



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

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<b>Control #</b>	<b>Rev.</b>	<b>Title:</b>	<b>Effective Date:</b>
A 5.1	03/18	Division Level II Incident Report Management and Closure process	03/16/2018
			<b>Next Review Date</b> 03/01/2020

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**1.0 POLICY:**

The Department of Public and Behavioral Health (DPBH), Clinical Services Branch monitors, tracks and evaluates all Level II Incidents.

**2.0 PURPOSE:**

To provide a standardized process for reviewing and closing Division Level II Incident reports.

**3.0 SCOPE:** Clinical Services Branch

**4.0 DEFINITIONS:**

4.1 **Division Level II Incident** is a serious incident that may represent a high risk to the safety of consumers or staff or liability to the State. Such incidents are reported to the Administrator of the Division to ensure that appropriate safeguards are implemented and all level II incidents are evaluated and addressed by the Division Incident Report Committee.

4.2 **Patient Safety Officer (PSO)** as used in this policy references [NRS. 439.815](#) means a person who is designated pursuant to [NRS 439.870](#).

4.3 **Division Incident Report Committee** is a Clinical Services Branch Committee consisting of membership of each agency's PSO or Quality Assurance Specialist (QAS).

4.4 **Closed Chart:** A Medical Record that has been reviewed and all forms, documents and signatures are completed by clinical staff. Inpatient paper/hard copy charts are uploaded into Avatar and the paper chart if filed as a closed chart.

4.5 **Locked Chart:** A Medical Record both electronic and hard/paper copy are secured by Health Information Services (HIS). The Avatar record is locked and the hard/paper copy is secured separately from open or closed charts.

**5.0 PROCEDURE:**

5.1 Division Incident Report Committee meetings will be convened on a periodic Basis, approximately every two (2) months by teleconference.



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---

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			<b>Next Review Date</b> 03/01/2020

---

- 5.2 Level II Division Incidents must be entered into Avatar by a QAS, a clinical staff person or a QAPI staff member, AAs do not enter Level II Incidents even with an SIR worksheet.
- 5.3 Prior to each meeting, PSO or QAS will be given assignments to review and report with recommendation for further review or closure of each of their assigned Level II Division incidents.
- 5.4 Incidents will not be assigned for review that are not at least three (3) months old. This will allow time for Root Cause Analysis (RCA), investigations or other necessary research to be completed.
- 5.5 Members of the Division Incident Report Committee will have access to closed and locked medical records both electronic and paper/hard copy on request. This will allow them to do the necessary research to determine the status of an open Division Level II Incident.
- 5.6 At each meeting, the PSO or QAS will report on each of their assigned incidents to include the following:
- 5.6.1 A brief summary of the incident;
  - 5.6.2 A recommendation for further review and research; or
  - 5.6.3 A recommendation to “close” the incident in Avatar.
- 5.7 After review and discussion the Committee will agree on the status of the incident approving either further research or closure.
- 5.8 Incidents not approved for closure by committee consensus will remain open for further research and committee review.
- 5.8.1 The Agency Manager or delegee will ensure that a final incident note be recorded in Avatar prior to closure of the indent.
  - 5.8.2 Level II Division Incidents may only be closed at the recommendation of this committee and by a committee member.
  - 5.8.3 Incidents not approved for closure remain on subsequent agendas until they are approved for closure.
  - 5.8.4 When incidents that remain on the agenda for more than three (3) months,



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
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---

<b>Control #</b>	<b>Rev.</b>	<b>Title:</b>	<b>Effective Date:</b>
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			<b>Next Review Date</b> 03/01/2020

---

the committee will work with the DPBH Deputy Administrator to resolve issues and facilitate closure.

5.9 The PSO or QAS assigned will close each of their assigned incidents approved for closure by the committee.

5.10 The Committee will focus on identifying trends that would point to opportunities for system improvements through out the Division and make recommendations for further action or analysis.

