Control #	Rev.	Title	Effective Date: 09/2017
A 4.1	New	Mail Room and Mail Safety	Next Review Date: 09/2019

1.0 POLICY:

To provide guidelines for safe screening and handling of all incoming packages and letters, whether delivered via the United States Postal Service (USPS), third party couriers (FedEx, UPS, DHL) special messengers, interoffice mail or guest and visitors.

2.0 PURPOSE:

To provide mail center managers, supervisors, staff and security personnel a framework for mitigating risk when handling mail and packages received. Mail security and screening protects employees, clients, facilities, business functions and guests.

3.0 SCOPE: DPBH

4.0 DEFINITIONS:

4.1 **Personal Protective Equipment (PPE)** protective clothing, helmets, goggles, masks (inclusive of N95) or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment may include physical, electrical, heat, chemicals, biohazards, and gaseous or airborne particulate matter.

4.2 **CBRNE** - Chemical, Biological, Radiological, Nuclear or Explosive Substances

4.2.1 **Chemical** –

Examples of chemical threats include nerve agents, blood agents, pulmonary agents, blister agents, industrial chemicals and irritants. Chemical threats can be solid, liquid or gaseous/vapor.

4.2.2 **Biological** -

4.2.3 **Radiological** -

4.2.4

4.2.5 **Explosive -** weapons that affect an area around the point of detonation, usually through the effects of blast and fragmentation.

4.2 **Dangerous Items** – items that can cut, shock or harm an individual when the letter or package is opened.

4.3 **Illegal or Contraband Items** – illegal drugs, guns, knives, swords or other potentially dangerous substances or weapons.

4.4 **Hoax** – a suspicious mail item that is designed to present the appearance of a dangerous substance or other threat but do not actually contain the actual substance necessary to cause harm.

4.5 **White Powder Envelope or Package**– Any white powdery substance that creates the appearance of anthrax, a dangerous biological substance or toxin.

4.6 **Threats** – suspicious mail may contain threatening language on the envelop or inside the envelope's contents. The threat intends to inflict pain, injury, damage or other hostile action on someone or something.

4.7 **Mailroom** – a point of receipt, sorting and distribution of mail and packages.

4.8 **Types of Mail and Package Deliveries**

4.8.1 **U.S. Postal Service (USPS)** agency responsible for general delivery of a full range of items.

4.8.1.2 **U.S. Postal Service Accountable Mail Certified and Registered Mail**. Includes the deliverer and recipient signature and is assigned a unique tracking number.

4.8.2 **Express Couriers** provide pickup and delivery of express mail and packages. Security features include end to end tracking and limited security screening. Terrorist have begun using global express couriers for delivery of explosive packages.

4.8.3 **Interoffice Mail** – Mail created and delivered entirely within a system,

building, or campus environment. Interoffice mail cannot be assumed safe and must be considered a potential source of suspicious mail. Disgruntled employees, visitors and others can introduce suspicious mail directly into the internal mail sorting process.

5.0 PROCEDURE

5.1 Basic Mail Security Procedures:

- 5.1.1 All mail including packages must be delivered through a central location in each agency; preferably a designated mail center or room.
- 5.1.2 Ensure that all mail delivery personnel from the postal service and other package delivery and supply vendors are clearly identified and log in.
- 5.1.3 Provide a designated parking area for delivery of mail, packages and supplies.
- 5.1.4 Staff handling and sorting mail should wear gloves and wash their hands or use hand sanitizer immediately after completion of the task.
- 5.1.5 Personal Protective Equipment (PPE) should be available in every mail center or room location.
- 5.1.6 Basic PPE – gloves, gowns and masks should be donned before handling suspicious mail.
  - 5.1.6.1 Suspicious mail indicators include the following but must be considered within the context of the organization and its population:
    - 5.1.6.1.1 Powdery substance on the outside of the package.
    - 5.1.6.1.2 Is an unexpected delivery
    - 5.1.6.1.3 Has excessive postage, is hand written or contains a poorly typed address, incorrect title, or just a title with no name, misspells of common words.
    - 5.1.6.1.4 Is addressed to someone no longer with the organization or is otherwise outdated.
    - 5.1.6.1.5 Has no return address or one that cannot be verified as legitimate.
    - 5.1.6.1.6 Unusual weight for its size or is lopsided or oddly shaped.
    - 5.1.6.1.7 Has an unusual amount of tape on it.
    - 5.1.6.1.8 Is marked with restrictive endorsements.
    - 5.1.6.1.9 Has strange odors, stains or protruding wires.

5.1.7 Close off the room including the ventilation system (if possible)
5.1.8 Call an Overhead Code as appropriate: example Code Bravo, Code 45, Code 77; Call 911 and notify Capitol Police.
5.1.9 Report immediately through your chain of command to activate the emergency notification process (DPBH Policy A.4 DPBH Emergency Notification).
5.1.10 Notify other agencies in immediate proximity as appropriate.
5.1.11 Notify the DPBH Statewide and Regional Emergency Operations Managers.
5.1.12 Update HAvBED and put agency status on Internal Disaster.
5.1.13 Notify the U.S.P.S Post Master.
5.1.14 Don't open any parcel until it is verified as safe.
5.1.15 If you receive a suspicious letter or package: handle with care, do not shake, bump, open, smell, touch or taste it.
- 5.1.15.1 Isolate it immediately – treat it as suspect.
- 5.1.15.2 If possible isolate it in a separate room that can be closed off and is away from personnel and staff traffic. If possible isolate the air ducts to and from the room or area.
- 5.1.15.3 If it has powdery or other substances leaking from the package, do not clean up and avoid further contact.
- 5.1.15.4 Calmly and immediately move away from the envelope or package and inform others in the area to leave.
- 5.1.15.5 Do not walk around and show others or invite others to come in and look.
- 5.1.15.6 If your clothes are contaminated, do not brush vigorously as this may disperse powder into the air. Remain in place and wait for directions from first responders.
- 5.1.15.7 Do not touch your eyes, nose, mouth, hair or any other part of your body.
- 5.1.15.8 If possible and without contaminating other ares, wash your hands with soap and water or hand sanitizing gel or wipe.

