ARC 1660C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 225C.6 and 331.397 and 2014 Iowa Acts, House File 2379, the Department of Human Services amends Chapter 24, "Accreditation of Providers of Services to Persons With Mental Illness, Mental Retardation, and Developmental Disabilities," Iowa Administrative Code.

These amendments allow for technical correction of the title of the chapter to be in compliance with the accepted change of the term "mental retardation" to the term "intellectual disabilities."

These amendments also restructure the chapter to add divisions that clearly outline service accreditation requirements.

Finally, these amendments provide new accreditation standards in Chapter 24 for crisis response services. Mental health and disability services (MHDS) regions are required to offer basic crisis response services, and as funding is available, additional crisis response services are to be provided in the MHDS regions.

2014 Iowa Acts, House File 2379, requires the Department to accredit crisis stabilization programs. MHDS regions began operation July 1, 2014, and are required to offer basic crisis response services. The MHDS regions will be developing additional core services in accordance with Iowa Code section 331.397. These amendments set an expected standard that providers must meet for crisis response services.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 1554C** on July 23, 2014.

Since publication of the Notice, the Department has changed the format of the rules to reflect parallel construction and has clarified synonymous terms for consistency. The style headings and numerical levels within the rule making were also revised due to structural changes.

The Department changed the number and value of indicators in paragraph 24.26(3)"c" to reflect the new construction of the rules.

Service	Number of Indicators	Value of Each Indicator
24-hour crisis response	19	3.9
Crisis evaluation	20	3.5
24-hour crisis line	23	3.0
Warm line	20	3.5
Mobile response	18	3.9
23-hour observation and holding	44	1.6
Crisis stabilization, community-based	39	1.8
Crisis stabilization, residential	50	1.4

The Department received 156 comments on the proposed rules from six respondents. The comments and corresponding responses from the Department are consolidated into 14 topic areas as follows:

A. Crisis services in general.

1. One respondent commented that the rules state that the standards apply to providers not required to be licensed by the Department of Inspections and Appeals (DIA) and asked whether that means providers licensed by DIA for other services are excluded from these rules.

Department response: The rules apply to all providers of the crisis stabilization services described herein. A provider of crisis stabilization services may or may not be licensed by DIA for the provision of other services.

2. One respondent commented that in defining crisis services, it should be noted that effective crisis intervention and suicide prevention respect the autonomy of the individual and the individual's need and

right to be engaged in finding appropriate safety measures that do not require entering a hospital or other facility.

Department response: The Department agrees with this statement and believes the rules are consistent; no change to the rules is needed.

3. One respondent commented that crisis services should always include the assumption of the highest level of risk and suicidal action. The respondent suggested that training should be conducted, and ongoing monitoring should be in place, to ensure that evidence-based risk assessments of suicidal behavior are utilized for all clients in behavioral health crisis. The respondent also suggested that trainings, such as Applied Suicide Intervention Skills Training (ASIST), should be required for all crisis response staff.

Department response: The rules require appropriate Department-approved training for crisis response staff. ASIST is one example of a training program the Department would approve.

4. One respondent commented that the rules do not seem to allow for people in crisis who do not meet the criteria for a mental health disorder.

Department response: The eligibility standard in subrule 24.25(1) does not require a mental health diagnosis for an individual to be eligible for a crisis response service.

5. One respondent commented that training in regard to means restriction, as part of suicide response, should be required for all crisis response staff and training for securing all environments for suicide safety should also be provided.

Department response: The rules require Department-approved training for crisis response staff, and the standards for organizational activities in Chapter 24 address any situation that poses a danger or threat to staff or individuals using the services for necessity appropriateness, effectiveness and prevention.

6. One respondent commented that trauma-informed care training and practices should be required.

Department response: The rules allow the organization to identify training appropriate for crisis response staff, and trauma-informed care training would be approved by the Department.

7. One respondent commented that peer support services should be an integral part of each crisis response service and that each provider should be required to have the necessary supervision and support for peers who are providing direct stabilization service.

Department response: The Department agrees, and the rules include requirements for staff development, training and supervision for crisis response staff, which includes peer support specialists.

8. One respondent commented that the use of a peer specialist who has made significant progress in that person's own recovery to assist another individual with the same disorder is powerful and that the intent should be to match a peer specialist with a crisis client that recognizes their situations as similar.

Department response: The rules allow providers reasonable flexibility in staffing and in the assignment of peer support specialists.

9. Three respondents commented that the services do not include crisis care management to ensure postcrisis linkage to other services or to ensure that stabilization has been achieved to prevent a future similar crisis. One of the respondents also suggested that online chat and text crisis services should be included in the rules.

Department response: Follow-up services are required to be addressed in the treatment summary and action plan. The rules do not limit how crisis stabilization services can be provided as long as the means of communication are sensitive to confidentiality of users and, when required, are HIPAA-compliant.

10. One respondent commented that the rules do not address crisis aversion services as an option for people on the verge of crisis who need support to get through a difficult time.

Department response: Crisis aversion services were not included in the regional core services or additional core services required in Iowa Code section 331.397, and, therefore, crisis aversion services are beyond the scope of the rules.

11. One respondent noted that the rules state that crisis response services shall not be denied because of co-occurring conditions and asked whether crisis response services can be denied if the individual is in a state of intoxication that presents a medical or behavioral safety issue. The respondent also asked what funding sources are anticipated.

Department response: Provider policy and procedures should address appropriate crisis response services to individuals with co-occurring conditions and should address actions to be taken for the safety of individuals and staff. The rules do not address funding sources.

B. Definitions.

1. One respondent commented that the definition of "action plan" should be clarified to state that the action plan is developed collaboratively with the client and should include internal coping strategies, as well as professional providers and social supports, and identify environmental issues that assist the individual to be safe from self-harm.

Department response: The Department has changed the definition of "action plan" in response to this comment. The definition in rule 441—24.20(225C) now reads as follows: "*'Action plan'* means a written plan developed for discharge in collaboration with the individual receiving crisis response services to identify the problem, prevention strategies, and management tools for future crises."

Coping strategies, staffing qualifications, social supports, and environmental issues are all items to be addressed through the assessment requirement in subrule 24.32(2).

2. One respondent commented that the rules include a definition of "clinical supervisor," yet the term is not used in the rules.

Department response: The Department agrees that the term was not used in the rules, and the definition has been removed in response to this comment.

3. Two respondents commented that the definition of "crisis assessment" does not include telephonic or other electronic methods of interview.

Department response: Crisis assessment must be done utilizing face-to-face clinical interviewing as defined in rule 441—24.20(225C). The Department has changed the definition of "face-to-face." The revised definition now reads as follows: "*'Face-to-face'* means services provided in person or utilizing telehealth in conformance with the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules."

4. One respondent commented that the definition of "crisis response services" seemed to indicate that either crisis screening or crisis assessment must be done, but not both.

Department response: Crisis response services can occur after either a crisis screening or crisis assessment.

5. Three respondents commented that the differences between the definition of "crisis stabilization community-based services" and "crisis stabilization residential services" are not clear enough to distinguish between the two service levels.

Department response: The crisis stabilization service levels are the same, with the difference being that an individual receiving crisis stabilization residential services needs a short-term alternative living arrangement. The Department changed the definitions to clarify this difference. The definitions in rule 441—24.20(225C) now read as follows:

"*'Crisis stabilization community-based services'* or *'CSCBS'* means short-term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and provided where the individual lives, works or recreates."

"*'Crisis stabilization residential services'* or *'CSRS'* means a short-term alternative living arrangement designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and is provided in organization-arranged settings of no more than 16 beds."

6. One respondent commented that the definition of "stabilization plan" should state that the stabilization plan is written by crisis response staff, rather than by a mental health professional, and in collaboration with the client, rather than with the consent of the individual.

Department response: The stabilization plan is to be written within 24 hours of an individual's admission to the crisis service. The Department feels that the mental health professional should complete the plan through collaboration with crisis response staff and an individual. The Department has changed the definition of "stabilization plan." It now reads as follows: "*'Stabilization plan'* means a written short-term strategy used to stabilize a crisis and developed by a mental health professional, in collaboration with the crisis response staff and with the involvement and consent of the individual or the individual's representative."

7. Two respondents commented that the definition of "warm line" states that the warm line will be operated by peer counselors. The respondents suggested that crisis response staff or non-peer staff should also be included.

Department response: The Department agrees that the intent of a warm line was unclear and has changed the definition to read: "*'Warm line'* means a telephone line staffed by individuals with lived experience who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis." It is the Department's intent that warm lines will be operated by peer support specialists and family support peer specialists. This would follow the national model of established warm lines.

8. One respondent commented that the definitions do not provide for crisis response services to be provided by chat or text and suggested that chat and text be included.

Department response: The definition of "crisis response services" does not limit how all crisis response services can be provided as long as the means of communication is sensitive to confidentiality of users and, when required, is HIPAA-compliant.

9. One respondent commented that the terms "peer support" and "peer counseling" are used in the rules but are not defined.

Department response: Definitions for "peer support services," "peer support specialist," and "family support peer specialist" have been added to rule 441—24.20(225C), and the term "peer counseling" has been removed from the rules. The new definitions read as follows:

"*'Peer support services'* means a service provided by a peer support specialist, including but not limited to education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community."

"*'Peer support specialist'* means the same as defined in rule 441—25.1(331)."

"*'Family support peer specialist'* means the same as defined in rule 441—25.1(331)."

10. One respondent asked if crisis incident reporting applies only to physical injury or death resulting from a medication error.

Department response: The Department has changed the definition of "crisis incident" in rule 441—24.20(225C) to clarify that crisis incident reporting applies to any one of the situations listed. The definition now reads: "*'Crisis incident'* means an occurrence leading to physical injury or death, or an occurrence resulting from a prescription medication error, or an occurrence triggering a report of child or dependent adult abuse."

