans and overall improved patient care.

Home health agencies benefit the general public by providing essential medical and personal care services, improving health outcomes, and enhancing the quality of life for patients, which help elderly and disabled individuals maintain independence, reduce hospital stays, lower healthcare costs, and support families with professional assistance. The new rules are expected to significantly benefit the public by ensuring proper administration and enforcement of public health laws, promoting continuity, and improving patient outcomes.

The Department expects that most small businesses operating as home health agencies may incur minimal costs under the new rules. However, administrators overseeing more than 40 agencies could face substantial costs due to the new limit of five agencies per administrator. Despite these potential costs, the rule changes are expected to significantly benefit the public by reducing fraudulent activity and improving oversight. With home health and hospice agencies categorized as "high risk" by the Centers for Medicare and Medicaid, the stringent administrative requirements aim to enhance survey readiness and reduce the number of unprepared providers.

The new rules for home health agencies are expected to enhance oversight, improve patient care, and promote better health outcomes. By limiting the number of facilities an administrator can oversee and requiring timely responses to referrals, the rules aim to provide more focused and efficient services. These changes may incur minimal administrative costs for agencies, but the overall benefits, including improved collaboration in care plans, better patient outcomes, and reduced healthcare costs, outweigh the expenses. The general public will benefit from the proper administration and enforcement of public health laws, leading to improved continuity and quality of care.

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

The Department did not make any changes between the proposed rulemaking and the final rulemaking.

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

The Department received three written formal comments from Erica Drury with MGA Healthcare, Jim Melancon with Aveanna Healthcare, and Catherine (Kate) Morrison with Maxim Healthcare.

Comment Summary from Erica Drury, MGA Healthcare:

Drury advocated for amendments to the proposed home health rule to better align with the unique nature of private duty nursing (PDN) services and highlighted that PDN, unlike home health, involves continuous, long-term care for medically stable patients with predictable routines. As such, the frequent supervision required for home health patients is unnecessary for stable PDN patients, imposing undue financial and administrative burdens on providers without improving care outcomes. Drury suggests exempting PDN services from the frequent supervision requirements in section R9-10-1207 and proposes amendments to clearly define PDN in the regulations

Department Response:

In response to Erica Drury's comments, the Department acknowledges the distinction between private duty nursing (PDN) and home health services, but clarifies that the requirement for a Home Health Agency (HHA) license to provide PDN is an Arizona Health Care Cost Containment System (AHCCCS) requirement, not within the Department's regulatory scope. Since PDN is not explicitly addressed in the current rules, the Department cannot define it or make specific exemptions for it in this rulemaking process. The focus of the rulemaking is on clarifying regulations, updating cross-references, and aligning with CMS standards. The Department encourages Erica to continue working with AHCCCS on PDN-related concerns.

Comment Summary from Jim Melancon with Aveanna Healthcare:

Melancon's comments emphasize the need for private duty nursing (PDN) services in Arizona to be distinguished from traditional home health services due to their continuous nature. The comment suggested that supervision requirements for PDN patients, who are often medically stable with well-established care routines, should align with the type of care being provided to avoid unnecessary administrative burdens and costs. Frequent supervision, as required for intermittent home health services, is unnecessary for stable PDN patients. Melancon suggested the Department to further amend the rules to exempt PDN from the rules.

Department Response:

The Department's response acknowledged the differences between private duty nursing (PDN) services and traditional home health care but clarifies that the requirement for a home health agency license to provide PDN services falls under Arizona Health Care Cost Containment System (AHCCCS) regulations, not state licensing rules. The Department does not define or regulate PDN services in the current Chapter 10 rules, and therefore cannot exempt PDN from the proposed changes. While recognizing the concerns about supervision requirements for stable patients, the rules are designed to regulate home health services and align with state and CMS standards. The Department recommended engagement with AHCCCS for PDN-specific issues.

