



**DEPARTMENT OF MENTAL HEALTH  
DIVISION OF BEHAVIORAL HEALTH**

**CERTIFICATION RULES FOR  
RECOVERY SUPPORT PROGRAMS**

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# CERTIFICATION RULES FOR RECOVERY SUPPORT PROGRAMS



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**Title 9—DEPARTMENT OF MENTAL HEALTH**  
**Division 30—Certification Standards**  
**Chapter 3—Alcohol and Drug Abuse Programs**

**9 CSR 30-3.310 Recovery Support Programs**

*PURPOSE: This rule describes the certification and service delivery requirements for recovery support programs.*

(1) Program Description. Recovery support programs offer individuals recovery support services such as, care coordination, spiritual and group counseling, life skills training, recovery housing, and transportation assistance, before, during, after, or independent of substance use disorder treatment provided by an organization certified by the department. These services are offered in a multitude of settings including, but not limited to, community support groups, faith-based organizations, and self-help and peer recovery groups. Recovery support programs are person-centered, allowing individuals the opportunity to direct his/her recovery process.

(2) Types of Programs. Certification is available for the following types of recovery support programs and services:

(A) Care coordination. Care coordination consists of assisting individuals with accessing the network of services and other community resources available to facilitate retention in substance use disorder treatment and/or sustained recovery. This may include, but is not limited to, consultation with the individual's treatment provider, procurement of medication for a mental and/or substance use disorder through charitable programs, assistance in finding and securing permanent housing, development of a social support system, and when funded by the department, bus passes to eligible individuals. A care coordination service provider shall meet the following requirements:

1. Services shall be provided by recovery support program staff;
2. Services shall include, but are not limited to:

A. Arranging, referring, and when necessary, advocating for quality services to which the individual is entitled;

B. Monitoring provider service delivery and ensuring communication among service providers;

C. Locating and coordinating services specific to crisis resolution; and

D. Training in resource acquisition;

(B) Peer recovery drop-in center. Peer recovery drop-in center service emphasizes building peer relationships to help support personal choice(s), respect, and recovery. A peer recovery drop-in center shall meet the following requirements:

1. Each center shall be managed by a Missouri Recovery Support Specialist or Missouri Recovery Specialist – Peer as designated by the Missouri Credentialing Board;

2. Each center shall be staffed with a minimum of eighty percent (80%) staff and volunteers who are in recovery from a substance use disorder or co-occurring mental and substance use disorder;

3. The drop-in center shall create a home-like environment, including a living room type space with chairs, couches, and lighting for informal conversation, and a separate space for group meetings;

4. The drop-in center shall provide coffee, tea, or other free or low-cost beverages and may offer free or low-cost healthy food items;

5. The drop-in center shall offer recreational activities that induce social interaction, such as playing cards and other games, as well as the opportunity to participate in formal peer counseling and structured life-skill building groups;

6. The drop-in center shall provide a physically and emotionally safe environment that is accessible on foot or through public transportation; otherwise, the program shall provide or arrange for alternative transportation;

7. The drop-in center hours of operation shall be geared to the needs of individuals and include evening and weekend hours, at a minimum five (5) days per week for four (4) hours per day;

8. Drop-in center services shall be voluntary, free of charge, and free of expectations of length of participation;

9. A calendar of groups meetings, educational opportunities, and recreational activities shall be posted and updated at least monthly; and

10. Drop-in center services shall provide information on and coordination with social service support agencies in the community, as well as traditional behavioral health and physical health care service providers;

(C) Recovery coaching. Recovery coaching offers the individual support to develop proactive recovery-oriented problem solving skills for the future. A recovery coaching program shall meet the following requirements:

1. Recovery coaching shall be offered before, after, or concurrently with any department-funded certified substance use disorder treatment program;

2. Recovery coaching shall be a one-to-one service delivered face-to-face or, with department approval, through telehealth;

3. Recovery coaching shall not be considered a substitute for services delivered by a certified substance use disorder treatment program;

4. Recovery coaching shall be provided by a Missouri Recovery Support Specialist or a Missouri Recovery Support Specialist – Peer as designated by the Missouri Credentialing Board; and

5. Recovery coaching services and activities shall include, but are not limited to:

A. Helping individuals connect with peers and their communities to develop a network for information and support;

B. Sharing experiences of recovery, including the use of recovery tools, and modeling successful recovery behaviors;

C. Helping individuals make independent choices and taking a proactive role in their recovery;

D. Assisting individuals with identifying strengths and personal resources to aid in setting and achieving recovery goals; and

E. Conducting periodic recovery management check-ups and assessing victories, strengths, challenges, and setbacks;

6. Wellness coaching is recovery coaching that focuses on the relevant physical health factors previously identified by the individual as problematic, including:

A. Low levels of physical activity/sedentary lifestyle;

B. Use of tobacco and other addictive substances;

C. Lack of nutrition and dietary education;

D. Diet and glucose monitoring for diabetes prevention and management;

E. Oral hygiene/dental health practices; and/or

F. Use of medications which contribute to metabolic syndrome, obesity, and other health conditions;

7. Employment coaching is recovery coaching that assists individuals in finding and maintaining competitive and gainful employment and may include, but is not limited to:

A. Assisting in identifying tasks and activities geared toward career exploration and planning;

B. Assisting with job searching and preparation; and/or

C. Assisting in the development of self-management skills, interpersonal skills for the workplace, social and communication skills, and job maintenance;

(D) Spiritual counseling. Spiritual counseling helps individuals explore problems and conflicts from a spiritual perspective. Spiritual counseling shall meet the following requirements:

1. Services shall be provided by qualified clergy. A qualified clergy is defined as an ordained clergy by a recognized religious organization with at least one (1) of the following credentials:

A. Missouri Recovery Support Specialist (MRSS);

B. Missouri Recovery Support Specialist-Peer (MRSS-P);

C. Certified Alcohol Drug Counselor (CADC);

D. Certified Reciprocal Alcohol Drug Counselor (CRADC);

E. Certified Reciprocal Advanced Alcohol Drug Counselor (CRAADC);

F. Recognized Substance Abuse Professional (RSAP);

G. Certified Criminal Justice Professional (CCJP);

H. Physician;

I. Licensed Professional Counselor (LPC);

J. Licensed Marriage and Family Therapist (LMFT);

K. Licensed Clinical Social Worker (LCSW); or

L. Licensed Psychologist;

2. Religious organization shall mean that defined in 352.400.1(5), RSMo.

3. The individual's spiritual beliefs, morals, ideas, values, and conflicts shall be explored in a safe and non-judgmental manner; and

4. Spiritual counseling services shall include one (1) or more of the following:

A. Establishing or re-establishing a relationship with a higher power;

B. Developing personal connectedness with a spiritual, religious, or faith-based entity;

C. Acquiring skills needed to cope with life-changing incidents;

D. Adopting positive values or principles;

E. Identifying a sense of purpose and mission for one's life;

F. Achieving serenity and peace of mind;

G. Finding life purpose;

H. Overcoming emotional, social, mental, or physical obstacles; and/or

I. Putting pain and grief into perspective;

(E) Support, educational, or life-skills groups. Support, educational, or life-skills groups provide support for individuals in recovery by offering encouragement and connections with others who share similar experiences. Support, educational, or life-skills groups shall meet the following requirements:

1. Group services shall address recovery, employment, spiritual, and/or wellness issues relevant to the needs of the individuals served;

2. Groups may be formed around shared identity such as common cultural or religious affiliation, shared experiences, and/or goals such as community re-entry following incarceration, HIV status, or challenges in parenting;

3. Group sessions may consist of the presentation of general information and application of the information to participants through group discussion designed to promote recovery and enhance social functioning;

4. Support group services shall include, but are not limited to:

A. Classroom-style didactic lecture to present information about a topic and its relationship to substance use disorders and recovery;

B. Presentation of educational audiovisual materials with required follow-up discussion;

C. Promotion of discussion and questions about the topic presented to the individuals in attendance;

D. Generalization of the information and demonstration of its relevance to recovery and enhanced functioning;

E. Facilitating disclosure of issues that permits generalization of the issue to the larger group;

F. Promoting positive help-seeking and supportive behaviors; and

G. Encouraging and modeling productive and positive interpersonal communication;

5. A support, educational, or life-skills group session shall include a qualified facilitator and at least two (2) but no more than thirty (30) individuals per group in order to promote participation;

(F) Transportation. Transportation services assist individuals enrolled in a certified recovery support program or substance use disorder treatment program in achieving and sustaining recovery goals when they do not have the means to provide personal transportation.

Transportation services shall meet the following requirements:

1. Transportation shall be limited to specific destinations and/or appointments as defined by the department. Allowable transportation services shall include:

A. To and from a certified substance use disorder treatment program;

B. To and from a certified recovery support program;

C. To and from a doctor's appointment, dental appointment, or appointment with other healthcare providers;

D. To and from probation and parole, court, or other criminal justice agencies; and

E. To and from employment-seeking activities and/or active employment;

2. Staff or volunteers who provide transportation services shall meet the background screening requirements in 9 CSR 10-5.190 and hold a class E chauffeur's license, or if transporting more than fifteen (15) passengers, a CDL license;

3. The vehicle used for transportation shall be currently licensed, properly insured, and provide safe and reliable transportation for individuals served;

4. Staff or volunteers who provide transportation shall have access to a communication device in the vehicle at all times;

(G) Recovery housing. Recovery housing is a direct service that provides supervised, short-term housing to individuals with substance use disorders or co-occurring mental and substance use disorders. Recovery housing services shall meet the following requirements:

1. To be eligible for recovery housing, the individual shall be participating in a department certified and funded substance use disorder treatment program or recovery support program;

2. Recovery housing levels of support and supervision shall include one (1) of the following:

A. Peer-run: At least weekly house meetings facilitated by staff; or

B. Monitored: At least a daily monitoring visit by staff; or

C. Supervised: twenty-four- (24-) hour supervision of individuals by staff, with a minimum of three (3) different staff members providing supervision per twenty-four- (24-) hour period;

3. Each recovery housing provider that offers the self-pay option to individuals served shall have written rental agreement policies and procedures that include, but are not limited to:

A. An explanation of the housing arrangements shall be posted in all housing units;

B. The grounds for termination of the rental agreement;

C. The terms of the agreement shall be established and explained to each individual at admission to housing services; and

D. If an individual enters into a rental agreement for housing with the recovery support organization, a signed copy of that rental agreement shall be kept in the individual record;

4. Recovery housing properties shall:

A. Provide proof of an initial successful Housing Quality Standards (HQS) inspection conducted by an HQS inspector;

B. Provide proof of a successful annual fire inspection; and

C. Provide proof of meeting all local government occupancy/safety requirements such as an occupancy permit, zoning approval, and/or other correspondence showing approval from the local municipal or county governing body;

5. Recovery housing properties inspected and approved as meeting standards of a state/local/regional/national provider organization such as the National Association of Recovery Residences shall be exempt from requirements in paragraph (2)(G)4. of this rule.

(3) Specialized Services. Recovery support programs that specialize in serving minority or other populations with unique recovery needs may tailor individual and group services to address specific needs.

These specialized populations, services, and philosophies may be combined in multiple ways to include, but not limited to:

(A) Employment;

(B) Faith and spiritual beliefs;

(C) Housing;

(D) Offender re-entry;

(E) Peer supports; and

(F) Wellness.

(4) Program Certification. Certification is required for a recovery support organization to obtain and maintain a contract with the department, to participate in department programs eligible for Medicaid reimbursement, and to serve individuals whose referral sources require the provider to be certified by the department. Organizations accredited under standards of care for recovery support services by the National Association of Recovery Residences (NARR), the Council on Accreditation of Peer Recovery Support Services (CAPRSS), the local affiliates of NARR or CAPRSS, or other entity recognized by the department may be eligible for certification through deeming. Certification or deemed status does not constitute an assurance or guarantee that the department or other entity will fund or utilize designated services or programs.

(A) An organization seeking certification or deemed status as a recovery support program shall comply with certification requirements set forth in 9 CSR 10-7.130, as well as all department rules and standards contained herein.

(B) The following core rules for psychiatric and substance use disorder treatment programs shall be met by recovery support programs:

1. 9 CSR 10-7.010 Treatment Principles and Outcomes;

2. 9 CSR 10-7.020 Rights, Responsibilities, and Grievances;

3. 9 CSR 10-7.040 Quality Improvement;

4. 9 CSR 10-7.050 Research;

5. 9 CSR 10-7.060 Behavior Management;

6. 9 CSR 10-7.070 Medications;

7. 9 CSR 10-7.080 Dietary Service;

8. 9 CSR 10-7.090 Governing Authority and Program Administration;

9. 9 CSR 10-7.100 Fiscal Management;

10. 9 CSR 10-7.110 Personnel;

11. 9 CSR 10-7.120 Physical Plant and Safety;
12. 9 CSR 10-7.130 Procedures to Obtain Certification;
13. 9 CSR 10-7.140 Definitions.

(C) The following general program procedures shall be met by recovery support programs:

1. 9 CSR 10-5.190 Background Screening for Employees and Volunteers;
2. 9 CSR 10-5.200 Report of Complaints of Abuse, Neglect, and Misuse of Funds/Property;
3. 9 CSR 10-5.206 Report of Events;
4. 9 CSR 10-5.210 Exceptions Committee Procedures;
5. 9 CSR 10-5.220 Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA); and
6. 9 CSR 10-5.230 Hearings Procedures.

(D) The following department rules and standards shall be waived for recovery support programs unless the department determines that a specific requirement is applicable due to the unique circumstances and service delivery methods of a particular recovery support program:

1. 9 CSR 10-7.030 Service Delivery Process and Documentation;
2. 9 CSR 30-3.100 Service Delivery Process and Documentation; and
3. 9 CSR 30-3.110 Service Definitions and Staff Qualifications.

(5) Staff. Qualified staff shall be available in sufficient numbers to ensure effective service delivery.

(A) All staff and volunteers of recovery support programs shall meet background screening requirements in 9 CSR 10-5.190. The Missouri Department of Health and Senior Services Family Care Registry or other department-approved background screening service shall be used.

(B) All staff and volunteers who have contact with individuals receiving services shall, at a minimum, meet department-approved qualifications and complete six (6) hours of annual training on ethics and professional boundaries. The six (6) hours of annual ethics and boundaries training shall apply to the required thirty-six (36) hours of training, every two (2) years, for personnel as referenced in 9 CSR 10-7.110(2)(E)1.

(C) Training activities shall be documented in each employee's personnel file and shall include the training topic, name of instructor, date(s) of training, certification/continuing education units, and location.

(D) Former recipients of services who transition to staff and volunteer roles shall have been in continuous personal recovery from a substance use disorder or co-occurring mental and substance use disorder for a period equal to or greater than twelve (12) months.

Continuous personal recovery shall mean the individual—

1. Has not used any illegal drugs;
2. Has not used any physician-prescribed medication in a non-prescribed way;
3. Has not used any over-the-counter medication except for its intended use;
4. Has abstained from all use of alcohol; and
5. Is successfully managing their mental illness.

(E) All staff and volunteers of a certified recovery support program shall adhere to the Missouri Recovery Support Specialist (MRSS) Code of Ethics, or if functioning in a peer role, Missouri Recovery Support Specialist - Peer (MRSS-P) Code of Ethics, January, 2016, incorporated by reference, without any later amendments or additions, as published by the Missouri Credentialing Board, 428 E. Capitol Avenue, Jefferson City, MO 65101.

(F) The recovery support program shall establish and consistently implement policies and procedures to guide the roles and activities of volunteers and staff in an organized and productive manner.

(G) Minimum qualifications for supervision of staff and volunteers include holding any of the following credentials: qualified substance abuse professional (QSAP) as defined in 9 CSR 10-7.140(2)(RR); Licensed Professional Counselor (LPC); Licensed Marriage and Family Therapist (LMFT); Licensed Clinical Social Worker (LCSW); Licensed Psychologist; qualified clergy as defined in paragraph (2)(D)1. of this rule; or a director of a certified recovery support program. Acceptable supervision shall include a minimum of one (1) hour every month of face-to-face individual or group supervision.

(6) Admission Criteria. The criteria for admission to a recovery support program shall include at least one (1) of the following:

(A) The individual has a current substance use disorder or co-occurring mental and substance use disorder as identified in the screening and assessment process outlined in section (8) of this rule;

(B) The individual is in recovery from a substance use disorder or co-occurring mental and substance use disorder and in need of services as identified in the screening and assessment process outlined in section (8) of this rule; or

(C) The individual is re-entering the community from a correctional facility and has a prior history of a substance use disorder or co-occurring mental and substance use disorder.

(7) Treatment Goals. Successful outcomes for individuals participating in recovery support services include, but are not limited to:

(A) Obtaining and maintaining sobriety;

(B) Minimizing the risk of relapse;

(C) Improving family, natural support, and social relationships;

(D) Improving employment/educational functioning;

(E) Promoting productive use of time;

(F) Developing social support;

(G) Developing spiritual support;

(H) Developing safe and stable housing;

(I) Complying with all legal, court, probation, or parole requirements;

(J) Minimizing harmful social or behavioral risk; and/or

(K) Improving physical health and wellness.

(8) Screening, Assessment, and Recovery Plan. Each individual participating in recovery support services, as defined in this rule, shall be subject to a screening, an assessment, and the development of an individualized recovery plan.