11. One respondent asked whether the definition of "face-to-face" includes phone and online communications.

Department response: The definition of "face-to-face" as revised includes in-person, Telehealth and Web-based communications that are compliant with HIPAA privacy rules.

12. One respondent asked if the definition of "dispatch" includes rescue.

Department response: The organization operating a crisis line is required to have a triage procedure to link to emergency services, mobile response services and provider support services. If someone is screened for a life-threatening situation, a call to 9-1-1 would be a part of the triage protocol.

13. One respondent commented that the definition of "24-hour crisis line" should include online as well as in-person crisis counseling.

Department response: The definition does not limit the use of the Internet for the delivery of crisis response services.

C. Organizational activities.

One respondent commented that the rules state that all toys and other materials used by children are to be clean and safe and asked if there are clearer guidelines for safety.

Department response: There are no additional guidelines for safety. The rules include the same standards for organizational environment that are contained in subrules 24.23(1) through 24.23(5) and apply to all providers accredited under Chapter 24.

D. Standards for crisis response staff.

1. One respondent commented that the rules state that law enforcement and EMTs must be trained in crisis intervention and asked what the guidelines are for approval of courses.

Department response: The Department will review and approve training programs submitted by providers to ensure that the training programs address staff competencies for crisis response services. Nationally recognized training will provide guidelines to fulfill the crisis response training requirement.

2. Two respondents commented that the rules require Department-approved crisis intervention training for all staff other than mental health professionals and asked who will develop the training and administer the posttraining assessment of competency. The respondent also asked if the assessment of competency will be skill- or knowledge-based and if it will be similar to the training requirement for current Chapter 24 accreditation.

Department response: The training requirement allows flexibility for providers, and they can request Department recommendations for various training designs or programs that best fit the needs of the organization and the people the organization serves. Training will be arranged by the organization and will include posttraining assessment for competency. The assessment should reflect competencies in skill and knowledge necessary to the trainee's job duties.

3. Five respondents commented that the rules should not assume that all licensed mental health professionals are skilled to respond with crisis response services or complete suicide risk assessments based only on their licensure. The respondents suggested that mental health professionals be required to have previous training in crisis and suicide intervention prior to working as crisis response staff.

Department response: While specific training in crisis and suicide prevention is not required for mental health professionals, subparagraph 24.3(4)"b"(5) requires that training and education be provided to all staff relevant to their positions.

4. One respondent commented that accreditation through the American Association of Suicidology (AAS) should be considered as an alternative to the trainings required by the Department, and another respondent similarly commented that accreditation through Contact USA should be considered.

Department response: The Department has changed rule 441—24.27(225C) to allow deeming through AAS and Contact USA.

5. One respondent commented that the staff requirement for bachelor level accepts experience in behavioral or mental health, but the other categories only seem to accept mental health experience.

Department response: The Department has changed the staffing requirements in subparagraph 24.24(2)"a"(7) for registered nurse qualifications to include two years of behavioral or mental health experience. As noted in the comment, bachelor's degree qualifications include experience in behavioral or mental health services.

6. Two respondents commented that all crisis response staff should be required to receive Applied Suicide Intervention Skills Training (ASIST) and training in means restriction and securing environments for suicide safety, as well as Mental Health First Aid training.

Department response: ASIST is an appropriate training the Department would approve, and all staff are required to receive training relevant to their positions as required by subparagraph 24.3(4)"b"(5).

7. One respondent asked if crisis response service staff must meet all the qualifications listed or only one of the qualifications listed.

Department response: This comment refers to a prepublication draft of the rules, and any issue of clarity has been addressed with the renumbering of the rule.

8. One respondent asked if the same training requirement applies to peer counselors in the warm line definition as to peer support specialists and suggested that peer counselors be trained in ASIST.

Department response: The term "peer counselor" has been removed from the rules as the term was causing confusion regarding the intent of the warm line. ASIST is an appropriate training that the Department would approve, and all staff are required to receive training relevant to their positions as required by subparagraph 24.3(4)"b"(5).

9. One respondent asked if a registered nurse with three years of mental health experience means a "psychiatric nurse."

Department response: The Department did not adopt the definition of "psychiatric nurse," and an ARNP is required to have two years of mental health experience.

10. One respondent commented that the staff requirements for crisis response services seem to state all levels are equal and that formal years of education should not be considered equal to training or

certification in Mental Health First Aid. The respondent further commented that with the exception of the warm line, direct responders and first responders of crisis services should not be peer specialists alone.

Department response: Each crisis response service has specific staff requirements that relate to the particular level of crisis response service to ensure that all staff are appropriately trained and credentialed for the crisis response services they provide.

11. One respondent commented that crisis services should be provided in addition to mental health evaluation and treatment, not as a replacement, which indicates that the handoff to longer term treatment should be clarified. The respondent further commented that it is not a crucial requirement for at least one ARNP, physician assistant or psychiatrist to be available for consultation 24 hours per day for crisis services.

Department response: Crisis response services include eight services, and access to clinical staff is important in crisis response service provision. The Department feels it is important that the crisis is assessed with the designated level of staff under each array of crisis response services. No change was made to the rules in response to this comment.

E. Deemed status.

Two respondents commented that each national accrediting body should have specific divisions related to crisis services if included as meeting division criteria and asked if this is accurate for the Council on Quality & Leadership in Supports for People With Disabilities.

Department response: The Department agrees. The Department will review each accrediting organization's standards to ensure they meet the rules. An organization may be one of these accredited organizations but will be required to provide additional policies and procedures for the crisis response service.

F. Crisis evaluation.

1. One respondent commented that the rules provide for crisis screening by face-to-face service or telephone and suggested that electronic methods such as chat should also be included.

Department response: Methods such as chat, text, and Skype may be used for crisis screening if the provider's policies and procedures allow for this and meet all applicable confidentiality standards, such as HIPAA.

2. One respondent commented that a mental health assessment within 24 hours is not necessary for all clients who receive crisis services.

Department response: The rules do not require an assessment. The screening process determines the next level of care, which may or may not indicate a need for a mental health assessment.

3. One respondent commented that subparagraph 24.32(1)"b"(3) requires that crisis screening be available 24 hours a day, 365 days a year, yet crisis screening can be a valuable service, even if not available at all hours.

Department response: The Department believes that the availability of crisis screening is important in crisis response. Crisis evaluation is required in Iowa Code section 331.397 for regional core services. Many of the crisis stabilization services are available 24 hours a day and require 24-hour screening capability. The Department did not adopt the performance indicators in subparagraph 24.32(1)"b"(3) of the Notice because the requirement for 24-hour screening is listed under each applicable service. The Department has adopted the following new wording under the performance indicators in paragraph 24.32(1)"b":

"(1) Crisis response staff are trained in crisis screening.

"(2) A uniform process for crisis screening and referrals is outlined in policies and procedures.

"(3) Crisis screening records are kept in individual files."

4. One respondent asked what is meant by including physical health in the assessment in addition to medical history in paragraph 24.32(2)"a." The respondent also asked how physical health is to be determined.

Department response: The Department has changed the definition of "crisis assessment" to include a reference to physical health. The definition now reads: "*'Crisis assessment'* means a face-to-face clinical interview to ascertain an individual's current and previous level of functioning, potential for

dangerousness, physical health, and psychiatric and medical condition. The crisis assessment becomes part of the individual's action plan."

The Department has also added the following definition of "physical health": "*'Physical health'* means any chronic or acute health factors indicated in the crisis assessment that need to be addressed during crisis service delivery."

5. One respondent commented that a licensed mental health professional is not necessary to conduct a crisis assessment within 24 hours of an individual's admission to a crisis response service and that the crisis assessment should be done by crisis response staff or a crisis counselor.

Department response: The Department feels that the crisis assessment includes diagnosis and does need to be conducted by a mental health professional.

G. Twenty-four-hour crisis response.

One respondent commented that the requirement that at least one ARNP, physician assistant or psychiatrist be available for consultation 24 hours per day, 365 days per year will be a very costly and unnecessary requirement for 24-hour crisis response services.

Department response: The Department feels that clinical consultation is important to provide effective crisis response services to the individual and support to all staff. The Department has changed the requirement in paragraph 24.33(2)"d" to read as follows: "*d.* A mental health professional is available for crisis assessment and consultation 24 hours a day, 365 days a year. The mental health professional has access to a qualified prescriber for consultation."

In addition, the Department did not adopt the proposed paragraph 24.33(2)"e," which required that an advanced registered nurse practitioner, physician assistant or psychiatrist be available for consultation 24 hours a day, 365 days a year.

H. Twenty-four-hour crisis line.

1. One respondent commented that it should be required that the 24-hour crisis line be answered by a live person, as is the warm line.

Department response: The Department agrees that the crisis line should be answered live, which is required in the AAS and Contact USA accreditation (deeming). Paragraph 24.34(2)"b" has been changed in response to the comment and now reads as follows: "*b.* Policies are in place regarding how the crisis line is answered live, when to utilize the hold feature, the use of queue systems and triage of calls."

2. One respondent commented that the 24-hour crisis line should provide crisis screening and crisis counseling, which can stabilize the client and would not require further intervention.

Department response: The Department agrees with this statement, and the rules have been changed to include this requirement. The definition of "twenty-four-hour crisis line" has been changed to read: "*'Twenty-four-hour crisis line'* means a crisis line providing information and referral, counseling, crisis service coordination, and linkages to crisis screening and mental health services 24 hours a day."

The Department has changed the performance benchmark in subrule 24.34(1) to read: "**24.34(1)** *Performance benchmark.* Crisis screening, counseling, crisis service coordination and referrals are provided to individuals in crisis."

3. One respondent commented that 24-hour crisis lines that do not have suicide prevention as a major component should be clearly distinguished from those crisis lines that do offer comprehensive crisis services.

Department response: The Department agrees that appropriate education and awareness will be necessary to market the crisis line. No change to the rules is necessary.