Comment Summary from Catherine (Kate) Morrison with Maxim Healthcare:

Morrison urges the rules to be amended to exempt PDN agencies from the proposed changes to home health agency licensing requirements under R9-10-1207. Morrison explained that while PDN agencies in Arizona must follow Medicare Conditions of Participation, most states do not require this, as PDN agencies do not typically provide Medicare services. Morrison stated that the proposed changes, particularly regarding care plan updates, are unnecessary and duplicative for PDN agencies, adding administrative burden without improving patient care. In addition, Morrison mentioned the continuous nature of PDN services, where patients have stable, long-term needs, unlike traditional home health patients. Morrison suggested the Department amend the rules to exempt PDN from the requirements outlined in Article 12.

Department Response:

The Department's response to Kate Morrison, the Department acknowledged the feedback on the proposed changes to Home Health Agency licensing requirements. The Department clarified that the requirement to follow Medicare Conditions of Participation for private duty nursing (PDN) services is governed by the Arizona Health Care Cost Containment System (AHCCCS), not the Department. The Department does not regulate or define PDN in Chapter 10 and, therefore, cannot exempt PDN services from the proposed rule changes, which are specific to home health agencies and aligned with Medicare and CMS standards. The Department recommends further engagement with AHCCCS on requirements for PDN services.

Oral Proceeding:

During the Oral Proceeding that the Department held on Tuesday, September 10, 2024, three individuals attended and made comments Catherine (Kate) Morrison and Heather Alvarez from Maxim Healthcare Services and Bill Sczepanski from Team Select Homecare.

Below is a summary of key concerns raised by Morrison and Alvarez:

1. **Care Plan Review and Documentation**: Section R9-10-1207 (Care Plan) requires agencies to review a patient's care plan every 30 days and document the review. However, they believe this is duplicative of their existing processes and would increase the

administrative burden without adding significant value. The rule was designed with traditional home health in mind, where visits are short and less frequent (e.g., one hour a day or once a week). In contrast, PDN involves extended daily shifts with patients, often delivered by LPNs or RNs. Since PDN is deeply involved in patient care, reviewing the care plan every 30 days seems unnecessary. Adding this requirement would strain their staffing resources, particularly in rural areas, where they may have to decline patients due to increased workload. Alvarez requested clarification on whether the care plan review must be conducted by an RN or if an LPN, who is already working with the patient, could perform it. Additionally, she questioned whether the review must be in person or if telehealth would suffice since it's a verbal review, not an assessment.

2. **Referral Response Time**: The rule mandates that home health agencies respond to a referral from a healthcare provider within 48 hours. The team expressed concern about whether this requirement is necessary for their specific type of service, particularly for private duty nursing (PDN). This rule also seems suited to traditional home health, not PDN. PDN agencies receive a large number of irrelevant referrals, including for services they don't provide. Responding to every referral would require hiring additional staff and would burden healthcare providers unnecessarily.
3. **Private Duty Nursing (PDN) Exemption**: A key request was to exempt private duty nursing from these rules because PDN differs significantly from traditional home health. They emphasized that their patients typically have stable conditions and do not experience the same frequent changes that warrant the proposed requirements. They argue that PDN should be defined and treated separately in the regulations.

Sczepanski expressed his agreement with the points made by Morrison and Alvarez and mentioned that the proposed rules, while well-intentioned, were created with traditional home health services in mind, not private duty nursing (PDN). PDN patients are typically stable but have acute, long-term care needs. The current rules fail to recognize these differences. Sczepanski recommended the Department to amend the rules to clarify the distinction between PDN and other home health services before finalizing the rules. Bill clarifies that while PDN agencies fall under the home health umbrella in Arizona, they do not provide the same range of services as traditional home health. PDN agencies are focused solely on providing long-term, hourly care, primarily for children with serious medical needs (e.g., tube feeding, ventilators). Unlike home health, PDN does not involve short-term, intermittent care or use of a wide range of disciplines like occupational or physical therapy. He explained that in Arizona, PDN is billed under specific codes (e.g., s9123, s9124), and while agencies must be home health-certified to provide PDN, they are not required to offer all traditional home health services. This distinction is crucial, but it appears misunderstood by those drafting the regulations.