(A) Screening. Each individual requesting a recovery support service(s) shall have prompt access to a screening to determine eligibility, substance use and/or co-occurring mental and substance use disorder history, and recovery needs. The screening shall—

1. Be conducted by a recovery support program and/or substance use disorder treatment program certified by the department;

2. Be conducted by trained staff;

3. Be responsive to the individual's requests and needs; and

4. Include written notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community. Referrals to other community resources shall include active care coordination to ensure the individual accesses appropriate supports.

(B) Assessment. Each individual requesting a recovery support service(s) shall participate in a recovery-oriented assessment that identifies his/her needs and goals, guides the development of an individualized recovery plan, and ensures engagement in appropriate recovery services. The

participation of family and other natural supports and collateral parties (e.g., referral source, employer, other community agencies) in the assessment and development of the recovery plan shall be encouraged, as appropriate, and based upon the wishes of the individual.

1. The assessment shall be conducted by an organization certified by the department as a substance use disorder treatment program or a recovery support program.

2. The assessment shall be completed by a person who meets established criteria for a qualified substance abuse professional (QSAP) as defined in 9 CSR 10-7.140(2)(RR).

3. The assessment shall be completed within thirty (30) days of initial contact with the recovery support program. This time period does not include weekends and holidays observed by the state of Missouri.

A. If an individual is determined to have active or a severe substance use disorder, mental illness, or co-occurring mental and substance use disorder, presents symptoms of intoxication, impairment or withdrawal, cannot achieve abstinence without close monitoring, or requires structured support and daily supervision, he or she shall be referred to a certified substance use disorder treatment program or certified community mental health center for services.

B. The recovery support program may provide interim services for individuals with severe substance use, mental illness, or a co-occurring mental and substance use disorder while he/she is waiting for higher intensity services.

4. Documentation of the screening and assessment shall include, but is not limited to, the following:

A. Demographic and identifying information;

B. Needs, goals, and expectations from the person requesting services;

C. Presenting situation/problem and referral source;

D. History of previous and current psychiatric and/or substance use disorder treatment;

E. Wellness screening;

F. Current medications and medication allergies;

G. Alcohol and drug use history, including duration, patterns, and consequences of use;

H. Current psychiatric symptoms;

I. Family, social, legal, vocational and educational status, and functioning;

J. Current use of resources and services from other community agencies; and

K. Personal strengths, including family and other natural supports, social, peer, and recovery history.

5. The recovery support program shall actively coordinate other services and make appropriate referrals to ensure the safety and wellbeing of individuals with severe substance use, mental illness, physical health conditions, or other basic needs.

(C) Individualized Recovery Plan. The individualized recovery plan shall reflect the person's unique needs and goals with a focus on integration and inclusion in his/her community, building healthy relationships with family and other natural supports systems, and accessing other community supports. Services may begin before the assessment is completed and the recovery plan is fully developed.

1. Each individual participating in a recovery support program shall actively participate in the creation of a recovery plan within thirty (30) days of admission to the recovery support program. A qualified substance abuse professional and other member(s) of the individual's recovery team shall also participate in development of the recovery plan.

2. The recovery plan shall guide ongoing service delivery and shall be signed by the individual.

3. The recovery plan shall be based on the individual's initial screening and assessment as well as an assisted self-assessment of his or her goals and the strengths and capacities that he or she will use or rely upon to achieve these goals.

4. Service needs beyond the scope of the recovery support program that are being addressed by referral to or coordination with another community organization shall be included in the recovery plan.

5. Progress toward achievement of recovery goals shall be reviewed on a periodic basis to ensure the plan reflects current issues and maintains relevance for the individual. Each individual shall directly participate in regular reviews and updates of their recovery plan and shall sign the review.

(9) Organized Record System. Each recovery support program shall have an organized record system for each individual that receives recovery support services.

(A) Records shall be maintained in a manner that ensures confidentiality and security. The organization shall abide by all local, state, and federal laws and regulations concerning the confidentiality of records.

(B) If records are maintained on a computer system, there shall be a backup process in place to safeguard records in the event of operator or equipment failure and to ensure security from inadvertent or unauthorized access.

(C) The recovery support program shall retain individual records for at least six (6) years from the date of service or until all litigation, adverse audit findings, or both, are resolved.

(D) The recovery support program shall assure ready access to all records, including computerized records, by authorized staff and other authorized parties including department staff.

(10) Documentation. Services funded by the department shall be entered in the department-approved electronic record system. Services documented shall be legible, clear, complete, accurate, and recorded in a timely fashion not to exceed twenty-four (24) hours from service delivery with indelible ink, print, or approved electronic record system.

(A) Entries shall be dated and authenticated by the staff member providing the service, including name and title. Any errors on paper documentation shall be marked through with a single line, initialed, and dated.

(B) There shall be documentation of services provided and results accomplished.

(C) Individual service notes and group logs shall include:

1. Description of the specific service provided;
2. The date and actual time (beginning and ending times) the service was rendered;
3. Name and title of the person who rendered the service;
4. The setting in which the service was rendered;
5. The relationship of the services to the recovery plan; and
6. Description of the individual's response to the service provided.

(D) Where applicable, the record shall also include documentation of referrals to other services or community resources and the outcome of those referrals, signed authorization to release confidential information, missed appointments and efforts to re-engage the individual, urine drug screening or other toxicology reports, and crisis or other significant events that may impact the recovery process.

*AUTHORITY: section 630.050, RSMo Supp. 2013, and section 630.055, RSMo 2000. Original rule filed on April 4, 2016.*

**Title 9—DEPARTMENT OF MENTAL HEALTH**  
**Division 10—Director, Department of Mental Health**  
**Chapter 7—Core Rules for Psychiatric and Substance Abuse Programs**

**9 CSR 10-7.010 Treatment Principles and Outcomes**

*PURPOSE: This rule describes treatment principles and outcomes in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs. The performance indicators listed in this rule are examples of how a treatment principle can be met and do not constitute a list of specific requirements. The indicators include not only data that may be compiled by a program but also circumstances that a surveyor may observe or monitor, consumer satisfaction and feedback compiled by the department, and other data that the department may compile and distribute. A program may also use additional or other means to demonstrate achievement of these principles and outcomes.*

(1) Applying the Treatment Principles. The organization's service delivery shall apply the key principles listed in this rule in a manner that is:

- (A) Adapted to the needs of different populations served;
- (B) Understood and practiced by staff in providing services and supports; and
- (C) Consistent with clinical studies and practice guidelines for achieving positive outcomes.

(2) Outcome Domains. Services shall achieve positive outcomes in the emotional, behavioral, social and family functioning of individuals. Positive outcomes shall be expected to occur in the following domains:

- (A) Safety for the individual and others in his or her environment;
- (B) Improved management of daily activities, including the management of the symptoms associated with a psychiatric and/or substance use disorder and also the reduction of distress related to these symptoms;
- (C) Improved functioning related to occupational/educational status, legal situation, social and family relationships, living arrangements, and health and wellness; and
- (D) Consumer satisfaction with services.

(3) Outcome Measures and Instruments. An organization shall measure outcomes for the individuals it serves and shall collect data related to the domains listed in section (2) of this rule. In order to promote consistency and the wider applicability of outcome data, the department may require, at its option, the use of designated outcome measures and instruments. The required use of particular measures or instruments shall be applicable only to those services funded by the department or provided through a service network authorized by the department.

(4) Essential Treatment Principle—Therapeutic Alliance.

(A) The organization shall promote initial attendance, engagement and development of an ongoing therapeutic alliance by—

- 1. Treating people with respect and dignity;
- 2. Enhancing motivation and self-direction through identification of meaningful goals that establish positive expectations;
- 3. Working with other sources (such as family, guardian or courts) to promote the individual's participation;
- 4. Addressing barriers to treatment;

5. Providing consumer and family education to promote understanding of services and supports in relationship to individual functioning or symptoms and to promote understanding of individual responsibilities in the process;

6. Encouraging individuals to assume an active role in developing and achieving productive goals; and

7. Delivering services in a manner that is responsive to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators of a therapeutic alliance can include, but are not limited to, the following:

1. Convenient hours of operation consistent with the needs and schedules of persons served;
2. Geographic accessibility including transportation arrangements, as needed;
3. Rate of attendance at scheduled services;
4. Individuals consistently reporting that staff listen to and understand them;
5. Treatment dropout rate;
6. Rate of successfully completing treatment goals and/or the treatment episode; and
7. Consumer satisfaction and feedback.

(5) Essential Treatment Principle—Individualized Treatment.

(A) Services and supports shall be individualized in accordance with the needs and situation of each individual served.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. There is variability in the type and amount of services that individuals receive, consistent with their needs, goals and progress;
2. There is variability in the length of stay for individuals to successfully complete a level of care or treatment episode, consistent with their severity of need and treatment progress;
3. In structured and intensive levels of care, group education/counseling sessions are available to deal with special therapeutic issues applicable to some, but not all, individuals;
4. Services on a one-to-one basis between an individual served and a staff member (such as individual counseling and community support) are routinely available and scheduled, as needed; and
5. Individuals consistently report that program staffs are helping them to achieve their personal goals.

(6) Essential Treatment Principle—Least Restrictive Environment.

(A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to the following:

1. Utilization rate of inpatient hospitalization and residential treatment;
2. Length of stay for inpatient and residential treatment;
3. Consistent use of admission/placement criteria;
4. Distribution of individuals served among levels of care;
5. Consumer satisfaction and feedback.

(7) Essential Treatment Principle—Array of Services.

(A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.

2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.

3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.

4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.

5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. Percentages of individuals who complete inpatient or residential treatment and receive continuing services on an outpatient basis;

2. Readmission rates to inpatient or residential treatment;

3. Number of individuals receiving detoxification who continue treatment;

4. Number of individuals who have progressed from more intensive to less intensive levels of care;

5. Feedback from referral sources and other community resources; and

6. Consumer satisfaction and feedback.

(8) Essential Treatment Principle—Recovery.

(A) Services shall promote the independence, responsibility, and choices of individuals.

1. An individual shall be encouraged to achieve positive social, family and occupational/educational functioning in the community to the fullest extent possible.

2. Every effort shall be made to accommodate an individual's schedule, daily activities and responsibilities when arranging services, unless otherwise warranted by factors related to safety or protection from harm.

3. Individuals shall be encouraged to accomplish tasks and goals in an independent manner without undue staff assistance.

(B) Reducing the frequency and severity of symptoms and functional limitations are important for continuing recovery.

(C) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. Measures of symptom frequency and severity;

2. Improved functioning related to—

A. Occupational/educational status;

B. Legal situation;

C. Social and family relationships;

D. Living arrangements; and

E. Health and wellness;

3. Tapering the intensity and frequency of services, consistent with individual progress; and

4. Consumer satisfaction and feedback.

(9) Essential Treatment Principle—Peer Support and Social Networks.

(A) The organization shall mobilize peer support and social networks among those individuals it serves.

1. The organization shall encourage participation in self-help groups.

2. Opportunities and resources in the community are used by individuals, to the fullest extent possible.

(B) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. Rate of participation in community-based self help groups;

2. Involvement with a wide range of individuals in social activities and networks (such as church, clubs, sporting activities, etc.);

3. Open discussion of therapeutic issues in group counseling and education sessions with individuals giving constructive feedback to one another; and

4. Consumer satisfaction and feedback.

(10) Essential Treatment Principle—Family Involvement.

(A) Efforts shall be made to involve family members, whenever appropriate, in order to promote positive relationships.

1. Family ties and supports shall be encouraged in order to enrich and support recovery goals.

2. Family members shall be routinely informed of available services, and the program shall demonstrate the ability to effectively engage family members in a recovery process.

3. When the family situation has been marked by circumstances that may jeopardize safety (such as domestic violence, child abuse and neglect, separation and divorce, or financial and legal difficulties), family members shall be encouraged to participate in education and counseling sessions to better understand these effects and to reduce the risk of further occurrences.

(B) Particular emphasis on family involvement shall be demonstrated by those programs serving adolescents and children.

(C) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization to demonstrate achievement of this essential treatment principle. Indicators can include, but are not limited to, the following:

1. Rate of family participation in treatment planning;

2. Rate of family participation in direct services, such as family therapy;

3. Improved family relationships;

4. Reduction of family conflict; and

5. Satisfaction of family members with services.

(11) Pharmacological Treatment. When clinically indicated for the person served, pharmacological treatment shall be provided or arranged to ameliorate psychiatric and substance abuse problems.

(12) Co-Occurring Disorders. For individuals with clearly established co-occurring disorders, coordinated services for these disorders shall be provided or arranged.

(A) Each individual shall have access to a full range of services provided by qualified, trained staff.

(B) Each individual shall receive services necessary to fully address his/her treatment needs. The program providing screening and assessment shall—

1. Directly provide all necessary services in accordance with the program's capabilities and

certification;

2. Make a referral to a program which can provide all necessary services and maintain appropriate involvement until the individual is admitted to the other program; or

3. Provide those services within its capability and promptly arrange additional services from another program.

(C) Services shall be continuously coordinated between programs, where applicable. Programs shall—

1. Ensure that services are not redundant or conflicting; and

2. Maintain communication regarding the individual's treatment plan and progress.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10-7.020 Rights, Responsibilities, and Grievances

*PURPOSE: This rule describes the rights of individuals being served and grievance procedures in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) General Policy and Practice. The organization shall demonstrate through its policies, procedures and practices an ongoing commitment to the rights, dignity, and respect of the individuals it serves. In addition to the requirements of this rule, the organization must also comply with 9 CSR 10-5.200 regarding protection from abuse and neglect and investigations of any such allegations.

(2) Information and Orientation. Immediately upon admission, each individual shall be informed and oriented as to what will happen as care and treatment are provided.

(A) An individual who is admitted on a voluntary basis shall be expected to give written, informed consent to care and treatment.

(B) The orientation given to each individual shall address service costs, availability of crisis assistance, rights, responsibilities, and grievance procedures.

1. Information regarding responsibilities shall include applicable program rules, participation requirements or other expectations.

2. Information regarding grievance procedures shall include how to file a grievance, time frames, rights of appeal, and notification of outcome.

3. Each client shall be given the name, address and phone number of the department's client rights monitor and informed that the monitor may be contacted regarding a complaint of abuse, neglect or violation of rights.

(C) The orientation information shall be provided in written form using simple, straightforward language understandable to the individual and explained by staff as necessary.

(D) When appropriate, families receive information to promote their participation in or decisions about care and treatment.

(3) Rights Which Cannot Be Limited. Each individual has basic rights to humane care and treatment that cannot be limited under any circumstances.

(A) The following rights apply to all settings:

1. To receive prompt evaluation, care and treatment;
2. To receive these services in the least restrictive environment;
3. To receive these services in a clean and safe setting;
4. To not be denied admission or services because of race, gender, sexual preference, creed, marital status, national origin, disability or age;
5. To confidentiality of information and records in accordance with federal and state law and regulation;
6. To be treated with dignity and addressed in a respectful, age appropriate manner;
7. To be free from abuse, neglect, corporal punishment and other mistreatment such as humiliation, threats or exploitation;
8. To be the subject of an experiment or research only with one's informed, written consent, or the consent of an individual legally authorized to act;
9. To medical care and treatment in accordance with accepted standards of medical practice, if the certified substance abuse or psychiatric program offers medical care and treatment; and
10. To consult with a private, licensed practitioner at one's own expense.

(B) The following additional rights apply to residential settings, and where otherwise applicable, and shall not be limited under any circumstances:

1. To a nourishing, well-balanced, varied diet;
2. To attend or not attend religious services;
3. To communicate by sealed mail with the department and, if applicable, legal counsel and court of jurisdiction;
4. To receive visits from one's attorney, physician or clergy in private at reasonable times; and
5. To be paid for work unrelated to treatment, except that an individual may be expected to perform limited tasks and chores within the program that are designed to promote personal involvement and responsibility, skill building or peer support. Any tasks and chores beyond routine care and cleaning of activity or bedroom areas within the program must be directly related to recovery and treatment plan goals developed with the individual.

(4) Rights Subject to Limitation. Each individual shall have further rights and privileges, which can be limited only to ensure personal safety or the safety of others.

(A) Any limitation due to safety considerations shall occur only if it is—

1. Applied on an individual basis;
2. Authorized by the organization's director or designee;
3. Documented in the individual's record;
4. Justified by sufficient documentation;
5. Reviewed on a regular basis at the time of each individualized treatment plan review; and
6. Rescinded at the earliest clinically appropriate moment.

(B) In all care and treatment settings, each individual shall have the right to see and review one's own record, except that specific information or records provided by other individuals or agencies may be excluded from such review. The organization may require a staff member to be present whenever an individual accesses the record.

(C) The following additional rights and privileges apply to individuals in residential settings, and where otherwise applicable:

1. To wear one's own clothes and keep and use one's own personal possessions;
2. To keep and be allowed to spend a reasonable amount of one's own funds;
3. To have reasonable access to a telephone to make and to receive confidential calls;
4. To have reasonable access to current newspapers, magazines and radio and television programming;
5. To be free from seclusion and restraint;
6. To have opportunities for physical exercise and outdoor recreation;
7. To receive visitors of one's choosing at reasonable hours; and
8. To communicate by sealed mail with individuals outside the facility.

(5) Other Legal Rights. The organization shall ensure that all individuals have the same legal rights and responsibilities as any other citizen, unless otherwise limited by law.