4. One respondent commented that the 24-hour crisis line should provide evidence-based suicide risk assessment.

Department response: The rules include a lethality assessment. No change was made to the rules.

5. One respondent asked what is meant by call center software standardized to crisis services.

Department response: There are crisis call center software products available, and each provider can determine which product best meets the needs of the provider's organization. The Department is not mandating one software program over another. The crisis line software selected shall include a standardized capability to track usage.

6. One respondent commented that the triage procedure should include the ability to keep the caller on the phone line while dispatching services on another separate phone line.

Department response: The Department agrees with this statement, and paragraph 24.34(2)"i" states that the organization shall have written policies and procedures describing a uniform process of screening and training for crisis line staff.

7. Three respondents commented on the requirement that a crisis line obtain accreditation through AAS within two years. The respondents recommended eliminating the requirement and allowing deeming though AAS accreditation.

Department response: The Department did not adopt the requirement of accreditation through AAS in proposed paragraph 24.34(2)"f" and has added requirements to meet the standards.

8. One respondent commented that crisis lines located within the state of Iowa will generally have better knowledge of state resources, including regional services, and have ongoing relationships with emergency providers.

Department response: The Department agrees with this statement. No change was made to the rules.

9. One respondent commented that AAS does not have a requirement to utilize peer support staff, nor any prohibition to using peers, as long as the peers meet the personal qualifications and demonstrate the requisite skills.

Department response: The Department agrees with this statement. No change was made to the rules.

10. One respondent commented that the description of mobile response states that 24-hour access to a mental health professional is required and suggested that the same should apply to the 24-hour crisis lines that will be dispatching the mobile teams.

Department response: The Department agrees and, in response to this comment, has added paragraphs 24.34(2)"k" and 24.35(2)"h" so that crisis lines and warm lines have 24-hour access to a mental health professional.

11. One respondent asked if the number of contacts, including terminated and lost calls, is tracked by the phone system or by software.

Department response: The call center software has the capability to track the number of contacts, and whether the software will also track terminated or lost calls would depend on which software product the organization utilizes. Arrangements can also be made with the telephone provider to gather this data.

I. Warm line.

One respondent asked if the requirement for the organization to document staff qualifications and training for peer support specialists, family support peer specialists and peer counselors is a minimum requirement.

Department response: The documentation is a minimum requirement.

J. Mobile response.

1. One respondent commented that AAS certification should be required for mobile response and indicated that updated standards were scheduled to be released in September 2014.

Department response: AAS certification is an option, not a requirement, for mobile response.

2. One respondent commented that mobile response should be dispatched after the provision of crisis phone counseling and, therefore, should not be required to occur within 15 minutes from the initial call for assistance, and the decision to dispatch should be made by the crisis counselor, with the client, based on the client's needs.

Department response: The Department agrees with this comment, and paragraph 24.36(2)"a" has been changed to read: "*a.* Mobile response staff are dispatched immediately after crisis screening has determined the appropriate level of care. If the mobile response staff already are responding to another call, staff explain to the caller that there may be a delay in receiving mobile response and offer an alternative response."

3. Two respondents commented that it would not be possible to dispatch mobile response staff in less than 15 minutes if the staff are already responding to another call.

Department response: The Department agrees with this comment, and paragraph 24.36(2)"a" has been revised as described in the Department's response to comment "2" just above.

In addition, paragraph 24.36(2)"c" regarding the requirement to track and trend data, response time and delays has been revised to read: "*c.* Data is collected to track and trend response time from initial dispatch, the time to respond to dispatch when a team is already in response; diversion from or admission to hospitals, correctional facilities and other crisis response services. The data for each fiscal year shall be reported to the department within 60 days of the close of the fiscal year."

4. One respondent commented that organizations are required to track and trend data of response time for initial dispatch, response resulting in hospitalization, and diversion from inpatient and jail and asked whether diversions from hospitals should be tracked as well. Two respondents further commented that the standards may need to clarify what is meant by diversion and asked whether the Department would want to track the number of individuals who go to crisis residential treatment services or a hospital, and one of the respondents suggested that the data be shared with mental health and disability services (MHDS) regions.

Department response: The Department replaced the words "diversion from inpatient" to "diversion from or admission to hospitals" in paragraph 24.36(2)"c" to include both admissions and emergency room diversions. The Department is not specifying with whom the data can be shared and agrees that the data could be shared with MHDS regions.

5. Two respondents commented that the action plan should be copied and given to the client as well as to service providers with proper consents.

Department response: The Department has changed paragraph 24.36(2)"d" to clarify that a copy of the action plan is to be given to the individual and to others with signed consent. Paragraph 24.36(2)"d" now reads: "*d.* When an action plan is developed, a copy is sent within 24 hours, with the individual's signed consent, to service providers, the individual and others as appropriate."

6. One respondent commented that within at least 24 hours, follow-up should occur with the client and others present during the crisis.

Department response: The rule allows, but does not specifically require, follow-up within 24 hours. Paragraph 24.36(2)"f" does require that a follow-up appointment with the individual's preferred provider be made and that mobile response staff maintain periodic contact with the individual until the appointment takes place.

7. One respondent commented that traditional law enforcement response, including uniformed officers, sirens and other emergency vehicles, should be reserved for only those situations where there is a credible threat of violence.

Department response: The Department agrees with this statement. No change was made to the rules.

8. One respondent commented that the standard requires mobile response staff to have face-to-face contact with individuals in crisis within 60 minutes from dispatch and expressed concern that response times may need to be longer after hours and on weekends and that such constraints may cause responders to ignore safety issues so they do not exceed the time limit.

Department response: The 60-minute response time will remain as the standard in paragraph 24.36(2)"b." The Department agrees there will be times when the response time will not be obtainable. Paragraph 24.36(2)"b" has been revised to read as follows: "*b.* Mobile response staff have face-to-face contact with the individual in crisis within 60 minutes from dispatch. If the mobile response staff are responding to another request, there may be a delay in receiving mobile response and an alternative response should be provided."

9. One respondent commented that the organization should have documentation in the individual's service record on evaluation and criteria for admission to inpatient psychiatric hospital care and that only the designated psychiatric provider for a hospital's inpatient unit may direct orders for admission.

Department response: The Department agrees with the comment. Proposed subparagraph 24.36(2)"e"(5), which would have required that evaluation criteria for admission to inpatient psychiatric hospital care be documented in the individual's record, was not adopted.

10. One respondent commented that the mobile response description states that staff shall respond in pairs to ensure the safety of both the provider and the individual served and suggested adding the following exception: unless there is a clear reason documented why one person would be safe, for example, responding to an emergency room setting.

Department response: The Department believes the requirement for mobile response staff to work in pairs is necessary to ensure the safety of the staff, the individual being served, and others. The language in the introductory paragraph of rule 441—24.36(225C) has been clarified to allow for situations where another qualified person is available on site. The relevant sentences now read: "Staff work in pairs to ensure staff safety and the safety of the individual served. A single staff member may respond if another person who meets one of the criteria listed in paragraph 24.24(2)*"a"* will be available on site."

11. One respondent commented that the rules require an organization to document contact with the individual at 10, 30, and 60 days postdischarge and suggested that this requirement be changed.

Department response: The Department has changed the wording in paragraph 24.36(2)"f" to read as follows: "*f.* A follow-up appointment with the individual's preferred provider will be made, and mobile response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place."

K. Twenty-three-hour crisis observation and holding.

1. One respondent commented that staff are required to be on duty 24 hours a day and shall remain awake for the 24-hour schedule. The respondent asked what staff-to-client ratio is required.

Department response: No specific staff-to-client ratio is required. Organizations are expected to take a team approach to staffing, and each organization will need to address staffing needs based upon the structure of the program the organization is operating.

2. One respondent commented that the treatment summary is to include an assessment of the crisis, including challenges and strengths, and asked if a suicide risk level is included.

Department response: The assessment is required to include a lethality assessment, and the assessment is included in the treatment summary.

3. One respondent commented that 23-hour crisis observation and holding is primarily used as a diversion from inpatient level of care and asked if it is used to determine if further care is needed.

Department response: The 23-hour observation time will determine whether further care is needed and what level of care is appropriate.

4. One respondent commented that the rules state that the organization shall have a plan to demonstrate phone contact for parents and significant others and asked how that is different from contacting providers, family members, and natural supports within 23 hours of admission.

Department response: The Department agrees that the meaning of the two statements were similar and has changed subparagraph 24.37(4)"d"(1) to read: "(1) Individuals give informed consent." The performance indicator in subparagraph 24.37(4)"d"(2) remains the same and reads as follows: "(2) Treatment providers, family members and other natural supports as appropriate are contacted within 23 hours of the individual's admission."

5. One respondent commented that the rules state that the organization shall track and trend data of an individual's re-admission and asked if there are requirements for contact with the individual postdischarge, similar to the follow-up requirement for mobile crisis response.

Department response: The Department has added in subparagraph 24.37(4)"d"(8) the same follow-up requirement to 23-hour observation and holding as is included in the mobile crisis response requirements. The subparagraph now reads: "(8) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place."

6. One respondent asked if there are requirements for suicide safety in the environment where 23-hour observation and holding services are provided.

Department response: The environment is required to be safe, accessible, and supportive, and the organization establishes intervention procedures for behavior that presents significant risk of harm to the individual using the service or to others. If an assessment indicates an individual is at high risk or actively suicidal, a higher level of care is indicated.

L. Crisis stabilization community-based services (CSCBS).

1. One respondent commented that follow-up within 24 hours of discharge should be required for CSCBS.

Department response: The Department agrees and has adopted new subparagraph 24.38(6)"c"(4), which reads: "(4) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place."

2. One respondent commented that requirements should be included to ensure facilities are evaluated for environmental risks for suicide attempts.

