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**NORTH CENTRAL MISSOURI
MENTAL HEALTH CENTER**

**POLICY AND PROCEDURE
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**NORTH CENTRAL MISSOURI
MENTAL HEALTH CENTER**

**Policy and Procedure
Manual**
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SECTION 1 – NAME

The name of this organization shall be North Central Missouri Mental Health Center. The organization is incorporated in Missouri, and is in good standing.

SECTION 2 – OBJECTIVES

The objectives of the organization are:

- A. To involve the people of the Green Hills Area (Service Area 13), consisting of the counties of Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Sullivan and Putnam, in the governance of North Central Missouri Mental Health Center.
- B. To help the residents of North Missouri enhance a system of care that ensures major mental health needs are met through North Central Missouri Mental Health Center.
- C. To unite people of all social groups and ages in an understanding of mental health problems to enhance the development of a sound community.
- D. To provide high quality services in mental health treatment services.

ARTICLE II – MEMBERSHIP

SECTION 1 – NO MEMBERS

In lieu of members, the corporation shall have only a self-perpetuating Board of Directors.

ARTICLE III – BOARD OF DIRECTORS

SECTION 1 – GENERAL POWERS

The affairs of the corporation shall be managed by its Board of Directors. The Board of Directors shall be charged with dealing with mental health issues throughout the entire service area of the corporation.

SECTION 2 – NUMBER AND TENURE

The number of the Board of Directors shall be nine. Directors shall serve for a term of three (3) years from the date of their election. Terms shall be staggered so that one-third (1/3) of the Directors are elected each year.

SECTION 3 – QUALIFICATIONS

The Board of Directors shall be comprised of three (3) members each from Grundy and Livingston counties, with the remainder of members from any other county in the Green Hills Area. The Executive Director is responsible for recruiting board members who are representative of the specific cultures and populations the agency serves. The Executive Director shall ensure board members shall have a wide range of needed skills and abilities and provide a mix on terms of skills, strengths, community knowledge, professions, age, race, gender and ethnicity reflective of the area the agency serves.

Over half of the members of the Board of Directors shall be persons who are not providers of health care, providers defined in P.L. 94-63.

No paid employee or family member that is a spouse, son, son-in-law, daughter, daughter-in-law, parent, or parent-in-law of a North Central Missouri Mental Health Center employee may serve on the Board of Directors except that the Executive Director shall be an ex-officio, non-voting member as officially designated.

SECTION 4 – EX-OFFICIO MEMBERS

The Executive Director of North Central Missouri Mental Health Center shall be a member of the Board of Directors, ex-officio and non-voting.

SECTION 5 – ANNUAL MEETING

The Board of Directors shall hold its annual meeting during the month of November each year, on a date selected by the President of the corporation. The purpose of the annual meeting shall be to fill vacancies on the Board created by expired terms of members. Nominations to fill the vacancies shall be submitted by a nominating committee, appointed by the President and consisting of three (3) or more members of the Board, at least two (2) weeks prior to the date set for the annual meeting. Additional nominations may be made by the Board from the floor during the annual meeting. The election of Board members shall be by secret ballot or by acclamation.

SECTION 6 – REGULAR MEETINGS

The Board of Directors shall meet at least quarterly. Regular meetings of the Board shall be called from time to time, by notice. Notice of such meeting shall be delivered to Board members not more than 30 days or less than seven (7) days before the date of any such general meeting. Notice shall be given to the general public at least 24 hours prior to the meeting. When it is necessary to hold a meeting on less than

24 hours' notice, or at a place or time that is not reasonably accessible or convenient to the public, the nature of the good cause justifying that departure from the normal requirements shall be stated in the minutes. All regular meetings shall be called by the President.

SECTION 7 – ANNUAL REPORT TO THE BOARD

The Executive Director shall prepare and submit to the Board of Directors an annual report at the end of each fiscal year, in which report shall be a complete review of the operations of the corporation for the preceding year, and will include recommendations for changes in the operation of the corporation for the succeeding year.

SECTION 8 – SPECIAL MEETINGS

Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) Directors of the Board, and shall be held at the principal office of the corporation or at such other place as the Directors may determine. Except in emergencies which threaten the existence of the corporation, notice to the Directors of any special meeting of the Board of Directors shall be given at least two (2) days notice prior to the date of such meeting, by written notice delivered personally or sent by mail to each Director at his/her address as shown by the Directors' records of the corporation. Notice shall be given to the general public at least 24 hours prior to the meeting. When it is necessary to hold a meeting on less than 24 hours' notice, or at a place or time that is not reasonably accessible or convenient to the public, the nature of the good cause justifying that departure from the normal requirements shall be stated in the minutes.

SECTION 9 – QUORUM

A majority of the current members of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board.

SECTION 10 – VACANCIES

Any vacancy occurring in the Board of Directors shall be filled by election by the remaining members of the Board of Directors. A Director elected to fill a vacancy shall serve for the un-expired term of his/her predecessor in office.

SECTION 11 – COMPENSATION

Directors shall not receive any compensation for their services but may be

reimbursed for their action, reasonable and necessary expenses of attendance.

SECTION 12 – MEETINGS

- A. Agenda. An agenda for meetings of the Board of Directors shall be prepared by the Executive Director in consultation with the President of the Board. Additional items may be taken up at any regular meeting in addition to the agenda items by the consent of a majority of the members of the Board of Directors there present.
- B. Robert's Rules of Order shall govern the proceedings of the meeting.
- C. Official minutes of open and closed meetings shall be taken and recorded. Minutes shall include, but not be limited to, the date, time, place, members present, members absent, and a record of any votes taken.

SECTION 13 – REMOVAL

Members of the Board of Directors may be removed as follows:

- A. By a two-thirds (2/3) vote of the remaining members of the Board of Directors.
- B. Following three (3) consecutive unexcused absences from regular Board of Directors meetings.

ARTICLE IV – RESPONSIBILITIES, BUDGETING AND MANAGEMENT

SECTION 1 – BOARD RESPONSIBILITIES

The Board of Directors has the following specific duties and responsibilities:

- A. To formulate, create, approve, review, change or delete general policies for the corporation.
- B. To give direction, suggestions and recommendations to the Executive Director of the corporation.
- C. To approve the annual budget, approve the selection of an Executive Director of the corporation, evaluate the performance of the Executive Director, govern and oversee the affairs and services of the corporation, and annually review and update the by-laws and policies and procedures of the corporation.
- D. To monitor and champion the interests of the community in regard to provisions of treatment and rehabilitation services within the organization on local, state, regional and national levels.
- E. To help in the assessment of community needs and problems relevant to community mental health.
- F. To serve as a liaison between the community and the organization.

SECTION 2 – ANNUAL BUDGET, CONTRACTS

The Board of Directors shall approve the annual budget of the corporation. The approval of the annual budget shall thereafter authorize the Executive Director to operate the business of the corporation in accordance therewith. The Board of Directors shall review at least quarterly the fiscal reports of the corporation and shall document recommendations and actions in regard to such reports in its official minutes.

SECTION 3 – EXECUTIVE DIRECTOR

The Board of Directors shall employ an Executive Director of the corporation with the authority to manage and conduct the routine business and affairs of the corporation including, but not limited to, the following:

- A. Approval of non-budgeted expenditures not in excess of \$750.00 per expenditure.
- B. Approval of emergency capital expenditures not in excess of \$5000.00 per expenditure.
- C. Hiring or firing of employees in accordance with the personnel procedure policies of the corporation.
- D. Co-signing corporate checks with another authorized officer or person.
- E. Preparing, formulating and presenting to the Board the proposed annual budget of the corporation.
- F. Executing contracts, grant applications and other agreements on behalf of the corporation as authorized by the Board either specifically or by general authorization.
- G. Formulating and presenting to the Board and carrying out those policies approved by the Board of Directors.

SECTION 4 – APPROVAL OF EXPENDITURES, CONTRACTS AND GRANTS

All expenditures, contracts, grants and other legal obligations of the corporation, other than regular expenses and petty cash disbursements not included in the approval annual budget, shall be approved by the Board of Directors on any expense or obligation in excess of \$750.00, or \$5000.00 for emergency capital expenditures. The Board of Directors may authorize the Executive Director, or officers of the corporation, to enter into any contract or execute and deliver any instrument in the name of and

behalf of the corporation, and such authority may be general and may be confined to specific instances.

SECTION 5 – CHECKS, DRAFTS, AND ORDERS

All checks, drafts and orders for the payment of money, notes or other evidences of indebtedness issued in the name of the corporation, in excess of \$200.00, shall be signed by 1) the President or Secretary/Treasurer of the corporation, or by another authorized Board member, and 2) the Executive Director or his/her designee.

ARTICLE V – OFFICERS OF THE BOARD OF DIRECTORS

SECTION 1 – OFFICES, TERMS, AND VACANCIES

- A. Officers shall be President, Vice-President and Secretary/Treasurer.
- B. Terms of office for all officers shall be for one (1) year or until the election of new officers.
- C. Officers may be elected to successive terms.
- D. Vacancies in office shall be filled for the remainder of the term by the Board of Directors when such vacancies occur for any reason.

SECTION 2 – ELECTION

Officers shall be elected annually by the Board of Directors at the first Board of Directors meeting following the annual meeting. Members elected to office shall take office immediately upon election.

SECTION 3 – DUTIES

- A. President: The President shall be the principal executive officer of the corporation and shall: (a) supervise and control all the business and affairs of the corporation; (b) preside at all meetings of the Board of Directors; (c) sign, with the Secretary/Treasurer, or any other proper officer, thereunto authorized by the Board of Directors, together with the Executive Director, checks, deeds, mortgages, bonds, contracts, or other instruments which the Board of Directors has authorized to be executed, or is authorized by these By-laws, or shall be required by law to be otherwise signed or executed; and (d) perform all duties incident to the office of President and such other duties as may be prescribed by the Board of Directors from time to time.
- B. Vice-President: In the absence of the President or in the event of his/her inability or refusal to act, the Vice-President shall: (a) perform the duties of the President

and when so acting, shall have all the powers of and be subject to all the restrictions upon the President; and (b) be the assistant Secretary/Treasurer.

- C. Secretary/Treasurer: The Secretary/Treasurer shall (a) be accountable to the Board of Directors for maintenance of the official records of the corporation including minutes of all corporation and Board of Directors meetings and circulation of notices as required by these By-laws or other authority; (b) be empowered to co-sign all corporate checks; and (c) perform all duties incidental to the office and other duties as assigned by the Board of Directors.

ARTICLE VI – COMMITTEES

SECTION 1 – STANDING COMMITTEES

- A. There shall be the following standing committees: Operations and Finance.
- B. Standing committees shall be governed by the rules below:
1. The responsibility of dealing with the overall administrative and operational issues of North Central Missouri Mental Health Center shall be exercised by the entire Board of Directors in its relationship with the Executive Director.
 2. The chairperson of each committee shall be designated by the President with the approval of the Board.
 3. The committee chairperson chooses committee members subject to the approval of the Board.
 4. The President is an ex-officio member of each committee (and has no vote in the committee except in the case of a tie vote).
 5. The Executive Director, in consultation with the Board of Directors, may assign staff consultants to standing committees. Such consultants are ex-officio and non-voting.

SECTION 2 – AD-HOC COMMITTEES

Ad-Hoc Committees shall be appointed by the President with the Board of Directors' approval. Such committees are governed by the same rules as for standing committees.

ARTICLE VI – MISCELLANEOUS

SECTION 1 – OFFICES

The corporation may have such offices as the Board of Directors may designate

or as the business of the corporation may require.

SECTION 2 – WAIVER OF NOTICE

Unless otherwise provided by law, whenever any notice is required to be given to any member, Executive Director or officer of the corporation under the provisions of these By-laws or under the provisions of the Articles of Incorporation, waivers thereof in writing, signed by the person(s) entitled to such notices, whether before or after the time stated therein, or actual attendance by the person(s) at the meeting, except a special appearance solely to object to the insufficiency of the notice, shall be deemed equivalent to the giving of such notice.

SECTION 3 – AMENDMENTS

Each of these By-laws may be altered, amended or repealed and new By-laws may be adopted by a vote of the Board of Directors at any meeting. Notification of the proposed amendment(s) will be made to each Board member at least fifteen (15) days and not more than thirty (30) days prior to such meeting. The notification requirement of such meeting may be waived by an affirmative vote of 75-percent of the Board of Directors.

SECTION 4 – FISCAL YEAR

The fiscal year of the corporation shall be July 1 through June 30, unless required by law to be otherwise.

SECTION 5 – CONFLICT OF INTEREST

When, in discharging any responsibility associated with the business of the corporation, there is an apparent conflict of interest on any Board member's part, said member shall withdraw and/or abstain from such proceedings with such action being noted in the official record of the corporation. When an apparent conflict of interest is not voluntarily raised by the Board member involved, another Board member shall raise the question and if the Board member does not withdraw and/or abstain after the point is raised, the Board may vote to prohibit such member from voting and/or participating in such proceedings.

SECTION 6 – P.L. 94-63 DEFINITION: PROVIDER OF HEALTH CARE

The term "provider of health care" is defined as an individual who:

- A. Is a direct provider of health care (including a physician, dentist, nurse, podiatrist, or physician assistant) in that (1) the individual's primary current activity is in the

provision of health care to individuals or the administration of facilities, outpatient facilities or health maintenance organizations in which such care is provided; and (2) when required by State Law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or

B. Is an indirect provider of health care in that the individual (1) holds a fiduciary position with, or has a fiduciary interest in, any entity described in Paragraph A above; (2) receives (either directly or through his/her spouse) more than one-tenth (1/10) of his/her gross annual income from any one or combination of the following:

1. Fees or other compensation for research into or instruction in provision of health care; (b) entities engaged in the provisions of health care of in such research or instruction; (c) producing or supplying drugs or other articles for individuals or entities for use in the provision of, in research into, or instruction in the provision of health care; (d) entities engaged in producing drugs or such other article; (e) is a member or the immediate family member of an individual described above; or (f) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

SECTION: ADMINISTRATION

**SUBJECT: GOVERNING
AUTHORITY**

SECTION NO. 1

SUBJECT NO. 2

- A. The Governing Board of North Central Missouri Mental Health Center shall assume full legal authority and responsibility for the overall functioning of the corporation. (Ref. By-Laws) A current list of board members is maintained by the Executive Assistant.
1. As a private not-for-profit agency, North Central Missouri Mental Health Center's authority is documented within the corporation By-Laws.
- B. The Governing Board of North Central Missouri Mental Health Center shall establish policies and procedures in accordance with corporate By-Laws and comply with local, state, and federal laws and regulations.
- C. The Governing Board of North Central Missouri Mental Health Center shall appoint an Executive Director whose qualifications, duties and authority are defined in the job description and in the By-Laws.
1. The Governing Board shall delegate the management of the agency to the Executive Director.
 2. The selection and delegation of the Executive Director shall be in writing.
 3. The Executive Director shall provide quarterly programmatic reports to the Governing Board which shall consist of:
 - a. Financial status.
 - b. Client utilization.
 - c. Personnel status and changes.
 - d. Progress in achieving goals and objectives.
 4. The Executive Director shall have:
 - a. The authority to request and receive authorization from the Board of Directors to negotiate contracts on behalf of the agency; and
 - b. The authorization and responsibility for the day-to-day operations of the administration of the agency.
- D. The Governing Board or the Executive Director, or both, of NCMMHC shall

establish and maintain a policy and procedure manual which reflects the agency's overall functioning of the corporation.

1. The policy and procedure manual shall be reviewed and updated by the Governing Board annually.
 2. The Executive Director and his/her designees are responsible for the maintenance and upkeep of the policy and procedure manual.
 3. Staff may participate in the program policy development and goal planning process by:
 - a. Making recommendations to the Executive Director or their immediate supervisor.
 - b. Requesting an audience with the Board of Directors through the Executive Director.
 4. This policy and procedure manual shall be available to staff, members of the Board of Directors, and the public upon request and shall be maintained in an open, unlocked area in the Administrative Office and any other Agency facility to ensure accessibility.
 5. The Executive Director and Staff shall follow this policy and procedure manual in operating the program and providing services in order to ensure responsiveness to the community and individuals being served.
- E. This policy and procedure manual shall describe in writing the following:
1. The philosophy, hiring practices, program goals, types of services, organizations, and quality assurance.
 2. The objectives to be attained.
 3. The organization and methods of personnel utilization.
 4. The interrelationship within the organization and with outside agencies.
 5. The outreach plan for all services offered.
 6. Grievance and appeal procedures for all personnel.
 7. Non-discrimination policies in the areas of:
 - a. Employment
 - b. Compensation
 - c. Assignment of work
 - d. Promotion

SECTION: ADMINISTRATION

**SUBJECT: ROLES AND
RESPONSIBILITIES**

SECTION NO. I

SUBJECT NO. 3

- A. Executive Director – The Executive Director is responsible for the administration of the agency as delegated by the Board of Directors in order to provide the components of care and to carry out the purposes, goals and objectives of the agency. Directly supervises the Clinical Director, Chief Financial Officer, Quality Assurance Coordinator, Executive Assistant, and staff psychiatrists. The Executive Director is responsible to the Governing Authority of the agency.
- B. Clinical Director – The Clinical Director is responsible for the administration of clinical programs in all agency offices. This position currently supervises all clinical program and rehabilitation components. Directly supervises Children and Youth Services Director, CPRC Director, ACI Coordinator and outpatient clinical staff.
- C. Chief Financial Officer – The Chief Financial Officer is responsible for maintaining corporate accounting records in accordance with agency policy, contract requirements and certification standards. Directly supervises Accounting Assistant, Insurance Specialist, Invoicing Specialist, and Clinical Records Clerk.
- D. CPRC Director – The CPRC Director for Adult Services is responsible for the planning, implementation, monitoring and supervision of the services of the Community Psychiatric Rehabilitation Center (CPRC) program in accordance with agency policies and procedures, contractual requirements and certification requirements. Directly supervises CPRC Team Leaders.
- E. CPRC Team Leader – The CPRC Team Leader is responsible for ensuring appropriate, quality service provision to seriously mentally ill adults for psychiatric rehabilitation purposes. Directly supervises CPRC community support specialists.
- F. Children & Youth Services Director – The Children and Youth Services Director is responsible for the general organization, supervision and administration of Children's Services activities. Directly supervises Children & Youth Services

Team Leader and community support specialists.

- G. Quality Assurance Coordinator – The Quality Assurance Coordinator is responsible for providing ongoing support to ensure continuous quality assurance programming to achieve the highest quality of care. Responds to questions from the public regarding its accredited services, including questions about its CARF survey results and the survey report, the quality and effectiveness of services, descriptions of services and persons served, performance outcomes of the services, and consumer and satisfaction with services. Does not directly supervise any position.
- H. Executive Assistant – The Executive Assistant is responsible for assisting the Executive Director in the administration and facilitation of programmatic operations of the agency and is responsible for the human resource department. Also responsible for marketing and ensuring that agency flyers used for marketing accurately reflect current practices. Directly supervises the Secretary/Receptionists, Transcriptionists, and Part-Time Secretary.

SECTION: ADMINISTRATION

**SUBJECT: PLANNING AND
EVALUATION**

SECTION NO. I

SUBJECT NO. 4

- A. The agency shall employ a planning system which sets goals and objectives annually and evaluates the attainment of these goals at the end of each fiscal year, as referenced in Attachment A.
- B. The agency utilizes the incidence and prevalence of mental illness statistics provided by the Department of Mental Health, along with its ADA and CPS Advisory Councils. If the agency should conduct a needs assessment, it will provide information that may aid in the development of clear, reasonable and measurable goals and objectives which this agency may expect to achieve.
 - 1. Should a local needs assessment be conducted, it will utilize existing records and surveys for the documentation and analysis of mental health needs in the area.
 - 2. Should a local needs assessment be conducted, it will include an inventory of existing resources for the population of the area.
 - 3. The agency may establish a formal accountable relationship with any contractor or affiliate who provides direct service but is not an employee of the organization.
 - 4. Should a local needs assessment be conducted, the agency shall consider current literature and professional consensus concerning technology to support operations and service delivery.
- C. Planning System
 - 1. During June of each Fiscal Year, a strategic planning team comprised of the Executive Director and the Management Team shall convene to establish program goals and objectives for the upcoming fiscal year.
 - 2. The strategic planning team shall be concerned with discussion and identification of recommendations in the following:
 - a. Program improvements;
 - b. Annual staff objectives;

- c. Operational directives and guidelines;
 - d. Corporate policy and procedure;
 - e. Financial opportunities;
 - f. Financial threats;
 - g. Agency's capabilities;
 - h. Legislative environment.
3. In June of each fiscal year, the strategic planning team shall submit to the Agency's Governing Board for approval of its written plan of action comprised of program goals and objectives for the upcoming fiscal year.

D. Goals and Objectives

1. Each program shall direct the goals and objectives to address:
 - a. Program process;
 - b. Program outcome;
 - c. Staff utilization;
 - d. Resource utilization.
2. All goals and objectives shall be clear, reasonable and measurable.
3. Each program shall have written time-limited goals and objectives.
4. All goals and objectives shall stipulate a target and completion date.
5. All goals and objectives shall indicate the person(s) responsible to achieve completion.
6. The strategic planning team will convene quarterly to review program(s) goals and objectives.

E. Evaluation

1. An evaluation team comprising of the Executive Director and the Management Team shall be established.
2. The evaluation team shall convene quarterly to evaluate progress toward completion of goals and objectives.
3. The Executive Director shall submit to the Governing Board written quarterly progress evaluations.
4. In June of each fiscal year, the evaluation team shall evaluate the outcome of each program(s) goals.
5. In June of each fiscal year, the Executive Director shall submit to the Governing Board written results of the outcome evaluation.

6. Results of the outcome evaluation shall be made available to all staff, persons served as appropriate, and other stakeholders as appropriate.

SECTION: ADMINISTRATION

SUBJECT: ENVIRONMENT

SECTION NO. I

SUBJECT NO. 5

- A. The Agency shall establish and maintain a healthy and safe environment that enhances a positive self-image and preserves human dignity.
- B. The facility utilized by the Agency shall be accessible to impaired individuals or have a written plan for how these impaired individuals can access necessary services.
 - 1. Those people whose impairments indicate they are in need of:
 - a. Reasonable accommodations. Requested reasonable accommodations that are identified and documented will be reviewed and decided upon by the Executive Director.
 - b. Facility equipped for impairments other than North Central's will be referred to a facility that can meet their specific need.
 - c. Staff shall secure a release in order to make a direct referral to a facility that can meet their specific need.
- C. This agency shall provide an environment appropriate to the needs of the client.
 - 1. The design, space, structure, furnishings, equipment, and lighting shall be sufficient to staff, clients, and functions of program activities and for maintaining safety, privacy and confidentiality.
 - 2. All functional areas shall be adequately ventilated, and temperature will be maintained between 68 and 80 degrees.
 - 3. This facility shall be clean and comfortable.
 - 4. A reception/waiting area will be provided.
 - 5. There will be convenient toilet facilities.
 - 6. The agency will provide screens on all outside doors and windows.
- D. The following policies and procedures have been established to enhance staff-client interaction.
 - 1. Areas shall be available for a full range of social activities from two-person conversation to group activities. There will be private areas for individual

- counseling, family therapy, group counseling, and education services.
2. The use of appliances (TV, radio, record players, etc.) shall not interfere with any therapeutic program for clients.
- E. This agency shall have appropriate furnishings and equipment available.
1. Furnishings, equipment, and appliances shall be clean, comfortable, and in good repair.
- F. This agency shall maintain and ensure a safe and healthy environment to all occupants.
1. All buildings, current and relocated, shall conform to the requirements of local, state, and/or federal authorities, fire safety and health requirements.
 2. Annual records of inspections by local and/or state officials (if required) and corrections of all cited deficiencies shall be maintained and available for review upon request.
 3. Maintenance personnel will conduct self-inspections at least semi-annually on each building regularly used by NCMMHC clients. Self-inspections are conducted in order to identify and correct existing hazards and to determine whether regulatory standards are being met and to keep NCMMHC ready for compliance inspections by the fire department
 - a. The results of the self-inspection will be written in a report that identifies the areas inspected, recommendations for areas needing improvement, and actions taken to respond to the recommendations.
 - b. The results of the self-inspection shall be held in a file maintained by the Executive Assistant.
 - c. The Executive Assistant shall report the inspection findings to the Management Team in a timely manner.
 - d. The Management Team shall ensure the follow-up action plan facilitates improvement so the desired goals are being attained.
 - e. The Accessibility Committee designee will prepare an Accessibility Status Report annually, in writing, about the progress made in the removal of identified barriers and areas needing improvement.
 4. The program shall develop written plans identifying the steps and timetable for correction of conditions cited as non-compliant.

5. The agency will provide effective pest control measures.
 6. Refuse will be stored in covered containers.
 7. The facility will be free of undesirable odors.
 8. Measures will be taken to prevent, detect and control infections.
 9. Hazardous materials will be handled safely and disposed of according to local and state laws as required. Materials such as industrial strength cleaning supplies, oil-based paints, fluorescent light bulbs, copier toner and computer monitors will be kept in locked areas when not in use.
- G. The agency shall have written and posted plans for meeting medical emergencies and natural disasters.
1. The plan shall include assignment of tasks, instructions for use of an alarm, notification of authorities, use of special emergency equipment, specification of escape routes and assembly areas. Staff will be notified of any changes in the plan. Evacuation routes shall be posted.
 2. Each new client and staff member shall be oriented to the disaster plan and procedures.
 3. All staff members shall review the plan annually and verbally demonstrate knowledge and ability to effect the emergency preparedness plan and evaluation plan.
 4. Drills, which address all types of natural disasters, shall be held at least quarterly in the day treatment program.
 - a. Drills shall be documented and evaluated for effectiveness.
 5. All staff members will be trained and know what to do to help all persons served in the event of complete evacuation from an agency building. Staff will assess the situation and take appropriate action according to the relevant emergency while considering any safety and unique need of the person served. After contacting the Executive Director and all emergency contacts, the agency phone tree system will be utilized to provide direction to all appropriate personnel and identify any essential service contacts. When the evacuees cannot return to an agency building, the Executive Director will identify the next available agency building from which agency services will be provided.
- H. Unless prohibited by law, the Agency shall have an insurance program that

provides for the protection of the physical and financial resources of the program and that provides coverage for all people, buildings, and equipment.

- I. This agency shall maintain an adequately supplied first aid kit in each of its facilities.
 1. Each first aid kit shall be inspected annually and restocked as needed by the Program Directors.
 2. Inspection shall be documented with the inspector's initials and date of inspection.
- J. This agency shall post the emergency numbers near its telephone for fire, police, and poison control center.
- K. North Central does not utilize physical restraints and therefore all clients have access to the entrance/exit.
- L. In the event of a natural disaster (fire, flood, tornado, earthquake) the community leaders will be contacted and the professional resources of this agency will be offered.
- M. North Central staff shall insure the proper maintenance and operation of all agency vehicles to assure safety of clients and staff, to minimize repair costs and extend the life of the vehicles.
 1. There shall be a current certificate of insurance for all agency-owned vehicles.
 2. Agency vehicles shall be cleaned on a regular basis and current state inspection decals shall be prominently displayed.
 3. Each vehicle will maintain a mileage log to be documented when utilized.
 4. All vehicles shall be stocked with a readily accessible first aid kit and fire extinguisher, which will be inspected quarterly and restocked as needed by the Program Director. The first aid kit and fire suppression equipment are to be securely fastened in each vehicle in order to prevent additional hazards in the event of an emergency stop or accident.
 5. The agency shall maintain records of periodic inspections and incidents in which vehicles require repairs.
 6. All staff shall follow the vehicle maintenance operations procedures as specified by the manufacturer.
 7. All agency vehicle drivers will ensure procedures addressed above will be

carried out. All staff that transport persons served will be properly licensed, with driving records acceptable to the agency.

8. Emergency response procedures shall be posted in each vehicle. In case of accident:
 - a. Ensure the safety of all passengers, evacuate if necessary. Administer basic First Aid if needed.
 - b. Do not move vehicle from the scene of the accident. Notify the police.
 - c. If the vehicle needs towing, call the Program Director and his/her designee to make arrangements for payment and for transporting passengers.
 - d. Upon return, notify the insurance company representative. Proof of insurance must be maintained in the vehicle.
 - e. Complete an accident report as soon as possible.
 - f. North Central is a Smoke-Free Environment agency wide. All offices, including outreach facilities, will be smoke-free. Smoking will have to be done outside all agency buildings and agency-owned vehicles.
- N. The agency will maintain fire safety equipment and practices to protect all occupants.
 1. Portable ABC fire extinguishers shall be located on each floor so that no one will have to travel more than 100 feet from any point to reach the nearest extinguisher.
 2. The fire extinguishers will be clearly visible and maintained with a charge.
 3. There will be at least two means of exit on each floor. The exits will be free from items that would obstruct the exit route.
 4. Combustible supplies and equipment shall be separated from other parts of the building in accordance with stipulations of the fire authority.

SECTION: ADMINISTRATION

SUBJECT: FISCAL MANAGEMENT

SECTION NO. I

SUBJECT NO. 6

- A. North Central Missouri Mental Health Center shall have written policies and procedures in accordance with generally accepted accounting principals and state and federal law, regulations or funding requirements governing the fiscal management of the corporation.
1. The Chief Financial Officer shall be responsible to the Governing Board for maintenance of the corporate financial records.
 - a. The Chief Financial Officer of the agency, or any other designated staff person, shall have the responsibility of maintaining the accounting system and the preparation of the monthly and quarterly financial reports.
 - b. The Chief Financial Officer shall have the skills, authority and support to fulfill these responsibilities.
 2. Those persons responsible for maintaining the agency accounting system and records shall be excluded from authorization to handle cash, except in such cases where those authorized to handle cash are not available, (e.g. absenteeism due to some cause).
 3. The Chief Financial Officer and all other persons authorized to handle cash/checks and those authorized to sign checks shall be eligible for bonding.
- B. Budget
1. The corporation shall have and shall operate from a written fiscal plan and budget. In addition to an operating budget, the corporation shall maintain a written plan for securing financial resources for at least one year beyond the current operating year.
 2. The Executive Director and the Chief Financial Officer shall be responsible for preparing the annual and projected budget and submitting it to the

Governing Board for review and approval prior to the start of each fiscal year.

3. The annual budget shall reflect personnel and non-personnel costs as well as direct costs and support costs. The budget shall depict service components, hour (units) of direct service per component, cost per unit for individual services, categorized and the agency as a whole.
4. The budget shall include all revenues by sources and all expenses by components of care.
5. The budget will be developed in the following manner:
 - a. Initial planning by the Executive Director and the Management Team.
 - b. Input and review by staff.
 - c. Input, review, and adoption by the Board of Directors.
6. All current and projected budget revisions/variances shall be prepared in writing and submitted to the corporate Chief Financial Officer for approval of the Governing Board.

C. Fiscal Reporting

1. A written report and financial statement shall be submitted and reviewed at least quarterly at a regularly scheduled meeting of the Board of Directors. This report and statement shall include:
 - a. Accounts Receivable
 - b. Expenses
 - c. Fiscal standing of the corporation.
 - d. Budgeted and actual expenses and revenues with reasons for variances.
2. All financial records shall be audited annually by an independent Certified Public Accountant. A report of the audit shall be presented to the Governing Board for review and approval as soon as it becomes available from the auditor.
 - a. In all cases where audit questions have arisen, records shall be retained until resolution of all such questions has been attained.
 - b. All adverse audit findings shall be corrected and all such corrections shall be approved by the Governing Board.

3. Fiscal reports shall be provided to the Governing Board and administrative staff who have ongoing responsibility for budget and program management.

D. Accounting System

1. The Chief Financial Officer shall be responsible for maintaining the accounting system.
 - a. Adequate internal controls for safeguarding or avoiding misuse of assets shall be maintained.
 - b. Segregation of duties with the accounting staff will be used as much as allowed by the number of staff.
2. The accounting system shall be maintained on the accrual method and will reflect the operational budget documenting actual revenues and expenses by contract number. The accounting system shall include:
 - a. Cash Receipts Journal.
 - b. Cash Disbursements Journal.
 - c. General Ledger.
3. All financial records shall be retained for seven (7) years.
4. All entries in the accounting system shall be documented in a legible manner and all entries in the corporation books shall debit and credit the appropriate accounts. All transactions shall be entered and dated.
5. General Ledger
 - a. The control and accountability of the General Ledger shall be utilized through the use of a Cash Receipts Journal, a Cash Disbursements Journal, along with accounts identified with a contract number.
 - b. The ledger shall contain a depreciation schedule as well as accounts reflecting assets, liabilities, income, and expense.
 - c. The General Ledger shall contain an index of accounts by account number. Each account shall be followed by a breakdown reflecting funding source.
 - d. Each account shall maintain a running balance.
 - e. Accounts Receivable shall be controlled by monthly bill of all contractors, third-party payers, and clients.

6. Cash Receipts Journal

- a. The control and accountability of the Cash Receipts Journal shall be documented through the use of numbered receipts, numbered deposits, and numbered invoices.
- b. All entries shall be posted within forty-eight (48) hours of receipt, deposit, or invoicing.
- c. All entries shall reflect the date, source, control number (receipt, deposit, or invoice), and amount which shall be debited/credited to the specific account.
- d. Entries shall be totaled by account and debit/credit balanced within 48 hours following the last workday of each month.
- e. Monthly account totals shall be posted to the appropriate general ledger accounts.

7. Cash Receipts, Policy & Procedure

- a. The control system for cash receipts shall include the following:
 - 1) All checks received in the mail to the agency shall be posted by the Executive Assistant or designee into the cash receipts notebook, and will include date received, payer, check number, and amount received.
 - 2) All checks will be entered into QuickBooks Accounting Software for the generation of a deposit summary.
 - 3) The deposit summary shall be printed and placed into the Deposit Summary binder, which will include payer, date received, check number and amount received.
- b. Deposits
 - 1) The deposit slip shall identify date, amount, and list separately currency, coins, and checks.
 - 2) Each check shall be recorded separately on the deposit slip and identified by the cash receipt number rather than name.
 - 3) Deposits shall be made no less than every Friday, or more often if cash balance on hand is more than \$200.00.
 - 4) Deposits shall be recorded in QuickBooks Accounting Software.

- 5) The Chief Financial Officer shall monitor cash flow to ensure ability to pay current liabilities.

c. Invoices

- 1) Invoices shall be submitted to all contractors on a monthly basis and within a time element to ensure reimbursement. The Chief Financial Officer or designee shall be responsible for all billing/invoicing using QuickBooks Accounting Software.
- 2) Invoices shall be prepared on, but not limited to, Department of Mental Health Contracts, Division of Family Services Contracts, Insurance Claims, client fees, and other third-party payer sources.
- 3) All monies not paid by the insurance company shall be invoiced to the client, if said client is not eligible for Department of Mental Health assistance.
- 4) All invoices shall be assigned a number, for control, in a sequential manner.
- 5) Any discrepancy between amount invoiced and amount received shall be resolved prior to invoice cancellations. Cancellation may occur when invoices are received, re-invoiced, or disallowed.
- 6) All invoices shall be classified as uncollectible after a period of one year.

8. Cash Disbursement Journal

- a. The control and accountability of the Cash Disbursements Journal shall be the use of numbered checks.
 - 1) All entries shall reflect the date, payee, check number, account number, and amount.
 - 2) Entry shall be made when a check is written.
 - 3) Daily entries shall be totaled by account and debit/credit balance within 48 hours following the last workday of each month.
 - 4) Monthly account totals shall be posted to the appropriate

general ledger accounts.

b. Cash Disbursements, Policy and Procedures

- 1) All disbursements shall be made by check and substantiated by an approved bill, invoice or voucher, with the exception of payroll, which is direct deposited into employee bank accounts, and petty cash. All blank checks shall be secured in a locked area.
- 2) Four positions shall be authorized to sign checks: President, Vice-President, Secretary/Treasurer or other designee from the corporation Board of Directors, and the Executive Director.
- 3) Each check, in excess of \$200.00, shall require two authorized signatures, which shall not include the person who prepares the checks or the person who maintains the accounting records.
- 4) Invoices/Bills for payment
 - a) The Chief Financial Officer shall be responsible for authorizing receipt of merchandise and comparing invoices against receipt ticket prior to payment.
 - b) All incoming bills, invoices, or vouchers, shall be reviewed and approved for payment by the Executive Director and the Board of Directors President, or Vice-President, or Secretary/Treasurer, or other Board member authorized to sign checks. Approval shall be designated by the signatures on the check. In the Executive Director's absence, two (2) of the above mentioned Board Members may serve in the approving capacity.
 - c) Payment of bills will occur by entering the bill into QuickBooks Accounting Software by account category. QuickBooks maintains a check register with dates and check numbers when a bill is paid.
- 5) A check register shall be maintained in numerical order and

all checks shall be used in numerical order.

- a) Each register entry shall include date written, payee, account number, check amount, and updated register balance.
- b) The check register shall be reconciled monthly by a fiscal staff person with the bank statement and the book balance from the General Ledger. The bank statement reconciliation shall be printed from QuickBooks Accounting Software, placed with the appropriate statement, and filed into the appropriate checking account binder.

6) Petty Cash

- a) Petty cash shall follow the standard cash disbursement policy. A printed receipt will be required from the person using the petty cash, which shows what the cash was used to purchase.
- b) Receipts shall be totaled and attached to an Excel spreadsheet for reimbursement.
- c) Receipts and reimbursement requests shall be maintained in a file by fiscal year.
- d) Petty cash shall be used only for materials and supplies that are not generally kept on inventory or for those things not currently in inventory. At no time shall petty cash be used for making change, cashing checks, or making loans.
 - 1) The petty cash fund shall be administered and maintained in the same manner as the cash disbursement policy and procedure.
 - 2) Petty cash shall be kept in a locked file and separate from other cash receipts.
 - 3) No more than \$100.00 and no less than \$5.00 shall be maintained on hand. Petty cash shall be replenished on an as-needed basis.

- 4) Purchasing from the fund shall be authorized by the Executive Director, Chief Financial Officer and/or designee.
- e) Petty cash shall be accessed only through the Chief Financial Officer or designated Support Staff or, in his/her absence, the Executive Director.
 - 1) The receipt for the purchase shall be by a voucher, which will identify the date, person receiving cash, item(s) purchased.
 - 2) Generally, petty cash is used for postage only. The PSR staff have a \$50.00 petty cash balance and it is used to purchase food and supplies for the PSR House.

9. Contribution Plan

- a. Contributions to the Agency, either in money or materials, shall be reported to the Board of Directors by the Executive Director and be reflected in the minutes of the meeting.
- b. Distribution shall be the responsibility of the Executive Director according to the contributor's wishes, whenever feasible.
- c. Contributions not designated toward a specific program shall be distributed by the Executive Director to the most appropriate program.
- d. Each contributor shall receive a signed receipt to document estimated value, date, and type of contribution.

10. Operations of Chief Financial Officer

- a. Insurance coverage for all people, buildings, automobiles and equipment shall be maintained and shall include:
 1. Fire and theft insurance shall be maintained on all equipment owned or leased by the corporation.
 2. Liability insurance shall be maintained for the protection of bodily injury to any person(s) on the premises.
 3. Professional liability insurance shall be maintained on staff members; personal liability insurance is at the discretion of

the employee.

4. Employee Dishonesty Policy.
 5. Automobile liability and collision on all vehicles owned or leased by the corporation.
- b. The Chief Financial Officer shall be responsible for product selection and evaluation. The Chief Financial Officer shall select and evaluate office supplies. The Clinical Director shall select and evaluate psychological testing and assessment measures, professional library materials, and forms. The Executive Director shall select and evaluate business materials and supplies and major building repairs, as well as oversee the process according to available funds with the Board of Directors' approval.
 - c. Product selection will be made in accordance with the procedures. Non-budgeted purchases over \$1000.00 will require Board approval. There should be at least three (3) secured bids in writing when supplies are secured over \$1000.00 in value.
 - d. The Chief Financial Officer shall be responsible for supply storage and distribution.
 - 1) Control of inventory and control of supplies shall be maintained by the Chief Financial Officer and be verified semi-annually.
 - 2) Identification of fixed assets by inventory listing.
 - e. Distribution of office supplies shall include:
 - 1) Office supplies shall be maintained in a locked area.
 - 2) A file shall be maintained on items ordered.
 - 3) Each employee shall sign a requisition order for needed supplies.
 - 4) Items shall be distributed within 48-hours if the item is in stock, or ordered as soon as possible if not in stock.

11. Petty Cash (Ref. Cash Disbursement Journal)

12. Client Fees Scheduled for Services

- a. Sliding fee scale, based upon the Department of Mental Health's income eligibility, shall be used to formulate service charges for

clients receiving Department of Mental Health supported services. This sliding fee scale will be made available to all staff members and will be explained to all clients upon intake. (See Attachment B.)

- 1) The program and charge policy shall be determined annually by line item budgeting and shall be approved by the Governing Board prior to the beginning of each fiscal year.
 - 2) Income eligibility will be determined by and documented on the DMH Standard Means, and be a permanent part of a client record for clients receiving Department of Mental Health supported services.
- b. Each client will be encouraged to assume financial responsibility for his/her treatment. However, no one will be denied treatment due to inability to pay.
- c. The client fee schedule for 'private clients' shall be established annually and approved by the Board of Directors, and made available to staff and individuals being served.

13. Fee Payment Policy & Procedures

- a. Payment for service is due at the time service is rendered, and this policy shall be posted in the reception area of all offices. Clients will be encouraged to pay on a per-session basis to prevent creation of burdensome debts, unhealthy facility use, or client self-termination because of cost. A formal statement shall be mailed at the end of each month to those clients who do not wish or are unable to pay at the time service is delivered.
- b. Clients must pay their fees according to their fee schedule by one the following means:
 - 1) Payment on a per-session basis following each session.
 - 2) Mailing fees in by check during the week following a session.
- c. If a client is unable to pay, and in order to receive financial

assistance, the client will be required to sign the Department of Mental Health's Standard Means Test Financial Questionnaire.