(6) Access to Services. An individual shall not be denied admission or services solely on the grounds of prior treatment, withdrawal from treatment against advice, or continuation or return of symptoms after prior treatment.

(7) Grievances. The organization shall establish policies, procedures and practices to ensure a prompt, responsive, impartial review of any grievance or alleged violation of rights.

(A) Reasonable assistance shall be given to an individual wishing to file a grievance.

(B) The review shall be consistent with principles of due process.

(C) The organization shall cooperate with the department in any review or investigation conducted by the department or its authorized representative.

(8) Practices to Promote Safety and Well-Being. The organization shall demonstrate a commitment to the safety and well-being of the individuals it serves. The organization's policies, procedures and practices shall—

(A) Promote therapeutic progress by addressing matters such as medication compliance, missed appointments, use of alcohol and drugs, and other program expectations or rules;

(B) Encourage appropriate behavior by providing positive instruction and guidance; and

(C) Ensure safety by effectively responding to any threats of suicide, violence or harm. Any use of seclusion or restraint shall be in accordance with 9 CSR 10-7.060 Behavior Management.

(9) All certified agencies, upon learning of the death of a client receiving services, must report the death to the Department of Mental Health (DMH) within twenty-four (24) hours. DMH report form 9719 shall be completed and faxed to the appropriate division director.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Dec. 12, 2001, effective June 30, 2002. Amended: Filed July 29, 2002, effective March 30, 2003.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10–7.040 Quality Improvement

*PURPOSE: This rule describes requirements for quality improvement activities in Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) The organization develops and implements a written plan for a systematic quality assessment and improvement process that is accountable to the governing body and addresses those programs and services certified by the department.

(A) An individual or committee is designated as responsible for coordinating and implementing the quality improvement plan.

(B) Direct service staff and consumers are involved in the planning, design, implementation and review of the organization's quality improvement activities.

(C) Records and reports of quality improvement activities are maintained.

(D) The organization updates its plan for quality assessment and improvement at least annually.

(2) Data are collected to assess quality, monitor service delivery processes and outcomes, identify opportunities for improvement, and monitor improvement efforts.

(A) Data collection shall reflect priority areas identified in the plan.

(B) Consumer satisfaction data shall be included as part of the organization's quality assessment and improvement process. Such data must be collected in a manner that promotes participation by all consumers.

(C) Data are systematically aggregated and analyzed on an ongoing basis.

(D) Data collection analyses are performed using valid, reliable processes.

(E) The organization compares its performance over time and with other sources of information.

(F) Undesirable patterns in performance and sentinel events are intensively analyzed.

(3) The organization develops and implements strategies for service improvement, based on the data analysis.

(A) The organization evaluates the effectiveness of those strategies in achieving improved services delivery and outcomes.

(B) If improved service delivery and outcomes have not been achieved, the organization revises and implements new strategies.

(4) The department may require, at its option, the use of designated measures or instruments in the quality assessment and improvement process, in order to promote consistency in data collection, analysis, and applicability. The required use of particular measures or instruments shall be applicable only to those programs or services funded by the department or provided through a service network authorized by the department.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10–7.050 Research

*PURPOSE: This rule establishes standards and procedures for conducting research in Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) General Policy. The organization shall have a written policy regarding research activities involving individuals served. The organization may prohibit research activities.

(2) Policies and Practices in Conducting Research. If research is conducted, the organization shall assure that—

(A) Compliance is maintained with all federal, state and local laws and regulations concerning the conduct of research including, but not limited to, sections 630.192, 630.199, 630.194, and 630.115, RSMo, 9 CSR 60-1.010 and 9 CSR 60-1.015;

(B) Participating individuals are not the subject of experimental research without their prior written and informed consent or that of their parents or guardian, if minors;

(C) Participating individuals understand that they may decide not to participate or may withdraw from any research at any time for any reason.

(3) Notice to the Department. If any participating individual is receiving services funded by the department or provided through a service network authorized by the department, the organization shall assure that the research has the prior approval of the department. The organization shall immediately inform the department of any adverse outcome experienced by an individual served due to participation in a research project.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10-7.060 Behavior Management

*PURPOSE: This rule establishes requirements for the use of restraint, seclusion and time out in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) General Policy. Any behavior management methods used by an organization shall promote the rights, dignity and safety of individuals being served. An organization may prohibit by policy and practice the use of behavior management, including physical, mechanical and chemical restraint; seclusion; time out; and the use of behavior management plans for selected individuals. If any of these methods of behavior management are to be used within the organization, it shall develop policies and procedures which define, describe and limit the conditions and circumstances of their use.

(A) Organizations utilizing seclusion and restraint must obtain a separate written authorization from the appropriate division of the Department of Mental Health, in addition to other requirements of this rule. The department may issue such authorization on a time-limited basis subject to renewal.

(B) The organization must prohibit by policy and practice:

1. Aversive conditioning of any kind. Aversive conditioning is defined as the application of startling, unpleasant or painful stimulus or stimuli that have a potentially noxious effect on an individual in an effort to decrease maladaptive behavior;
2. Withholding of food, water or bathroom privileges;
3. Painful stimuli;
4. Corporal punishment; and
5. Use of seclusion, restraint, time out, discipline or coercion for staff convenience.

(C) Behavior management policies and procedures shall be:

1. Approved by the organization's board of directors;
2. Made available to all program employees and providers;
3. Made available to the individuals served, their families and others upon request;
4. Developed with the participation of the individuals and, whenever possible, their family members or advocates, or both; and
5. Consistent with department rules regarding individual rights.

(2) Seclusion and Restraint.

(A) The organization shall assure that seclusion and restraint are only used when an individual's behavior presents an immediate risk of danger to themselves or others and no other safe or effective treatment intervention is possible. They shall only be implemented when alternative, less restrictive interventions have failed or cannot be safely implemented. Seclusion and restraint are never used as a treatment intervention. They are emergency/security measures to maintain safety when all other less restrictive interventions are inadequate.

(B) Seclusion and restraint shall only be implemented by competent, trained staff.

(C) The organization shall assure that seclusion or restraint is used only when ordered by a licensed practitioner trained in the use of emergency safety interventions or a certified substance abuse counselor trained in the use of emergency safety interventions. Orders for seclusion or restraint must define specific time limits. Seclusion and restraint shall be ended at the earliest possible time.

1. If seclusion or restraint is initiated prior to obtaining an order, staff must obtain an order immediately.

2. Within one (1) hour of the initiation of the seclusion or restraint a certified substance abuse counselor or licensed practitioner trained in the use of emergency safety interventions and assessment of the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well-being of the resident, including but not limited to:

- A. The resident's physical and psychological status;
- B. The resident's behavior;
- C. The appropriateness of the intervention measures; and
- D. Any complications resulting from the intervention.

3. Standing or *pro re nata* (PRN) orders for seclusion or restraint are not allowed.

4. An order cannot exceed four (4) hours for adults, two (2) hours for children and adolescents ages nine to seventeen (9–17), or one (1) hour for children under age nine (9). When nonlicensed staff initiate seclusion or restraint, an order based on a face-to-face evaluation must be obtained from a licensed practitioner trained in the use of emergency safety interventions or a certified substance abuse counselor trained in the use of emergency safety interventions within one (1) hour.

5. Individuals in restraint shall be monitored continuously. Monitoring may be face-to-face by assigned staff or by audiovisual equipment.

6. Individuals in seclusion shall be visually monitored at least every fifteen (15) minutes.

7. Individuals in seclusion or restraint are offered regular food, fluid and an opportunity to meet their personal hygiene needs no less than every two (2) hours.

8. The need for continuing seclusion or restraint shall be evaluated by and, where necessary, re-ordered by a licensed practitioner trained in the use of emergency safety interventions or certified substance abuse counselor trained in the use of emergency safety interventions at least every four (4) hours for adults, two (2) hours for children and adolescents ages nine through seventeen inclusively (9–17), or one (1) hour for children under age nine (9).

9. The evaluation for the first renewal following an order based on a face-to-face evaluation by a licensed practitioner trained in the use of emergency safety interventions or certified substance abuse counselor trained in the use of emergency safety interventions may be based on a telephone consultation between a licensed practitioner trained in the use of emergency safety interventions or a certified substance abuse counselor trained in the use of emergency safety intervention and on-site staff who have done a face-to-face evaluation with the person in seclusion or restraint. The evaluation for every alternate renewal period shall be based on face-to-face observation and/or interview with the individual by the licensed practitioner or certified substance abuse counselor trained in the use of emergency safety interventions.

10. The organization's clinical director or quality improvement coordinator shall review every episode of seclusion or restraint within seventy-two (72) hours.

11. Any incident of restraint or seclusion shall be promptly reported to the person's parent or legal guardian, when applicable.

### (3) Individualized Behavioral Management Plan.

(A) Definitions. The following terms shall mean:

- 1. Behavioral management plan, array of positive and negative reinforcement to reduce unacceptable or maladaptive interactions and behaviors;
- 2. Time out, an individual's voluntary compliance with the request to remove himself or herself from a service area to a separate location.

(B) The need for a behavioral management plan shall be evaluated upon—

- 1. Any incident of seclusion or restraint;

2. The use of time-out two (2) or more times per day; or

3. The use of time-out three (3) or more times per week.

(C) Behavioral plan shall include the input of the individual being served and family, if appropriate.

(D) The plan shall identify what the individual is attempting to communicate or achieve through the maladaptive behavior before identifying interventions to change it.

(E) The plan shall be reevaluated within the first seven (7) calendar days and every seven (7) days thereafter to determine whether maladaptive and unacceptable behaviors are being reduced and more functional alternatives acquired.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10-7.070 Medications

*PURPOSE: This rule describes training and procedures for the proper storage, use and administration of medications in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) General Guidelines, Policies and Practices. The following requirements apply to all programs, where applicable.

(A) The organization shall assure that staff authorized by the organization and by law to conduct medical, nursing and pharmaceutical services do so using sound clinical practices and following all applicable state and federal laws and regulations.

(B) The organization shall have written policies and procedures on how medications are prescribed, obtained, stored, administered and disposed.

(C) The organization shall implement policies that prevent the use of medications as punishment, for the convenience of staff, as a substitute for services or other treatment, or in quantities that interfere with the individual's participation in treatment and rehabilitation services.

(D) The organization shall allow individuals to take prescribed medication as directed.

1. Individuals cannot be denied service due to taking prescribed medication as directed. If the organization believes that a prescribed medication is subject to abuse or could be an obstacle to other treatment goals, then the organization's treatment staff shall attempt to engage the prescribing physician in a collaborative discussion and treatment planning process. If the prescribing physician is nonresponsive, a second opinion by another physician may be used.

2. Individuals shall not be denied service solely due to not taking prescribed medication as directed. However, a person may be denied service if he or she is unable to adequately participate in and benefit from the service offered due to not taking medication as directed.

(2) Medication Profile. Where applicable, the individual's record shall include a medication profile that includes name, age, weight, current diagnosis, current medication and dosage, prescribing physician, allergies to medication, non-prescription medication and supplements, medication compliance; and other pertinent information related to the individual's medication regimen.

(3) Prescription of Medication. If a program prescribes medications, there shall be documentation of each medication service episode including description of the individual's presenting condition and symptoms, pertinent medical and psychiatric findings, other observations, response to medication, and action taken.

(4) Medication Administration and Related Requirements. The following requirements apply to programs that prescribe or administer medication and to those programs where individuals self-administer medication under staff observation.

(A) Staff Training and Competence. The organization shall ensure the training and competence of staff in the administration of medication and observation for adverse drug reactions and medication errors, consistent with each staff individual's job duties.

1. Staff whose duties include the administration of medication shall complete Level I medication aide training in accordance with 19 CSR 30-84.030. This requirement shall not apply to those staff who—

A. Have prior education and training which meets or exceeds the Level I medication aide training hours and skill objectives; or

B. Work in settings where clients self-administer their own medication under staff observation.

2. Staff whose duties are limited to observing clients self-administer their own medication or to documenting that medication is taken as prescribed shall have available to them a physician, pharmacist, registered nurse or reference material for consultation regarding medications and their actions, possible side effects, and potential adverse reactions.

3. Staff whose duties are limited to observing clients self-administer their own medication or to documenting that medication is taken as prescribed shall receive education on general actions, possible side effects, and potential adverse reactions to medications.

(B) Education. If medication is part of the treatment plan, the organization shall document that the individual and family member, if appropriate, understands the purpose and side effects of the medication.

(C) Compliance. The program shall take steps to ensure that each individual takes medication as prescribed and the program shall document any refusal of medications. A licensed physician shall be informed of any ongoing refusal of medication.

(D) Medication Errors. The program shall establish and implement policies defining the types of medication errors that must be reported to a licensed physician.

(E) Adverse Drug Reactions. A licensed physician shall be immediately notified of any adverse reaction. The type of reaction, physician recommendation and subsequent action taken by the program shall be documented in the individual's record.

(F) Records and Documentation. The organization shall maintain records to track and account for all prescribed medications in residential programs and, where applicable, in nonresidential programs.

1. Each individual receiving medication shall have a medication intake sheet which includes the individual's name, known allergies, type and amount of medication, dose and frequency of administration, date and time of intake, and name of staff who administered or observed the medication intake. If medication is self-administered, the individual shall sign or initial the medication intake sheet.

2. The amount of medication originally present and the amount remaining can be validated by the medication intake sheet.

3. Documentation of medication intake shall include over-the-counter products.

4. Medication shall be administered in single doses to the extent possible.

5. The organization shall establish a mechanism for the positive identification of individuals at the time medication is dispensed, administered or self-administered under staff observation.

(G) Emergency Situations. The organization's policies shall address the administration of medication in emergency situations.

1. Medical/nursing staff shall accept telephone medication orders only from physicians who are included in the organization's list of authorized physicians and who are known to the staff receiving the orders. A physician's signature shall authenticate verbal orders within five (5) working days of the receipt of the initial telephone order.

2. The organization may prohibit telephone medication orders, if warranted by staffing patterns and staff credentials.

(H) Periodic Review. The organization shall document that individuals' medications are evaluated by qualified staff at least every six (6) months to determine their continued effectiveness.

(I) Individuals Bringing Their Own Medication. Any medication brought to the program by an individual served is allowed to be administered or self-administered only when the medication is appropriately labeled.

(J) Labeling. All medication shall be properly labeled. Labeling for each medication shall include drug name, strength, dispense date, amount dispensed, directions for administration, expiration date, name of individual being served, and name of the prescribing physician.

(K) Storage. The organization shall implement written policies and procedures on how medications are to be stored.

1. The organization shall establish a locked storage area for all medications that provides suitable conditions regarding sanitation, ventilation, lighting and moisture.

2. The organization shall store ingestible medications separately from noningestible medications and other substances.

3. The organization shall maintain a list of personnel who have been authorized access to the locked medication area and who are qualified to administer medications.

(L) Inventory. Where applicable, the organization shall implement written policies and procedures for:

1. Receipt and disposition of stock pharmaceuticals must be accurately documented;

2. A log shall be maintained for each stock pharmaceutical that documents receipts and disposition;

3. At least quarterly, each stock pharmaceutical shall be reconciled as to the amount received and the amount dispensed; and

4. A stock supply of a controlled substance must be registered with the Drug Enforcement Administration and the Missouri Department of Health, Bureau of Narcotics and Dangerous Drugs.

(M) Disposal. The organization shall implement written procedures and policies for the disposal of medication.

1. Medication must be removed on or before the expiration date and destroyed.

2. Any medication left by an individual at discharge shall be destroyed within thirty (30) days.

3. The disposal of all medications shall be witnessed and documented by two (2) staff members.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10–7.080 Dietary Service

*PURPOSE: This rule establishes dietary and food service requirements in Alcohol and Drug Abuse Treatment Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

### (1) Dietary Standards for Programs with an Incidental Dietary Component.

(A) Programs defined as having only an incidental dietary component shall include:

1. A permanent residence serving no more than four (4) individuals; or
2. Programs and service sites that do not provide for the preparation, storage or provision of food including food brought by the individuals being served.

(B) Programs and service sites defined as having only an incidental dietary component shall address diet and food preparation on a person's individualized treatment plan, if it is identified as an area in need of intervention based on the assessment.

(C) Where the program does not provide meals, but individuals are allowed to bring their own food, the following standards apply:

1. All appliances must be clean and in safe and proper operating condition; and
2. Hand washing facilities including hot and cold water, soap and hand drying means shall be readily accessible.

### (2) Dietary Standards for Programs and Treatment Sites with Minimal Dietary Component.

(A) A program or service site shall be defined as having a minimal dietary component if one of the following criteria apply and it does not meet the definition of incidental dietary component:

1. It provides for the preparation, storage or consumption of no more than one (1) meal a day; or
2. The program or service site has an average length of stay of less than five (5) days.

(B) The following standards apply for programs with a minimal dietary component:

1. Meals shall be nutritious, balanced and varied based on the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The practical application of these recommendations can be met by following the Dietary Guidelines for Americans and the Food Guide Pyramid of U.S. Department of Agriculture and the U.S. Department of Health and Human Services;
2. Special diets for medical reasons must be provided;
3. Menus shall be responsive to the cultural and religious beliefs of individuals;
4. Food will be served at realistic meal times in a pleasant, relaxed dining area;
5. Food will be stored safely, appropriately and sanitarily;
6. Food shall be in sound condition, free from spoilage, filth or other contamination and safe for human consumption;
7. All appliances shall be in safe and proper operating condition;
8. Food preparation areas will be cleaned regularly and kept in good repair. Utensils shall be sanitized according to Missouri Department of Health standards;
9. Hand washing facilities that include hot and cold water, soap and a means of hand drying shall be readily available; and
10. Paragraphs 5.–9. of this subsection shall be met if the site has a current inspection in compliance with 19 CSR 20-1.010.