5.1.16.1 Make a list of all people who had contact with the powder or were in the area when the powder was released.

Control #	Rev.	Title	Effective Date: 09/2017
A 4.1	New	Mail Room and Mail Safety	Next Review Date: 09/2019

6.0 TRAINING

6.1 Suspicious Mail Training:
- 6.1.1 All staff will be trained on hire and annually
  - 6.1.1.1 Training will include emergency response procedures.
- 6.1.2 Mail Center staff will be trained on hire and twice per year.

7.0 REFERENCES:

- 6.0.1 Maintaining Mail Safety and Security on A Budget: White Paper, Pitney Bowes, 2009
- 6.0.2 Handling Powdery Substances
- 6.0.3 Best Practices for Mail Screening and Handling Processes: A Guide for the Public and private Sectors, September 2012, 1st Edition, US Department of Homeland Security and the Interagency Security Committee.

8.0 ATTACHMENTS

9.0 Implementation of Policy

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

EFFECTIVE DATE: 9/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 9/2017
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2017

Control #	Rev.	Title	Effective Date: 09/2017
A 4.1	New	Mail Room and Mail Safety	Next Review Date: 09/2019

Control	Rev.	Title	Effective Date
CRR-1.1	3/17	Consumer Rights	03/2017
			Next Review Date
			03/2019

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) provides a process that supports and protects all of the rights granted to people receiving services from Division agencies through Nevada Revised Statutes chapters, 433.003, 433.456 -433.536, 433A

2.0 PURPOSE:

DPBH is committed to ensuring that DPBH staff, contract service provider staff, and consumers have all the necessary information about consumer rights. Consumer rights are an essential feature of all services and cannot be denied without due process. Division programs are expected to demonstrate knowledge of and respect for consumer rights through supportive staff interaction with consumers.

3.0 SCOPE:

Division wide including services by contract providers

4.0 REFERENCES:

4.1 Nevada Revised Statutes (NRS): 433.003, 433.5493, 433.456-433.536, 433A.270, 433A.290, 435.350

4.2 DPBH Policy #2.014 Labor of Persons Receiving Services

4.3 DPBH – Clinical Services Branch HIPAA Manual 2016

5.0 PROCEDURE:

5.1 Staff Education Regarding Consumer Rights

5.1.1 Each DPBH agency employee or contract service provider staff will be apprised of this policy in orientation and educated in its implications prior to working independently with consumers. Through this education, each staff member or provider staff will be knowledgeable about the consumer rights as defined. Documentation of this training will be maintained within the agency

5.1.2 Each employee will receive a minimum of annual training on consumer rights. Documentation of this training will be maintained within the agency.

5.2 Consumer Education Regarding Consumer Rights

5.2.1 Each consumer will be given a list, during the admission process, of the rights granted to them and a copy of the agency's policies regarding when these rights can be suspended (NRS 433.531). The Division and/or provider agency staff member will review these rights with the consumer and/or legal representative or guardian, as appropriate, within a reasonable time following admission. This will be documented by having the consumer sign a statement that they have reviewed these rights, and being countersigned by the admitting staff (NRS 433.533).

5.2.2 A list of the rights of all consumers receiving services will be prominently posted in all agencies providing services, and all policies regarding the rights of consumers of the agency are to be prominently posted in the agency (NRS 433.531, 433.484, 433.472).

5.3 Reporting violations and Denials of Rights

All violations and denials of rights must be reported per Policy CRR-1.4 Reporting Denials of Rights (NRS 433.543, 433.5493, 433.5499, 433.5503, 433.551, and 435.350).

5.4 Consumer Rights:

5.4.1 Dispose of property
5.4.2 Marry
5.4.3 Execute instruments
5.4.4 Make Purchases
5.4.5 Enter into contractual relationships
5.4.6 Vote
5.4.7 Hold a driver's license
5.4.8 Freedom of religion
5.4.9 Free association

5.5 The rights of a consumer can only be denied for cause to protect the consumer's health and safety or to protect the health and safety of others, or both (NRS 433.534, 435.350).

5.6 Right to habeas corpus unimpaired (NRS 433.464).

5.7 Rights concerning admission and discharge (NRS 433.471).

5.7.1 Right not to be admitted to the agency under false pretenses.

5.7.2 The right to receive a copy, upon request, of the criteria upon which the agency makes admission and discharge decisions.

5.8 Rights concerning involuntary commitment (NRS433.472):

5.8.1 Right to request and receive a second evaluation by a psychiatrist or psychologist who does not have a financial interest in the agency.

5.8.2 Right to receive a copy of the procedure of the agency regarding involuntary commitment and treatment.

5.8.3 Right to receive a list of consumer rights concerning involuntary commitment or treatment.

5.9 Personal Rights (NRS 433.482):

5.9.1 Right to wear his/her own clothing, to keep personal possessions (unless they may be used to endanger his/her or another's life), and to keep and spend a reasonable sum of his/her own money.

5.9.2 Right to have access to individual space for storage for his/her private use.

5.9.3 Right to privacy regarding the consumer's program.

5.9.4 Right to see visitors daily.

5.9.5 Right to have reasonable access to a phone to make and receive confidential calls.

5.9.6 Right to ready access to materials for writing letters, including stamps.

5.9.7 Right to send and receive unopened correspondence (not packages). Correspondence containing checks payable to the consumer may be subject to safekeeping by the Agency Director or designee, as specified in the service plan.

5.9.8 Right to reasonable access to an interpreter if the consumer does not speak English or is hearing impaired.

5.9.9 Right to have information presented in a manner that meets their specific needs.

5.9.10 Right to designate a person to be kept informed of the consumer's condition by the agency.

5.9.11 Right to deny access to the medical records to any person other than a member of the staff of the agency or related medical personnel, as appropriate, persons with a waiver from the consumer, and persons with a court order.

5.10 Rights concerning care, treatment and training (NRS 433.484):

5.10.1 Right to medical, psychosocial and rehabilitative care, and treatment and training, including prompt and appropriate medical treatment and care.