- d. Credit arrangements may be made for payment of fees. A client may open an account by indicating to the Primary Counselor or Executive Director of his/her needed arrangement.

The client will be given a copy of the monthly payment schedule.

- 1) Payment on accounts shall be made promptly each month on the outstanding balance, according to the following schedule:

Highest Balance	Monthly Payment
Under \$50	\$10
\$ 50-100	\$15
\$101-200	\$20
\$201-300	\$30
\$301-400	\$40
Over \$400	\$50

- 2) If a client terminates counseling, his/her account is to be paid in full within 90 days if the balance is under \$100, and within 120 days if the balance is over \$100 unless other arrangements are made.

14. Client Accounts Receivable

- a. Accounts Receivable shall be recorded on individual accounts and shall be reflected in the accounting system records. All accounts shall be reviewed annually by the Executive Director and Corporate Secretary/Treasurer.
- b. Discounts below cost for services are given only in accordance with the fee schedule policy.
- c. All bad debts may be written-off annually.
- d. All 'Accounts Receivable' shall be billed monthly. Clients who have unpaid accounts will be given repeated reminders and requests for payment in a courteous manner.

15. Accounts Receivable Ledger

- a. Receivable accounts shall be established and maintained when service fees are not collected upon service delivery. All accounts shall have a running receivable balance.
- b. Each transaction shall be dated and debited/credited to the appropriate account.
- c. Accounts established by a third party contract shall be posted monthly and billed monthly.
- d. Accounts established by individual clients shall be posted and billed monthly.
- e. All accounts not paid in sixty (60) days shall be considered delinquent and three (3) monthly bills denoting state of delinquency shall be mailed. All accounts not paid in one (1) year shall be designated as uncollectible and be written off.
- f. Receipt of accounts receivable shall be posted immediately to the appropriate account, and shall reflect receipt number, if a receipt is available.

16. Payroll

- a. Payroll shall be maintained on all persons employed by the Agency and shall address: Position classification, tax deductions claimed, social security number, deductions by type and amount, date of promotion or termination, pay period, gross salary, and demographic data.
- b. The Corporate Secretary/Treasurer and the Chief Financial Officer shall be responsible for the overall maintenance of payroll.
- c. Employees will be required to submit a signed W-4 form for payroll purposes. The signed form shall be kept in each individual personnel file.
- d. Monthly time sheets shall be kept by support staff and part-time personnel and reviewed and signed by the designated supervisor. Activity reports shall reflect days worked, sick leave, vacation, holidays and leave-of-absences. Payroll shall be determined from this report and direct deposit prepared by the Chief Financial Officer or designee.

- e. Clinical monthly schedules will be kept in the Electronic Clinical Records system for all full-time clinical staff. The Accounting Assistant will review all vacation and sick leave for each full-time clinician. Clinical payroll is determined from an annualized wage. Additional payments for contract work that is submitted by check request and approved by the supervisor, by the 25th of each month, will be added to the clinician's wages before taxes. Any expenses (i.e. travel) will be added to the clinician's wages after taxes.
- f. Payroll tax deposits shall be current and in accordance with established procedures of the State and Federal Governments.

17. Third-Party Reimbursement

- a. This office shall file insurance claims at the end of each month for clients requesting this service and assistance shall be provided to those clients choosing to file their own claims.
 - 1) Insurance coverage will be assessed on each client at intake to determine third party payor benefits.
 - 2) Should a client have insurance, the Insurance Specialist or designee will contact the insurance company to pursue third party reimbursement status after securing the client's release form for said purpose.
- b. Invoicing to all third party contractors shall be done on a monthly basis to ensure a timely reimbursement.

18. Supportive Housing Funds

- a. The corporation is responsible for funds belonging to individuals served.
 - 1) Such funds shall be maintained in a bank account separate from the corporations' funds.
 - 2) Disbursements of funds will follow all policies and procedures for agency cash disbursements (D.8).
 - 3) Separate ledger accounts shall be maintained on each individual, documenting funds received and disbursements made on behalf of the individuals.
 - 4) Community support specialist are responsible for accessing

monies on behalf of their client and ensuring monies are used only for the purpose for which those funds were received.

- 5) The individual, or their legally appointed representative, shall have access to the records of their funds, and such funds shall be expended or invested only with the informed consent and approval of the individual, or their legally appointed representative.

SECTION: ADMINISTRATION

SUBJECT: RISK MANAGEMENT

SECTION NO. I

SUBJECT NO. 7

North Central Missouri Mental Health Center will engage in a coordinated set of activities that are designed to control threats to its people, property, income, goodwill and ability to accomplish agency goals. (See Risk Management Plan, Attachment D.) The agency will identify and manage risk procedurally and through insurance. Insurance policies will provide adequate amounts and types of coverage for all aspects of the agencies operations and protect and defend staff and board members, volunteers and persons served against reasonable claims due to adverse events for which the agency is liable. The types of coverage typically include worker's compensations, liability insurance, malpractice, property and casualty insurance as appropriate.

Reasonable efforts shall be made to protect the privacy of confidential information and the safety and security of consumers and employees. When identifying, analyzing and evaluating the reasonableness of the effort, various factors may be considered such as cost, level of risk, environmental considerations, legal considerations, amount of control of physical environment (i.e. leased building or need for extensive physical modifications), and consistency with the mission and values of the agency.

Potential risks may include, but are not limited to, changes in funding, new or growing populations, problems with the agencies facilities or grounds, newly identified security issues or internal procedures. Risk management is intended to reduce the severity of a risk if one were to occur, reduce the possibility of a risk, or how to rectify the identified risk.

For example: If a NCMMHC employee or volunteer is injured while on duty, the department director or designee shall ensure that an employee incident report is filled out and have the appropriate workers compensation form completed and sent to the Executive Director.

If an incident results in injury to an employee or consumer caused by the condition of agency property, the department director or designee shall immediately report the incident by telephone to the Executive Director and ensure that the appropriate incident report is filled out.

If loss by fire occurs at an agency site, the department director or designee shall send a copy of the fire department's report as well as an incident report to the Executive Director. If damage to a facility building is sufficiently damaged to prevent conducting normal service delivery, the Executive Director will determine the next available building belonging to NCMHHC that will become the temporary shelter for service delivery.

If loss occurs with an agency vehicle, the department director will submit an incident report along with a copy of the accident report to the Executive Director as soon as the accident report is available. Copies of the completed accident report shall be kept on file with the appropriate department personnel.

Workers' compensation may be provided to employees who suffer injury during the course of employment, subject to the determination by the appropriate staff. This includes injuries resulting from vehicular accidents in rental or personal vehicles when conducting official business in accordance with the provisions of the Missouri Workers' Compensation Law.

Sentinel Events will be reviewed quarterly by the Clinical Review Committee and will recommend performance improvement activities as needed. A sentinel event is an unexpected occurrence such as, involving death or serious physical or psychological injury, or the risk thereof.

Risk management will also be reviewed through agency procedures such as, annual reviews of the agency Goals and Objectives and the Equal Employment Opportunity Committee.

SECTION: ADMINISTRATION

SUBJECT: DISASTER PLANNING

SECTION NO. I

SUBJECT NO. 8

Definition: A major disaster is defined as any catastrophe which causes damage of sufficient severity and magnitude to warrant major disaster assistance in alleviating the damage, loss, hardship or suffering caused by the disaster.

Disaster types: Different types of disasters include, hurricane, tornado, storm, high water, wind driven water, earthquake, volcanic eruption, landslide, mudslide, snowstorm drought, fire, flood, explosion, airplane crashes, or major chemical leaks. (See Attachments F, G, H, I, J, K and L)

Disasters differ in characteristic such as: Origin of disaster (natural versus human caused), length of warning time, intensity of the event, extent of property damage, number of persons impacted, number of injuries and/or deaths, and the dynamics of the recovery period.

Each disaster has its own unique pattern on destruction. Flood disasters can result in long incident periods and the evacuation of whole communities. Earthquakes strike without warning and after shocks intensify fright and despair. Tornadoes randomly choose their victims, skipping one house and striking the next.

Disasters may be classified as either natural or human-caused. Disaster survivors of human caused disasters may blame and feel anger toward individuals, groups, or organizations they believe caused or contributed to the disaster. Survivors of natural disasters may blame and feel anger toward themselves, believe it is "God's will" or a punishment and may project their anger onto caretakers, disaster workers or others.

Disaster counseling will begin with establishing lines of authority and communication. Work will be focused on generating contracts with various providers, formulating various memoranda of understanding, establishing reporting requirements

and forms, developing an agenda for initial training and scheduling meetings to coordinate and monitor the counseling program. The program will be identified with a name, such as “Project Recovery” that is separate and distinct from the mental health program that identifies workers and staff. Workers will integrate activities with other community responders who are characterized by networking with community groups and local, state and federal organizations.

Disaster counseling projects will establish referrals to resources such as Voc-Rehab for retraining those forced out of work. Staff will refer disaster survivors with ongoing needs to other resources in the community.

CRISIS COUNSELING

Crisis counseling provides short term interventions (less than one year) with individuals and groups, helping people to understand their current situation and reactions, assisting in the review of their options, provide emotional support and encouraging linkage with other resources and agencies who may assist. It is best to view disaster crisis counseling as assisting persons with a process of coping rather than seeing them through to some predetermined outcome (regular counseling).

Crisis counseling may begin with immediate services then move the client into regular services. The goal of crisis counseling is to help the individual resume a productive and fulfilling life following the disaster experience.

DISASTER CRISIS COUNSELING

Disaster crisis counseling will address incident specific stress reactions rather than ongoing mental health needs. The emphasis is on serving individuals, families and groups of people, all of whom share a devastating event.

Disaster counselors will work hand in hand with paraprofessionals, volunteers, community leaders and survivors/victims of the disasters.

REGULAR SERVICES

Regular services include counseling services, case management, psychiatric services, crisis intervention, community outreach, consultation and education will be offered as needed.

PUBLIC INFORMATION

Public information may be provided through printed materials in different languages, local radio, churches, schools, facilities, agencies, organizations and groups already known to the local public. Inter-agency collaboration is expected in crisis situations. Contact to all local television, radio stations and print media regarding updates and contact information will be made by the Executive Director or designee.

OUTREACH TO RURAL AREAS

Outreach is conducted door-to-door and services may be provided at locations convenient for the crisis victim(s). Networking should be done with the local churches, schools, senior citizen centers, Meals on Wheels programs, university extension services, fire, police, agricultural networks, Lions club, Masons, insurance companies, and any other group that can offer a strategy of service delivery.

Rural isolation creates difficulty getting into town, getting children to school, and perhaps obtaining food and medical care. Consequently, support groups, educational events, case management and other services may have to take place at the disaster survivor's home rather than at an office. People who do not have a telephone may be difficult to contact if there is not a neighbor or family member close by to relay information.

DEBRIEFINGS

Debriefings are offered within 72 hours following traumatic emergencies to provide support to personnel and clients served. Debriefings may include crisis or grief counseling when needed. Critical incidents will be documented according to the Incident report procedure.

The Clinical Director will review each incident report and will instruct the clinicians involved in the traumatic emergency to debrief (be provided emotional support) with their immediate supervisor (or designee) no later than the assigned target date on the Core Competency QA Incident Reporting form. The supervisors will contact their clinician(s) involved in the incident to ensure the debriefing is scheduled and occurs. The supervisors (or designee) will ensure the debriefing is documented on a supervision form and will copy the supervision form with the documented debriefing to the Clinical

Director.

EMERGENCY OFFICE CLOSING

Emergency office closing may occur for situations such as blizzards, ice storms and snowstorms.

SECTION: ADMINISTRATION

SUBJECT: PERSONNEL POLICIES

SECTION NO. I

SUBJECT NO. 9

- A. Equal Opportunity Employment: North Central Missouri Mental Health Center is an Equal Opportunity Employer and ensures equal employment opportunity through non-discriminatory practices by complying with state and federal regulations regarding employment, compensation, assignment of work, and promotion.
- B. Reasonable accommodations shall be made for persons with physical or mental impairment who are applicants and employees capable of performing the essential duties of their positions.
 - 1. An employee designated by the Executive Director shall serve as the Chairman for the Equal Employment Opportunity Committee.
 - a. The committee shall be comprised, as a minimum, of two (2) additional employees and at least one physically or mentally impaired person, whether or not an employee.
 - b. The committee shall assess the following areas on an annual basis: employment practices, reasonable accommodations, employment criteria, pre-employment inquiry, and service accessibility in regard to the Americans with Disabilities Act and federal Equal Employment Opportunity regulations.
 - c. These five (5) aforementioned areas shall be assessed to determine whether policies or practices conform to federal regulations.
 - d. The committee shall propose to the Management Team any appropriate modification and remedial steps to address any potential discrimination.
- C. A Human Rights Assurance shall be filed with the Missouri Department of Mental Health.

1. The Vice-President of the Board of Directors shall be the Equal Opportunity Officer.

D. Staff Recruitment

1. Employees shall be notified of vacancies by posting of said vacancies.
2. First consideration shall be given to current employees. If a position remains unfilled, then openings may be advertised in the newspaper.
3. Advertisements for employment shall contain the phrase: "Equal Employment Employer – Male, Female, Impaired, Veteran". Employment advertisements shall be sent to the local office of the Missouri Division of Employment Security.
4. Applications shall be received in writing on agency application forms or via personal resume.
5. Application forms shall document this agency's policy on Equal Opportunity Employment.

E. Staff Selection

1. Program Directors and their teams shall serve as the Personnel Selection Committee for positions supervised by said Director/Supervisor, subject to the Executive Director's approval. Selection of the Executive Director position shall be made by the Governing Board's 'Personnel Committee' and final selection will be made subject to Board of Directors' approval.
2. Personnel shall be selected for employment upon verification of their applications, training, qualifications, experience, references, credentials, licensure, certification, registration, and the interview. All credentials will be verified with primary sources within 90 days. In the event that credentials cannot be verified, continued employment can be contingent upon positive verification for some positions. However, the agency will make the determination of when this should occur.
3. Personnel shall meet any local, state, or federal requirements for his/her profession.
4. Consistent fair practices shall be utilized in determining qualifications for hiring and termination of staff. An individual having or not having had a past problem with alcohol and/or drugs will not be the sole factor in denying employment.

5. Personnel shall be employed in sufficient qualified numbers to support the functions of the agency, i.e., service delivery to maximize annual contracts. Efforts shall be made to employ adequate staff within budgetary limits.
 6. The agency will maintain personnel policies, procedures and practices that comply with federal, state and local law/regulations and contain job descriptions. All personnel policies and practices apply to all employees and volunteers working under the supervision of employees.
 7. The 'Personnel Handbook' distributed to employees during orientation shall be considered as part of the Policy and Procedure Manual.
- F. Criminal background checks and inquiries shall be initiated prior to the employee, practicum student or volunteer having contact with clients.
1. Background screenings with the Missouri State Highway Patrol are initiated within two (2) working days of beginning employment. A private investigatory agency may be used to conduct this review.
 2. An inquiry with the Department of Health and Senior Services to determine whether the new employee or volunteer having contact with clients is listed on the employee disqualification list of the Department of Social Services or the Department of Health and Senior Services.
 3. An inquiry with the Department of Mental Health to determine whether the new employee or volunteer is on the DMH disqualification registry.
 4. In the event that a background check or credential cannot be verified, the staff person's continued employment will be contingent upon positive verification.
- G. Staff Promotions
1. Persons currently on staff shall be made aware of promotional opportunity within the agency, should such an opportunity arise. Staff shall be informed verbally, by memo, or through staff minutes.
 2. Qualified staff shall be encouraged to apply for any existing vacancy, and may do so by submitting a letter of intent to apply.
 3. In the case of newly created positions, staff may be required to comply with regular application procedures.

H. Employee Termination

1. Major offenses may require legal action regarding investigation and reporting to the proper authorities such as local law enforcement and/or licensing agencies. Major offenses which are subject to disciplinary action, and may result in termination, include, but are not limited to:
 - a. Physical or mental abuse of patients.
 - b. Possession/use of intoxicating substances or drugs while on duty.
 - c. Possession of a weapon.
 - d. Theft.
 - e. Gross negligence.
 - f. Insubordination.
 - g. Any crime.
 - h. A breach of client confidentiality.
2. Minor offenses will be handled under a progressive disciplinary procedure. Minor offenses will include, but are not limited to:
 - a. Failure to follow instructions.
 - b. Leaving the job without permission.
 - c. Safety rule violation.
 - d. Profane or abusive language.
 - e. Gambling.
 - f. Excessive absenteeism or tardiness.
 - g. Failure to maintain an acceptable work standard.

I. Employee Resignation

1. To resign in good standing, an employee must:
 - a. Submit his/her notice in writing ten (10) working days in advance. Waiver of this notice may be given by the Executive Director under unusual circumstances. Resignation without written notice or waiver by any employee will be grounds for forfeiture of accrued vacation time. Vacation time cannot be considered as notice of termination of employment.
 - b. Ensure all paperwork and documentation is completed.
 - c. Complete an exit interview with his/her supervisor and the Executive Assistant.

J. Organizational Operations of Staff Positions

1. An organizational chart that identifies each position shall outline how staff is supervised. (See Attachment C.)
2. Each staff person, student, or volunteer shall be assigned to one supervisor. The role of a supervisor is to focus on the employee's job performance.

K. Employee Performance Evaluations

1. Each staff person will receive a copy of their job description at the time of their annual performance evaluation that will be signed and returned to the Human Resources department. Performance evaluations will include job functions and competencies. Job performance evaluations will assess performance related to the objectives established in the previous evaluation period and will reflect measurable performance objectives for the next year.

Contracted employees will have a documented assessment annually for performance of their contracts to ensure that they follow all applicable policies and procedures and to ensure that they conform to CARF standards as applicable to the services they provide.

2. Supervisors shall provide monthly feedback to supervisees with regard to job responsibilities and performance expectations. Clinical supervision of direct staff, including volunteers, trainees, interns and contractors, will assure adequate oversight and guidance. The provision of feedback will be designed to enhance the clinical skills of the direct service staff.
3. Additional supervision and oversight of case handling, including dealing with unplanned absences of direct care staff, will occur during regular staff meetings conducted by the Clinical Director with all supervisees.
4. A written job performance evaluation shall be conducted in collaboration with the direct supervisor and input from the staff being evaluated six months after hire date and annually on each employee.
 - a. The written evaluation shall include:
 - 1) An assessment of performance related to objectives established in the last evaluation period;
 - 2) Measurable performance-based objectives for the next year;
 - 3) Essential and non-essential job functions when applicable;

- 4) An annual review of all contract personnel will assess performance of their contract to ensure that they follow all applicable policies and procedures of the agency.
- b. Each employee will conjointly review his/her job performance evaluation with the immediate supervisor.
- c. The Executive Director shall, and the Board of Directors may, review all job performance evaluations.
- d. When financially feasible, salary increases will be awarded based on performance outcomes.

L. Quality of Treatment Services

1. The Agency shall provide counseling by qualified professionals and/or staff supervised by qualified professionals.
 - a. Supervisors shall be responsible for monitoring supervisee's knowledge and demonstrated skills of mental health treatment services.
 - b. Supervisors shall sign off on all written documentation for "Counselor Trainees".
 - c. Qualified staff shall provide mental health counseling services to include individual, group, and family therapy; vocational, educational, and recreational therapy; peer support; and self-help groups.

M. Clinical Privileges

1. Each treatment discipline, which provides services by assisting in the treatment and rehabilitation of clients, shall define specific required criteria for clinical privileges. (See Clinical Privileges Application for specific criteria.)
2. A new employee must apply for clinical privileges and provide required documentation for review by the Board of Directors who will award the clinical privileges.
3. The application for privileges, documentation, and letter from the Board of Directors will be placed in the employee's personnel file.

N. Productivity Standards for Clinical Staff

1. Agency policy requires each employee to maintain an acceptable work

standard. Both the quality and quantity of work are viewed as performance indicators for clinical staff in order to assess an acceptable work standard. (Reference: Continuous Quality Improvement, Section V). One of the methods for measuring quantity of work is through productivity reports that are measured at the end of each month. The productivity standard for clinicians in each program is 100%.

O. Hiring Procedures for Clinical Staff

1. Clinical staff is defined as employees who provide direct care to clients, which includes, but is not limited to, treatment and rehabilitation services.

Clinical Employees:

- Each clinician is expected to maintain 100% production every month, with a minimum of 90%, including full-time and part-time employees.
- If an employee falls below the 90% minimum in any month, a Record of Verbal Counseling shall be placed in the employee's personnel file.
- Upon three (3) consecutive months of an employee falling below the 90% minimum, a First Written Warning shall be placed in the employee's personnel file. The written warning shall include an Action Plan with specific areas of concern defined. In addition, the immediate supervisor, with the Executive Director's approval, may elect to change the employee's pay status to that of a per-billable reimbursement rate. The rate of reimbursement for services will be the employee's annualized gross salary prorated on an hourly rate times the number of billed services, approved by the supervisor and submitted per payroll period deadlines.
- Repeated failure to meet the 90% minimum may result in termination of employment.

Part-time Clinical Employees:

- An hourly rate of pay will be reimbursed for each one (1) hour billable unit.
- The agency's benefit package will be limited to FICA, Missouri Employment Contribution, Workers' Compensation and mileage.

Contract Clinical Employees:

- A rate of pay for contract services will be reimbursed per individual

contract agreement.

- The agency's benefit package does not apply to contract employees.

Clinical Practicum Students:

- When financially feasible, students will receive a monthly stipend.
- The agency's benefit package does not apply to practicum students.

1. Utilization of Practicum Students

- a. If utilized, a practicum/intern student must be enrolled and participating in an accredited college/university, enrolled in a field of study including, but not limited to, social work, psychology, sociology, or nursing.

- 1) The agency and student must have a written plan documenting:

- a) The name of the individual, educational institution, and degree program;
- b) Description of the status of the individual with respect to degree completion;
- c) Description of the specific job status of the individual with respect to agency program and client population;
- d) Specific plan for supervision of the student, including name and title of the direct supervisor; and
- e) List of the specific Purchase of Service (POS) services the agency has approved for the student to deliver.

- b. The student must have a letter from their academic advisor attesting to their qualifications and eligibility for the proposed practicum.
- c. The student must be under the close supervision of the Clinical Director of the agency. The person providing the supervision must be qualified to provide the services they are supervising.

- 1) To provide counseling services, a student must be in a master's program or above and be approved for the practicum by the college/university.
 - 2) To provide case management and community support work and other support services, a student must be in the final year of a bachelor's program or above.
 - 3) A student may be assigned a limited caseload based on background and prior experience.
- d. A student must be background screened, oriented and trained as consistent with the agency's policies and procedures.
 - e. Service delivery by the student must be documented according to Department of Mental Health standards and policy.
 - 1) All documentation of billable services must be reviewed and countersigned by an individual who meets the Division criteria for a QMHP or supervisor of counselors, or community support specialist, as appropriate.
 - 2) Services shall be billed using appropriate existing codes and reimbursed at the established contract rate for the anticipated degree, unless a distinct student rate has been established for the service.
2. As practicum students are utilized within the Agency, procedures on screening, training, supervision, and cause for dismissal shall be implemented for all program components.
 - a. Practicum Student Screening and Selection
 - 1) Program Directors/Supervisors shall screen written application forms and invite qualified candidates for an interview.

- 2) Practicum students shall be selected on the basis of their application, qualifications, experience, references, and interview.
- 3) A personnel file shall be maintained on every practicum student.
- 4) Personnel policies and procedures apply to all practicum students.

b. Training of Practicum students

- 1) Practicum students shall receive training on program orientation as needed and assessed by their designated supervisor that includes duties, responsibilities, client confidentiality and supervision.
- 2) Practicum students may receive inservice training as needed and assessed by their designated supervisor.

c. Supervision of Practicum students

- 1) Each practicum student shall have one immediate supervisor as appointed by the Program Director/Supervisor.
- 2) An annual review of performance shall be conducted by each practicum student's immediate supervisor and shall be documented by letter and maintained in the personnel file.

d. Cause for Dismissal

- 1) Practicum students may be terminated in accordance with the policies and procedures of Employee Termination.
- 2) Practicum students may be terminated when they have fulfilled a specific need for services during a 'Time-Limited' period.

P. Professional Growth and Development

1. The agency promotes professional growth and development of all

personnel by providing orientation of new employees, along with inservice training, continuing education, and resource materials. Orientation of staff varies throughout the agency. In some areas, orientation consists of self-study, didactic and on-the-job orientation; others give a basic overview and immediately pair up the new employee with a more experienced employee. The new employee may be rotated among several other employees for their orientation and on-the-job training; and still other areas assign responsibility for training to the staff supervisor who uses his/her own methods. Orientation will be consistent within departments in an effort to positively affect turnover and retention and to assist new staff to feel prepared for the responsibilities of their position.

- a. Orientation of New Employees. New employees shall be given orientation training as outlined in the orientation manual which includes but is not limited to:
 - 1) Familiarization of program structure, policies and procedures.
 - 2) Job responsibilities, reporting and management procedures.
 - 3) Client intake and record maintenance.
 - 4) Area Resources.
 - 5) Orientation may include site visits to area treatment facilities, satellite offices, and visits to referral sources.
 - 6) New employees during the introductory period will be eligible for workshops and seminars at the discretion of the immediate supervisor.
 - 7) Each community support specialist or clinical supervisor will complete ten (10) hours of initial training before receiving an assigned client caseload or supervisory caseload.
- b. Inservice Training/Staff Meetings
 - 1) Two (2) hours of staff inservice shall be provided each month, or as time is available. All staff shall participate in at least 36 clock hours of relevant training during a two (2) year period. All staff working within the CPR program shall receive a minimum of 12 clock hours per year of continuing

education and relevant training.

- 2) Inservice education/training may be conducted on or off the premises, or online, and may involve all or part of the staff at a given time.

Q. Training and Staff Development

1. Agency employees shall be provided a comprehensive training program that is designed to promote professionalism consistent with operational practices and accomplishment of the agency's mission and goals.
2. Clinical training outcomes will be reviewed to ensure that staff members new to a program are adequately trained prior to providing direct clinical services. Clinical staff training is intended to build clinical skills to the point where the staff is able to assist clients served in accomplishing client treatment outcomes. Clinical skills and competencies will be assessed at least annually. Resources and additional training will be provided as needed to maintain competency and for continued learning and development. The type of training will vary depending on the nature of the clinical services provided.
3. Tenured employees should keep apprised of their profession through continuing education. Through the establishment of training guidelines, all employees will have opportunity for professional staff development.

R. Procedure

1. The Program Director/Supervisor shall ensure that all employee training needs are addressed through the provision of a variety of programs and training modules.
 - a. Training – Program Director/Supervisor shall ensure that each employee receives the required annual training, and that it is properly documented.
 - b. Training File – "If it is not documented, it did not happen." All training received, including areas covered, must be thoroughly documented. The training file will be included in the employee's personnel file. Training files should include:
 - 1) Date of the employee's hire.
 - 2) Dates, duration, times, topics of training, instructor, and the

number of training hours completed.

- 3) Skills targeted/objective of skill.
 - 4) Copy of all certificates/continuing education units issued.
 - 5) Location of training.
 - 6) Copies of all requests for additional training or education.
 - 7) Copies of all transcripts and/or documentation issued for all inservice (formal) training completed.
- c. It shall be the responsibility of the program Director/Supervisor to thoroughly document each training section.
- d. This documentation shall be available to the following personnel:
- 1) The individual employee.
 - 2) The employee's immediate supervisor.
 - 3) The Executive Director.
 - 4) The contact liaison and program evaluators.
 - 5) The Executive Assistant.

2. Employee Orientation

- a. Within the first thirty (30) days of employment, all employees and volunteers who have direct contact with clients shall participate in an orientation training program provided by the Agency. Employees new to the clinical service delivery system will complete training prior to the delivery of services, and throughout their employment, to ensure that they are familiar with the unique procedures and characteristics of the environment in which they work. The orientation training program shall include, but not be limited to:
- 1) The Agency's approach to treatment including philosophy, goals and methods.
 - 2) The employee's specific job description and role in relationships to other staff.
 - 3) Emergency preparedness plan and all safety related policies and procedures.
 - 4) Client rights and confidentiality including a review of 42 CFR, Part 2 and definitions of client abuse and neglect.

- 5) Procedures for involuntary civil detention, as applicable.
- 6) Personnel policies and procedures.
- 7) The proper documentation of services in client records.
- 8) Quality Assurance Plan.
- 9) Admission procedures and screening.

3. Inservice

- a. Inservice training may occur following revisions to policies and procedures, during time of high turnover, or when new programs are added or new populations are served. The level of training provided to staff may vary depending on the staff's position in the agency. For example, clinical staff may receive comprehensive training while support staff may simply be trained in the meaning of person- and family-centered services and how that fits with the mission of the agency.
- b. Interdisciplinary cross-training will include staff members providing specialized services (i.e., forensic) providing training to other clinical staff and also for clinical staff to provide training to the staff involved in specialized services.
- c. All employees may participate in service related formal initial and annual training. All clinicians shall participate in a minimum of eighteen (18) hours of service related annual training, and/or continuing education per year, exclusive of orientation. Staff providing services or responsible for supervision of persons served are to have at least eighteen (18) hours of training each year.
 - 1) Initial and ongoing training will include at a minimum:
 - a. Client rights;
 - b. Person- and family-centered services;
 - 1) Person- and family-centered services are based on the strengths, needs, abilities, preferences, desired outcomes and cultural background of the person or families served. The treatment plan is developed with the input of the person and/or families served. Person-and family-centered

services are a way of identifying what people want to achieve and what kind of supports they need to reach those goals, hopes or dreams. The process considers the needs and goals of the person or family served, and develops or directs those services to be provided in a manner that reflects and responds to those needs and goals.

- c. The prevention of workplace violence where staff are trained in the prevention and safe management of violence, aggression, and other unsafe behaviors;
 - d. Confidentiality requirements;
 - e. Cultural competency in working with ethnically or otherwise diverse populations. Cultural competency includes recognizing any unique aspects of the persons served. (See Attachment E.) Cultural competency includes:
 - 1) Language; dress; traditions; notions of modesty; eye contact; health values; help-seeking behaviors; work ethics; spiritual values; attitudes regarding treatment of mental illness and substance use; concept of status; and issues of privacy and personal boundaries.
 - f. Expectations regarding professional conduct and business ethics that may include:
 - 1) Expectations regarding non-discrimination or sexual harassment
 - 2) Reporting abuse or misconduct
 - 3) Community education
 - 4) Reduction of stigma
 - 5) Advocacy
- 2) Employees attending inservice training shall be required to sign a Staff Attendance Roster that will be used to document their participation in their training at its conclusion.

4. Outside Training/Continuing Education

- a. Employees may attend appropriate outside training sessions that reflect the specific needs of the clients served. Training must be approved by both the supervisor and the Executive Director. A Training Request Form must be completed by the employee requesting training and include the name of the training, date(s), and estimated costs. The form must then be submitted to the supervisor for approval/disapproval and routed to the Executive Director.
- b. Employees shall be required to submit proof of attendance at the outside training event. This documentation shall be maintained in the employee's personnel file.
- c. A trainee shall have a written individualized training plan designed to increase knowledge and skills. The training plan shall be a part of the employee's performance appraisal.
 - 1) The plan shall be signed by the supervisor and trainee.
 - 2) The plan shall be reviewed and updated to ensure the necessary competencies are established and demonstrated.
 - 3) The plan shall include specific education and training to develop further knowledge, appropriate to their position in the agency. There shall be documentation of education and training completed.
- d. Trainees may perform, under close supervision, only those functions specified in their training plans.
- e. Other staff members will not perform counselor functions unless:
 - 1) Functions performed are limited to screening detoxification admission, intake, orientation, education, referral and record keeping.
 - 2) The staff member has training or experience in each function performed.
 - 3) Functions performed are consistent with the job description.
 - 4) A qualified employee supervises the performance of functions by reviewing and countersigning documentation of

screening and referrals.

5. Annual Training Plan

a. The Program Director/supervisor shall convene a committee each year to identify an annual training plan for the Agency employees, which will assist staff in meeting the needs of persons served. The training plan and accomplishments of the previous year will be reviewed. The committee's written plan shall be forwarded to the Executive Director for review and approval, and will reflect inservice trainings.

1) The annual training plan shall include monthly identification of inservice training to be provided, date and length of training and the instructor.

2) The annual training plan shall ensure that staff has an opportunity to participate in the required clock hours of inservice training.

6. Other Staff Training

a. Staff training for those who do not provide clinical services to clients shall be given inservice training on a quarterly basis in topics related to their job functions, i.e., emergency procedures, handling the resistant client, paperwork requirements, medical interventions, rules and regulations, etc. Such training will be no less than 1-2 hours per quarter. All staff members are offered training in CPR and First Aid.

b. Inservice education/training may be a resource person from either inside or outside the agency.

c. Inservice/staff meetings shall be recorded and maintained in personnel files.

7. Continuing Education

a. Staff shall be recommended to participate up to eighteen (18) hours of continuing education/workshops each year on agency time and expense as the budget permits.

b. The Agency will support continuing education applicable to staff job descriptions.

8. Reference Materials

- a. Staff shall be made aware of and acquainted with the professional resource materials at North Central Missouri Mental Health Center.
- b. The Program Director/Supervisors shall be in charge of staff training by recommending and approving requests for training, workshops, and seminars outside of the agency, and by planning and scheduling staff meetings, and inservice education programs with input from immediate supervisors.
- c. Staff is encouraged to plan for their own professional growth and development by submitting a written self-assessment of training needs to the immediate supervisor and to the Executive Assistant annually. A training plan will be developed from the self-assessment.
- d. Each plan for professional growth and development along with the plan shall be reviewed annually by staff and subsequently revised to reflect changing needs.
- e. Each plan shall be approved by the Executive Director and the appropriate Program Director/Supervisor.

9. Salary Schedule

- a. Employees shall be paid at a rate no lower than the Federal minimum wage.
- b. Annual salaries shall be reviewed and set by action of the Board of Directors prior to the beginning of each fiscal year.
- c. Employees may make requests for salary increases to their immediate supervisors.

10. Records and Payroll

- a. A personnel file shall be kept on each employee containing:
 - 1) Histories/Resumes, Vitae
 - 2) Evaluations
 - 3) Time and attendance reports on hourly employees only
 - 4) Sick leave and vacation time (maintained in payroll ledger)
 - 5) Disciplinary actions
 - 6) Payroll information (kept in payroll ledger)

- 7) Physician statement on freedom from communicable disease (kept in separate medical file; for PSR staff only)
 - 8) Confirmation of Clinical Privileges
 - 9) Training and staff development records.
 - 10) Verification of credentials including certification, licensure, or registration when applicable
 - 11) Evidence of orientation.
 - 12) Background checks.
- b. Personnel files shall be accessible only to the Executive Director, Executive Assistant, President of the Board of Directors, Auditors, State or Federal Examiners, or employees designated by the Executive Director.

11. Expense Accounts

- a. Employees shall be reimbursed, as funds are available, for authorized business mileage at the agency's current mileage reimbursement rate.
- b. Employees may be reimbursed for approved work-related tuition, workshops, seminars, business trips and related mileage.
- c. Travel, motel and meal costs shall be documented on standard expense sheets and shall be submitted along with receipts of expenses by the 10th of the month to be included with mid-month checks and by the 25th of the month to be included in payroll.
 - 1) Meal allowances shall not exceed \$20.00 per day (reimbursed only if staff member is outside the nine-county service area).
 - 2) Motel expenses shall not exceed \$80.00 per single room or \$100.00 per double room per day.
 - 3) Mileage will not exceed 200 miles one way or 400 miles round trip without special approval by the Executive Director.
 - 4) Verification of expenses will be required, and costs that appear excessive may be cause for disciplinary action.
- d. If an advance of a planned expenditure is felt necessary, a request for it must be submitted in writing and approved by the Executive

Director.

12. Employed Clients

- e. Any wages paid to a client for work in a program unrelated to their treatment shall be in compliance with local, state, and/or federal requirements for minimum wage.
- f. Utilization of Volunteers
 - 1) As volunteers are utilized within the Agency, procedures on recruitment, screening, training, supervision, and cause for dismissal shall be implemented for all program components.
 - a) Volunteers will be recruited under the same policy and procedures as staff with regard to Equal Opportunity Employment.
 - 2) Openings may be advertised in the newspaper and/or individuals may be solicited to meet a specific need for services.
 - 3) Advertisements for volunteers shall contain the phrase: "Equal Opportunity Employer – Male, Female, Impaired, Veteran."
 - 4) Applications shall be received in writing on Agency application forms or via personal resume.
- g. Volunteer Screening and Selection
 - 1) Program Directors/Supervisors shall screen written application forms and invite qualified candidates for an interview.
 - 2) Volunteers shall be selected on the basis of their application, qualifications, experience, references, and interview.
 - 3) Volunteers selected shall obtain documentation that they are free from communicable disease.
 - 4) A personnel file shall be maintained on every volunteer that includes a background check.
 - 5) Personnel policies and procedures apply to all volunteers.
- h. Training of Volunteers
 - 1) Volunteers shall receive training on program orientation as

needed and assessed by their designated supervisor that will identify their duties, responsibilities, and supervision.

2) Volunteers may receive inservice training as needed and assessed by their designated supervisor.

i. Supervision of Volunteers

3) Each volunteer shall have one immediate supervisor as appointed by the Program Director/Supervisor.

4) An annual review of performance shall be conducted by each volunteer's immediate supervisor that shall be documented by letter and maintained in the personnel file.

j. Cause for Dismissal

1) Volunteers may be terminated in accordance with the policies and procedures of Employee Termination.

2) Volunteers may be terminated when they have fulfilled a specific need for services during a 'Time-Limited' period.

13. Review of Personnel Policies

a. Staff shall be involved in the initial formation of the above policies and procedures by:

1) A review of comments sent to the Executive Director.

2) Staff recommendations for change submitted in writing to the Board of Directors or President.

3) Personnel policies shall be reviewed by the staff and the Board of Directors annually.

4) New policies may be added after review by the staff and approved by the Board of Directors.

b. Staff shall have access to the Policy and Procedure Manual at all times.

c. The Policy and Procedure Manual shall be made available to others on request.

d. The 'Personnel Handbook' is considered a part of the Policy and Procedure Manual.

SECTION: ADMINISTRATION

SUBJECT: INFECTION CONTROL

SECTION NO. I

SUBJECT NO. 10

A. It is the philosophy of this agency that any client receiving services will be treated with dignity and respect regardless of the possibility that a client has contracted a condition through blood-borne pathogens.

1. Clients can and will benefit from continued participation in services, and there is no reason to exclude him/her from services unless the client's presence does disrupt efficient operation.
2. Incomplete and/or misinformation may generate fears among clients and staff, which will be handled through professional example.

B. It is the philosophy of this agency that all clients are considered to be at risk for HIV or hepatitis.

1. During the intake process, clients are asked if they have been tested for HIV or hepatitis, results of said testing, and if the client has been involved in risk taking behavior since the last test. A re-test of HIV will be encouraged for clients engaging in risk taking behavior.
2. Clients will routinely be given a list of clinics that conduct free HIV testing.

C. Management of Exposure

If an employee has a parenteral (e.g. needle stick or cut) or mucous membrane exposure to blood or other body fluids or has a cutaneous exposure involving large amounts of blood or prolonged contact with blood (especially dermatitis), an incident report should be filed and the source individual should be informed of the incident and tested for serologic evidence of HIV and hepatitis infection after consent is obtained. The public Health Department should be consulted for testing source individuals in situations in which consent cannot be obtained (e.g. an unconscious person). Human bites that puncture will be evaluated on a case-by-case basis.

If the source individual has AIDS, is positive for HIV/hepatitis antibody, or refuses the test, the employee should be counseled regarding the risk of infection and

evaluated clinically and serologically for evidence of HIV/hepatitis infection as soon as possible after the exposure. The employee should be advised to report and seek medical evaluation for any acute febrile illness that occurs within twelve (12) weeks after the exposure. Such an illness, particularly one characterized by fever, rash, or lymphadenopathy, may be indicative of recent HIV/hepatitis infection. Seronegative employees should be retested six (6) weeks post exposure and on a periodic basis thereafter (6 weeks, 3 months, 6 months, 12 months and 24 months, or as recommended by the U. S. Public Health Service) to determine whether transmission has occurred. During this follow-up period (especially the first 6-12 weeks after exposure, when most infected persons are expected to seroconvert) exposed employees should follow U.S. Public Health Service (PHS) recommendations for preventing transmission of HIV and hepatitis.

No further follow-up of an employee exposed to infection as described above is necessary if the source individual is seronegative unless the source person is at high risk of HIV/hepatitis infection. In the latter case, a subsequent (e.g. 12 weeks following exposure) may be obtained from the individual for antibody testing. If the source person cannot be identified, decisions regarding appropriate follow-up should be individualized. Serologic testing should be available to all individual workers who are concerned that they may have been infected with HIV or hepatitis. If an individual has a parenteral or mucous-membrane exposure to blood or other body fluids of an employee, the individual should be informed of the incident, and the same procedure outlined above for management of exposure should be followed for both the source employee and the exposed person.

Reportable diseases, conditions, or findings (see 19CSR 20-20.020) shall be reported to the local health authority or to the Department of Health and Senior Services immediately upon knowledge or suspicion by telephone, facsimile or other rapid communication.