Department response: This service is not facility-based. The environment is required to be safe, accessible, and supportive, and the organization establishes intervention procedures for behavior that presents significant risk of harm to the individual using the service or to others. If an assessment indicates an individual is at high risk or actively suicidal, a higher level of care is indicated.

3. One respondent commented that in addition to gender-specific bathrooms, facilities should be equipped to address transgender individuals.

Department response: This service is not facility-based. The minimum standard is to provide privacy if a bathroom has multiple toilets. Facilities shall designate and have privacy in bathrooms for all individuals.

4. One respondent asked, in the event an individual leaves the facility prior to discharge, what action will be taken to ensure the safety of the individual.

Department response: This service is not facility-based. The service is voluntary. Staff would contact emergency services if necessary. Policies and procedures should address actions to be taken for the safety of individual and staff.

5. One respondent commented that the rules do not clearly define the environments where crisis response services can be provided and asked if the Department can provide examples of community-based and non-community-based residential settings or environments where the services can be provided.

Department response: The Department has changed the definition of "crisis stabilization community-based services." It now reads as follows: "*'Crisis stabilization community-based services'* or *'CSCBS'* means short-term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and provided where the individual lives, works or recreates." The goal of CSCBS is to stabilize the individual within the community. CSCBS is designed for voluntary services for individuals in need of a safe, secure environment where they can receive voluntary services less intensive and restrictive than those in an inpatient hospital.

The definition of "crisis stabilization residential services" has been changed to read: "*'Crisis stabilization residential services'* or *'CSRS'* means a short-term alternative living arrangement designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and is provided in organization-arranged settings of no more than 16 beds." The goal of CSRS is to stabilize and reintegrate the individual back into the community. CSRS is designed for voluntary individuals who are in need of a safe, secure environment less intensive and restrictive than an inpatient hospital.

6. Two respondents commented that the staffing requirement does not state 24/7 awake staffing.

Department response: In response to this comment, the Department has added new paragraph 24.38(2)"f," which reads: "*f.* Crisis response staff must be awake and attentive 24 hours a day."

7. One respondent suggested rewording the provision which initially stated that mental health services shall be provided by a mental health professional to service individual's needs. The respondent suggested replacing the words "to service individual's needs" with the words "with expertise appropriate to the individual's needs."

Department response: The Department agreed with this suggestion and the wording of paragraph 24.38(2)"c" in the published Notice read as suggested by the respondent and reads that way in this Adopted and Filed rule making.

M. Crisis stabilization residential services.

1. One respondent commented that requiring documentation for stays beyond three to five days is confusing. The respondent suggested that the Department look at the standards for crisis intervention and crisis stabilization from the Council on Accreditation of Rehabilitation Facilities for direction on the grouping of the services and level of specificity for the actual standards. The respondent noted the absence of arbitrary time limits and other specifics could interfere with an organization's need to be flexible in meeting the needs of the area in which it is located. The respondent suggested that crisis response standards would cover the crisis residential services and that the rest of the services could be organized under crisis intervention.

Department response: The Department agrees with the statement that requiring documentation for stays beyond three to five days is confusing. The Department has changed the wording of paragraph 24.39(4)"e" to require documentation for stays of more than five days, rather than three to five days. No organizational changes to the rules were made in response to these comments.

2. One respondent commented that there is a reference to programs or facilities of no more than 16 beds and asked if this excludes the use of existing infrastructure for crisis response programs and if facilities currently licensed under DIA are ineligible to provide these services even if accredited. The respondent also asked if these services could be provided in an unlicensed part of a building that also houses a licensed section and if facilities licensed by DIA for 16 or fewer beds would be eligible to provide these services.

Department response: Crisis stabilization residential services can be provided in existing infrastructure, whether a stand-alone building or a part of a larger structure, as long as the facility does not have more than 16 beds. If a facility is licensed by DIA for other services, it would have to comply with the provisions of Iowa Administrative Code rule 481—57.50(135C) for operating another business or activity in the facility.

N. Medication.

One respondent commented that the rules state that medication shall be administered by a qualified prescriber or an individual following instruction of a qualified prescriber and trained staff shall observe an individual taking medication. The respondent asked if the Department would define what is meant by trained staff and what training would be required.

Department response: Medication training for staff would be included in the requirement that staff receive appropriate Department-approved training. The Department is not requiring a specific training program to allow providers more flexibility in choosing training programs that fit their organizational and client needs.

The Mental Health and Disability Services Commission adopted these amendments on September 18, 2014.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 331.397 and 2014 Iowa Acts, House File 2379.

These amendments will become effective December 1, 2014.

The following amendments are adopted.

ITEM 1. Amend **441—Chapter 24**, title, as follows:

ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS, ~~MENTAL RETARDATION~~ INTELLECTUAL DISABILITIES, ~~AND~~ OR DEVELOPMENTAL DISABILITIES

ITEM 2. Amend **441—Chapter 24**, preamble, as follows:

PREAMBLE

The mental health~~, mental retardation, developmental disabilities,~~ and ~~brain injury~~ disability services commission has ~~established~~ adopted this set of standards to be met by all providers of services to people

with mental illness, ~~mental retardation~~ intellectual disabilities, or developmental disabilities ~~that are under the authority of the commission~~. These standards apply to providers that are not required to be licensed by the department of inspections and appeals. These providers include community mental health centers, mental health services providers, case management providers, ~~and~~ supported community living providers, and crisis response providers in accordance with Iowa Code chapter 225C.

The standards serve as the foundation of a performance-based review of those organizations for which the ~~commission~~ department holds accreditation responsibility, as set forth in Iowa Code chapters 225C and 230A. The mission of accreditation is to assure individuals using the services and the general public of organizational accountability for meeting best practices performance levels, for efficient and effective management, and for the provision of quality services that result in quality outcomes for individuals using the services.

The ~~commission's~~ department's intent is to establish standards that are based on the principles of quality improvement and are designed to facilitate the provision of excellent quality services that lead to positive outcomes. The intent of these standards is to make organizations providing services responsible for effecting efficient and effective management and operational systems that enhance the involvement of individuals using the services and to establish a best practices level of performance by which to measure provider organizations.

ITEM 3. Adopt the following **new441—Chapter 24**, Division I title and preamble:

DIVISION I
SERVICES FOR INDIVIDUALS WITH DISABILITIES

PREAMBLE

This set of standards in this division has been established to be met by all providers of case management, day treatment, intensive psychiatric rehabilitation, supported community living, partial hospitalization, outpatient counseling and emergency services.

ITEM 4. Amend rule **441—24.1(225C)**, definition of "Commission," as follows:

"Commission" means the mental health~~, mental retardation, developmental disabilities,~~ and ~~brain injury~~ disability services commission (~~MH/MR/DD/BI~~ MH/DS commission) as established and defined in Iowa Code section 225C.5.

ITEM 5. Reserve rules **441—24.10** to **441—24.19**.

ITEM 6. Adopt the following **new441—Chapter 24**, Division II title and preamble:

DIVISION II
CRISIS RESPONSE SERVICES

PREAMBLE

The department of human services in consultation with the mental health and disability services commission has established this set of standards to be met by all providers of crisis response services.

ITEM 7. Adopt the following **new** rules 441—24.20(225C) to 441—24.40(225C):

441—24.20(225C) Definitions.

"Action plan" means a written plan developed for discharge in collaboration with the individual receiving crisis response services to identify the problem, prevention strategies, and management tools for future crises.

"Crisis assessment" means a face-to-face clinical interview to ascertain an individual's current and previous level of functioning, potential for dangerousness, physical health, and psychiatric and medical condition. The crisis assessment becomes part of the individual's action plan.

"Crisis incident" means an occurrence leading to physical injury or death, or an occurrence resulting from a prescription medication error, or an occurrence triggering a report of child or dependent adult abuse.

"Crisis response services" means short-term individualized crisis stabilization services which follow a crisis screening or assessment and which are designed to restore the individual to a prior functional level.

"Crisis response staff" means a person trained to provide crisis response services in accordance with rule 441—24.24(225C).

"Crisis screening" means a process to determine what crisis response service is appropriate to effectively resolve the presenting crisis.

"Crisis stabilization community-based services" or *"CSCBS"* means short-term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and provided where the individual lives, works or recreates.

"Crisis stabilization residential services" or *"CSRS"* means a short-term alternative living arrangement designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and is provided in organization-arranged settings of no more than 16 beds.

"Department" means the department of human services.

"Dispatch" means the function within crisis line operations to coordinate access to crisis care.

"Face-to-face" means services provided in person or utilizing telehealth in conformance with the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

"Family support peer specialist" means the same as defined in rule 441—25.1(331).

"Informed consent" means the same as defined in rule 441—24.1(225C).

"Mental health crisis" means a behavioral, emotional, or psychiatric situation which results in a high level of stress or anxiety for the individual or persons providing care for the individual and which cannot be resolved without intervention.

"Mental health professional" means the same as defined in Iowa Code section 228.1.

"Mobile response" means a mental health service which provides on-site, face-to-face mental health crisis services for an individual experiencing a mental health crisis. Crisis response staff providing mobile response have the capacity to intervene wherever the crisis is occurring, including but not limited to the individual's place of residence, an emergency room, police station, outpatient mental health setting, school, recovery center or any other location where the individual lives, works, attends school, or socializes.

"Peer support services" means a service provided by a peer support specialist, including but not limited to education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community.

"Peer support specialist" means the same as defined in rule 441—25.1(331).

"Physical health" means any chronic or acute health factors that need to be addressed during crisis delivery services.

"Qualified prescriber" means a practitioner or other staff following the instruction of a practitioner as defined in Iowa Code section 155A.3 and a physician assistant or advanced registered nurse practitioner operating under the prescribing authority granted in Iowa Code section 147.107.

"Restraint" means the application of physical force or the use of a chemical agent or mechanical device for the purpose of restraining the free movement of an individual's body to protect the individual, or others, from immediate harm.

"Rights restriction" means limitations not imposed on the general public in the areas of communications, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, and place of residence.