In conclusion, all three individuals who attended the Oral Proceeding advocated for the exemption of PDN services from these home health rules, as they feel the regulations are not well-suited to their specific type of care and operational needs.

Department's Response:

The Department thanked the stakeholders for their attendance and comments. The majority of comments made were geared towards private duty nursing, which is a term not used in the Article 12 rules. The Department clarified that the rules under discussion were for medical licensing by the Arizona Department of Health Services (AZDHS) and not related to access rules from other agencies. Amending the rules further to exempt private duty nurses from the requirements in Article 12 would be outside of the scope of this rulemaking. The Department was approved to amend the rules to address the issues identified in a recent five-year review report

which include making the rules more clear, concise, and understandable; updating cross-references and correct grammatical errors; aligning the rules with the Centers for Medicare and Medicaid Services (CMS) standards; and amending rules necessary for the proper administration and enforcement of the laws relating to public health to promote continuity and improve patient outcomes. The proposed rules are intended to encompass all home health facilities, including PDN, under the state's home health services license. The Department acknowledged the concerns stakeholders expressed but emphasized that the Department does not specifically address PDNs in the rules and that the final rulemaking process was moving forward, pending approval from the Governor's office.

13. 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:

Not applicable

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 rule does not require the issuance of a regulatory permit. Therefore, a general permit is not applicable.

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:

There are no federal rules applicable to the subject of the rule.

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:

Not applicable

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

Not applicable

15. 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

16. The full text of the rules follows:

Rule text begins on the next page.

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

ARTICLE 12. HOME HEALTH AGENCIES

Section

ARTICLE 12. HOME HEALTH AGENCIES

R9-10-1201. Definitions

In addition to the definitions in A.R.S. §§ 36-401, 36-151 and R9-10-101, the following apply in this Article, unless otherwise specified:

1. "Branch office" means a location other than a home health agency's main administrative office that:
   a. Operates under the license of the home health agency, and
   b. Is under the control of the home health agency's administrator.
2. "Home health services director" means an individual who provides direction for the home health services provided by or through a home health agency.
3. "Medical social services" means activities that assist a patient to cope with concerns about the patient's illness or injury, and may include helping to find resources to address the patient's concerns.

R9-10-1203. Administration

A. A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of the home health agency;
2. Establish, in writing:
   a. A home health agency'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 R9-10-1204;
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 in a home health agency's administrative office for more than 30 calendar days, or
   b. Not present in a home health agency's administrative office 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 administrator and identify the name and qualifications of the new administrator;
8. Appoint, according to A.R.S. § 36-151(5)(b), an advisory group that consists of four or more members that include:
   a. A physician;
   b. A registered nurse who has at least one year of experience as a registered nurse providing home health services; and
   c. Two or more individuals who represent a medical, nursing, or health-related profession; and
9. Ensure that the advisory group appointed according to subsection (A)(8):
   a. Meets at least once every 12 months,
   b. Documents meetings, and
   c. Assists in establishing and evaluating policies and procedures for the home health agency.

B. An administrator:

1. Shall serve no more than five home health agencies;
~~1.~~2. Is directly accountable to the governing authority of a home health agency for all services provided by the home health agency;
~~2.~~3. Has the authority and responsibility to manage the home health agency;

~~3.~~4. Except as provided in subsection (A)(6), designates, in writing, an individual who is present at the home health agency's administrative office and accountable for services provided by the home health agency when the administrator is not present at the home health agency's administrative office; and

~~4.~~5. Ensures compliance with A.R.S. § 36-411.