SECTION: ADMINISTRATION

**SUBJECT: MANDATORY CHILD
ABUSE REPORTING**

SECTION NO. I

SUBJECT NO. 11

- A. Any staff member of NCMMHC who has "reasonable cause to suspect" that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect shall immediately notify their supervisor and the Executive Director.
- B. The Executive Director or designee shall be responsible for making an immediate report to the Division of Family Services.
- C. The staff member suspecting or detecting abuse shall also be responsible for ensuring that said report is made.
- D. The report shall be made orally by telephone to the child abuse/neglect hotline, **1-800-392-3738**. The Executive Director or designated staff member making the report will record the name of the DFS staff member taking the report, the time, and the date. The Division of Family Services does not require a written report.
- E. Staff members will not discuss a child abuse report or a child abuse investigation with other personnel or authorized DFS personnel unless authorized. Staff members will respond to inquiries about a child abuse report or investigation by referring inquiries to the Division of Family Services.

SECTION: ADMINISTRATION

**SUBJECT: INCIDENT / ACCIDENT
MANAGEMENT PROCEDURES**

SECTION NO. I

SUBJECT NO. 12

- A. NCMMHC staff shall respond to incidents/accidents involving clients, other staff members and/or visitors to assist with emergency procedures as needed. Permission must be obtained from involved persons prior to providing assistance whenever possible. All incidents, accidents, or procedural errors which cause harm or potential harm to clients, staff members, and/or visitors must be reported verbally to the supervisor within the same working day as the occurrence, and within twenty-four (24) hours in writing to the Executive Director or designee.
1. Examples include, but are not limited to:
 - a. Falls, burns, electric shock.
 - b. Error in client care procedures.
 - c. Errors in diagnostic or therapeutic procedures.
 - d. Failures to obtain informed consent from client.
 - e. Personal property loss or damage.
 - f. Accidents or injuries involving clients, staff members, or visitors.
 - g. Attempted or actual suicide.
 - h. Attempted or actual assault.
 - i. Abuse and/or neglect of a client.
 - j. Harassment or threats.
 - k. Death.
 - l. Homicide.
 - m. Physical restraint.
 - n. Client rights violation.
 - o. Elopement.
 2. Each staff member involved in, or witnessing an incident addressed by the policy will complete a written incident report within 24 hours of when the incident occurred or was discovered.
 - a. Each incident report will be completed and given to an available

secretary to type that same day. Once the report is typed, it must be signed by the appropriate staff member.

- b. The report will be given to the Executive Director for review and signature.
 - c. The Executive Director will review the report with the Clinical Director. Any actions taken will be described in writing and forwarded to the Department of Mental Health. Reports will then be kept separately in a locked file in the Executive Assistant's office.
 - d. The Clinical Review Committee will review all incident/accident reports on a quarterly basis.
- B. Staff shall provide basic life support (CPR and/or First Aid), and take any secondary steps such as calling an ambulance, and staff will identify and report all undesirable incidents, accidents, service delivery problems or situations which contain the potential for harm to clients, visitors, or staff, which might be the result of breach of duty by the responsible staff, the responsible unit, and/or the agency.
- C. Any staff witnessing or the first to arrive upon the scene of an accident, cardiac arrest, or injury must take steps to provide or assure provision of CPR and/or First Aid. If the staff member is not trained in CPR or First Aid, then he/she is to secure help from those so trained: first from staff or others present, or by calling local hospital emergency personnel for assistance.
- D. Immediately after the emergency, the staff person involved in an accident, witness to an accident, or first to arrive at the scene will first verbally report to his/her supervisor, and then complete the EMT – Community Event Report Form – ADA/CPS and route this form to the Executive Director or designee.
- E. Reporting procedures for all deaths, serious injuries, elopements and other serious incidents shall follow Department of Mental Health guidelines.

SECTION: ADMINISTRATION

SUBJECT: DEATH OF A CLIENT

SECTION NO. I

SUBJECT NO. 13

Death of a client is defined as a serious event by the Department of Mental Health. Upon learning of the death of a client receiving services, the director/designee of the Agency shall notify the Department of Mental Health within 24 hours. The appropriate DMH report form shall be completed and faxed to the appropriate division director.

A. Death on the premises

1. Administer cardiopulmonary resuscitation (CPR).
2. Call an ambulance for transport to the emergency room.
3. Once a physician pronounces the death, notify next of kin.
4. Notify the following immediately: Program Coordinator/Supervisor, Executive Director, and appropriate State of Missouri Contracting Division.
5. Review record to determine if death could have been anticipated.
6. Write discharge summary and close the record.

B. Death off the premises

1. When the death of a client or former client is known, review the record to determine if the death could have been anticipated.
2. Write notation on death.
3. If a current client, write discharge summary and close record.

C. Death from unnatural causes

1. Suicide
 - a. Review the clinical record to determine level of risk, including documentation of therapeutic activities/interventions; determine appropriateness of therapeutic efforts.
 - b. Cooperate with law enforcement authorities.
 - c. Provide psychological autopsy if requested by coroner.
 - d. Write discharge summary and close record.
2. Homicide of current or former client

- a. Review record for evidence of danger from others.
 - b. Evaluate effectiveness of therapeutic activities and adequacy of actions.
 - c. Write discharge summary and close record.
3. Homicide committed by current or former client
- a. Review record to determine the adequacy of the documentation on level of danger to others.
 - b. Evaluate adequacy of actions taken, if any.
 - c. Cooperate with law enforcement authorities.
 - d. Write discharge summary and close record, if necessary.

SECTION: ADMINISTRATION

SUBJECT: CODE OF ETHICS

SECTION NO. I

SUBJECT NO. 14

NCMMHC identifies, develops and documents its required ethical practices and values. NCMMHC has an Ethics Task Force process to follow-up, investigate and address all allegations of violations of ethical conduct and allegations of infringements of the rights of the persons served. The ethics violation complaint will be given to the Executive Director, who will decide which department director to work with regarding the composition of the Task Force. The Task Force will investigate the ethics complaint and copy its report, with recommendations for follow-up, to the Executive Director.

Each employee is encouraged to adhere to the following Code of Ethics:

1. The employee shall conduct him/herself in a manner that is in the best interest of the public health, safety or welfare;
2. The employee shall be able to justify all services rendered to clients as necessary for diagnostic or therapeutic purposes;
3. The employee shall practice only within the competency areas for which they are qualified by training and/or experience;
4. The employee shall report to their supervisor or Executive Director known or suspected violations of the laws and regulations governing the practice of professional counselors;
5. The employee shall neither accept nor give commissions, rebates or other forms of remuneration from referral of clients for professional services;
6. The employee shall ensure clients are aware of fees and billing arrangements before rendering services;
7. The employee shall keep confidential their counseling relationships with clients, with the following exceptions:
 - a. When the client constitutes a danger to him/herself or to others; or
 - b. When the professional counselor is under court order to disclose information; or
 - c. As required by law.

8. The employee shall disclose counseling records to others only with the expressed written consent of the client per State/Federal regulations;
9. The employee shall ensure the welfare of clients is in no way compromised in any experimentation or research involving those clients;
10. The employee shall avoid dual relationships with clients that might compromise the client's well-being or impair the counselor's objectivity and professional judgment including, but not limited to, counseling close friends or relatives and engaging in sexual intimacies with a client;
11. The employee shall engage in no social or personal relationships, including sexual intimacies, with a former client or patient for 24 months (two years) after termination of services;
12. The employee shall not use relationships with clients to promote for personal gain or the profit of an agency, commercial enterprises of any kind;
13. The staff shall adhere to a strict policy of non-discrimination because of disability, race, ethnicity, religion, age, gender, sexual orientation, national ancestry, and other protected classes including persons served, and will work toward the prevention and elimination of such discrimination in rendering service and overall employment practices;
14. The employee shall respect the basic human rights of the client, including the client's right to make his/her own decision, even to reject help unless a court order stipulates otherwise;
15. The employee shall recognize the fact that professional practices require professional education, and further, shall hold themselves responsible for their personal growth and continuing education and training;
16. The employee shall adhere to a strict policy of professional respect for the views, actions and findings of colleagues and members of other professions and programs and shall use appropriate practices to express disagreement in judgment on these matters;
17. The employee shall respect program policies and cooperate with management functions; and
18. The employee shall abstain from the non-medical use of any mood altering chemicals while on the job.

SECTION: ADMINISTRATION

SUBJECT: CLIENT RIGHTS

SECTION NO. I

SUBJECT NO. 15

- A. NCMMHC shall ensure that all individuals have the same legal rights and responsibilities as any other citizen, unless otherwise limited by law. The agency has established the following procedures to protect the human, civil, constitutional and statutory rights, dignity and respect of each individual served:
1. Upon admission, and annually thereafter, each individual shall be informed of his/her rights in written, simple language the client understands, and explained by staff as necessary.
 - a. Each client shall receive and sign a handout, along with a brochure, which describes the program's facility, services, costs, program rules, client rights and responsibilities, and participation requirements, along with grievance procedures and availability of crisis assistance.
 - 1) The handout includes the Department of Mental Health Client Rights Monitor address and telephone number.
 - 2) Each client will be informed that the Client Rights Monitor may be contacted regarding client complaints of abuse, neglect, or violation of rights.
 - b. Each client shall be informed they are entitled to receive an impartial review of alleged violation of rights.
 - c. The staff shall read and explain the brochure to the client if the client cannot read or understand the brochure.
 - d. A readily available notice to clients about rights, opinions, recommendations, and grievances and how to express his/her rights, opinions, recommendations and grievances shall additionally be posted in each facility. Reasonable assistance, and forms if applicable, will be given to an individual wishing to file a grievance. A grievance action will not result in retaliation or

barriers to services. The client may file a complaint of abuse, neglect or violation of rights:

- 1) Verbally, or in writing, to staff, the Program Director, the Clinical Director or the Executive Director within ten (10) days of the incident.
- 2) In writing to the President of the Board of Directors. The Board of Directors shall render a decision within three (3) days after the completion of its investigation.
- 3) In writing to the Department of Mental Health, Division of Behavioral Health Services, PO Box 687, Jefferson City MO 65102, 1-800-364-9687.
- 4) The agency will respond in writing regarding the actions to be taken to address the complaint within ten (10) calendar days of receiving the report. The agency shall cooperate with the Department in any review or investigation conducted by the Department or its authorized representative.
- 5) The Clinical Review Committee will review all formal complaints annually to determine any trends, areas needing performance improvement, and actions to be taken that will result in better client services.
- 6) To use crisis intervention services. North Central Missouri Mental Health Center does not use seclusion or restraint.

B. Each client shall be entitled to the following rights and privileges without limitation:

1. To receive prompt evaluation, care and treatment;
2. To receive these services in a private, clean and safe setting;
3. To humane care and treatment; and to have the treatment/rehabilitation explained;
4. To be treated with respect and dignity as a human being and addressed in an age-appropriate manner;
5. To be the subject of an experiment or research only with the client's informed, written consent or the consent of a person legally authorized to act on the client's behalf;

6. To have records kept confidential in accordance with federal and state laws and regulations;
 7. To have the same legal rights and responsibilities as any other citizen, unless otherwise stated by law;
 8. To not be denied admission or services because of race, gender, creed, legal status, marital status, sexual orientation, national origin, disability, age, prior treatment, withdrawal from treatment against advice, or continuation or return of symptoms after prior treatment;
 9. To be free from verbal, sexual and physical abuse, neglect, humiliation, corporal punishment, threats or exploitation;
 10. To refuse hazardous treatment, unless ordered by the court;
 11. To medical care and treatment in accordance with accepted standards of medical treatment;
 12. To consult with a private, licensed practitioner at the client's own expense;
 13. To request and receive a second opinion before hazardous treatment, except in an emergency; and
 14. To receive these services in the least restrictive environment.
- C. Outpatient client rights and privileges which may be limited include:
1. To see own records.
 2. Limitations necessary to ensure personal safety or the safety of others.
- D. Any limitations of the client's rights and privileges listed shall be listed on an individual basis, documented and justified in the client's records and reviewed and authorized by the Executive Director. Limitations will be reviewed regarding the purpose or benefit of any restriction at each treatment plan review and rescinded at the earliest clinically appropriate moment.
- E. Confidentiality
1. The strictest rules of confidentiality shall be observed in regard to information about clients and personnel. (See HIPAA policy, Section VI)
 2. Written permission must be obtained to release, or refuse to release, information about a client.
 3. When appropriate, families receive information to promote their participation in, or decisions about, care and treatment.
 4. Care must be taken in public places not to reveal information about

clients.

- F. This agency has established the following uniform criteria for client admission for treatment and rehabilitation services.
1. Clients will be received and treated regardless of gender, race, color, religion, national origin, impairment status, veteran status, marital status, social or economic condition, or length of local residency.
 2. Services will be administered in a safe manner with consideration given to the physical, developmental, and abuse history of the client served.
 3. Clients may receive services if:
 - a. They personally have a possible or actual mental health disorder.
 - b. They are a family member of a person who has a possible or actual mental health disorder. For example: when a child chart is opened, family therapy may occur on that open chart.
 - c. They are employees of a company contracted under an Employee Assistance Program, and have documented work deterioration problems.
 - d. They are employees of a company contracted under an Employee Assistance Program and desire evaluation and counseling on personal problem areas.
 - e. They are a family member of a person employed by a company contracted under an Employee Assistance program, and desire evaluation and counseling on personal problem areas.
 - f. They are referral persons of any organization or agency with whom this corporation has a signed contract or affiliation services.
 4. A client, whenever possible, will be treated on a voluntary, rather than involuntary, basis. Individuals admitted on a voluntary basis will give written informed consent, or refusal, to care and treatment, including the composition of the service delivery team.
 5. A client will not be denied treatment solely because that person has withdrawn from treatment against medical or clinical advice on a prior occasion.
 6. A client will not be denied treatment solely because that person has relapsed after treatment.

7. The client shall be assigned to treatment in the least restrictive environment whenever possible.
- G. Client behavior which creates treatment and/or facility problems shall be addressed as follows:
1. A client is expected to follow the rules and regulations of the agency, and failure to do so may lead to termination of services. A client is expected to:
 - a. Take responsibility for himself/herself and his/her behavior.
 - b. Take part in formulation of and abide by his/her own treatment plan.
 - c. Keep all appointments as scheduled. If unable to maintain appointments, the client is responsible for notifying the agency as soon as possible. If two (2) consecutive appointments are missed without prior notification, the client may be discharged.
 - d. Respect the privacy, confidentiality and identify of other clients being served that he/she may come in contact with at the agency.
 - e. Maintain non-destructive, non-violent behavior toward agency property, staff and other clients.
 2. Any client behavior that is deemed “inappropriate” or “atypical” which interferes with agency operations shall be treated on an individual basis utilizing the following guidelines:
 - a. Broken rules, missed appointments, chronic lateness for appointments, appearing under the influence of alcohol/drugs, loitering and other commonly occurring problems will be addressed therapeutically by the primary clinician.
 - b. Suicide threats, suicide attempts, verbal and behavioral threats, harassment, disruptive behavior, and any other behavioral crises will be addressed by the primary clinical and/or on-call staff and handled through crisis response.
 - c. Life-threatening behavior or behavior infringing upon the rights of others that cannot be successfully resolved shall be reported to the primary clinician and/or on-call staff for referral to inpatient treatment and/or legal authorities, depending on the circumstances.
 - d. Suicide attempts involving overdose or physical injury to the client

should first receive medical attention in an emergency room or hospital. The hospital staff may then call the agency for therapeutic assistance.

- e. Chronic missed appointments, appearing under the influence of alcohol/drugs, and/or disruptive behavior that cannot be resolved therapeutically by the therapist may require discharge from the program.
- f. Patients who are actively psychotic and may feel they are becoming psychotic will be seen by the staff psychiatrist and may be referred for inpatient treatment as appropriate.
- g. In case of any other behavioral crisis, including harassment, threats, accidents, or needing additional assistance, local law enforcement officers will be called to the site. If required, the Program Director/Supervisor and the hospital emergency room physician will be contacted.

SECTION: ADMINISTRATION

SUBJECT: CLIENT ABUSE/NEGLECT

SECTION NO. I

SUBJECT NO. 16

- A. Client related abuse or neglect is clearly not tolerated by the agency.
- B. Abuse shall be identified through three categories:
 - 1. Physical abuse
 - 2. Verbal abuse
 - 3. Sexual abuse
- C. Neglect shall be defined as the absence of behaviors on the part of the primary clinician such as not returning phone contacts, missing or consistently arriving late for appointment, or other behaviors of not maintaining the intended program components. Neglect of clients will not be tolerated and will be addressed through disciplining measures. Neglect includes, but is not limited to, failure to provide adequate supervision during an event in which one client causes serious injury to another client.
- D. If an emergency occurs, resulting in the defense of oneself or other people at the agency from a client, the staff member is to use the least possible force at all times for a client's proper control, treatment or management and, more importantly, the staff member is to clearly call for assistance.
 - 1. When two (2) or more staff members are present, another staff member is to immediately contact the legal authorities for assistance.
 - 2. When possible, the staff members shall first make an attempt to remove themselves and any other persons physically from the assaulting client.
 - 3. The agency does not use physical restraint. Physical restraint is defined as physically holding an individual and restricting freedom of movement to restrain temporarily for a period longer than ten (10) minutes an individual who presents a likelihood of physical injury to self or others. If physical holding is used, it must be reported to the Program Director/Supervisor within 24 hours with a written incident report presented to the Executive Director to be reviewed by the Executive Committee of the Board of

Directors within six (6) working days.

4. Briefly holding a client without undue force to prevent injury of a client or another is not considered a restraint.
 5. Separating clients who are threatening to harm each other is not considered a restraint.
- E. Physical contact demonstrated in anger without a need for the defense of self or others is prohibited and may result in either a 90-day probation or dismissal from employment.
- F. Physical contact beyond common pleasantries (brief touching, shaking of hands, hugging, patting on the back, or holding a client's hands) must be discussed between the staff member and his/her immediate supervisor to determine the appropriateness and/or advisability.
- G. Clients will not be verbally abused.
1. Some therapeutic approaches use highly confronting responses to clients. While there may be cases where these approaches are appropriate, it must first be reviewed by the Program Director/Supervisor prior to the therapeutic intervention. The staff person utilizing highly confrontive or verbal techniques shall be advised that they bear the burden of responsibility.
 2. Clear cases of verbal abuse, such as using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner to a client or about a client in the presence of a client is not viewed as a tolerable therapeutic modality, which may result in a 90-day probation or dismissal. Verbal abuse includes, but is not limited to, an employee making a threat of physical violence to a client, when such threats are made directly to a client or about a client in the presence of a client, or an employee using profanity or speaking in a demeaning non-therapeutic, undignified, threatening or derogatory manner to a client or about a client in the presence of a client.
 3. Cases in which verbal abuse is alleged will be investigated within 24-hours by either the Program Director/Supervisor or the Executive Director.
- H. Sexual contact with clients is prohibited at any of the agency offices or anywhere else. Sexual abuse/exploitation of a client, if substantiated, will result in

immediate dismissal.

- I. Staff members shall engage in no social or personal relationships, including sexual intimacies, with a former client for 24 months (2 years) following termination of services.
- J. Sexual contact shall be defined as physical or other contact by and/or between the staff member and/or the client including, but not limited to:
 - 1. Sexual intercourse: any penetration or contact with the female genitals by any body part, male genitals, or any object.
 - 2. Sodomy: oral or anal copulation; or any sexual intercourse between a person and an animal; or any penetration of the anal opening by any body part or object.
 - 3. Kissing, hugging or caressing by either the staff member or the client.
 - 4. Touching by either the staff member or the client of the other person's legs, stomach, chest, breasts, genitals or buttocks, for the purpose of sexual gratification.
 - 5. Exhibitionism and voyeurism: exposing oneself or encouraging another to expose himself/herself for the purpose of sexual gratification.
 - 6. Deliberate or repeated comments, gestures, or physical contacts of a sexual nature that exploit the professional relationship with the client, or failing to intervene or attempting to stop inappropriate sexual activity or performance between clients.
- K. For alleged abuse/neglect charges other than those defined by the Department of Mental Health as serious events, the following procedures shall occur:
 - 1. As the circumstances require, the employee accused of client abuse/neglect may be relieved of duty or transferred to duty not involving direct client contact for the duration of the investigation.
 - 2. Personnel involved shall make a written incident report and be interviewed individually by the Program Director/Supervisor, Executive Director, and/or the Executive Committee of the Board of Directors.
 - 3. Persons claiming abuse/neglect shall be interviewed individually by the Program Director/Supervisor, Executive Director and/or the Executive Committee of the Board of Directors.
 - 4. Eye-witnesses to the abuse/neglect shall be interviewed individually by the

Program Director/Supervisor, Executive Director and/or Executive Committee of the Board of Directors.

5. Other investigations shall be conducted by the Executive Director and the Management Team and/or Executive Committee of the Board of Directors as deemed necessary.
 6. The Executive Director and/or the Executive Committee of the Board of Directors shall then decide if the alleged violations were true or false.
 - a. If false, no action shall be taken and the employee shall be reinstated to full duty.
 - b. If true, the staff member(s) involved may be dismissed or placed on 90 days probationary status as determined necessary by the Executive Director and the Executive Committee of the Board of Directors.
 7. Copies of all reports and investigative results shall be kept in a separate file in a secure area in the Executive Assistant's office.
- L. The Executive Director shall report to local law enforcement officials if there is a reasonable suspicion that any of the following abuse or neglect has occurred:
1. Sexual abuse;
 2. Abuse or neglect that results in physical injury;
 3. Abuse, neglect, or misuse of funds/property if the Executive Director has cause to believe that criminal misconduct is involved.

NOTE: Refer to the Code of Ethics subscribed to by North Central Missouri Mental Health Center employees.

SECTION: ADMINISTRATION

SUBJECT: GRIEVANCE PROCEDURE

SECTION NO. I

SUBJECT NO. 17

NCMMHC is committed to the promotion of best practices and to hearing and responding to client concerns in a fair, expedient, open and client-centered manner. NCMMHC will respond, regarding the actions to be taken to address the complaint, within ten (10) calendar days of receiving the report. Whenever possible, NCMMHC seeks to prevent complaints by practicing open and direct communication with clients and community partners.

Any complaint process is in addition to, and does not limit, a client's right to pursue other remedies, including legal action. Any complaint or concern put forth by an individual accessing NCMMHC services will not result in retaliation or create a barrier to accessing services. The complaints process must be culturally responsive and inclusive and must not present any administrative or systemic barriers for persons with disabilities.

Clients have the right to address and bring forward any concern or complaint regarding an employee, a program procedure, a breach of confidentiality or any infringement of rights. There is no limit to the number of complaints that may be submitted. Except in emergencies, the first complaint will be investigated before any additional complaints. If several complaints regarding the same issue are received, they may be investigated together.

Complaint proceedings may end if all parties concerned agree.

The **first step** in the complaint process is to try to work out concerns informally with the NCMMHC clinician about whom the complaint is being made. This is usually the quickest and easiest way to try to solve a problem. Although the complaint is taken directly to the person involved, the Program Director, Clinical Director, and Executive Director may be notified of the concern and the steps being taken toward resolution.

If the complaint is not satisfactorily addressed by the clinician involved, or the client chooses not to use the informal approach, the following formal complaints procedure will be followed.

- A client shall contact the Program Director or Clinical Director, who will endeavor to resolve the concern within 10 working days.
- If the concern remains unresolved by the Program Director or Clinical Director, the concern will be forwarded to the Executive Director, who will respond in writing, within 10 calendar days of receiving the complaint.
- If the concern remains unresolved by the Executive Director, the concern may then be taken to the Board of Directors who will respond, in writing, ideally completing the formal process within three (3) days after the completion of its investigation. Service related concerns will be directed to the Quality Assurance Committee.
- If the concern remains unresolved, a client may choose to access assistance external to NCMMHC and may choose to contact a local ombudsmen.
- Any serious complaint, including those alleging negligence and/or abuse of clients, shall be brought to the immediate attention of the Program Director, Clinical Director and Executive Director.
- All complaints, including their resolutions, shall be documented and stored in the Clinical Director's filing cabinet to ensure confidentiality is respected.
- Complaints may be made verbally, in written form, or by using an alternative confidential communication device or using the assistance of an interpreter.
- NCMMHC encourages and supports anyone making a complaint to include an advocate or other identified support person(s) to assist in the complaints process.

SECTION: ADMINISTRATION

**SUBJECT: REPORT OF COMPLAINTS
OF ABUSE AND NEGLECT**

SECTION NO. I

SUBJECT NO. 18

North Central Missouri Mental Health Center shall adhere to Missouri Department of Mental Health procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property in a residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health. This procedure also sets forth due process procedures for persons who have been accused of abuse, neglect and misuse of client funds/property.

1. The following words and terms, as used in this rule, mean:
 - a. Neglect – failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any client when that failure presents either imminent danger to the health, safety or welfare of a client, or a substantial probability that death or physical injury would result; failure of an employee to provide reasonable or necessary services to a client according to the individualized treatment or habilitation plan, if feasible, or according to acceptable standards of care. This includes action or behavior that may cause psychological harm to a client due to intimidating, causing fear, or otherwise creating undue anxiety. Neglect would include, but is not limited to, failure to provide adequate supervision during an event in which one client causes serious injury to another client;
 - b. Client – individual (consumer, client, resident, patient) receiving services directly from any program or facility contracted, licensed, certified or funded by the Department;
 - c. Misuse of client funds/property – the misappropriation or conversion for any purpose of a client’s funds or property by an employee or employees with or without the consent of the client, or the purchase of property or services from a client in which the purchase price substantially varies from the market value;
 - d. Physical abuse –

- 1) An employee purposefully beating, striking, wounding or injuring any client, or;
 - 2) In any manner whatsoever, an employee mistreating or maltreating a client in a brutal or inhumane manner. Physical abuse includes handling a client with any more force than is reasonable for a client's proper control, treatment or management.
- e. Sexual abuse – any touching, directly or through clothing, of a client by an employee, for sexual purpose or in a sexual manner. This includes but is not limited to:
- 1) Kissing;
 - 2) Touching of the genitals, buttocks, or breasts;
 - 3) Causing a client to touch the employee for sexual purposes;
 - 4) Promoting or observing for sexual purposes any activity or performance involving clients including any play, motion picture, photography, dance or other visual or written representation; or
 - 5) Failing to intervene or attempting to stop inappropriate sexual activity or performance between clients; and/or
 - 6) Encouraging inappropriate sexual activity or performance between clients.
- f. Verbal abuse – Verbal abuse includes, but is not limited to, an employee making a threat of physical violence to a client, when such threats are made directly to a client or about a client in the presence of a client, or an employee using profanity or speaking in a demeaning non-therapeutic, undignified, threatening or derogatory manner to a client or about a client in the presence of a client.
2. This section applies to any director, supervisor or employee of any residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health. Facilities, programs and services that are operated by the Department are regulated by the Department's operating regulations and are not included in this definition.
- a. Any such person shall immediately file a written or verbal complaint if that person has a suspicion or allegation to believe that a client has been

subjected to any of the following misconducts while under the care of a residential facility, day program or specialized service:

- 1) Physical abuse;
 - 2) Sexual abuse;
 - 3) Misuse of funds/property;
 - 4) Neglect;
 - 5) Verbal abuse;
 - 6) Serious medication error; or
 - 7) Diversion of medication from intended use by the client for whom it was prescribed.
- b. A complaint under subsection (a) above shall be made to the head of the facility, day program or specialized service, and to the department's regional center, supported community living placement office or district administrator office.
- c. The head of the facility, day program or specialized service shall forward the complaint to –
- 1) The Children's Division if the alleged victim is under the age of eighteen (18); or
 - 2) The Division of Senior Services and Regulation if the alleged victim is a resident or client of a facility licensed by the Division of Senior Services and Regulation or receiving services from an entity under contract with the Division of Senior Services and Regulation.
- d. Failure to report shall be cause for disciplinary action, criminal prosecution, or both.
3. The head of the facility, day program or specialized service that is licensed, certified or funded by the department shall immediately report to the local law enforcement official any alleged or suspected –
- a. Sexual abuse; or
 - b. Abuse or neglect that results in physical injury; or
 - c. Abuse, neglect, or misuse of funds/property that may result in a criminal charge.
4. If a complaint has been made under this rule, the head of the facility or program all employees of the facility, program or service shall fully cooperate with law

enforcement and with department employees or employees from other agencies authorized to investigate the complaint. Failure to cooperate may result in contract termination or dismissal of the employee.

5. A department investigator shall gather facts and conduct an investigation regarding the alleged abuse or neglect. The investigation shall be conducted in accordance with the procedures and time frames established under the Department's operation regulations. Upon completion of its investigation, the investigator shall present written findings of facts to the head of the supervising facility.
6. Within twenty (20) calendar days of receiving the final report from the investigator, if there is a preliminary determination of abuse, neglect or misuse of funds/property, the head of the supervising facility or department designee shall send to the alleged perpetrator a summary of the allegations and findings which are the basis for the alleged abuse/neglect/misuse of funds or property; the provider will be copied. The summary shall be sent by regular or certified mail.
 - a. The alleged perpetrator may meet with the head of the supervising facility or department designee and submit comments or present evidence; the provider may be present and present comments or evidence in support of the alleged perpetrator. If the alleged perpetrator wishes to have this meeting, s/he must notify the head of the supervising facility or department designee within twenty (20) working days of receiving the summary.
 - b. This meeting shall take place within twenty (20) working days of notification, unless the parties mutually agree upon an extension.
 - c. Within twenty (20) working days of the meeting, or if no request for a meeting is received within twenty (20) working days of the alleged perpetrator's receipt of the summary, the head of the supervising facility or department designee shall make a final determination as to whether abuse/neglect/misuse of property or funds took place. The perpetrator shall be notified of this decision by regular and certified mail; the provider will be copied. If the charges do not meet the criteria in paragraphs (11) & (12), the decision of the head of the supervision facility or department designee shall be the final decision of the department.
 - d. If the charges meet the criteria in paragraphs (11) & (12), the letter shall

advise the perpetrator that they have twenty (20) working days following receipt of the letter to contact the department's hearings administrator if they wish to appeal a finding of abuse, neglect or misuse of funds/property.

- e. If there is no appeal, the decision of the head of the supervising facility or department designee shall be the final decision of the department.
 - f. The department's effort to notify the alleged perpetrator at his/her last known address by regular and certified mail shall serve as proper notice. The alleged perpetrator's refusal to receive certified mail does not limit the department's ability to make a final determination. Evidence of the alleged perpetrator's refusal to receive certified mail shall be sufficient notice of the department's determination.
7. If an appeal is requested, the hearings administrator shall schedule the hearing to take place within ninety (90) calendar days of the request, but may delay the hearing for good cause shown. At the hearing, the head of the supervising facility or designee, or other department designee shall present evidence supporting its findings of abuse, neglect, misuse of funds/property, or all. The provider or perpetrator may submit comments or present evidence to show why the decision of the head of the supervising facility or department designee should be modified or overruled. The hearings administrator may obtain additional information from department employees as s/he deems necessary.
8. The decision of the hearings administrator shall be the final decision of the department. The hearings administrator shall notify the perpetrator, and the head of the supervising facility or department designee by certified mail of the decision within twenty (20) calendar days of the appeal hearing; the provider will be copied.
9. The opportunities described in Sections (6), (7) and (8) of this rule regarding a meeting with the head of the supervising facility and an appeal before the department's hearings administrator apply also to providers and alleged perpetrators in an investigation of misuse of funds/property.
10. For those charges in paragraphs (11) & (12), an alleged perpetrator does not forfeit his/her right to an appeal with the department's hearings administrator when s/he declines to meet with the head of the supervising facility under

Subsection (6) (a) and (b) of this rule.

11. If the department substantiates that a person has perpetrated physical abuse, sexual abuse, neglect, or misuse of funds/property, the perpetrator shall not be employed by the department, nor be licensed, employed or provide services by contract or agreement at a residential facility, day program or specialized service that is licensed, certified or funded by the department. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to Section 630.170, RSMo. Persons who have been disqualified from employment may request an exception by using the following procedure:

- a. By sending to the Department of Mental Health Exceptions Committee a written request which:
 - 1) Cites the rule number in question;
 - 2) Indicates why and for how long compliance with the rule should be waived; and
 - 3) Is accompanied by supporting documentation, if appropriate.
- b. In addition, the following additional items must be part of a request related to disqualification from employment:
 - 1) A letter from the disqualified personal containing the following information:
 - a) A description of the disqualifying incident;
 - b) When the disqualifying event occurred;
 - c) If the disqualifying incident was a crime, the sentence of the court;
 - d) Mitigating circumstances, if any;
 - e) Activities and accomplishments since the disqualifying incident;
 - f) The names and dates of any relevant training or rehabilitative services;
 - g) The type of service and/or program the applicant wishes to provide for mental health clients;
 - h) Identification of the type of employment or position the applicant wishes to maintain or obtain and the name of the mental health program in which s/he wishes to work or

continue working; and

i) Changes in personal life since the disqualifying incident (e.g., marriage, family, and education);

2) References, i.e., written recommendations from at least three (3) persons who verify the applicant's assertions; and

3) Work history, with particular emphasis on work in the mental health field.

c. Request for exceptions should be sent to Exceptions Committee Coordinator, Office of Quality Management, Department of Mental Health, PO Box 687, Jefferson City MO 65102.

12. If the department substantiates that a person has perpetrated two (2) counts of verbal abuse, or two (2) counts of neglect, or one (1) count of verbal abuse and one (1) count of neglect, within a twelve (12)-month period, the perpetrator shall not be employed by the department, nor be licensed, employed, or provide services by contract or agreement at a residential facility, day program or specialized service that is licensed, certified or funded by the department. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to Section 630.170, RSMo.

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

14. No director, supervisor or employee of a residential facility, day program or specialized service shall evict, harass, dismiss or retaliate against a client or employee because he or she or any member of his or her family has made a report of any violation or suspected violation of client abuse, neglect or misuse of funds/property. Penalties for retaliation may be imposed up to and including cancellation of agency contracts and/or dismissal of such person.

*AUTHORITY: Sections 630.050, 630.135, 630.165, 630.167, 630.168 and 630.655 and 630.705, RSMo 2000 and 630.170, RSMo Supp 2003. *Original rule filed Oct. 29, 1998, effective May 30, 1999. Emergency amendment filed March 29, 2002, effective May 2, 2002, terminated Oct. 30, 2002. Amended: Filed March 20, 2002, effective Oct. 2002.*

Last Revised: 4/17 **101**

30, 2002. Amended: Filed May 5, 2003, effective Dec. 30, 2003. Emergency amendment filed August 11, 2005, effective September 16, 2005, expires February 28, 2006. Amended: Filed August 11, 2005.

SECTION: ADMINISTRATION

SUBJECT: RESEARCH

SECTION NO. I

SUBJECT NO. 19

North Central Missouri Mental Health Center is supportive of research activities as long as its primary goal of service to individuals is not compromised.

Persons wishing to conduct research at NCMMHC must first obtain the approval of the agency's Utilization Review Committee. A complete procedural proposal detailing recruitment, instruments, and protection of subjects shall be submitted to the Executive Director. The Executive Director will form a committee consisting of the particular Program Director and one or two (1 or 2) professional staff to review the proposed research activity and to decide whether it may be conducted at NCMMHC. Final approval must be obtained from the Management team and the Executive Director. Compliance is maintained with all federal, state and local laws and regulations concerning the conduct of research.

No client will participate as a research subject without his or her voluntary, written, informed and timely consent. Participating individuals understand that they may decide to not participate or may withdraw from any research at any time for any reason. Children will only participate as research subjects with the parent(s)/guardian(s) written consent and their own assent. Individual programs (i.e., CPRC, etc.) may elect to limit or not participate in research. All data will support individual client confidentiality.

Research on Department of Mental Health clients will additionally be approved by the Missouri Department of Mental Health Professional Review Committee, 9 CSR 60. NCMMHC will immediately inform the Department of any adverse outcome experienced by an individual served due to participation in a research project.

NCMMHC will receive a final report on any research conducted. These reports will be kept in the Administrative office.

Compliance is maintained with all federal, state and local laws and regulations concerning the conduct of research.

SECTION: ADMINISTRATION

**SUBJECT: DRUGS, ALCOHOL
AND/OR WEAPONS**

SECTION NO. I

SUBJECT NO. 20

In order to maintain a safe, supportive environment, alcohol, street drugs and/or weapons are not allowed on NCMMHC premises, in agency vehicles, or at any activity of the agency. This prohibition does not apply to off-site agency social functions where the use of alcohol is governed by state or local law. If a person arrives, or becomes, intoxicated or “high”, temporary exclusion of that person from other clients, at minimum, will be expected. In these situations, asking the person to leave may not always be appropriate. As circumstances warrant, protective measures will be taken by the employee(s) in charge, including summoning local law enforcement if necessary.

**NORTH CENTRAL MISSOURI MENTAL HEALTH CENTER
ANNUAL RISK MANAGEMENT PLAN**

Insurance

Identification of loss

North Central Missouri Mental Health Center (NCMMHC) will review insurance annually for appropriate financial coverage.

Evaluation/analysis of loss

Appropriate coverage will be discussed with the Chief Financial Officer and the insurance carrier in order to determine adequate coverage and determine the amount of potential/actual loss.

How loss will be rectified

If insurance is lost, Chief Financial Officer will seek more than one insurance carrier quote to determine the best fiscally responsible coverage.

Actions/monitoring/reporting, actions to reduce risk

The Chief Financial Officer will report annually to the Board of Directors and will be reflected the review in the board minutes.

Performance improvement activities

The Chief Financial Officer will review insurance coverage annually.

Confidentiality

Identification of loss

A client has the right to address and bring forward any concern or complaint regarding an employee, a program procedure, a breach of confidentiality, or any infringement of their basic rights, to the Program Director and/or Clinical Director. There is no limit to the number of complaints submitted.

The Privacy Officer will be notified as soon as possible, but no later than two (2) business days after a breach is discovered.

Evaluation/analysis of loss

The Privacy officer or designee will notify each client whose information has been reasonably believed to have been accessed, acquired, or disclosed as a result of a breach.

How loss will be rectified

The Privacy officer or designee will initiate the improvement process. Staff members who fail to comply or assure compliance may receive disciplinary action, or dismissal.

In the event that a breach of PHI in any form is discovered, the following procedures will be followed. Failure of staff members to comply or assure compliance may result in disciplinary action, including dismissal.

1) The Privacy Officer or designee should be notified as soon as possible, but no later than two (2) business days after the breach is discovered, in order for the Privacy Officer or designee to initiate the mitigation/improvement process.

2) The Privacy Officer or designee shall notify each client whose PHI has been or is reasonably believed to have been accessed, acquired, or disclosed as a result of such breach. All notifications shall be made without unreasonable delay and in no case later than 60 calendar days after the date of discovery of a breach by the agency.

3) Notice with respect to a breach of PHI shall be provided in the following form:

- a. Written notification by first-class mail to the client (or next of kin, if the client is deceased) at the last known address of the client (or next of kin), or if specified as a preference by the client, by electronic mail. The notification may be provided in one or more mailing(s) as information is available.

- b. In the case in which there is insufficient, or out-of-date contact information (including phone number, email, address, or any other form of appropriate communication) that prohibits direct written notification to the client, a substitute form of notice shall be provided, including:

1. A conspicuous posting for a determined period of time on the agency home page of the website; or

2. Notice in major print or in broadcast media where the client affected by the breach likely resides, including a toll-free number where the client can learn what PHI was included in the breach.

Actions/monitoring/reporting, actions to reduce risk

A Privacy Officer is designated to receive any breach notifications.

All staff will be trained at orientation, ongoing by supervisors and annually in group trainings. NCMMHC staff will obtain an authorization prior to the disclosure of any confidential information.

Electronic records are password protected. Access to the ECR is limited to the minimum necessary amount of information to accomplish the purpose of any requested use of information.

The Unauthorized Access report will be reviewed by the Privacy Officer and reported to the management team each month. Communications between staff will not take place in public areas.

The NCMMHC personnel handbook is given to each new employee to read, keep and review often as needed. It states that a client's confidential information must not be divulged to third parties except with proper authority from the client, or prior legal process or regulation. HIPAA regulations will be strictly followed.

Performance improvement activities

The Privacy Officer will perform random mock surveys with written reported results. Survey results are reported to the involved staff and their supervisors. The survey report will include recommendations for environmental or process change as needed. The involved staff will be trained immediately as needed according to survey results.

Public Awareness

Identification of loss

NCMMHC will solicit information from clients and community members by engaging in health fairs, community education groups, quarterly newspaper articles, agency web site, newsletters, and a variety of consumer satisfaction surveys including:

Closed chart consumer satisfaction survey

Lobby consumer satisfaction survey

Annual Agency consumer satisfaction survey

ACI Stakeholder consumer satisfaction survey

Evaluation/analysis of loss

Feedback from consumer satisfaction surveys will be reviewed by the management team and Board of Directors to determine if any gaps in public awareness exist.

How loss will be rectified

NCMMHC will provide information to clients and community members through verbal and printed material. Public awareness activities will be provided that include information on mental health. Information settings and materials may include the media, meetings with agencies, community groups, health fairs, interested individuals, brochures, pamphlets, and Power Points.

Actions/monitoring/reporting, actions to reduce risk

Public awareness activities shall provide information on mental health issues that may include the media, meetings with agencies, community groups, interested individuals, brochures, pamphlets, and Power Points. The Executive Assistant and the management team are responsible for marketing materials and will ensure that agency flyers used for marketing accurately reflect current practices.

Performance improvement activities

The consumer satisfaction surveys will be presented to the Management Team and Board of Directors each year in the Annual Programs Review report.

Social Media

Identification of loss

A client or a staff member has the right to address and bring forward any concern or complaint regarding an employee, a program procedure, a breach of confidentiality, or any infringement of their basic rights, to the Program Director and/or Clinical Director. There is no limit to the number of complaints submitted.

The Privacy Officer will be notified as soon as possible, but no later than two (2) business days after a breach is discovered.

Evaluation/analysis of loss

The Privacy officer or designee will notify each client whose information has been reasonably believed to have been accessed, acquired, or disclosed as a result of a breach.