**6.0 REFERENCES:**

6.1 [NRS. 439.815](#)

6.2 [NRS 439.870](#)

6.3 [DPBH Clinical Services Branch CRR .014 Risk Management and Reporting Serious Incidents](#)

**7.0 ATTACHMENTS:**

7.1 CRR .014 Risk Management and Reporting Serious Incidents Attachment 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 COMMISSION ON BEHAVIORAL HEALTH: 03/16/2018



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

---

<b>Control #</b>	<b>Rev.</b>	<b>Title:</b>	<b>Effective Date:</b>
A 5.1	03/18	Division Level II Incident Report Management and Closure process	03/16/2018
			<b>Next Review Date</b> 03/01/2020

---



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>1 of 22</u>

**1.0 POLICY**

~~The Division will ensure timely access to case management services under an established statewide service delivery model based on an integrated system of care that meets the individually assessed biopsychosocial needs of individuals served. The provision of services will be based on medical necessity and the emergent, urgent, and stabilization needs of each individual. All care will be coordinated and services will be provided in conjunction with policy BHO-003: Service Delivery.~~

~~Division agencies will ensure that people receive timely case management services to meet their individual needs related to gaining access to needed medical, social, educational, and other support services including housing and transportation. The provision of case management services will be based on eligibility criteria within Service Coordination services will be provided according to~~ the most recent Nevada Medicaid Services Manual, Chapter 2500 - Case Management. Individuals may receive case management services in conjunction with other services or independent of other services. Services are based on the assessed ~~case management~~resource/service needs of the individual served.

**2.0 PURPOSE**

DPBH will ensure effective and systematic compliance with Federal, State and Division policies through uniformity in the access, provision and documentation of all outpatient mental health services. The purpose of this policy is also to establish policy for compliance with Nevada Medicaid in the provision of Targeted Case Management services.

**3.0 SCOPE**

This policy applies to all Division's behavioral health agencies and integrated care centers. This policy is to be implemented in conjunction with ~~BHO~~ DPBH-Policies, BHO-003 Service Delivery and BHO-005 Outpatient Therapy and Rehabilitative Mental Health (RMH) Services. ~~This policy supersedes Division policies 3.002 Service Coordination Services, and 4.047 Utilization and Quality Review for Service Coordination for Mental Health Agencies.~~

**4.0 DEFINITIONS**

**4.1 Case Management:** ~~A Federally defined ancillary service~~ Service designed to ensure referral, linkage, ~~referral~~ and receipt of needed services. The intent of these services is to

**Commented [LV1]:** This paragraph appears to be more related to the provision of clinical care. I have indicated my suggestion as an attachment to the second paragraph

**Commented [JH2R1]:** I prefer the original. All Medicaid services, including TCM, must meet the "medical necessity" requirement of Chapter 100. I have spelled this out in 6.1 below in order to demonstrate compliance with Chapter 100 (103.1) and NRS 433.494(1)(a).

**Commented [LV3]:** Again, as TCM can be provided without a person needed to receive MH services, I am not sure if "in conjunction" is a term to use

**Commented [JH4]:** "In conjunction" means that there are parts of BHO-003 and BHO-005 that apply to this policy. For example, BHO-003 provides more directive on Progress Notes, and BHO-005 addresses what a QMHP is.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>2 of 22</u>

assist eligible individuals in gaining access to needed medical, social, educational, and other support services including housing and transportation needs. Components of this service include assessment, care planning, referral/linkage and monitoring/follow-up. These services do not include the direct delivery of medical, clinical, or other direct services.

4-14.2 Case Management Assessment: A biopsychosocial assessment of the recipient that identifies, documents, and substantiates the resource/service needs of the recipient; and demonstrates eligibility for a corresponding Targeted Case Management group. The assessment must be completed at the time of admission to case management services, and the recipient reassessed at least annually thereafter. Initial assessment requires a face-to-face assessment. Reassessment requires an annual face-to-face assessment. A reassessment may occur more frequently if there is a change in the recipient's condition. The assessment and reassessment are limited to no more than four per 365 days. This does not preclude qualified providers from adjusting the care plan and service arrangements more frequently through monitoring activities. To avoid duplication of services and to reduce frustration on the part of the recipient and/or their family due to repetitious disclosure, information from available previous psychiatric evaluations, psychosocial assessments, or other relevant assessments and sources may be obtained, included, and updated in the Assessment.

**Commented [JH5]:** Included/copied language from Nevada Medicaid State Plan, Supplement 1 to Attachment 3.1-A

4.3 Case Management Care Plan: A Pplan jointly developed with the individual and that is based on the reason for referral to case management services, and the medically necessary assessed case management resource/service needs of the individual recipient for . This plan outlines the need for any medical, educational, social or other services needed to regain for improved societal integration and functioning. The plan describes and the specific goals and actions needed to attain these goals. The initial care plan is developed jointly with the recipient (or their legal representative) at the time of admission to services, and documented at the conclusion of the Case Management Assessment. A new updated/revised plan is jointly developed with the recipient (and/or their legal representative) at least annually thereafter, or sooner whenever there is a substantial change in the recipient's functioning/situation.