### (3) Dietary Standards for Programs and Treatment Sites with a Substantial Dietary Component.

(A) Programs with a substantial dietary component shall be defined as meeting one of the following criteria and are not the permanent residence of more than four (4) individuals:

1. Programs or treatment sites that serve more than one (1) meal per day; and
2. Programs or treatment sites with an average length of stay of over five (5) days.

(B) Programs with a substantial dietary component shall have the following:

1. An annual inspection finding them in compliance with the provisions of 19 CSR 20-1.010. Inspections should be conducted by the local health department or by the Department of Health;

2. Those organizations arranging for provision of food services by agreement or contract with the second party shall assure that the provider has demonstrated compliance with this rule;

3. Programs providing meals shall implement a written plan to meet the dietary needs of the individuals being served, including:

A. Written menus developed and annually reviewed by a registered dietitian or qualified nutritionist who has at least a bachelor's degree from an accredited college with emphasis on foods and nutrition. The organization must maintain a copy of the dietitian's current registration or the qualified nutritionist's academic record.

B. Any changes or substitution in menus must be noted;

C. Menus for at least the past three (3) months shall be maintained;

D. The written dietary plan shall insure that special diets for medical reasons are provided. Menu samples shall be maintained showing how special diets are developed or obtained;

E. Menus shall be responsive to cultural and religious beliefs of individuals;

4. Meals shall be served in a pleasant, relaxed dining area; and

5. Hand washing facilities including hot and cold water, soap and hand drying means shall be readily accessible.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10-7.090 Governing Authority and Program Administration

*PURPOSE: This rule describes requirements for and responsibilities of the governing body in Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) **Governing Body.** The organization has a designated governing body with legal authority and responsibility for the operation of the program(s).

(A) The organization is incorporated in the state of Missouri, maintains good standing in accordance with state law and regulation, and has bylaws identifying the structure of its governing body.

(B) Methods for selecting members of the governing body are delineated. A current list of members is maintained.

(C) Requirements of section (1) are not applicable to government entities, except that a government entity or public agency must have an administrative structure with identified lines of authority to ensure responsibility and accountability for the successful operation of its psychiatric and substance abuse services.

(2) **Functions of the Governing Body.** The governing body shall effectively implement the functions of—

(A) Providing fiscal planning and oversight;

(B) Ensuring organizational planning and quality improvement in service delivery;

(C) Establishing policies to guide administrative operations and service delivery;

(D) Ensuring responsiveness to the communities and individuals being served;

(E) Delegating operational management to an executive director and, as necessary, to program managers in order to effectively operate its services; and

(F) Designating contractual authority.

(3) **Meetings.** The governing body shall meet at least quarterly and maintain an accurate record of its meetings. Minutes of meetings must identify dates, those attending, discussion items, and actions taken.

(4) **Policy and Procedure Manual.** The organization maintains a current policy and procedure manual which accurately describes and guides the operation of its services, promotes compliance with applicable regulations, and is readily available to staff and the public upon request.

(5) Each agency shall develop a corporate compliance plan designed to prevent, detect, and report health care fraud and abuse.

(A) An individual shall be identified as a corporate compliance officer who shall have responsibility for coordinating, implementing, and monitoring the plan.

(B) The corporate compliance plan shall include education and training of staff and specific oversight activities to monitor and detect potential fraud and abuse.

(6) **Accountability.** The organization establishes a formal, accountable relationship with any contractor or affiliate who provides direct service but who is not an employee of the organization.

(7) Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Regulatory Compliance. The organization must comply with other applicable requirements as set forth in 9 CSR 10-5.220.

*AUTHORITY: section 630.050, RSMo Supp. 2009 and section 630.055, RSMo 2000. 45 CFR parts 160 and 164, the Health Insurance Portability and Accountability Act of 1996.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed April 1, 2003, effective April 14, 2003, expired Oct. 14, 2003. Amended: Filed April 1, 2003, effective Oct. 30, 2003. Amended: Filed March 15, 2010, effective Sept. 30, 2010.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 630.055, RSMo 1980.*

## 9 CSR 10-7.100 Fiscal Management

*PURPOSE: This rule describes fiscal policies and procedures for Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) Generally Accepted Accounting Principles. The organization has fiscal management policies, procedures and practices consistent with generally accepted accounting principles and, as applicable, state and federal law, regulation, or funding requirements.

(2) Monitoring and Reporting Financial Activity. The organization assigns responsibility for fiscal management to a designated staff member who has the skills, authority and support to fulfill these responsibilities.

(A) There is an annual budget of revenue by source and expenses by category that is approved in a timely manner by the governing body. Fiscal reports are prepared on at least a quarterly basis which compare the budget to actual experience. Fiscal reports are provided to and reviewed by the governing body and administrative staff who have ongoing responsibility for financial and program management.

(B) The organization utilizes financial activity measures to monitor and ensure its ability to pay current liabilities and to maintain adequate cash flows.

(C) There are adequate internal controls for safeguarding or avoiding misuse of assets.

(D) The organization has an annual audit by an independent, certified public accountant if required by funding sources or otherwise required by federal or state law or regulation.

(3) Fee Schedule. The organization has a current written fee schedule approved by the governing body and available to staff and individuals being served.

(4) Retention of Fiscal Records. Fiscal records shall be retained for at least five (5) years or until any litigation or adverse audit findings, or both, are resolved.

(5) Insurance Coverage. The organization shall have adequate insurance coverage to protect its physical and financial resources. Insurance coverage for all people, buildings and equipment shall be maintained and shall include fidelity bond, automobile liability, where applicable, and broad form comprehensive general liability for property damage, and bodily injury including wrongful death and incidental malpractice.

(6) Accountability for the Funds of Persons Served. If the organization is responsible for funds belonging to persons served, there shall be procedures that identify those funds and provide accountability for any expenditure of those funds. Such funds shall be expended or invested only with the informed consent and approval of the individuals or, if applicable, their legally appointed representatives. The individuals shall have access to the records of their funds. When benefits or personal allowance monies are received on behalf of individuals or when the organization acts as representative payee, such funds are segregated for each individual for accounting purposes and are used only for the purposes for which those funds were received.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10-7.110 Personnel

*PURPOSE: This rule describes personnel policies and procedures for Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) Policies and Procedures. The organization shall maintain personnel policies, procedures and practices in accordance with local, state and federal law and regulation. In addition to the requirements of this rule, the organization must also comply with 9 CSR 10-5.190 regarding criminal record background check and eligibility for employment.

(A) The policies and procedures shall include written job descriptions for each position and a current table of organization reflecting each position and, where applicable, the relationship to the larger organization of which the program or service is a part.

(B) Policies and procedures shall be consistently and fairly applied in the recruitment, selection, development and termination of staff.

(2) Qualified and Trained Staff. Qualified staff shall be available in sufficient numbers to ensure effective service delivery.

(A) The organization shall ensure that staff possess the training, experience and credentials to effectively perform their assigned services and duties.

(B) A background screening shall be conducted in accordance with 9 CSR 10-5.190.

(C) Qualifications and credentials of staff shall be verified prior to employment, with primary source verification completed within ninety (90) days.

(D) There is clinical supervision of direct service staff that ensures adequate supervisory oversight and guidance, particularly for those staff who may lack credentials for independent practice in Missouri.

(E) Training and continuing education opportunities are available to all direct service staff, in accordance with their job duties and any licensing or credentialing requirements.

1. All staff who provide services or are responsible for the supervision of persons served shall participate in at least thirty-six (36) clock hours of relevant training during a two (2)-year period.

2. Training shall assist staff in meeting the needs of persons served, including persons with co-occurring disorders.

3. The organization shall maintain a record of participation in training and staff development activities.

(F) When services and supervision are provided twenty-four (24) hours per day, the organization maintains staff on duty, awake and fully dressed at all times. A schedule or log is maintained which accurately documents staff coverage.

(3) Ethical Standards of Behavior. Staff shall adhere to ethical standards of behavior in their relationships with individuals being served.

(A) Staff shall maintain an objective, professional relationship with individuals being served at all times.

(B) Staff shall not enter dual or conflicting relationships with individuals being served which might affect professional judgment or increase the risk of exploitation.

(C) The organization shall establish policies and procedures regarding staff relationships with both individuals currently being served and individuals previously served.

(4) Volunteers. If the agency uses volunteers, it shall establish and consistently implement policies and procedures to guide the roles and activities of volunteers in an organized and productive manner. The agency shall ensure that volunteers have a background screening in accordance with 9 CSR 10-5.190 and adequate supervision.

(5) Practicum/Intern Students. A practicum/intern student if used in a Department of Mental Health (DMH) program must be enrolled and participating in an accredited college/university in a field of study including but not limited to social work, psychology, sociology or nursing.

(A) The student and agency must have a written plan documenting the following:

(B) Name of individual, educational institution, and degree program;

(C) Brief description of the status of the individual with respect to degree completion, including: semester/hours remaining, projected completion date, and time period of the practicum or internship;

3. A description of the specific job status of the individual with respect to agency program and client population;

4. A specific plan for supervision of the student, including name and title of the direct supervisor. The plan must detail the frequency and duration of the supervision activities including the scope of case/record reviews, the location of the supervisor with respect to the service delivery locations, and emergency backup supervision arrangements; and

5. A list of the specific Purchase of Service (POS) services the agency has approved for the student to deliver. Students may not deliver Medicaid-eligible services unless they meet the provider eligibility requirements through prior experience and education.

(B) The student must have a letter from their academic advisor attesting to their qualifications and eligibility for the proposed practicum.

(C) The student must be under the close supervision of the direct clinical supervising professional of the agency. The person providing the supervision must be qualified to provide the services they are supervising.

1. For providing counseling services a student must be in a master's program or above, and be approved for the practicum by the college/university.

2. To provide case management and community support work, and other support services, a student must be in the final year of a bachelor's program or above.

3. A student may be assigned a limited caseload based on background and prior experience.

(D) A student must be background screened, oriented and trained as consistent with the agency's policies for new employees.

(E) Service delivery by the student must be documented according to department standards and policy.

1. All documentation of billable services must be reviewed and countersigned by an individual who meets the division criteria for a qualified mental health professional or supervisor of counselors, a community support worker, or case manager, as appropriate.

2. Services shall be billed using appropriate existing service codes and reimbursed at the established contract rate for the anticipated degree, unless a distinct student rate has been established for the service.

(F) For Division of Alcohol and Drug Abuse funded contracts, the services are limited to individual counseling, group counseling, group education and community support work.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Aug. 28, 2002, effective April 30, 2003.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10-7.120 Physical Plant and Safety

*PURPOSE: This rule describes requirements for the physical facilities and safety in Alcohol and Drug Treatment Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) Applicable Requirements for All Facilities and for Residential Facilities. This rule is organized as follows:

(A) Sections (2) through (9) apply to all facilities and program sites subject to certification by the department; and

(B) Section (10) applies to residential facilities only.

(2) Safety Inspections. Each individual shall be served in a safe facility.

(A) All buildings used for programmatic activities or residential services by the organization shall meet applicable state and local fire safety and health requirements. At the time of the initial application and after that, whenever renovations are made, the organization shall submit to the department verification that the facility complies with requirements for the building, electrical system, plumbing, heating system and, where applicable, water supply.

(B) The organization shall maintain documentation of all inspections and correction of all cited deficiencies to assure compliance with applicable state and local fire safety and health requirements. These inspection and documentation requirements may be waived for a nonresidential service site that operates less than three (3) hours per day, two (2) days per week.

(C) A currently certified organization that relocates any program into new physical facilities shall have the new facilities comply with this rule in order to maintain certification. All additions or expansions to existing physical facilities must meet the requirements of this rule.

(3) Physical Access. Individuals are able to readily access the organization's services. The organization shall demonstrate an ability to remove architectural and other barriers that may confront individuals otherwise eligible for services.

(4) Adequate Space and Furnishings. Individuals are served in a setting with adequate space, equipment and furnishings for all program activities and for maintaining privacy and confidentiality.

(A) In keeping with the specific purpose of the service, the organization shall make available—

1. A reception/waiting area;
2. Private areas for individual counseling and family therapy;
3. A private area(s) for group counseling, education and other group services;
4. An area(s) for indoor social and recreational activities in residential settings and in nonresidential settings where individuals are scheduled for more than four (4) hours per day; and
5. Separate toilet facilities for each sex, except where reasonable evidence is shown to the department that this is not necessary.

(B) The organization shall have appropriate furnishings which are clean and in good repair.

(C) The use of appliances such as television, radio and stereo equipment shall not interfere with the therapeutic program.

(5) Clean and Comfortable Setting. Individuals are served in settings that are clean and comfortable, in good repair, and in safe operating order. The organization shall—

(A) Provide adequate and comfortable lighting;

- (B) Maintain a comfortable room temperature between sixty-eight degrees Fahrenheit (68° F) and eighty degrees Fahrenheit (80° F);
- (C) Provide screens on outside doors and windows if they are to be kept open;
- (D) Provide effective pest control measures;
- (E) Store refuse in covered containers so as not to create a nuisance or health hazard;
- (F) Maintain the facility free of undesirable odors;
- (G) Provide stocked, readily accessible first-aid supplies; and
- (H) Take measures to prevent, detect and control infections among individuals and personnel, and have protocols for proper treatment.

(6) Off-Site Functions. If the organization offers certain services at locations in the community other than at its facilities, the organization shall take usual and reasonable precautions to preserve the safety of individuals participating in these off-site locations.

(7) Emergency Preparedness. The organization shall have an emergency preparedness plan.

- (A) The plan shall address medical emergencies and natural disasters.
- (B) Evacuation routes shall be posted, or the organization shall maintain a written evacuation plan.
- (C) Staff shall demonstrate knowledge and ability to effect the emergency preparedness plan and, where applicable, the evacuation plan.
- (D) Emergency numbers for the fire department, police and poison control shall be posted and readily visible near the telephone.

(8) Fire Safety. The organization shall maintain fire safety equipment and practices to protect all occupants.

(A) Portable ABC type fire extinguishers shall be located on each floor used by individuals being served so that no one will have to travel more than one hundred feet (100') from any point to reach the nearest extinguisher. Additional fire extinguishers shall be provided, where applicable, for the kitchen, laundry and furnace areas.

(B) Fire extinguishers shall be clearly visible and maintained with a charge.

(C) There shall be at least two (2) means of exit on each floor used by individuals being served, which are independent of and remote from one another.

1. Outside fire escape stairs may constitute one (1) means of exit in existing buildings. Fire escape ladders shall not constitute one (1) of the required means of exit.

2. The means of exit shall be free of any item that would obstruct the exit route.

3. Outside stairways shall be substantially constructed to support people during evacuation. Newly constructed fire exits shall meet requirements of the National Fire Protection Association (NFPA) *Life Safety Code*.

4. Outside stairways shall be reasonably protected against blockage by a fire. This may be accomplished by physical separation, distance, arrangement of the stairs, protection of openings exposing the stairs or other means acceptable to the fire authority.

5. Outside stairways at facilities with three (3) or more stories shall be constructed of noncombustible material, such as iron or steel.

(D) Unless otherwise determined by the fire inspector based on a facility's overall size and use, the requirement of two (2) or more means of exit on each floor shall be waived for those sites that meet each of the following conditions:

- 1. Do not offer overnight sleeping accommodations;
- 2. Do not cook meals on a regular basis; and
- 3. Do not provide services on-site to twenty (20) or more individuals at a given time as a usual and customary pattern of service delivery.

(E) The requirement for two (2) means of exit from the second floor shall be waived for a residential facility if it serves no more than four (4) individuals and each of those individuals—

1. Is able to hear and see;
2. Is able to recognize a fire alarm as a sign of danger;
3. Is ambulatory and able to evacuate the home without assistance in an emergency; and
4. Has staff available in the event that assistance is needed.

(F) Ceiling height shall be at least seven feet ten inches (7'10") in all rooms used by persons served except as follows:

1. Hallways and bathrooms shall have a ceiling height of at least seven feet six inches (7'6"); and

2. Existing facilities inspected and approved by the department during a certification site survey prior to the effective date of this rule may request an exception from this ceiling height requirement.

(G) Combustible supplies and equipment, such as oil base paint, paint thinner and gasoline, shall be separated from other parts of the building in accordance with stipulations of the fire authority.

(H) The use of wood, gas or electric fireplaces shall not be permitted unless they are installed in compliance with the NFPA codes and the facility has prior approval of the department.

(I) The *Life Safety Code* of the NFPA shall prevail in the interpretation of these fire safety standards.

(J) Fire protection equipment required shall be installed in accordance with NFPA codes.

(K) The facility shall be smoke-free, unless otherwise stipulated in program specific rules.

(9) Safe Transportation. Where applicable, the organization shall implement measures to ensure safe transportation for persons served.

(A) Agency owned vehicles which are used by the organization to transport persons served shall have—

1. Regular inspection and maintenance as legally required; and
2. Adequate first-aid supplies and fire suppression equipment which are secured in any van, bus or other vehicle used to transport more than four (4) clients. Staff which operate such a vehicle shall have training in emergency procedures and the handling of accidents and road emergencies.