How loss will be rectified

The Privacy officer or designee will initiate the improvement process. Staff members who fail to comply or assure compliance may receive disciplinary action, or dismissal. Staff members are always (24/7) a representative of this agency. Any disparaging comments or unbecoming conduct can be grounds for termination

In the event that a breach of PHI in any form is discovered, the following procedures will be followed. Failure of staff members to comply or assure compliance may result in disciplinary action, including dismissal.

1) The Privacy Officer or designee should be notified as soon as possible, but no later than two (2) business days after the breach is discovered, in order for the Privacy Officer or designee to initiate the mitigation/improvement process.

2) The Privacy Officer or designee shall notify each client whose PHI has been or is reasonably believed to have been accessed, acquired, or disclosed as a result of such breach. All notifications shall be made without unreasonable delay and in no case later than 60 calendar days after the date of discovery of a breach by the agency.

3) Notice with respect to a breach of PHI shall be provided in the following form:

- a. Written notification by first-class mail to the client (or next of kin, if the client is deceased) at the last known address of the client (or next of kin), or if specified as a preference by the client, by electronic mail. The notification may be provided in one or more mailing(s) as information is available.

- b. In the case in which there is insufficient, or out-of-date contact information (including phone number, email, address, or any other form of appropriate communication) that prohibits direct written notification to the client, a substitute form of notice shall be provided, including:

1. A conspicuous posting for a determined period of time on the agency home page of the website; or

2. Notice in major print or in broadcast media where the client affected by the breach likely resides, including a toll-free number where the client can learn what PHI was included in the breach.

Actions/monitoring/reporting, actions to reduce risk

NCMMHC staff members shall be informed of their obligations with respect to PHI by mandatory participation in HIPAA Privacy Training. NCMMHC staff members that receive or maintain PHI shall be required to agree to the protection of such PHI in accordance with the state and federal laws as set forth above. These staff members shall sign a confidentiality statement. A copy of the signed confidentiality statement shall be maintained in the personnel file of NCMMHC staff, or in a separate file if not a staff member.

The NCMMHC personnel handbook is given to each new employee to read, keep and review often as needed. It states that a client's confidential information must not be divulged to third parties except with proper authority from the client, or prior legal process or regulation. HIPAA regulations will be strictly followed. It is a violation of agency confidentiality rules to discuss client information on any social media such as Facebook, MySpace, Twitter, Chat Rooms or any other like media.

Staff members who fail to comply or assure compliance may receive disciplinary action, or dismissal.

Performance improvement activities

Major offenses may require legal action regarding investigation and reporting to the proper authorities such as local law enforcement and/or licensing agencies. Major offenses which are subject to disciplinary action, and may result in termination, include a breach of client confidentiality.

Changes in Funding

Identification of loss

Identification of loss of funding would be reported from the Department of Mental Health.

Evaluation/analysis of loss

Services would be evaluated by the management team and provided to the limit of resources available.

How loss will be rectified

The following outline describes what each program would do if the funding for that program was discontinued.

1. Agency
 - a. Reserve 3-6 months of funding at all times.
 - b. Refer all clients to existing community services
 - c. Reduce staff to the level of existing funding
2. Adult CPRC program
 - a. Transfer funds from other programs
 - b. Triage to see only the most severe
 - c. Refer clients to existing community services
 - d. Reduce staff to the level of existing funding
 - e. Integrate (if possible), staff into other programs
3. Youth CPRC program
 - a. Transfer funds from other programs
 - b. Triage to see only the most severe
 - c. Refer clients to existing community services
 - d. Reduce staff to the level of existing funding
 - e. Integrate (if possible), staff into other programs
4. HCH program
 - a. Transfer duties to Adult/Youth programs
 - b. Reduce staff to the level of existing funding
 - c. Integrate (if possible), HCH staff into other programs
5. ACI program
 - a. Transfer funds from other programs
 - b. Reduce staff to the level of existing funding

- c. Integrate (if possible), staff into other programs
 - d. Distribute crisis duties to approved clinical staff
6. Therapy program
- a. Refer clients out to community services
 - b. Integrate (if possible), staff into other programs
 - c. Continue to bill private insurance
7. Doctor program
- a. Refer out to community services
 - b. Transfer funds from other programs
 - c. Triage to see only the most severe
 - d. Continue to bill private insurance

Actions/monitoring/reporting, actions to reduce risk

Services and service limitations, and financial status will be reported to the Board of Directors for approval. Waiting lists will be monitored monthly.

Performance improvement activities

Department of Mental Health (DMH) billing reviews are done annually. Financial reports are presented to the Board of Directors. CARF accreditation will be kept current as a requirement of the DMH to retain funding.

Injury while on duty

Identification of loss

All accidents and critical incidents and sentinel events will be reported to management immediately by staff according to agency policy and procedure and documented using the incident report form.

If loss occurs with an agency vehicle, the department director will submit an incident report along with a copy of the accident report to the Executive Director as soon as the accident report is available. Copies of the completed accident report shall be kept on file with the Executive Assistant.

Evaluation/analysis of loss

In case of vehicle accident an employee will:

- Ensure the safety of all passengers, evacuate if necessary. Employees should not remove injured passengers unless absolutely necessary for safety (risk of fire, explosion, etc.). The employee will administer basic First Aid if needed, call 911 for an ambulance if needed, and call local law enforcement.
- Employees will not move the vehicle from the scene of the accident before local law enforcement has arrived at the scene. Employees shall be cooperative with law enforcement in providing all necessary information.
- If the vehicle needs towing, the employee will call their Program Director and/or his/her designee to make arrangements for payment, for transporting passengers, tow services and for possible assistance in managing the agency response to the accident.
- Upon return to the office the employee will notify, client guardians if applicable, and a member of the management team so that a representative of the insurance company may be contacted. Proof of current insurance must be maintained in the vehicle.
- The employee will complete an Internal Incident accident report within 24 hours (as soon as possible) and a DMH EMT incident report if a client was involved.

How loss will be rectified

Unless prohibited by law, the agency shall have an insurance program that provides for the protection of the physical and financial resources of the program and that provides coverage for all people, buildings, and equipment.

Actions/monitoring/reporting, actions to reduce risk

Emergency drills, orientation and group trainings will include education regarding safety while on duty.

All vehicles shall be stocked with a readily accessible first aid kit and fire extinguisher, which will be inspected annually and restocked as needed by the CPRC Program Director or designee. The first aid kit and fire suppression equipment are to be securely fastened in each vehicle in order to prevent additional hazards in the event of an emergency stop or accident.

In order to maintain a safe, supportive environment, alcohol, street drugs and/or weapons are not allowed on the NCMMHC premises, in the agency vehicles, or at any activity of the agency. This prohibition does not apply to off-site agency social functions where the use of alcohol is governed by state or local law.

Performance improvement activities

All critical incidents and sentinel events will be reviewed by the Clinical Review Committee. The annual Critical Incidents and Sentinel event report will be presented to the management team and will include recommendations and corrective actions to negative trends.

Minimizing Loss by fire

Identification of loss

Annual fire inspections of the environment and fire extinguishers will be reflected in the fire inspection report.

Evaluation/analysis of loss

Maintenance personnel will conduct self-inspections at least semi-annually on each building regularly used by NCMMHC clients and staff. Self-inspections are conducted in order to identify and correct existing hazards and to determine whether regulatory standards are being met and to keep NCMMHC ready for compliance inspections by the fire department.

How loss will be rectified

All corrective actions recommended by the Fire Marshall will be addressed immediately.

Service provision will be conducted from the next available agency building in the event of any agency building being lost by fire. The agency will attempt to rebuild in the event of agency building loss.

Actions/monitoring/reporting, actions to reduce risk

All client electronic records are backed-up off site. All buildings, current and relocated, shall conform to the requirements of local, state, and/or federal authorities, fire safety and health requirements.

Performance improvement activities

NCMMHC will maintain a safe environment and will document the results of all emergency drills in each office location. Types of drills will include fire. Fire drills are to be done quarterly. Short descriptions of scenarios will be documented when doing drills. Staff shall demonstrate knowledge and ability to be involved in the emergency preparedness drill.

Recommendations for improvement will be documented on the Emergency Drill form. Each calendar year, the Emergency Drill form will be sent to the Executive Assistant.

Minimizing Loss of an Agency Vehicle

Identification of loss

All accidents and critical incidents and sentinel events will be reported by staff according to agency policy and procedure using the incident report form.

If loss occurs with an agency vehicle, the department director will submit an incident report along with a copy of the accident report to the Executive Director as soon as the accident report is available. Copies of the completed accident report shall be kept on file with the Executive Assistant.

Evaluation/analysis of loss

In case of vehicle accident an employee will:

- Ensure the safety of all passengers, evacuate if necessary. Employees should not remove injured passengers unless absolutely necessary for safety (risk of fire, explosion, etc.). The employee will administer basic First Aid if needed, call 911 for an ambulance if needed, and call local law enforcement.
- Employees will not move the vehicle from the scene of the accident before local law enforcement has arrived at the scene. Employees shall be cooperative with law enforcement in providing all necessary information.
- If the vehicle needs towing, the employee will call their Program Director and/or his/her designee to make arrangements for payment, for transporting passengers, tow services and for possible assistance in managing the agency response to the accident.

- Upon return to the office the employee will notify, client guardians if applicable, and a member of the management team so that a representative of the insurance company may be contacted. Proof of current insurance must be maintained in the vehicle.
- The employee will complete an Internal Incident accident report within 24 hours (as soon as possible) and a DMH EMT incident report if a client was involved.

How loss will be rectified

Unless prohibited by law, the agency shall have an insurance program that provides for the protection of the physical and financial resources of the program and that provides coverage for all people, buildings, and equipment.

Fleet vehicles may be used as temporary agency vehicles

Actions/monitoring/reporting, actions to reduce risk

Emergency drills, orientation and group trainings will include education regarding safety while on duty.

All vehicles shall be stocked with a readily accessible first aid kit and fire extinguisher, which will be inspected annually and restocked as needed by the CPRC Program Director or designee. The first aid kit and fire suppression equipment are to be securely fastened in each vehicle in order to prevent additional hazards in the event of an emergency stop or accident.

In order to maintain a safe, supportive environment, alcohol, street drugs and/or weapons are not allowed on the NCMMHC premises, in the agency vehicles, or at any activity of the agency. This prohibition does not apply to off-site agency social functions where the use of alcohol is governed by state or local law.

The agency will attempt to purchase new vehicles as current vehicles age. The agency will ensure proper vehicle maintenance by engaging in scheduled maintenance and safety checks. All agency vehicles will have a working fire extinguisher. All agency drivers will participate in driver training.

Performance improvement activities

All agency drivers will participate in driver training. All critical incidents and sentinel events will be reviewed by the Clinical Review Committee. The annual Critical

Incidents and Sentinel event report will be presented to the management team and will include recommendations and corrective actions to negative trends.

Cultural Competency Plan
for facilitating the development of Cultural Competence

In accordance with North Central Missouri Mental Health Center's service philosophy, our services will be offered in a manner that is responsive to and effective for individuals, couples, families and groups who are seeking behavioral health services. Our services will be delivered in a manner that is responsive to and effective for each individual's age, cultural background, gender, language and communication skills.

The cultural makeup of our agency's staff members and governing board both closely mirror the culture of the population served by our agency.

The monthly staff training curriculum will continue to include training designed to develop cultural awareness and responsiveness. This training curriculum includes topics specific to the diversity of the local community, such as age, gender, sexual orientation, religion/spiritual beliefs, socioeconomic status, language, ethnicity, race and disabilities of the population served by our agency. In addition to training offered directly by North Central Missouri Mental Health Center, cultural competency education will be available to staff members through online resources provided by the Missouri Coalition of Community Mental Health Centers and by Essential Learning, our online training/education resource.

CTS Language Link, a telephonic translation service will continue to be used to assist staff members in communicating with clients who are interested in language translation assistance. Local Spanish translators can also be utilized if a client desires local Spanish translator assistance.

North Central Missouri Mental Health Center has completed an evaluation tool distributed by the Missouri Coalition for Community Mental Health Centers in order to determine the current level of cultural awareness and responsiveness of our agency.

The evaluation tool will be used, along with other resources, in the ongoing development of cultural competency of our staff members and agency practices.

Each year, as part of the development of agency strategic goals and objectives, one area of cultural competency development will be identified and addressed as an agency goal.

SECTION: OUTPATIENT SERVICES

**SUBJECT: INFORMATION AND
REFERRAL**

SECTION NO. II

SUBJECT NO. 1

- A. Scope of Service: The outpatient program has identified essential treatment principles regarding the target populations to be served, which include, but are not limited to, seriously emotionally disturbed children; seriously mentally ill adults, forensic clients and persons experiencing acute emotional distress. Services shall be appropriate to the individual's age and development and shall be responsive to the individual's social/cultural situation, and any linguistic/communication needs.
1. Entry Criteria: Services are available to clients upon referral. Referrals may be initiated by the client, a friend, parent, guardian, physician, minister, attorney or school personnel. Each individual requesting NCMMHC services will have access to a screening in order to determine service eligibility and to plan an initial course of action. The screening will include presenting problems, need for services and legal criteria when applicable, demographic information and whether or not there are factors related to harm or safety. The screening interview will be conducted by a trained qualified mental health professional. When resources become limited we may prioritize service delivery to those who do not have active professional services in the community.
 2. Transition Criteria: Transition planning assists a client to move from one level of service to another within NCMMHC. The transition process is planned with the active participation of each client. Transition may include a planned discharge, a movement to/from a different *service* or a different level of *intensity of contact*. Transition to a different level of intensity of contact may include:
 - a. 2 or more times per week
 - b. 4 time per month
 - c. 2 times per month

- d. 1 time per month
- e. 1 time per quarter
- f. 2 times per year

A Transition Summary is completed by the primary/serving clinician when a client transitions from one level of intensity of contact, or adds or removes a service from one clinical service provider to another. When transitioning to another service/level of care, the transitioning clinician will ensure that a new Master Treatment Plan is completed.

Reasons for transition to a new service may include:

- a. Client requires additional support
- b. To reduce/eliminate episodes of crisis/hospitalizations/legal involvement
- c. Needs community support
- d. Needs Therapy
- e. Needs doctor services

Reasons for transition out of a current service may include:

- a. The client no longer desires that service
- b. The client has achieved treatment goals
- c. The client no longer needs community support
- d. The client no longer needs therapy
- e. The client no longer needs doctor services
- f. The client has completed program requirements
- g. The client is transitioning from youth to adult

3. Exit Criteria: Clients shall be actively involved in discharge planning and aftercare as a final step of the treatment process. Reasons for a client to discharge from services may include:

- a. The client is transferred to another community provider
- b. The client's chart was administratively discontinued after 180 days (6 months) of no contact.

- c. The client died
 - d. The client terminated services against advice
 - e. The client was non-compliant with treatment services
 - f. The client successfully completed treatment services
 - g. The client was referred to another provider
 - h. The client was incarcerated
- B. The outpatient program has identified essential treatment principles regarding the target populations to be served, which include, but are not limited to, seriously emotionally disturbed children; seriously mentally ill adults; forensic clients and persons experiencing acute emotional distress. Services shall be appropriate to the individual's age and development and shall be responsive to the individual's social/cultural situation, and any linguistic/communication needs.
- C. The outpatient program will provide client and family education to promote understanding of services in relationship to individual functioning and to promote understanding of individual responsibilities.
- D. These programs shall provide crisis intervention by telephone or for walk-ins through the facilities located in the nine counties served by North Central Missouri Mental Health Center. At the individual's first contact with NCMMHC, any emergency or urgent service needs shall be identified and addressed. A person who presents at the main agency office site with emergency service needs shall be seen by a qualified mental health professional (QMHP) within 15 minutes of presentation. As staffing pattern may limit services in some of the satellite offices, every effort shall be made to intervene by:
- 1. Sending a QMHP to the respective county where a crisis situation occurs and/or:
 - 2. Encouraging the prospective client to find transportation to the nearest county where a QMHP is available for services.
 - a. A 24-hour service and referral for crisis care and support is additionally available through CommCare in Kansas City, Missouri.
 - 3. A person who presents with urgent service needs and does not pose imminent harm to self or others will be seen within 48 hours or provide appropriate treatment alternatives or community supports where available.
- E. Screening, evaluation, and referral of clients.

1. Each individual or referral source requesting services shall have prompt access to a screening in order to determine service eligibility and to plan an initial course of action, including referral to other services and resources in the community as needed. A client shall be screened for services in accordance with applicable criteria for acceptance of clients, including presenting problems, need for services, and legal criteria when applicable. The screening interview can be done face-to-face, via telephone, or by other technological means. A person with routine service needs will be seen as soon as possible to the extent that appropriate resources are available.
2. A standardized screening interview shall be conducted by a trained qualified mental health professional to determine client eligibility and be responsive to client needs and requests. A proper referral shall be made if the primary QMHP assesses that this program cannot meet the needs of the client. The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.
3. When a person is found ineligible for services, the person will be informed as to the reasons they were ineligible and will be directed to alternative or more appropriate services. In accordance with the choice of the person served, the family/support system, and/or the referral source will also be informed as to the reasons for their ineligibility and the recommendations made for alternative services. The screening interviewer will document the reason(s) a person is found to be ineligible for services in the ECR.
4. Upon completion of the screening interview and/or initial assessment, the primary QMHP shall formulate a composite of multi-axis diagnostic impressions in accordance with the current edition of the DSM that documents level of care and whether the treatment program appears conducive to the client's needs and if further evaluation appears warranted. Recommendations for specialized services may require more extensive diagnostic testing.
5. A range of service options will be available consistent with individual needs, including emotional, mental, physical and spiritual whenever

applicable.

6. The outgoing referral process may be initiated by the primary QMHP and/or the client.
 - a. Outgoing shall mean to any component other than the one that the client is currently actively involved in or applying for admission.
7. The outgoing referral shall be planned and accomplished in a cooperative manner between the QMHP and client, and should be acceptable to the client except when the client is being denied admission.
 - a. If a client is denied admission, he/she shall be informed of the reason and referred to an appropriate program.
8. Effective working relationships with other community resources shall be maintained with, at a minimum, one inpatient facility, one outpatient component, and one residential facility. At least one inpatient facility and one residential facility shall be equipped to handle impaired clients. The cooperative referral agreements shall be renewed annually.
9. Outgoing referrals shall be assessed to determine effectiveness based on feedback received.
10. Staff shall provide referral assistance to clients who seek or would benefit from services not provided within the client's current treatment component.
 - a. Staff shall familiarize themselves with available resources.
 - b. Staff shall be familiar with the referral procedures, documented by annual staff sign-off of the Policy and Procedure Manual.
11. The client's participation and acceptance of any referral shall be documented in the progress notes with frequency of contact.
12. Background information shall be provided to referral sources when deemed necessary only with the written consent of the client by completing and signing an "Authorization of Release of Information Form" releasing said information.
13. Clients will be encouraged to take responsibility for making their own referral contacts, and may do so from the office via telephone.
14. Referrals may be outgoing referrals procedures.
 - a. Referral procedure shall be utilized to ensure continuity of care.
 - i. Referral shall be utilized when the treatment needs and/or

personal/social needs of the client have changed and cannot be met within the current treatment component.

1. Client shall be referred to an appropriate setting.
- ii. When a decision to refer for continuity of care has been made, written consent shall be obtained from the client which authorizes the component/organization where the client is being referred to provide at a minimum the following feedback:
 1. Did the client follow through?
 2. Was the referral appropriate?
 3. Is the client continuing to participate?
 4. Appropriate "Level of Care" may be found in different components within the same organization or within other service provider organizations.
 5. Referrals that relate to continuity of care shall be made in writing and documented on the client's discharge summary. One copy shall remain within the client record unless the referral was at the time of application for admission.
- b. Referral may be utilized to aid in the client's rehabilitation/habilitation.
 - i. Unemployed clients who are disabled mentally, physically or emotionally, and may benefit from additional training or education may be referred to Vocational Rehabilitation.
 - ii. Clients who did not complete high school or obtain a GED may be referred to a GED course.
 - iii. Clients who cannot read and/or write may be referred to a source of literacy training.
 - iv. Depending on client resources, clients may be referred to area vocational technical schools or colleges.
 - v. Referrals that relate to rehabilitation/habilitation shall be made in writing and documented in the client record.
 - c. Referral may be utilized to assist the client in achieving and

maintaining self-sufficiency.

- i. Clients may be referred to self-help groups, i.e. Alcoholics Anonymous, Weight Watchers, Emotions Anonymous, etc.
 - ii. Staff may organize or refer clients to peer support groups and/or social networks.
 - iii. Clients may be referred to recreational activities, i.e. bowling, volleyball, exercise groups, etc.
 - iv. Clients may be referred to a different treatment setting in order to improve his/her self-sufficiency.
 - v. Referrals that relate to achieving self-sufficiency are not required to be in writing but should be documented in the client record.
- d. Staff shall document in the client record the rationale for making the medical referral.
- i. The appropriate forms shall be completed.
 - ii. The referral shall be to a medical facility that has a service agreement with North Central.
 - iii. The required referral to a medical facility may be overridden by order of a licensed physician.
 - iv. A written copy of the order should be placed in the client record.

15. Incoming referrals may be received from an external organization or individual, or from another component within North Central Missouri Mental Health Center. An incoming referral log shall be developed and maintained.

- a. Incoming referrals shall be assigned to a QMHP and it shall be the QMHP's responsibility to:
 - i. Develop a Release of Information to share pertinent information with the referring agency. The assigned QMHP shall be responsible for the continuity of care between the North Central Missouri Mental Health Center component and the referring agency or component and shall ensure the coordination of service.

- ii. The assigned QMHP, with the appropriate Release of Information, shall provide feedback to the referring agency upon request regarding services and continued client participation.
 - iii. If a client is required to wait for services, the client's ECR evaluation will document the client's need and length of time waiting for services. A therapist will continually review the client names on their caseload and contact clients according to each client's need. The therapist will document any and all contacts with the client waiting for services.
 - b. Incoming referrals (telephone, walk-in, or written) shall be maintained on file with the following information:
 - i. Date received.
 - ii. Name of person referred.
 - iii. Referred by whom.
- F. The agency shall be responsible for inter-agency coordination to develop an adequate services delivery system involving, but not limited to, the legal, medical, and social professionals within the area.
- G. The agency shall maintain a resource directory that lists community services/area resources by name, location, telephone number, fees, eligibility requirements, and referral procedures. This directory shall be updated as changes are noted on an ongoing basis.
- H. Public awareness activities of the program shall provide information on mental health issues that may include the media, meetings with agencies, community groups, interested individuals, brochures, pamphlets, and films. North Central Missouri Mental Health Center staff responsible for marketing will ensure that agency flyers used for marketing accurately reflect current practices.

A. Service Philosophy

1. Outpatient Services shall be made available to, and in a manner that is responsive to, individuals, couples, families, children and groups who are in need of psychological or psychiatric services in the least intensive and restrictive environment. Services will be delivered in a manner that is responsive to each individual's age, cultural background, gender, language and communication skills. Services will be consistent with individual needs that promote independence, responsibility and choices of individuals.
2. Outpatient services shall be designed to provide identification, intervention, treatment, and referral to persons on both a scheduled and unscheduled basis. Services shall be adapted to the needs of different populations.
3. Outpatient services shall be made available to persons from all social and economic backgrounds.
4. Services shall be provided in the most appropriate setting available, consistent with the individual's safety and protection.
5. NCMMHC will demonstrate a commitment to the safety and well-being of the individuals it serves by promoting therapeutic process, encouraging appropriate behavior and ensuring safety by responding to any threats of suicide, violence or harm.
 - a. No weapons or firearms shall be kept on any client or employee providing client services, in any office or vehicle used to transport a client. An exception will be made for any person who must carry a weapon as part of their job responsibilities (i.e., law enforcement officers).
6. Training programs are designed to develop awareness and sensitivity,

including training specific to the diversity of the local community, such as culture, age, gender, sexual orientation, religion/spiritual beliefs, socioeconomic status, language, ethnicity, race, and disabilities of the population served by the agency. Training and education may be offered directly by NCMHHC, community resources, or through online access to Essential Learning to address agency and Department of Mental Health required topics. Services are designed and delivered in a manner that is most effective given the cultures served, and in settings that promote comfort, trust and familiarity.

B. Goals/Objectives

1. To make outpatient services readily available and accessible to residents in service areas by maintaining satellite clinics.
2. To provide outpatient services to persons who may be directly or indirectly affected by mental illness or other mental disorder and to encourage individuals to assume an active role in developing and achieving productive goals. Each person and/or guardian directly participates in developing his/her individualized treatment plan, including signing the treatment plan.
3. To enhance motivation and self-direction through meaningful goals and working with others, such as family, guardian or the court, that establish positive expectations and promote individual participation.
4. To facilitate continuity of care for the persons served through a referral process to other treatment facilities within or outside the area as needed.
5. To enhance recovery by referring clients to other resources within the communities and by addressing barriers to treatment.
6. To assist clients in accessing transportation, childcare, and safe and appropriate housing as necessary for the individual to participate in treatment.

C. Standards of Treatment

1. The standards of treatment of this agency shall comply with Federal Funding Criteria as described in Federal Register Issued May 27, 1975, part IV by the Federal Register Issued January 21, 1977, Vol. 42, No. 20.
2. The standards of treatment set forth by this agency shall apply to all

psychiatric treatment provided by this agency.

3. The Policy and Procedure Manual of the agency, client records, logs, management books, and other documents shall reflect compliance with State and Federal Funding Criteria.
4. This agency shall be certified by the Department of Mental Health, Division of Behavioral Health Psychiatric Services.
5. Treatment principles, services and supports shall be provided and understood by qualified, experienced, professionals with due regard for the client's best interest and in accord with treatment goals and objectives jointly established and agreed to by both client and staff.
6. Treatment principles will be consistent with clinical studies and practice guidelines for achieving positive outcomes. Individualized treatment plan development includes consideration of a person's cultural, spiritual and economic background. Knowledge of cultural and spiritual diversity is a critical component when providing respectful and individualized quality services.

D. Facilities

1. Satellite offices shall be established and maintained on a regularly scheduled basis as availability of time and funding allows.
2. All facilities shall be maintained in a clean, sanitary, and safe condition, and shall be easily accessible.
3. The facilities shall be in compliance with local building, health, and safety ordinances.
4. Programs that allow provision of food to individuals will make sure that appliances are clean and in safe and proper operating condition. Hand washing facilities, including hot and cold water, soap, and hand drying shall be readily accessible.

E. Hours of Operation

1. The outpatient program shall maintain reasonable hours of operation consistent with the needs and schedules of the population served.
2. Direct service shall be available at least five (5) days per week, 45 hours per week, through Friday with option of Saturday and evening appointments.

3. A minimum of two (2) hours per day, Monday through Friday shall be hours other than the standard 8 a.m. to 5 p.m. hours.
4. Emergency services other than regular working hours shall be provided by telephone contact at **1-888-279-8188**.

F. Organization

1. The Clinical Director shall be responsible for supervising clinical staff of the outpatient components.
2. A designated staff member will coordinate services and ensure implementation of the treatment plan.

G. Setting, Roles and Responsibilities

1. To treat people with respect and dignity.
2. See Job Descriptions. (Section VIII)

H. Client Eligibility Requirements

1. Clients will be received and treated, regardless of age, gender, race, religion, national origin, social or economic condition, or length of local residency.
2. Services may be available if:
 - a. They personally have a possible or actual emotional problem(s).
 - b. They are a family member of a person who has a possible or actual emotional problem.
 - c. They are an employee of a company contracted under the Employee Assistance Program, and have documented work deterioration problems.
 - d. She/he is an employee of a company contracted under the Employee Assistance Program, and desire evaluation and counseling on personal problem areas.
 - e. They are family members of employees of companies contracted under the Employee Assistance Program, and desire evaluation and counseling on personal problem areas.
 - f. They are persons referred by any organization or agency with which this corporation has a signed contract for evaluation/counseling.
3. A client, if possible, will be treated on a voluntary rather than an

involuntary basis.

4. A client will not be denied treatment solely because that person has withdrawn from treatment against medical or clinical advice on a prior occasion.
5. A client will not be denied treatment solely because that person has relapsed after treatment.
6. A client is expected to follow the rules and regulations of the program and failure to do so may lead to the termination of services.
7. A minor client must have a parent or legal guardian consent to treatment.

I. Referral of the Ineligible

1. In the event that outpatient services are deemed inappropriate, the client will receive said justification for ineligibility.
2. If admission is denied due to ineligibility, the client shall be referred to an alternative source of service(s) that is deemed more appropriate.

J. Client Intake and Assessment

1. Orientation to the outpatient program shall be provided at intake that relates to their understanding of what will happen as services are delivered.
 - a. The "Client Information Brochure", which provides information on facilities, office hours, cost, description of services, client rights, client responsibilities, and client grievance procedures, shall be given to each client at intake.
 - b. Each client will receive orientation information that includes an explanation of:
 - 1) An agency brochure that describes hours of operation and services offered;
 - 2) How to access after-hours services;
 - 3) Code of Ethics;
 - 4) Confidentiality policy;
 - 5) Familiarization with the premises, including emergency exits and/or shelters;
 - 6) Policies regarding:

A) *The use of seclusion or restraint*

- B) Use of tobacco products
- C) Illegal or legal drugs brought into the program
- D) Prescription medication brought into the program
- E) Weapons brought into the program

7) The purpose and process of the assessment;

8) Treatment planning:

A) *How the treatment plan will be developed*

- B) The client's participation in goal development and objectives of the treatment plan

9) Any restrictions a program may place on a client;

10) Events, behaviors or attitudes that may lead to the loss of rights or privileges:

- A) The means by which the client may regain rights or privileges that have been restricted.

2. An "Intake Assessment", diagnostic formulation, and treatment plan shall be completed by qualified, trained staff with each client/guardian at intake to assess client needs, goals and appropriateness of outpatient services. With written permission of the client/guardian, the assessing staff person may choose to contact collateral sources for the assessment. Collateral sources may include parents/guardians, teachers, social workers, probation officers, physicians, friends, peers, etc. The assessment process shall gather sufficient information to develop a person-centered treatment plan and assist in ensuring an appropriate level of care. The assessment must include: demographic and identifying information; presenting problems, personal strengths, abilities and interests, individualized needs, current psychiatric symptoms, goals and treatment expectations; physical and mental status; referral source; history of previous psychiatric and/or substance use treatment, including number and type of admissions; history of abuse/neglect/violence; health screening; past/current medications, allergies, adverse reactions, recent and past tobacco, alcohol and/or drug use for at least the past 30 days;

and family/social/legal/educational/vocational functioning; preferences; risk-taking behaviors; any need for assistive technology in the provision of services; recommendations; and prognosis. An individualized treatment plan is then developed based on the assessment.

3. The need for a physical examination shall be determined at intake.
 - a. The procedure may include consultation with a physician.
 - b. The procedure shall include health questions, date of last physical examination, awareness of any medical problems, current medications, and identification of any medication allergies and adverse reactions.
 - c. In addition to the client's physical health, questions regarding the client's emotional status shall be obtained to further screen any organically based psychiatric problems, as well as current uses of resources and services from other community agencies, and personal and social resources and strengths, including the availability and use of family, social, peer and other natural supports.
 - d. The results of implementing the procedure will be used to determine if a physical examination is needed.
 - 1) Each therapist is responsible for determining said need based on the clinical information gleaned from the intake assessment.
 - 2) Documentation of said need is placed in the client file at the end of the intake assessment.
 - 3) In the event a physical examination is requested/recommended, the results of the physical examination will be kept in the client records.

K. Treatment Planning

1. An "Initial Master Treatment Plan" shall be developed at intake for all clients during admission to the outpatient program.
2. A "Master Treatment Plan" shall be developed with the client within 60 days of admission.
 - a) Services and supports shall be individualized in accordance with

the unique needs, goals and situation of each individual served.

- b) The treatment plan shall include: measurable goals and outcomes, services and supports and actions to accomplish each goal/outcome, staff member responsible, involvement of family when indicated, referral services, projected time frame of completion, estimated discharge/completion date for the level of care, and criteria regarding discharge of successful completion.
3. The primary QMHP will ensure the "Master Treatment Plan" will be updated with the client every 90 days to assure ongoing service delivery with applicable eligibility and utilization criteria. The frequency of treatment plan reviews shall be based on the individual's level of care.
4. Decisions regarding level of care and the treatment setting will be based on: client choice, personal safety, severity of presenting problem; emotional/behavioral functioning; need for structure; social/family/community functioning; readiness social supports for recovery; ability to avoid high risk behaviors; identifying and addressing gaps in service provision; and the ability to cooperate with and benefit from the services offered.

L. Support and Rehabilitation of Clients

1. The frequency of formalized counseling shall be determined by the counselor and the client.
2. At least 60 percent (60%) of therapist time shall be spent on direct client contact.
3. Missed Appointments: Contact should be initiated within 48 hours to clients who fail to show for their appointments unless client's symptoms and functioning indicates a more immediate contact. Efforts made to contact the client are to be documented in the client record. Behavioral Health Psychiatric Services clients who have not received services for a six (6) month period shall be discharged from the outpatient program.
4. Outpatient CPS services shall include screening; emergency services; psychotherapy; aftercare; information/education about the person's disorder(s); family therapy; peer-support, principles and availability of self-help groups, health and nutrition, skill development, personal recovery,

promotion of positive family relationships, and relapse prevention.

5. Services shall be delivered by qualified professionals with appropriate licenses or credentials and consistent with the current state of knowledge and generally accepted practices.
6. The outpatient program shall meet the requirements in 9 CSR 10-7.
7. Services shall include assistance in accessing employment, vocational, and educational resources in the community, relevant to client needs.
8. Individuals shall be encouraged to achieve positive social, family, and occupational/educational functioning in the community. To the fullest extent possible, clients shall be responsible for the action steps to achieve their goals. Services and supports provided by staff shall be readily available to encourage, assist, and advocate for clients in their recovery.

M. Criteria for Discharge and Termination

1. NCMMHC shall consistently implement criteria regarding discharge and readmission. Clients shall be actively involved in discharge planning and aftercare as a final step of the treatment process when rehabilitation/treatment goals have been successfully completed.
2. Services to a client may be terminated prior to successful discharge if a client fails to follow the rules and regulations of the program outlined in "Client Responsibilities".
3. A discharge summary and, where applicable, an aftercare plan shall be prepared upon: transferring to a different provider; successfully completing treatment; or discontinuing further participation in services.
4. A discharge summary shall include: date of admission and discharge; reason for admission and source; diagnosis or diagnostic impression; description of service provided; outcomes achieved; prescribed medications, dosage and response; reason for or type of discharge; medical status; needs that may require ongoing monitoring and support; and success level of completion.

N. Criteria for Follow-Up Services

1. See Subject: Follow-up. (Section II, Subject 4)

O. Criteria for Re-entry

1. Clients who request to re-enter services on an outpatient basis shall be re-

admitted in accordance with the "Client Eligibility Requirements".

P. Behavior Management

1. NCMMHC shall promote the rights, dignity and safety of individuals being served. NCMMHC is mindful of developing cultures that create healing along with healthy and safe environments, and include client engagement, partnership with a client and not power over a client, holistic approaches, respect, hope and self-direction. Clients may require supports to fully benefit from their services. Supports may include environmental supports, verbal prompts, written expectations, clarity of rules and expectations, or praise and encouragement. Even with these supports, clients may show signs of fear, anger, or pain, which may lead to aggression or agitation. NCMMHC staff will respond to these signs through de-escalation, changes to the physical environment, implementing meaningful and engaging activities, re-direction, and active listening. NCMMHC does not recognize the use of timeout, physical, mechanical, and/or chemical restraint, or seclusion as acceptable treatment of a client under any circumstances, either as a behavioral intervention or as an emergency response.
2. Briefly holding a client without undue force, for the purpose of comforting him or her or to prevent self-injurious behavior or injury to self, or holding a client's hand or arm to safely guide him or her from one area to another is not considered a restraint. Separating clients threatening harm to one another, without implementing restraints, is not considered restraint. Seclusion refers to restriction of the client to a segregated room with the client's freedom to leave physically unrestricted. Voluntary time-out is not considered seclusion. Aversive conditions, withholding of food, water, bathroom privileges, painful stimuli, corporal punishment, discipline or coercion for staff convenience, or retaliation, of any kind is prohibited.

Problematic or disruptive behaviors will be managed and de-escalated through verbal measures with involvement of a QMHP or the client's community support specialist when possible. Repeated or ongoing behavioral problems will be reported to the community support specialist and addressed in the treatment plan for appropriate short and long-range interventions.

Behavior management policies are responsive to feedback received from clients and their family members or advocates.

Responses to explosive behavior will be handled according to crisis response procedures.

SECTION: OUTPATIENT SERVICES

SUBJECT: COUNSELING

SECTION NO. II

SUBJECT NO. 3

- A. The agency shall provide counseling services to individuals who have progressed through some component of treatment and rehabilitation to a point in their recovery where they will benefit from a level of continued contact which will sustain and continue the gains made in the recovery process.
- B. Counseling will involve two essential components.
 - 1. Individuals referred from other treatment facilities for counseling services.
 - 2. Individuals entering counseling following sufficiently progressing in their treatment from this agency.
- C. The Goals and Objectives of counseling are:
 - 1. To provide therapeutic counseling/support to individuals, groups, and/or families, referred from within or outside this agency. Counseling services are designed and implemented to increase independence and maximize integration into the community.
 - 2. Recovery will focus on the development of new meaning and purposes as individuals or families grow beyond the problems associated with the concerns that led them to seek services.
 - 3. To provide continuity of care and to sustain improvements made for clients by offering supportive care and referring to other available community resources.
 - 4. To develop an individualized after care plan with all clients participating in this component.
 - 5. Each counselor/therapist is responsible for providing aftercare to those individuals residing in the counselor/therapist's assigned geographic area.

SECTION: OUTPATIENT SERVICES

**SUBJECT: DISCHARGE, TRANSFER
AND AFTERCARE PLAN**

SECTION NO. II

SUBJECT NO. 4

- A. Each client shall be actively involved in planning for discharge and aftercare. The participation of family and other collateral parties (e.g. referral source, employer, school, other community agencies) in such planning shall be encouraged, as appropriate to the age, guardianship, service provided, or wishes of the client.
- B. A discharge summary, and where applicable an aftercare plan, shall be prepared upon:
 - 1. Transferring to a different provider;
 - 2. Successfully completing treatment;
 - 3. Discontinuing further participation in services.
- C. An aftercare plan shall be completed prior to discharge. The plan shall identify services, designated provider(s), or other planned activities designed to promote further recovery.
 - 1. The plan shall include methods and procedures, whereby the needs of individual care are met by the aftercare staff through direct services and/or assistance from other community human services resources.
 - 2. The plan shall include documentation verifying that the plan is jointly formulated by prior providers of treatment and/or rehabilitation, aftercare personnel, and clients.
 - 3. The plan shall document the nature of the client's participation in formulating the service plan.
 - 4. The plan shall document that the client has a specified point of contact to facilitate obtaining service upon demand.
 - 5. The plan shall include provisions for referral to another aftercare program in the event of patient relocation.

SECTION: OUTPATIENT SERVICES

SUBJECT: FOLLOW-UP

SECTION NO. II

SUBJECT NO. 5

- A. A closed chart consumer satisfaction survey will be used to assess the quality of service provided to a previous client.
- B. The objectives of closed chart consumer satisfaction surveys are:
 - 1. To assess the effectiveness of treatment intervention.
 - 2. To obtain feedback from the client regarding the degree of satisfaction with service delivery.
 - 3. To assess the client's need for continued support.
 - 4. To provide continuity of care if needed by offering supportive services and/or referring to other agencies.
 - 5. To contact at least ten (10) percent of all clients discharged from the agency within each fiscal year.
- C. Follow-up services are directed to clients of the agency who have been discharged from treatment.
- D. Clients shall receive a follow-up plan according to their aftercare plan:
 - 1. The follow-up plan shall describe the services the program will provide, the frequency, and how the contacts shall be made.
 - 2. For face-to-to face or telephone contact, the clinical staff will document follow-up efforts and contacts in the client's Memo to Chart showing date, method, and results of follow-up attempts.

SECTION: OUTPATIENT SERVICES

**SUBJECT: OUTREACH SERVICES –
SUBSTANCE USE**

SECTION NO. II

SUBJECT NO. 6

- A. **PHILOSOPHY:** The outreach component of the agency utilizes a philosophy of treatment with persons and their families who have co-occurring disorders related to the use of alcohol and other drugs. It is the goal of the agency to develop a comprehensive delivery system within the Green Hills region, including Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam, and Sullivan counties in the state of Missouri. This necessitates the involvement of many organizations, agencies, and individuals who are aware of existing services and how to utilize them. Assistance is given to help other service agencies in the treatment of the client; medical personnel, social service agencies, educational institutions, and industrial and manufacturing groups. This system hopefully will maximize the greatest possible return, given the available resources with the areas served.
- B. **GOALS/OBJECTIVES:**
1. To treat individuals in the early and middle stages of problem substance use or emotional disturbances before loss of job or family is apparent.
 2. To work with existing agencies and service providers to maximize efforts toward treatment of substance addiction and other mental health problems.
 3. To develop an adequate service delivery system involving family, social, medical and legal professionals within the two basic service areas.
- C. **ORGANIZATION/PROCEDURE:**
1. Outreach activity:
 - a. All counselors are required to do outreach activity, on a time available basis, in their assigned counties.
 - b. Case findings and caseload is dependent on maintaining contact with community social referral agencies, and this is an activity expected from and assumed by each counselor/therapist.