4-24.4 Qualified Mental Health Professional (QMHP): A licensed mental health professional that meets the corresponding qualifications defined in the Nevada Medicaid Services Manual, Chapter 400 – Mental Health and Alcohol and Substance Abuse Services.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<b><u>Control #</u></b>	<b><u>Rev.</u></b>	<b><u>Type</u></b>	<b><u>Title</u></b>	<b><u>Effective Date</u></b>	<b><u>Page</u></b>
<b><u>BHO-006</u></b>	<b><u>23</u></b>		<b><u>Behavioral Health Outpatient (BHO) Case Management</u></b>	<b><u>0709-01-2018</u></b>	<b><u>3 of 22</u></b>

~~4.21.1 Case Management Discharge Summary. Written documentation of the last case management contact with the individual, a summary statement that describes the effectiveness of the services provided, the reason for discharge, recommendations for ways to maintain stabilization. Discharge summaries are completed within one working day of a planned discharge and within 30 calendar days following an unplanned discharge. In the case of an individual's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven (7) calendar days of the transfer.~~

**4.44.5 Target Groups for Case Management Services**

Case management is based on the assessed eligibility status as determined by a QMHP (see BHO-003 *Service Delivery*; BHO-005 *Outpatient Therapy and Rehabilitative Mental Health (RMH) Services*). Case management for DPBH will be provided to the following four eligible target groups as defined by [Chapter 2500 of the Nevada Medicaid Services Manual \(MSM\)-Addendum](#):

~~4.4.14.5.1~~ Adults ([individuals 18 years of age or older, Statewide](#)) with a Serious Mental Illness (SMI)

~~4.4.24.5.2~~ Adults ([individuals 18 years of age or older, Statewide](#)) with a Non-Serious Mental Illness (Non-SMI)

~~4.4.34.5.3~~ Children and adolescents ([individuals under age 18 years of age, in rural areas](#)) with a Severe Emotional Disturbance (SED)

~~4.5.4~~ Children and adolescents ([individuals under age 18 years of age, in rural areas](#)) with a Non-Severe Emotional Disturbance (Non-SED)

**4.6 Eligibility Summary.** [Documentation in the client's case record that demonstrates initial/ongoing eligibility for case management services. This summary documents the following elements:](#)

**4.6.1 Eligible Diagnosis.** [The International Classification of Diseases \(ICD\) reason-for-encounter codes and descriptions/specifiers \(a.k.a. diagnosis\) that substantiate the initial and ongoing eligibility and medical necessity for case management services. This diagnosis must have been made at the time of admission to services or within the preceding 12 months. The diagnosis should be congruent with the reason for referral and the identified resource/support needs within the assessment. For example, if the assessment identifies a need for behavioral health medication stabilization, a congruent ICD diagnosis from the F00 thru F99 ICD code](#)



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<b><u>Control #</u></b>	<b><u>Rev.</u></b>	<b><u>Type</u></b>	<b><u>Title</u></b>	<b><u>Effective Date</u></b>	<b><u>Page</u></b>
<b><u>BHO-006</u></b>	<b><u>23</u></b>		<b><u>Behavioral Health Outpatient (BHO) Case Management</u></b>	<b><u>0709-01-2018</u></b>	<b><u>4 of 22</u></b>

range should be listed; if the assessment identifies a need for housing and/or financial stability/support, a congruent ICD reason-for-encounter code from the Z59.x code range should be listed; and so forth. If more than one qualifying ICD diagnosis is relevant to the consumer's case management needs, the diagnoses are listed in order of treatment priority. Ongoing eligibility for case management services is demonstrated by a qualifying ICD diagnosis that has not become more than 12 months old. The Eligible Diagnosis along with the date of diagnosis and the name and credentials of the diagnosing QMHP are documented in (1) the Diagnosis form in Avatar, and additionally documented as part of the Eligibility Summary listed in both (2) the Assessment of Case Management Need and (3) the Case Management Care Plan.

