PROPOSED REGULATION OF THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

AUTHORITY: NRS 449.0302

Italics, blue, underlined: New proposed language
~~[bracketed, red strikethrough]:~~ Omitted regulatory language

Section 1. Chapter 449 of NAC is hereby amended by adding thereto the provisions set forth in sections 2 to 7 inclusive of this regulation.

Sec. 2

1. A provider of health care that delivers or provides medical services to an infant in a medical facility and who, in his or her professional occupational capacity, knows or has reasonable cause to believe that the infant has been affected by a fetal alcohol spectrum disorder or prenatal substance abuse or is experiencing withdrawal symptoms resulting from in utero drug exposure the medical facility shall ensure a CARA plan of care is in place prior to or upon the infant's discharge.

2. The CARA plan of care must be submitted to the Division of Public and Behavioral Health, in a manner prescribed by the Division, within 24 hours after the infant is discharged from the medical facility.

3. The Division of Public and Behavioral Health shall monitor the CARA plan of care to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver (section 106(b)(2)(B)(iii)(2) of CAPTA).

As used in Section 2:

1. "Infant" is defined as up to one year of age.

2. "Medical facility" means a hospital as defined in NRS 449.012 or an obstetric center as defined in NRS 449.0155.

3. "Provider of health care" has the meaning ascribed in NRS 629.031.

4. "CARA plan of care" means a comprehensive addiction and recovery act plan of care that meets the requirements outlined in section 3.

Sec. 3

1. A CARA plan of care must address:

- *a) the immediate safety needs of the affected infant;*
- *b) the health and substance use disorder treatment need of the infant and affected family or caregiver;*
- *c) appropriate referrals and delivery of appropriate services to the infant and affected family or caregiver;*
- *d) any other information required by the Division to ensure the CARA plan of care meets the needs of the infant.*

2. The CARA plan of care must be completed on a form prescribed by the Division.

3. The CARA plan of care shall be given to the mother, father and/or the legal guardian of the infant upon the infant's discharge.

4. The CARA plan of care shall be made available to an agency which provides child welfare services as defined by NRS 432B.030, upon request.
5. Except as otherwise provided in NRS 239.0115, information collected, maintained, stored, backed up or on file pursuant to sections 2 to 3 is confidential, not subject to subpoena or discovery and is not subject to inspection by the general public.
6. The Division shall ensure that any information collected, maintained or stored pursuant to sections 2 to 3 is protected adequately from fire, theft, loss, destruction, other hazards and unauthorized access, and is backed-up in a manner that ensures proper confidentiality and security, except for the information collected pursuant to subsection 4 of section 3 by a child welfare service as defined by NRS 432B.030, in which case the child welfare service that collects, maintains or stores the information shall ensure it is adequately protected in accordance with this subsection.

As used in Section 3:
1. "Infant" is defined as up to one year of age.
2. "CARA plan of care" means a comprehensive addiction and recovery act plan of care that meets the requirements outlined in section 3.

Sec. 4
1. All hospitals not designated as a psychiatric hospital, a Centers for Medicare and Medicaid Services certified critical access hospital, as a hospital with a distinct part which meets the requirements of a skilled nursing facility or nursing facility pursuant to 42 C.F.R. § 483.5(b)(2), or a rural hospital must be primarily engaged in providing inpatient services.
2. A hospital is primarily engaged in providing inpatient services when it is directly providing services to inpatients.
3. Initial determinations of whether a hospital, not designated as a psychiatric hospital, a Centers for Medicare and Medicaid Services critical access hospital, as a hospital with a distinct part which meets the requirements of a skilled nursing facility or nursing facility pursuant to 42 C.F.R. § 483.5(b)(2), or a rural hospital, which has 20 inpatient beds or fewer, is primarily engaged in providing inpatient services will be based on the hospital having an equal or greater number of designated inpatient beds as it has designated emergency room bays. Initial determinations will only apply for the first 12 months of licensed operation. This provision does not apply to hospitals currently licensed by the Division of Public and Behavioral Health that obtained initial licensure on or prior to adoption of these regulations.
4. After 12 months of licensed operation, capacity or potential capacity will not be considered as actually providing inpatient care.
5. In making a determination of whether or not a hospital, not designated as psychiatric, critical access, as a hospital with a distinct part which meets the requirements of a skilled nursing facility or nursing facility pursuant to 42 C.F.R. § 483.5(b)(2), or rural hospitals, is primarily engaged in providing inpatient services and care to inpatients, the Division will consider multiple factors and will make a final determination based on an evaluation of the facility in totality. Such factors include, but are not limited to, average daily census and average length of stay, scope of services offered, volume of outpatient surgical procedures compared to inpatient surgical procedures, staffing patterns, and patterns of average daily census by day of the week. Hospitals which have more than 20 inpatient beds are not required to have a specific inpatient to outpatient ratio.

6. The average daily census is calculated by adding the midnight daily census for each day of the period being evaluated and then dividing the total number by the number of days in the period. In order to be considered primarily engaged in providing inpatient services, prospective hospitals and currently licensed hospitals must also maintain an average length of stay of two midnights or greater. The average length of stay is calculated by dividing the total number of inpatient hospital days (day of admission to day of discharge, including day of death) by the total number of discharges from the hospital over the period.
7. It will be determined that the facility is not primarily engaged in providing care to inpatients, when a facility does not have a minimum average daily census of two inpatients and an average length of stay of two over the last 12 months, or when other evaluated factors show the facility is not primarily engaged.