- c. Counselors/therapists are not required nor expected to document each outreach/referral source contacted.
 - d. The outreach component shall maintain documentation verifying outreach/personal report activities and recommendations back to any person, agency and/or organization assisting in the treatment of the client and/or his/her family members. These reports shall specifically include a description of services provided to the clients and only after appropriate authorization for release of information is given by the person(s) being served. Documentation shall be made in a client's chart.
2. Education and community programs are considered to be outreach activity.
- a. All requests for programs from community organizations, schools, industrial, manufacturing, civic groups, etc. will be honored as time is available.
 - b. A log documenting community presentations will be maintained. Each counselor is responsible for entering and completing the necessary information in the log.
 - c. The general public will be kept informed of available services in various ways: brochures, public speaking engagements, memberships in various professional and civic organizations, recipients of the services, agency friends, neighbors, newspaper, radio, etc. Employees are also expected to inform the public about agency services.

SECTION: OUTPATIENT SERVICES

**SUBJECT: TREATMENT SERVICES –
SUBSTANCE USE**

SECTION NO. II

SUBJECT NO. 7

A. POLICY

1. Outpatient co-occurring disorders and substance use treatment programs shall be designed, directed, and implemented by a philosophy of treatment instituted by North Central Missouri Mental Health Center. All co-occurring disorders and substance use treatment services provided shall reflect the philosophy of the agency.

B. DISCUSSION

1. There must be a common understanding of addiction and the methods by which treatment is to thereby be provided. Through the adoption of a common philosophy by the treatment staff, the curriculum and counseling services can sensibly and consistently address the population's treatment needs.

C. PROCEDURES

1. Mission Statement – The mission of the agency is to provide treatment and related supportive services to those whose lives have become unmanageable as a result of co-occurring disorders and chemical dependency with dysfunctional lifestyles. The goal is to return these individuals to the community as fully functioning members.
2. Philosophy of Treatment – The philosophy of the agency is based upon the disease concept. For individuals with co-occurring disorders, coordinating services shall be provided or arranged. The treatment approach emphasizes the need for accurate individual screening, assessment, diagnosis and development of an individualized treatment plan by qualified, trained staff that includes improving the client's physical health, psychosocial functioning, spiritual life, relationships and coping skills in the least restrictive environment. The agency views substance use as a disorder of the whole person affecting some or all areas of

functioning. Individuals involved in substance addiction become entrenched in a lifestyle that includes antisocial behavior, negative patterns, attitudes and roles. Confused values, behavioral problems, family difficulties, vocational and educational deficits, health problems and legal difficulties are frequently evidenced among the chemically dependent and act within the cycle of substance addiction. Each individual shall receive a multi-dimensional approach that comprehensively addresses not only addictive thinking but also directs attention to a global change in lifestyle that fully addresses his/her treatment needs. The decision to commit to a sobriety-based lifestyle requires a great deal of understanding and support if it is to take root in new behaviors, thoughts, attitudes and values. Caring about people, and expressing that care, combined with a comprehensive knowledge and understanding of chemical dependency provides an ideal mixture to help give direction to the decision to live a chemical-free life.

3. Treatment Approach – The treatment approach includes several different modalities. The program offers several levels of treatment focus and intensity, and reflects a comprehensive treatment design that holistically addresses the individual needs of the client and/or his family. The program maintains communication regarding the individual's treatment plan and progress, and provides all necessary services in accordance with the program's capabilities and certification.
 - a. Continuum of Treatment – The service delivery structure shall be a continuum which includes four (4) time limited stages of treatment, which shall provide for the individual's entry at that level of care indicated by their need: 1) Engagement; 2) Persuasion; 3) Active treatment; and 4) Relapse prevention.
 - b. Individualized Services – Services shall be individualized. The programs shall be designed to provide for the unique needs of the client as identified in the screening/assessment process. When indicated, programming shall be adopted based on the individual's age, cultural background, race, gender, or other factors.
 - c. Rehabilitation Approach – Rehabilitation efforts shall be focused on

the skills, attitudes and behavior that have specific relevance to the individual's ability to maximize functioning in his/her current social environment and the individual's ability to achieve and maintain recovery. The program's structure and delivery system shall promote client independence and client involvement in productive, meaningful activity in the least restrictive environment.

- d. Outpatient Counseling Services – Includes evaluation, education and counseling for individuals with alcohol and drug use problems and family members affected by their usage. Individual and group sessions are available. Family members are encouraged to take part in the client's treatment during family counseling and co-dependency groups, which are provided weekly.
4. Program Principles – The programs shall be further guided by a set of principles designed to ensure effective substance addiction treatment. The following principles will guide the design of any and all contracts the agency receives regardless of the nature of the contract or the services contracted:
- a. Staff will, at all times, show care and concern for all clients.
 - b. Staff will serve as positive role models for the clients.
 - c. Staff will recognize the dignity and value of each client as a human being.
 - d. Staff will act as rational authorities.
 - e. All program rules and consequences will be clearly explained and enforced quickly, fairly and consistently.
 - f. The program process will be designed to prepare the client to use appropriate tools in resolving problems effectively.
5. Program Design – The alcohol/drug addiction program shall be designed to offer substance addiction treatment services to those who are referred and/or who walk in. Services shall be delivered to promote the recovery process, provide skill development and address relapse prevention.
- a. Client Independence – To the extent possible, the program structure and service delivery system shall promote client independence and client involvement in productive, meaningful

activity.

- b. Holistic – The program design shall address the client’s physical, mental, emotional and spiritual needs.
- c. Comprehensive – Services and supports shall be comprehensive in nature to maximize the likelihood of sustained recovery.
- d. Interdisciplinary Staff – A staff with a variety of professional, educational and experience background shall be available. A team approach to treatment involving collaboration and team problem solving shall be used.
- e. Coordination of Services – There shall be coordination and collaboration of care both within and outside the program. Program referrals will provide necessary services and maintain appropriate involvement and promptly arrange additional services as needed. Services shall be continuously coordinated between programs to ensure that services are not redundant or conflicting.
- f. Education – There shall be education of clients regarding substance addiction and related issues.
- g. Least Restrictive Environment – Service delivery shall be conducted with the concept of least restrictive environment as applicable to each individual client.
- h. Availability – Individuals shall be accepted for treatment who are in need of treatment and can profit from the programs.
- i. Family Involvement – The program shall be sensitive to the needs of family and friends during the recovery process, and staff is willing to meet with family/friends to address (or refer assistance) issues of importance to these groups.
- j. Client-Specific Design – The program shall address therapeutic issues relevant to the client and shall address their specific needs.
- k. Groups – The client and his/her family shall be offered groups of various types so as to meet his/her specific needs. Groups can be individual/group therapy and/or educational groups. Group curriculum includes, but is not limited to, skill building, relapse prevention, co-occurring disorders, spirituality, healthy

relationships, assertiveness, mental illness education, and smoking cessation.

SECTION: OUTPATIENT SERVICES

SUBJECT: CRISIS RESPONSE

SECTION NO. II

SUBJECT NO. 8

Policy: Crisis intervention and resolution services are available to clients and non-clients of Service Area 13, North Central's encatchment area as designated by the Department of Mental Health. Access to crisis intervention services is provided by qualified staff through the use of a twenty-four hour a day, seven day a week crisis hotline, which is answered by CommCare staff in Kansas City, Missouri at **1-888-279-8188**. Crisis intervention includes face-to-face intervention when clinically indicated.

Procedure: Crisis intervention and resolution services are divided into Daytime On-call services and Evening/Weekend/Holiday On-call services as follows:

Daytime On-Call: The Intake Specialist is available from 8:30 am to 4:30 pm to take crisis calls and walk-ins. The ACI Coordinator is back-up to the Intake Specialist. In the event either of the two are not available, arrangements are made in advance for coverage by another QMHP.

Evening/Weekend/Holiday On-Call: The ACI Coordinator prepares this assignment on a quarterly basis, rotating holidays. There are two clinicians on-call to CommCare staff from 4:30 pm to 8:30 am every weekday evening and all day on weekends and holidays when the agency is closed.

Refer to the CPRC Manual, Section VII for more specifics.

SECTION: MEDICATION SERVICES

SUBJECT: PHILOSOPHY

SECTION NO. III

SUBJECT NO. 1

The purpose of prescribing and/or administering medication for any individual seeking treatment is to reduce the symptoms that interfere with the client's ability to adapt to his/her surroundings.

Psychotherapy and related services such as case management are the treatment of choice for many clients; medication treatment is used as an adjunct to these services.

Based on client need and resource availability, medication services are provided to children, youth and adults residing in Service Area 13.

Staff authorized to conduct medical, nursing and pharmaceutical services do so using sound clinical practices and following all applicable state and federal laws pertaining to medications and controlled substances.

NCMMHC will not use medication as punishment, prevent use of medication for the convenience of staff, as a substitute for services or treatment, or prevent use of medication in quantities that interfere with participation in treatment services.

Individuals shall be allowed to take prescribed medication as directed, and shall not be denied services solely due to taking or not taking prescribed medications as directed.

The physician, nurse practitioner, and/or registered nurse may provide medical consultation for policies and procedures involving medication use, medical emergencies, health and safety, infection control, or other medically related issues.

SECTION: MEDICATION SERVICES

**SUBJECT: MEDICATION
SUPERVISION**

SECTION NO. III

SUBJECT NO. 2

This service consists of medication management, including prescription use, and review of medications by the treating psychiatrist/nurse practitioner as deemed appropriate for quality care.

A. Frequency

1. Clients receiving medication services will be seen at least every six (6) months by the psychiatrist/nurse practitioner for medication management, review and evaluation.
2. Medication visits may be more frequent as specified in the treatment plan, or as the client condition merits.
3. A psychiatrist/nurse practitioner shall see all clients requiring medication at the earliest appointment unless an emergency.

B. Required Documentation for Each Service Episode

1. Description of the client's presenting condition and symptoms.
2. Pertinent medical and psychiatric findings.
3. Observations and conclusions.
4. Client's response to medications.
5. Actions and recommendations regarding the client's ongoing medication regimen.
6. Pertinent/significant information reported by family members or significant others regarding a change in the client's condition and/or an unusual or unexpected occurrence in the client's life.
7. Items 1-6 will be recorded for each visit by the psychiatrist/nurse practitioner on the progress note form.
8. When medication is part of the treatment plan, documentation will show that the individual and, if appropriate, family member(s) or other significant others who are involved in making decisions related to the use of medications and understand the purpose and side-effects of the

medications.

9. Clients are encouraged to take medications as prescribed. Refusal of medications will be documented. Ongoing refusal will be reported to the physician/nurse practitioner.
10. The physician/nurse practitioner/registered nurse will ensure that information and education that is relevant to the needs of the client is provided. Client education may be provided individually, as a group (family), audio or written materials, Internet, or through resource, listings. Education may also be provided through community resources/providers who would assist the client to access information on their own.

*All documentation requirements such as legibility, black ink, and procedures for corrections apply. * NOTE: Red ink will be used to denote any allergies.*

SECTION: MEDICATION SERVICES

**SUBJECT: MEDICATION
ADMINISTRATION**

SECTION NO. III

SUBJECT NO. 3

Medication Administration is restricted to the administration of medications by injection or by mouth, as prescribed by a licensed NCMHHC prescriber. Only a licensed registered nurse or licensed practice nurse under the supervision of a physician/nurse practitioner or RN can perform medication administration services.

Medications will only be prescribed by agency-privileged staff psychiatrists/nurse practitioner. A list of personnel who have authorized access to the locked medication area will be maintained.

A. Emergency Administration of Medications:

1. The agency will not administer medication on an emergency basis unless ordered by a staff psychiatrist/nurse practitioner. Clients in need of emergency administration of medication will be referred to a local hospital emergency room.

B. Storage of Sample Medications:

1. All sample medications will be signed for upon receipt from the drug representative by the staff psychiatrist/nurse practitioner. They will then be turned over to the clinic nurse for storage. Ingestible medications must be stored separately from non-ingestible medications and other substances.
2. The clinic nurse will keep a perpetual inventory control on the sample medications, regarding amount received and dispensed.
3. All sample medications will be stored in the original boxes. They will be kept under locked security in the medication cabinet/refrigerator/cart that provides suitable conditions regarding sanitation, ventilation, lighting and moisture. The boxes will contain the drug's name, strength and expiration date. Sample medications needing refrigeration shall be kept in a locked refrigerator separate from food.
4. All sample medications administered to patients will be accounted for.

The patient's name, drug name, dose, remaining stock and the nurse's signature will be recorded on the ECR medication form.

5. The clinic nurse will perform monthly audits of all sample medications each month. Discrepancies will be corrected before the next month begins. Discrepancies that cannot be accounted for will be brought to the attention of the staff psychiatrist/nurse practitioner.
6. The perpetual inventory will run from month to month. When the sample medication log is full, the inventory will be copied and originals will be returned to the prescribing psychiatrist. Copies of these records will be kept in a separate file for a minimum of five (5) years in the Clinical Records Department.
7. The monthly count will be written as a "monthly count" and recorded on the line written as patient name/medication.

C. Wasting of Medications:

1. Medication must be removed and destroyed on or before the expiration date. Medications must be transported by an RN/LPN and a witness to the local (Trenton, Chillicothe or Bethany) law enforcement office for medication destruction. Outlying offices (i.e. Brookfield, Milan, Hamilton) will arrange for an RN/LPN and a witness to transport the expired medication to the closest law enforcement office for destruction.
2. Disposal or wasting of all sample medications will be verified by two (2) staff persons. Signatures and documentation of the medication by name of the drug, the date and strength will be recorded on the "Sample Medication Monthly Count Log" (See Attachment A).
3. The staff psychiatrist/nurse practitioner will be notified of all medication wastage. Checking for outdated medications will be done during the monthly inventory and recorded on the "Sample Medication Monthly Count Log."

D. Disposal of Medical Supplies:

1. Used syringes are placed into SHARPS infectious waste biohazard container. The filled SHARPS container is picked up by waste management contractor each month.

E. Medication Administration:

1. Only agency-privileged psychiatrists/nurse practitioners and nurses will administer medication in accordance with sound clinical practices and following all state and federal laws.
2. Medication is administered at regularly scheduled appointments per physician/nurse practitioner order. The administration of medication (intramuscular) is recorded in the client record by the administering QMHP. This documentation will include the client name, medication, dose of medication and date.
3. All clients receiving medication shall have completed agency intake procedures. Client identity is verified through visual identification by the Staff Psychiatrist/nurse practitioner or nurse administering the medication. NCMHHC clients will be allowed to self-administer medication as directed.
4. Any adverse drug reactions are reported immediately to the physician/nurse practitioner responsible for the client, and if this is not possible, to a physician on-call for emergency consultation. Any adverse drug reaction and physician/nurse practitioner recommendations are documented in the client record, as well as the action taken by the program, including presenting condition and symptoms, pertinent medical and psychiatric findings, other observations, response to medications, and action taken.
5. Any medication error is documented in the client record, and the attending physician/nurse practitioner and Clinical Director are notified. A Department of Mental Health EMT - Community Event Report Form - ADA/CPS is completed and forwarded to the Executive Director for any medication error as defined below:

Medication Error:

1. "Medication Error" category – no physician order, prescription written to the wrong person, a mistake in prescribing, dispensing, or administering medications. A medication error occurs if a client receives an incorrect drug, drug dose, dosage form, or route of administration. This includes failing to administer the drug or administering the

drug on an incorrect schedule. Levels of medication errors are:

- a. "Moderate" – medication error is one in which the client experiences short-term reversible adverse consequences and receives treatment and/or intervention in addition to monitoring or observation; and
 - b. "Serious" – medication error is one in which the client experiences life threatening and/or permanent adverse consequences or results in hospitalization or an emergency room episode of care.
6. The agency-privileged psychiatrists/nurse practitioners and nurses will participate in ongoing inservice seminars and review of medical literature on recent developments in psychotropic medications and any side-effects. Records of continuing education attendance are placed in the staff personnel file.
 7. Psychiatrists/nurse practitioners and nurses are available to provide consultation to the individual, and if appropriate family member, and staff regarding the purpose and side-effects of client medication, medication concerns or regarding medication administration procedures.
 8. The nurse will accept telephone orders for medication only from physicians/nurse practitioners who are on the agency's list of authorized physicians/nurse practitioners and who are known to the staff receiving orders. A physician's/nurse practitioner's signature will authenticate verbal orders within five (5) working days of the receipt of the initial telephone order.

SECTION: MEDICATION SERVICES

SUBJECT: MEDICATION RECORD

SECTION NO. III

SUBJECT NO. 4

Psychotropic medications may only be prescribed by licensed physicians/nurse practitioners.

Medication may be dispensed or administered only by the staff psychiatrist/nurse practitioner and/or psychiatric nurse.

Any psychotropic medication written for a client shall be recorded in the ECR Medication Administration Record that includes the following:

A. Medication Record

1. Client name
2. Age
3. Current diagnosis
4. Medication
5. Medication dose
6. Date and frequency of intake
7. Name of staff person authorizing prescription
8. Allergies
9. Non-prescription medication and supplements

Client weight shall be recorded on the ECR Metabolic Monitoring Form.

NOTE: Medication compliance, effectiveness, side-effects, special dietary needs/restrictions, adverse reactions and/or errors with medication will be logged in the progress notes.

SECTION: MEDICATION SERVICES

**SUBJECT: ABNORMAL
INVOLUNTARY
MOVEMENT SCALE**

SECTION NO. III

SUBJECT NO. 5

To facilitate early identification of clients developing abnormal involuntary movements, each client receiving a neuroleptic medication will be screened using the Abnormal Involuntary Movement Scale (see Attachment B).

A. Procedures: If there is evidence of complication

1. The Abnormal Involuntary Movement Scale (AIMS) will be used to screen clients at least every six (6) months.
2. The AIMS will be administered by a nurse, nurse practitioner, Psychiatrist, or Physician.
3. Upon completion of the form, it will be reviewed and signed by a Psychiatrist/nurse practitioner or Physician.
4. The AIMS will be filed in the client's clinical record.
5. In case of abnormal findings, the reviewing physician/nurse practitioner will designate when the client will be given an appointment for medication services and will evaluate the client.
6. If abnormal findings continue to be present, the client will be screened every three (3) months utilizing the AIMS.
7. The Psychiatrist/Physician/nurse practitioner may choose to refer the client for a neurological evaluation. If such evaluation is ordered, the community support specialist and nurse will work with the client and resources to ensure the client is evaluated.
8. The results of the neurological evaluation will be obtained for review by the treating Psychiatrist or Physician/nurse practitioner for inclusion in the client's paper record.

SECTION: MEDICATION SERVICES

**SUBJECT: PRESCRIBING
GUIDELINES**

SECTION NO. III

SUBJECT NO. 6

The agency has adopted the following guidelines when prescribing medications:

A. Prescribing Guidelines:

- a. Prescriptions will be written for all medications in compliance with all applicable local, state or provincial, and federal laws regulations pertaining to medications and controlled substances.
- b. Medication treatment will include active involvement of the persons served, when able, or the parents or guardians, when appropriate, in making decisions related to the use of medications. The psychiatrist/nurse practitioner will receive confirmation of informed consent for each medication prescribed when possible.
- c. A physician/nurse practitioner or qualified professional licensed to prescribe will be available for consultation 24 hours a day, 7 days a week.
- d. Quantities of medication will not exceed a 90 day supply. Refills can be given for quantities to reach the client's next appointment.
- e. The client will be educated regarding identifying potential drug interactions, including the use of over the counter or homeopathic supplements. Observed and or reported medications as well as medication errors will be documented according to progress note form and/or incident reporting procedures.
- f. The psychiatrist/nurse practitioner will review past medication use including the effectiveness, side effects and allergies or adverse reactions.
- g. The psychiatrist/nurse practitioner will identify any use of alcohol, tobacco, and other drug use.
- h. Prescriptions will not be written for non-psychotropic and/or over-the-counter medications on CPS prescription orders. A physician/nurse practitioner may prescribe medications other than psychotropic

medications, but these must be written on outside prescription orders and paid for by the client.

- i. Rationale and symptoms for use of a particular medication will be documented in the progress notes. Rationale for continuing, initiating or changing medication will be documented.
- j. The physician/nurse practitioner will document the use of medications by women of childbearing age and during pregnancy.
- k. The physician/nurse practitioner will consider special dietary needs and restrictions associated with medication use.
- l. The physician/nurse practitioner will consider necessary lab studies and tests or other procedures as needed.
- m. When applicable, the physician/nurse practitioner will document the assessment of the AIMS (Abnormal Involuntary Movement Scale) at the initiation of treatment and every six months thereafter for persons receiving typical antipsychotic medications.
- n. When possible, the physician/nurse practitioner will coordinate with client's primary care physician (PCP) as needed.
- o. Medication use, medication errors and drug reactions will be reviewed as part of the quality assurance monitoring system.
- p. The physician/nurse practitioner will perform a screening for common medical co-morbidities, and an evaluation of co-existing medical conditions regarding medication impact.
- q. If a generic medication is not available, the physician/nurse practitioner will assist in linking the client to services that will ensure the continuation of a prescribed medication.
- r. When transitioning a client to identified services, the physician/nurse practitioner will ensure the continuity of medication treatment in the transition plan.

I have read and agree to the above Prescribing Guidelines policy.

Staff Psychiatrist

Date

SECTION: MEDICATION SERVICES

SUBJECT: CLOZAPINE PROTOCOLS

SECTION NO. III

SUBJECT NO. 7

These are the following protocols for clients undergoing Clozapine treatment:

1. The Global Assessment of Functioning Scale will be performed at least annually. (See Attachment C.)
2. The Abnormal Involuntary Movement Scale (AIMS) will be performed every six (6) months, unless abnormal findings suggest the scale should be performed every three (3) months to monitor closely.
3. The client will be seen weekly for blood draws and medical management.

SECTION: MEDICATION SERVICES

SUBJECT: LABORATORY SERVICES

SECTION NO. III

SUBJECT NO. 8

Metabolic laboratory services may be conducted on site.

The staff psychiatrist(s) /nurse practitioner will assess and prescribe laboratory services if needed.

The client may receive laboratory services by the local hospital of choice.

Policy: Laboratory Studies for Metabolic Syndrome

Due to being at increased risk for chronic illness resulting from metabolic syndrome and smoking, all Healthcare Home/Community Psychiatric Rehabilitation Center (HCH/CPRC) clients meeting any of the following criteria shall have metabolic screening at least annually. Glucose and cholesterol results may be obtained by using the Cholestech LDX machine or outside labs. Clients with abnormal values from prior metabolic screenings may be offered repeat metabolic screening quarterly.

Procedure:

- 1) Clients to receive metabolic screening annually:
 - a. All clients enrolled in the HCH/CPRC program
- 2) Clients to receive metabolic screening quarterly:
 - a. Any client with an abnormal blood pressure, HbA1c, or fasting blood glucose on their most recent prior metabolic screening
- 3) Metabolic screening shall consist of:
 - a. Height
 - b. Weight
 - c. BMI
 - d. Waist circumference
 - e. Presence of tobacco use
 - f. Blood pressure
 - g. HbA1c or fasting blood sugar
 - h. Total cholesterol

- i. LDL
- j. HDL
- k. Triglycerides

This policy constitutes a standing physician order for metabolic screening as listed above for HCH/CPRC clients current enrolled meeting the above criteria. Nursing staff are to implement this order in the same manner that they would a verbal physician order documenting that it was done upon order of the agency Staff Psychiatrist.

Signature, Agency Staff Psychiatrist

Date

SECTION: MEDICATION SERVICES

**SUBJECT: MEDICATION
ASSISTANCE**

SECTION NO. III

SUBJECT NO. 9

The cost of psychotropic medication(s) will be assumed by North Central Missouri Mental Health Center only if the prescription is written by an authorized physician/nurse practitioner on an authorized visit, and the client is eligible for financial assistance.

***NOTE:** Clients who have Medicaid may choose any pharmacy that honors Medicaid.

SECTION: MEDICATION SERVICES

**SUBJECT: PURCHASING
MEDICATION SUPPLIES**

SECTION NO. III

SUBJECT NO. 10

Medical supplies are purchased by the Psychiatric Nurse(s) at a pharmacy designated by the Agency Administration. The nursing personnel will determine the need for medical supplies and are responsible for purchase, storage, administration and inventory of medication supplies.

GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF SCALE)

ATTACHMENT C

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.

Code

- | | |
|----------|---|
| 100 – 91 | Superior functioning in a wide range of activities, life's problems never seem to get out hand, is sought out by others because of his/her many positive qualities. No symptoms. |
| 90 –81 | Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members). |
| 80 - 71 | If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work). |
| 70 – 61 | Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupations, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships. |

- 60 - 51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers).
- 50 - 41 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

ATTACHMENT C

Page 2 of 2

- 40 – 31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is falling at school).
- 30 – 21 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
- 20 – 11 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
- 10 – 1 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
- 0 Inadequate information.

SECTION: THE CLINICAL RECORD

SUBJECT: PURPOSE

SECTION NO. IV

SUBJECT NO. 1

NCMMHC has an organized clinical record system for each individual. The primary purpose of the clinical record is to document the course of a client's treatment and care, whether seen for outpatient services or community support. The record is important in clinical practice and medical care. It serves as an instrument for communication among physicians and other professionals who contribute to the client's care and as a basis for planning and evaluating that care. There shall be documentation of services provided and results accomplished. Documentation shall be made in the client's ECR or with indelible ink if in the paper clinical record.

The clinical record provides information for the review and evaluation of treatment provided to the client. It also serves as a database for supervision, quality assurance activities and program evaluation functions.

The secondary purposes of the clinical record are to (a) serve as a source of substantiation of client care services and treatment; (b) provide clinical data to authorized researchers and the Department of Mental Health; and (c) meet and support legal and quasi-legal obligations of the agency and staff.

Clinical records shall be maintained in a manner, which ensures confidentiality and security. NCMMHC shall abide by all local, state and federal laws and regulations concerning the confidentiality of records.

Records maintained on computer systems have a back-up system to safeguard records in the event of operator or equipment failure and to ensure security from inadvertent or unauthorized access.

SECTION: THE CLINICAL RECORD

SUBJECT: OWNERSHIP

SECTION NO. IV

SUBJECT NO. 2

It is legally established that all clinical records which are maintained for the benefit of the client, clinical staff, medical staff and the agency are regarded as property of North Central Missouri Mental Health Center.

No record may be removed from the premises without court order or subpoena duces tecum. The Clinical Director must be advised. A copy of the court order or subpoena duces tecum under which the record is removed from the premises must be filed in the Records Department to document destination and location of the clinical record.

SECTION: THE CLINICAL RECORD

**SUBJECT: TO CHECK OUT
CLINICAL RECORDS**

SECTION NO. IV

SUBJECT NO. 3

When authorized clinical staff, physicians or Department of Mental Health staff find they need a clinical record for an "unscheduled" client service or contact, the record can be requested by intercom and the records staff will deliver the paper record as needed.

Any time a chart is pulled from the central filing system and is to be removed from the records department, the out guide should be filed in place of the chart removed. The staff member listed on the record log is charged with the responsibility of returning the clinical record to the records department. It is the responsibility of the clinician to notify records staff when a chart is given to another staff member.

Any chart signed out should be returned within 72 hours to the central records filing system. Charts still awaiting completion of service or documentation may be placed "on hold" in the records room. Charts "on hold" are not considered returned to the records department/central filing system and are still "signed out" and charged to that staff member.

SECTION: THE CLINICAL RECORD

**SUBJECT: CLOSING A CLINICAL
RECORD**

SECTION NO. IV

SUBJECT NO. 4

Criteria for closing a clinical record:

1. Any client who has not sought services for twelve (12) months.
2. Any client who has moved out of the agency's encatchment area.
3. Any client who has completed treatment/counseling authorized.
4. Any client who has refused to comply with the agreed upon treatment.
5. Any client who dropped out of counseling and sought no other services for 180 days for CPS services.
6. Any client seen for medication services will be discharged when no services have been sought for over six (6) months.

Procedures to close a clinical record:

1. Staff will complete an Aftercare Plan in the Client's ECR and forward to the Clinical Records Department.
2. Staff will document in the ECR whenever a client relocates outside the agency's encatchment area.
3. Quantitative review of the chart will be conducted to assure documentation has been completed.
4. The Clinical Records Clerk will notify Data Entry to discharge the client from the CIMOR system.

SECTION: THE CLINICAL RECORD

**SUBJECT: REOPENING A CLINICAL
RECORD**

SECTION NO. IV

SUBJECT NO. 5

The procedure to be followed when a client seeks services from the agency, and the record is found to have been closed, is:

1. If the financials are less than one (1) year old, an internal referral will be completed.
2. The Clinical Records Clerk will contact the Invoicing Specialist to back out the closing process. The Clinical Records Clerk will re-open the paper chart (i.e., remove from manila folder and place into formal chart binder).
3. The assigned clinician will update the assessment and treatment plan, and financials if needed.
4. If the financials are more than one (1) year old, the client will be instructed to contact the ACI Coordinator/Intake Specialist/designee to schedule a full intake.

SECTION: THE CLINICAL RECORD

SUBJECT: RECORDS RETENTION

SECTION NO. IV

SUBJECT NO. 6

Clinical records will be retained for seven (7) years in accordance with State of Missouri guidelines for records retention, or until all litigation, adverse audit findings, or both are resolved.

Clinical records/documents will be destroyed (shredded) thereafter only by authority of the Clinical Director following review by the Executive Director.

Paper clinical records that have been closed will be stored in a separate section in the Clinical Records Department.

SECTION: THE CLINICAL RECORD

**SUBJECT: FEES FOR COPYING
RECORDS**

SECTION NO. IV

SUBJECT NO. 7

Authorization for release of records (which requires informed written consent by the client, parent, guardian or legal representative) to attorneys, disability determinations, insurance companies, etc. will be subject to a copying fee. Reimbursement for subpoenaed records will also be requested through the court system's established procedure. However, records requested to be released to another mental health agency or for physicians facilitating care will be at no charge.

The agency has an established fee for authorized requests for records. The base rate for fees for copying medical records and per page costs for supplies and labor varies and is revised by the State of Missouri annually in February. Charges for processing and copying records will be noted on the form letter returned with the requested clinical records. An invoice will be sent for copying fees due.

SECTION: THE CLINICAL RECORD

**SUBJECT: COPYING CLIENT
INFORMATION**

SECTION NO. IV

SUBJECT NO. 8

Any request for client information or records (photocopies) should be processed by the Clinical Records Clerk, who is responsible for verifying there is a properly executed release of information.

Clinical staff will not copy information from client records to forward to physicians, other agencies, or individuals accompanying the client (juvenile officer, etc.). Such requests should be made of the Clinical Records Clerk, even when involving a referral to a physician or health care facility for immediate intervention/emergency services. In any instance where client information is being disclosed or sent outside the agency location, a release of information is required.

SECTION: THE CLINICAL RECORD

**SUBJECT: CRITERION FOR
OPENING CLINICAL
RECORDS**

SECTION NO. IV

SUBJECT NO. 9

A clinical record is opened for any individual when NCMMHC has provided an assessment and referral for clinical care. Opening a record requires an intake assessment, a Standard Means Test, and assignment of a POS number (which is the client identification number regardless of funding source).

NCMMHC will maintain an "agency" record, which will contain all contacts with and/or services provided to individuals who do not later become clients.

All entries in the individual record will be legible, clear, complete, accurate and recorded in a timely fashion. Entries will be dated and authenticated by the staff member providing the service, including name and title. Any errors will be marked through with a single line, initialed and dated.

NOTE: Any individual assessed at the agency and determined to require further services is considered a client and a clinical record will be opened.

SECTION: THE CLINICAL RECORD

**SUBJECT: GENERAL PRINCIPLES
OF CONFIDENTIALITY**

SECTION NO. IV

SUBJECT NO. 10

All client records are confidential. Federal client confidentiality statutes and guidelines govern disclosure of alcohol and drug use records and prohibit secondary disclosure of client information under general written consent for release of information.

Three additional aspects of confidentiality to adhere to are:

1. Confidentiality guidelines require the use of the client's name as seldom as possible. When names must be used, only first names or first names with last initial (in the case of duplicate first names) should be given. Family members should be referred to by family relationship (i.e. sibling, spouse, etc.) or gender (i.e. another female family member).
2. Special care will be taken in documenting any time a client reports being involved in an illegal act. The clinical note should simply state "client reports being involved in . . ." (i.e. burglary, etc.). No mention should be made of any details of an illegal act committed by the client.
3. Staff members will restrict the discussion of client history and diagnosis to staff members who are involved in the treatment or formulation of treatment planning. Discussion will only be conducted within the confines of a private office or meeting room.

SECTION: THE CLINICAL RECORD

**SUBJECT: CONFIDENTIALITY OF
THE CLINICAL RECORD**

SECTION NO. IV

SUBJECT NO. 11

To help insure a client's right to confidentiality, staff will adhere to the following guidelines:

1. Clinical records will be secured and will not be within view in a mailbox, desk, in the front reception area, or elsewhere.
2. Clinical records, or any part thereof, will not be accessible to, or read by, anyone not involved in the client's care, treatment planning, or consultation thereof.
3. Progress notes, evaluations and intakes will be transmitted to and from staff members for signature inside a dictation folder or inter-office envelope.
4. Staff members will check mailboxes and work areas at the end of the day and secure in a locked office, desk or file any documents containing client names or information.
5. Clinical records will be returned within 72 hours, unless client is receiving medical services later that afternoon.

SECTION: THE CLINICAL RECORD

**SUBJECT: TRANSPORTATION OF
CLIENT RECORDS**

SECTION NO. IV

SUBJECT NO. 12

To ensure the confidentiality and security of client information, client records will only be transported when concealed and enclosed in an inter-office envelope, a briefcase, or the records cases specifically purchased for this purpose. Any record hand-carried between agency locations or to court should be protected from weather, the public eye, and from possible loss.

Clinical staff who must document on-call services, off-site staffing, etc. will secure any progress notes/documentation to ensure confidentiality. Whenever possible, the full name of the client will be written after the information has been transported back to the agency location where the record is maintained.

SECTION: THE CLINICAL RECORD

**SUBJECT: WRITTEN CONTACT
WITH A CLIENT**

SECTION NO. IV

SUBJECT NO. 13

It is a policy of the agency that any time written contact (letter, release form, correspondence, etc.) is made with an individual who is seen through this agency, their confidentiality to pursue that service will be protected. This includes sending correspondence or written material in an envelope that does not denote the name of the agency as sender, but provides a return address in case the correspondence is not deliverable at the last known client address.

Return address only envelopes are available within the agency.

SECTION: THE CLINICAL RECORD
SECTION NO. IV

**SUBJECT: DISCLOSURE OF
CLIENT INFORMATION**
SUBJECT NO. 14

Disclosure of client identity or information requires an authorized release of information. Authorization for such release must be by informed written consent of the client, parent, guardian or legal representative.

All requests for release of information from the clinical record will be directed to the Clinical Records Department. All requests must be in writing. Any request to view and/or receive copies of client records must be referred to the Clinical Records Department.

The Clinical Records Department will reply to requests for disclosure of information Monday through Friday, excluding holidays. The Clinical Records Department will respond to requests within seven (7) business days and client records can be viewed, after valid authorization, by appointment only. Identification may be requested.

Any questions regarding disclosure of client information will be referred to the Clinical Director.

SECTION: THE CLINICAL RECORD

**SUBJECT: AUTHORIZATION FOR
RELEASE OF
INFORMATION**

SECTION NO. IV

SUBJECT NO. 15

By written request, a client may authorize disclosure to third parties for the inspection and/or copies of his clinical records.

A valid authorization must:

1. Be written.
2. Be addressed to the Agency.
3. Provide the name and address of person or agency viewing and/or receiving copies of the clinical record.
4. State the purpose for the review and/or copies of the clinical record.
5. Be signed by the client or legal guardian (or parent, if a minor).
6. Be dated at time of signature.
7. Be considered valid for 30 days after the date of signature if date of expiration is not specified.
8. Be signed by a witness.

Any adult eighteen years and older who is competent to contract is authorized and empowered to consent.

A minor who is considered emancipated may give authorization to release his records. A minor is emancipated (a) if married; (b) if has a child of his/her own; or (c) if self-supporting and on own. Proof of emancipation must be provided.

Any unusual circumstances regarding release of information to third party will be reviewed by the Clinical Director and Executive Director.

SECTION: THE CLINICAL RECORD

SUBJECT: INTERNAL DISCLOSURE

SECTION NO. IV

SUBJECT NO. 16

Internal disclosure policies provide guidelines for proper access to the clinical record without the written consent of the client. However, the Clinical Records Department has the responsibility to question (a) the authority of the person making the request; (b) the reason for the request; and (c) the kind of information requested. The request may be held in abeyance until approval from the Executive Director is received.

All employees of the agency are made aware of their responsibility to maintain confidentiality of clinical record information.

Governing Board - Legal precedents recognize the right of access by the Governing Board of the agency in order to ensure quality of client care.

Agency Legal Counsel - With administrative approval, the Agency Legal Counsel may review and copy any clinical record without the client's consent.

Professional Staff - Professional and Clinical Staff may inspect clinical records only as required to carry out their professional duties. The record may not be copied.

Data Entry/Billing - The diagnosis will be released to the agency business office for data entry and payment of bill without patient consent.

Quality Assurance Activities - Because of administrative responsibility for monitoring the quality of care provided to all clients, clinical records will be provided without client authorization.

Research - Third-party request for research information must have the Executive Director's approval. Information released for research purposes will not identify the client unless the researcher first shows: (a) the information is needed for worthwhile purpose; (b) access is vital to that purpose; and (c) the client's expectation of confidentiality will be protected.

SECTION: THE CLINICAL RECORD

SUBJECT: EXTERNAL DISCLOSURE

SECTION NO. IV

SUBJECT NO. 17

External disclosure policies have been established to provide guidelines for authorized access to the clinical record. Only information requested on the written authorization will be disclosed unless limited by law (i.e., drug and alcohol use records).

Other Health Care Agency - This agency will not honor a request for another health care facility for client-identifiable clinical record information unless the request is accompanied by the client's authorization for disclosure. Exceptions include a showing of compelling circumstances affecting the health or safety of a person.

Non-staff Physicians - This agency will not honor a request from a non-staff physician for client identifiable clinical record information unless the request is accompanied by the client's authorization for disclosure, except showing a compelling circumstance affecting the health or safety of a person.

Insurance Companies - This agency will not disclose to an insurance company or plan any client identifiable record information maintained by the agency unless the request is accompanied by the client's authorization.

Government Agencies - This agency will not honor a request from government agencies (such as Division of Family Services, Disability Determinations, etc.) for client identifiable clinical record information unless the request is accompanied by the client's authorization for disclosure. Exception: The reporting of suspected child abuse/neglect as mandated by state laws.

Worker's Compensation - In accordance with Missouri law (Section 287.140-6), "parties to a claim for compensation are entitled to review the record of a patient making a claim through the division of Worker's Compensation without the permission of the patient. However such person must present Division Form 43 as proof of division of Worker's Compensation action in the case.

SECTION: THE CLINICAL RECORD

**SUBJECT: DISCLOSURE WITHOUT
CLIENT CONSENT**

SECTION NO. IV

SUBJECT NO. 18

It is the policy of the Agency to ensure the confidentiality of client records at all times. However, certain circumstances will justify disclosure without client consent.

Client identifying information may be disclosed to medical personnel who have a need for information about a client for the purpose of treating medical emergencies.

The program must document the disclosure in the client's record, including (a) the name of the medical personnel to whom disclosure was made and their affiliation with any health care facility; (b) the individual making the disclosure; (c) date and time of disclosure; (d) nature of the emergency (or error, if the report was to FDA); and (e) information disclosed.

Client identifying information may be disclosed for the purpose of conducting scientific research if the Executive Director determines that the researcher has a protocol under which the client's expectation of confidentiality will be protected.

The researcher will not identify any individual client in any report of that research or otherwise disclose client identifies.

Client-identifying information may be disclosed for audit by any federal, state or local government entity that provides financial assistance to the program or is authorized by law to regulate its activities.

Client-identifying information may be disclosed for audit and evaluation by a program-funding source or by a peer review organization performing a utilization or quality control review.

SECTION: THE CLINICAL RECORD

**SUBJECT: SUBPOENA DUCES
TECUM**

SECTION NO. IV

SUBJECT NO. 19

Upon receipt of a valid subpoena duces tecum, the agency is required to respond or to be held in contempt of court.

When the subpoena is received, clinical records staff will:

1. Verify the validity of the subpoena.
2. Verify the name and phone number of the attorney/individual requesting the appearance of the Clinical Records Clerk.
3. Ensure completeness of only those records specifically requested.
4. Tag the record so that it will not be removed from the Clinical Records Department.
5. Notify the Executive Director for instructions prior to answering the subpoena if the subpoena is in reference to a legal claim against the agency, physician or agency staff.
6. Photocopy the entire clinical record.
7. Both the original and photocopy are to be taken to court.
8. Call the person issuing the subpoena and request to be on one (1) hour standby. Information may not be disclosed in response to a subpoena without a specific court order or patient consent.
9. Possession of the clinical record will not be relinquished unless ordered by the court.
10. Request that the court retain the copy of the record and return the original record to file. If the original record is retained by the court, request a receipt and a date when the record could be reclaimed by the agency.
11. Examination of the record will not be allowed unless ordered by the court.
The party issuing the subpoena has no right to see the record until examination is ordered by the court.
12. Answers will be limited to identification of the record. Clinical Records personnel will not interpret the record.

13. The attorney issuing the subpoena will be given a statement for charges including:

- a. Photocopying the clinical record.
- b. Employee's time and appearance.
- c. Transportation.

Exception: Federal regulations protect alcohol and drug use records from being subpoenaed without the authorization of the patient or specific court order. When a subpoena is received for records containing evidence of alcohol and drug use, the patient's consent must be obtained or the court must be notified that the record contains privileged information that cannot be released without court order.

Section 42 United States Code 4572 provides criminal penalties for violating disclosure of information about alcohol or drug use. Particular consideration must be given to records protected by this legislation.