**4.6.2 Functional Impairment.** An intensity of needs determination is completed to demonstrate the consumer's level of functional impairment, and to help substantiate the initial and ongoing eligibility and medical necessity for case management services. This determination is completed upon admission to case management services, and at least annually thereafter, or sooner if there is a substantial change in the consumer's condition. Ongoing eligibility for case management services is demonstrated by the results of an intensity of needs determination that have not become more than 12 months old. The results of the intensity of needs determination along with the date of determination and the name and credentials of the rating Qualified Mental Health Associate (QMHA) or QMHP are documented in (1) the corresponding LOCUS or CASII form in Avatar, and additionally documented as part of the Eligibility Summary listed in both (2) the Assessment of Case Management Need and (3) the Case Management Care Plan. The consumer's functional impairment / intensity of needs is determined by using one of the following Medicaid-approved/recommended service intensity assessment instruments:

**4.6.2.1 Level Of Care Utilization System (LOCUS).** For recipients 18 years of age or older, the most recent version of the LOCUS published by the American Association of Community Psychiatrists (AACCP) is approved by Nevada Medicaid to determine the intensity of needs.

**4.6.2.2 Child and Adolescent Service Intensity Instrument (CASII).** For recipients 6 years of age thru 17 years of age, the most recent version of the CASII published by the American Academy of Child Adolescent Psychiatry





**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>5 of 22</u>

(AACAP) is approved by Nevada Medicaid to determine the intensity of needs.

4.6.2.3 For recipients less than 6 years of age, a tool comparable to the CASII and recognized as a standard of practice in determining the intensity of needs must be used, such as the Early Childhood Service Intensity Instrument (ECSII) also published by the American Academy of Child Adolescent Psychiatry (AACAP).

4.6.3 Target Group Determination. The results of a Serious Mental illness (SMI) or Severe Emotional Disturbance (SED) determination that documents the target group (listed in 4.5) for which the consumer is eligible. This determination is completed by a QMHP upon admission to case management services, and at least annually thereafter, or sooner if there is a substantial change in the consumer’s condition. Ongoing eligibility for case management services is demonstrated by the results of an target group determination that has not become more than 12 months old. The results of the target group determination along with the date of determination and the name and credentials of the rating Qualified Mental Health Aide (QMHA) or QMHP are documented in (1) the SMI/SED Determination form in Avatar, and additionally documented as part of the Eligibility Summary listed in both (2) the Assessment of Case Management Need and (3) the Case Management Care Plan.

**Commented [LV6]:** People can receive TCM services as Non-SMI/SED with scores that are lower

4.7 Utilization Review: A retrospective approach to the analysis of the services provided based on medical necessity, clinical appropriateness, and quality of care according to the established DPBH policies and procedures.

**5.0 ELIGIBILITY**

**5.1 ADMISSION CRITERIA**

DPBH strives to serve all people in Nevada with a mental/behavioral health disorder in need of services that are not available or accessible in the private sector. To be eligible for case management services, an individual must meet the diagnostic and impairment criteria ~~infor~~ one of the four targeted groups listed in 4.45 and require assistance in obtaining and coordinating needed resources and support services.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>6 of 22</u>

**5.2 CONTINUING STAY CRITERIA**

Must meet all of the following:

- 5.2.1 Continues to meet admission criteria.
- 5.2.2 Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as the unmet needs of the individual.
- 5.2.3 Documentation supports progress towards specific case management goals identified in the case management care plan with barriers identified and addressed.
- 5.2.4 Care plan and goals are established.

**5.3 DISCHARGE/EXCLUSIONARY CRITERIA**

Must meet at least one of the following:

5.3.1 The individual/recipient or their legal representative chooses not to participate in the program.

5.3.2 The recipient has not responded to attempts to contact him/her and/or see them face-to-face within 90 days.

5.3.25.3.3 No longer meets the diagnostic and impairment criteria in one of the four targeted groups listed in 4.45.

5.3.35.3.4 No longer meets the admission and continuing stay criteria:

5.3.45.3.5 Has been incarcerated or admitted into a psychiatric hospital, IMD, or nursing facility for more than 60 consecutive days.

5.3.55.3.6 Has sufficient support system to sustain stability, thus not requiring unnecessary or frequent acute treatment.

Commented [JH7]: Added from Policy 4.047



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>7 of 22</u>

5.3.65.3.7 The individual recipient's independent actions or lack thereof creates a situation that does not allow the agency to assure the individual recipient's health and safety.