5.10.2 Before instituting a plan of care, express and informed consent must be obtained in writing from the consumer, the parent or legal guardian of a minor consumer, or the legal guardian of a consumer adjudicated incompetent.

5.10.3 Right to be free from abuse, neglect, and aversive interventions.

5.10.4 Right to consent to transfer from one agency to another.

5.10.5 Right to be respected for cultural and personal values, beliefs, and preferences.

5.10.6 Right to an individualized written plan of care that provides for the least restrictive treatment that may reasonable be expected to benefit the consumer;

5.10.7 The plan must be current and modified when indicated by the consumer's change of circumstances, and thoroughly reviewed at least every three (3) months.

5.10.8 The plan must be developed with the input and participation of the consumer to the extent that they are able to participate.

5.10.9 The plan must designate the individual that is in charge of implementing the plan (NRS 433.494).

5.10.10 Right to participate in decisions about his/her care.

5.11 Right to information (433.504):

5.11.1 A consumer must be permitted to inspect his/her records.

5.11.2 A consumer must be informed of his/her clinical status at reasonable intervals, no longer than every three (3) months, in a manner appropriate to his/her clinical condition.

5.11.3 Consumers are entitled to a copy of their clinical records unless a psychiatrist has made a specific note to the contrary in the record or if the information is created for litigation compiled in anticipation of use in a civil, criminal, or administrative proceeding.

5.12 Medication (NRS 433.514):

5.12.1 Attending psychiatrist or physician will be responsible for all medications given to the consumer.

5.13 Labor by consumers (NRS 433.524):

5.13.1 Consumers may perform labor at Division agencies per Policy 2.014 Labor of Persons Receiving Services.

5.13.2 Consumers must voluntarily agree to perform labor.

5.14 Right to counsel (NRS 433A.270):

5.14.1 In any proceeding before a district court related to an involuntary court ordered admission, the person alleged to have a mental illness has a right to counsel.

5.15 Right to be present and testify at hearing (NRS 433A.290):

5.15.1 In proceedings for an involuntary court ordered admission, the person has a right to be present and testify.

6.0 IMPLEMENTATION OF POLICY:

Each Division agency shall implement this policy and may develop specific written procedures as necessary to do so effectively.

Cody Phinney
ADMINISTRATOR

EFFECTIVE DATE: 04/30/98
Reviewed/Revised: 12/21/2007, 7/30/2010, 3/15/2013
Supersedes: Policy 2.001 Consumer Rights
DATE APPROVED BY MHDS ADMINISTRATOR: 08/06/10, 3/15/2013
DATE APPROVED BY MHDS COMMISSION: 09/17/2010
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:

Control #	Rev.	Title:	Effective Date: 03/16/2018
		Health Care and Psychiatric	
CRR 1.4	New	Advance Directives	Next Review Date: 03/01/2020

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health (DPBH) Clinical Services Branch to preserve client autonomy and dignity by maintaining the client's legal and ethical rights to make decisions regarding treatment as defined by the Patient Self Determination Act of 1990.

2.0 PURPOSE:

This process establishes guidelines for clinical Services Branch facilities to use in establishing protocols for informing and assisting clients who wish to make Advance Health Care or Psychiatric Health Care Directives.

3.0 SCOPE: DPBH Clinical Services Branch

4.0 DEFINITIONS:

4.1 Advance Directive is a written executed document that expresses a client's wishes in advance about what types of healthcare treatments, services or other assistance they might want in a health care crisis.

4.2 Psychiatric Advance Directive (PAD) for mental health care means a written executed document in which a competent client makes a declaration of instructions, information and preferences regarding acceptance or refusal of types of mental health treatment and intervention during a future mental health crisis and or to appoint a proxy decision maker to carry out their wishes.

4.3 The Patient Self Determination Act (PSDA) is a federal law that ensures a client's right to self-determination in healthcare decisions is both communicated and protected. PSDA applies equally to psychiatric and general health care facilities.

principal's direction and attested by two witnesses.

4.12.1 Neither of the witnesses may be:

4.12.1.1 The attending physician or provider of health care;

4.12.1.2 An employee of the attending physician or provider of health care;

4.12.1.3 An owner or operator of a medical facility in which the principal is a patient or resident or an employer of such an owner or operator; or

4.12.1.4 A person appointed as an attorney-in-fact by the advance directive

5.0 PROCEDURE:

5.1 On admission to any DPBH facility clients will be asked if they have Advance Health Care or Psychiatric Advance Directives.

5.1.1 Clients will be informed that under state law they have the right to make decisions concerning their own health care and psychiatric health care, including the right to accept or refuse treatment and the right to formulate advance directives;

5.1.2 Psychiatric Advance health Care Directives become effective on execution and expire two years from that date.

5.2 Staff must document in the patient's current medical record whether the patient has an Advance Health care or Psychiatric Health Care directive; if the client states that they do have Health Care or Psychiatric Health Care Directives but do not have a copy, notify the Social Work Department.

5.2.1 The Social Work Department will work to secure a copy of the Advance Directive for Health Care and /or Psychiatric care within three (3) working days.

5.3 Clients must be informed of their rights in writing, including the right to prepare advance health care and psychiatric health care directives.

5.4 Provide education for staff on issues concerning advance health care and psychiatric health care directives (United States Code, 2000).

Control #	Rev. Date:	Title:	Effective Date:	10/16
CRR 1.14	10/16	Root Cause Analysis (RCA)	Next Review Date:	10/18

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health, Clinical Services Branch to review all sentinel events, designated near misses or at the discretion of the Medical Director, Patient Safety Officer or Statewide QAPI (Quality Assurance and Performance Improvement) Director.

2.0 PURPOSE:

To overview the Root Cause Analysis methodology used to analyze actual or potential adverse events using a systems approach. A root cause analysis focuses primarily on systems and processes, not individual performance. The objective of an RCA must not be to assign individual blame but to determine a process or processes and the causes or potential causes of variation that can lead to error, and identify process changes that would make variation less likely to recur. The goal of the root cause analysis is to produce an *action plan* that identifies the strategies the organization intends to implement to reduce the risk of similar events occurring in the future.