"Self-administered medication" means the process where a trained staff member observes an individual inject, inhale, ingest or, by any other means, take medication following the instructions of a qualified prescriber.

"Stabilization plan" means a written short-term strategy used to stabilize a crisis and developed by a mental health professional, in collaboration with the crisis response staff and with the involvement and consent of the individual or the individual's representative.

"Staff-administered medication" means the direct application of a prescription drug, whether by injection, inhalation, ingestion, or any other means, to the body of an individual by a qualified prescriber or authorized staff following instructions of a qualified prescriber.

"Telehealth" is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

"Treatment summary" means a written summarization of the treatment and action plan at the point of an individual's discharge or transition to another service.

"Twenty-four-hour crisis line" means a crisis line providing information and referral, counseling, crisis service coordination, and linkages to crisis screening and mental health services 24 hours a day.

"Twenty-four-hour crisis response" means services are available 24 hours a day, 365 days a year, providing access to crisis screening and assessment and linkage to mental health services.

"Twenty-three-hour observation and holding" means a level of care provided for up to 23 hours in a secure and protected, medically staffed, psychiatrically supervised treatment environment.

"Warm line" means a telephone line staffed by individuals with lived experience who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis.

441—24.21(225C) Standards for crisis response services. An organization may be accredited to provide any one or all of the identified crisis response services. An organization seeking crisis response service accreditation shall comply with the general standards within this division and additional standards for each specific service.

441—24.22(225C) Standards for policies and procedures. Policies and procedures manuals contain policy guidelines and administrative procedures for all activities and services and address the standards in rule 441—24.2(225C).

441—24.23(225C) Standards for organizational activities. The organization shall meet the standards in subrules 24.3(1) through 24.3(5).

441—24.24(225C) Standards for crisis response staff. All crisis response staff shall meet the qualifications described in this rule. Additional staff requirements are described in each service.

24.24(1) *Performance benchmark.* Qualified crisis response staff provide crisis response services.

24.24(2) *Performance indicators.*

a. One or more of the following qualifications are met:

(1) A mental health professional as defined in Iowa Code section 228.1.

(2) A bachelor's degree with 30 semester hours or equivalent in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education) and at least one year of experience in behavioral or mental health services.

(3) A law enforcement officer trained in crisis intervention including, but not limited to, mental health first aid and mental health in-service training.

(4) An emergency medical technician (EMT) trained in crisis intervention including, but not limited to, mental health first aid.

(5) A peer support specialist with a minimum certification of mental health first aid.

(6) A family support peer specialist with a minimum certification of mental health first aid.

(7) A registered nurse with two years of mental or behavioral health experience.

b. Documentation in staff records to verify satisfactory completion of department-approved training including:

(1) A minimum of 30 hours of department-approved crisis intervention and training.

(2) A posttraining assessment of competency is completed.

441—24.25(225C) Standards for services.

24.25(1) *Standard for eligibility.* An eligible recipient is an individual experiencing a mental health crisis or emergency where a mental health crisis screening is needed to determine the appropriate level of care.

24.25(2) *Confidentiality and legal status.* Standards in subrule 24.4(6) are met.

24.25(3) *Service systems.* Standards in subparagraphs 24.4(7)*"b"*(1) to (3) are met.

24.25(4) *Respect for individual rights.* Standards in subrule 24.4(8) are met.

441—24.26(225C) Accreditation. The administrator for the division of mental health and disability services shall determine whether to grant, deny or revoke the accreditation of the centers and services as determined in Iowa Code section 225C.6(1)*"c."*

24.26(1) The organization shall meet the standards of subrule 24.5(1), with the addition of crisis response service organizations.

24.26(2) The organization shall meet the standards in subrules 24.5(2) and 24.5(3).

24.26(3) Performance outcome determinations are as follows:

a. Quality assurance staff shall determine a performance compliance level based on the number of indicators found to be in compliance.

(1) For service indicators, if 25 percent or more of the files reviewed do not comply with the requirements for a performance indicator, that indicator is considered out of compliance and corrective action is required.

(2) Corrective action is required when any indicator under policies and procedures or activities is not met.

b. In the overall rating, the performance rating for policies and procedures shall count as 15 percent of the total, activities as 15 percent of the total, and services as 70 percent of the total.

(1) Each of the three indicators for policies and procedures has a value of 5.0 out of a possible score of 15.

(2) Each of the 34 indicators for activities has a value of .44 out of a possible score of 15.

(3) Each service has a separate weighting according to the total number of indicators applicable for that service, with a possible score of 70, as follows:

c. Quality assurance staff shall determine a separate score for each service to be accredited. When an organization offers more than one service under this chapter, there shall be one accreditation award for all the services based upon the lowest score of the services surveyed.

Service	Number of Indicators	Value of Each Indicator
24-hour crisis response	19	3.9
Crisis evaluation	20	3.5
24-hour crisis line	23	3.0
Warm line	20	3.5
Mobile response	18	3.9
23-hour observation and holding	44	1.6
Crisis stabilization, community-based	39	1.8
Crisis stabilization, residential	50	1.4

24.26(4) The organization shall meet the standards in subrules 24.5(5) to 24.5(7).

441—24.27(225C) Deemed status. The department shall grant deemed status to organizations accredited by a recognized national, not-for-profit, accrediting body when the department determines the accreditation is for similar services. The organization shall fulfill the standards described in subrules 24.6(1) to 24.6(6). The national accrediting bodies currently recognized as meeting division criteria for possible deeming are:

1. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
2. The Commission on Accreditation of Rehabilitation Facilities (CARF).
3. The Council on Quality and Leadership in Supports for People with Disabilities (The Council).
4. The Council on Accreditation of Services for Families and Children (COA).
5. The American Association of Suicidology (AAS).
6. Contact USA.

441—24.28(225C) Complaint process. The department shall receive and record complaints by individuals using services, employees, any interested people, and the public relating to or alleging violations of applicable requirements of the Iowa Code or administrative rules in accordance with the standards described in rule 441—24.7(225C).

441—24.29(225C) Appeal procedure. The department shall receive appeals according to the process in rule 441—24.8(225C).

441—24.30(225C) Exceptions to policy. The department shall receive exceptions to policy meeting the standards in rule 441—24.9(225C).

441—24.31(225C) Standards for individual crisis response services. Crisis response services provided to children and youth include coordination with parents, guardians, family members, natural supports, and service providers and with other systems such as education, juvenile justice and child welfare.

Crisis response services for individuals who have co-occurring or multi-occurring diagnoses focus on the integration and coordination of treatment services, and supports necessary to stabilize the individual, without regard to which condition is primary. Crisis response services are not to be denied due to the presence of a co-occurring substance abuse condition or developmental or neurodevelopmental disability.

441—24.32(225C) Crisis evaluation. Crisis evaluation consists of two components: crisis screening and crisis assessment.

24.32(1) *Crisis screening.* The purpose of crisis screening is to determine the presenting problem and appropriate level of care.

a. Performance benchmark. Crisis screening includes a brief assessment of suicide lethality, substance use, alcohol use and safety needs. Crisis screening can be provided through contact with crisis response staff and through communication with the individual.

b. Performance indicators.

(1) Crisis response staff are trained in crisis screening.
(2) A uniform process for crisis screening and referrals is outlined in policies and procedures.
(3) Crisis screening records are kept in individual files.

24.32(2) *Crisis assessment.* The purpose of crisis assessment is to determine the precipitating factors of the crisis, the individual and family functioning needs, and the diagnosis if present and to initiate a stabilization plan and discharge plan. A licensed mental health professional conducts a crisis assessment within 24 hours of an individual's admission to a crisis response service.

a. Assessment requirements. The crisis assessment includes:

(1) Action plan.
(2) Active symptoms of psychosis.
(3) Alcohol use.
(4) Coping ability.
(5) History of trauma.
(6) Impulsivity or absence of protective factors.
(7) Intensity and duration of depression.
(8) Lethality assessment.
(9) Level of external support available to the individual.
(10) Medical history.

(11) Physical health.

(12) Prescription medication.

(13) Crisis details.

(14) Stress indicators and level of stress.

(15) Substance use.

b. *Performance benchmark.* Individuals receive comprehensive assessment by a mental health professional to determine the appropriate level of care.

c. *Performance indicators.*

(1) Written policies and procedures describe a uniform process for assessment, referrals and record documentation.

(2) Mental health professionals as defined in Iowa Code section 228.1(6) will complete assessments.

(3) Information collected is sufficient to determine the appropriate level of care.

(4) Assessment results are explained to the individual and family or guardian when appropriate.

(5) The individual's strengths, preferences and needs are included in an action plan. The family or guardian may receive a copy of an action plan with a signed release.

441—24.33(225C) Twenty-four-hour crisis response. The purpose of 24-hour crisis response is to provide access to crisis screening and assessment to de-escalate and stabilize the crisis. When the assessment indicates, a stabilization plan is developed to support the individual's return to a prior level of functioning. Twenty-four-hour crisis response staff link the individual to appropriate services. Crisis response staff provide service to individuals of any age.

24.33(1) *Performance benchmark.* Individuals in crisis have the ability to access crisis response services, including, but not limited to, crisis screening, crisis assessment and stabilization in the least restrictive level of care appropriate.

24.33(2) *Performance indicators.*

a. Information on how to access 24-hour crisis response is publicized to facilitate availability of services to individuals using the service, family members and the public.

b. Individuals accessing the service receive crisis screening and crisis response services from appropriate crisis response staff.

c. Crisis screening is available and accessible face-to-face, using telephone or Web-based options, 24 hours a day, 365 days a year.

d. A mental health professional is available for crisis assessment and consultation 24 hours a day, 365 days a year. The mental health professional has access to a qualified prescriber for consultation.

e. The staffing pattern and schedule is documented.

f. The integration and coordination of care is documented in the individual's record.

g. The discharge, action and follow-up plans are documented in the individual's record, and copies of the plans are provided to the individual. The family or guardian may receive a copy with a signed release.