**6.0 SERVICES**

6.1 All reimbursable case management services must:

6.1.1 Meet the **medical necessity** criteria stipulated in Chapter 100 of the Nevada Medicaid Services Manual (MSM), with a reasonable expectation that the case management services will:

6.1.1.1 Remediate and/or reduce symptoms;

6.1.1.2 Improve behaviors necessary to regain optimal functioning;

6.1.1.3 Increase the potential for recovery; and

6.1.1.4 Maintain current levels of functioning, without which decompensation or relapse will result;

6.1.2 Pursuant to Nevada Revised Statute (NRS) 433.494(1)(a), be provided in the least restrictive manner/setting available that may reasonably be expected to regain/maximize the recipient's safety, stability, and independence; and

6.1.3 Be associated with both (1) an International Classification of Diseases (ICD) reason-for-encounter code (a.k.a. diagnosis) which is documented in 7.1, 7.4, and 7.5 below; and (2) a Healthcare Common Procedure Coding System (HCPCS) procedure/service/intervention code, which is documented by the Progress Note in 7.6 below.

6.2 Individuals **determined as having SMI or SED** may receive a maximum of thirty (30) case management hours per calendar month. **Individuals determined as having Non-SMI or Non-SED** may receive up to ten (10) case management hours for the initial calendar month, and up to five (5) hours for the next three (3) consecutive calendar months. The maximum hours of case management services allowed per target group, per calendar month, per consumer may be exceeded with a prior authorization from Medicaid.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>8 of 22</u>

6.3 Individuals under 21 years of age residing at a psychiatric facility or hospital may receive transitional targeted case management services 14 days prior to discharge. Transitional case management activities must be coordinated with and not a duplication of institutional discharge planning services.

6.4 Services must be provided by a qualified individual.

6.5 Services may be provided face-to-face, or telephonically by telecommunication.

~~6.16.6~~ ~~Transitional targeted case management services may be provided 14 days prior to discharge to individuals under the age of 21 transitioning to a community setting after a period of time in a psychiatric facility or hospital. Transitional case management activities must be coordinated with and not a duplication of institutional discharge planning services. Services must be provided by a qualified individual and include the following functions:~~

Commented [JH8]: Moved to 6.3

~~6.1.16.6.1~~ **Case Management Assessment:** A strengths-based biopsychosocial assessment of the ~~individual's~~ recipient's resource/service needs. ~~The assessment must be completed at the time of admission to case management services and reassessed at least annually thereafter. The assessment~~ Assessment includes the following activities:

Commented [JH9]: Moved to 4.2

~~6.1.1.16.6.1.1~~ Taking, updating, or reviewing the ~~individual~~ recipient's psychosocial history.

~~6.1.1.26.6.1.2~~ Identifying the resource/service needs of the ~~individual~~ recipient.

~~6.1.1.36.6.1.3~~ Gathering additional information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment.

~~6.1.26.6.2~~ **Case Management Care Plan:** A ~~P~~ person-centered care plan ~~devised~~ signed to meet the assessed resource/service needs of the ~~individual~~ recipient. ~~The care plan is developed jointly with the individual at the time of admission to services and revised at least annually thereafter.~~ The care plan includes:

Commented [JH10]: Moved to 4.3

~~6.1.2.16.6.2.1~~ The recipient-stated (or guardian-stated) personal outcomes desired (G.i.e. goals) and actions required to address the medical, social, educational, and other resource/service needs of the ~~individual~~ recipient.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>9 of 22</u>

~~The Case Management Care Plan is completed and documented at the conclusion of the Case Management Assessment.~~

~~6.1.2.26.6.2.2~~ Activities that ensure the active participation of the individual recipient and others identified by the individual recipient to reach the identified goals.

~~6.1.2.36.6.2.3~~ The course of action (objectives) to respond to the assessed needs of the individual recipient.

~~6.1.36.6.3~~ **Case Management Referral and Linkage:** Activities to help the individual recipient obtain the identified resource/service needs. Referral and related activities help link the individual recipient with medical, social, educational providers; or other programs and services to provide the needed resources/services specified in the care plan.