3.0 DEFINITIONS:

3.1 *Root Cause* is the most fundamental reason (or one of several fundamental reasons) a failure or situation in which performance does not meet expectation, has occurred.

3.2 *Cause* refers to the relationship or potential relationship between certain factors that enable an event to occur. Cause does not imply the assignment of blame.

3.3 *Sentinel Event* is an unexpected occurrence involving the death of a person or serious physical or psychological injury, or the risk thereof when he/she is on state property or in residential services with 24 hour awake staff. Serious injury specifically includes but is not limited to loss of limb or function. Events are considered "sentinel" because they signal a need for an immediate investigation and response.

3.4 *Patient Safety Officer* as used in this policy references NRS 439.815 and means a person who is designated as such by a medical facility pursuant to NRS 439.870.

3.5 *Root Cause Analysis* is a formal process for identifying causal factors that contribute to an event associated with adverse outcomes or near miss/close call situations.

3.6 *Reportable Event* is an event that occurs on state property or in residential services with 24 hour awake staff and results in:

3.6.1 Death or unanticipated death within 48 hours of discharge.
3.6.2 Suicide within 72 hours of discharge from an inpatient setting
3.6.3 Loss of limb or permanent loss of function.
3.6.4 Sexual assault.
3.6.5 Paralysis, coma or other major permanent loss of function associated with a medication error or other treatment intervention.
3.6.6 Consumer death or major permanent loss of function which occurs during an elopement, i.e., unauthorized departure.
3.6.7 Any elopement of a person from a staffed around-the-clock care setting leading to death, permanent harm, or severe temporary harm to the patient.
3.6.8 Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while onsite at the hospital.
3.6.9 Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.
3.6.10 *Sexual abuse/assault* (including rape) as a sentinel event is defined as nonconsensual sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal, or anal penetration or fondling of a patient's sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event:

3.6.10.1 Any staff-witnessed sexual contact, as described above that occurred on the premises;
3.6.10.2 Admission by the perpetrator that sexual contact, as described above, occurred on the premises
3.6.10.3 Sufficient clinical evidence obtained by the hospital to support allegations of nonconsensual sexual contact

3.6.11 *Severe Temporary Harm* is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care

for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

3.6.12 *Adverse outcomes* are outcomes that are directly related to the natural course of an illness or underlying condition are exempt from the reporting requirement.

4.0 PROCEDURE:

4.1 Agency Medical Director or Designee shall appoint a Root Cause Analysis Facilitator.

4.1.1 The facilitator must be a Supervising Manager and have had training in the root cause analysis process
4.1.2 The facilitator will ensure collection of all necessary materials, i.e. medical records, police reports, policies, equipment
4.1.3 Assign team members, to include the attending physician, social worker, mental health technician, nurse.
4.1.4 Assign a member of Performance Improvement to be a consultant to the team for specific policy, procedure, external standards and PI monitoring features and the Health Information Director or appropriate designee to serve as technical consult in reviewing the clinical record for completion and adherence to agency standards regarding records.
4.1.5 Assign other representatives as needed i.e. Occupational Therapy, Activity Therapy, Psychology, Dietary, Maintenance, Pharmacy and any other pertinent disciplines.
4.1.6 Assign team members to conduct any necessary interviews, data collection (monitor boards, allegation packets, equipment, policies, etc.)

4.1.6.1 The first meeting is to be convened within 48 hours.
4.1.6.2 The facilitator will contact staff supervisors and staffing department with meeting schedules to ensure coverage on the units.
4.1.6.3 The facilitator will provide involved staff with information on the root cause analysis process and prepare the team for process.

4.2 Use the Joint Commission RCA framework form.

4.2.1 Each element of the RCA Framework Template must be addressed. "Not applicable (NA)" may not be used.

4.3 The RCA must focus on identifying the systems and processes that may have led to the event.

4.3.1 Gather information to find out what happened.
4.3.2 Analyze why the event happened.
4.3.3 Develop what steps you need to take to prevent it from happening again.
4.3.4 Prepare RCA Action Plan.
4.3.5 Submit to the Agency Medical Director for review and approval.
4.3.6 Submit to the Agency Administrator for review and approval.
4.3.7 Upon final approval Agency Administrator submit to QAPI for submission to
4.3.8 appropriate agencies (The Joint Commission and/ or Nevada Sentinel Event Registry, or OSHA).

5.0 REFERENCES:

5.1 Root Cause Analysis in Health Care: Tools and Techniques 5th Edition Joint Commission Resources
5.2 Sentinel Events CAMBHC Update 2, January 2016
5.3 Sentinel Events CAMH Update 2, January 2016
5.4 Root Cause Analysis Basics Candace J. Hamner, RN MA and Kurt a. Patton, MS, RPh 2008
5.5 DPBH policy A 5.2 Review of Client Death for Adult Mental Health Agencies
5.6 DPBH policy CRR 014 Risk Management and Reporting Serious Incidents
5.7 DPBH policy CRR 1.13 Sentinel Event

6.0 ATTACHMENTS:

6.1 CRR 1.14 ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE Attachment A
6.2 CRR 1.14 Root Cause Analysis Sentinel Event Reporting Requirements Attachment B

7.0 Implementation of Policy

Each Division agency within the scope of this policy shall implement this policy and may develop specific written protocols as necessary to do so effectively.

Control #	Rev.	Title	Effective Date: 4/14/04
CRR 2.7 (2.007)	9/18	Client Access to Clinical Records	Next Review Date: 09/01/2020

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health (DPBH) to maintain and protect the client's right to a confidential clinical record of care as specified in state and federal laws while allowing access to those clinical record for diagnosis and treatment of the client.

2.0 PURPOSE:

This process establishes guidelines for Clinical Services Branch facilities to use in establishing protocol for assisting clients in obtaining copies, reviewing, amending, or restricting clinical records.

3.0 SCOPE:

DPBH Clinical Services Branch

4.0 DEFINITIONS:

4.1 Clinical Records: A clinical medical record is defined as a legal document within which is a recorded detail of an individual patient's course of illness, treatment rendered, outcome of treatment, and continuum of care plan.

