



Rules of
Department of Mental Health
Division 10—Director, Department of Mental Health
Chapter 5—General Program Procedures

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

**9 CSR 10-5.010 General Rules Applicable
for Foster Care Homes for the Mentally
Retarded Subject to Certification**
(Rescinded July 11, 1983)

*AUTHORITY: sections 630.050 and 630.705,
RSMo Supp. 1982. Original rule filed Dec.
17, 1975, effective Dec. 27, 1975.
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9 CSR 10-5.020 Definitions
(Rescinded July 11, 1983)

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**9 CSR 10-5.030 Application and Discus-
sion of Standards**
(Rescinded July 11, 1983)

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9 CSR 10-5.040 Hearing Procedure
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**9 CSR 10-5.050 Admission Policies for
Foster Care Homes**
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**9 CSR 10-5.060 Education, Training and
Recreation**
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9 CSR 10-5.070 Records
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9 CSR 10-5.080 Resident Living
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**9 CSR 10-5.090 Construction of Physical
Plant Facilities**
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**9 CSR 10-5.100 Food Handling and
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9 CSR 10-5.110 Fire Protection and Safety
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9-CSR 10-5.120 Medical and Health Care
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**9 CSR 10-5.130 Qualifications of Foster
Care Parents**
(Rescinded July 11, 1983)

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**9 CSR 10-5.150 Individualized Habilita-
tion Plan Procedures**
(Moved to 9 CSR 45-3.010)

9 CSR 10-5.170 Residential Rate Setting
(Moved to 9 CSR 45-4.010)

9 CSR 10-5.180 Advance Directives

*PURPOSE: This rule defines terms and
establishes policies and procedures to be fol-
lowed by all facilities operated by the
Department of Mental Health and by other
department-related facilities for assuring the
rights of residents and patients to participate
in and direct health care decisions affecting
them.*

(1) Terms defined in sections 630.005,
631.005, 632.005 and 633.005, RSMo are
incorporated by reference for use in this rule.
Also, as used in this rule, unless the context
clearly indicates otherwise, the following
terms shall mean:

(A) Adult—an individual eighteen (18)
years of age or older;

(B) Advance directive—a written instru-
ment, such as a living will or durable power
of attorney for health care, relating to the pro-
vision of health care for an individual when
that individual is in a terminal condition or is
incapacitated;

(C) Attending physician—the physician
selected by or assigned to an individual and
who has primary responsibility for the treat-
ment and care of the individual. If more than
one (1) physician shares that responsibility,
any of those physicians may act as the attend-
ing physician;

(D) Attorney-in-fact—an individual or cor-
poration appointed to act as an agent of a
principal (resident or patient) in a written



power of attorney for health care allowed under law;

(E) Competent—not having been adjudicated incapacitated;

(F) Death-prolonging procedure—any medical procedure or intervention that, when applied to an individual, would serve only to artificially prolong the dying process and where, in the judgment of the attending physician pursuant to usual and customary medical standards, death will occur within a short time whether the procedure or intervention is used. Death-prolonging procedures shall not include administration of medication or performance of a medical procedure considered necessary to provide comfort or care or to alleviate pain, or the performance of any procedure to provide nutrition or hydration;

(G) Decision-making capacity—ability to make choices that reflect an understanding of the nature and effect of treatment options as well as the consequences of choices;

(H) Department facilities—facilities operated by the department;

(I) Durable power of attorney for health care—a written instrument executed by a competent adult, notarized and expressly giving an agent or attorney-in-fact the authority to consent to or to prohibit any type of health care, medical care, treatment or procedures to the extent authorized in sections 404.800–404.865, RSMo;

(J) Health care—any treatment, service or procedure to diagnose or treat the physical or mental condition of a resident or patient;

(K) Health care facility—an individual or agency licensed, certified or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice;

(L) Incapacitated—unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to an extent that an individual lacks capacity to meet essential requirements for food, clothing, shelter, safety or other care such that serious physical injury, illness or disease is likely to occur;

(M) Living will—a written instrument executed by a competent adult under sections 459.010–459.055, RSMo and declaring direction for the withholding or withdrawal of death-prolonging procedures and becoming operative if the adult is in a terminal condition;

(N) Patient—an individual under observation, care, treatment or rehabilitation by any hospital or other mental health facility pursuant to the provisions of Chapter 632, RSMo;

(O) Resident—a person receiving residential services from a facility, other than a men-

tal health facility, operated by the department;

(P) Terminal condition—an incurable or irreversible condition that, in the opinion of the attending physician, is such that death will occur within a short time, regardless of the application of medical procedures; and

(Q) Voluntary resident or patient—a person who has willingly chosen or consented to receive services from the department and who is receiving services in a department facility, or a person for whom a guardian has been appointed under Chapter 475, RSMo and the guardian has been authorized to admit the resident or patient for services from the department.