(B) All staff who transport persons served shall be properly licensed with driving records acceptable to the agency.

(C) There shall be a current certificate of insurance for agency owned vehicles in accordance with the organization's requirements.

(10) Residential Facilities. In addition to the requirements under sections (1) through (8) of this rule, residential facilities shall also meet the following additional requirements:

(A) Residential facilities shall provide—

1. At least one (1) toilet, one (1) lavatory with a mirror and one (1) tub or shower for each six (6) individuals provided overnight sleeping accommodations;
2. Bathroom(s) in close proximity to the bedroom area(s);
3. Privacy for personal hygiene, including stalls or other means of separation acceptable to the department when a bathroom has multiple toilets, urinals or showers;
4. Laundry area or service;
5. Adequate supply of hot water;
6. Lockable storage space for the use of each individual being served;
7. Furniture and furnishings suitable to the purpose of the facility and individuals;

8. Books, newspapers, magazines, educational materials, table games and recreational equipment, in accordance with the interests and needs of individuals;

9. An area(s) for dining;

10. Windows which afford visual access to out-of-doors and, if accessible from the outside, are lockable; and

11. Availability of outdoor activities;

(B) Bedrooms in residential facilities shall:

1. Have no more than four (4) individuals per bedroom;

2. Have separate areas for males and females subject to the department's approval;

3. Provide at least sixty (60) square feet of floor space per individual in multiple sleeping rooms and eighty (80) square feet per individual in single sleeping rooms. Additional space shall be required, if necessary to accommodate special medical or other equipment needed by individuals. In the computation of space in a bedroom with a sloped ceiling, floor space shall be limited to that proportion of the room having a ceiling height as required elsewhere in this rule. Square feet of contiguous floor space for each individual shall be computed by using the inside dimensions of the room in which the person's bed is physically located less that square footage of floor space required by any other individuals and less any walled, closed space within the room;

4. Have a separate bed with adequate headroom for each individual. Cots and convertibles shall not be used. If bunk beds are used they shall be sturdy, have braces to prevent rolling from the top bunk, and be convertible to two (2) floor beds if an individual does not desire a bunk bed;

5. Provide storage space for the belongings of each individual, including space for hanging clothes;

6. Encourage the display of personal belongings in accordance with treatment goals;

7. Provide a set of linens, a bedspread, a pillow and blankets as needed;

8. Have at least one (1) window which operates as designed;

9. Have a floor level which is no more than three feet (3') below the outside grade on the window side of the room; and

10. Not be housed in a mobile home, unless otherwise stipulated in program specific rules;

(C) Activity space in residential facilities shall:

1. Total eighty (80) square feet for each individual, except that additional space shall be required, if necessary to accommodate special medical or other equipment needed by individuals. Activity space includes the living room, dining room, counseling areas, recreational and other activity areas. Activity space does not include the laundry area, hallways, bedrooms, bathrooms or supply storage area; and

2. Not be used for other purposes if it reduces the quality of services;

(D) In all residential facilities, fire safety precautions shall include—

1. An adequate fire detection and notification system which detects smoke, fumes and/or heat, and which sounds an alarm which can be heard throughout the facility above the noise of normal activities, radios and televisions;

2. Bedroom walls and doors that are smoke resistant. Transfer grilles are prohibited;

3. A range hood and extinguishing system for a commercial stove or deep fryer. The extinguishing system shall include automatic cutoff of fuel supply and exhaust system in case of fire; and

4. An annual inspection in accordance with the *Life Safety Code* of the National Fire Protection Association (NFPA);

(E) Residential facilities with more than four (4) individuals shall provide—

1. Smoke detectors powered by the electrical system with an emergency power backup. These detectors shall activate the alarm system. They shall be installed on all floors, including

basements. Detectors shall be installed in living rooms or lounges. Heat detectors may be used in utility rooms, furnace rooms and unoccupied basements and attics;

2. Smoke detectors in each sleeping room. Those detectors may be battery operated and are not required to initiate the building fire alarm system;

3. At least one (1) manual fire alarm station per floor arranged to continuously sound the smoke detection alarm system or other continuously sounding manual alarms acceptable to the authority having jurisdiction. The requirement of at least one (1) manual fire alarm station per floor may be waived where there is an alarm station at a central control point under continuous supervision of a responsible employee;

4. An alarm which is audible in all areas. There shall be an annual inspection of the alarm system by a competent authority;

5. A primary means of egress which is a protected vertical opening. Protected vertical openings shall have doors that are self-closing or automatic closing upon detection of smoke. Doors shall be at least one and one-half inches (1 1/2") in existing facilities and one and three-fourths inches (1 3/4") in new construction, of solid bonded wood core construction or other construction of equal or greater fire resistance;

6. Emergency lighting of the means of egress; and

7. Readily visible, approved exit signs, except at doors leading directly from rooms to an exit corridor and except at doors leading obviously to the outside from the entrance floor. Every exit sign shall be visible in both the normal and emergency lighting mode;

(F) In residential facilities with more than twenty (20) individuals—

1. Neither of the required exits shall be through a kitchen;

2. No floor below the level of exit discharge, used only for storage, heating equipment or purposes other than residential occupancy shall have unprotected openings to floors used for residential purposes;

3. Doors between bedrooms and corridors shall be one and one-half inches (1 1/2") in existing facilities, and one and three-fourths inches (1 3/4") in new construction, solid bonded wood core construction or other construction of equal or greater fire resistance;

4. Unprotected openings shall be prohibited in interior corridors serving as exit access from bedrooms; and

5. A primary means of egress which is an enclosed vertical opening. This vertical opening shall be enclosed with twenty (20)-minute fire barriers and doors that are self-closing or automatic closing upon detection of smoke.

(G) In detoxification programs—

1. The means of exit shall not involve windows;

2. The interior shall be fully sheathed in plaster or gypsum board, unless the group can evacuate in eight (8) minutes or less; and

3. Bedroom doors shall be one and one-half inches (1 1/2") in existing facilities, and one and three-fourths inches (1 3/4") in new construction, solid bonded wood core construction or other construction of equal or greater fire resistance, unless the group can evacuate in eight (8) minutes or less.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10-7.130 Procedures to Obtain Certification

*PURPOSE: This rule describes procedures to obtain certification as Alcohol and Drug Abuse Programs, Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR), Compulsive Gambling Treatment Programs, Substance Abuse Traffic Offender Programs (SATOP), Required Education Assessment and Community Treatment Programs (REACT), Community Psychiatric Rehabilitation Programs (CPRP), and Psychiatric Outpatient Programs.*

(1) Under sections 630.655, 630.010, and 376.779.3 and 4, RSMo, the department is mandated to develop certification standards and to certify an organization's level of service, treatment or rehabilitation as necessary for the organization to operate, receive funds from the department, or participate in a service network authorized by the department and eligible for Medicaid reimbursement. However, certification in itself does not constitute an assurance or guarantee that the department will fund designated services or programs.

(A) A key goal of certification is to enhance the quality of care and services with a focus on the needs and outcomes of persons served.

(B) The primary function of the certification process is assessment of an organization's compliance with standards of care. A further function is to identify and encourage developmental steps toward improved program operations, client satisfaction and positive outcomes.

(2) An organization may request certification by completing an application form, as required by the department for this purpose, and submitting the application form, and other documentation, as may be specified, to the Department of Mental Health, PO Box 687, Jefferson City, MO 65102.

(A) The organization must submit a current written description of those programs and services for which it is seeking certification by the department.

(B) A new applicant shall not use a name which implies a relationship with another organization, government agency or judicial system when a formal organizational relationship does not exist.

(C) Certification fees are not required, except for the Substance Abuse Traffic Offender Program (SATOP). A nonrefundable fee of one hundred twenty-five dollars (\$125) is required upon initial application. Renewal fees are as follows:

1. A fee of one hundred twenty-five dollars (\$125) is required if the aggregate number of individuals being served in the SATOP program(s) during the preceding state fiscal year was less than two hundred fifty (250) individuals;

2. A fee of two hundred fifty dollars (\$250) is required if the aggregate number of individuals being served in the SATOP program(s) during the preceding state fiscal year was at least two hundred fifty (250) but no more than four hundred ninety-nine (499); or

3. A fee of five hundred dollars (\$500) is required if the aggregate number of individuals being served in the SATOP program(s) during the preceding state fiscal year was at least five hundred (500).

(D) The fee schedule may be adjusted annually by the department.

(E) The department will review a completed application within thirty (30) calendar days of receipt to determine whether the applicant organization would be appropriate for certification. The department will notify the organization of its determination. Where applicable, an organization may qualify for expedited certification in accordance with subsections (3)(B) and (C) of this rule by submitting to the department required documentation and verification of its accreditation or other deemed status.

(F) An organization that wishes to apply for recertification shall submit its application forms to the department at least sixty (60) days before expiration of its existing certificate.

(G) An applicant can withdraw its application at any time during the certification process, unless otherwise required by law.

(3) The department shall conduct a site survey at an organization to assure compliance with standards of care and other requirements. The department shall determine which standards and requirements are applicable, based on the application submitted and the on-site survey.

(A) The department shall conduct a comprehensive site survey for the purpose of determining compliance with core rules and program/service rules, except as stipulated in subsections (3)(B) and (C).

(B) The department shall conduct an expedited site survey when an organization has attained full accreditation under standards for behavioral healthcare from the Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the Council on Accreditation of Services to Families and Children (COA).

1. The survey shall monitor compliance with applicable program/service rules promulgated by the department.

2. The survey shall not monitor core rules, except for those requirements designated by the department as essential to—

A. Providing and documenting services funded by the department or provided through a service network authorized by the department;

B. Assuring the qualifications and credentials of staff members providing these services;

C. Protecting the rights of individuals being served, including mechanisms for grievances and investigations; and

D. Funding, contractual, or other legal relationship between the organization and the department.

(C) The department shall grant a certificate, upon receipt of a completed application, to an organization which has attained full accreditation under standards for behavioral healthcare from CARF, JCAHO or COA; does not provide methadone treatment; does not receive funding from the department; and does not participate in a service network authorized by the department.

1. The organization must submit a copy of the most recent accreditation survey report and verification of the accreditation time period and dates.

2. The department shall review its categories of programs and services available for certification and shall determine those which are applicable to the organization. The department, at its option, may visit the organization's program site(s) solely for the purpose of clarifying information contained in the organization's application and its description of programs and services, and/or determining those programs and services eligible for certification by the department.

(4) The department shall provide advance notice and scheduling of routine, planned site surveys.

(A) The department shall notify the applicant regarding survey date(s), procedures and a copy of any survey instrument that may be used. Survey procedures may include, but are not limited to, interviews with organization staff, individuals being served and other interested parties; tour and inspection of treatment sites; review of organization administrative records necessary to verify compliance with requirements; review of personnel records and service documentation; observation of program activities; and review of data regarding practice patterns and outcome measures, as available.

(B) The applicant agrees, by act of submitting an application, to allow and assist department representatives in fully and freely conducting these survey procedures and to provide department representatives reasonable and immediate access to premises, individuals, and requested information.

(C) An organization must engage in the certification process in good faith. The organization must provide information and documentation that is accurate, and complete. Failure to participate in good faith, including falsification or fabrication of any information used to determine compliance with requirements, may be grounds to deny issuance of or to revoke certification.

(D) The surveyor(s) shall hold entrance and exit conferences with the organization to discuss survey arrangements and survey findings, respectively. A surveyor shall immediately cite any deficiency which could result in actual jeopardy to the safety, health or welfare of persons served. The surveyor shall not leave the program until an acceptable plan of correction is presented which assures the surveyor that there is no further risk of jeopardy to persons served.

(E) Within thirty (30) calendar days after the exit conference, the department shall provide a written survey report to the organization's director and governing authority.

1. The report shall note any deficiencies identified during the survey for which there was not prompt, remedial action.

2. The organization shall make the report available to the staff and to the public upon request.

3. Where applicable, the department shall send a notice of deficiency by certified mail, return receipt requested.

(F) Within thirty (30) calendar days of the date that a notice of deficiency is presented by certified mail to the organization, it shall submit to the department a plan of correction.

1. The plan must address each deficiency, specifying the method of correction and the date the correction shall be completed.

2. Within fifteen (15) calendar days after receiving the plan of correction, the department shall notify the organization of its decision to approve, disapprove, or require revisions of the proposed plan.

3. In the event that the organization has not submitted a plan of correction acceptable to the department within ninety (90) days of the original date that written notice of deficiencies was presented by certified mail to the organization, it shall be subject to expiration of certification.

(5) The department may grant certification on a temporary, provisional, conditional, or compliance status. In determining certification status, the department shall consider patterns and trends of performance identified during the site survey.

(A) Temporary status shall be granted to an organization if the survey process has not been completed prior to the expiration of an existing certificate and the applicant is not at fault for failure or delay in completing the survey process.

(B) Provisional status for a period of one hundred eighty (180) calendar days shall be granted to a new organization or program based on a site review which finds the program in compliance with requirements related to policy and procedure, facility, personnel, and staffing patterns sufficient to begin providing services.

1. In the department's initial determination and granting of provisional certification, the organization shall not be expected to fully comply with those standards which reflect ongoing program activities.

2. Within one hundred eighty (180) calendar days of granting provisional certification, the department shall conduct a comprehensive or expedited site survey and shall make a further determination of the organization's certification status.

(C) Conditional status shall be granted to an organization which, upon a site survey by the department, is found to have numerous or significant deficiencies with standards that may affect quality of care to individuals but there is reasonable expectation that the organization can achieve compliance within a stipulated time period.

1. The period of conditional status shall not exceed one hundred eighty (180) calendar days. The department may directly monitor progress, may require the organization to submit progress reports, or both.

2. The department shall conduct a further site survey within the one hundred eighty (180)-day period and make a further determination of the organization's compliance with standards.

(D) Compliance status for a period of three (3) years shall be awarded to an organization which, upon a site survey by the department, is found to meet all standards relating to quality of care and the safety, health and welfare of persons served.

(E) For organizations that have attained full accreditation under standards for behavioral healthcare from CARF, JCAHO, and COA, and that receive an expedited site survey from the department, compliance status from the department shall be for a period of time equal to the length of the accreditation received from the accrediting entity.

(6) The department may investigate any written complaint regarding the operation of a certified program or service.

(7) The department may conduct a scheduled or unscheduled site survey of an organization at any time to monitor ongoing compliance with these rules. If any survey finds conditions that are not in compliance with applicable certification standards, the department may require corrective action steps and may change the organization's certification status consistent with procedures set out in this rule.

(8) The department shall certify only the organization named in the application, and the organization may not transfer certification without the written approval of the department.

(A) A certificate is the property of the department and is valid only as long as the organization meets standards of care and other requirements.

(B) The organization shall maintain the certificate issued by the department in a readily available location.

(C) Within seven (7) calendar days of the time a certified organization is sold, leased, discontinued, moved to a new location, has a change in its accreditation status, appoints a new director, or changes programs or services offered, the organization shall provide written notice to the department of any such change.

(D) A certified organization that establishes a new program or type of program shall operate that program in accordance with applicable standards. A provisional review, expedited site survey or comprehensive site survey shall be conducted, as determined by the department.

(9) The department may deny issuance of and may revoke certification based on a determination that—

(A) The nature of the deficiencies results in substantial probability of or actual jeopardy to individuals being served;

(B) Serious or repeated incidents of abuse or neglect of individuals being served or violations of rights have occurred;

(C) Fraudulent fiscal practices have transpired or significant and repeated errors in billings to the department have occurred;

(D) Failure to participate in the certification process in good faith, including falsification or fabrication of any information used to determine compliance with requirements;

(E) The nature and extent of deficiencies results in the failure to conform to the basic principles and requirements of the program or service being offered; or

(F) Compliance with standards has not been attained by an organization upon expiration of conditional certification.

(10) The department, at its discretion, may—

(A) Place a monitor at a program if there is substantial probability of or actual jeopardy to the safety, health or welfare of individuals being served.

1. The cost of the monitor shall be charged to the organization at a rate which recoups all reasonable expenses incurred by the department.

2. The department shall remove the monitor when a determination is made that the safety, health and welfare of individuals being served is no longer at risk.

(B) Take other action to ensure and protect the safety, health or welfare of individuals being served.

(11) An organization which has had certification denied or revoked may appeal to the director of the department within thirty (30) calendar days following notice of the denial or revocation being presented by certified mail to the organization. The director of the department shall conduct a hearing under procedures set out in Chapter 536, RSMo and issue findings of fact, conclusions of law and a decision which shall be final.

(12) The department shall have authority to impose administrative sanctions.

(A) The department may suspend the certification process pending completion of an investigation when an organization that has applied for certification or the staff of that organization is under investigation for fraud, financial abuse, abuse of persons served, or improper clinical practices.

(B) The department may administratively sanction a certified organization that has been found to have committed fraud, financial abuse, abuse of persons served, or improper clinical practices or that had reason to know its staff were engaged in such practices.

(C) Administrative sanctions include, but are not limited to, suspension of certification, clinical utilization review requirements, suspension of new admissions, denial or revocation of certification, or other actions as determined by the department.

(D) The department shall have the authority to refuse to accept for a period of up to twenty-four (24) months an application for certification from an organization that has had certification denied or revoked or that has been found to have committed fraud, financial abuse or improper clinical practices or whose staff and clinicians were engaged in improper practices.