4.2 Clinical Documentation (CD): is the creation of a digital or analog record detailing a medical treatment, medical trial or clinical test. Clinical documents must be accurate, timely and reflect specific services provided to a patient.

4.3 Protected Health Information (PHI): is individually identifiable health information that relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.

4.4 Patient Identifiable Information (PII): Personally Identifiable Information (PII) is any information which identifies the individual, name, date of birth, social security number, government issued ID, address, telephone number, email or other electronic address.

Control #	Rev.	Title	Effective Date: 4/14/04
CRR 2.7 (2.007)	9/18	Client Access to Clinical Records	Next Review Date: 09/01/2020

5.0 REFERENCES:

5.1 NRS: 433A.360 Confidentiality

5.2 NRS: 433.482 Right to Information

5.3 NRS: 629.041 Records Retention

6.0 PROCEDURE:

6.1 Review and request: A client must be permitted to inspect his/her records and informed of his/her clinical status and progress at least every three months. unless a psychiatrist has made a specific entry to the contrary in a client's record, a client is entitled to copies of his/her records upon notice to the administrator and payment of the cost of reproducing the record.

6.2 Release of client's confidential health information to agencies outside the Division requires a Release of Protected Health Information Consent Form:

6.2.1 A Release of PHI Consent Form

6.2.2 Dated within 365 days or less of the request; and

6.2.3 Specifies the agency releasing the information, the agency requesting the information, the dates of release of information request.

6.3 The Division, through its various agencies and contractors, is responsible for diagnosis and treatment of its clients.

6.3.1 There shall be no impediment to the free exchange of client information from one DPBH agency to another or to a contractor of the Division.*

6.3.2 No release of PHI Consent Form is required for transfer of care.

6.3.3 A record of each document sent to another Division agency or contractor shall be made a permanent part of the client's clinical record.

6.3.4 Each page of a released client clinical record shall contain a redisclosure statement indicating the name of the individual or agency the information is released to and indicating the information is confidential and not to be redisclosed.

6.3.5 No part of a released client clinical record may be redisclosed by the receiving agency.

6.3.5.1 Any subsequent request for records from another agency must be directed to the originating agency on a properly completed Release of Protected Health Information Consent Form.

6.3.6 The agency administrator or designee shall know the laws governing confidential records, including medical records, reports by committees, quality assurance reports.

6.4 If the agency administrator or designee responding to a request for clinical medical records has a question about whether any part of the requested information is public record or whether the information should be released they should request guidance from the attorney general.

6.5 Depending on the reason for request, agencies may impose a nominal charge for copies of requested information. Payment should be received in advance of the release.

6.6 Record keeping of all releases, pay or nonpaying, will be logged in the Disclosure Management, electronic, database (Avatar).

6.7 There will be no copying charge for a patient who is requesting copies of their records to support a claim or appeal for federal or state financial needs based on benefits such as SSI/SSA.

6.8 If the client requests a second copy of their records, the normal fee will be charged regardless of whether the records are to support a claim for federal or state financial needs-based benefits.

6.9 All original records request forms received by any agency should be maintained in the correspondence section of the client's record/file.

6.10 Requests for clinical medical records should be processed within ten (10) business days of receiving the request unless exceptional circumstances exist which delay the process, such as determining medical or legal justification for delay or denial. Notification must be provided to the client regarding the delay or denial.

6.11 Court records (legal) filed in a client's record are not to be released as part of the clinical medical record.

7.0 ATTACHMENTS:

7.1 CRR 2.7 DPBH Release of Protected Health Information English
7.2 CRR 2.7 DPBH Release of Protected Health Information Spanish

8.0 IMPLEMENTATION OF POLICY:

Each Division agency shall implement this policy and may develop specific written protocols and procedures as necessary to do so effectively.

EFFECTIVE DATE: 4/30/99
REVISION DATE: 7/1/02, 4/14/04
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2018

Control #	Rev. Date:	Title:	Effective Date: 03/2017
CRR 2.4	NEW	VOTER REGISTRATION POLICY	Next Review Date: 03/2019

1.0 POLICY:

Department of Public and Behavioral Health (DPBH) takes an active role in supporting the client's civil rights by offering them the opportunity to register to vote. DPBH facilities will remain in compliance with all Federal, State, and County laws, as well as the National Voter Registration Act (NVRA).

2.0 PURPOSE:

To ensure the civil rights of clients by offering the opportunity to register to vote and to ensure employees follow all the legal requirements of this process.

3.0 SCOPE:

Division of Public and Behavioral Health – Clinical Services Branch

4.0 DEFINITIONS:

4.1 Division Facility: Per NRS 433.094 "Division facility" means any unit or subunit operated by the Division for the care, treatment and training of consumers.

4.2 NVRA: refers to the National Voter Registration Act of 1993.

4.3 VRA refers to a Voter Registration Agency (NRS 293.504) or the act of providing voter registration opportunities at a Voter Registration Agency

4.4 DHHS NVRA Coordinator: refers to the Nevada Department of Health and Human Services National Voter Registration Act Department Coordinator.

4.5 Division Coordinator: refers to the Nevada Department of Health and Human Services National Voter Registration Act Division Coordinator.

4.6 Site Coordinator: refers to the Nevada Department of Health and Human Services National Voter Registration Act local Site Coordinator.

4.7 Voter Preference/Notice Form: means the form required pursuant to Section 7 of the NVRA, 52 U.S.C. § 20506(a)(6)(B), that includes boxes for Public Assistance Clientsto check indicating whether the applicant would like to register or declines to register to vote and/or any version of a form asking Public Assistance Clients if they would like to register to vote.

4.8 Voter Registration Form or Voter Registration Application: means the Nevada voter registration application form prescribed in NRS 293.507 and Section 9 of the NVRA, 52 U.S.C. § 20508(a)(2).

4.9 Local Election Official: means all county clerks, all city clerks or all county election departments, including the officers, agents, employees and representatives of the same.