441—24.34(225C) Twenty-four-hour crisis line. A 24-hour crisis line provides counseling, crisis service coordination, information and referral, linkage to services and crisis screening. Crisis line staff are qualified to provide crisis stabilization services pursuant to subrule 24.24(2).

24.34(1) *Performance benchmark.* Crisis screening, counseling, crisis service coordination and referrals are provided to individuals in crisis.

24.34(2) *Performance indicators.*

a. The crisis line service is available 24 hours a day, 365 days a year.

b. Policies are in place regarding how the crisis line is answered live, when to utilize the hold feature, the use of queue systems and triage of calls.

c. Policies and procedures govern the use of technology, including telephonic and Internet capability in the service delivery structure, quality assurance, data integrity and confidentiality.

d. Procedures are in place for ensuring the quality of the crisis line, including monitoring calls and corrective action plans.

e. The crisis line is an integrated component of the crisis response service system; the crisis line is answered in an organization setting by trained crisis response staff.

f. Policies define collaborative efforts and triage procedure between the mobile outreach teams, law enforcement and emergency services.

g. Policies are in place to ensure follow-up contacts are provided within 24 hours of a crisis call for all risk cases. The crisis line integrates follow-up into all crisis service contacts.

h. The crisis line utilizes standardized call center software with the capability to track:

(1) Date and time of answered call, topic of call, crisis screening provided, referral made, hold time, and demographics of call.

(2) Number of contacts, including terminated and lost calls.

i. Policies and procedures describe a uniform process of crisis screening and training for crisis line staff.

j. Training includes crisis screening tools, lethality assessment, crisis counseling, cultural competence, crisis service coordination, and information and referral.

k. Twenty-four-hour access to a mental health professional is required.

441—24.35(225C) Warm line. A peer-operated warm line is a service individuals can access to talk with someone with lived experience with mental, behavioral health and trauma issues. The line provides a resource for individuals experiencing emotional distress.

24.35(1) *Performance benchmark.* A warm line provides nonjudgmental listening, nondirective assistance, information, referral, and triage when appropriate.

24.35(2) *Performance indicators.*

a. Policies are in place regarding how the warm line is answered live, placing callers on hold and when appropriate to use a queue system.

b. Policies and procedures are in place for standard collection of demographics, the presented reason for calling and outcome of call.

c. Policies and procedures are in place for crisis screening and when to triage a caller to a higher level of service.

d. Data collection includes call answer times, duration of calls, and number of calls dropped, lost or terminated.

e. Policies and procedures describe the staffing pattern and schedule.

f. Warm line staff can receive calls remotely through telephones or computers or within an organization.

g. Staff qualifications and training for peer support specialists and family support peer specialists are required.

h. Twenty-four-hour access to a mental health professional is required.

441—24.36(225C) Mobile response. Crisis response staff provide on-site, in-person intervention for individuals experiencing a mental health crisis. The mobile response staff provide crisis response services in the individual's home or at locations in the community. Staff work in pairs to ensure staff safety and the safety of the individual served. A single staff member may respond if another person who meets one of the criteria listed in paragraph 24.24(2)*"a"* will be available on site. Twenty-four-hour access to a mental health professional is required.

24.36(1) *Performance benchmark.* Mobile response services are delivered to individuals in crisis in a timely manner.

24.36(2) *Performance indicators.*

a. Mobile response staff are dispatched immediately after crisis screening has determined the appropriate level of care. If the mobile response staff already are responding to another call, staff explain to the caller that there may be a delay in receiving a mobile response and offer an alternative response.

b. Mobile response staff have face-to-face contact with the individual in crisis within 60 minutes from dispatch. If the mobile response staff are responding to another request, there may be a delay in receiving mobile response and an alternative response should be provided.

c. Data is collected to track and trend response time from initial dispatch, the time to respond to dispatch when a team is already in response; diversion from or admission to hospitals, correctional facilities and other crisis response services. The data for each fiscal year is reported to the department within 60 days of the close of the fiscal year.

d. When an action plan is developed, a copy is sent within 24 hours, with the individual's signed consent, to service providers, the individual and others as appropriate.

e. The following information is documented in the individual's service record:

(1) Triage and referral information.

(2) Reduction in the level of risk present in the crisis situation.

(3) Coordination with other mental health resources.

(4) Names and affiliation of all individuals participating in the mobile response.

f. A follow-up appointment with the individual's preferred provider will be made, and mobile response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

441—24.37(225C) Twenty-three-hour crisis observation and holding. Twenty-three-hour crisis observation and holding services may be a stand-alone service or embedded within a crisis stabilization residential service. Twenty-three-hour crisis observation and holding services are designed for individuals who need short-term crisis intervention in a safe environment less restrictive than hospitalization. This level of service is appropriate for individuals who require protection or when an individual's ability to cope in the community is severely compromised and it is expected the crisis can be resolved in 23 hours. Twenty-three-hour crisis observation and holding services include, but are not limited to, treatment, medication administration, meeting with extended family or significant others, and referral to appropriate services. Twenty-three-hour crisis observation and holding chairs can be utilized.

24.37(1) *Admission criteria.* The services may be provided if any of the following admission criteria are met:

a. There are indications the symptoms can be stabilized and an alternative treatment can be initiated within a 23-hour period.

b. The presenting crisis cannot be safely evaluated or managed in a less restrictive setting, or no such setting is available.

c. The individual does not meet inpatient criteria, and it is determined a period of observation assists in the stabilization and prevention of symptom exacerbation.

d. Further evaluation is necessary to determine the individual's service needs.

e. There is an indication of actual or potential danger to self or others as evidenced by a current threat or ideation.

f. There is a loss of impulse control leading to life-threatening behavior and other psychiatric symptoms requiring stabilization in a structured, monitored setting.

g. The individual is experiencing a crisis demonstrated by an abrupt or substantial change in normal life functioning brought on by a specific cause, sudden event or severe stressor.

24.37(2) *Staffing requirements.*

a. A designated medical director or administrator is responsible for the management and operation of the organization or facility.

b. Registered nurse practitioners and physician assistants have at least two years of mental health experience.

c. At least one mental health professional is available for consultation 24 hours a day, 365 days a year.

d. A mental health professional as defined in Iowa Code section 228.1(6) provides mental health services appropriate to the individual's needs.

e. Crisis response staff are on duty 24 hours a day.

f. A registered nurse is available on site 24 hours a day.

24.37(3) *Twenty-three-hour observation and holding safety.*

a. Performance benchmark. An incident report is created when staff are notified an incident has occurred.

b. Performance indicators.

(1) The incident report documents:

1. The name of the individual or individuals who were involved in the incident.
2. Date and time of occurrence of the incident.
3. A description of the incident.
4. Names and signatures of all staff present at the time of the incident.
5. The action taken by the staff.
6. The resolution or follow-up to the incident.

(2) A copy of the incident report is kept in a centralized file and a copy is given to the individual, the mental health and disability services region, and the individual's parent or guardian when appropriate.

24.37(4) *Service requirements.*

a. Performance benchmark. A treatment summary is provided to the individual and the individual's treatment team when applicable.

b. Performance indicators. The minimum treatment summary requirements include:

(1) Action plan.

(2) Crisis assessment, including challenges and strengths.

(3) Course and progress of the individual with regard to each identified challenge.

(4) Evaluation of the individual's mental status to inform ongoing placement and support decisions.

(5) Recommendations and arrangements for further service needs.

(6) Signature of the mental health professional.

(7) Treatment interventions.

c. Performance benchmark. The individual using this service is provided a safe, secure observation and holding service in a location meeting the needs of the individual and in the least restrictive setting.

d. Performance indicators.

(1) Individuals give informed consent.

(2) Treatment providers, family members and other natural supports as appropriate are contacted within 23 hours of the individual's admission.

(3) Written policies and procedures cover medication administration, storage and documentation.

(4) Individual records include, but are not limited to, a treatment summary and verification of individual choice.

(5) The 23-hour crisis observation and holding facility is a welcoming and comfortable environment conducive to recovery.

(6) The 23-hour crisis observation and holding is primarily used as a diversion from hospital level of care.

(7) Communication attempts and contact with the individual's team will be documented.

(8) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

(9) There are written policies and procedures of how to document and track discharge locations.

(10) The actual number of individuals served within the 23-hour period is documented. Individual treatment records contain reasons why individuals stay beyond the 23-hour period.

(11) Readmission data and length of time between admissions are tracked for data trend reports.

e. Performance benchmark. Policies and procedures address the additional safety standards for 23-hour crisis and observation services.

f. Performance indicators.

(1) Service compliance is documented regarding state fire marshal rules and fire ordinances and applicable local health, fire, occupancy code, and safety regulations.

(2) Based on standards used for public facilities, all food and drink is clean, wholesome, free from spoilage, and stored and served in a manner safe for human consumption.

(3) Doors must not be locked from the inside. The use of door locks is as approved by the fire marshal and professional staff.

(4) Twenty-three-hour observation and holding services have an emergency preparedness plan to describe the process for an individual to continue receiving services during a disaster including, but not limited to, cases of severe weather or fire.

g. Performance benchmark. Policies and procedures address the cleanliness of the 23-hour observation and holding service.

h. Performance indicators.

(1) Services provide a safe, clean, well-ventilated, properly heated environment in good repair and free from vermin.

(2) An individual's resting or sleeping area includes:

1. A sturdily constructed bed or comfortable chair.
2. A sanitized mattress protected with a clean mattress pad, or sanitized chair.
3. Curtains or blinds are on bedroom windows.
4. Available clean linen.
5. Doors or partitions for privacy.
6. Right to privacy is respected.

(3) Bathrooms include items necessary for personal hygiene and personal privacy.