(E) An organization may appeal these sanctions pursuant to section (11).

(13) An organization may request the department's exceptions committee to waive a requirement for certification if the head of the organization provides evidence that a waiver is in the best interests of the individuals it serves.

(A) A request for a waiver shall be in writing and shall include justification for the request.

(B) The request shall be submitted to Exceptions Committee, Department of Mental Health, PO Box 687, Jefferson City, MO 65102.

(C) The exceptions committee shall hold meetings in accordance with Chapter 610, RSMo and shall respond with a written decision within forty-five (45) calendar days of receiving a request.

(D) The exceptions committee may issue a waiver on a time-limited or other basis.

(E) If a waiver request is denied, the exceptions committee shall give the organization forty-five (45) calendar days to fully comply with the standard, unless a different time period is specified by the committee.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Sept. 25, 2002, effective April 30, 2003. Amended: Filed March 3, 2003, effective Sept. 30, 2003.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

## 9 CSR 10-7.140 Definitions

*PURPOSE: This rule defines terms used in the certification of psychiatric and substance abuse programs.*

(1) The definitions included in this rule shall apply to:

- (A) 9 CSR 10-7 Core Rules for Psychiatric and Substance Abuse Programs;
- (B) 9 CSR 30-3 Certification Standards for Alcohol and Drug Abuse; and
- (C) 9 CSR 30-4 Certification Standards for Mental Health Programs.

(2) Unless the context clearly indicates otherwise, the following terms shall mean:

- (A) Abstinence, the non-use of alcohol and other drugs;
- (B) Admission, entry into the treatment and rehabilitation process after an organization has determined an individual meets eligibility criteria for receiving its services;
- (C) Adolescent, a person between the ages of twelve through seventeen (12–17) years inclusive;
- (D) Agency, this term may be used interchangeably with organization. See the definition of organization;
- (E) Alcohol or drug-related traffic offense, an offense of driving while intoxicated, driving with excessive blood alcohol content, or driving under the influence of alcohol or drugs in violation of state law;
- (F) Alcohol or drug treatment and rehabilitation program, a program certified by the Department of Mental Health as providing treatment and rehabilitation of substance abuse in accordance with service and program requirements under 9 CSR 30-3.100 through 9 CSR 30-3.199;
- (G) Applicant, an organization seeking certification from the department under 9 CSR 30;
- (H) Assessment, systematically collecting information regarding the individual's current situation, symptoms, status and background, and developing a treatment plan that identifies appropriate service delivery;
- (I) Associate substance abuse counselor, a trainee that must meet requirements for registration, supervision, and professional development as set forth by either—
  - 1. The Missouri Substance Abuse Counselors Certification Board, Inc.; or
  - 2. The appropriate board of professional registration within the Department of Economic Development for licensure as a psychologist, professional counselor, or social worker;
- (J) Certification, determination and recognition by the Department of Mental Health that an organization complies with applicable rules and standards of care under 9 CSR;
- (K) Client, this term may be used interchangeably with individual. See the definition of individual;
- (L) Clinical utilization review, a process of service authorization and/or review established by the department and conducted by credentialed staff in order to promote the delivery of services that are necessary, appropriate, likely to benefit the individual, and provided in accordance with admission criteria and service definitions;
- (M) Compulsive gambling, the chronic and progressive preoccupation with gambling and the urge to gamble. This term may be used interchangeably with pathological gambling;
- (N) Co-occurring disorders, presence of both substance and psychiatric disorders which impede the individual's functioning or ability to manage daily activities, consistent with diagnostic criteria established in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association;
- (O) Corporal punishment, purposeful infliction of physical pain upon an individual for punitive or disciplinary reasons;

(P) Crisis, an event or time period for an individual characterized by substantial increase in symptoms, legal or medical problems, and/or loss of housing or employment or personal supports;

(Q) Day, a calendar day unless specifically stated otherwise;

(R) Deficiency, a condition, event or omission that does not comply with a certification rule;

(S) Department, the Department of Mental Health;

(T) Director, the Department of Mental Health director or designee;

(U) Discharge, the time when an individual's active involvement with the program concludes in accordance with treatment plan goals, any applicable utilization criteria, and/or program rules;

(V) Discharge planning, an activity to assist an individual's further participation in services and supports in order to promote continued recovery upon completion of a program or level of care;

(W) Facility, physical plant or site used to provide services;

(X) Family/family members, persons who comprise a household or are otherwise related by marriage or ancestry and are being affected by the psychiatric or substance abuse problems of another member of the household or family;

(Y) Improper clinical practices, performance or behavior which constitutes a repeated pattern of negligence or which constitutes a continuing pattern of violations of laws, rules, or regulations;

(Z) Individual, a person/consumer/client receiving services from a program certified under 9 CSR 30;

(AA) Least restrictive environment and set of services, a reasonably available setting or program where care, treatment, and rehabilitation is particularly suited to the type and intensity of services necessary to implement a person's treatment plan and to assist the person in maximizing functioning and participating as freely as feasible in normal living activities, giving due consideration to the safety of the individual, other persons in the program, and the general public;

(BB) Licensed independent practitioner, a person who is licensed by the state of Missouri to independently perform specified practices in the health care field;

(CC) Medication, a drug prescribed by a physician or other legally authorized professional for the purpose of treating a medical condition;

(DD) Medication (self-administration under staff observation), actions wherein an individual takes prescribed medication, including selection of the appropriate dose from a properly labeled container. The individual has primary responsibility for taking medication as prescribed, with the staff role to ensure client access to their personal medication in a timely manner and to observe clients as they select and ingest medication;

(EE) Mental health, a broad term referring to disorders related to substance abuse, mental illness and/or developmental disability;

(FF) Mental illness, impairment or disorder that impedes an individual's functioning or ability to manage daily activities and otherwise meets eligibility criteria established by the Division of Comprehensive Psychiatric Services;

(GG) Neglect (Class I), in accordance with 9 CSR 10-5.200;

(HH) Neglect (Class II), in accordance with 9 CSR 10-5.200;

(II) Nonresidential, service delivery by an organization that does not include overnight sleeping accommodations as a component of providing twenty-four (24) hour per day supervision and structure;

(JJ) Organization, an agency that is incorporated and in good standing under the requirements of the Office of the Secretary of State of Missouri and that provides care, treatment or rehabilitation services to persons with mental illness or substance abuse;

(KK) Outcome, a specific measurable result of services provided to an individual or identified target population;

(LL) Peer support, mutual assistance in promoting recovery offered by other persons experiencing similar psychiatric or substance abuse challenges;

(MM) Performance indicator, data used to measure the extent to which a treatment principle, expected outcome, or desired process has been achieved;

(NN) Physical abuse, in accordance with 9 CSR 10-5.200;

(OO) Primary diagnosis, a diagnosis of a mental illness, disability, or substance abuse disorder that is not due to a co-existing illness. A person with a primary diagnosis would still meet full criteria for that diagnosis in the absence of any co-existing disorder. A person may have several primary diagnoses, and a primary diagnosis is not necessarily the diagnosis causing the most severe impairment.

(PP) Program, an array of services de-signed to achieve specific goals for an identified target population in accordance with designated procedures and practices;

(QQ) Qualified mental health professional—any of the following:

1. A physician licensed under Missouri law to practice medicine or osteopathy and with training in mental health services or one (1) year of experience, under supervision, in treating problems related to mental illness or specialized training;

2. A psychiatrist, a physician licensed under Missouri law who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program identified as equivalent by the department;

3. A psychologist licensed under Missouri law to practice psychology with specialized training in mental health services;

4. A professional counselor licensed under Missouri law to practice counseling and with specialized training in mental health services;

5. A clinical social worker licensed under Missouri law with a master's degree in social work from an accredited program and with specialized training in mental health services;

6. A psychiatric nurse, a registered professional nurse licensed under Chapter 335, RSMo with at least two (2) years of experience in a psychiatric setting or a master's degree in psychiatric nursing;

7. An individual possessing a master's or doctorate degree in counseling and guidance, rehabilitation counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling or family therapy or related field who has successfully completed a practicum or has one (1) year of experience under the supervision of a mental health professional;

8. An occupational therapist certified by the American Occupational Therapy Certification Board, registered in Missouri, has a bachelor's degree and has completed a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting, or has a master's degree and has completed either a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting;

9. An advanced practice nurse—as set forth in section 335.011, RSMo, a nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Board of Nursing; and

10. A psychiatric pharmacist as defined in 9 CSR 30-4.030;

(RR) Qualified substance abuse professional, a person who demonstrates substantial knowledge and skill regarding substance abuse by being one (1) of the following—

1. A physician or qualified mental health professional who is licensed in Missouri with at least one (1) year of full-time experience in the treatment of persons with substance use disorders;

2. A person who is certified or registered as a substance abuse professional by the Missouri Substance Abuse Counselors Certification Board, Inc.; or
3. An individual who is within one (1) year of meeting one of the above criteria and has a department approved written training plan;
- (SS) Quality improvement, an approach to the continuous study and improvement of the service delivery process and outcomes in order to effectively meet the needs of persons served;
- (TT) Recovery, continuing steps toward a positive state of health that includes stabilized symptoms of mental illness, substance abuse or both, meaningful and productive relationships and roles within the community, and a sense of personal well-being, independence, choice and responsibility to the fullest extent possible;
- (UU) Rehabilitation, a process of restoring a person's ability to attain or maintain normal or optimum health or constructive activity by providing services and supports;
- (VV) Relapse, recurrence of substance abuse in an individual who has previously achieved and maintained abstinence for a significant period of time beyond detoxification;
- (WW) Relapse prevention, assisting individuals to identify and anticipate high risk situations for substance use, develop action steps to avoid or manage high risk situations, and maintain recovery;
- (XX) Research, in accordance with 9 CSR 60-1.010 this term is defined as experimentation or intervention with or on individuals, including behavioral or psychological research, biomedical research, and pharmacological research. Excluded are those instances where the manipulation or application is intended solely and explicitly for individual treatment of a condition, falls within the prerogative of accepted practice and is subject to appropriate quality assurance review. Also excluded are activities limited to program evaluation conducted by staff members as a regular part of their jobs, the collection or analysis of management information system data, archival research or the use of departmental statistics;
- (YY) Residential, service delivery by an organization that includes overnight sleeping accommodations as a component of providing twenty-four (24) hour per day supervision and structure;
- (ZZ) Restraint, restricting an individual's ability to move by physical, chemical or mechanical methods in order to maintain safety when all other less restrictive interventions are inadequate;
- (AAA) Restraint (chemical), medication not prescribed to treat an individual's medical condition and administered with the primary intent of restraining an individual who presents a likelihood of physical injury to self or others;
- (BBB) Restraint (mechanical), the use of any mechanical device that restricts the movement of an individual's limbs or body and that cannot be easily removed by the person being restrained;
- (CCC) Restraint (physical), physically holding an individual and restricting freedom of movement to restrain temporarily for a period longer than ten (10) minutes an individual who presents a likelihood of physical injury to self or others;
- (DDD) Screening, the process in which a trained staff member gathers and evaluates relevant information through an initial telephone or face-to-face interview with a person seeking services in order to determine that services offered by the program are appropriate for the person;
- (EEE) Seclusion, placing an individual alone in a separate room with either a locked door or other method that prevents the individual from leaving the room;
- (FFF) Sentinel event, a serious event that triggers further investigation each time it occurs. It is typically an undesirable and rare event;
- (GGG) Service, the provision of prevention, care, treatment, or rehabilitation to persons affected by mental illness or substance abuse;
- (HHH) Sexual abuse, in accordance with 9 CSR 10-5.200;
- (III) Staff member/personnel, an employee of a certified organization or a person providing services on a contractual basis on behalf of the organization;

(JJJ) Substance, alcohol or other drugs, or both;

(KKK) Substance abuse, unless the context clearly indicates otherwise, a broad term referring to alcohol or other drug abuse or dependency in accordance with criteria established in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association;

(LLL) Supports, array of activities, resources, relationships and services designed to assist an individual's integration into the community, participation in treatment, improved functioning, or recovery;

(MMM) Treatment, application of planned procedures intended to accomplish a change in the cognitive or emotional conditions or the behavior of a person served consistent with generally recognized principles or practices in the mental health field;

(NNN) Treatment plan, a document which sets forth individualized care, treatment and rehabilitation goals and the specific methods to achieve these goals for persons affected by mental illness or substance abuse, and which details the individual's treatment program as required by law, rules and funding sources;

(OOO) Treatment principle, basic precept or approach to promote the effectiveness of care, treatment and rehabilitation services and the dignity and involvement of persons served; and

(PPP) Verbal abuse, in accordance with 9 CSR 10-5.200.

(3) Singular terms include the plural and vice versa, unless the context clearly indicates otherwise.

*AUTHORITY: sections 630.050 and 630.055, RSMo 2000.\* Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 15, 2002, effective Nov. 30, 2002. Amended: Filed Aug. 31, 2006, effective April 30, 2007.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.055, RSMo 1980.*

**Title 9--DEPARTMENT OF MENTAL HEALTH**  
**Division 10--Director, Department of Mental Health**  
**Chapter 5--General Program Procedures**

**9 CSR 10-5.190 Background Screening for Employees and Volunteers**

*PURPOSE: This rule establishes standards for obtaining background screening for certain staff and volunteers in residential facilities, day programs or specialized service operated or funded by the Department of Mental Health.*

(1) For the purposes of this rule, residential facilities, day programs and specialized services are divided into two (2) categories, as follows:

(A) Category I. Those that are certified or licensed exclusively by the Department of Mental Health (DMH) or, although not certified or licensed, are funded by the department. Specifically this category includes:

1. Agencies certified by DMH as community psychiatric rehabilitation programs (CPRP), comprehensive substance abuse and treatment and rehabilitation programs (CSTAR), residential and/or outpatient programs;

2. Agencies certified by DMH in the community-based waiver certification program;

3. Agencies certified by the Division of Alcohol and Drug Abuse;

4. Facilities that have contractual arrangements with the department but are exempt from the department's licensing and certification rules due to accreditation or other reason; and

5. Facilities and day programs which are licensed by the department and do not have a license from another state agency; and

(B) Category II. Those that, in addition to a license or certificate from DMH, have a license or certification from another state agency. Specifically, this category includes facilities licensed by the Children's Division or the Department of Health and Senior Services; also included are intermediate care facilities/mental retardation (ICF/MR). Facilities and agencies included in Category II are subject to rules regarding criminal record review as promulgated by the state agency which licenses or certifies them and are not subject to sections (2) through (6) of this rule. However such agencies are subject to sections (7), (8), (9) and (10).

(2) This rule applies to—

(A) Staff;

(B) Volunteers who are recruited as part of an agency's formal volunteer program but does not apply to volunteers who assist individuals as a friend would by providing assistance with shopping, transportation, recreation, etc.; and

(C) Members of the provider's household who have contact with residents or clients, except for minor children.

(3) Each residential facility, day program or specialized service defined under Category I above shall make the following inquiries for all new employees and volunteers:

(A) An inquiry with the Department of Health and Senior Services to determine whether the new employee or volunteer having contact with residents or clients is listed on the employee disqualification list of the Department of Social Services or the Department of Health and Senior Services;

(B) An inquiry with the Department of Mental Health to determine whether the new employee or volunteer is on the DMH disqualification registry; and

(C) A criminal background check with the State Highway Patrol. The request for the background check shall not require fingerprints and shall be in accordance with requirements of the State Highway Patrol under Chapter 43, RSMo. The facility, program or service may use a private investigatory agency to conduct this review.

(4) The criminal background check and inquiries required under section (3) of this rule shall be initiated prior to the employee or volunteer having contact with residents, clients or patients.

(5) Each residential facility, day program and specialized service included under Category I shall require all new applicants for employment or volunteer positions involving contact with residents or clients to—

(A) Sign a consent form authorizing a criminal record review with the highway patrol, either directly through the patrol or through a private investigatory agency;

(B) Disclose his/her criminal history, including any conviction or a plea of guilty to a misdemeanor or felony charge and any suspended imposition of sentence, any suspended execution of sentence or any period of probation or parole; and

(C) Disclose if s/he is listed on the employee disqualification list of the Department of Social Services or the Department of Health and Senior Services, or the DMH disqualification registry.

(6) Each agency shall develop policies and procedures regarding the implementation of this rule and the disposition of information provided by the criminal record review. At a minimum the guidelines shall address—

(A) Procedures for obtaining the criminal record review;

(B) Procedures for confidentiality of records; and

(C) Guidelines for evaluating information received through the criminal record review which establish a clear boundary between those convictions which, by statute, must exclude an individual from service, and those convictions which would not automatically exclude an individual.

(7) Offenses which under section 630.170, RSMo disqualify a person from service are as follows:

(A) A person shall be disqualified from holding any position in the agency if that person—

1. Has been convicted of, found guilty of, pled guilty to or *nolo contendere* to any of the following crimes.

A. Physical abuse or Class I Neglect of a patient, resident or client; or

B. Furnishing unfit food to patients, residents or clients.

2. Is listed on the DMH disqualification registry; or

3. Is listed on the employee disqualification list of the Department of Health and Senior Services or Department of Social Services.