5.0 PROCEDURE:

5.1 Triggering Events:

5.1.1 Per the NVRA requirements, the voter registration process must occur when applications for benefits is requested. All clients will be asked the question if they want to register to vote during the below "triggering event(s)":

5.1.1.1 New Application -During the initial intake interview (completing initial paperwork);

5.1.1.2 Recertification/Renewal -If the client completes paperwork to renew services (if applicable); and

5.1.1.3 Change of Information- If a client completes paperwork, or staff on the client's behalf change the client's name or address.

5.2 Language:

5.2.1 All Voter Registration forms are available through State Printing and may be order by notifying the Secretary of State NVRA Coordinator and DHHS NVRA Coordinator when supplies are low.

5.2.2 Forms are available in both Engliash and Spanish.

5.2.3 Clients who request Tagalog may use the English or Spanish forms;

5.2.4 Staff or client may print "TAGALOG" at the top of the form and enter their personal and contact information.

5.2.5 The form will then be submitted to the Secretary of State's Office.

5.2.6 The client will be contacted by a Tagalog speaking staff who will assist the client in completing the forms.

5.3 Signage:

5.3.1 Signage is to be posted in all client waiting rooms and main lobbies notifying clients, visitors, and staff of the availability to register to vote.

5.3.2 Signage must be in a typed font no smaller than 12 points.

5.3.3 Signage must be in English, Spanish, and Tagalog.

5.4 Division Facility:

5.4.1 Once discharge is planned, the assigned staff will offer and present the option for the client to register to vote. In the event the client response "no", the client is still to offered the voter registration form to take with them.

5.4.2 The assigned staff will forward all voter registration paperwork daily, to include the Voter Registration Inquiry forms and Voter Registration forms to the Agency's Voter Registration Coordinator for data collection and processing.

5.5 Outpatient Clinics:

5.5.1 The Voter Registration Inquiry Form and Voter Registration Form will be handed to the client separate from admission paperwork.

5.5.1.1 If the client needs assistance, they will be referred to the Consumer Service Assistance staff or designee at the client

5.5.1.1.1 The administrative staff at the front desk or designee will collect all Voter Registration forms and Voter Registration Inquiry forms and turn them into the AA III or designee for data collection and processing daily.

5.5.1.1.2 The assigned staff will forward all voter registration paperwork daily, to include the Voter Registration Inquiry forms and Voter Registration forms to the Agency's Voter Registration Coordinator for data collection and processing daily.

5.6 Confidentiality:

5.6.1 No information regarding a person's declination to register to vote will be used for any purpose other than voter registration. If a client does register to vote, the voter registration application will not be publicly disclosed.

5.6.2 All Voter Registration Inquiry forms will be sent daily to the Medical Records Department and kept in an "umbrella" file.

5.7 Data Reporting:

5.7.1 DPBH facilities will have an internal data reporting process maintained by the Agency's Voter Registration Coordinator.

5.7.2 Internal data will be reported to the Secretary of State's Office through the DHHS NVRA Coordinator.

5.8 Training:

5.8.1 All DHHS staff who provide voter registrations services will be required to complete voter registration training on hire and twice a year, preferable in June and December.

5.8.2 NVRA Training is avaialable online via NVelearn (https://nvelearn.nv.gov/moodle/).

5.8.3 Training logs must be completed and returned to the DHHS NVRA Department Coordinator no later than the last Friday in January each year.

6.0 ATTACHMENTS:

6.1 CRR 2.4 VOTER REGISTRATION FORM ENGLISH Attachment A

6.2 CRR 2.4 VOTER REGISTRATION FORM ENGLISH Attachment B

6.3 CRR 2.4 VOTER REGISTRATION INQUIRY FORM - ENGLISH - 2 SIDED Attachment C

6.4 CRR 2.4 VOTER REGISTRATION INQUIRY FORM - SPANISH - 2 SIDED Attachment D

7.0 IMPLEMENTATION OF POLICY:

7.1 Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

Control #	Rev.	Title	Effective Date: 4/14/04
CRR 2.7 (2.007)	9/18	Client Access to Clinical Records	Next Review Date: 09/01/2020

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health (DPBH) to maintain and protect the client's right to a confidential clinical record of care as specified in state and federal laws while allowing access to those clinical record for diagnosis and treatment of the client.

2.0 PURPOSE:

This process establishes guidelines for Clinical Services Branch facilities to use in establishing protocol for assisting clients in obtaining copies, reviewing, amending, or restricting clinical records.

3.0 SCOPE:

DPBH Clinical Services Branch

4.0 DEFINITIONS:

4.1 Clinical Records: A clinical medical record is defined as a legal document within which is a recorded detail of an individual patient's course of illness, treatment rendered, outcome of treatment, and continuum of care plan.

4.2 Clinical Documentation (CD): is the creation of a digital or analog record detailing a medical treatment, medical trial or clinical test. Clinical documents must be accurate, timely and reflect specific services provided to a patient.

4.3 Protected Health Information (PHI): is individually identifiable health information that relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.

4.4 Patient Identifiable Information (PII): Personally Identifiable Information (PII) is any information which identifies the individual, name, date of birth, social security number, government issued ID, address, telephone number, email or other electronic address.

Control #	Rev.	Title	Effective Date: 4/14/04
CRR 2.7 (2.007)	9/18	Client Access to Clinical Records	Next Review Date: 09/01/2020

5.0 REFERENCES:

5.1 NRS: 433A.360 Confidentiality

5.2 NRS: 433.482 Right to Information

5.3 NRS: 629.041 Records Retention

6.0 PROCEDURE:

6.1 Review and request: A client must be permitted to inspect his/her records and informed of his/her clinical status and progress at least every three months. unless a psychiatrist has made a specific entry to the contrary in a client's record, a client is entitled to copies of his/her records upon notice to the administrator and payment of the cost of reproducing the record.

6.2 Release of client's confidential health information to agencies outside the Division requires a Release of Protected Health Information Consent Form:

6.2.1 A Release of PHI Consent Form

6.2.2 Dated within 365 days or less of the request; and

6.2.3 Specifies the agency releasing the information, the agency requesting the information, the dates of release of information request.