(2) The department shall honor the right of all competent adult voluntary residents and patients to make decisions regarding their health care, including the right to accept or refuse medical or surgical treatment, except that if a Division of Comprehensive Psychiatric Services facility's clinical staff determines that an emergency exists because a resident or patient is likely to do physical harm or present life-threatening behavior to him/herself or other residents or patients, the staff may administer psychotropic medication without the resident's or patient's consent. All competent adult residents and patients shall have the right to execute advance directives without regard to their voluntary or involuntary status. No department facility shall condition the provision of care or treatment, or otherwise discriminate against a resident or patient based on whether the individual has executed an advance directive.

(3) Using materials prepared by the department, all department facilities shall provide staff and community education about advance directives and the department's policy on carrying out those directives by department facilities.

(4) Except as provided in sections (5) and (6), at the time an adult resident or patient is admitted to a department facility, the facility's staff shall—

(A) Provide written information about resident's or patient's rights to accept or refuse death-prolonging procedures and to execute advance directives;

(B) Provide written information about the department's policy on advance directives;

(C) Ask the resident or patient if s/he has executed an advance directive; and

(D) At his/her request, refer a competent adult resident or patient without an advance directive for assistance in completing one.

(5) If, at time of admission, department facility staff determine that a competent adult resident or patient lacks decision-making capacity, for example, due to intoxication or an acute episode of mental illness, the staff shall—

(A) If the resident or patient is accompanied by a friend, relative or guardian, discuss health care decisions and advance directives with that person as set out in section (4) of this rule; and

(B) Document the lack of decision-making capacity in the resident's or patient's medical record and the discussion of health care decisions and advance directives with the friend, relative or guardian rather than the resident or patient; or

(C) If the resident or patient is unaccompanied, delay a discussion of health care decisions and advance directives; and

(D) Document the lack of decision-making capacity in the resident's or patient's medical record and that a discussion of health care decisions and advance directives was delayed.

(6) For a resident or patient with whom department facility staff did not discuss health care decisions and advance directives at the time of admission as set out in section (4) because the resident or patient lacked decision-making capacity, when the staff determine that the resident or patient has regained decision-making capacity, the staff shall hold the discussion and document it in the resident's or patient's medical record, regardless of whether the resident or patient was accompanied at time of admission.

(7) Staff of department facilities shall document in each adult resident's or patient's medical record whether the resident or patient has executed an advance directive. If a resident or patient has executed an advance directive, staff shall presume the resident or patient was competent when the advance directive was executed and that the advance directive was properly executed unless a court determines otherwise. Upon permission of the resident or patient, guardian or attorney-in-fact, and if a copy of the advance directive is provided by the resident or patient, guardian or attorney-in-fact, staff shall place a copy of the advance directive in the resident's or patient's medical record.

(8) Because the department has a statutory mission to habilitate, treat or rehabilitate its residents and patients in department facilities, it shall not withhold or withdraw—

(A) Food, hydration, antibiotics or anti-seizure medication for the purpose of ending life;



(B) Psychotropic drugs essential to treatment of mental illness that are otherwise authorized by law or department rule; or

(C) Any medication, medical procedure or intervention that, in the opinion of facility staff, is necessary to prevent the suicide of a resident or patient.

(9) When it is determined that a resident or patient is incapacitated or in a terminal condition and that the resident or patient has an advance directive, department facility staff shall carry out the advance directive in the facility where the resident or patient resides unless—

(A) The resident's or patient's advance directive specifies procedures prohibited under the department policy set out in section (8);

(B) The resident's or patient's attorney-in-fact under a durable power of attorney for health care requests procedures prohibited under the department policy set out in section (8);

(C) The resident or patient is pregnant and has a living will that calls for withdrawing or withholding treatment; or

(D) The head of the facility determines that the facility is not equipped to provide acute and specialized medical care needed by the resident or patient.

(10) If based upon section (9) of this rule, the head of a department facility determines that the facility shall not carry out a resident's or patient's advance directive in the facility, the department facility staff, in conjunction with the resident or patient or the resident's or patient's guardian or attorney-in-fact, shall take all reasonable steps to transfer the resident or patient to a health care facility that is equipped and willing to carry out the resident's or patient's advance directive. At a minimum, these steps shall include, if necessary, assistance from department facility case managers in locating a health care facility that is equipped and willing to carry out the advance directive and case managers' assistance with transferring the resident or patient to the health care facility.