~~6.1.46.6.4~~ **Case Management Monitoring and Follow-Up:** Activities and contacts that are necessary to ensure that the case management care plan is effectively implemented and is adequate to meet the assessed needs of the individual recipient. These activities and contacts may be with the individual recipient, family members, service providers or other entities or individuals. The monitoring is to be conducted as frequently as necessary, and at least annually to determine ~~if whether~~ the services are being provided according to the ~~individual's recipient's~~ care plan, whether the services are adequate, and ~~if whether~~ there are any changes in resource/service needs or status of the individual recipient. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers to respond to outcomes, barriers to progress, or other changes in the ~~individual's recipient's~~ status or needs.

**7.0 ADOCUMENTATION**

The recipient's case file must include the following documentation in the corresponding case management services episode in Avatar:

7.1 Eligible Diagnosis as defined in 4.6.1.

7.2 Functional Impairment as defined in 4.6.2.

**Commented [LV11]:** I would suggest separating out the progress notes from this section, possibly others. I would like one section that clarifies all of the "stuff" that needs to be documented and/or done prior to beginning services.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<b>BHO-006</b>	<b>23</b>		<b>Behavioral Health Outpatient (BHO) Case Management</b>	<b>0709-01-2018</b>	<b>10 of 22</b>

**7.3 Target Group Determination** as defined in 4.6.3.

**7.4 Case Management Assessment of Needs.** The identified resource/support needs of the recipient are documented and substantiated in the corresponding case management services episode of Avatar. When Avatar is unavailable, this information may be temporarily documented using a paper version of the assessment (attachment A) until it can be transcribed into Avatar. Because the Case Management Assessment is sometimes used as a stand-alone document, to demonstrate eligibility and for auditing purposes it must also list the **eligibility summary** elements defined in 4.6.

**7.5 Case Management Care Plan.** The Case Management Care Plan is documented in Avatar. When Avatar is unavailable, this information may be temporarily documented using a paper version of the Care Plan (attachment B) until it can be transcribed into Avatar. The plan is based on the reason for referral and the needs identified in the Case Management Assessment. When needed and in conjunction with a valid Release Of information (ROI), the Case Management Care Plan can be printed from Avatar and given to the recipient, their guardian, or a provider of services. The Case Management Care Plan includes the following elements:

**Commented [LV12]:** Much of this information is documented in the initial assessment progress note. As there is no Medicaid requirement for a psychosocial assessment, this is not being done at RC. I also suggest indicating care plan, not treatment plan

**7.5.1 A Plan Review Summary.** Pursuant to NRS 433.494(2), all outpatient plans (which includes Case Management Care Plans) “must be thoroughly reviewed at least every 3 months” (i.e. 90 days). Evidence of this review is demonstrated by appending to the Plan a dated summary of the outcomes, progress, and/or barriers experienced by the client towards achieving the goals and objectives listed in the Plan, or by jointly developing a new updated/revised Plan with the client (and/or their legal representative) if the current Plan is inadequately addressing the client’s needs. For initial Plans, the dated Plan Review Summary may simply indicate “Initial Plan.”

**7.5.2 An Eligibility Summary** as defined in 4.6 that has not become more than 12 months old.

**7.5.3 A Discharge Plan** that includes:

**7.5.3.1** The anticipated duration of overall services, including the expected timeframe for the identified goals to be completed;



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<b><u>Control #</u></b>	<b><u>Rev.</u></b>	<b><u>Type</u></b>	<b><u>Title</u></b>	<b><u>Effective Date</u></b>	<b><u>Page</u></b>
<b><u>BHO-006</u></b>	<b><u>23</u></b>		<b><u>Behavioral Health Outpatient (BHO) Case Management</u></b>	<b><u>0709-01-2018</u></b>	<b><u>11 of 22</u></b>

7.5.3.2 The criteria, factors, and/or targets that will indicate when a goal has been satisfied and the recipient is ready and/or able to transition to a less restrictive level of care/services;

7.5.3.3 Any anticipated or required step-down services;

7.5.3.4 The identified agency(ies) or independent provider(s) to provide anticipated step-down services; and

7.5.3.5 A plan to assist the recipient in accessing these anticipate step-down services.

7.5.4 **Strengths:** Strengths are the existing strengths and resources the recipient already has. A summary of from the Case Management Assessment of the identified strengths/resources of the recipient is documented in the Strengths section of the Treatment Plan form in Avatar. Strengths may also include and list progress the recipient has experienced.