(B) A person who has been convicted of, found guilty to, pled guilty to or *nolo contendere* to any of the following crimes shall be disqualified from holding any position having contact with patients, residents or clients in the agency. The crimes listed below are not disqualifying unless they are felonies, except for failure to report abuse and neglect to the Department of Health and Senior Services, which is a Class A misdemeanor. The disqualifying crimes are:

1. First or second degree murder;

2. Voluntary manslaughter (includes assistance in self-murder);

3. Involuntary manslaughter;

4. First or second degree assault;

5. Assault while on school property;

6. Unlawful endangerment of another;

7. First or second degree assault of a law enforcement officer;

8. Tampering with a judicial officer;

9. Kidnapping;

10. Felonious restraint;
11. False imprisonment;
12. Interference with custody;
13. Parental kidnapping;
14. Child abduction;
15. Elder abuse in the first degree or the second degree;
16. Harassment;
17. Stalking;
18. Forcible rape;
19. First or second degree statutory rape;
20. Sexual assault;
21. Forcible sodomy;
22. First or second degree statutory sodomy;
23. First or second degree child molestation;
24. Deviate sexual assault;
25. First degree sexual misconduct;
26. Sexual abuse;
27. Endangering the welfare of a child;
28. Abuse of a child;
29. Robbery in the first degree or second degree;
30. Arson in the first or second degree;
31. First or second degree pharmacy robbery;
32. Incest;
33. Causing catastrophe;
34. First degree burglary;
35. Felony count of invasion of privacy;
36. Failure to report abuse and neglect to the Department of Social Services as required under subsection 3 of section 198.070, RSMo; or
37. Any equivalent felony offense.

(8) Any person disqualified from employment under this rule may request an exception from the DMH Exceptions Committee in accordance with 9 CSR 10-5.210 Exceptions Committee Procedures.

(A) The right to request an exception under this subsection shall not apply to persons who are disqualified due to being listed on the employee disqualification registry of the Department of Social Services or Department of Health and Senior Services, nor does it apply to persons who are disqualified due to any of the following crimes:

1. First or second degree murder;
2. First or second degree statutory rape;
3. Sexual assault;
4. Forcible sodomy;
5. First or second degree statutory sodomy;
6. First or second degree child molestation;
7. Deviate sexual assault;
8. Sexual misconduct involving a child;
9. First degree sexual misconduct;
10. Sexual abuse;
11. Incest;
12. Causing catastrophe;
13. Abuse of a child;

14. First degree pharmacy robbery; or
15. Forcible rape.

(9) For the purposes of this rule, a verdict of not guilty by reason of insanity (NGRI) is not per se disqualifying. A suspended imposition of sentence (SIS) or suspended execution of sentence (SES) is disqualifying.

(10) A provider shall not hire any person who has committed a disqualifying crime as identified in section (7) of this rule, unless the person has received an exception from the department. However, the provider retains the discretionary authority to deny employment to persons who—

- (A) Have committed crimes not identified as disqualifying;
- (B) Have received an exception from the Exceptions Committee; or
- (C) Have received a verdict of Not Guilty by Reason of Insanity.

*AUTHORITY: sections 630.170 and 660.317, RSMo Supp. 2003 and 630.655 and 630.710, RSMo 2000.\* Emergency rule filed Aug. 15, 1997, effective Aug. 28, 1997, expired Feb. 26, 1998. Original rule filed Aug. 15, 1997, effective March 30, 1998. Amended: Filed Oct. 29, 1998, effective May 30, 1999. Amended: Filed Nov. 3, 2003, effective April 30, 2004. Amended: Filed March 29, 2004, effective Sept. 30, 2004.*

*\*Original authority: 630.170, RSMo 1980, amended 1982, 1996, 1998, 2001, 2003; 630.655, RSMo 1980; 630.710, RSMo 1980, amended 1996, 1998, and 660.317, RSMo 1996, amended 1997, 1998, 2003, 2003.*

## **9 CSR 10-5.200 Report of Complaints of Abuse, Neglect and Misuse of Funds/Property**

*PURPOSE: This rule prescribes procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property in an agency that is licensed, certified, accredited, in possession of deemed status, and/or funded by the Department of Mental Health (department) as required by sections 630.135, 630.167, 630.168, 630.655, and 630.710, RSMo. The rule also sets forth due process procedures for persons who have been accused of abuse, neglect, and misuse of funds/property.*

(1) The following words and terms, as used in this rule, mean:

(A) Agency: An organization that is licensed, certified, accredited, in possession of deemed status, and/or funded by the Department of Mental Health;

(B) Consumer: An individual (client, resident, patient) receiving department-funded services directly from an agency;

(C) Department: Department of Mental Health;

(D) Employee: A person employed by or contracted by an agency or a person serving as a volunteer or student for the agency;

(E) Misuse of funds/property: The misappropriation or conversion for any purpose of a consumer's funds or property by an employee or employees with or without the consent of the consumer or the purchase of property or services from a consumer in which the purchase price substantially varies from the market value;

(F) Neglect: Failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety, or welfare of a consumer or a substantial probability that death or serious physical injury would result. This would include, but is not limited to, failure to provide adequate supervision during an event in which one consumer causes serious injury to another consumer;

(G) Physical abuse:

1. An employee purposefully beating, striking, wounding, or injuring any consumer;

2. In any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner; or

3. An employee handling a consumer with any more force than is reasonable for a consumer's proper control, treatment, or management;

(H) Sexual abuse: Any touching, directly or through clothing, of a consumer by an employee for sexual purpose or in a sexual manner. This includes, but is not limited to:

1. Kissing;

2. Touching of the genitals, buttocks, or breasts;

3. Causing a consumer to touch the employee for sexual purposes;

4. Promoting or observing for sexual purpose any activity or performance involving consumers including any play, motion picture, photography, dance, or other visual or written representation;

5. Failing to intervene or attempting to stop inappropriate sexual activity or performance between consumers; and/or

6. Encouraging inappropriate sexual activity or performance between consumers; and

(I) Verbal abuse: An employee making a threat of physical violence to a consumer, when such threats are made directly to a consumer or about a consumer in the presence of a consumer.

(2) This rule applies to any director, supervisor, or employee of any agency. Facilities, programs, and services that are operated by the department are regulated by the department's operating regulations and are not included in this rule.

(A) Any such person shall immediately file a written complaint if that person has reasonable cause to believe that a consumer has been subjected to any of the following while under the care of an agency:

1. Physical abuse;
2. Sexual abuse;
3. Misuse of funds/property;
4. Neglect; or
5. Verbal abuse.

(B) A complaint under subsection (2)(A) above shall be made to the head of the agency and to the department's regional office, supported community living placement office, or district administrator office. If the allegation results in an investigation, the head of the agency shall make reasonable arrangements with respect to the alleged perpetrator to assure the safety of all of the agency's consumers. Such arrangements may include, but are not limited to, leave with or without pay or transfer to a position where there is no client contact.

(C) The head of the agency shall forward the complaint to—

1. The Children's Division if the alleged victim is under the age of eighteen (18); or
2. The Division of Senior Services and Regulation if the alleged victim is a resident or client of a facility licensed by the Division of Senior Services and Regulation or receiving services from an entity under contract with the Division of Senior Services and Regulation.

(D) Failure to report shall be cause for disciplinary action, criminal prosecution, or both.

(3) The head of the agency shall immediately report to the local law enforcement official if there is a reasonable suspicion that any of the following abuse or neglect has occurred—

- (A) Sexual abuse; or
- (B) Abuse or neglect that results in physical injury; or
- (C) Abuse, neglect, or misuse of funds/property if the head of the agency has cause to believe that criminal misconduct is involved.

(4) If a complaint has been made under this rule, the head of the agency shall fully cooperate with law enforcement authorities and with department employees or employees from other agencies authorized to investigate the complaint. Failure to cooperate may result in contract termination or dismissal of the employee.

(5) A department investigator shall gather facts and conduct an investigation regarding the alleged abuse or neglect. The investigation shall be conducted in accordance with the procedures and time frames established under the department's operating regulations. Upon completion of the investigation, the investigator shall present written findings of facts to the head of the supervising facility.

(6) Within twenty (20) calendar days of receiving the final report from the investigator, if there is a preliminary determination of abuse, neglect, or misuse of funds/property, the head of the supervising facility or department designee shall send to the alleged perpetrator a letter summarizing the allegations and findings that are the basis for the alleged abuse/neglect/misuse of funds or property; the agency will be copied. The letter shall comply with the constraints regarding confidentiality contained in section 630.167, RSMo, and shall be sent by regular and certified mail.

(A) The alleged perpetrator may meet with the head of the supervising facility or department designee, submit comments, or present evidence; the agency may be present and present comments or evidence in support of the alleged perpetrator. If the alleged perpetrator wishes to have this meeting, s/he must notify the head of the supervising facility or department designee within twenty (20) calendar days from the date of the letter.

(B) This meeting shall take place within twenty (20) calendar days from the date of the letter, unless the parties mutually agree upon an extension.

(C) Within twenty (20) calendar days of the meeting, or if no request for a meeting is received within twenty (20) calendar days from the date of the letter, the head of the supervising facility or department designee shall make a final determination as to whether abuse/neglect/misuse of funds or property took place. The perpetrator shall be notified of this decision by regular and certified mail; the agency will be copied. If the charges do not meet the criteria in section (10), the decision of the head of the supervising facility or department designee shall be the final decision of the department.

(D) If the charges meet the criteria in section (10), the letter shall advise the perpetrator that they have twenty (20) calendar days from the date of the letter to contact the department's hearings administrator if they wish to appeal a finding of abuse, neglect, or misuse of funds/property.

(E) If there is no appeal, the decision of the head of the supervising facility or department designee shall be the final decision of the department.

(F) The department's effort to notify the alleged perpetrator at his/her last known address by regular and certified mail shall serve as proper notice. The alleged perpetrator's refusal to receive certified mail does not limit the department's ability to make a final determination. Evidence of the alleged perpetrator's refusal to receive certified mail shall be sufficient notice of the department's determination.

(7) If an appeal is requested, the hearings administrator shall schedule the hearing to take place within ninety (90) calendar days of the request, but may delay the hearing for good cause shown. Hearings shall be conducted in accordance with the procedures set forth in 9 CSR 10-5.230.

(8) The decision of the hearings administrator shall be the final decision of the department. The hearings administrator shall notify the perpetrator, by certified mail, and the head of the supervising facility or department designee of the decision within twenty (20) calendar days of the appeal hearing; the agency will be copied.

(9) For those charges in section (10), an alleged perpetrator does not forfeit his/her right to an appeal with the department's hearings administrator when s/he declines to meet with the head of the supervising facility under subsections (6)(A) and (6)(B) of this rule.

(10) If the department substantiates that a person has perpetrated physical abuse, sexual abuse, verbal abuse, neglect, or misuse of funds/property, the perpetrator shall not be employed by the department, nor be licensed, employed, or provide services by contract or agreement at an agency. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to section 630.170, RSMo. Persons who have been disqualified from employment may request an exception by using the procedures described in 9 CSR 10-5.210 Exception Committee Procedures.

(11) In accordance with 9 CSR 10-5.190, no person convicted of specified crimes may serve in facilities or programs licensed, certified, or funded by the department.

(12) No director, supervisor, or employee of an agency shall evict, harass, dismiss, or retaliate against a consumer or employee because he or she or any member of his or her family has made a report of any violation or suspected violation of consumer abuse, neglect, or misuse of funds/property. Penalties for retaliation may be imposed up to and including cancellation of agency contracts and/or dismissal of such person.

(13) If an event deadline falls on a Saturday, Sunday, or legal holiday, the last day of the period so computed shall extend to the next calendar day that is not a Saturday, Sunday, or legal holiday.

*AUTHORITY: sections 630.135, 630.168, 630.655, and 630.705, RSMo 2000 and sections 630.050, 630.165, 630.167, and 630.170, RSMo Supp. 2008.\* Original rule filed Oct. 29, 1998, effective May 30, 1999. Emergency amendment filed March 29, 2002, effective May 2, 2002, terminated Oct. 30, 2002. Amended: Filed March 29, 2002, effective Oct. 30, 2002. Amended: Filed May 5, 2003, effective Dec. 30, 2003. Emergency amendment filed Aug. 11, 2005, effective Sept. 16, 2005, expired Feb. 28, 2006. Amended: Filed Aug. 11, 2005, effective March 1, 2006. Amended: Filed Dec. 1, 2008, effective May 30, 2009.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.135, RSMo 1980; 630.165, RSMo 1980, amended 1996, 2003, 2007, 2008; 630.167, RSMo 1980, amended 1985, 1990, 1993, 1996, 1998, 2003, 2007, 2008; 630.168, RSMo 1980, amended 1987, 1996; 630.170, RSMo 1980, amended 1982, 1996, 1998, 2001, 2003, 2008; 630.655, RSMo 1980; and 630.705, RSMo 1980, amended 1982, 1984, 1985, 1990, 2000.*

## 9 CSR 10-5.206 Report of Events

*PURPOSE: This rule prescribes procedures for documenting, reporting, analyzing and addressing certain events that affect individuals in residential facilities, day programs or specialized services that are licensed, certified or funded by the Department of Mental Health as required by sections 630.005, 630.020, 630.165, 630.167 and 630.655, RSMo.*

(1) The following words and terms, as used in this rule, mean:

(A) Consumer, individual receiving department funded or contracted services directly from any program or facility;

(B) Corrective Action Plan, the document a provider submits to the department in response to the results of an event or events which outlines those measures that are intended to reduce the likelihood that the event(s) will recur or to remediate a deficiency. Such actions include but are not limited to: removal of an individual receiving services or staff from a provider; staff training; improvements in the physical plant; revision of operating procedures;

(C) Department, the Department of Mental Health's local regional center, district administrator, or supported community living office, depending on the division providing service;

(D) Guardian, individual who is legally responsible for the care and custody of the consumer;

(E) "On call" system, procedure of the specific regional department personnel being available to receive notification of events during nonbusiness hours. A telephone number is provided to verbally relay this information to the individual representing the specific region and division providing service;

(F) Provider—

1. A residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health;

2. Provider does not include facilities licensed by the Department of Health and Senior Services under Chapter 198, RSMo unless the facility is also licensed by the Department of Mental Health. In this case this rule applies only to consumers that have a primary diagnosis of mental illness and whose board and care are funded by the Department of Mental Health.

3. Duties of the provider under this rule are the responsibility of the chief administrative officer of the residential facility, day program or specialized service, or his/her designee;

(G) Reportable events, those specific incidents and medication errors identified on the applicable department report form dependent on the division providing service to the consumer; and

(H) Report form, Department of Mental Health form identifying reportable events and the timelines for reporting such events to the department. The form is used for data entry into the department Incident and Investigation Tracking System for statewide data collection. This form is identified as DMH-9719A (Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services) or DMH-9719B (Division of Mental Retardation/Developmental Disabilities), dependent on department division of service, which is included herein.

(2) This section applies to event notification and reporting requirements for employees of providers, as defined under section 630.005, RSMo. Facilities, programs and services that are operated by the Department of Mental Health are regulated by the department's operating regulations and are not included in this definition, because this rule does not apply to Department of Mental Health operated facilities.

(A) Providers must maintain written policies requiring their employees to report events under this regulation and those events identified in 9 CSR 10-5.200. The policies must make clear that administrative or disciplinary sanctions may result from failure to report. Providers must ensure that their employees and those who support the agency are educated about the department's notification and reporting requirements.

(B) It is the responsibility of the provider to—

1. Notify the department with a written or verbal report of all events reportable under this regulation involving consumers as identified on the report form. For those events requiring immediate notification, if a verbal report, it will be followed up in writing on the report form and faxed or otherwise transmitted to arrive within one (1) business day to the appropriate department office. All other events not requiring immediate notification shall be provided in writing on the report form in the time frame specified on the report form.

2. Notify the department using the department's "on call" system after 5:00 p.m. or on weekends/holidays for those events on the report form requiring immediate department notification, and any event resulting in extensive property damage or major disruption of the program or service the consumer receives; and

3. Within twenty-four (24) hours of knowledge of an event that requires immediate department notification, verbally notify the legal guardian or parent (if consumer is a minor) of the specifics regarding the event. The provider shall also communicate that the event has been reported to the department. The only exception to this verbal notification is if the parent(s) or legal guardian is the suspected primary person involved that forms the basis for the reported event. If the provider is unable to verbally contact the guardian/parent, the provider shall document on the report form all efforts made to comply.

(3) The provider shall ensure that patterns and trends of reportable events, specific to a consumer, are included and addressed in the consumer's personal/treatment plan upon approval by the planning team. To the extent that specific consumer issues are identified, the department staff may meet with the provider to discuss action steps to address and resolve issues, including submission of corrective action plans.

(4) The department may request a corrective action plan be provided by the provider based on the facts surrounding the event. This plan is subject to approval by the department within a time frame specified by the department. This plan must be carried out as specified.

(5) Programs licensed or certified by the Department of Mental Health must maintain internal records of similar events or information for individuals who do not receive department funded or contracted services, for purposes of quality review to assure that problems are identified and resolved. Non-identifying event records or non-identifying analysis of these events must be available for review by the department as needed for monitoring or licensure/certification activities. This section does not apply to facilities licensed under Chapter 198, RSMo.

(6) Failure to follow the above referenced regulations may result in administrative sanctions up to and including contract cancellation or licensure/certification revocation.