(11) If a resident or patient with an advance directive is transferred from a department facility to another health care facility at the request of the department, the department will pay for transportation to and care in the health care facility if all other resources available to the resident or patient have been exhausted.

(12) A resident or patient may revoke an advance directive at any time and in any man-

ner by which s/he is able to communicate, regardless of mental or physical condition. If an incapacitated resident or patient or a resident or patient in a terminal condition revokes an advance directive, department facility staff shall notify the resident's or patient's attorney-in-fact or legal guardian of the revocation and the manner by which the advance directive was revoked.

(13) If any resident or patient notifies department facility staff in any manner by which s/he is able to communicate that s/he wishes to revoke an advance directive, department facility staff shall immediately document the revocation in the resident's or patient's medical record and the manner by which the advance directive was revoked and shall notify orally any other staff known to be involved in the resident's or patient's health care.

(14) An advance directive also shall be revoked upon execution of a subsequent advance directive by the resident or patient.

(15) No department employee may recommend or otherwise suggest to a resident or patient that the resident or patient alter or revoke his/her advance directive.

(16) Department facility staff shall act upon a revocation of a resident's or patient's advance directive when the resident or patient is incapacitated or in a terminal condition and is not able to make treatment decisions if—

(A) The revocation is documented in the resident's or patient's medical record; or

(B) The staff member in charge of the resident's or patient's treatment at that time has actual knowledge of the revocation.

(17) Department facility staff shall periodically review the status of resident's and patient's advance directives as necessary or when requested by the resident or patient or the guardian or attorney-in-fact.

(18) Except to the extent the right is limited by the durable power of attorney for health care or any federal law, an attorney-in-fact under a durable power of attorney for health care has the same right as the resident or patient to receive information about health care proposed for the resident or patient, to receive and review the resident's or patient's medical records and to consent to disclosure of the medical records, except that the right of access to medical records is not a waiver of any evidentiary privilege.

(19) No employee of a department facility shall serve as an attorney-in-fact under a

durable power of attorney for health care for any resident or patient receiving care or treatment at the facility at which the employee works unless that employee is related by marriage or consanguinity within the second degree or unless the employee and resident or patient are members of the same community of persons who are bound by vows to a religious life and who conduct or assist in the conducting of religious services and actually and regularly engage in religious, benevolent, charitable or educational ministry, or the performance of health care services.

AUTHORITY: section 630.050, RSMo 1986. Original rule filed June 30, 1992, effective April 8, 1993.*

**Original authority: 630.050, RSMo 1980.*

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; 630.163, 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.



Department of Mental Health
Incident and Investigation Tracking System- Event Report Form
(Community Report Form —ADA/CPS)

DIVISION: [] Alcohol and Drug Abuse [] Comprehensive Psychiatric Services
Program/Service type regarding consumer/Event (CPR, CSTAR, etc.)

Consumer Name (Last) (First) (MI) AGE [] Male [] Female [] DMH ID# [] Medical Record # [] SSN#
[] Female (check one)

Address/Home

Person(s) who witnessed or have direct knowledge of the event: (attach additional page if necessary)

Table with 3 columns: Last Name, First Name, Relationship to Consumer

Event Date and Time Discovery Date and Time
Month Day Year Time : AM PM Month Day Year Time : AM PM

Event location or where discovered (be specific) Name of Provider Agency/Organization involved in event:

Reporter's Name (Last, First, MI) Reporter's Phone Number Reporter's Employer (Agency/Facility/Admin. Agent)
VENDOR NUMBER (REQUIRED):

Table for Persons /Agencies Notified: (Check all that apply) with columns for Name of Person Contacted, DATE, TIME, AM, PM and various notification categories like Family / Guardian, Physician, etc.

EVENT DESCRIPTION—(Describe what happened & attach additional page(s) if necessary)



Consumer Name _____

Event Date _____

REPORTABLE EVENTS

All events identified below shall be recorded on this form and faxed within one business day to the appropriate Division of Alcohol and Drug Abuse District Administrator or Division of Comprehensive Psychiatric Services Supported Community Living Office. Abuse and neglect requires an immediate verbal or written report according to 9 CSR 10-5.200.