C. An administrator shall:

1. Ensure that 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, and volunteers;
   b. Cover orientation and in-service education for personnel members, employees, and volunteers;
   c. Cover how a personnel member may submit a complaint relating to patient care;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Include a method to identify a patient to ensure the patient receives the appropriate services;
   f. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
   g. Cover specific steps for:
      i. A patient to file a complaint, and
      ii. The home health agency to respond to a patient complaint;
   h. Cover health care directives;
   i. Cover medical records, including electronic medical records;
   j. Cover a quality management program, including incident reports and supporting documentation;
   k. Cover contracted services; and
   l. Cover and designate which personnel members or employees are required to have current certification in cardiopulmonary resuscitation and first aid training;
2. Ensure that policies and procedures for services provided by a home health agency are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover patient admission, discharge planning, and discharge;
   b. Cover the provision of home health services and, if applicable, specific types of supportive services and medical social services;
   c. Include when general consent and informed consent are required;
   d. 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;
   e. Cover medication procurement, if applicable, and administration; and
   f. Cover infection control;
3. Ensure that policies and procedures are:
   a. Available to personnel members, employees, and volunteers, and
   b. Reviewed at least once every three years and updated as needed;
4. Ensure that records of advisory group meetings are maintained for at least 24 months after the date of the meeting;
5. Designate, in writing, a home health services director who is:
   a. A physician with at least 24 months of experience working for or with a home health agency; or
   b. A registered nurse with at least three years of nursing experience, including at least 24 months of experience as a registered nurse providing home health services;
6. Ensure that:

a. Speech therapy or speech-language pathology services are provided by a speech-language pathologist according to A.R.S. § 36-1940.01 or speech-language pathologist assistant licensed according to A.R.S. § 36-1940.04;

b. Nutritional services are provided by a registered dietitian;

c. Occupational therapy services are provided by an occupational therapist or occupational therapy assistant;

d. Physical therapy services are provided by a physical therapist or a physical therapist assistant;

e. Respiratory care services are provided by a respiratory therapist, respiratory therapy technician licensed according to A.R.S. Title 32, Chapter 35, or a practical nurse or registered nurse licensed according to A.R.S. Title 32, Chapter 15;

f. Pharmacy services are provided by a pharmacist; and

g. Medical social services are provided:

i. By a personnel member qualified according to policies and procedures that coordinates medical social services; and

ii. For medical social services, related to the practice of social work in A.R.S. § 32-3251, by a personnel member licensed under A.R.S. Title 32, Chapter 33, Article 5;

7. Ensure that the services specified in subsection (C)(6) are provided to a patient only under an order by the patient's physician, registered nurse practitioner, or podiatrist, as applicable; and

8. Unless otherwise stated, ensure that:

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 home health agency, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the home health agency.

R9-10-1207. Care Plan

A. An administrator shall ensure that a care plan is developed for each patient:

1. Based on an assessment of the patient as required in R9-10-1210(D)(1) or (F)(2)(e)(i);

2. With participation from:

a. The patient's physician, registered nurse practitioner, or podiatrist, as applicable; and

b. A registered nurse; ~~and~~

3. That includes:

a. The patient's diagnosis;

b. Surgery dates relevant to home health services, if applicable;

c. The patient's cognitive awareness of self, location, and time;

d. Functional abilities and limitations;

e. Goals for functional rehabilitation, if applicable;

f. The type, duration, and frequency of each service to be provided;

g. Treatments the patient is receiving from a source other than the home health agency;

h. Medications and herbal supplements reported by the patient or the patient's representative as being used by the patient, and the dose, route of administration, and schedule for administration of each medication or herbal supplement;

i. Any known drug allergies;

j. Nutritional requirements and preferences;

k. Specific measures to improve the patient's safety and protect the patient against injury; and

l. A discharge plan for the patient including, if applicable, a plan for assessing the accomplishment of treatment or therapy goals for the patient~~.~~; and