7.5.5 **Needs:** The identified resource/support needs of the recipient. Needs identify what is missing/lacking to help keep the recipient safe, stable, and independent in a given life domain, such as health/medical, self-maintenance and basic living skills, housing, finances/employment, community/legal, family and social supports and interpersonal relationships, and education/literacy; and help to demonstrate the **Medical Necessity** of the services/interventions provisioned. Thus, when listed in the Plan, they are worded: *Client needs* . Needs may also be in the recipient's own words, and thus, enclosed in quotation marks (see example 3 below). Needs must directly relate to reason for referral and reason-for-encounter codes (a.k.a. ICD diagnoses) that warrant (continued) eligibility for services. A summary from the Case Management Assessment all the recipient's identified needs are listed in the Assessed Needs section of the Avatar Treatment Plan form. From this list, the specific needs selected by the recipient of services (or their legal guardian) to be addressed by the Plan are also additionally recorded/listed in the Problem section(s) of the Avatar Treatment Plan form.

**Example 1**

**Reason for encounter:** *F25.0 Schizoaffective disorder, bipolar type*

**Need:** *Client needs consistent administration of his behavioral health medications to maximize his safety, stability, and independence.*



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>12 of 22</u>

**Example 2**

**Reason for encounter: Z59.1 Inadequate housing**

**Need: Client needs to obtain and maintain safe and stable housing.**

**Example 3**

**Reason for encounter: F10.10 Alcohol use disorder, mild**

**Need: "I need to get sober."**

**7.5.6 Goals that:**

**7.5.6.1 Reflect what the recipient wants to improve, and state the recipient's desired personal outcome(s);**

**7.5.6.2 Directly relate to the diagnosis and reason for referral;**

**7.5.6.3 Are focused, individualized, and based upon the actual recipient's current life functioning;**

**7.5.6.4 Are action oriented, and are worded with a positive focus of what needs to occur, instead of a negative focus of what needs to stop.**

**7.5.7 Action Steps (Objectives) (including multiple short-term action steps to accomplish an identified goal) that:**

**7.5.7.1 Use easily understood language worded with a positive focus that describes what the recipient will do to improve the current "need" area, instead of a negative focus on the actions they need to stop;**

**7.5.7.2 Specifically describe what action is to be taken in detail;**

**7.5.7.3 Are measurable (i.e. action oriented), to verify/index recipient progress. An example of a poor action step is: "I will accept 'no' from authority figures 70% of the time"; because without a consistent way to measure from all authority figures in the recipient's life, the percentage would be impossible to measure. An example of a good action step for youth is: "I am in bed and quiet by 10:00 pm, 5 out of 7 nights per week so I can be more alert during class." An example of good action step for an adult is: "I get a refill on my medication when I have 10 pills left so I don't run out of medication."**





**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<b><u>Control #</u></b>	<b><u>Rev.</u></b>	<b><u>Type</u></b>	<b><u>Title</u></b>	<b><u>Effective Date</u></b>	<b><u>Page</u></b>
<b><u>BHO-006</u></b>	<b><u>23</u></b>		<b><u>Behavioral Health Outpatient (BHO) Case Management</u></b>	<b><u>0709-01-2018</u></b>	<b><u>13 of 22</u></b>

7.5.7.4 Are achievable, meaning that recipient is willing to follow through on the described action step and is capable of achieving it;

7.5.7.5 Are realistic to the circumstances of the recipient; and

7.5.7.6 Are time limited, meaning an estimated time period for meeting each action step is specified.

7.5.8 **Interventions:** When included in the Care Plan, interventions indicate the specific services that will be put in place to meet the goal(s) and address the identified need(s), such as case management (T1016, G9012), targeted case management (T1017), Basic Skills Training (H2014), psychosocial rehabilitation (H2017), CBLA services, etc.; and the anticipated amount (i.e. total anticipated minutes or units of service), scope (i.e. the daily, weekly, or monthly frequency of services), duration (i.e. anticipated end date), and the anticipated provider of each service provisioned. Any specialized services by a contracted provider, such as CBLA services, must be included in the Plan and include the (1) amount and (2) frequency of the service provided. For example:

*Example: CLBA Provider will provide 60 hours per month of supervision, monitoring, and assistance; to include daily tracking, dispensing, and monitoring of medications; meal preparation; money management; maintaining clean and uncluttered living space; and transportation to and from appointments.*

7.5.9 Signatures of:

7.5.9.1 The recipient (or their legal representative). The recipient's (or legal representative's) signature indicates that the recipient (or their legal representative) (1) participated in the development of the plan, (2) consented to the plan, (3) received a copy of the plan, and (4) were informed that they have individual choice in determining service providers.