- Consumer Death (Regardless of cause, including all known deaths of discharged consumers up to and including 30 days post-discharge from a residential program)
- Elopement/Unauthorized Absence (The timeframe for reporting shall be when this absence raises reasonable concern for the safety of the consumer or others, or concern that the consumer will not return. For the Division of Alcohol and Drug Abuse, this applies to adolescents and involuntary commitments only)
- Alleged or Suspected Abuse/Neglect:**
 - Alleged or Suspected Verbal Abuse
 - Alleged or Suspected Physical Abuse
 - Alleged or Suspected Sexual Abuse
 - Alleged or Suspected Neglect
- Alleged or Suspected Misuse of Consumer Funds/Property
- Medication Error (Occurring in residential programs or programs in which medication is administered or self administration is observed by agency staff)**
 - Moderate Medication Error: Treatment and/or intervention is needed in addition to monitoring or observation
 - Serious Medication Error: Life threatening and/or permanent adverse consequences
- Serious Injury (injury to a consumer requiring medical inpatient hospitalization)

IF DEATH, SUSPECTED MANNER:

- Accident
- Homicide
- Natural
- Suicide
- Unknown

INJURY TYPE:

- Accident
- Consumer Inflicted
- Other Inflicted
- Self-Inflicted
- Staff Inflicted
- Unknown

Signature of Reporter _____

MM / DD / YR
REPORT DATE

____ AM ____ PM
REPORT TIME

TO BE COMPLETED BY DEPARTMENT OF MENTAL HEALTH STAFF

Action Taken:

- Inquiry
- Local Investigation
- Central Office Investigation
- No Investigation

Signature of ADA or CPS Staff: _____

Date: _____

INCIDENT TYPE (TO BE COMPLETED BY DMH STAFF)

- Consumer Rights
- Consumer Struck Object
- Consumer Self Harm
- Fall
- Fire
- Inappropriate language by staff toward consumer
- Medical Emergency
- Notification of death in the community
- Physical altercation-consumer & consumer
- Physical altercation-consumer & staff
- Property loss/destruction
- Possession of drugs not prescribed
- Possession of weapon
- Sexual conduct-consumer & staff
- Sexual conduct – consumer non-consensual
- Suicide Attempt
- Theft
- Vehicular accident
- Other _____

NOTES:

7/14/05

DMH-9719A



iITS # _____
 DMH Use Only
 7-14-09

Department of Mental Health
 iITS- Community Event Report Form-MRDD

All events must be reported to the regional center immediately, unless otherwise specified on this form. The written event report form must be submitted the next working day, unless requested sooner by the regional center.

EVENT CATEGORY (CHECK ONE) 1. INCIDENT MEDICATION ERROR DEATH
 PROGRAM CATEGORY (CHECK ONE) 2. COMMUNITY PLACEMENT PURCHASE OF SERVICE (POS) CASE MANAGEMENT

3. Event Date & Time ____/____/____ : ____AM ____PM
 Month Day Year
 4. Discovery Date & Time ____/____/____ : ____AM ____PM
 (Complete this section only if different than event date/time)

INVOLVED

5. Consumer Name (Last) (First) (MI) 6. DOB 7. Male Female 8. Consumer ID
 9. Address/Home Telephone Number 10. DMH/County Board Service Coordinator Name

11. Event Location or where discovered (Name of agency or location) 12. Name of Provider Agency/Organization involved in event & VENDOR NUMBER

13. Persons who witnessed or have direct knowledge of the event		Relationship (CHOOSE FROM LIST BELOW)	Telephone Number
Last Name	First Name		

*Relationship to Consumer-consumer, parent/guardian, staff, visitor, volunteer, complainant, perpetrator, reporter, victim, witness, other -specify)

14. NOTIFIED: Persons /Agencies (CHECK ALL THAT APPLY)	Name of Person Contacted	DATE	TIME
<input type="checkbox"/> DMH Regional Center			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Family or Guardian			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Physician			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Law Enforcement			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> DSS Children's Division			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Division of Senior Services			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> 911			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Other			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM

15. **EVENT DESCRIPTION:** Describe what happened and interventions used by staff: - Refer to instruction sheet for items to be included in this section.