SECTION: THE CLINICAL RECORD

SUBJECT: PATIENT ACCESS

SECTION NO. IV

SUBJECT NO. 20

As the agency provides mental health services, special consideration must be given prior to disclosure of clinical records information. Each individual shall have the right to see and review his/her own record. In view of the increased confidential nature of information contained within the agency's clinical record, the following policies and procedures have been adopted:

1. The client, parent or guardian must submit a written request for inspection of the clinical record and state the purpose of the review and dates of treatment.
2. The client, parent or guardian must make an appointment to review the clinical record. A NCMMHC representative, preferably the community support specialist, will be present to clarify the information.
3. An appointment to review the record will be given within 14 days of receipt of the written request, unless the Program Director or physician determines that such disclosure would not be in the client's best interest.
4. The client may designate another individual to inspect, or have a copy of, the information on behalf of the client.
5. A minor has a right to access his/her substance use clinical record without knowledge or consent of his/her parents.
6. When a claim against the agency or staff is threatened or pending, requests by clients or their representatives for access to the client's clinical record will be brought to the attention of the Executive Director and legal counsel immediately.
7. Request for review and copies of child abuse cases will be denied. These will be released to the client's authorized representative only with court order or subpoena.
8. Specific information or records provided by other individuals or agencies may be excluded from such review.

SECTION: THE CLINICAL RECORD

**SUBJECT: DOCUMENTATION
PROTOCOL**

SECTION NO. IV

SUBJECT NO. 21

The following are standard procedure and records protocol:

1. All entries in the clinical record will be made in only black ink. Exception: Red pen will be used for any allergies.
2. All entries will be written in clear sentences, using only approved abbreviations.
3. Handwritten entries will be legible and easy to read.
4. Any correction will be made by drawing one line through the error and initialing and dating the correction.
5. Contacts with a client or regarding a client will be documented in a progress note.
6. Each entry will be signed with first and last name of author, credentials and title.
7. NCMMHC requires many internal documents to have a witness signature as well as client signature. For example, the following documents require a staff person to witness a client signature:
 - All releases and consents (A witness is not required when verbal approval is given by phone.)
 - Intake evaluations
 - Master Treatment Plans
 - After Care Plans
 - Critical Intervention Plans
 - Safety Plans
 - Quarterly Review of Services

For an individual's request for services to be considered, NCMMHC must receive a valid intake evaluation documenting the need for services.

Services will begin only after all required forms are signed or marked by

the applicant. A mark must be witnessed.

If the client signature is made by mark, the mark is identified as such and then enclosed in parentheses with the applicant's name typed or handwritten as shown. SIGNATURE OF CONSUMER: Robert T. (X) (his mark) Cummins, then a witness signs and dates the document.

Other times when a witness signature is required include:

- The disposal of all medications
 - Destruction of PHI
8. Any form to be included and/or filed in the clinical record must have been authorized and approved by the agency.
 9. Each clinical record will include:
 - Documentation of screening
 - Consent to treatment
 - Orientation
 - Assessment
 - Diagnostic interview
 - Individualized treatment plan
 - Treatment plan reviews
 - Service delivery and progress notes
 - Discharge summary with plans for continuing recovery
 - When applicable, documentation of referrals to other services or community resources and the outcome of those referrals
 - Signed authorization to release confidential information
 - Documentation of missed appointments, and efforts to re-engage the individual
 - When applicable, urine drug screening or other toxicology reports
 - Documentation of crisis or other significant clinical events

SECTION: THE CLINICAL RECORD

SUBJECT: RECORDS ORDER

SECTION NO. IV

SUBJECT NO. 22

Clinical notes and all client record material will be stored in chronological order with the most recent material on top for quick access.

When tabbed index divider sheets are employed to divide the record into pertinent sections (i.e. progress notes, lab, assessment, correspondence, etc.) all documentation within each section will be filed chronologically with the most recent information on top.

SECTION: THE CLINICAL RECORD

**SUBJECT: TIMELINESS OF
DOCUMENTATION**

SECTION NO. IV

SUBJECT NO. 23

The Agency has adopted the following guidelines for timeliness of documentation:

1. Dictation will be completed within one (1) business day of service delivery and turned in for transcription.
2. Transcription will be completed within one (1) business day of receipt and returned for clinician's signature.
3. Documentation will be completed within three (3) business days of service delivery and included in the clinical record.
4. Treatment summary or correspondence will be completed within three (3) business days of authorized request.

SECTION: THE CLINICAL RECORD

SUBJECT: INTAKE

SECTION NO. IV

SUBJECT NO. 24

Any individual or family member new to the agency and seeking behavioral health services will be screened for appropriateness of admission.

1. Client intake contact form.
2. Crisis intervention note and/or clinical note documenting screening session(s).
3. Documented need for admission and further service delivery through the agency or the agency's provider network.
4. Documentation that client rights and responsibilities have been explained.
5. Documentation that treatment required can be appropriately provided by the organization or program component; or
6. Documentation that the client is not appropriate for services through this agency.
7. Documentation that the ineligible client is being referred to other resources.

SECTION: THE CLINICAL RECORD

SUBJECT: ASSESSMENT

SECTION NO. IV

SUBJECT NO. 25

Each program will make an initial assessment to include but is not limited to:

1. Presenting problem.
2. Physical health.
3. Emotional status.
4. Behavioral functioning.
5. Family and social history.
6. Financial and recreational data.
7. When appropriate, legal, vocational and nutritional needs.
8. Prior treatment.
9. Presence of a primary or secondary DSM-IV diagnosis.

The need for referral for a physical examination will be determined by: (a) ascertaining date of last physical, (b) health history, (c) awareness of any medical problems, (d) ascertaining if client is currently under physician care, and (e) current medications being taken. This screening will be performed either through a health questionnaire or inquiry.

Investigation to determine a client's ability to pay for the cost of services will be completed at the time of assessment or admission. (See fiscal policies re: client business file).

SECTION: THE CLINICAL RECORD

**SUBJECT: INITIAL TREATMENT
PLAN**

SECTION NO. IV

SUBJECT NO. 26

An Initial Treatment/Rehabilitation Plan (ITRP) will be developed at the time of admission and included in the clinical record. The ITRP will include the following information:

1. Description of presenting problem.
2. Immediate objectives.
3. Proposed services, including treatment modality (individual, chemotherapy, group, day program, etc.).
4. Signature of QMHP who participated in the formulation of the plan.
5. Signature of the client/parent/guardian, or documentation that the client participated in the formulation of the plan. If a client is unable to participate in the formulation of the treatment plan, that information must be documented.
6. Designated community support specialist in the absence of the primary therapist or community support specialist.

The ITRP outlines the treatment goals and objectives for the period of the first ten (10) visits or three (3) months, whichever occurs first.

SECTION: THE CLINICAL RECORD

**SUBJECT: MASTER TREATMENT
PLAN**

SECTION NO. IV

SUBJECT NO. 27

A Master Treatment Plan (MTP) will be developed after a maximum of thirty (30) days. The MTP will be on a form clearly designated MTP and include the following information:

1. A specific description of the client's problems and needs.
2. Specific treatment objectives and interventions.
3. The treatment modality or modalities to be used in fulfilling the treatment objectives.
4. Guidelines denoting when services required to meet the objectives will be implemented.
5. Projection when treatment objectives will be achieved.
6. Those staff members who will be involved in carrying out the treatment.
7. Criteria for release to less restrictive treatment conditions and/or discharge.
8. The community support specialist (if appropriate) who is responsible for the client's treatment.
9. Signature of at least one QMHP who actively participated in the formulation of the treatment plan.
10. Signature of client/parent/guardian, or documentation that the client participated in the formulation of the treatment plan.

The MTP will be updated to reflect changes in services provided, staff providing the service, and treatment goals.

1. Master treatment plans will be reviewed and updated at least every ninety (90) days and reflect client progress and changes in goals.
2. The MTP will be reviewed and updated at major key decision points in each client's care and treatment, including admission, transfer, and/or discharge.
3. The client's participation in the formulation of the MTP must be

documented. If the client does not sign the MTP, a progress note outlining the client's participation in the preparation of the MTP is acceptable. This documentation must be separate from other progress notes, clearly identified, and updated each time the MTP is revised. A notation of "client refuses to sign" or "client unable to sign" and the date should be written on the MTP.

4. Progress notes document services delivered, client activities and provide an ongoing reference to the MTP.
5. Hospitalization and or crisis intervention/stabilization will require review of the MTP and an update of goals and interventions planned.
6. The MTP includes referrals for needed services that are not provided directly by the agency.

SECTION: THE CLINICAL RECORD

SUBJECT: PROGRESS NOTES

SECTION NO. IV

SUBJECT NO. 28

The primary purpose of the progress note is to record information that shows client movement in relation to his/her treatment goals. A progress note will be used to document all client services, activities, or sessions. Contacts and description will describe the individual and specific services provided. Documentation will include:

1. Month, day and year of service.
2. Name and specific service(s) rendered.
3. The actual time (of day) of rendered service, with beginning and ending times.
4. The amount of time spent (in minutes) it took to deliver the services.
5. Service code or notation if not billed.
6. Location/Setting of service (i.e. Home, Community, Office).
7. The relationship of the services to the treatment described in the master treatment plan, including a synopsis of the service activity provided.
8. A description of the individual's response to the service provided.
9. Phone contacts.
10. Signatures, credentials and title of person providing the service.

The body of the CPRC/therapy progress note shall address:

1. Situation – will include the setting/location (i.e. home, community, office) in which the services were rendered. This section may include, but is not limited to, the circumstances of the visit, barriers to treatment, life circumstances of the individual, level of functioning, and/or appropriateness of dress and behavior of the client;
2. Intervention – as appropriate to the above situation, such as assisting a person to overcome an immediate difficulty, or routinely addressing goals and objectives of the treatment plan;
3. Response – which shall be the record of what the client agrees to do, or his/her refusal to do, and the client's attitude and behaviors in relation to

the intervention(s); and

4. Plan – which may include what the client shall work on until the next visit, or other scheduled activities, as well as the next scheduled visit.

Whether billable or non-billable, any service provision, conversation with or about a client, or actions taken to facilitate coordination of care or facilitation of client's progress toward achieving treatment goals will be documented in a progress note.

Progress notes for PSRC day program will be written at least weekly.

A client staffing will be documented in a progress note (including any recommendations made) and in treatment team meeting minutes.

All billable documentation will be individualized to the client (not copied and pasted across sessions or clients) and specific to the master treatment plan.

SECTION: THE CLINICAL RECORD

SUBJECT: REFERRALS

SECTION NO. IV

SUBJECT NO. 29

Referrals for consultation or service provision will be documented in the progress note. Documentation must specify how the criterion for referral has been met, the reason for the referral, and the treatment objective.

Referral documentation will include:

1. Appropriate client identification and pertinent history.
2. Treatment objectives desired.
3. Sessions/days authorized, when appropriate.
4. Suggestions for continued coordination between the referring and receiving resource.
5. Information on how the patient can be returned to the referring organization or program component.
6. Request for a follow-up report when client fails to show, drop out, requires authorization for additional sessions or has been discharged.

The referring clinician will obtain from the client written authorization for release of information to any external provider. The referring clinician will also document in the progress notes any contacts or attempts to contact to ascertain whether client pursued services or not.

SECTION: THE CLINICAL RECORD

**SUBJECT: DISCHARGE/TRANSFER
SUMMARY**

SECTION NO. IV

SUBJECT NO. 30

A transfer summary will be completed when the client is transferred to another program or another provider. The transfer will be discussed with the client and document that agreement in the progress notes. A reason for the transfer must be stated on the transfer form in the space provided.

A discharge summary will be completed within 15 days from date of discharge/termination from a service or program and will include:

1. Significant findings.
2. Course and progress of the client with regard to each identified clinical problem.
3. Clinical course of client's treatment.
4. Final assessment, including the general observations and understanding of the client's condition initially, during treatment and at discharge.
5. Recommendations and arrangements for further treatment, including prescribed medications and continuing care.
6. When appropriate, documentation for the planning for, and securing of, living arrangements appropriate for the individual's level of functioning.
7. Final primary and secondary diagnoses and global assessment of function.

SECTION: THE CLINICAL RECORD

**SUBJECT: CRISIS INTERVENTION
SERVICES**

SECTION NO. IV

SUBJECT NO. 31

Crisis intervention services may be provided to an individual, family member, or significant other to ameliorate a specific emotional trauma.

The documentation must include:

1. Presenting problem.
2. Mental status exam (hallucinations, delusions, suicidal/homicidal thoughts).
3. Any disturbance in sleeping or eating or pattern of drinking and/or drug use.
4. Scope of service delivery/interventions used.
5. Individual's response to intervention.
6. Time of day/time spent.
7. Resolution/disposition.
8. Signature and credentials of service provider.

Telephone crisis intervention services will be documented in a separate progress note with client name and identification number. Face-to-face crisis intervention services will be documented on the approved agency form.

Admitting diagnosis must be recorded in the crisis note if a chart is to be opened for further service delivery (hospitalization, structured group, psychiatric evaluation).

SECTION: THE CLINICAL RECORD

**SUBJECT: INFORMATION/
EDUCATION SERVICES**

SECTION NO. IV

SUBJECT NO. 32

When information/education services are provided to community agencies or interested groups for the purpose of promoting mental health principles, documentation must be retained in a file for that purpose.

The documentation for information/education services will include:

1. Date and place of service.
2. Name of the group receiving services.
3. Number attending.
4. Topic(s) discussed.
5. Documentation of time.
6. Signature and credentials of person providing the service.

An agency record will be maintained of Information/ Education Services delivered by staff members. Progress note should be written and submitted to clinical records within 48 hours of service delivery.

SECTION: THE CLINICAL RECORD

SUBJECT: CHART REVIEW

SECTION NO. IV

SUBJECT NO. 33

Quantitative Review (Level I) will be performed to check clinical records for completeness and accuracy. Clinical Records staff performs the quantitative review under the direction of the Clinical Director.

A quantitative review is performed annually on all clinical records. The primary clinician will correct the deficiencies noted within five (5) working days.

Standard chart review/audits will be conducted monthly to check the completeness, timeliness and accuracy of documentation on clients seen for services.

Qualitative Review (Level II) is established to evaluate, analyze, and assure the quality of client care provided to a client as documented in the clinical records.

Qualitative Review is performed by the direct supervisor and/or program director, QMHP and, when possible, a peer committee assisted by the Clinical Director.

Any charts found to have deficiencies in documentation or other deficiencies or have not met with approval of the quality reviewer or review committee are returned to the appropriate clinician for completion and/or modification. These charts are then targeted for the following month for second review.

The results of Level I and Level II reviews will be forwarded to the appropriate supervisor for appropriate corrective action, as necessary, and as a component of performance based appraisals.

SECTION: THE CLINICAL RECORD

SUBJECT: LEGAL

*CONSIDERATIONS FOR
GUARDIANSHIP*

SECTION NO. IV

SUBJECT NO. 34

In the interest of protecting clients served and the Agency, any individual claiming guardianship status must provide a "Letter of Guardianship" from the court whereby the guardianship was awarded.

Guardianship status can only be awarded by the court and can be either "limited" with a delineation of what areas the client cannot make his own decisions on or "full" indicating the client is in need of full protection from the court. The limitations of the guardianship are important to know, even if the guardian is the Public Administrator.

It is the Agency's policy to have the financial intake worker inquire by phone at the time the initial financial information is obtained if there is a guardian and to state that the "Letter of Guardianship" is to be among the documentation brought to the intake appointment. A copy of the "Letter of Guardianship" will then be required documentation to be included in the clinical record.

In those instances where the client has already been seen for services and a guardianship noted, the clinical records clerk will compile a list of client names and guardian and letters will be sent requesting the "Letter of Guardianship" for the Agency's records.

SECTION: THE CLINICAL RECORD

**SUBJECT: LEGAL
CONSIDERATIONS FOR
COURT PROCEEDINGS**

SECTION NO. IV

SUBJECT NO. 35

Professional staff is not authorized to communicate with an attorney, court or other law enforcement entity or to respond to attorneys, courts or legal entity requests except as the following procedures are followed:

1. Appropriate authorization for Release of Information is obtained.
EXCEPTION: When subpoenaed on any case EXCEPT alcohol and drug use information.
2. Notification of the Executive Director and the Clinical Director.
3. When a court ordered subpoena is served, the client should be notified of this order and in the event of a diagnosis of drug and/or alcohol, a release of information must be obtained.
4. Clinical staff will encourage acceptance of written reports as opposed to personal appearances in court.
5. Clinicians will discuss any written report or intended testimony with their program director and document this consultation in the client's chart.

SECTION: THE CLINICAL RECORD

**SUBJECT: LEGAL
CONSIDERATIONS FOR
SECURED RECORDS**

SECTION NO. IV

SUBJECT NO. 36

A clinical record will be secured from general circulation and will be available for review in the Clinical Records Department whenever:

1. A client death has occurred.
2. Subpoena has been received for court appearance or production of the records.
3. Legal precedents require or legal counsel advises restriction of client information.
4. There is possible intent to sue the agency from a client or representative of the client.
5. The Clinical Director learns of potential liability to the agency.

It will be the responsibility of the primary clinician to advise the records department whenever court proceedings or court action are rescheduled and/or concluded.

SECTION: QUALITY ASSURANCE

SUBJECT: PHILOSOPHY

SECTION NO. V

SUBJECT NO. 1

North Central's Quality Assurance Plan (See Attachment A) will include quality assurance activities to objectively and systematically monitor and evaluate the quality of client care, pursue opportunities to improve client care, and correct identified problems.

NCMMHC will implement systematic quality assessments and improvement processes that are accountable to the governing body and address those programs and services certified by the Department of Mental Health.

Services shall achieve positive outcomes in the emotional, behavioral, social and family functioning of individuals.

SECTION: QUALITY ASSURANCE

SUBJECT: MONITORING ACTIVITIES

SECTION NO. V

SUBJECT NO. 2

- A. Quality Assurance shall be the approach in behavioral health care. Quality can effectively be improved by addressing three (3) major activities:
 - 1. Focusing on important functions in the organization, including direct service, management and support services;
 - 2. Using effective performance measures (including accessibility, appropriateness, continuity, effectiveness, efficacy of care, and timeliness) to collect reliable data; to monitor service delivery processes and outcomes; and
 - 3. Focusing on opportunities to improve processes and monitor improvement efforts.
- B. Quality Assurance will also assess achievement of the agency's mission and goals through process review during the next year and will result in opportunities to enhance outcomes as soon as they are detected.
- C. Direct service staff and clients are involved in the planning, design, implementation and review of the organization's quality improvement activities.
- D. Data are systematically aggregated and analyzed on an ongoing basis.
- E. Data collection analysis is performed using valid reliable processes.
- F. NCMMHC compares its performance over time and with other sources of information.
- G. Undesirable patterns in performance and sentinel events are analyzed. Strategies are developed and implemented for service improvement based on the data analysis. NCMMHC will evaluate the effectiveness of those strategies in achieving improved service delivery outcomes. If improved service delivery and outcomes have not been achieved, NCMMHC revises and implements new strategies.

SECTION: QUALITY ASSURANCE

SUBJECT: OBJECTIVES

SECTION NO. V

SUBJECT NO. 3

The overall objectives of the Quality Assurance Plan for North Central Missouri Mental Health Center will be:

1. To achieve the highest possible quality of client care; to measure and address outcomes for the individuals served and collect data as follows:
 - A. Positive outcomes shall be expected to occur in:
 - 1) Safety for the individual and others in his/her environment.
 - 2) Improved management of daily activities.
 - 3) Improved management of symptoms associated with a psychiatric and/or substance use disorder, and also the reduction of distress related to these symptoms.
 - 4) Improved functioning related to occupational, educational, legal, social, family, living arrangements and health and wellness.
 - 5) Consumer satisfaction with services.
 - 6) Drop-out rates.
2. To monitor and evaluate clinical performance and clinical privileges of the professional staff and those who deliver identified services either at the facility or through contracted services;
3. To identify and resolve at various organizational levels any problems in client care, service provision, or clinical performance;
4. To make recommendations to the Executive Director and the Management Team regarding corrective actions that can resolve or reduce identified problems.
5. To be cost-effective without compromising the quality of care given.
6. To maintain improvement over time.

SECTION: QUALITY ASSURANCE

**SUBJECT: PROGRAM
ORGANIZATION**

SECTION NO. V

SUBJECT NO. 4

- A. The administration is represented by the Executive Director and the Management Team. The latter is composed of the Executive Assistant, Community Psychiatric and Rehabilitation Center Director, Children's Services Director, Clinical Director, Chief Financial Officer, and the Executive Director. (Refer to the attached Table of Organization.)
- B. Treatment and rehabilitation staff, along with the administration, shall evaluate the quality of client care, service provision and clinical performance, and correct identified problems. The Board of Directors will receive a written summary report on quality improvement activities by the Clinical Director annually.
- C. Records and reports of quality improvement activities will be maintained.

SECTION: QUALITY ASSURANCE

SUBJECT: COMMITTEES

SECTION NO. V

SUBJECT NO. 5

The following committees will be established to conduct specific reviews of client care. The chairpersons shall be appointed by the Executive Director.

1. Credentials Committee - The credentials of professional staff will be reviewed for privileging by the Executive Director, program directors, designated staff member(s), and the Clinical Director. Privileges will be granted for one year and renewed annually.
2. Utilization Review Committee - Utilization of resources such as staff time, budget and space, medication usage, adverse reactions and/or medication errors will be reviewed quarterly by the program director and/or designee and the Chief Financial Officer.
3. Program Review Committee - The quality and appropriateness of clinical services will be reviewed each quarter by each program service. The team review will include, at a minimum, the direct supervisors and/or program directors assisted by the Clinical Director.
4. Clinical Review Committee - Any incident involving potential clinical risk will be reviewed by the Executive Director or designee, and the psychiatrist's recommendations will be made for clinical intervention or action.
5. The Quality Assurance Committee is designated as responsible for coordinating and implementing the Quality Improvement Plan.

SECTION: QUALITY ASSURANCE

SUBJECT: SCOPE

SECTION NO. V

SUBJECT NO. 6

The scope of the quality of care and services provided shall be agency-wide and focus on all important functions of the organization, including direct service, management and support services. The following activities will be a part of the Quality Improvement Program:

1. Client Care Monitoring - The care provided to case management clients is monitored by their community support specialist. Regular reviews are also conducted at team meetings to address specific problems and complications in treatment, placement or care.
2. Staff Development - Staff development activities will be established to meet training needs and address identified problems and strengths.
3. Utilization of Resources - The under-utilization, over-utilization and inefficient scheduling of facility staff, space and budget resources shall be regularly evaluated. Specific review will include:
 - a. Appropriateness and clinical necessity of admissions;
 - b. Appropriateness and medical necessity of referral and admissions to the CPRC/PSRC programs;
 - c. Appropriateness and medical necessity of referrals.
 - d. Analysis of services provided.
4. Review of Client Care Incidents - The agency will prioritize policies regarding unusual incidents, missing or runaway clients, client deaths or injuries, abuse/neglect allegations or use of restraints. Monitoring will be conducted to detect problems in the reporting system and to ensure timeliness and appropriateness of response, notification of the Executive Director and the Department of Mental Health, and any recommendations for implementation of clinical intervention or action.
5. Consumer Satisfaction - A Consumer Satisfaction Questionnaire will solicit recommendations and feedback from clients, client family members and

client advocates. This feedback process shall allow for identification from clients of strengths and weaknesses in service delivery and allow for input to improve service provision. Consumer satisfaction data will be collected in a manner that promotes participation by all.

SECTION: QUALITY ASSURANCE

**SUBJECT: EVALUATION, PROBLEM-
SOLVING, MONITORING**

SECTION NO. V

SUBJECT NO. 7

The agency plan for Quality Assurance will involve the following mechanisms for overseeing the evaluation, problems solving, and monitoring activities to improve quality of client care and services. Data collection shall be systematically aggregated and reflect priority areas identified in the plan.

1. Clinical Staffing - Clinical staffing meetings shall be conducted to improve quality through a team approach and to discuss and facilitate client treatment. The team will review the client's treatment plan in concert with the program director and/or psychiatrist.
2. Qualitative Review - Qualitative review will be established to evaluate, analyze, and assure the quality of client care provided to a client as documented in the clinical records. Qualitative review shall be performed by the direct supervisor and/or program director with the assistance of the Clinical Director. Qualitative review of each service modality will occur every quarter.
3. Quantitative Review - Quantitative review will be performed on all open charts to check the clinical record for completeness and accuracy as specified in the Clinical Records Policies and Procedures. The Clinical Records Clerk shall be responsible for performing the quantitative review under the direction of the Clinical Director. Quantitative review will be performed on all clinical records. Quantitative review will also be performed on all charts upon discharge from services. Quantitative reviews of each service modality will occur every quarter.

SECTION: QUALITY ASSURANCE

SUBJECT: EVALUATION

SECTION NO. V

SUBJECT NO. 8

The Clinical Director shall evaluate the effectiveness of the overall Quality Assurance Plan. Based on these findings, the Management Team shall make recommendations for revisions to the Quality Assurance Plan or an annual action plan. Recommendations will be submitted to the Board of Directors. The Quality Assurance Plan is updated at least annually.

SECTION: HIPAA REGULATIONS

**SUBJECT: AMENDMENT OF
PROTECTED HEALTH
INFORMATION**

SECTION NO. VI

SUBJECT NO. 1

PURPOSE: It is the policy of North Central Missouri Mental Health Center to ensure that the records of individually identifiable protected health information are accurate and complete. It is also the policy of NCMMHC to recognize the rights of consumers to amend protected health information pertaining to them in a designated record set, if the consumer believes that information is incomplete or incorrect, as referenced in 45 CFR Section 164.526. NCMMHC further recognizes that amendments to protected health information may be limited or restricted as defined in this policy, in the Notice of Privacy Practices and as allowed by law. In cases where the consumer has been civilly adjudicated as incapacitated (and therefore appointed a guardian) or is a minor, the parent (if a minor), or the legal guardian or personal representative may request the amendment.

APPLICATION: North Central Missouri Mental Health Center, its facilities, and workforce.

1) CONTENTS

- A) Definitions
- B) Request of Amendment to Protected Health Information
- C) Denial of Request for Amendment to Protected Health Information
- D) Statement of Disagreement of Denial

2) DEFINITIONS

Consumer – any individual who has received or is receiving services from NCMMHC.

- A) Designated Record Set – a group of records under the control of a covered entity from which Protected Health Information is retrieved by the name of the individual or by identifying number.
- B) Personal Representative – person with a court order appointing them as a guardian or with a valid Power of Attorney signed by the consumer

specifying the authority to review and make decisions regarding medical, psychiatric, treatment or habilitation concerns. In the case of juveniles who have consented to treatment for alcohol and drug use issues as allowed under Section 431.031, RSMO, they are their own personal representatives.

C) Protected Health Information (PHI) – individually identifiable health information. Individually identifiable health information is defined as any information, including demographic information, collected from an individual that:

1. is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
2. is related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual; and
 - a. identifies the individual, or
 - b. with respect to which, there is a reasonable basis to believe that the information can be used to identify the individual.

D) Disclosure of PHI Summary – an accounting of disclosures of PHI (in paper or electronic format) containing: date of disclosure; name and address of the organization or person who received the PHI; a brief description of the information disclosed; and purpose for which the PHI was disclosed.

3) REQUEST FOR AMENDMENT TO PROTECTED HEALTH INFORMATION

A) A consumer, parent of a minor, or personal representative or legal guardian as relevant to their representation, who believes information in their health records is incomplete or incorrect, may request an amendment or correction of the information as outlined below:

1. For minor discrepancies, i.e., typos, misspelled name, wrong date, etc., the consumer may approach the author of the entry, point out the error, and ask the author to correct it.
 - a. If the entry author agrees, the entry can be corrected according to the best documentation practices by drawing a

single line through the error, adding a note explaining the error (such as “wrong date” or “typo”), date and initial it, and make the correction as close as possible to the original entry in the record.

- b. Any information added to a MTP, in the regular course of business, is not considered an amendment. An example would be when a consumer provides the name of a new private physician whom s/he sees in the community.

B) All other requests for amendments to PHI shall be in writing and provide a reason to support the amendment. Specifically, any request should be supported by documentation of any incorrect information or incomplete information.

1. The “Request for Amendment to Protected Health Information” form shall be provided to facilitate the request. Facility personnel may assist in initiating the process of requesting an amendment to PHI and a copy shall be provided to the consumer.
2. All requests for amendment of PHI must be forwarded to the facility Privacy Officer or designee who will route the original request to the author of the PHI or that individual’s direct supervisor.
3. If the author chooses to add a comment to the request form, a second copy of the form will be given to the consumer with the author’s comments.
4. This request shall be processed in a timely consistent manner according to established time frames but not more than 60 days after receipt of the request.
5. If the request for amendment cannot be processed within the 60 days, the time frame may be extended no more than an additional 30 days with notification in writing to the individual outlining reasons for the delay and the date the request will be concluded.
6. If a consumer with a guardian requests an amendment, a letter is to be sent to the guardian stating that the consumer is requesting an amendment, and further requesting that the guardian complete the Request for Amendment form.

C) If the request is granted, the facility shall:

1. Insert the amendment or provide a link to the amendment at the site of the information that is the subject of the request for amendment, and then document the change in the same section of the record as the original information.
2. Inform the consumer that the amendment is accepted.
3. Obtain the authorization of the consumer to notify all relevant persons or entities with whom the amendment needs to be shared.
4. Within a reasonable time frame, make reasonable efforts to provide the amendment to the persons identified by the consumer, and any persons, including business associates, that the covered entity knows has been provided the PHI that is the subject of the amendment and who may have relied on or could foreseeably rely on the information to the detriment of the consumer. A reasonable time frame is defined as attempts to complete this process within 60 days of the date of the amendment to the record.
5. If the amendment affects a service for which billing or a charge has already been submitted, then the billing must be reviewed to see if it should be amended or changed as well to reflect the new information.

4) DENIAL OF REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

A) NCMMHC may deny the request for amendment to PHI if the health information that is the subject of the request

1. was not created by NCMMHC. However, if the consumer can provide reasonable proof that the person or entity that created the information is no longer available to make the amendment, and the request is not denied on other grounds, NCMMHC must amend the information
2. is not part of the medical information kept by or for NCMMHC
3. is not part of the information that the consumer would be permitted to inspect and copy (for specifics on consumer access to PHI, please see DOR 8.030)

4. is accurate and complete.

A) If NCMMHC denies the requested amendment, it must provide the consumer with a timely, written denial, written in plain language, that contains:

1. The basis for the denial;
2. The consumer's right to submit a written statement disagreeing with the denial and how the consumer may file such a statement;
3. The name, title, address, and telephone number of the person to whom a statement of disagreement should be addressed;
4. The steps to file a complaint with the Secretary of HHS;
5. A statement that if the consumer does not submit a statement of disagreement, the consumer may request that the facility provide the Request for Amendment and the denial with any future disclosures of PHI. (See Section 5 for further information.);
6. A copy must also be provided to the guardian if applicable; to the parent(s) if applicable; or to the Division of Family Services if that agency has legal and physical custody of the juvenile.

5) STATEMENT OF DISAGREEMENT OF DENIAL

A) Consumers shall be permitted to submit to NCMMHC a written statement disagreeing with the denial of all or part of a requested amendment and the basis for the disagreement. This statement of disagreement shall be limited to one page.

B) The statement of disagreement shall be submitted in writing to the Clinical Director of NCMMHC.

C) NCMMHC may prepare a written rebuttal to the statement of disagreement and must provide the consumer with a copy of the rebuttal.

D) NCMMHC will identify the record of PHI that is the subject of the disputed amendment and append or link the request for an amendment, the denial of the request, the individual's statement of disagreement, if any, and NCMMHC's rebuttal statement, if any.

1. If the consumer has submitted a statement of disagreement, NCMMHC will include the documents in 5(D), or an accurate summary of the information, with any subsequent disclosure of the

PHI to which the disagreement relates.

2. If the consumer has not submitted a written statement of disagreement, NCMMHC will include the consumer's request for amendment and its denial, or an accurate summary of the information, with any subsequent disclosure of PHI only if the consumer has requested it.

E) If NCMMHC receives information from another facility of an amendment of a consumer's PHI, the PHI from that sending facility must be amended in written or electronic form.

SECTION: HIPAA REGULATIONS

**SUBJECT: NOTICE OF PRIVACY
PRACTICES PROCEDURES**

SECTION NO. VI

SUBJECT NO. 2

PURPOSE: It is the policy of North Central Missouri Mental Health Center to protect the privacy of individually identifiable health information in compliance with federal and state laws governing the use and disclosure of protected health information (PHI) pursuant to the requirements of HIPAA (45 CFR Section 164.502 et seq.). Therefore, all consumers (or their legal guardian or parent, if a minor) should be provided access to the most current Notice of Privacy Practices, and that a good faith attempt must be made to have each consumer acknowledge the Notice of Privacy Practices as required in 45 CFR Section 164.520.

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) DEFINITIONS:

- A) Emergency contact situation – where a telephone call is made to NCMMHC or its crisis line from a member of the community seeking mental health treatment or information about such mental health treatment.
- B) Emergency treatment situation – an appearance in an acute care psychiatric emergency room; or emergency admission to a long-term psychiatric or habilitation center.
- C) Notice of Privacy Practices – a document outlining adequate notice of the uses or disclosures of protected health information (PHI) that may be made by NCMMHC and which sets out the consumer’s rights and NCMMHC’s legal duties with respect to PHI.

2) PROCEDURE:

- A) At the date of the first delivery of, or appearance for, service at this facility, or application for services, even those services received electronically, the consumer (or their legal guardian or parent, if a minor) should be

presented with the Notice of Privacy Practices. This timing is considered the initial moment of contact between a consumer and NCMMHC. The sending of an application packet is not considered the point of first delivery of or appearance for service.

1. When the consumer presents in any way described in (A), NCMMHC shall make a good faith effort to obtain a written acknowledgment of the receipt of the Notice of Privacy Practices.
2. Documentation of acknowledgement (the consumer's signature or mark) that such a Notice has been presented to a consumer (or their legal guardian or parent, if a minor) for review shall be placed in the consumer's record. The full Notice of Privacy Practices is then given to the consumer.
3. If the consumer's first point of contact of service is an emergency treatment situation as defined above, then the Notice of Privacy Practices shall be provided as soon as reasonably practicable after the emergency treatment situation. In such emergency treatment situations, an acknowledgment is not initially required, but should be obtained as soon as reasonably practicable.
4. If the consumer's first point of contact of service is an emergency contact situation as defined above, then the Notice of Privacy Practices should be mailed to the consumer, with acknowledgment obtained during the telephone contact. A request should be made to have the acknowledgment mailed back to the sending office.
5. Examples: If the consumer transfers from one program to another program within NCMMHC, then no new Notice of Privacy Practices is required. If the consumer is discharged and then presents for another admission, then a new Notice of Privacy Practices is given. If the consumer has been placed on "inactive" status, then a new Notice of Privacy Practices shall be given at the time of service re-initiation.
6. If NCMMHC does not obtain the acknowledgment in a non-emergency situation, then the facility shall document its good faith efforts to obtain the acknowledgment, and document the reason(s)

why the acknowledgment was not obtained on the acknowledgment cover sheet to the Notice of Privacy Practices.

B) In addition to the Notice of Privacy Practices, the consumer shall also be given a condensed version of the Notice, the “Tri-Fold HIPAA Administrative Simplification Privacy Practices” document. The HIPAA Privacy Rule allows both versions to be presented as a “layered” approach to presenting the Notice.

- A copy of the Notice of Privacy Practices shall be posted in a highly visible and prominent location at the facility, where it is reasonable to expect individuals will be able to locate and read the Notice.
- Whenever the Notice of Privacy Practices is revised, the revised Notice shall be made available upon request by a consumer.
- The Privacy Officer will be responsible for updating, as necessary, the Notice of Privacy Practices. When a material change is made, the facility shall make that revised Notice available upon request, and the revised Notice shall be posted.
- The Privacy Officer or designee will be responsible for ensuring employees are trained regarding the Notice of Privacy Practices in accordance with the Department of Mental Health’s DOR 8.110 related to employee HIPAA education/training.
- Consumer questions related to the Notice of Privacy Practices should be directed to the Privacy Officer or designee.
- The Privacy Officer shall maintain a historical record of all versions of the Notice of Privacy Practices, and the applicable dates for each.

SECTION: HIPAA REGULATIONS

**SUBJECT: ACCESS TO CONSUMER
PROTECTED HEALTH
INFORMATION (PHI) BY
DEPARTMENT OF
MENTAL HEALTH STAFF,
VOLUNTEERS, OR
STUDENTS**

SECTION NO. VI

SUBJECT NO. 3

PURPOSE: It is the policy of North Central Missouri Mental Health Center to protect the privacy of individually identifiable health information in compliance with federal law. To assist in assuring that protection, it is the practice of NCMMHC to assure that its workforce recognizes the importance of such confidentiality provisions, and affirmatively acknowledge those guidelines. See 45 CFR Sections 160 and 164, et seq.

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) CONTENTS

- A) Definitions
- B) Staff Access
- C) Training
- D) Required Confidentiality Agreement
- E) Visitors
- F) Sanctions

2) DEFINITIONS

- A) Workforce – includes employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity (facility or department). This shall include client workers employed by NCMMHC or its facilities. (45 CFR Section 160.103.)

3) STAFF ACCESS

- A) NCMMHC staff members shall be granted access to protected health information (PHI), whether written, electronic, or verbal in nature, in

accordance with state and federal law (HIPAA, P.L. 104-191); (42 CFR Part 2 et seq.); (Sections 630.140 and 630.167, RSMo). Such access shall be limited to the minimum necessary amount of PHI to accomplish the purpose of any requested use or disclosure of PHI, e.g. to the amount of the PHI the employee or staff member needs to know in order to accomplish their job or tasks. In addition, communications between staff members that involve PHI shall also be considered confidential and should not take place in public areas. If it is absolutely necessary to conduct such conversations in public areas, reasonable steps shall be taken to assure the confidentiality of the PHI.

- B) Consumer PHI should never be removed from this facility without specific authorization from the Privacy Officer or designee, or the appropriate medical records personnel. Each facility shall establish a procedure for how staff members are to physically access PHI in medical records (i.e. how to sign records in and out and under what conditions, etc.).
 - C) If PHI in any form is lost or stolen, the Privacy Officer or designee should be notified as soon as possible, but no later than two (2) business days after the loss is discovered, in order for the Privacy Officer or designee to initiate the mitigation/improvement process.
- 4) TRAINING
- A) NCMMHC staff members shall be informed of their obligations with respect to PHI by mandatory participation in HIPAA Privacy Training (See Attachment A).
- 5) REQUIRED CONFIDENTIALITY AGREEMENT
- A) NCMMHC staff members that receive or maintain PHI shall be required to agree to the protection of such PHI in accordance with the state and federal laws as set forth above. These staff members shall sign a confidentiality statement. A copy of the signed confidentiality statement shall be maintained in the personnel file of NCMMHC staff, or in a separate file if not a staff member.

6) VISITORS

- A) Visitors are not required to sign the confidentiality agreement. However, a copy of the confidentiality agreement shall be located at each facility to be

available for review by each visitor.

- 7) **SANCTIONS:** Failure of staff members to comply or assure compliance may result in disciplinary action, including dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: ACCESS TO CONSUMER
PROTECTED HEALTH
INFORMATION (PHI) BY
CONSUMER, PARENT,
GUARDIAN OR
PERSONAL
REPRESENTATIVE**

SECTION NO. VI

SUBJECT NO. 4

PURPOSE: It is the policy of North Central Missouri Mental Health Center to protect the privacy of individually identifiable health information in compliance with federal and state laws governing the use and disclosure of protected health information. NCMMHC recognizes the rights of consumers to access health information pertaining to them in a designated record set as set forth in 45 CFR Section 164.524. NCMMHC further recognizes that access to protected health information (PHI) may be limited to restricted as defined in this policy, in the Notice of Privacy Practices, and as allowed by law. In cases where the consumer has been civilly adjudicated, incapacitated, or is a minor, the parent (if a minor) or the legal guardian or personal representative may request access. An exception to this statement occurs when a minor signs in for substance addiction treatment without parental consent, and in that situation, parents shall not have access to the protected health information. There may be additional exceptions as allowed by law.

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) CONTENTS

A) Definitions

B) Request for Access to Protected Health Information

C) Denial of Access

D) Appeal and Review of Denial

E) Provision of Access and Fees

F) Release of Protected Health Information of a Deceased Consumer

2) DEFINITIONS

- A) Abstract (Summary) – a brief summary on facility letterhead of the essential information as requested on a proper authorization.
- B) Consumer – any individual who has received or is receiving services from NCMMHC.
- C) Designated Record Set – a group of any records under the control of a covered entity from which Protected Health Information (PHI) is retrieved by the name of the individual or by identifying number.
- D) Direct Access – an in-person review of the medical record, and/or obtaining a copy of the record.
- E) Licensed Health Care Professional – as defined in Section 630.005, RSMo; 9 CSR 30-4.010; and 9 CSR 45-2.010 (2) (U). Such professionals may be a licensed psychiatrist; a licensed psychologist; a psychiatric nurse; a master's degree social workers with specialized training in mental health services (one year of experience under supervision may be substituted for training); a licensed professional counselor; a master's or doctorate in counseling, psychology, family therapy or related field with one year's experience related to mental illness; or a doctor of medicine or registered nurse, or a bachelor's level social worker with one year's experience in working with consumers with developmental disabilities.
- F) Personal Representative – person with a court order appointing them as a guardian or with a valid Power of Attorney signed by the consumer specifying the authority to review and make decisions regarding medical, psychiatric, treatment or habilitation concerns.
- G) Protected Health Information (PHI) – individually identifiable health information, defined as any information, including demographic information, collected from an individual that:
 - 1. is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
 - 2. is related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual; and

- a. identifies the individual, or
 - b. with respect to which, there is a reasonable basis to believe that the information can be used to identify the individual.
- H) Psychotherapy Notes – notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Such notes exclude medication prescriptions and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
- I) Official Signature – legal name, credentials, and job title or position description.
- J) Disclosure of PHI Summary – an accounting of disclosures of PHI (in paper or electronic format) containing: date of disclosure; name and address of the organization or person who received the PHI; a brief description of the information disclosed; and the purpose for which the PHI was disclosed.

3) REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

- A) A consumer who has or is receiving services from NCMMHC, parent of a minor, and personal representative or legal guardian as relevant to their representation, must request in writing for access to inspect, or receive copies of, PHI except in those instances covered by Federal Regulation and outlined in the Notice of Privacy Practices acknowledged at admission, and must further specify the exact information requested for access.
- B) The “Request for Consumer Access to Their Protected Health Information” form shall be provided to facilitate the request. NCMMHC personnel may assist in initiating the process requesting access to PHI.
- C) All requests by consumers and their legal representatives for PHI must be forwarded to the Privacy Officer or designee for action.
- D) If it is acceptable after discussion with the consumer, NCMMHC may

provide a summary of the PHI to the consumer. If the summary is acceptable, NCMMHC shall determine the appropriate staff to provide that explanation to the consumer. The consumer's agreement to a summary shall be documented in writing in the record as a check in the appropriate box in the "Request for Consumer Access to Their Protected Health Information" form. The consumer's agreement to any costs associated with the summary shall be documented in the record as a check in the appropriate box in the "Request for Consumer Access to Their Protected Health Information" form. The form shall be filed in the consumer's medical record.

- E) This request shall be processed in a timely consistent manner according to established timeframes, but not more than 30 days after the receipt of the request.
1. If the record cannot be accessed within the 30 days, the timeframe may be extended once for no more than an additional 30 days with notification in writing to the individual outlining reasons for the delay and the date the request will be concluded.
- F) Requests for Access to PHI may be denied without a right to review as follows:
1. If the information conforms to one of the following categories: psychotherapy notes; information compiled for use in a civil, criminal, or administrative action or proceeding; or information that would be prohibited from use or disclosure under the Certified Laboratory Information Act (CLIA) laws and regulations;
 2. If the consumer is participating in research related treatment and has agreed to the denial of access to records for the duration of the study;
 3. If access is otherwise precluded by law;
 4. If the information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. All Victim Notification and Duty to Warn forms, as well as any other documentation that contains demographics of victims

or potential victims, shall be removed before any review of the record by anyone not employed by NCMMHC or the Department of Mental Health, and if the NCMMHC or DMH employee is a consumer worker, then the information shall be removed before any review of the record; or

5. If the facility has been provided a copy of a court order from a court of competent jurisdiction that limits the release or use of PHI.

G) Requests for Access to Protected Health Information may be denied provided the individual is given a right to have the denial reviewed as follows:

1. A licensed health care professional, based on an assessment of the particular circumstances, determines that the access requested is reasonably likely to endanger the life or physical safety of the consumer or another person.
2. NCMMHC may deny the consumer access to PHI if the information requested makes reference to someone other than the consumer and a licensed health care professional has determined that the access requested is reasonably likely to cause serious harm to that other person.
3. NCMMHC may deny a request to receive a copy or inspect PHI by a personal representative of the consumer if the facility has a reasonable belief that the consumer has been or may be subjected to domestic violence, abuse, or neglect by such person; or treatment such person as the personal representative could endanger the individual; and the facility, exercising professional judgment, decides that it is not in the best interest of the consumer to treat that person as the consumer's personal representative.

4) DENIAL OF ACCESS

- A) Upon denial of any request for access to PHI, in whole or in part, a written letter shall be sent to the consumer, or other valid representative making the request for access, stating in plain language the basis for the denial.
- B) If the consumer has a right to a review of the denial as outlined in subsection (3) (G) above, the letter shall contain a statement of how to

make an appeal of the denial including the name, title, address, and telephone number of the person to whom an appeal should be addressed.

- C) This letter shall also address the steps to file a complaint with the Secretary of HHS.
- D) If the information requested is not maintained by NCMMHC, but it is known where the consumer may obtain access, NCMMHC must inform the consumer where to direct the request for access.

5) APPEAL AND REVIEW OF DENIAL OF REQUESTS AS DEFINED IN SUBSECTION (3) (G)

- A) A consumer, parent of a minor, or guardian of a consumer has the right to appeal the decision to withhold portions or all of the record for safety or confidentiality reasons.
- B) The appeal shall be submitted in writing to the Clinical Director, who will designate a licensed health care professional.
- C) The designated licensed health care professional, who did not participate in the original decision to deny access, shall review the record and the request for access to the consumer's record.
 - 1. The reviewer must determine if access meets an exception as described in Section 3.
 - 2. If the reviewer determines that the initial denial was appropriate, the consumer must be notified in writing, using plain language, that the review resulted in another denial of access. The notice must include the reasons for denial and must describe the process to make a complaint to the Secretary of HHS.
 - 3. If the denial was not appropriate, the licensed health care professional who acts as the reviewer shall refer to the Privacy Officer or designee for action.
 - 4. If access is denied to any portion of the PHI, access must still be granted to those portions of the PHI that are not restricted.
 - 5. NCMMHC is bound by the decision of the reviewer.

6) PROVISION OF ACCESS AND FEES

- A) If NCMMHC provides a consumer or legal representative with access, in whole or in part, to PHI, NCMMHC must comply with the specifications as

outlined in federal regulations to the extent of NCMMHC's capabilities and as identified in the Notice of Privacy Practices.

1. Requested information must be provided in designated record sets.
2. If the requested information is maintained in more than one designated record set or in more than one location, NCMMHC only needs to produce the information one time in response to the request.
3. NCMMHC may provide a summary or explanation of the requested PHI if:
 - a. The consumer agrees in advance to the summary or explanation in place of the record.
 - b. The consumer agrees in advance to any fees imposed for the summary or explanation.
 - c. These agreements shall be documented as set forth in subsection (3) (D) above.

B) NCMMHC shall provide the access requested in a timely manner and arrange for a mutually convenient time and place for the consumer to inspect the PHI or obtain copies, unless access by another method has been requested by the consumer and agreed to by NCMMHC as set forth in subsection (6) (A) (4) above. Any requests for accommodations shall be sent or given in writing to the Privacy Officer or designee.

C) The fee charged will be in compliance with the current Missouri State Statute (See Section 191.227, RSMo), and federal law.

7) RELEASE OF PROTECTED HEALTH INFORMATION OF A DECEASED CONSUMER

A) The PHI of a deceased consumer may only be released via a Probate Court order from the County Circuit Court where the deceased resided or from another Probate Court in the State of Missouri.

B) Upon request to obtain information, the Privacy Officer or designee shall ask for a copy of the Probate Court Order.

8) SANCTIONS – Staff failing to comply or assure compliance with the policy may result in disciplinary action, including dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: OBTAINING
AUTHORIZATION FOR
THE DISCLOSURE OF
PROTECTED HEALTH
INFORMATION**

SECTION NO. VI

SUBJECT NO. 5

POLICY: It is the policy of North Central Missouri Mental Health Center to protect the privacy of individually identifiable health information in compliance with federal and state laws governing the use and disclosure of protected health information (PHI) and confidentiality. It is also the policy of NCMMHC to provide for the consumer's voluntary authorization for use or disclosure of his or her PHI as set out in 45 CFR Sections 164.508; 164.510; and 164.512. Whether PHI may be used or disclosed is subject to the review of the Privacy Officer or his/her designee.

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) DEFINITIONS

- A) Consumer – any individual who has received or is receiving services from NCMMHC.
- B) Disclosure – the release, transfer, provision or access to, or divulging in any other manner of information outside the facility holding the information.
- C) Psychotherapy notes – notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and **that are separated** from the rest of the consumer's medical record. Such notes **exclude** medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress notes to date.

2) PROCEDURE

- A) This facility may not use or disclose PHI without a valid authorization completed by the consumer or applicable personal representative, with limited exceptions. The authorization form is attached. The Clinical Records Clerk should obtain written information regarding the identify of the requestor, the date of the request, the nature and purpose of the request, and any authority that the requestor has to request such information, consistent with DOR 8.070 on Verification Procedures. If other staff receives a completed authorization form for the release of PHI, they shall direct it to the Clinical Records Clerk for review.
- B) Any disclosures that occur shall be limited to the minimum amount of information necessary to meet the purpose of the use or disclosure.
1. **Exceptions** to the minimum necessary requirement are as follows:
 - a. When the consumer authorizes the disclosure.
 - b. Disclosures required by law.
- C) NCMMHC must obtain an authorization for any use of disclosure or psychotherapy notes **except**:
1. To carry out treatment, payment or health care operations;
 2. For NCMMHC to use in defending itself in litigation or other proceedings brought by the consumer.
- D) PHI may only be disclosed **without authorization** in the following situations:
1. To a public health authority (i.e., required reporting to the Missouri Department of health and Senior Services);
 2. To report child abuse/neglect situations, and other situations involving abuse, neglect or domestic violence (if disclosure is allowed by law);
 3. To the Food and Drug Administration;
 4. To a health oversight agency;
 5. To judicial or administrative proceedings (a subpoena from a court is not enough);
 6. To law enforcement (but only in certain circumstances; including when they present a grand jury subpoena; information concerning

forensic clients; to locate a missing person, suspect, or fugitive; or at the discretion of the head of the facility when the information is requested to assist law enforcement in their investigation [see Section 630.140, Revised Statutes of Missouri]);

7. To avert a serious threat to health or safety [see also DMH Department Operating Regulation 4.410, concerning the duty to warn requirements, which are still in effect after HIPAA becomes effective April 14, 2003];
 8. Governmental functions (such as national security; veterans information);
 9. To other agencies administering public benefits;
 10. To medical examiners and coroners;
 11. To funeral directors;
 12. For organ donation purposes;
 13. For some research purposes; or
 14. As required by law.
- 3) Any questions as to whether a use or disclosure is permitted or required by law should be directed to the Clinical Records Clerk, or Privacy Officer or his/her designee.
- 4) Subpoenas – A subpoena alone, delivered to NCMMHC, is not considered enough to disclose client information
- A) When a subpoena is received, the receiving NCMMHC staff person will check the client's ECR and paper clinical record to confirm that there is a current Authorization for Release of Information to the court signed by the client or legal guardian.
 - B) If there is no signed Authorization for Release of Information, the NCMMHC staff person may contact the client to request a signed authorization or contact the court to request a court order signed by the judge that requests the desired records.
 - C) Once a signed authorization or court order is received, the NCMMHC staff person will copy only the specific information requested by the subpoena or court order.
 - D) Any records transported by NCMMHC staff will be delivered in a

concealed, confidential manner, and NCMMHC staff will not interpret records provided unless they are the creator of said records.

- E) Examination of the records will not be allowed by anyone other than the issuing party of the subpoena or court order.
- 5) Search Warrant – A search warrant is a court order, based on probable cause, issued by a judge that authorizes law enforcement to conduct a search (or arrest) of a person or location for evidence of a criminal offense and seize such items or information.
- A) NCMMHC staff shall notify the Executive Director and Clinical Director that a search warrant has been delivered.
 - B) NCMMHC staff shall read the search warrant and cooperate with law enforcement. The search warrant must be reasonable and specific. This means a search warrant must specify the person or object to be searched for and the place to be searched. Other items, rooms, outbuildings, persons, vehicles, etc. may require additional search warrants.
 - C) NCMMHC staff shall accompany law enforcement during the search and protect all client information that is not part of the written search warrant.
- 6) SANCTIONS: Any person found to have violated the requirements of this policy shall be subject to the sanctions up to and including dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: THE PROVISION OF AN
ACCOUNTING OF
DISCLOSURES OF
PROTECTED HEALTH
INFORMATION TO
CONSUMERS**

SECTION NO. VI

SUBJECT NO. 6

PURPOSE: It is the policy of North Central Missouri Mental Health Center to abide by the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, standards for privacy of individually identifiable health information. A consumer has the right to receive a written accounting of disclosures of his/her protected health information made by NCMMHC in the six (6) years prior to the date of which the accounting is requested. (45 CFR Section 164.528). A consumer may request an accounting of a period of time less than six (6) years. Beginning on April 14, 2003, a consumer is only entitled to request an accounting of disclosures from April 14, 2003 to the current date. After April 14, 2009, a consumer is entitled to request a full six (6) years' worth of disclosures.

APPLICATION: North Central Missouri Mental Health Center, it's facilities and workforce.

1) DEFINITIONS

- A) Consumer: any individual who has received or is receiving services from NCMMHC.
- B) Disclosure is defined as, "the release, transfer, provision or access to, or divulging in any other manner of information outside the entity which holds the information". This includes disclosures to or by business associates of the covered entity.
- C) Individually identifiable health information: any information, including demographic information, collected from an individual that:
 - 1. is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
 - 2. related to the past, present, or future physical or mental health or

condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual; and

- a. identifies the individual; or
- b. with respect to which, there is reasonable basis to believe that the information can be used to identify the individual.

D) Protected Health Information (PHI) is defined as, “individually identifiable health information that is (1) transmitted by electronic media; (2) maintained in any medium described in the definition of electronic media; or (3) transmitted to maintained in any other form or medium”.

2) PROCEDURES

A) All disclosures of PHI need to be accounted for upon the request of the individual. This is not limited to hard copy information by any manner of communication that discloses information, including verbal release. However, the following list of exceptions to this requirement do not require tracking or need to be accounted for upon the request of the individual:

1. Disclosures made for treatment, payment, and healthcare operation purposes.
2. Disclosures made to the consumer.
3. Disclosures made for national security or intelligence purposes.
4. Disclosures made to correctional institutions or law enforcement officials.
5. Disclosure made prior to the date of compliance with the privacy standards, meaning prior to April 14, 2003.
6. There are further exceptions for disclosures to health oversight agencies. Please contact the Privacy Officer should this situation arise.

3) The Privacy Officer shall assure that a mechanism is in place which tracks disclosure of both written and verbal protected health information.

4) NCMMHC will include the following required content in the accounting of disclosures:

A) The name and identification number of the consumer whose PHI was disclosed.

- B) Date of disclosure.
 - C) Name and address, if known, of the entity or person who received the PHI.
 - D) Brief description of the PHI disclosed.
 - E) Brief statement of purpose that reasonably informs the consumer the purpose of the disclosure, or provide the consumer with a copy of the authorization, or provide the consumer with a copy of the written request for disclosure.
- 5) If multiple disclosures are made to the same entity or person for the same reason, it is not necessary to document items (4) (A-D) for each disclosure. NCMMHC may document instead the first disclosure, the frequency or number of disclosures made during the accounting period, and the date of the last disclosure in the accounting period.
- 6) The consumer (or legal guardian) must make a written request for an accounting of disclosures to the Privacy Officer or designee. The request shall be on the Request for Accounting of Disclosures of Consumer Protected Health Information form. Staff may assist the consumer in completing the form if requested to do so.
- 7) NCMMHC has 60 days after receipt of the request for such an accounting to act on that request for an accounting of disclosure. If NCMMHC has disclosed information to a business associate regarding the consumer requesting the accounting, then NCMMHC through its Privacy Officer or designee must request an accounting of disclosures of that consumer's information from that business associate, who has 20 calendar days to provide the accounting. NCMMHC may request one 30-day extension, which is allowed, but the consumer must be informed in writing:
- A) Of the delay;
 - B) The reason for the delay;
 - C) The date the accounting will be provided; and
 - D) Such notification to the consumer or person requesting the accounting if disclosures of any delay must take place within the 60-day timeframe.
- 8) NCMMHC must provide the first accounting of disclosures free of charge in any 12-month period. Any subsequent requests can be charged based on Missouri Statute (RSMo Section 191.227). Before charging a fee, NCMMHC must inform the consumer and allow them the opportunity to withdraw or modify their request

to avoid or reduce the fee. No handling fee is allowed.

- 9) NCMMHC must retain a copy of the written accounting that is provided to the consumer in the consumer's medical record.
- 10) SANCTIONS: Failure of staff to comply or assure compliance may result in disciplinary action, including dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: VERIFICATION OF
IDENTITY AND
AUTHORITY OF
REQUESTOR**

SECTION NO. VI

SUBJECT NO. 7

PURPOSE: It is the policy of North Central Missouri Mental Health Center to protect the privacy of individually identifiable health information in compliance with federal and state laws governing the use and disclosure of protected health information. To accomplish that policy, and to establish uniformity in the verification process, prior to disclosing individually identifiable health/protected health information to third parties, the Privacy Officer or designee shall verify the identity of the requestor and ensure the requestor has the proper authority to request such information.

1) DEFINITIONS

- A) Protected Health Information (PHI) – Individually identifiable health information that is transmitted or maintained in any form or medium, by a covered entity, health plan or clearinghouse as defined under HIPAA administration simplification standards.
- B) Individually Identifiable Health Information – any information, including demographic information, collected from an individual that:
 - 1. Is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
 - 2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual, and:
 - a. identifies the individual, or
 - b. with respect to which, there is reasonable basis to believe that the information can be used to identify the individual.
- C) Verification – Process to verify the identity of a person requesting PHI and the authority of any such person to have access to PHI under this subpart

if the identity or any such authority of such person is not known to the covered entity; and must include obtaining any documentation, statements, or representations, whether oral or written from the person requesting the PHI when such documentation, statement or representation is a condition of the disclosure under this subpart.

- D) Privacy Officer – The person officially designated to oversee all ongoing activities related to the development, implementation, maintenance of, and adherence to HIPAA regulations pertaining to the privacy of, and access to, consumer health information in compliance with federal and state laws and North Central Missouri Mental Health Center’s Notice of Privacy Practices.
- E) Public Official – A person who has been legally elected or appointed and who has been empowered by law/regulation to exercise the duties and functions of their office for the public good.

2) PROCEDURE

- A) The consumer or personal representative must sign a valid authorization for the disclosure of confidential PHI before such PHI can be released, except in accordance with existing HIPAA requirements.
- B) All requests for disclosure shall be forwarded to the Privacy Officer or designee including the following:
 - 1. The name of the requesting party or parties; and
 - 2. Any documentation, statement or representations from the person requesting the PHI of his/her authority to request such information (i.e., legal representative of consumer, law enforcement official, etc.)
- C) The consumer must present identification prior to receipt of any records regarding themselves.
- D) The Privacy Officer or designee staff may rely on the following information to demonstrate identity:
 - 1. Presentation of agency identification, credentials or other proof of government status (a badge, identification card, etc.);
 - 2. A written request on agency letterhead or an oral statement if a written statement would not be possible (a natural disaster, other

emergency situations, etc.);

3. If the disclosure is requested by a person acting on behalf of a public official, a written statement on government letterhead that the person is acting under the government's authority, or a contract or purchase order evidencing the same; or
 4. A court order.
- E) The Privacy Officer or designee shall verify identity of any phone requests from all individuals, including law enforcement officers and others who have an official need for PHI by using a callback phone number before releasing information.
- F) The Privacy Officer or designee shall verify the facsimile number of any faxed requests. The main number of the sending agency shall be called, and the fax number verified. North Central Missouri Mental Health Center shall set its fax machines to imprint the origin. All incoming faxes shall be reviewed for imprint origin.
- G) The Privacy Officer or designee shall verify email addresses by calling the requestor. The general number for the sending agency shall be called, and then a request shall be made to be transferred to the specific individual that made the contact.
- H) The Privacy Officer or designee personnel are responsible for copying verification information or obtaining badge number, etc. and for maintaining it in the consumer's health information filed located in the Clinical Records Department.
- I) The Privacy Officer or designee must review the forwarded information and determine if he or she is satisfied that the documents verify the identity of the requestor and also demonstrate that the requestor has authority to request the information under state and federal law.
- J) The Privacy Officer or designee may disclose information to the requestor if all requirements for use and disclosure are met.
- K) The Privacy Officer or designee shall contact agencies or other entities for further verification of identity or authority to receive PHI if necessary.
- L) The Privacy Officer or designee may deny access to information if verification of identity or authority is not accomplished.

- 3) The Privacy Officer shall assure that a mechanism is in place which tracks disclosure of both written and verbal PHI.
- 4) SANCTIONS: Failure of staff to comply or assure compliance with this policy may result in disciplinary action, including dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: ENSURING
CONFIDENTIALITY OF PHI
FOR STAFF WORKING
AWAY FROM A FACILITY
SETTING**

SECTION NO. VI

SUBJECT NO. 8

PURPOSE: In compliance with the Health Insurance Portability and Accountability Act of 1996 (45 CFR Sections 164 et seq.) it is the policy of North Central Missouri Mental Health Center to provide procedures for best practices for employees to utilize in the field when traveling outside NCMHHC facilities. These procedures are to protect the privacy of Protected Health Information (PHI) of consumers in compliance with federal and state laws governing the use and disclosure of such PHI.

1) DEFINITIONS

- A) Authorized persons – those individuals involved in the treatment, payment, or health care operations pertaining to the subject of the PHI.
- B) Designated Record Set – a group of records under the control of a covered entity from which personal health information is retrieved by the name of the individual or by identifying number.
- C) Individually Identifiable Health Information – any information, including demographic information, collected from an individual that:
 - 1. Is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
 - 2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual, and:
 - a. identifies the individual, or
 - b. with respect to which, there is reasonable basis to believe that the information can be used to identify the individual.
- D) Protected Health Information (PHI) – individually identifiable health information.

- E) Vehicle – any mode of transportation utilized in carrying out NCMMHC’s business.
- 2) PHI that is unattended shall be secured in a manner to protect such information from persons without authorized access to this PHI.
- A) Vehicles containing any PHI shall be kept locked while unoccupied. PHI shall be kept locked in the trunk of the vehicle, when possible. In the event of extreme temperature situations, an electronic device (laptop, personal digital assistant [PDA], etc.) containing PHI shall be maintained in the temperature-controlled cab in a case while the vehicle is occupied.
 - 1. In the event of a vehicle accident, any NCMMHC employee who suspects there is PHI in the vehicle shall make every reasonable attempt to make sure that the PHI is not accessible to anyone who does not need to have access to it, after assuring the health and safety of any individual(s).
 - B) Upon an employee leaving an area where they have materials containing PHI, e.g. to use the restroom, the employee shall ensure that the area is protected from viewing by those without authorization by locking the area, or using some other reasonable intervention.
 - C) Employees shall travel in the field taking only PHI necessary to carry out their duties.
 - D) Any documentation or equipment, such as laptops, pagers, briefcases, palm pilots, etc., that may contain PHI shall be secured from access to those without authorization to the PHI. This includes all locations, including an employee’s home. Each document that is contained on the laptop shall be password protected.
 - E) If a designated record set is checked out from the Clinical Records department, the Clinical Records policy shall be followed.
 - F) Data contained on all laptops, etc. should be backed-up to a disk when at all possible to avoid loss of valuable consumer PHI.
 - G) If PHI in any form is lost or stolen, the Privacy Officer or designee should be notified as soon as practical, not to exceed two business days, in order to initiate the mitigation process.
- 3) PHI that is potentially within view of others, even if staff is present, shall be

protected in a manner that such information is not communicated to persons without authorized access to this PHI.

- A) All PHI within a vehicle shall be maintained so as to protect from plain view through the windows of the vehicle.
 - B) Any electronic device containing PHI shall not have the screen placed in view of others and if left attended briefly, a screen saver shall be employed.
 - C) All documentation containing PHI shall be maintained out of the view of unauthorized persons.
 - 1. While working with PHI, the employee shall keep the documentation within line of sight or within arm's reach.
 - 2. This documentation shall be viewed in the most private settings available.
 - 3. Only PHI documentation necessary for the task at hand shall be in view.
 - 4. Briefcases containing PHI shall remain closed when not in use.
 - 5. When having PHI material copied, the employee shall ensure that this material is viewed only by authorized persons.
 - D) Employees shall send and receive faxed materials containing PHI to and from NCMMHC locations only, unless such locations are not readily available and timely transmission of records is necessary for safety needs.

If in locations other than a NCMMHC facility:

 - 1. When sending or receiving a fax containing PHI, the employee shall ensure only those authorized to view have access to the material during the process of transmission.
 - 2. The fax cover sheet shall not contain PHI.
 - 3. The employee shall be waiting to receive the fax at the fax machine when the transmission is expected if the material could be accessed by those without authorization to view the PHI.
 - E) When using sign language interpreters where PHI may be transmitted, the most private setting available out of view of others shall be used.
- 4) PHI that is verbally transmitted to others shall be protected in a manner that such information is not communicated to persons without authorized access to this

PHI.

- A) Conversations where PHI is discussed shall occur in the most private settings. There shall be as much distance as possible between any individuals without authorized access to the PHI.
 - B) Conversations where PHI is discussed shall occur with the employee using a volume level that cannot be overheard by those without authorized access to the PHI. This includes telephone conversations. If there is no way to prevent being overheard, a specific code shall be used to identify an individual, such as consumer initials.
 - 1. The employee shall make every effort to keep the volume level of all participants low enough so as not to be overheard.
 - 2. Conversations shall involve using only the first name of an individual whenever possible.
 - C) Wireless/cellular and cordless telephones shall be used for communicating PHI only if necessary. There is currently no device to monitor digital cellular telephone calls, so PHI discussions are currently acceptable. The employee shall not communicate PHI on a cordless or analog cellular telephone, unless using a code specified in (4)(B).
- 5) PHI that may be shared with others in the course of an employee carrying out duties shall be protected in a manner that such information is not communicated to persons without authorized access to this PHI.
- A) Deaf and linguistic interpreters shall be used in accordance with guidelines established by the Department of Mental Health Office of Deaf and Linguistic Support Services.
 - 1. The interpreter shall not be an immediate family member of close family friend of the subject of the PHI, unless the subject of the PHI consents.
 - 2. The interpreter shall not use or disclose any PHI obtained as a result of providing interpretation services. If at all possible, the interpreter shall sign a confidentiality agreement.
- 6) **SANCTIONS:** Failure of staff to comply or assure compliance with this policy may result in disciplinary action, up to and including dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: MANDATORY HIPAA
PRIVACY AND SECURITY
TRAINING**

SECTION NO. VI

SUBJECT NO. 9

PURPOSE: Describes mandatory training as required by the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Section 164.500 et seq.

1) Definitions. Terms are defined as follows:

- A) Health Insurance Portability and Accountability Act (HIPAA) – Public Law 104-191, enacted on August 21, 1996.
- B) Code of Federal Regulations (CFR) – refers to 45 CFR Parts 160, 164 and 142, for Privacy and Security rules.
- C) Privacy Training Rule – 45 CFR Section 164.530(b)(1) states “a covered entity must train all members of its workforce on policies and procedures with respect to health information required by this subpart, as necessary and appropriate for the members of the workforce to carry out their function within the covered entity”.
- D) Proposed Security Training Rule – 45 CFR Section 142.308(a)(12) requires “education concerning the vulnerabilities of the health information in an entity’s possession and ways to ensure the protection of that information”.
- E) Protected Health Information (PHI) – individually identifiable health information that is (1) transmitted by electronic media; or (2) transmitted or maintained in any form or medium.
- F) Mandatory Training – the requirements as noted in (1)(C) privacy and (1)(D) proposed security as defined above, plus any additional training requirements adopted in the final Privacy and/or Security rules.

2) Mandatory Training for All Employees.

- A) All employees, as well as volunteers, students, and contract employees in a North Central Missouri Mental Health Center facility on a regular course of business, shall receive training on the privacy and security provisions of

HIPAA.

- B) Employees, as well as volunteers, students, and contract employees in a NCMMHC facility on a regular course of business, hired or engaged prior to April 14, 2003, shall receive HIPAA privacy and security training prior to April 14, 2003.
 - 1. Trainings shall be conducted at NCMMHC.
 - 2. Additional mandatory privacy training shall be scheduled whenever there is a material change in the privacy policies or procedures as determined by the Privacy Officer.
 - 3. Periodic mandatory security training shall be scheduled as determined by the Security Officer.
 - C) Employees hired after April 14, 2003 shall receive training as part of their initial employee orientation. New employee orientation on HIPAA regulations must take place within 30 days of the date of hire.
 - D) Volunteers, students, and contract employees in a NCMMHC facility on a regular course of business who are hired or accepted after April 14, 2003 shall receive training as a part of their initial orientation. Such training must be done within 30 days of the initial date of employment.
 - E) The Management Team, along with the Privacy Officer, shall identify group(s) or individuals who, due to the nature of their job function, will require in-depth training related to HIPAA and then arrange for the provision of that specialized training prior to April 14, 2003.
- 3) Documentation of Mandatory Training – documentation of mandatory HIPAA training shall be maintained in the employee's personnel file.
 - 4) Sanctions. Employees who do not complete the respective mandatory HIPAA training(s) are subject to disciplinary action that may include, but is not limited to, suspension, demotion, or dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: RETENTION AND
DESTRUCTION OF
PROTECTED HEALTH
INFORMATION**

SECTION NO. VI

SUBJECT NO. 10

PURPOSE: To ensure the availability of relevant data and information, it is the policy of North Central Missouri Mental Health Center to maintain specific retention schedules for various types of individually identifiable health information in compliance with federal and state law and professional practice standards.

PROCEDURE:

- 1) Storage: All storage systems used by NCMHHC shall be designed and implemented to ensure the safety, security, and integrity of consumer Protected Health Information (PHI). The storage method selected shall be dependent on the security of the area and the volume of the information stored.
 - A) Paper PHI records storage must be adequate to protect the physical integrity of the record and prevent loss, destruction, and unauthorized use.
 1. PHI records are retained in a lockable office that is not shared with other staff, or in a separate locked file room. The office or file room should always be locked when staff is not in attendance.
 2. Storage area environment should not cause damage to the records and documents and meet safety standards.
 3. A record tracking system must be in place to identify when a record has been removed, who took the record, and where it is located.
 - B) Electronic storage of medical records, if applicable, should have a permanent retrievable capability, and such capability should occur even when there is a technology change.
- 2) Retention: Retention of PHI records and databases shall comply with federal and state regulations, accreditation, licensure and accepted standards of practice. The more stringent between federal and state law must be followed. This policy refers to the following types of PHI and databases:

- A) Master Client Index
 - B) Admission/Discharge Register or Database
 - C) Medical Record
 - D) Consumer Financial Records: These records include consumer receipt and disbursement records, reimbursement information including, but not limited to, Standards Means Test and Consumer Financial File.
 - E) Accounting of Disclosure of Information, to be retained a minimum of six (6) years according to the HIPAA Privacy Rule.
- 3) Destruction: Destruction of PHI in paper or electronic format shall be carried out in accordance with federal and state law. Records approved for destruction must be destroyed so that there is no possibility of reconstruction of information.
- A) Paper.
 - 1. Because all media and reproductions typically have the same legal effect as originals, when a record meets the guidelines for destruction, all copies in any media should be destroyed.
 - 2. Appropriate methods for destroying paper records include burning, shredding, pulping, and pulverizing.
 - 3. Documentation of the destruction of records should include: date of destruction; method of destruction; description of records; inclusive date of records; statement that the records were destroyed in the normal course of business; and the signatures of the individuals supervising and witnessing the destruction. Destruction documents should be permanently retained. Documentation records must be maintained by the facility Privacy Officer.
 - 4. If destruction services are contracted, the contract should be a business associate's agreement that specifies the method of destruction, the time that will elapse between acquiring and destroying the records, identify safeguards against breaches in confidentiality, indemnify the facility from loss due to unauthorized disclosure, and provide proof of destruction to the facility Privacy Officer.
 - B) Electronic. When electronic records or computerized data is destroyed, it should be permanently and irreversibly non-retrievable.

1. Computer Disks: Methods may include overwriting data with a series of characters, reformatting the disk or physical destruction. Deleting a file does not destroy the data but merely deletes the file name from the directory preventing easy access until it is overwritten.
2. For laser disks, back-up tapes, hard drives, and servers, the method of destruction shall be in a format or process that ensures that the data is irreversibly non-retrievable either through electronic or physical destruction.
3. All destruction of paper and electronic records shall stop in the event of any legal process initiated against the agency.
- 4) Any questions as to whether information retention or destruction is permitted or required by law should be directed to the facility Privacy Officer or designee, or the Security Officer as appropriate.
- 5) The Clinical Records Clerk with notify the Privacy Officer prior to each record destruction event as a provision for stopping the destruction of records in the event that a legal process is initiated against the agency.
- 6) SANCTIONS: Failure to comply or assure compliance with this policy may result in disciplinary action, up to and including dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: DESIGNATED RECORD
SETS**

SECTION NO. VI

SUBJECT NO. 11

PURPOSE: It is the policy of North Central Missouri Mental Health Center to identify those records maintained that meet the definition of designated record set covered by the HIPAA Privacy Rule, specifically 45 CFR Section 164.501.

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) DEFINITIONS

A) Designated Record Set – a group of records maintained by or for a covered entity that is: (a) the medical records and billing records about individuals maintained by or for a covered health care provider; (b) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (c) used, in whole or in part, by or for the covered entity to make decisions about individuals.

1. The designated record set of forms includes:

- a. Intake Evaluation and the most recent assessment
- b. Treatment Plan
- c. Doctor progress notes
- d. Community Support Specialist progress notes
- e. Medication profile
- f. Health Screen
- g. Standard Means

B) Record – any item, collection, or grouping of information that includes Protected Health Information (PHI) and is maintained, collected, use or disseminated by or for a covered entity.

C) Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury, or the risk there of.

2) PROCEDURE

- A) NCMMHC shall identify all information systems (defined as an organized collection of information) that contain PHI, including the location, unique system identifier, the form of the data (electronic or paper), the data maintainer, and a description of the type of PHI contained.
- B) That inventory shall be maintained by the facility Privacy officer or designee. Assistance may be requested from appropriate staff members. Any new or modified systems shall be added to the inventory by the Privacy Officer, his/her designee, or Security Officer.
- C) In order to maintain an accurate inventory of record systems, when new systems are created, the staff responsible for developing and maintaining the information shall notify the Privacy Officer that the system is in production and it contains PHI. When a current system that contains PHI is no longer used or needed, the staff responsible for maintaining the information shall notify the Privacy Officer so that the inventory system can be amended and the information retained or destroyed according to retention policies.
- D) For the purpose of the implementation of this policy, the term “designated record set” includes any item, collection or grouping of information that includes PHI and is maintained, collected, used or disseminated by or for NCMMHC for consumer care or payment decision making, including but not limited to:
 - 1. Medical records and billing records about consumers maintained by or for NCMMHC;
 - 2. Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for NCMMHC; and
 - 3. Any records or information used, in whole or in part, by or for NCMMHC to make decisions about consumers.
- E) Information that is not part of the designated record set is defined as any documents that are used for census information, quality assurance or quality improvement, peer review, sentinel event, centers for Medicare and Medicaid purposes, utilization review, abuse/neglect investigations, incident/injury reports, state auditors, or various electronic databases, etc., which are not used to make decisions regarding an individual consumer,

and shall not be considered as part of the designated record set.

However, please note that these types of information may be accessible by parents or guardians. In addition, for forensic cases, the pretrial commitment order, the pretrial evaluation, or any correspondence relating to the pretrial is not part of the designated record set. Neither is the victim notification information.

1. Working files, either paper or electronic, are also not considered part of the designated record set, and are defined in Attachment B. Working files are not substituted for the main client record and are only considered to be secondary documents with the main client record.
 2. Psychotherapy notes are not included in the designated record set (psychotherapy notes are defined in 45 CFR Section 164.501, and are to be kept separate from the medical record).
- F) When an individual or department has been given sanctioned, exclusive possession and control of PHI as part of their assigned duties, they shall be responsible for all administrative duties of a data trustee in terms of security, data access, privacy, data backup, disaster recovery and accountability. When the department or individual does not have the technical expertise or equipment to adequately protect the PHI, they must arrange for technical assistance through the Privacy Officer or Security Officer to assure the confidentiality of the PHI.
- G) The designated record set shall be created, stored, released, transported, copied and destroyed based on the Record Retention and Destruction Policy.
- H) SANCTIONS – Failure to comply or assure compliance may result in disciplinary action, up to and including dismissal.

SECTION: HIPAA REGULATIONS

SUBJECT: PERSONNEL FILES

SECTION NO. VI

SUBJECT NO. 12

PURPOSE: Maintaining necessary personnel records in an appropriate format is vital to the operation of a facility's payroll, benefits, and employee management systems.

APPLICATION: *North Central Missouri Mental Health Center, its facilities, and workforce.*

PROCEDURES

- 1) Access to employee personnel files is limited to the Executive Director, the President of the Board of Directors, the Executive Assistant and employees designated by the Executive Director. Access to such files shall be authorized by the Executive Assistant or designee. Information may be released to other individuals or entities with a proper authorization form/request completed by the employee. However, there may be certain situations in which auditors, federal investigators, etc. may have access to such employee personnel files.
- 2) In order to provide management with appropriate information to base personnel decisions upon, an employee personnel file must be maintained. Such files are required to be maintained in locked files or within a locked room to assure privacy and security. The contents of such files should be maintained in accordance with current State of Missouri Records Retention Schedule. An employee's personnel file shall consist of two separate files: the personnel file and the medical file. Specific pieces of information are to be maintained in each separate file.

Items maintained in the individual personnel files should include, but are not limited to:

- A) Application and background information – application, license or certification, qualification correspondence, record of reference checks, reference letters, resume or curriculum vitae, and transcripts;
- B) Employment status and history – address change or update, armed services information, conflict of interest, interviews, jury duty, memos

regarding probationary period changing over to regular appointment, merit increase requests, memos, registered letters, requests for transfer of employment, resignation letters, and wage record;

- C) Performance – change of supervision, job description, letters of commendation, performance evaluation, staff development plan, probationary period extension, re-evaluating positions or review, reprimands/notices of disciplinary actions if for reasons other than medical, written counseling, or any documents which set forth specific expectations of behaviors/duties;
 - D) Background screening information – application for Missouri Division of Family Services, Missouri Division of Aging, Missouri Department of Mental Health, and Missouri State Highway Patrol screenings and results, and abuse/neglect issues (i.e., abuse/neglect investigative reports and related disciplinary letters).
 - E) Employee grievances – grievances and/or grievance responses.
 - F) Miscellaneous – exit questionnaire, financial disclosure statement, release of information authorization, confidentiality statement, and key assignments;
 - G) Compensation benefits – requests for deduction, retirement forms, and tax forms.
- 3) Information maintained in the medical file include:
- A) Requirements for doctor’s verification of illness;
 - B) Physician’s statements;
 - C) Workers’ Compensation issues;
 - D) FMLA and other initial and subsequent health clearances;
 - E) Medical clearance to return to work, clinical evaluations, ability to perform essential functions statements
- 4) The information maintained in the medical file will not be considered as part of the employee’s individual personnel file. This information will be accessed only on a need-to-know basis.
- 5) Failure to comply or assure compliance with the requirements of this policy will result in disciplinary action up to and including dismissal.

SECTION: HIPAA REGULATIONS**SUBJECT: MINIMUM NECESSARY
STANDARD****SECTION NO. VI****SUBJECT NO. 13**

PURPOSE: This policy will provide instruction regarding North Central Missouri Mental Health Center's obligations relating to the HIPAA requirement to use, disclose, or request only the minimum amount of Protected Health Information (PHI) necessary to accomplish the intended purpose of the use, disclosure or request.

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) **DEFINITIONS:** As used in this operating regulation, the following terms shall mean:

- A) Protected Health Information (PHI) – individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
- B) Staff Members – employees, volunteers, trainees, and other persons whose conduct, in the performance of work for NCMMHC, its offices, programs or facilities, is under the direct control of NCMMHC, its offices, programs or facilities, regardless of whether they are paid by the entity.

2) **PROCEDURE**

A) NCMMHC, its facilities and its workforce will make reasonable efforts to ensure that the minimum necessary PHI is disclosed, used or requested.

Exceptions to the minimum necessary requirement include:

- 1. Disclosures to the individual who is the subject of the information;
- 2. Disclosures made pursuant to an authorization;
- 3. Disclosures to or requests by healthcare providers for treatment purposes;
- 4. Disclosures required for compliance with the standardized HIPAA transactions;
- 5. Disclosures made to HHS/OCR pursuant to a privacy investigation;

or

6. Disclosures otherwise required by the HIPAA regulations or other law.

- B) Each user of PHI will be subject to the provisions of HIPAA privacy requirements relating to staff access to PHI.
 - C) Reasonable efforts will be made to limit each PHI user's access to only the PHI that is needed to carry out his/her duties. These efforts will include the Privacy Officer or designee monitoring staff use and disclosure of PHI.
 - D) For situations where PHI use, disclosure or request for PHI occurs on a routine and recurring basis, the Privacy Officer or designee will issue directives as to what information constitutes the minimum necessary amount of PHI needed to achieve the purpose of the use, disclosure or request.
 - E) For non-routine disclosures (other than pursuant to an authorization), staff should address questions to the Privacy Officer or designee to assure that PHI is limited to that which is reasonably necessary to accomplish the purpose for which disclosure is sought. Examples of non-routine disclosures include providing PHI to accrediting bodies, insurance carriers, research entities, funeral homes, etc.
 - F) If the PHI is being requested by a member of NCMMHC's Organized Health Care Arrangement, and it is for the purposes of use for treatment, payment or health care operations, then the minimum necessary is whatever information is necessary in order to complete the referral, etc.
 - G) Any questions related to this policy must be directed to the Privacy Officer or designee.
- 3) **SANCTIONS:** Failure to comply or assure compliance with this policy shall result in disciplinary action, up to and including dismissal.

SECTION: HIPAA REGULATIONS

**SUBJECT: HIPAA COMPLAINT
PROCESS**

SECTION NO. VI

SUBJECT NO. 14

PURPOSE: It is the policy of North Central Missouri Mental Health Center to provide consumers with the means to file a complaint if they believe that their Protected Health Information (PHI) has been improperly used or disclosed.