Sec. 5
1. The operator of a hospital, other than a psychiatric hospital, a Centers for Medicare and Medicaid Services certified critical access hospital, a hospital with a distinct part which meets the requirements of a skilled nursing facility or nursing facility pursuant to 42 C.F.R. § 483.5(b)(2), a hospital described in 42 U.S.C. § 1395ww(d)(1)(B)(iv) which accepts payment through Medicare, a state-owned hospital, a hospital licensed only with rehabilitation beds or a rural hospital, shall:
(a) Not later than 12 months after obtaining a license, submit proof to the Division that the hospital has been deemed to meet the Centers for Medicare and Medicaid Services standards by an accrediting organization approved by the Centers for Medicare and Medicaid Services; and
(b) Maintain current accreditation during the term of licensure.
2. Subsection 1 does not apply to hospitals currently licensed by the Division of Public and Behavioral Health that obtained initial licensure on or prior to adoption of these regulations.
3. If a hospital is required to be deemed in accordance with subsection 1 or if a hospital is not required to be deemed in accordance with subsection 1 but chooses to be deemed, the hospital shall provide to the Division proof from the accrediting organization that the hospital has been deemed to meet the Centers for Medicare and Medicaid Services standard upon initial accreditation.
4. If a hospital is required to be deemed in accordance with subsection 1 or if a hospital is not required to be deemed in accordance with subsection 1 but chooses to be deemed, the hospital shall submit with each renewal application proof from the accrediting organization that the hospital is deemed to meet the Centers for Medicare and Medicaid Services standards. If a hospital loses its deemed status, it shall notify the Division that it is no longer deemed.

Sec. 6
1. A hospital shall submit to the Division, upon renewal of its license, upon penalty of perjury, an attestation that the hospital is aware of and is in compliance with NAC 449.331.

Sec. 7 NAC 449.289 is hereby amended to read as follows**:**

NAC 449.332 Discharge planning. (NRS 449.0302**)**
1. A hospital shall:
(a) Have a process for discharge planning that applies to all inpatients; and
(b) Develop and carry out policies and procedures regarding the process for discharge planning.

2. The process for discharge planning must include the participation of registered nurses, social workers or other personnel qualified, through education or experience, to perform discharge planning.

3. A hospital shall, at the earliest possible stage of hospitalization, identify each patient who is likely to suffer adverse health consequences upon discharge if the patient does not receive adequate discharge planning. The hospital shall provide for an evaluation of the needs related to discharge planning of each patient so identified.

4. An evaluation of the needs of a patient relating to discharge planning must include, without limitation, consideration of:

(a) The needs of the patient for postoperative services and the availability of those services;

(b) The capacity of the patient for self-care; and

(c) The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge.

5. If the evaluation of a patient relating to discharge planning indicates a need for a discharge plan, a discharge plan must be developed under the supervision of a registered nurse, social worker or other person qualified to perform discharge planning.

6. An evaluation of a patient relating to discharge planning and a discharge plan for the patient may be requested by the patient, a physician, a member of the family of the patient or the guardian of the patient, if any.

7. If a hospital finds that a patient does not need a discharge plan, the attending physician may still request a discharge plan for the patient. If the attending physician makes such a request, the physician shall collaborate as much as necessary with the hospital staff in the development of the discharge plan.

8. Activities related to discharge planning must be conducted in a manner that does not contribute to delays in the discharge of the patient.

9. The evaluation of the needs of a patient relating to discharge planning and the discharge plan for the patient, if any, must be documented in his or her medical record.

10. The discharge plan must be discussed with the patient or the person acting on behalf of the patient.

11. The patient, members of the family of the patient and any other person involved in caring for the patient must be provided with such information as is necessary to prepare them for the posthospital care of the patient.

12. If, during the course of a patient's hospitalization, factors arise that may affect the needs of the patient relating to his or her continuing care or current discharge plan, the needs of the patient must be reassessed and the plan, if any, must be adjusted accordingly.

13. A hospital shall arrange for the initial implementation of the discharge plans of its patients.

14. If identified in a discharge plan, referral of a patient to outpatient services or transfer of the patient to another facility must be accomplished in a manner that meets the identified needs of the patient, including the sharing of necessary *administrative and* medical information about the patient with the receiving service or facility *upon transfer of the patient to the receiving service or facility or will be made promptly available to the receiving service or facility.*

15. The transfer conducted pursuant to subsection 14, must provide for the security of, and the accountability for, the personal effects of the patient.

Sec. 8 NAC 449.289 is hereby amended to read as follows**:**
"Inpatient" means a person who has been formally admitted ~~[into]~~ *to* a hospital *bed occupancy* for diagnosis or treatment*, with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed. The expectation of a two midnight stay for an inpatient is that the intent of the physician was that the patient be admitted to the hospital for an inpatient stay as opposed to that of observation status which is an outpatient service.*

Sec. 9 NAC 449.297 is hereby amended to read as follows:
"Outpatient" means a person who has been registered or accepted for care in a hospital but who has not been formally admitted as an inpatient, and who does not remain in the hospital for more than 48 hours. *The expectation is that for an outpatient the intent of the physician is for the patient to only remain in the hospital for observation and will not require hospital care expected to span more than two midnights and will not occupy a hospital bed occupancy.*