Attach additional pages if necessary



Consumer Name _____		Event Date _____	
16. MEDICATION ERROR CATEGORY (SELECT ONE) <input type="checkbox"/> Failure to Administer Reason _____ <input type="checkbox"/> No Physician Order <input type="checkbox"/> Wrong Dose <input type="checkbox"/> Wrong Form <input type="checkbox"/> Wrong Medication <input type="checkbox"/> Wrong Person <input type="checkbox"/> Wrong Route <input type="checkbox"/> Wrong Time		17. MEDICATION ERROR SEVERITY RATING (SELECT ONE) <input type="checkbox"/> Minimal: No treatment or intervention other than monitoring or observation Notification and written report to regional center within five (5) working days of discovery unless a suspicion or allegation of neglect <input type="checkbox"/> Moderate: Treatment and/or interventions in addition to monitoring or observation <input type="checkbox"/> Serious: Life threatening and/or permanent adverse consequences	
18. EVENT/ INCIDENT TYPE (SELECT ONE) ** emergency medical intervention or hospitalization of consumer <input type="checkbox"/> Choking with ** <input type="checkbox"/> Violation of Client Rights in RSMo 630.110 & 630.115 <input type="checkbox"/> Consumer struck object resulting in injury <input type="checkbox"/> Elopement/Unauthorized absence when absence raises reasonable concern for the safety of consumer or others, or concern the consumer will not return <input type="checkbox"/> Fall with ** <input type="checkbox"/> Fire <input type="checkbox"/> Inappropriate language by staff toward consumer (Verbal Abuse-9 CSR 10-5.200) <input type="checkbox"/> Ingestion of non-food item <input type="checkbox"/> Medical emergency <input type="checkbox"/> Misuse of consumer funds/property-(9 CSR 10-5.200) <input type="checkbox"/> Physical altercation-consumer & consumer <input type="checkbox"/> Physical altercation-consumer & non-staff <input type="checkbox"/> Physical altercation-consumer & staff <input type="checkbox"/> Possession of weapon <input type="checkbox"/> Property loss/destruction <input type="checkbox"/> Sexual conduct-consumer/non-consensual <input type="checkbox"/> Sexual conduct-consumer & staff <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Theft by consumer <input type="checkbox"/> Vehicular accident		19. DID THE EVENT RESULT IN Report any of the following three incidents only if • unusual and not being addressed in the personal plan; • there is an injury; or • there is an allegation/suspicion of neglect. <input type="checkbox"/> Consumer self harm <input type="checkbox"/> Graphic threat of harm <input type="checkbox"/> Seizures Check all that apply <input type="checkbox"/> Injury to consumer <input type="checkbox"/> Use of physical restraint <input type="checkbox"/> Administration of PRN psychotropic medication <input type="checkbox"/> Hospitalization/non-injury <input type="checkbox"/> None of the above If injury complete 20, 21 22, 23	
20. INJURY TYPE (SELECT ONE) <input type="checkbox"/> Accident <input type="checkbox"/> Consumer Inflicted <input type="checkbox"/> Other Inflicted <input type="checkbox"/> Self Inflicted <input type="checkbox"/> Staff inflicted <input type="checkbox"/> Unknown			
21. INJURY SEVERITY: (SELECT ONE) <input type="checkbox"/> Medical Intervention <input type="checkbox"/> Hospitalization <input type="checkbox"/> Death			
22. INJURY DESCRIPTION (CHECK ALL THAT APPLY) <input type="checkbox"/> Abrasion <input type="checkbox"/> Frostbite <input type="checkbox"/> Bite <input type="checkbox"/> Heat related illness <input type="checkbox"/> Bruise <input type="checkbox"/> Poisoning <input type="checkbox"/> Burn <input type="checkbox"/> Puncture <input type="checkbox"/> Complaint of Pain <input type="checkbox"/> Scratches <input type="checkbox"/> Cut <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Swelling <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture/Break <input type="checkbox"/> Other (specify) _____		23. INJURED BODY PARTS (CHECK ALL THAT APPLY) <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Back <input type="checkbox"/> Knee <input type="checkbox"/> Face <input type="checkbox"/> Upper Arm <input type="checkbox"/> Lower Back <input type="checkbox"/> Calf <input type="checkbox"/> Eye <input type="checkbox"/> Elbow <input type="checkbox"/> Abdomen <input type="checkbox"/> Shin <input type="checkbox"/> Ear <input type="checkbox"/> Forearm <input type="checkbox"/> Waist <input type="checkbox"/> Ankle <input type="checkbox"/> Nose <input type="checkbox"/> Wrist <input type="checkbox"/> Hip <input type="checkbox"/> Foot <input type="checkbox"/> Mouth <input type="checkbox"/> Hand <input type="checkbox"/> Genitals <input type="checkbox"/> Teeth <input type="checkbox"/> Chest <input type="checkbox"/> Buttock <input type="checkbox"/> Neck <input type="checkbox"/> Thigh	
24. IMMEDIATE ACTION TAKEN BY AGENCY AND ACTION STEPS TO PREVENT REOCCURENCE (To be completed by agency management) _____ _____ _____			
25. Signature-Reporter _____		Phone Number () _____ Date ____/____/____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
26. Signature-Agency Management/Supervisor _____		Date _____	
27. Signature-Service Coordinator _____		Date _____	
28. Signature-Other DMH Staff _____		Date _____	
29. ACTION/ COMMENTS (To be completed by DMH) _____ _____ _____			
Suspicion or Allegation of Abuse, Neglect or Misuse of Consumer Funds/Property? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, must be entered into IITS within 24 hours Suspected Manner of Death <input type="checkbox"/> ACCIDENT <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NATURAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNDETERMINED			



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 administra-

tor 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.*

9 CSR 10-5.240 Health Home

PURPOSE: This rule prescribes a Health Home as an alternative approach to the delivery of health-care services that promises better experience and better results than traditional care. This rule also establishes the payment methodology for those Community Mental Health Centers (CMHCs) participating as a Health Home.