4. That is established and implemented within five days of start of care.

B. An administrator shall ensure that:

1. Home health services are provided to a patient by the home health agency according to the patient's care plan;
2. The patient's care plan is reviewed and updated:
   a. Whenever there is a change in the patient's condition that indicates a need for a change in the type, duration, or frequency of the services being provided;
   b. If the patient's physician, registered nurse practitioner, or podiatrist, as applicable, orders a change in the care plan; and
   c. At least every 60 calendar days; ~~and~~
3. The patient's care plan is reviewed and documented by a registered nurse, a occupational therapist, a occupational therapist assistant, a physical therapist, or a physical therapist assistant, with the patient or the patient's representative at least every 30 calendar days;

~~3.~~4. The patient's physician, physician assistant, registered nurse practitioner, or podiatrist, as applicable, authenticates the care plan with a signature within 30 calendar days after the care plan is initially developed and whenever the care plan is ~~reviewed or~~ updated~~.~~; and

5. A home health agency documents and responds to a referral from a health care provider within 48 hours of receiving the referral.

R9-10-1209. 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 an individual authorized by ~~a~~ policies and procedures to make the entry;
   b. Dated, timed, 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 patient's medical record and includes the time of the order;
   b. Authenticated by a physician, registered nurse practitioner, or podiatrist according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the physician, registered nurse practitioner, or podiatrist 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 personnel members, physicians, registered nurse practitioners, or podiatrists authorized by policies and procedures to access the patient's medical record;
6. Information in a patient's medical record is disclosed to an individual not authorized under subsection (A)(5) only with the written consent of a patient or the patient's representative or as permitted by law; and
7. A patient's medical record is protected from loss, damage, or unauthorized use.

B. If a home health agency 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 patient's 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. The patient's name;
    b. The patient's address and telephone number;
    c. The patient's date of birth; and
    d. Any known allergies, including medication allergies;
2. The date the patient began receiving services from the home health agency and, if applicable, the date the patient stopped receiving services from the home health agency;
3. The name and telephone of the patient's physician or registered nurse practitioner;
4. The name and telephone number of patient's podiatrist, if applicable;
5. Documentation of general consent and, if applicable, informed consent;
6. Documentation of medical history and current diagnoses;
7. A copy of the patient's health care directive, if applicable;
8. 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;
        i. Is a legal guardian, a copy of the court order establishing guardianship; or
        ii. 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;
9. Orders;
10. Assessments;
11. Care plan;
12. Progress notes;
13. 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;
14. Documentation of meetings with the patient to assess the home health services and supportive services provided to the patient;
15. The disposition of the patient upon discharge;
16. The discharge plan;
17. Discharge instructions and discharge summary, if applicable;
18. If applicable:
    a. Laboratory reports,
    b. Radiologic reports,
    c. Diagnostic reports, and
    d. Consultation reports;
19. 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;

e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication; and

f. Any adverse reaction a patient has to the medication;

20. Documentation of tasks assigned to a home health aide or other personnel member;

21. Documentation of coordination of patient care;

22. Copies of patient summary reports sent to the patient's physician, registered nurse practitioner, or podiatrist, as applicable; and

23. Documentation of contacts with the patient's physician, registered nurse practitioner, or podiatrist, as applicable, by a personnel member or the patient.

R9-10-1210. Home Health Services

A. An administrator shall ensure that an individual admitted to the home health agency has an order from a physician, registered nurse practitioner, physician assistant, or podiatrist for home health services.

B. An administrator shall ensure that the home health services director provides direction for home health services provided by or through the home health agency.

C. A home health services director shall ensure that nursing services are provided by a registered nurse or practical nurse, according to policies and procedures.