6.3 The Division, through its various agencies and contractors, is responsible for diagnosis and treatment of its clients.

6.3.1 There shall be no impediment to the free exchange of client information from one DPBH agency to another or to a contractor of the Division.*

6.3.2 No release of PHI Consent Form is required for transfer of care.

6.3.3 A record of each document sent to another Division agency or contractor shall be made a permanent part of the client's clinical record.

6.3.4 Each page of a released client clinical record shall contain a redisclosure statement indicating the name of the individual or agency the information is released to and indicating the information is confidential and not to be redisclosed.

6.3.5 No part of a released client clinical record may be redisclosed by the receiving agency.

6.3.5.1 Any subsequent request for records from another agency must be directed to the originating agency on a properly completed Release of Protected Health Information Consent Form.

6.3.6 The agency administrator or designee shall know the laws governing confidential records, including medical records, reports by committees, quality assurance reports.

6.4 If the agency administrator or designee responding to a request for clinical medical records has a question about whether any part of the requested information is public record or whether the information should be released they should request guidance from the attorney general.

6.5 Depending on the reason for request, agencies may impose a nominal charge for copies of requested information. Payment should be received in advance of the release.

6.6 Record keeping of all releases, pay or nonpaying, will be logged in the Disclosure Management, electronic, database (Avatar).

6.7 There will be no copying charge for a patient who is requesting copies of their records to support a claim or appeal for federal or state financial needs based on benefits such as SSI/SSA.

6.8 If the client requests a second copy of their records, the normal fee will be charged regardless of whether the records are to support a claim for federal or state financial needs-based benefits.

6.9 All original records request forms received by any agency should be maintained in the correspondence section of the client's record/file.

6.10 Requests for clinical medical records should be processed within ten (10) business days of receiving the request unless exceptional circumstances exist which delay the process, such as determining medical or legal justification for delay or denial. Notification must be provided to the client regarding the delay or denial.

6.11 Court records (legal) filed in a client's record are not to be released as part of the clinical medical record.

7.0 ATTACHMENTS:

7.1 CRR 2.7 DPBH Release of Protected Health Information English
7.2 CRR 2.7 DPBH Release of Protected Health Information Spanish

8.0 IMPLEMENTATION OF POLICY:

Each Division agency shall implement this policy and may develop specific written protocols and procedures as necessary to do so effectively.

EFFECTIVE DATE: 4/30/99
REVISION DATE: 7/1/02, 4/14/04
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2018

Control #	Rev.	Title	Effective Date: 09/2018
CRR 6.25	New	**HIPAA Guidance for Privacy Practices Breach/Violation**	**Next Review Date 9/2020**

1.0 POLICY:

It is the policy of the Department of Public and Behavioral Health (DPBH) staff and its contractors are entrusted with information regarding our clients and we recognize that clients' health records and personal identifiable information is confidential and protected by Federal laws, State laws, and agency policy. Client information must be treated with confidentiality by all employees and can only be released with proper authorization.

2.0 PURPOSE:

The purpose of this policy is to provide guidance for staff breaches in patient privacy practices and confidentiality. To ensure compliance with privacy practices and confidentiality, DPBH shall follow the State of Nevada Personnel progressive disciplinary actions for all identified HIPAA Privacy Rule, ARRA HITECH breaches.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 As used in this policy ***breach*** of patient information has been divided into the following three levels:

4.1.1 Level 1 – Carelessness:
This level of breach occurs when an employee unintentionally or carelessly accesses, reviews or reveals patient information to him, herself or others without a legitimate need to know the patient information.

4.1.2 Level 2 – Curiosity or Concern (no personal gain):
This level of breach occurs when an employee accesses, reviews or discusses patient information for purposes other than the care of the patient or other authorized purposes, but for reasons unrelated to personal gain.

4.1.3 Level 3 – Personal Gain or Malice:
This level of breach occurs when an employee accesses reviews or discusses patient information for personal gain or with malicious intent.

DPBH HIPAA Privacy Officer is defined as Division of Public and Behavioral Health, Clinical Services Branch.

4.2 Progressive ***Disciplinary Action*** as defined in this policy is defined as State of Nevada Personnel standards for such.

5.0 REFERENCES:

5.1 Health Insurance Portability and Accountability Act (HIPAA), Privacy Rule, CFR 42.164.520, 164.522, 164.154, and 164.530

5.2 ARRA Public Law 111-5, Subtitle D, Privacy, &Title XIII, Sec.3001 ONC Authorization and Sec.3009. HIPAA Privacy and Security Law

5.3 NRS 433A.360, 629.021-629.061

6.0 PROCEDURE:

6.1 All DPBH employees shall receive training regarding confidentiality and HIPAA Privacy Practices.

6.1.1 Each agency within DPBH shall track training requirements.

6.1.2 Confidentiality statements (Attached) shall be placed into the employee's personnel file at each agency.

6.1.3 DPBH HIPAA Privacy Officer will be consulted in any breach of patient confidentially.

6.1.4 DPBH ISO Director will also be notified of breach of patient's electronic data.

6.2 All employees shall report verbally within one (1) hour to his/her supervisor all perceived violations of confidentiality. The supervisor shall ensure the proper incident form is completed in compliance with policy.

5.2.1 DPBH shall investigate or cause to investigate all allegations of breaches.

5.2.2 Employees failing to report shall receive progressive disciplinary actions equal to the level of breach.

6.3 Staff found in violation of this policy may be subject to disciplinary action up to and including dismissal as authorized by: NRS. Nevada Administrative Code 284.650 - Causes for disciplinary action and/or Prohibitions and Penalties of the Department of Health and Human Services and/or DPBH policies.

7.0 ATTACHMENTS:

7.1 CRR 6.25 DPBH HIPAA Confidentiality Agreement Attachment

8.0 IMPLEMENTATION OF POLICY:

Each Division agency shall implement this policy and may develop specific written protocols and procedures as necessary to do so effectively.