1. A safe supply of hot and cold running water which is potable.
2. Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap.
3. Natural or mechanical ventilation capable of removing odors.
4. Tubs or showers have slip-proof surfaces.
5. Partitions with doors which provide privacy if a bathroom has multiple toilet stools.
6. Toilets, wash basins, and other plumbing or sanitary facilities are maintained in good operating condition.
7. Privacy in bathrooms for male and female individuals.

i. Performance benchmark. Personal rights are acknowledged.

j. Performance indicator. The following are allowed:

(1) Areas in which an individual may be alone when appropriate.

(2) Areas for private conversations with others.

(3) Secure space for personal belongings.

(4) Personal clothing is allowed in accordance with organization policy.

k. Performance benchmark. Policies and procedures document health and safety standards.

l. Performance indicators.

(1) An emergency preparedness plan is designed to provide effective utilization of available resources during a disaster event including, but not limited to, cases of severe weather or fire.

(2) Services comply with rule 441—24.39(225C).

(3) There are written policies on safety.

(4) Seclusion is not used.

(5) Mechanical or chemical restraints are not used at any time.

(6) The smokefree air Act, Iowa Code chapter 142D, is followed.

441—24.38(225C) Crisis stabilization community-based services (CSCBS). The goal of CSCBS is to stabilize the individual within the community. CSCBS is designed as a voluntary service for individuals in need of a safe, secure location that is less intensive and restrictive than an inpatient hospital. Individuals receive CSCBS services including, but not limited to, psychiatric services, medication, counseling, referrals, peer support and linkage to ongoing services. The duration for CSCBS is expected to be less than five days.

24.38(1) *Eligibility.* To be eligible, an individual must:

a. Be determined appropriate for the service by mental health assessment; and

b. Be determined not to need inpatient acute hospital psychiatric services.

24.38(2) *Staffing requirements.*

a. A designated director or administrator is responsible for the management and operation of the CSCBS.

b. At least one licensed nurse practitioner, physician assistant, or psychiatrist is available for consultation 24 hours a day, 365 days a year.

c. Mental health professionals with expertise appropriate to the individual's needs provide services.

d. Contact between the individual and a mental health professional occurs at least one time a day.

e. Additional services are provided by crisis response staff at a minimum of one hour per day, including, but not limited to, skill building, peer support or family support peer services. The goal of CSCBS is to stabilize the individual within the community. CSCBS is designed for voluntary services for individuals in need of a safe, secure location that is less intensive and restrictive than an inpatient hospital.

f. Crisis response staff must be awake and attentive 24 hours a day.

24.38(3) *Performance benchmark.* The individual using CSCBS is provided safe, secure and structured crisis stabilization services in the least restrictive location meeting the needs of the individual. The CSCBS can be for youth aged 18 and under or adults aged 18 and older.

24.38(4) *Performance indicators.*

a. The individual can provide consent for treatment providers, family members and other natural supports to be contacted within 24 hours of admission.

b. Daily crisis stabilization services include, at minimum, daily contact with a mental health professional and one hour of additional crisis stabilization services from crisis response staff.

c. The numbers of days an individual receives crisis stabilization services are documented. The documentation records specific reasons for the delivery of services beyond five days.

d. Individual records are maintained to document the following:

(1) Daily contact with a mental health professional.

(2) Additional services provided including, but not limited to, skill building, peer support or family support peer services.

(3) Medication record.

e. Individual choice is verified including, but not limited to, treatment participation and discharge plan options.

f. Readmission data is tracked, including an analysis of data trends looking at effectiveness, and appropriate corrective action taken. The information is documented in the performance improvement system files.

24.38(5) *Crisis stabilization incident reporting.*

a. Performance benchmark. An incident report is filed when staff are notified an incident has occurred.

b. Performance indicators.

(1) The incident report documents:

1. The name of the individual involved in the incident.
2. Date and time the incident occurred.
3. A description of the incident.
4. Names and signatures of all staff present at the time of the incident.
5. The action the staff took to handle the situation.
6. The resolution or follow-up to the incident.

(2) A copy of the incident report is kept in a centralized file and a copy given to the individual, the mental health and disability services region, and the parent or guardian when appropriate.

24.38(6) *Service requirements.*

a. Stabilization plan. The individual in crisis is involved collaboratively in all aspects of crisis stabilization services including, but not limited to, admission, treatment planning, intervention, and discharge. The involvement of family members and others is encouraged.

Within 24 hours of an individual's admission to crisis stabilization services, a written short-term stabilization plan is developed, with the involvement and consent of the individual, and is reviewed frequently to assess the need for the individual's continued placement in CSCBS. At a minimum, this plan includes:

(1) Criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems.

(2) Description of any physical disability and any accommodations necessary to provide the same or equal services and benefits as those afforded nondisabled individuals.

(3) Evidence of input by the individual, including the individual's signature.

(4) Goal statement. Goals are consistent with the individual's needs and projected duration of service delivery and include objectives which build on strengths and are stated in terms allowing measurement of progress.

(5) Rights restrictions.

(6) Names of all other persons participating in the development of the plan.

(7) Specification of treatment responsibilities and methods.

b. Performance benchmark. A stabilization plan is completed within 24 hours of the individual's admittance.

c. Performance indicators.

(1) Individual records include a written short-term stabilization plan developed with the involvement and consent of the individual within 24 hours of admittance and reviewed frequently to assess the need for continued placement in CSCBS.

(2) Individual records indicate a crisis stabilization plan is completed within the 24-hour time frame.

(3) Reasons for crisis stabilization plans not meeting the criteria are documented.

(4) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

24.38(7) *Treatment summary.* Prior to the individual's discharge from CSCBS, a treatment summary is completed. A copy of the summary is provided to the individual and shared with the individual's treatment team of providers, if applicable.

a. Contents. At a minimum, the treatment summary includes:

(1) Course and progress of the individual with regard to each identified problem.

(2) Documented note of a mental health professional contact one time daily.

(3) Evolution of the mental status to inform ongoing placement and support decisions.

(4) Final assessment, including general observations and significant findings of the individual's condition initially while services were being provided and at discharge.

(5) Recommendations and arrangements for further service needs.

(6) Signature of the mental health professional.

(7) Stabilization plan.

(8) Reasons for termination of service.

(9) Treatment interventions.

b. Performance benchmark. A treatment summary is completed during the length of stay in CSCBS.

c. Performance indicators.

(1) Records include a written treatment summary developed with the involvement of the individual. A copy of the summary is provided upon discharge.

(2) Incidents in which a treatment plan was not completed within the length of stay and any corrective action necessary to alleviate this issue are documented.

24.38(8) *Health and safety.*

a. Performance benchmark. Emergency preparedness policies and procedures include health and safety measures.

b. Performance indicators.

(1) Emergency preparedness plans are designed to provide effective utilization of available resources for care to continue during a disaster event including, but not limited to, cases of severe weather or fire.

(2) Crisis services comply with rule 441—24.39(225C).

441—24.39(225C) Crisis stabilization residential services (CSRS). Crisis stabilization residential services are short-term services provided in facility-based settings of no more than 16 beds. The goal of CSRS is to stabilize and reintegrate the individual back into the community. Crisis stabilization residential services are designed for voluntary individuals who are in need of a safe, secure environment less intensive and restrictive than an inpatient hospital. Crisis stabilization residential services have the capacity to serve more than two individuals at a time. Crisis stabilization residential services can be for youth aged 18 and younger or adults aged 18 and older. Youth and adults cannot be housed in the same facility setting. Facilities licensed by the department of inspections and appeals for other services would have to comply with the provisions of Iowa Administrative Code rule 481—57.50(135C) for operating another business or activity in the facility.

24.39(1) *Eligibility.* To be eligible, an individual must:

a. Be an adult aged 18 or older or a youth aged 18 or under.

b. Be determined appropriate for the service by a mental health assessment; and

c. Be determined to not need inpatient acute hospital psychiatric services.

24.39(2) *Staffing requirements.*

a. A designated director or administrator is responsible for the management and operation of the CSRS of no more than 16 beds.

b. At least one licensed mental health professional is available for consultation 24 hours a day, 365 days a year.

c. Crisis stabilization residential services are provided by a mental health professional with expertise appropriate to the individual's needs.

d. Each individual has contact with a mental health professional at least one time a day.

e. Each individual has a minimum of one hour per day of additional services provided by crisis response staff including, but not limited to, skill building, peer support or family support peer services; or other therapeutic programming.

f. Awake and attentive staffing 24 hours a day, 365 days a year is provided.

24.39(3) *Performance benchmark.* The individual is provided safe, secure and structured crisis stabilization services in the least restrictive location meeting the individual's needs.

24.39(4) *Performance indicators.*

a. Individual's consent is documented, and treatment providers, family members and other natural supports are contacted within 24 hours of admission.

b. A comprehensive mental health assessment is completed within 24 hours of admission.

c. Daily crisis stabilization includes, at minimum, daily contact with a mental health professional and one hour of additional crisis stabilization service.

d. The length of stay is expected to be less than five days.

e. The number of days an individual receives crisis stabilization services is documented. The documentation records specific reasons for lengths of stay beyond five days.

f. Records include:

(1) Stabilization plan.

(2) Medication record.

(3) Treatment summary.

(4) Daily contact with a mental health professional.

g. Additional services provided include, but are not limited to, skill building, peer support or family support peer services.

h. Individual choice is verified including, but not limited to, treatment participation and discharge plan options.

i. Data of readmission is tracked including an analysis of data trends, looking at effectiveness, and appropriate corrective action. The information is documented in the performance improvement system.

j. Documentation tracks that the youth's education needs are met with educational services received in the CSRS, and an action plan is in place to return the youth to school upon discharge.

24.39(5) *Crisis stabilization incident reporting.*

a. Performance benchmark. An incident report is completed when staff are notified an incident has occurred.

b. Performance indicators.