D. A home health services director shall ensure that a registered nurse:

1. Unless a patient's physician, physician assistant, or registered nurse practitioner orders only speech therapy, occupational therapy, or physical therapy for the patient, within 48 hours after the patient begins receiving home health services provided by or through the home health agency, conducts and document an initial assessment of the patient to determine:

a. The needs of the patient;

b. Resources available to address the patient's needs;

c. The patient's home and family environment;

d. Goals for patient care;

e. Medications used by the patient, including non-compliance, drug interactions, side effects, and contraindications; and

f. Medical supplies or equipment needed by the patient;

2. Reviews a patient's health care directives at the time of the initial assessment;

3. Implements a patient's care plan, developed as specified in R9-10-1207;

4. Coordinates patient care with other individuals providing home health services or other services to the patient;

5. Immediately informs the patient's physician or registered nurse practitioner of a change in a patient's condition that requires medical services; and

6. At least every 60 calendar days until a patient is discharged:

a. Reassesses the patient based on the patient's care plan, needs, and medical condition; and

b. Summarizes the patient's condition and needs for the patient's physician, registered nurse practitioner, or podiatrist, as applicable.

E. A home health services director shall ensure that:

1. A patient's condition and the services provided to the patient are documented in the patient's medical record after each patient contact; and

2. Verbal orders from a patient's physician, registered nurse practitioner, or podiatrist, as applicable, are:
    a. Except as specified in subsection (F)(2)(d), received by a registered nurse and documented by the registered nurse in the patient's medical record; and
    b. Authenticated by the patient's physician, registered nurse practitioner, or podiatrist, as applicable, with a signature, within 30 calendar days.

F. A home health services director shall ensure that:

1. A registered nurse:
    a. Except as specified in subsection (F)(2)(b)(i) and (ii):
        i. Assigns tasks in writing to a home health aide or licensed health aide who is providing home health services to a patient; and
        ii. Verifies the competency of the home health aide or licensed health aide in performing assigned tasks;
    b. Except as specified in subsection (F)(2)(b)(iii), provides direction for the home health aide or licensed health aide services provided to a patient; and
    c. Except as specified in subsection (F)(2)(e)(ii), meets with a patient who is receiving home health aide or licensed health aide services to assess the home health services provided by the home health aide or licensed health aide:
        i. At least every two weeks when the patient is also receiving nursing services or therapy services, and
        ii. At least every 60 calendar days when the patient is only receiving home health aide or licensed health aide services;
2. When a patient's physician or registered nurse practitioner orders speech therapy, occupational therapy, or physical therapy for the patient, an individual specified in R9-10-1203(C)(6)(a), (c), or (d), as applicable:
    a. Provides the applicable therapy service to the patient according to the patient's care plan;
    b. If a home health aide or licensed health aide is assigned to assist the patient in performing activities related to the therapy service:
        i. Assigns tasks in writing to the home health aide or licensed health aide who is assisting the patient;
        ii. Verifies the competency of the home health aide or licensed health aide in performing assigned tasks; and
        iii. Provides direction to the home health aide or licensed health aide in performing the assigned tasks related to the therapy service;
    c. Coordinates the provision of the therapy service to the patient with the registered nurse providing direction for other home health services for the patient;
    d. Documents in the patient's medical record any orders by the patient's physician or registered nurse practitioner received concerning the therapy service; and
    e. If the only home health services ordered for the patient are speech therapy, occupational therapy, or physical therapy:
        i. Within 48 hours after the patient begins receiving home health services provided by or through the home health agency, conducts an initial assessment of the patient as specified in subsections (D)(1)(a) through (f); and

ii. Meets with a patient who is receiving home health services from a home health aide or licensed health aide every two weeks to assess the home health services provided by the home health aide; and

3. A home health aide:

a. Is only assigned to provide services the home health aide can competently perform; and

b. Only performs tasks assigned to the home health aide in writing by a registered nurse or as specified in subsection (F)(2)(b)(i).

4. A licensed health aide:

a. Is only licensed to provide services the licensed health aide can competently perform, and

b. Only performs tasks assigned to the licensed health aide in writing by a registered nurse and as specified under A.R.S. § 32-1601(14).