(1) Definitions.

(A) Community Mental Health Centers (CMHC)—An agency and its approved designee(s) authorized by the Division of Comprehensive Psychiatric Services (CPS) as an entry and exit point into the state mental health service delivery system for a geographic service area defined by the division.

(B) Department—Missouri Department of Mental Health (DMH).

(C) Electronic Medical Record (EMR) (also referred to as Electronic Health Records (EHR))—An electronic version of a patient's medical history that is maintained by the provider over time and may include all of the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The EMR automates access to information and has the potential to streamline the clinician's workflow. The EMR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.

(D) Health Home (also referred to as Health Care Home)—A site that provides comprehensive behavioral health care coordinated with comprehensive primary physical care to Medicaid patients with behavioral health and/or chronic physical health condi-

tions, using a partnership or team approach between the Health Home practice's/site's health-care staff and patients in order to achieve improved primary care and to avoid hospitalization or emergency room use.

(E) Learning Collaborative—Group training sessions that CMHCs must attend if they are chosen to participate in the Missouri Medicaid Community Mental Health Center Health Home program.

(F) Missouri Medicaid Audit and Compliance Unit (MMAC)—The unit within the Department of Social Services (DSS) which directly manages and administers Medicaid provider review, program integrity, audit and compliance initiatives, and provider contracts of the Medicaid program.

(G) MO HealthNet Division (MHD)—The Missouri Medicaid agency.

(H) Needy individuals—Individuals receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), or are furnished uncompensated care by the provider, or furnished services at either no cost or reduced cost based on a sliding scale.

(2) Health Home Qualifications.

(A) Initial Provider Qualifications. In order to be recognized as a Health Home, a CMHC must, at a minimum, meet the following criteria:

1. Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a considerable volume of needy individuals;

2. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated through the application process and agreement to participate in learning activities; and that agency leadership have presented the state-approved "Paving the Way for Health Homes" PowerPoint introduction to Missouri's Health Home Initiative to all agency staff;

3. Meet the state's minimum access requirements. Prior to implementation of Health Home service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, twenty-four (24) hours per day, seven (7) days per week;

4. Actively use MHD's comprehensive EHR to conduct care coordination and prescription monitoring for Medicaid participants;

5. Utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals,



automate care reminders, and produce exception reports for care planning;

6. Routinely use a behavioral pharmacy management system to determine problematic prescribing patterns;

7. Conduct wellness interventions as indicated based on client's level of risk;

8. Complete status reports to document client's housing, legal, employment status, education, custody, etc.;

9. Agree to convene regular, ongoing and documented internal Health Home team meetings to plan and implement goals and objectives of practice transformation;

10. Agree to participate in the Centers for Medicare and Medicaid Services (CMS) and state-required evaluation activities;

11. Agree to develop required reports describing CMHC Health Home activities, efforts, and progress in implementing Health Home services;

12. Maintain compliance with all of the terms and conditions as a CMHC Health Home provider or face termination as a provider of CMHC Health Home services; and

13. Present a proposed Health Home delivery model that the state determines to have a reasonable likelihood of being cost effective. Cost effectiveness will be determined based on the size of the Health Home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients, and other factors to be determined by the state.

(B) Ongoing Provider Qualifications. Each CMHC must also—

1. Within three (3) months of Health Home service implementation, have a contract or Memorandum of Understanding (MOU) under development with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking emergency department (ED) services that might benefit from connection with a Health Home site, and in addition motivate hospital staff to notify the CMHC primary care nurse manager or staff of such opportunities;

2. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;

3. Demonstrate continuing development of fundamental Health Home functionality at six (6) months and twelve (12) months through an assessment process to be determined by DMH;

4. Demonstrate improvement on clinical

indicators specified by and reported to the state; and

5. Meet accreditation standards approved by the state as such standards are developed.

(3) Scope of Services. This section describes the activities CMHCs will be required to engage in and the responsibilities they will fulfill if recognized as a Health Home provider.