EFFECTIVE DATE:
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:

Control #	Rev.	Title	Effective Date: 03/16/2018
HR 2.0	New	Employee use of Personal Adaptive Equipment in Client Care Areas	Next Review Date: 03/01/2020

1.0 POLICY:

DPBH Clinical Services Branch is committed to providing an accessible work environment for employees while maintaining safety for both employees and clients.

2.0 PURPOSE:

To provide guidance regarding employee use of Personal Assistive Devices (PAD) in Clinical Services Branch Facilities.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Essential job functions are the fundamental duties of a position: the things a person holding the job absolutely must be able to do. Essential job functions are used to determine the rights of an employee with a disability under the Americans with Disabilities Act (ADA).

4.2 Mobility Impairment: refers to the inability of a person to use one or more of his/her extremities, or a lack of strength to walk, grasp, or lift objects also defined as the state in which an individual has a limitation in independent, purposeful physical movement of the body or of one or more extremities.

4.3 Personal Assistive Devices: are products used either temporarily or permanently to assist persons with disabilities. PADs include a wide range of products such as wheelchairs, walkers, scooters (manual or electric), white canes, oxygen tanks, orthopedic assistive devices such as; boots, slings, braces, casts, boots or other products not listed here.

4.4 Return to work light-duty programs include temporary light-duty, limited-duty or modified-duty assignments.

4.5 Light duty: typically involves excusing an employee from performing certain tasks that he or she would normally perform.

4.6 Limited duty reduces the number of hours an employee normally works in a day.

4.7 Modified duty eliminate some tasks and replace them with others more suitable for the employee's physical limitations in the employee's normal position.

4.8 Release to Work can be a written or typed note signed by the employee's healthcare provider on the provider's letterhead, outlining when the employee can return to work and with what restrictions, if any. his or her job duties or what limitations pose a threat to the safety of the employee or others.

4.9 Family and Medical Leave Act (FMLA) generally requires an employee to be restored to his or her former position upon return, restoration is not necessarily required under the FMLA if the employee is physically unable to perform the essential functions of his or her position.

4.9.1 Under FMLA, an employer also is not required to create a new position simply to accommodate the employee's need for light duty. As FMLA regulation 825.215, paragraph (c) states: If the employee is unable to perform an essential function of the position because of a physical or mental condition, including the continuation of a serious health condition or an injury or illness also covered by workers' compensation, the employee has no right to restoration to another position under the FMLA.

4.9.2 The employer's obligations may, however, be governed by the Americans with Disabilities Act (ADA), as amended.

4.9.3 Light duty should not be confused with a reduced or intermittent leave schedule.

5.0 REFERENCES:

5.1. Society for Human Resource Management (2015 May) How to Create a Return to Work Light Duty Program. Retrieved from www.shrm.org

5.2 State of Nevada: Employee Handbook; Department of Administration, Division of Human Resource Management.

5.3 NAC 284.6014-284.6019

6.0 PROCEDURE:

6.1 Early Return to Work Program

6.1.1 The supervisor evaluates the information on the Physical Assessment form and determines if a light duty assignment is necessary.

6.1.2 If the employee will not be performing their regular job duties, the supervisor shall contact the agency HR office to coordinate an early return to work program.

6.1.3 Supervisors will follow procedures identified in the State of Nevada Early Return to Work program guidelines prepared by the Risk Management Division. Guidelines for supervisors are available in the agency personnel office.

6.1.4 Supervisors will continue to code timesheets using appropriate codes.

6.1.5 If an employee has been taken off work and/or if a modified duty assignment is not available, HR and the supervisor shall continue to communicate with the employee on a regular basis and initiate return to work efforts in collaboration with the agency HR office.

6.2 Modified Duty

6.2.1 When a supervisor is notified of the need for modified duty, the supervisor must notify HR

6.2.1.1 The supervisor is responsible for providing all worker's comp paperwork to HR.

6.2.1.2 The employee must provide copies of all doctor visits to HR as soon as possible.

6.2.2 HR will send a confirmation email to all parties (dept. heads, supervisors, staffing, temp supervisor and the employee), outlining the assignment and any restrictions and modified light duty requirements.

6.3 Responsibilities

6.3.1 Employees

6.3.1.1 Ensure client and staff safety and promote a safe working environment.

6.3.1.2 Follow established safety rules and policies for job/work location.

6.3.1.3 Report all work-incurred injuries, accidents or illness whether directly involved or witnessed, to their supervisor immediately.

6.3.1.4 Employees must accurately report and correctly code any work-related absences in their NEATS timesheet.

6.3.1.5 Cooperate with the intent and requirements of the Early Return to Work Program.

6.3.1.6 Follow up with the healthcare provider as needed and forward paperwork to the supervisor and or the HR Worker's Comp. Liaison.

6.3.2 Supervisors

6.3.2.1 Ensure client and staff safety and maintain a safe work environment.

6.3.2.2 Follow established safety rules and policies for job/work location.

6.3.2.3 Provide information and guidance to employees regarding safety rules and injury reporting procedures,

6.3.2.4 Report all work-incurred injuries, accidents or illness whether directly involved or witnessed, to their supervisor immediately.

6.3.3. Release to return to work

6.3.3.1 When an employee is released to work with restriction that will not allow them to perform the essential functions of their position, HR will determine whether reasonable accommodation can be made.

6.3.3.2 If reasonable accommodation cannot be made, every effort will be made to place the employee in a vacant position for which they are qualified, and which accommodates the stated work conditions.

6.3.3.3 Employees may be reemployed into a position that they qualify for and their restrictions DO NOT preclude them from performing the essential functions of the job.

6.3.3.4 Employees may be reemployed at or below their pre-injury position grade level. (NAC 284.6014-284.6019)

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

Each Division agency shall implement this policy and may develop specific written protocols and procedures as necessary to do so effectively.

EFFECTIVE DATE: 03/16/2018
DATE APPROVED BY DPBH ADMINISTRATOR: 03/16/2018
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 03/16/2018

Control #	Rev.	Title	Effective Date: 03/16/2018
HR 2.0	New	Employee use of Personal Adaptive Equipment in Client Care Areas	Next Review Date: 03/01/2020