(1) The incident report documents:

1. The name of the individual who was involved in the incident.
2. Date and time of occurrence of the incident.
3. A description of the incident.
4. Names and signatures of all staff present at the time of the incident.
5. The action staff took to handle the situation.
6. The resolution or follow-up to the incident.

(2) A copy of the incident report is maintained in a centralized file and a copy given to the individual, the mental health and disability services region, and the parent or guardian when appropriate.

24.39(6) *Service requirements.*

a. Stabilization plan. The individual is involved collaboratively in all aspects of crisis stabilization services including, but not limited to, admission, treatment planning, intervention, and discharge. The involvement of family members and others is encouraged.

Within 24 hours of admission to CSRS, a written short-term stabilization plan is developed, with the involvement and consent of the individual, and reviewed frequently to assess the need for continued placement in CSRS. At a minimum, this plan includes:

(1) Criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems.

(2) Description of any physical disability and accommodations necessary to provide the same or equal services and benefits as those afforded nondisabled individuals.

(3) Evidence of input by the individual, including the individual's signature.

(4) Goal statement.

(5) Goals consistent with needs and projected length of stay.

(6) Objectives that are built on strengths and allow measurement of progress.

(7) Rights restrictions.

(8) Signatures of all participating in the development of the plan.

(9) Specification of treatment responsibilities and methods.

b. Performance benchmark. A stabilization plan is completed within 24 hours of admittance.

c. Performance indicators.

(1) Records include a written short-term stabilization plan developed with the involvement and consent of the individual within 24 hours of admission and is reviewed frequently to assess the need for continued placement in CSRS.

(2) Records indicating a stabilization plan has been completed within the 24-hour time frame are maintained.

(3) Reasons the stabilization plan does not meet the criteria is documented.

(4) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

24.39(7) *Treatment summary.* Prior to discharge, a treatment summary is provided and a copy shared with the individual and treatment team as appropriate.

a. Contents. At a minimum, this treatment summary includes:

(1) Course and progress regarding each identified problem.

(2) Documentation of daily contact with a mental health professional.

(3) Impact on placement and support decisions.

(4) Assessment.

(5) Action plan.

(6) Stabilization plan.

(7) Treatment interventions.

(8) Reasons for termination of service.

(9) Signature of the mental health professional.

b. Performance benchmark. A treatment summary is completed during the individual's length of stay in CSRS.

c. Performance indicators.

(1) Records include a written treatment summary developed with the involvement and consent of the individual.

(2) An individual receives a copy of the treatment summary upon discharge.

(3) Corrective action steps are documented when treatment plans are not completed within the length of stay.

24.39(8) *Health and safety.*

a. Performance benchmarks.

(1) Emergency preparedness policies and procedures include health and safety measures.

(2) Crisis stabilization services meet all applicable local, state and federal regulations.

(3) Medication administration and documentation standards in rule 441—24.40(225C) are documented.

b. Performance indicators.

(1) Health and fire safety inspections.

1. Documentation includes Iowa fire marshal rules and fire ordinances, local health, fire, occupancy code, and safety regulations.

2. Standards for public facilities guide food and beverage safety, nutrition standards, and safe storage of all consumable products.

3. Crisis stabilization residential services comply with rule 441—24.40(225C).

(2) Emergency preparedness. Emergency preparedness policies are designed to provide effective utilization of available resources for continuation during a disaster event, including, but not limited to, cases of severe weather or fire.

(3) The facility is safe, clean, well-ventilated, and a properly heated environment in good repair and free from vermin.

(4) Bedrooms include:

1. A sturdily constructed bed.

2. A sanitized mattress protected with a clean mattress pad.

3. A designated space in proximity to the sleeping area for personal possessions including clothing.

4. Curtains or window blinds on bedroom windows.

5. Available clean linens.

(5) Sleeping areas include:

1. Doors for privacy.

2. Partitioning and placement of furniture to provide privacy.

3. Rooms accommodate no more than two per room. Single room dimensions are at least 80 square feet not including closets. Dual occupancy rooms are at least 120 square feet not including closets.

4. Personal belongings and personal touches in the rooms are defined within CSRS policy.

5. Respect by staff for an individual's right to privacy.

(6) Personal hygiene and privacy tools are provided:

1. A safe supply of hot and cold running water which is potable.

2. Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap.

3. Natural or mechanical ventilation capable of removing odors.

4. Tubs or showers with slip-proof surfaces.

5. Partitions with doors which provide privacy if a bathroom has multiple toilet stools.

6. Toilets, wash basins, and other plumbing or sanitary facilities are in good operating condition.

7. Privacy in bathrooms for male and female individuals.

(7) Federal laws regarding smoking on property are recognized and followed.

(8) The following is provided:

1. Areas in which an individual may be alone when appropriate.

2. Areas for private conversations with others.

3. A secure space for personal belongings.

c. Housekeeping. Maintenance of living quarters and day-to-day housekeeping activities are clearly defined in writing and a part of the orientation. Staff assistance and equipment are provided as needed.

d. Clothing.

(1) Personal clothing is allowed in accordance with CSRS policy.

(2) Clothing may be washed with provided laundry mechanisms.

e. Religion/culture. Rights to religion and culture include:

(1) The opportunity to participate in religious activities and services in accordance with the individual's faith or of a minor individual's parent(s) or guardian.

(2) Arrange for transportation to religious activities when appropriate per CSRS policy.

f. Smoking. The smokefree air Act, Iowa Code chapter 142D, is included in the CSRS policy.

441—24.40(225C) Medication—administration, storage and documentation. This rule sets forth medication requirements for 23-hour crisis observation and holding, crisis stabilization community-based services, and crisis stabilization residential services.

24.40(1) *Performance benchmark.* Policies and procedures ensure prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations. Medication is administered by a qualified prescriber or an individual following the instructions of a qualified prescriber. Medication storage is maintained in accordance with the security requirements of federal, state and local laws. Case records include written policies and procedures regarding use of medication.

24.40(2) *Performance indicators.*

a. Administration of medication.

(1) Medication administration dose schedules and standardization of abbreviations are documented.

(2) Throughout the CSRS specific methods for control and accountability of medication products are established.

(3) Prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations.

(4) Medications are prescribed by a qualified prescriber under Iowa law.

(5) Prescription drugs are not administered or self-administered without a written order signed by a qualified prescriber.

b. Staff-administered medication.

(1) Only qualified and authorized staff administers medication, and a current, accurate list of staff is maintained.

(2) Qualified prescribers instruct how medications are administered and documented. The type and amount of medication, time and date of medication administered, and the name of staff administering the medication are transcribed in the medication record.

c. Self-administered medication.

(1) Policies and procedures document which staff have completed department-approved training on self-administration of prescription medication.

(2) Self-administration of prescription and over-the-counter medications are permitted only when the medication label is clear and complete.

d. Medication storage. Medication storage policies under the care and control of the administration include:

(1) All medication is maintained in locked storage, and controlled substances are maintained in a locked box within locked storage.

(2) Medications requiring refrigeration are kept in a refrigerator separated from food and other edible items.

(3) Disinfectants and medication for external use are stored separately from internal and injectable medications.

(4) Each medication is stored in original containers and labeled with the name.

(5) All potent poisonous or caustic medications are clearly labeled; stored separately from other medication, in a specific well-illuminated cabinet, closet, or storeroom; and made accessible only to authorized staff.

(6) Medication provided is dispensed from a licensed pharmacy in the state of Iowa in accordance with the Iowa Code. It can also be provided by a qualified prescriber from a licensed pharmacy in another state according to the laws of the state.

(7) Prescription medications prescribed for one individual are not administered or allowed in the possession of another.

e. Medication labeling. All prescribed medications are clearly labeled with the full name; prescriber's name; prescription number; name and strength of the medication; dosage; directions for use; date of issue; and name, address and telephone number of the pharmacy or prescriber issuing the medication. Medications are packaged and labeled according to state and federal guidelines.

f. Monthly inspection. The staff member in charge of medication provides monthly inspection of all storage units.

g. Damaged labels. Medication containers having soiled, damaged, illegible, or makeshift labels are returned to the issuing pharmacist, pharmacy, or qualified prescriber for relabeling or disposal.

h. Unused medications. Unused prescription drugs are destroyed by staff with a witness present, when an individual leaves the crisis service without medication. A notation is documented in the record. When an individual is discharged or leaves the crisis service, medications currently being administered are sent in their original containers with the individual or with a designated person, with the approval of the qualified prescriber.

i. Medication brought by individual. If the prescribed and over-the-counter medication the individual brings to the CSRS is not used, the medication is packaged, sealed and stored. The sealed packages of medications are returned to the individual or family at the time of discharge.

j. Medication documentation.

(1) Written policies and procedures are in place for the review, approval, and implementation of ethical, safe, human and efficient behavioral intervention procedures.

(2) Written policies and procedures are in place to inform the individual and the individual's legal guardian, when appropriate, about prohibitions on the use of medication as a restraint.

(3) Documentation is required in case records on adverse drug reactions when medications are administered and self-administered.

(4) All medication orders are documented in the case records and document the name of the medication, dose, route of administration, frequency of administration, name of the qualified prescriber prescribing the medication, and name of the staff administering or dispensing the medication.

(5) Medication records are documented by authorized staff administering the medication.

k. Medication rights and responsibilities.

(1) Medication is not used as a restraint. The use of psychopharmacological medication in excess of the standard plan of care is prohibited. Using medication as a restraint includes:

1. Drugs or medications used to control behavior or restrict freedom of movement.

2. Drugs or medications used in excessive amounts or in excessive frequency.

3. Neuroleptics, anxiolytics, antihistamines, and atypical neuroleptics, or other medication used for calming, rather than for the medication's indicated treatment.

(2) Drugs or medications used for standard treatment of the individual's medical or psychiatric condition are not considered to be used as a restraint.

These rules are intended to implement Iowa Code section 331.397 and 2014 Iowa Acts, House File 2379.

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