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) **DEFINITIONS:** As used in this policy, the following terms shall mean:

- A) **Complaint:** Allegation that a consumer's PHI has been improperly used or disclosed. A consumer may file a complaint, or a legal guardian or personal representative or a parent of a minor may file the complaint. The original complaint form is to be placed in the consumer's clinical record. If the consumer has a guardian, a copy of the complaint shall be sent to the guardian, and the consumer should be notified that such action has occurred.
- B) **Consumer:** Any person who has received services or who is receiving services from NCMHHC.
- C) **Protected Health Information (PHI):** Individually identifiable health information, defined as any information, including demographic information, collected from an individual that:
 - 1. Is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
 - 2. Related to the past, present or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and
 - a. Identifies the individual, or
 - b. With respect to which, there is reasonable basis to believe that the information can be used to identify the individual.

- 2) **PROCEDURE:** NCMHHC strongly encourages and wishes to promote that consumers and service providers discuss and attempt to resolve issues in the most direct and informal manner and at the local level. The following steps constitute the HIPAA complaint process:
- A) Utilize standardized DMH HIPAA Privacy Complaint Form.
 - B) Forward a copy of the complaint form to the facility Privacy Officer or designee.
 - C) The HIPAA Privacy Complaint must describe the acts or omissions the consumer believes to have occurred.
 - D) The HIPAA Privacy Complaint must include the following information:
 - 1. The date on which the act or omission occurred;
 - 2. A description of the PHI affected and how it was affected; and
 - 3. The name(s) of anyone who may have improperly been provided with the PHI.
 - E) All Privacy Complaints received by the Privacy Officer or designee will be date-stamped upon arrival.
 - 1. The Privacy Officer or designee will review and act on the complaint in a timely manner and not more than 30 days from receipt of the complaint. If greater time is necessary to review and investigate the complaint, the Privacy Officer or designee shall, within 30 days, notify the consumer of the delay, and inform the grievant of the expected timeframe for completion of the review.
 - 2. The Privacy Officer or designee shall determine what PHI is affected by the complaint and if the PHI was provided to other covered entities and business associates.
 - 3. If the affected PHI was created and maintained by a business associate, the complaint will be forwarded to the business associate as outlined in the Business Associate Agreement. Complaints forwarded to business associates will be logged and a notice of the action sent to the consumer making the complaint.
 - F) The Privacy Officer or designee shall determine if there is cause to believe that a violation of the privacy policy occurred, and the course of action to be taken.

1. If no violation has occurred, the complaint and finding will be date-stamped, the complaint will be considered closed, and a written notice of this shall be provided to the consumer.
 2. If cause exists to believe that a violation has occurred, the Privacy Officer or designee shall determine if:
 - a. Performance or training need to be improved;
 - b. A recommendation for a change to the policy should be forwarded to the Executive Director.
 - c. A recommendation should be made to the Executive Director to establish a new privacy policy.
 3. The Privacy Officer or designee shall notify the appropriate administrators, staff or committees of the action needed.
 4. If employee discipline must be taken, it must follow NCMMHC's policy on sanction, and is to be initiated by the appropriate appointing authority.
- G) If the complaint resolution finds that no cause exists to believe a violation occurred, then the consumer may seek resolution from the Executive Director.
1. The consumer, through completion of the Complaint Form, will request that the Privacy Officer or designee forward the complaint to the Executive Director.
 2. The Executive Director shall review and act on the complaint in a timely manner, and not more than 30 days from receipt of the complaint form.
- H) The Executive Director shall determine one of the following:
1. That the original determination of the Privacy Officer is accurate.
 2. That remediation should occur at the facility level through increased training, or that a recommendation is made to the facility appointing authority for possible disciplinary action.
 3. That a recommendation for the policy be initiated.
 4. That a recommendation be made for the establishment of a new policy.
- I) The original complaint form shall be placed in the consumer's clinical

record.

- 3) **RETENTION:** The Privacy Officer or designee's primary responsibilities in the HIPAA Complaint process include logging and retaining complaints in a retrievable manner for a minimum of six (6) years and identifying:
 - A) Person or entity making the complaint;
 - B) Date complaint was received;
 - C) A list of what PHI was affected;
 - D) Status of complaint;
 - E) A list of businesses associates or facilities affected; and
 - F) Actions taken.
- 4) There shall be no retaliation against any consumer, or against a staff member for assisting a consumer to file a HIPAA Privacy Complaint.
- 5) **SANCTIONS:** Failure to comply or assure compliance with this policy shall result in disciplinary action, up to and including dismissal.

SECTION: HIPAA REGULATIONS

SUBJECT: BREACH NOTIFICATION

SECTION NO. VI

SUBJECT NO. 15

PURPOSE: It is the policy of North Central Missouri Mental Health Center to protect PHI according to The Health Information Technology for Economic and Clinical Health Act (HITECH Act). With the direction of the HITECH Act, NCMMHC will continually endeavor to strengthen the privacy and security of all PHI.

DEFINITIONS: As used in this policy, breach shall mean: A breach is considered an unsecured misuse of PHI and is defined as an unauthorized release, transfer, provision of, access to, or divulging in any other manner, of PHI outside the agency.

In the event that a breach of PHI in any form is discovered, the following procedures will be followed. Failure of staff members to comply or assure compliance may result in disciplinary action, including dismissal.

- 1) The Privacy Officer or designee should be notified as soon as possible, but no later than two (2) business days after the breach is discovered, in order for the Privacy Officer or designee to initiate the mitigation/improvement process.*
- 2) The Privacy Officer or designee shall notify each client whose PHI has been or is reasonably believed to have been accessed, acquired, or disclosed as a result of such breach. All notifications shall be made without unreasonable delay and in no case later than 60 calendar days after the date of discovery of a breach by the agency.*
- 3) Notice with respect to a breach of PHI shall be provided in the following form:
 - a. Written notification by first-class mail to the client/guardian (or next of kin, if the client is deceased) at the last known address of the client (or next of kin), or if specified as a preference by the client, by electronic mail. The notification may be provided in one or more mailing(s) as information is available.*
 - b. In the case in which there is insufficient, or out-of-date contact information (including phone number, email, address, or any other form of appropriate**

communication) that prohibits direct written notification to the client, a substitute form of notice shall be provided, including:

- 1. A conspicuous posting for a determined period of time on the agency home page of the website; or*
 - 2. Notice in major print or in broadcast media where the client affected by the breach likely resides, including a toll-free number where the client can learn what PHI was included in the breach.*
 - 3. If the breach involves 500 or more clients, the Executive Assistant will make available to the public on the Internet website of the Department of Health and Human Services a list that identifies each agency involved in the breach.*
- 4) The Privacy Officer or designee will maintain a log of any such breach occurring and annually submit the log information to the Clinical Review Committee, documenting such breaches occurring during the year.*
- 5) Regardless of the method by which notice is provided to clients, the notice of a breach shall include, to the extent possible, the following:*
- 1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.*
 - 2. A description of the types of unsecured PHI that was involved in the breach (such as full name, social security number, date of birth, home address, account number, disability code, etc.).*
 - 3. The steps a client(s) should take to protect themselves from potential harm resulting from the breach.*
 - 4. A brief description of what the agency is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.*
 - 5. Contact procedures for clients to ask questions or learn additional information, which shall include a toll-free telephone number, and email address, website, or postal address.*
- 6) If a law enforcement official determines that a notification, notice, or posting required under this policy would impede a criminal investigation or cause damage to national security, such notification, notice, or posting shall be delayed in the same manner as provided under Section 164.528(s)(2) of Title 45, Code of*

Federal Regulations.

- 7) *The Privacy Officer will ensure that the supervisor of the staff member(s) involved in the breach is notified of the breach and will work with the supervisor in designing a correction action for the staff member(s) involved in the breach.*

SECTION: HIPAA REGULATIONS

**SUBJECT: USER ACCESS TO
ELECTRONIC DATA**

SECTION NO. VI

SUBJECT NO. 16

PURPOSE: It is the policy of North Central Missouri Mental Health Center to secure our consumer's Protected Health Information (PHI) in compliance with federal law and federal regulations. To assist in assuring that protection, it is the practice of North Central Missouri Mental Health Center to assure that its workforce recognizes the importance of such security provisions, and affirmatively acknowledge those guidelines.

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) *Contents*

- a. *Definitions*
- b. *General*
- c. *User Access to NCMMHC Data*
- d. *Access to Electronic Media*
- e. *Training on Access*
- f. *Required Confidentiality Agreement*
- g. *Password Management*
- h. *Sanctions*

2) *Definitions*

- A) *Computer Systems – computers connected to local and statewide communication networks, database storage, or electronic records systems, Internet or email.*
- B) *DMH Network – electronic network allowing access to the DMH's personal computers, facility-based systems, and centrally-based systems (e.g. AS/400, Windows 2000 Server, Mainframe, etc.) and electronic data.*
- C) *Local Area Network – electronic network access allowing access to an individual facility's electronic data and computers.*
- D) *Network Attached Computer – any computer with access to a local area network and/or the DMH network.*

- E) *NCMMHC Workforce – includes employees, volunteers, contract workers, trainees and other persons who are in a NCMMHC facility on a regular course of business. This shall include client workers employed by NCMMHC.*
- F) *Client/Consumer – any individual who has received or is receiving services from NCMMHC.*
- G) *Restricted Access – computer systems with access limited to specific systems, activities, or files.*
- H) *Confidentiality Agreement – agreement between any business partners with which NCMMHC shares client data that sets for confidentiality requirements and limitations necessary for working with client, facility and information.*
- I) *Security Officer (Chief Security Officer) – individual designated by NCMMHC to oversee all activities related to the development, implementation, maintenance of, and adherence to NCMMHC’s policies and procedures covering the electronic and physical security of, and access to, PHI and other NCMMHC data in compliance with federal and state laws and regulations.*
- J) *Media – backup tapes, hard drives, floppy diskettes, CD’s, zip drives cartridges, optical, and paper hard copies.*
- K) *Protected Health Information (PHI) – individually identifiable health information.*

3) *General*

A) *Management’s Right to Access Information*

1. *Pursuant to the Electronic Communications Privacy Act of 1986 (18 USC 2510 et seq), the agency has complete access to all email and Internet activities. No electronic communications sent or received are considered private to the employee. The agency has the right to monitor messages and Internet use as necessary to assure efficient and appropriate use of the technology.*
2. *Each of the electronic communications technologies may create electronic records that are easily saved, copied, forwarded, retrieved, monitored, reviewed, and used for litigation. All electronic*

records are the property of NCMMHC and can be accessed and used by management when:

- a. A legitimate business need exists that cannot be satisfied by other means; or*
- b. The involved employee is unavailable and timing is critical to a business activity; or*
- c. There is reasonable cause to suspect criminal activity or policy violations; or*
- d. Law, regulation, or third-party agreement requires such monitoring.*

3. These disclosures of electronic records may be made without prior notice to the staff members who sent or received the communications. Staff members should not assume that any electronic communications are private.

4) User Access to Electronic NCMMHC Data

A) To gain access to any NCMMHC PHI, staff members are required to complete the NCMMHC Staff Computer Access Request form.

- 1. Such access shall be limited to the minimum necessary amount of PHI to accomplish the purpose of any requested use or disclosure of PHI.*
- 2. The request form(s) must be submitted each time a user's access status changes.*
- 3. Users will be assigned a role-based unique user ID.*
- 4. User ID's will be password protected.*

B) Users shall be required to protect confidential data.

C) NCMMHC shall maintain a Business Continuity/Disaster Recovery Plan, approved by the Security Officer to assure continued operations in the event of an emergency.

D) No NCMMHC client/consumer or volunteer shall have access to another person's PHI or any other NCMMHC client demographic system, or be allowed to input information to local systems that may be used to feed or modify those systems unless they have signed the confidentiality statement, or unless authorized by the consumer. Any proposed

client/consumer access shall include documentation of the client/consumer reviewing and agreeing to a confidentiality statement. Documentation shall include the types of systems and files accessed.

E) Such client/consumer access shall be approved by the facility director or designee with notification and documentation provided to the Security Officer.

5) Access to Electronic Media – Internet and Electronic Mail

A) Users are required to abide by the following guidelines when using electronic mail systems:

- 1. The Internet and email are intended to be used primarily for business purposes.*
- 2. The Internet may be used to access external databases and files to obtain reference information or to conduct research.*
- 3. Email may be used to disseminate business-related newsletters, press releases, or other documents to groups of people.*
- 4. Email and the Internet may be used for discussion groups on job-related topics.*
- 5. Personal use of email must be limited and must not interfere with the performance of work duties.*

B) Electronic mail and/or the Internet may not be used for:

- 1. Any illegal or unethical purpose;*
- 2. Private purposes such as advertising products or services, business transactions, or for private business activities;*
- 3. Operating a business, sending chain letters, or soliciting money for any purposes;*
- 4. Transmitting, downloading or viewing material that is obscene, pornographic, threatening or harassing, or information that may be perceived to be obscene, threatening or harassing to another individual;*
- 5. Disseminating, copying, or printing copyrighted materials (including articles, software, music and movies) in violation of copyright laws;*
- 6. Subscribing to mailing lists and broadcast services that do not relate to the business of NCMMHC.*

7. *Downloading software of any kind without prior approval of the Security Officer.*
 8. *Participating in Internet chat rooms or instant messaging, including but not limited to AOL Instant Messenger and Internet Relay Chat (IRC);*
 9. *Playing games; or*
 10. *Conducting any political activity.*
- 6) *Training on Access. All NCMMHC employees, client/consumers and volunteers must receive the privacy training required by HIPAA.*
- 7) *Required Confidentiality Agreement*
- A) *NCMMHC staff members that receive or maintain PHI shall be required to agree to the security of such PHI in accordance with the state and federal laws as set forth above. These staff members shall sign a confidentiality statement. A copy of the signed confidentiality statement shall be maintained in the personnel file of NCMMHC staff.*
- 8) *Password Management*
- A) *Passwords shall not be shared.*
 - B) *Passwords shall be changed immediately if user is aware that someone else knows it.*
 - C) *Users shall not change their passwords while others are present.*
 - D) *Passwords shall have no connection to the user, i.e., user name, children's name, etc.*
- 9) *Sanctions. Failure of staff members to comply or assure compliance with this policy may result in disciplinary action, including dismissal.*

SECTION: HIPAA REGULATIONS

SUBJECT: DATA SECURITY

SECTION NO. VI

SUBJECT NO. 17

PURPOSE: To prescribe practices which secure electronic consumer PHI in compliance with federal law and best information management practices and in accordance with 45 CFR 164.530 (c) (1) and(2) and 45 CFR Part 2. (Also see Technology Plan, Attachment C.)

APPLICATION: North Central Missouri Mental Health Center, its facilities and workforce.

1) Contents

- A) Definitions
- B) Data Security
- C) Sanctions

2) Definitions

- A) *Computer Systems – computers connected to local and statewide communication networks, database storage or electronic records systems, Internet or email.*
- B) *DMH Network – electronic network allowing access to the DMH’s personal computers, facility-based systems, and centrally-based systems (e.g. AS/400, Windows 2000 Server, Mainframe, etc.) and electronic data.*
- C) *Local Area Network – electronic network access allowing access to NCMMHC’s electronic data and computers.*
- D) *Network Attached Computer - any computer with access to a local area network and/or the DMH network.*
- E) *NCMMHC Workforce – includes employees, volunteers, contract workers, trainees and other persons who are in a NCMMHC facility on a regular course of business. This shall include client workers employed by NCMMHC.*
- F) *Client/Consumer – any individual who has received or is receiving services from NCMMHC.*

- G) *Restricted Access – computer systems with access limited to specific systems, activities, or files.*
- H) *Security Officer – individual designated by NCMMHC to oversee all activities related to the development, implementation, maintenance of, and adherence to facility policies and procedures covering the electronic and physical security of, and access to, PHI and other NCMMHC data in compliance with federal and state laws and regulations.*
- I) *Media – backup tapes, hard drives, floppy diskettes, CD's, zip drives cartridges, optical, and paper hard copies.*
- J) *Protected Health Information (PHI) – individually identifiable health information.*
- K) *CIMOR – Consumer Information Management Outcomes and Reporting system*

3) *Data Security*

- A) *Unattended computers should be returned to log on screen or close all programs.*
- B) *Access to NCMMHC networks from public networks shall be protected by access control systems such as firewalls, access control lists, and user authentication under the auspices of the designated Security Officer.*
- C) *Designed staff shall back up data to backup tapes and backup databases in their entirety, nightly Monday through Friday.*
- D) *Designated staff shall ensure that all media has been thoroughly cleansed of any client data before the media is surplussed or discarded.*
- E) *Access to media containing client data shall be controlled by designated staff through:*
 - 1. *Access control lists to network media.*
 - 2. *Physical access control to hardware.*
 - 3. *Purging data on any type of media before it is surplussed or discarded.*
 - 4. *Storage of data on media that is backed up.*
- F) *Designated staff shall maintain an up-to-date Standards List, which prescribes appropriate procedures and practices for data security purposes.*

G) *Virus protection for the network shall be maintained by designated staff, pursuant to the virus protection procedures listed below:*

1. *Email Servers. All email servers shall be protected using email-specific anti-virus software.*
2. *Network and Member Servers. All network and members servers shall be protected using anti-virus software.*
3. *Workstations, laptops, PDAs*
 - a. *All workstations, laptops, PDAs or any other device that connects to the network shall be protected using the anti-virus software for that device, installed by designated staff.*
 - b. *Equipment that has not been purchased by NCMMHC shall not be allowed to connect to the network.*
4. *Virus signature updates*
 - a. *Anti-virus server software shall be configured by designated staff to check for virus signature updates daily.*
 - b. *Anti-virus PC, laptops, PDAs software will check for virus signature updates from the master console of the anti-virus program, as a result of staff actions.*
 - c. *Special virus signature updates, created in the event of a known virus, will be manually pushed by designated staff to all servers, PCs, laptops, and PDAs within 24 hours of the time the receipt of the update has been received at the master console.*
5. *Software Updates. Anti-virus software shall be kept by designated staff at the current release or no more than one release below the most current release version.*
6. *Software Support shall maintain a support contract with the anti-virus software vendor(s) to ensure uninterrupted support.*
7. *Attachments. To avoid potentially virus-carrying attachments, designated staff shall not allow certain types of attachments, such as executable and JPEG files, to pass through email.*

H) *Staff members shall not load software, without approval, onto their assigned workstation or any other equipment. This software includes, but*

is not limited to, software from the Internet, a CD, or a floppy diskette.

Software shall be loaded on workstations only by approval of the Security Officer.

- l) Workstations shall be situated by respective designated staff to prevent more than incidental observation of work product.*
- 4) Sanctions. Failure of staff members to comply or assure compliance with this policy may result in disciplinary action, including dismissal.*

ATTACHMENT A

HIPAA Privacy Training Outline

1. Goals of Training
2. What is HIPAA?
3. HIPAA Key Terms
4. Designation of Organized Health Care Arrangement
5. Why the Concern Over Privacy?
6. HIPAA Enforcement
7. What HIPAA Requires DMH to Do
 - a. Identify PHI
 - b. Where do you find PHI?
 - c. What PHI does not include
 - d. What are psychotherapy notes
 - e. Learning through case scenarios
 - f. Regulatory privacy DOR's in Chapter 8
 - g. How individual staff protect PHI
 - h. Need to know, or minimum necessary standard
8. Other HIPAA Requirements for DMH
 - a. Authorization (DOR 8.050)
 - b. Notice or Privacy Practices (DOR 8.005)
 - c. Restrictions (DOR 8.020)
 - d. Access (DOR 8.030)
 - e. Staff Access (DOR 8.040)
 - f. Amendment (DOR 8.010)
 - g. Accounting of Disclosures (DOR 8.060)
 - h. Verification (DOR 8.070)
 - i. Complaint Process
 - j. State and Federal Law Preemption Analysis
 - k. Research Provisions
9. Integration of Security with Privacy
 - a. General Security Awareness
 - b. Computer Virus Protection
 - c. Password Management
10. Questions and Answers

ATTACHMENT B

- A) Working files, either paper or electronic, are not included as part of the designated record set. Working files are typically held by staff working or meeting with consumers away from a facility-based setting. Such workers may include therapists, and community support specialists.**
- B) Examples of this information may include, but is not limited to, copies of current IHP, MTP, IEP, guardianship information, client budgets, correspondence (including email), face or cover sheets (including demographic information), behavior support plan, discharge summary, any necessary monthly or quarterly reports, authorizations, conditional release plan, etc.**

ATTACHMENT C

TECHNOLOGY PLAN

EQUIPMENT:

- Desktop computers in offices at Trenton, Chillicothe, Brookfield and Laredo facilities. Access is password protected.
- Laptop computers for community support specialists and therapist (QMHP's).
- Server located in Trenton office in locked storage room. Installed April 2007.
- Epads for caseworkers, therapist (QMHP's) and support staff.
- Verizon wireless MiFi hot spots available for clinical staff as requested.
- Ground and wireless internet services available in most offices supported by NCMMHC. Unionville and Hamilton rely on wireless from the facility where we rent.
- 5 Sharp copiers/printers
- Desktop printers installed on most computers and/or access to above copiers.
- Tele-Health equipment at Trenton and Chillicothe offices to connect to Psychiatrist off-site. Installed May 2012.

Plans include updating computers on a regular cycle. Copiers are all on a four year lease and replaced at the end of the lease. Server is in FY2014 budget for replacement if needed.

SOFTWARE:

- CareLogic Clinical Records (ECR) available to all clinical, billing and management staff. Internet based secure software housed in Nashville, TN. Password protected and access restricted.
- CIMOR internet based secure software for the Department of Mental Health, housed in Jefferson City, available to staff on an as needed basis. Password protected and access protected.
- Server operating system – Windows 2008 for servers. All computers on Windows 7 Pro.
- Vipre installed on all desktops and laptops.
- Microsoft office 2010 installed on all desktops and laptops.

- QuickBooks Accounting Software installed on Chief Financial Officer's and Accounting Assistant's computers only.
- File transfer software (FTP/Filezilla) installed on Chief Financial Officer, Invoicing Specialist, ACI Coordinator and Intake Specialist computers. Password protected.
- Access to internet based software (EMOMED, CyberAccess, etc.) available to staff on an as needed bases. Password protected.
- Digital dictation/transcription equipment to send dictation via secure email to typist.

Future plans rely upon technology upgrades and needs of CareLogic.

SECURITY:

- Server located in locked storage area with limited access.
- Router/firewall installed on server.
- Computers password protected

CONFIDENTIALITY:

- All staff trained in confidentiality and sign North Central's confidentiality form and turns it into the Executive Assistant to be filed in their personnel record.
- All visitors/contract labor who have access to HIPAA information are asked to sign a HIPAA form, which it kept by the Executive Assistant.
- Secure email transfers (ZixMail)

Future plans ...

BACKUP POLICIES:

- The server computer is backed up each evening, Monday thru Friday.
- Chief Financial Officer, or designee, will change the backup tape each day and take the tape off site for two days before bringing it back into rotation.
- Backup tapes are replaced at least every two years.
- Computers in Trenton are set up to save their data to the Server.
- Information not saved to the Server should be backed up on a CD or jump drives at the staff's discretion.

Future plans include changing to a different style of backup within next fiscal year.

ASSISTIVE TECHNOLOGY:

- Community Support Specialist have access to internet and CareLogic through laptops/MiFi or wireless connections
- Tele-psychiatry is available in Trenton and Chillicothe offices on limited basis.
- Chair-lift is available in the Trenton office to access the basement.
- One agency van is impairment accessible with a lift chair.
- Adjustable, supportive chairs available for staff.
- Floor mats are available for ease in gliding chairs across carpet area.

DISASTER RECOVERY PREPAREDNESS:

- Server has dual hard drives in the event of one drive failing.
- Server backups, which are stored off-site, will be available in case of fire to restore data to a new server with minimal loss of information.
- ECR data is stored in Nashville, TN with a backup copy stored at a second location in Nashville.

No changes in the near future.

VIRUS PROTECTION:

- Vipre Antivirus software installed on all desktops and laptops. Updated daily when the computer is turned on and connected to the internet.
- Router/firewall installed on server.
- Computers password protected.

No changes in the near future.

WHERE WE WANT TO GO:

- CareLogic Unplugged – sync data and use without internet access, re-sync at end of day with changes made in the field.
- Alternative wireless internet connection for laptops, Verizon unreliable.
- Keep equipment and software updated.

HOW DO WE GET THERE?

- Collaborate with area hospitals/doctors for time.
- Qualifacts working on off-line sync capabilities with their software.
- Add budget line to replace equipment and upgrade software as budget allows.

SECTION: CORPORATE COMPLIANCE

SUBJECT: BOARD RESOLUTION

SECTION NO. VII

SUBJECT NO. 1

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: To promote accountability for administrative, business, clinical, financial and marketing management.

RESOLUTION OF THE BOARD OF DIRECTORS

WHEREAS, North Central Missouri Mental Health Center (NCMMHC) is dedicated to the delivery of behavioral health care services in an environment characterized by strict conformance with the highest standards of accountability for administrative, business, clinical, financial and marketing management;

WHEREAS, the leadership of NCMMHC is aware of and fully committed to the need to prevent fraud, waste, abuse, fiscal mismanagement and misappropriation of funds through the development and implementation of a formal "Corporate Compliance Program"; and

WHEREAS, NCMMHC is fully committed to the development and implementation of comprehensive policies, procedures and other corporate compliance measures to provide regular monitoring and conformance with all legal and regulatory requirements;

BE IT RESOLVED, that the Board of Directors of NCMMHC met and discussed the development of a corporate compliance plan for the organization on this date. The Board of Directors authorized the Executive Director to take all actions necessary to immediately and fully develop and implement the organization's Corporate Compliance Program.

IT IS SO APPROVED AND EFFECTIVE THIS DATE.

Printed Name of Board of Directors Secretary

Signature of Board of Directors Secretary/Date

Approved: _____
Signature of the President of the Board of Directors

Evaluation: This resolution will be revised as needed and reviewed at least annually.

Last Revised: 4/17

SECTION: CORPORATE COMPLIANCE

SUBJECT: PROGRAM OVERVIEW

SECTION NO. VII

SUBJECT NO. 2

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: Employees are a part of the process of ensuring the integrity of the service provision and billing system.

POLICY: North Central Missouri Mental Health Center operates a Corporate Compliance Program designed to ensure the integrity of service provision and billing.

PROCEDURE: This program includes the following elements:

1. Regular and systematic monitoring of services delivered and billed.
2. Maintain policies and procedures to assure that services delivered meet standards and are billed correctly.
3. The appointment of a Corporate Compliance Officer who is empowered by the Board of Directors to investigate, report to the Board and make an annual report of all corporate compliance issues to the Board on an annual basis.
4. Conduct education and training on its program in new employee orientation and on an ongoing basis. This education and training will be tailored to address any issues that are raised by auditing or monitoring as well as any perceived risks.
5. Respond to any detected offenses by developing a Plan of Correction and educate staff through the newsletter and training.
6. Although the Corporate Compliance Officer may be contacted formally through e-mail or by phone, an open door policy will be maintained to promote open informal communication of any potential issues that might arise.
7. A disciplinary process that establishes a method of consistent enforcement but flexible enough to account for mitigating or aggravating circumstances.

Evaluation: This policy will be revised as needed and reviewed at least annually.

SECTION: CORPORATE COMPLIANCE

SUBJECT: POLICY ISSUES

SECTION NO. VII

SUBJECT NO. 3

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: To have an ongoing process of assuring that services are delivered and billed in accordance with all laws, regulations and contracts.

POLICY: North Central Missouri Mental Health Center will have policies and procedures to assure that services provided by NCMHHC are delivered and billed accurately according to the laws, regulations and contracts.

PROCEDURE: *The Corporate Compliance Program will address the following issues at a minimum:*

1. Reasonable and necessary services – All services delivered should be reasonable and necessary for the diagnosis and/or treatment of a mental disorder defined in the Diagnostic and Statistical Manual (DSM) IV to improve functioning.
2. Documentation – All services delivered must be accurately, legibly and completely documented as soon as possible after the service is delivered, but within three (3) business days after the service is delivered. The following must be present for the documentation to be considered accurate and complete:
 - Identification of the individual served
 - The date, start and stop time are documented
 - The specific title or code of the service
 - Summary of the service rendered with clinical content related to the treatment plan
 - Timely updates to the treatment plan
 - Description of service provided
 - The individual's and/or family's response to the service rendered

- The signature of the person providing the service
 - The setting in which the services were rendered
3. Coding and Billing – Only services that are actually delivered will be billed. The clinician providing the service will enter the initial charge and care will be taken to avoid the following issues:
- Billing for services not rendered and/or documented
 - Claims that are not reasonable or necessary
 - Double billing and payment of claims
 - Billing for non-covered services
 - Knowingly misusing billing numbers
 - Failure to use coding modifiers
 - Clustering – using mid-level codes exclusively rather than billing for the actual service with the idea that it will all balance out with some higher and some lower
 - Up-coding – billing for a higher level of service than the one provided
4. Improper Inducements, Kickbacks and Self-referrals:
- Remuneration for referrals is strictly prohibited
 - Provision of services based upon profit incentive rather than the need of the person being served is prohibited
 - Self-referral to a clinician or health service provider in which the clinician or an immediate family member has financial interest is prohibited
 - No gifts will be received or given by clinicians, other than nominal value (less than \$50), from anyone who may benefit from referrals from NCMMHC or as an inducement to over-utilize services.
 - No contracts or joint ventures with hospitals, suppliers or referral sources that pay based upon referrals or referrals received.
5. Medical records, financial records and records of compliance-related activities shall be retained a minimum of 7 years or as provided for in contracts, if longer. In no case shall records be destroyed that are in

the course of an investigation of lawsuit. In the case of dissolution of the corporation or sale, medical records will be maintained by a reputable contractor for the allotted period of time or transferred to the new owner for safekeeping.

Evaluation: This policy will be revised as needed and reviewed at least annually.

SECTION: CORPORATE COMPLIANCE

SUBJECT: TRAINING/EDUCATION

SECTION NO. VII

SUBJECT NO. 4

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: All employees are a part of the process of ensuring the integrity of the service provision and billing system and need to be properly trained to understand how services are delivered and properly billed.

POLICY: North Central Missouri Mental Health Center will conduct and document both new employee orientation and ongoing corporate compliance program training of its employees to ensure the integrity of service provision and billing.

PROCEDURE: This program includes the following elements:

1. All employees will receive and document new employee orientation and training on NCMMHC's Corporate Compliance Program.
2. Each employee will be provided a copy of NCMMHC's corporate compliance policies and procedures and will sign that they understand and agree to follow these procedures. These policies and procedures will be a part of the annual policy and procedure update.
3. The Corporate Compliance Officer will attend training dealing with Corporate Compliance or Professional Ethics.
4. If specific issues arise as part of the Corporate Compliance Program, specialized training will be developed to address the issue(s).
5. Training topics will include:
 - Policies and Procedures
 - Coding and billing requirements
 - Compliance checks
 - Legal sanctions for submitting deliberately false or reckless billings
 - Disciplinary process

Evaluation: This policy will be revised as needed and reviewed at least annually.

**NORTH CENTRAL MISSOURI
MENTAL HEALTH CENTER**

**POLICY AND PROCEDURE
MANUAL**

SECTION: CORPORATE COMPLIANCE

SUBJECT: OPEN COMMUNICATION

SECTION NO. VII

SUBJECT NO. 5

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: To assure that employees feel comfortable reporting suspected corporate compliance violations and why it happened.

POLICY: North Central Missouri Mental Health Center strives to create an environment in which employees feel comfortable reporting any inconsistencies or billing irregularities.

PROCEDURE: NCMMHC will encourage both formal and informal communication between employees in assuring the integrity of the service delivery and billing system:

1. Corporate Compliance Hotline – employees will be encouraged to report any suspected corporate compliance issues to the Corporate Compliance Officer via telephone
2. E-mail Corporate Compliance Officer – the Corporate Compliance Officer can be e-mailed with any concerns
3. Open door policy – informal reporting with the Corporate Compliance Officer or any Program Director is encouraged when suspected violations are detected.

Evaluation: This policy will be revised as needed and reviewed at least annually.

SECTION: CORPORATE COMPLIANCE

SUBJECT: MONITORING/AUDITING

SECTION NO. VII

SUBJECT NO. 6

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: To have an ongoing process of assuring that services are delivered and billed in accordance with all laws, regulations and contracts.

POLICY: North Central Missouri Mental Health Center will monitor the accuracy of services billed through ongoing compliance monitoring of services and regular auditing of a random sample of billings.

PROCEDURE: This program includes the following elements:

1. Policy and Procedure integrity – On an annual basis, a review of current practices and regulations will be undertaken to insure that tools used in compliance monitoring are up-to-date.
2. Regular Compliance Audit – Periodically, random samples of billings and documentation will be reviewed to ensure that they accurately reflect services that were delivered. The process will be conducted as follows:
 - Goal: Bills are accurately coded; documentation is completed accurately; and services delivered are reasonable and necessary with no incentives for unnecessary services.
 - Sample size: A random sample of at least three progress notes per physician; three progress notes per outpatient therapist; and two progress notes per community support specialist.
 - Quarterly: The audits will be conducted as part of NCMHHC's ongoing quality assurance program.
 - Response: When an issue is found, the clinician will be notified with any corrective action necessary.

Evaluation: This policy will be revised as needed and reviewed at least annually.

SECTION: CORPORATE COMPLIANCE

SUBJECT: CORRECTIVE ACTION

SECTION NO. VII

SUBJECT NO. 7

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: To assure that when corporate compliance violations are detected, issues are addressed to assure service delivery integrity.

POLICY: North Central Missouri Mental Health Center will take appropriate action to address any detected corporate compliance issues.

PROCEDURE: This program includes the following elements:

1. Detection of Violation – Once a violation is detected:
 - A) An audit will be done within ten (10) days to determine if it is an individual clinician or staff person issue or a program issue, and if it is a pattern of practice or an individual incident;
 - B) The Corporate Compliance Officer or designee should be notified as soon as possible but no later than two (2) business days after the breach is discovered.
2. Corrective Action – Corrective action may include any or all of the following:
 - Corrective action plan – including re-education efforts and detection of further incidents. This report will be presented to the Board of Directors for its approval. The report will include the following elements:
 - i. How the violation was initially detected
 - ii. The extent of the audit for identification of trends
 - iii. Whether it is an individual employee, program or systems issue
 - iv. Actions already taken
 - v. Action to be taken to prevent future violations
 - vi. Plan for monitoring compliance for the next three months

- Return of overpayments – Services that were not delivered, documented or billed correctly will be returned within 60 days.
 - Re-bill claims correctly - if not beyond period of timely filing, the claim will be re-billed within 60 days.
 - Legal consultation – To see if referral to law enforcement or governmental agency is appropriate for intentional violations or where other fraud is suspected.
3. Annual review of the Corporate Compliance Program by the Corporate Compliance Officer and the Board of Directors to insure the adequacy of the program.

Evaluation: This policy will be revised as needed and reviewed at least annually.

SECTION: CORPORATE COMPLIANCE

SUBJECT: DISCIPLINARY PROCESS

SECTION NO. VII

SUBJECT NO. 8

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: To provide consistent enforcement process that allows flexibility for mitigating or aggravating issues relating to violations of NCMMHC Corporate Compliance policies.

POLICY: It is the policy of North Central Missouri Mental Health Center to have a disciplinary process related to violations of Corporate Compliance Policies.

PROCEDURE: This program includes the following elements:

1. When a violation of Corporate Compliance policies is detected, an investigation will be completed by the Corporate Compliance Officer or designee. A report will be generated outlining the violation including person(s) involved, methods used to investigate the violation, whether it is a systems issue or an individual employee issue, whether this is an isolated event or repetitive issue. Finally, it will include a list of recommended actions to correct the issue, report of repayment of erroneous claims, need for education and any disciplinary recommendations.
2. The following disciplinary process will be followed dependent upon the mitigating or aggravating circumstances of the violation:
 - a. Reorientation to the position or duty may be appropriate for minor violations that involve employees new to the agency or position with no intent to defraud or personally benefit from the error.
 - b. Additional training related to the violation including regulations related to service delivery, documentation of services, billing of services and/or ethics may be used as part of the written plan of correction when it involves individual employee actions.
 - c. When there is evidence that the employee has been adequately

trained and has a good base of experience and yet has violated regulations, a written plan of correction will be put in place and billing of services monitored for a period of not less than 30 days. Any additional violations may result in termination when it involves employee error or lack of attention to the established procedure.

- d. When the violation involves carelessness or inattention to detail, a written plan of correction will be implemented that will include at least 30 days of monitoring and may include suspension or, for repeated offenses, termination.
- e. Employees with violations that involve personal gain will be subject to termination based upon the magnitude and circumstances surrounding the violation. NCMMHC's attorney will be notified immediately upon detection of the violation for legal advice on how to proceed.
- f. When services are not provided, documented or billed because of a systems-related issue or inadequate processes, employees will not be disciplined, but will be asked to participate in improvement of the process or other corrective action.

Evaluation: This policy will be revised as needed and reviewed at least annually.

SECTION: CORPORATE COMPLIANCE

SUBJECT: RELATIONSHIPS AND
CONTRACTS

SECTION NO. VII

SUBJECT NO. 9

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: To assure that all contractual and relationships with referral sources or suppliers are lawful and do not give unfair status to other providers of health-related services.

POLICY: North Central Missouri Mental Health Center will deal with all referral sources and suppliers in a way that does not give unfair advantages or shut out other suppliers or referral sources.

PROCEDURE: This program includes the following elements:

1. NCMMHC will not implement any incentive plans that encourage clinicians to possibly provide more services or fewer services than are clinically indicated.
2. NCMMHC will not enter into any contracts with hospitals, pharmacies, equipment providers, or clinicians where the contract(s) may include gain-sharing provisions, or those that may exclude other qualified providers who may not be willing to pay for referrals or other arrangements.
3. No contracts will be entered into that “kick-back” money, goods or services for referrals unless it is covered by federal “safe harbor” provisions in federal regulation.
4. When seeking or entering into contracts, no preferential status or treatment will be given to any entity where an employee, contracted clinician, Board of Directors member, or their immediate family member possesses a financial interest in the contracting entity.

Evaluation: This policy will be revised as needed and reviewed at least annually.

SECTION: CORPORATE COMPLIANCE

SUBJECT: WHISTLEBLOWER
PROTECTION

SECTION NO. VII

SUBJECT NO. 10

ORIGINAL FORMULATION DATE: 04/2009

PURPOSE: Employees are a part of the process of ensuring the integrity of the service provision and billing system. It is necessary for employees to know that there will not be retaliation if they report suspicious practices.

POLICY: Any employee who reports alleged false claims or improper billing will be protected from retaliation by management or any employee, whether or not the allegation was found to be true. In the event that retaliation occurs, the whistleblower is to contact the Corporate Compliance Officer, or in the event that it involves the Corporate Compliance Officer, the Executive Director.

PROCEDURE: This program includes the following elements:

1. In order to assure the integrity of our billing for services, NCMMHC assures that anyone reporting suspected billing of false claims, documenting services that were not delivered, delivering more treatment than is necessary, misrepresenting credentials, performing services outside the clinician's scope of practice, or other improper billing practices is protected from retaliation.
2. In the event that the whistleblower suspects retaliation, the person may contact the Executive Director, or in the event that it involves the Executive Director, any member of the Board of Directors.
3. Any staff member who is found to have retaliated against a whistleblower shall be subject to disciplinary action that may include immediate termination.

Evaluation: This policy will be revised as needed and reviewed at least annually.

SECTION: CORPORATE COMPLIANCE

SUBJECT: RED FLAG RULES

SECTION NO. VII

SUBJECT NO. 11

ORIGINAL FORMULATION DATE: 10/2009

POLICY: North Central Missouri Mental Health Center shall have a procedure to ensure reasonable steps to identify, verify and mitigate possible identity theft that may occur during the admission process, and ongoing accounts receivable transactions with clients who establish and/or maintain an account with the agency.

PROCEDURE: This program includes the following elements:

1. Identification of Red Flags:

a. The following may be identified during the admission process as a “Red Flag” that may indicate an attempted identify theft:

- 1) A client who has an insurance number but never produces an insurance card or other physical documentation of insurance
- 2) Information provided on admission does not match other sources
- 3) The presentation of suspicious personal identifying information or documents

b. The following may be identified during account maintenance as a “Red Flag” that may indicate an attempted identity theft:

- 1) A complaint or question from a client based on the client’s receipt of:
 - a) A bill for another individual
 - b) A bill for a service the client denies receiving
 - c) An Explanation of Benefits (EOB) statement for services never received
- 2) The dispute of a bill by a client who claims to be a victim

of any type of identity theft

- 3) A complaint or question from a client about the receipt of a collection notice from a bill collector
- 4) A notice or inquiry from an insurance fraud investigator from a private insurance company or a law enforcement agency

2. Verifying Red Flags to Detect Identity Theft:

- a. Appropriate methods for verifying “Red Flags” to determine if identity theft has occurred or is occurring may include the following:

- 1) Contacting the client
- 2) Monitoring an account for evidence of identity theft
- 3) Contacting the Social Security office to verify client identity

3. Mitigation/Response to Red Flags:

- a. Responses to verified “Red Flags” should be appropriate to the risk posed. In determining a suitable response, consideration should be taken for any events or incidents that may increase the risk of identity theft. Appropriate responses may include, but are not limited to:

- 1) Contacting the client
- 2) Notifying the client’s insurance company
- 3) Notifying law enforcement
- 4) Determining that no response is needed given the specific circumstances
- 5) Adjusting the charges to the covered account that were fraudulently incurred

Evaluation: This policy will be revised as needed and reviewed at least annually.