(A) Health Home Services. The Health Home Team shall assure that the following health services are received as necessary by all members of the Health Home:

1. Comprehensive Care Management. Comprehensive care management includes the following services:

A. Identification of high-risk individuals and use of client information to determine level of participation in care management services;

B. Assessment of preliminary service needs;

C. Development of treatment plans, including client goals, preferences, and optimal clinical outcomes;

D. Assignment of Health Team roles and responsibilities;

E. Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;

F. Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and

G. Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery, and costs.

2. Care coordination. Care coordination consists of the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkage to long-term services and supports. Specific care coordination activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members. Health Homes must conduct care coordination activities across the Health Team. The primary responsibility of the Nurse Care Manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.

3. Health promotion services. Services shall minimally consist of providing health

education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screening, child physical and emotional development, providing support for improving social networks, and providing health promoting lifestyle interventions, including, but not limited to: substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity. Health promotion services also assist clients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.

4. Comprehensive transitional care. Members of the Health Team must provide care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. Members of the Health Team collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community and shift the use of reactive care and treatment to proactive health promotion and self-management.

5. Individual and family support services. Services include, but are not limited to: advocating for individuals and families; assisting with, obtaining, and adhering to medications and other prescribed treatments. In addition, Health Team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically-necessary services. A primary focus will be increasing health literacy, ability to self-manage care, and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with developmental disabilities (DD) the Health Team will refer to and coordinate with the approved DD case management entity for services more directly related to habilitation or a particular health care condition.

6. Referral to community and social support. Involves providing assistance for clients to obtain and maintain eligibility for health care, disability benefits, housing, personal need, and legal services, as examples. For individuals with DD, the Health Team



will refer to and coordinate with the approved DD case management entity for this service.

(B) Health Home Staffing. Health Home providers will augment their current Community Psychiatric Rehabilitation (CPR) teams by adding a Health Home Director, Physician Leadership, and Nurse Care Managers to provide consultation as part of the Care Team and assist in delivering Health Home services. Clerical support staff will also be funded to assist with Health Home supporting functions.

(C) Learning Activities. CMHCs will be supported in transforming service delivery by participating in statewide learning activities. Given CMHCs' varying levels of experience with practice transformation approaches, the state will assess providers to determine learning needs. CMHCs will therefore participate in a variety of learning supports, up to and including learning collaborative, specifically designed to instruct CMHCs to operate as Health Homes and provide care using a whole person approach that integrates behavioral health, primary care, and other needed services and supports.

1. Learning activities will support providers of Health Home services in addressing the following components:

A. Provide quality-driven, cost-effective, culturally-appropriate, and person-and-family-centered Health Home services;

B. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

C. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;

D. Coordinate and provide access to mental health and substance use services;

E. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings;

F. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;

G. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;

H. Coordinate and provide access to long-term care supports and services;

I. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services;

J. Demonstrate a capacity to use health information technology to link services, facilitate communication among team

members and between the Health Team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and

K. Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

(D) Patient Registry. Health Homes shall utilize the DMH/Department of Social Services (DSS) provided EHR patient registry. A patient registry is a system for tracking information that DMH/DSS deems critical to the management of the health of a Health Home's patient population, including dates of delivered and needed services, laboratory values needed to track chronic conditions, and other measures of health status. The registry shall be used for—

1. Patient tracking;

2. Patient risk stratification;

3. Analysis of patient population health status and individual patient needs; and

4. Reporting as specified by DMH.

(E) Data Reporting. CMHCs shall submit to DMH the following reports, as further specified by DMH, within the time frames specified below:

1. Monthly update CMHC report that describes the CMHC's efforts and progress to implement Health Home; including identifying the CMHC leadership and Health Home staffing and providing updates on Health Home enrollment status; and

2. Other reports, as specified by DMH/DSS.

(F) Demonstrated Evidence of Health Home Transformation. CMHCs are required to demonstrate evidence of Health Home transformation on an ongoing basis using measures and standards established by DSS and DMH, and communicated to the CMHCs. Evidence of Health Home transformation includes:

1. Demonstrates development of fundamental health home functionality at six (6) months and twelve (12) months based on an assessment process to be determined by DMH; and

2. Demonstrates improvement on clinical indicators specified by and reported to DMH.

(G) Participation in Evaluation. CMHCs shall participate in an evaluation. Participation may entail responding to surveys and requests for interviews with CMHC staff and clients. CMHCs shall provide all

requested information to the evaluator in a timely fashion.

(H) Notification of Staffing Changes. Practices are required to notify DMH within five (5) working days of staff changes in Health Home Director, Physician Leadership, Nurse Care Managers, and Clerical Support Staff.