*AUTHORITY: sections 630.005, 630.020 and 630.655, RSMo 2000 and 630.165 and 630.167, RSMo Supp. 2004.\* Original rule filed March 1, 2005, effective Oct. 30, 2005. Amended: Filed Aug. 26, 2005, effective Feb. 28, 2006.*

*\*Original authority: 630.005, RSMo 1980, amended 1981, 1982, 1990, 1993, 1995, 1996; 630.020, RSMo 1980; 630.165, RSMo 1980, amended 1996, 2003; 630.167, RSMo 1980, amended 1985, 1990, 1993, 1996, 1998, 2003; and 630.655, RSMo 1980.*

## 9 CSR 10-5.210 Exceptions Committee Procedures

*PURPOSE: This rule establishes procedures for requesting an exception from the administrative rules of the Department of Mental Health.*

(1) Definitions. The following terms are defined as follows:

(A) Disqualifying incident, a crime which under 9 CSR 10-5.190 results in a person being disqualified from employment, or one (1) or more administrative findings of abuse, neglect or misuse of client funds which, under 9 CSR 10-5.200 leads to a person being listed on the Department of Mental Health disqualification registry;

(B) Exception, a decision by the department not to enforce an administrative rule under the individual circumstances described in the request for an exception and the conditions described in the approval. None of the following are subject matter of an exception:

1. A contention that the rule is not valid;
2. A contention that the provider is in fact in compliance with the rule; and
3. A request for an interpretation of a rule.

(2) Rules Subject to an Exception. Only the following rules may be the subject of an exception:

(A) Licensure rules for residential facilities and day programs promulgated under 9 CSR 40;

(B) Certification rules for alcohol and drug abuse programs and psychiatric programs promulgated under 9 CSR 10-7 and 9 CSR 30;

(C) Certification rules under 9 CSR 45 for programs serving persons who are developmentally disabled under the Community Based Waiver Program;

(D) Any other administrative rule promulgated by the Department of Mental Health that specifically allows for an exception; and

(E) Rules related to disqualification from employment under 9 CSR 10-5.190 and 9 CSR 10-5.200. In the context of employment disqualification the following apply.

1. A person may not request an exception until twelve (12) months have passed since the sentence of the court or since the department gave official notice of the person's name being added to the Department of Mental Health disqualification registry.

2. The exceptions option under this administrative rule does not replace or substitute for the appeal procedures afforded under Department Operating Regulation (DOR) 2.205 and 9 CSR 10-5.200 or any other administrative process. A person is not required to exhaust the appeal procedures as a prerequisite to requesting an exception; however, an exception will not be considered while an appeal is pending.

(3) Who may apply for an exception?

(A) A chief executive officer, or designee, on behalf of a residential facility, day program or specialized service, or an employee thereof.

(B) An individual may request an exception on his or her own behalf with respect to disqualification from employment under 9 CSR 10-5.190 and 9 CSR 10-5.200.

(C) A facility operated by the department on behalf of a residential facility, day program or specialized service licensed, operated or funded by the department.

(D) Any other person or entity affected by an administrative rule under subsection (2)(E) of this rule.

(4) How to request an exception.

(A) A person may request an exception by sending to the exceptions committee a written request which—

1. Cites the rule number in question;

2. Indicates why and for how long compliance with the rule should be waived; and
3. Is accompanied by supporting documentation, if appropriate.

(B) In addition, the following additional items must be part of a request under 9 CSR 10-5.190, related to disqualification from employment.

1. A letter from the disqualified person containing the following information:

- A. A description of the disqualifying incident;
- B. When the disqualifying incident occurred;
- C. If the disqualifying incident was a crime, the sentence of the court;
- D. Mitigating circumstances, if any;
- E. Activities and accomplishments since the disqualifying incident;
- F. The names and dates of any relevant training or rehabilitative services;
- G. The type of service and/or program the applicant wishes to provide for mental health clients;

H. Identification of the type of employment or position the applicant wishes to maintain or obtain and the name of the mental health program in which he or she wishes to work or continue working; and

I. Changes in personal life since the disqualifying incident (e.g., marriage, family, and education);

2. References, i.e., written recommendations from at least three (3) persons who verify the applicant's assertions; and

3. Work history, with particular emphasis on work in the mental health field.

(C) Request for exceptions should be sent to Exceptions Committee Coordinator, Office of Quality Management, Department of Mental Health, PO Box 687, Jefferson City, MO 65102.

(5) Response. Within forty-five (45) calendar days of receiving a request for an exception, the exceptions committee shall respond in writing. The committee may approve a request, approve the request with conditions, deny the request or defer a decision pending receipt of additional information.

(6) Decisions of the exceptions committee are not subject to appeal. However persons aggrieved by a decision may modify and repeat a request after ninety (90) days. Persons requesting an exception under 9 CSR 10-5.190 must wait twelve (12) months before repeating a request.

(7) Documentation. A recipient of an exception shall maintain documentation of all approved exceptions and make the documentation available for review upon request by authorized staff of the department.

(8) Expiration Date for an Exception.

(A) An exception becomes null and void without any further action by the department under any of the following circumstances.

1. An expiration date is announced in the letter of approval.
2. The subject for whom the exception was granted changes employment.
3. There are changes in other circumstances described in the request.

(B) If an exception expires under this section, it may be renewed by submission of a new request.

(9) Rescinding Decisions. The exceptions committee may rescind any exception if, in its judgment, any of the following occur:

(A) The provider failed to meet a condition of the exception, or to maintain documentation required under section (7);

(B) It is discovered that the request contained misleading, incomplete or false information; or

(C) The exception results in poor quality of care, or risk/harm to a client or resident.

(10) If the committee rescinds an exception, the committee shall provide all concerned parties with a notice of rescission with an effective date. There shall be no appeal of a rescission of an exception.

*AUTHORITY: sections 630.050 and 630.656, RSMo 2000 and 630.170, RSMo Supp. 2003.\* Original rule filed Feb. 23, 2001, effective Sept. 30, 2001. Amended: Filed Nov. 3, 2003, effective April 30, 2004. Amended: Filed April 13, 2004, effective Oct. 30, 2004.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.170, RSMo 1980, amended 1982, 1996, 1998, 2001, 2003; 630.656, RSMo 1995.*

## **9 CSR 10-5.220 Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

*PURPOSE: This rule alerts providers to the possible HIPAA Privacy Rule requirements if the provider has determined that it is a covered entity as defined by HIPAA. Once that is established, this rule lists policies and procedures that the HIPAA Privacy Rule requires for each covered entity.*

(1) This rule applies to all programs licensed, certified or funded by the Department of Mental Health.

(2) Definitions.

(A) HIPAA: the Health Insurance Portability and Accountability Act of 1996 (45 CFR parts 160 and 164) as it relates to Privacy.

(B) Protected Health Information (PHI): As defined by HIPAA (45 CFR section 164.501), PHI is individually identifiable health information that is—

1. Transmitted by electronic media;
2. Maintained in any medium described in the definition of electronic media; or
3. Transmitted or maintained in any other form or medium.

(C) Individually identifiable health information: As defined by HIPAA (45 CFR section 160.103), individually identifiable health information is any information, including demographic information, collected from an individual that is—

1. Created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and

2. Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual, and which identifies the individual, or with respect to which there is reasonable basis to believe that the information can be used to identify the individual.

(D) Business associate: As defined by HIPAA (45 CFR section 160.103), a person who, on behalf of the covered entity or provider or of an organized healthcare arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

1. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or

2. Any other function or activity regulated by this subchapter; or provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized healthcare arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

(3) All providers who determine that they qualify as covered entities must comply with the provisions of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A covered entity is defined as a healthcare provider, who transmits any health information in electronic form in connection with a transaction covered by this subchapter (section 160.103 of 45 CFR part 160), a health plan or a clearinghouse. The effective date of the Privacy Rule is April 14, 2003. IF this provider is a covered entity, THEN HIPAA requires the appropriate policies and procedures be in place to comply with the HIPAA Privacy Rule. HIPAA requires such

policies and procedures to include, but not be limited to, the following topics: Notice of Privacy Practices, Amendment of Protected Health Information (PHI), Client Access to PHI, Accounting of Disclosures, Workforce Training, Verification, Authorization for Disclosures of PHI, HIPAA Complaint Process, Marketing (if applicable), Research (if applicable), Audit and Monitoring of HIPAA compliance, and Business Associates Agreements with those companies providing goods and services which require the disclosure of PHI, etc. Where existing confidentiality protections provided by 42 CFR part 2, related to the release of alcohol and drug abuse records, are greater than HIPAA, then the department anticipates that the provider will consider any such provision of 42 CFR part 2 as the guiding law.

*AUTHORITY: section 630.050, RSMo 2000\* and 45 CFR parts 160 and 164, the Health Insurance Portability and Accountability Act of 1996. Emergency rule filed April 1, 2003, effective April 14, 2003, expired Oct. 14, 2003. Original rule filed April 1, 2003, effective Oct. 30, 2003.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995.*

## 9 CSR 10-5.230 Hearings Procedures

*PURPOSE: This rule sets out procedures for requesting and conducting hearings before the Department of Mental Health Hearings Administrator as provided for in 9 CSR 10-5.200.*

(1) Requests for hearings shall be submitted in the following manner:

(A) All requests for hearings shall be made in writing by the appellant or his/her attorney to the hearings administrator within twenty (20) calendar days from the date of the final determination letter as set out in 9 CSR 10-5.200(6)(D). The request may be hand delivered or sent by mail or facsimile.

1. A request for hearing filed by hand delivery or mail is considered received on the date received by the office of the hearings administrator. Requests shall be sent to: Office of Hearings Administrator, Department of Mental Health, 1706 East Elm, PO Box 687, Jefferson City, MO 65102.

2. A request for hearing filed by facsimile is considered received at the time the office of the hearings administrator receives the request, provided that the original of the document is sent to the office of the hearings administrator and received within ten (10) calendar days of the fax. If a request arrives by fax after 5:00 p.m., Central Standard Time, and before 12:00 a.m., Central Standard Time, or on a Saturday, Sunday, or legal holiday, it is considered filed on the next working day. Requests filed by facsimile shall be sent to the office of hearings administrator's designated line at (573) 751-8069.

A. The time controlling when a facsimile arrives at the office of the hearings administrator is the office of the hearings administrator's facsimile machine journal.

B. The person filing by facsimile bears the risk of loss in transmission, non-receipt, or illegibility. If the request for hearing is not received or is materially illegible, the request is not considered filed and is totally null and void for all purposes.

C. A party filing a request for hearing by facsimile shall notify the office of the hearings administrator in advance, if possible, of its intention to file the request by fax; and

(B) The request for a hearing shall set out the appellant's name, current address, and telephone number and that of his or her attorney, if applicable; the decision being appealed, the date of the decision, and the name of the person making the decision and a brief statement of the appellant's reason for appealing the decision.

(2) Appellants may represent themselves and handle their own cases, but shall have the right to be represented by a Missouri licensed attorney. A party to an appeal cannot be represented by anyone other than a duly licensed attorney. If either party is represented by an attorney, the attorney shall promptly notify the office of hearings administrator and enter his/her appearance.

(3) When a hearing has been requested, the hearings administrator shall schedule the hearing within ninety (90) calendar days of receiving the request for hearing, but may delay the hearing for good cause shown.

(4) The hearings administrator may schedule a pre-hearing conference with the parties. The hearings administrator may meet (in person, via telephone, or video conference) with the parties and their representatives at a pre-hearing conference to determine the facts at issue. At the pre-hearing conference, the parties may stipulate to mutually agreed matters or the appeal may be resolved by agreement of the parties. All parties are required to provide the hearings administrator with a current address and telephone number. If the appellant fails to provide the hearings administrator with a current address or phone number and cannot be reached to schedule a pre-hearing conference or fails to participate in a pre-hearing conference after receiving written notice

of the date and time of the conference, it shall be deemed that the appellant no longer wishes to proceed with the appeal and is withdrawing the appeal.

(5) The hearings administrator shall send written notice of hearing and prehearing dates to the parties and representatives no less than ten (10) calendar days before the scheduled date for such hearing, unless there is good cause to shorten the period to provide notice.

(6) The hearings administrator may grant continuances for good cause. A continuance must be requested no later than seventy-two (72) hours, excluding Saturdays, Sundays, and legal holidays, prior to the scheduled date and time of the hearing or prehearing. Absent exigent circumstances, requests for continuances received less than seventy-two (72) hours prior to the hearing or prehearing shall not be considered.

(7) Requests for subpoena shall be governed by the following requirements:

(A) A request for a subpoena for attendance at depositions or hearings shall be made in writing and specify the name of the persons, the address(es) where the person can be served with the subpoena, the deposition or hearing location, and the time the person is expected to appear at the deposition or hearing location;

(B) A request for a subpoena *duces tecum* shall be made in writing and specify the name of the person, the address(es) where the person can be served with the subpoena, the documents the person is to provide, a statement of what is intended to be proved by the documents, where he or she should bring the documents, and a date when the documents are to be provided;

(C) All subpoena requests shall be sent by regular mail or fax to the hearings administrator and opposing party at least five (5) working days before the hearing or deposition, unless there is good cause to shorten the period to request the subpoena;

(D) Any motions to quash a subpoena must be sent to the hearings administrator within three (3) working days of receiving the subpoena request;

(E) If no objection is sustained to a subpoena request, the hearings administrator shall prepare the subpoena and send the subpoena to the party who requested it. It is the responsibility of the person who requested the subpoena to have it served. Service of the subpoena is to be effected in accordance with section 537.077, RSMo; and

(F) If a subpoena for a witness was not requested in accordance with this rule, good cause will not be found to continue the hearing for that witness's failure to appear.

(8) The appellant or his/her attorney may request copies of any documents referred to in the decision letter from the attorney representing the department. If the documents involve protected health information, the attorney shall request a protective order from the hearings administrator. The protective order shall provide that no documents containing protected health information shall be released to anyone except the appellant or his/her attorney, and the appellant or his/her attorney shall return any documents provided to him or her before the end of the hearing.

(9) All parties who are represented by an attorney shall submit a proposed order with every motion or request that is filed or presented to the hearings administrator.

(10) The hearing shall be conducted according to the following procedures:

(A) The hearing shall be conducted at the facility where the decision was made, unless the hearings administrator finds good cause to hold the hearing in another place;

(B) If the appellant or his/her attorney does not appear at the hearing and does not call the facility or the hearings administrator to provide notification of an exigent circumstance requiring a continuance within thirty (30) minutes of the time set out in the notice, it shall be deemed that the appellant no longer wishes to proceed with the appeal and is withdrawing the appeal;

(C) At the beginning of the hearing, the hearings administrator shall state the reason for the hearing and outline the hearing procedure;

(D) Both parties shall be given the opportunity to present opening statements. The department shall present its witnesses and exhibits first, then the appellant shall present his or her witnesses and exhibits. The department shall have the burden of proof by a preponderance of the evidence. Both parties shall be given the opportunity to present closing statements;

(E) All witnesses shall be sworn or affirmed. All witnesses are subject to cross-examination;

(F) The hearings administrator, at the request of either party or on his/her own motion, may order the witnesses to be separated so as to preclude any witness, other than the parties, from hearing the testimony of other witnesses. When requested by the appellant, only one (1) person in addition to counsel may remain in the room to represent the department;

(G) A witness may testify by telephone or videoconference upon request from either party. The appellant or his/her attorney if represented or the attorney representing the department should submit a written request, with a copy to the other party, for the approval of the hearings administrator for a witness to testify by telephone or videoconference at least five (5) working days before the hearing, unless there is good cause to shorten the period. Objections to a witness testifying by telephone or videoconference should be submitted to the hearings administrator at least two (2) working days prior to the hearing, unless there is good cause to shorten the period;

(H) The formal rules of evidence shall not apply at these hearings. Parties may introduce any relevant evidence at the discretion of the hearings administrator;

(I) In all cases of allegations of abuse, neglect, or misuse of funds/property, the attorney representing the department shall offer the investigative report into evidence at the administrative hearing. In accordance with section 630.167.3(1), RSMo, the investigative report shall be admitted into evidence;

(J) The hearings administrator may exclude evidence that is purely cumulative;

(K) The hearings administrator may take administrative notice of department rules, department operating regulations, and facility policies without the necessity of an offer into evidence; and

(L) The hearing shall be recorded. After the hearings administrator issues his or her decision, a copy of the recording shall be made available to either party upon request. The department will not transcribe the recording from aural to written form. The cost of a transcription shall be borne by the requesting party.

(11) All requests shall be in writing and directed to the attention of the hearings administrator and copied to the other party. This includes such matters as requests for continuances, documents, recordings, remote witness testimony, subpoenas, protective orders, and copies of decision. Requests may be sent to the office of the hearings administrator at 1706 East Elm, PO Box 687, Jefferson City, MO 65102 or faxed to (573) 751-8069.

(12) The hearings administrator's decision is final and is subject to judicial review in accordance with sections 536.100 to 536.140, RSMo. A motion for attorney's fees, if any, shall be filed with the office of the hearings administrator within thirty (30) calendar days of the date of the decision. The filing of a petition for judicial review does not stay the thirty (30)-day filing requirement.

*AUTHORITY: sections 630.050 and 630.167, RSMo Supp. 2008. \* Original rule filed Dec. 1, 2008, effective May 30, 2009.*

*\*Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 630.167, RSMo 1980, amended 1985, 1990, 1993, 1996, 1998, 2003, 2007, 2008.*