(I) CMHCs shall work cooperatively with DMH to support DMH approved training, technology, and administrative services required for implementation of the Health Care Home Program.

(4) Patient Eligibility and Enrollment.

(A) Medicaid beneficiaries eligible for Health Home services from recognized CMHC Health Home service providers must meet one (1) of the following criteria:

1. Diagnosed with a serious and persistent mental health condition (adults with Seriously Mentally Ill (SMI) and children with Serious Emotional Disturbance (SED)); or

2. Diagnosed with a mental health condition and substance use disorder; or

3. Diagnosed with a mental health condition and/or substance use disorder, and one (1) other chronic condition (diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease, overweight (body mass index (BMI) > 25), tobacco use, and developmental disability).

(B) Individuals eligible for Health Home services and identified by the state as being an existing service user of a Health Home will be auto-assigned to eligible providers based on qualifying conditions. Individuals will be attributed to the CMHC using a standard patient attribution algorithm adopted by DMH/DSS.

(C) After being assigned to a Health Home, participants will be granted the option to change their Health Home if desired. A participant assigned to a Health Home will be notified by DMH of all available Health Homes sites throughout the state. The notice will—

1. Describe the participant's choice in selecting a new Health Home;

2. Provide a brief description of Health Home services; and

3. Describe the process for the participant to decline receiving Health Home services from the assigned Health Home provider.

(D) Potentially eligible individuals receiving services in the hospital emergency department or as an inpatient will be notified about eligible Health Homes and referred based on their choice of provider. Eligibility for Health Home services will be identifiable through



the state’s comprehensive Medicaid electronic health record.

(E) Health Home providers to which patients have been auto-assigned will receive communication from the state regarding a patient’s enrollment in Health Home services. The Health Home will notify other treatment providers about the goals and types of Health Home services as well as encourage participation in care coordination efforts.

(5) Health Home Payment Components.

(A) General.

1. All Health Home payments to a practice site are contingent on the site meeting the Health Home requirements set forth in this rule. Failure to meet these requirements is grounds for revocation of a site’s Health Home status and termination of payments specified within this rule.

2. Health Home reimbursement will be in addition to a provider’s existing reimbursement for services and procedures and will not change existing reimbursement for a provider’s non-Health Home services and procedures.

3. DMH/DSS reserves the right to make changes to the payment methodology after consultation with recognized Health Homes and receipt of required federal approvals.

(B) Types of Payments.

1. Clinical Care Management Per Member Per Month (PMPM). PMPM reimburses for cost of staff primarily responsible for delivery of Health Home services not covered by other reimbursement and whose duties are not reimbursable otherwise by Medicaid.

AUTHORITY: section 630.050, RSMo Supp. 2011. Emergency rule filed Dec. 20, 2011, effective Jan. 1, 2012, expired June 28, 2012. Original rule filed Oct. 17, 2011, effective June 29, 2012.*

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

9 CSR 10-5.250 Screening and Assessment for Behavioral Changes

PURPOSE: This rule establishes guidelines for the screening and assessment of individuals receiving services from state owned or operated facilities to determine whether changes in behavior or mental status are caused by or associated with a medical condition.

(1) Definitions—

(A) Department—Department of Mental Health (DMH);

(B) Interdisciplinary team (IDT)—staff

who know the individual well and possess the knowledge, skills, and expertise necessary to accurately identify a comprehensive array of the individual’s needs and design a program responsive to those needs; and

(C) State owned or operated facilities— includes state Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) as defined in 42 CFR section 440.150, RSMo, psychiatric residential treatment facilities, and state operated home and community-based waiver services.

(2) The provisions of this rule do not apply to long-term care facilities licensed under Chapter 198, RSMo, hospitals licensed under Chapter 197, RSMo, or hospitals as defined in section 197.020, RSMo.

(3) Members of the IDT who are supporting individuals in state owned or operated facilities shall document and collect data.

(4) Based on a review of the data, the department shall first assess whether there is a relationship between a physiological event and/or illness and behavior. If a medical condition is suspected as the possible cause of the behavior change, medical assessment and treatment shall be accessed. After treating the medical condition or ruling out a medical or physiological event, the department shall then take other actions regarding psychiatric consultation and treatment.

AUTHORITY: section 630.050, RSMo Supp. 2013, and section 630.167, RSMo Supp. 2014. Original rule filed Dec. 10, 2015, effective June 30, 2016.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 630.167, RSMo 1980, amended 1985, 1990, 1993, 1996, 1998, 2003, 2007, 2008, 2011, 2014.*