7.5.9.2 Any outside providers contracted to provided services listed in the plan (such as a CBLA provider or BST provider).

7.5.9.3 The clinician that developed the plan, including their printed name and credentials.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>14 of 22</u>

7.5.9.4 The supervising QMHP that approved the plan (if required, and if different from the clinician that developed the plan), including their printed name and credentials.

7.5.10 For high-risk individuals or individuals with co-occurring disorders, evidence of care coordination by all treatment and/or case management providers involved with the individual's care.

7.5.11 Note: Temporary, but clinically necessary, services do not require an alteration of the Case Management Plan; however, these types of services, and why they are required (i.e. the need, goal, and action step that the service/intervention is addressing), must be identified in a progress note. The note must follow all the requirements for progress notes.

7.6 Progress Notes. The case management services, interventions, and contacts are documented in Avatar. The sample Case Management Progress Note template (attachment C) may be used for this. See BHO-003 for additional requirements for progress notes.

7.6.1 No Commingled Services. Non-case management services must be documented in a separate progress note. For example, documentation of a case management service cannot also include documentation of any other services such as Basic Skills Training (BST) or Psychosocial Rehabilitation (PSR) services, or non-reimbursable services such as transportation services, payee services, etc. within the same progress note.

7.6.2 Inpatient/Incarceration. Case management services provided while a consumer is hospitalized with an inpatient status or is incarcerated are not reimbursable as outpatient case management services. Progress notes for case management services provided under these circumstances must use Avatar service code 955 CM Discharge Planning instead of the case management service code that would usually apply.

Commented [JH13]: Added from Policy 4.047

7.7 Case Management-Discharge Summary. When a consumer is discharged from case management services, a discharge summary is entered into corresponding episode in Avatar. Discharge summaries are completed within one working day of a planned discharge and within 30 calendar days following an unplanned discharge. In the case of a consumer's transfer to another program, a verbal summary must be given at the time of



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<b>BHO-006</b>	<b>23</b>		<b>Behavioral Health Outpatient (BHO) Case Management</b>	<b>0709-01-2018</b>	15 of 22

~~transition and followed with a written summary within seven (7) calendar days of the transfer. This summary documents (1) the date of the last case management contact with the consumer; (2) the reason for discharge from services; (3) a summary statement that describes the effectiveness of the services provided and progress or lack of progress towards the case management care plan goals and objectives; (4) the ICD diagnosis at both admission and termination of services; (5) the consumer's current level of functioning; and (6) recommendations for further services and ways to maintain stabilization. The Discharge Summary template (attachment D) may be used for this. Written documentation of the last case management contact with the individual, a summary statement that describes the effectiveness of the services provided, the reason for discharge, recommendations for ways to maintain stabilization. Discharge summaries are completed within one working day of a planned discharge and within 30 calendar days following an unplanned discharge. In the case of an individual's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven (7) calendar days of the transfer.~~

**8.0 UTILIZATION REVIEW PROCEDURE**

- 8.1** Documentation in the recipient's case file (Avatar) must demonstrate (ongoing) eligibility for case management services, justify the frequency and quantity of case management services rendered, and reflect and chronicle any changes in the recipient's status.
- 8.2** The sample Case Management Records Review Checklist (attachment E) may be used to review documentation of (1) case management eligibility, and (2) services rendered.
- 8.3** Peer Reviews of documentation are conducted by each case manager on a monthly basis of their peers' individual records to assess the quality of documentation of the case management services rendered. Completed Peer Reviews are given to the case management supervisor (or other supervisory staff) for reporting and any needed corrective action.
- 8.4** Supervisory Review conducted by the supervisors of the case management staff should include establishing the recipient's continued eligibility and ongoing need for services, as well as ensuring that the frequency and quantity of the services rendered is congruent with the documented level of functioning of the recipient. Supervisor reviews should be conducted every six (6) months.

**Commented [LV14]:** As Utilization and Peer Reviews are not a specific Medicaid requirement, I would like there to be an opening statement that these activities assure quality service provision and that people continue to meet eligibility criteria for continuing to receive TCM, including assurance, as a state entity that services provided are of high quality and cost efficient – something about why we review

**Commented [JH15]:** That is addressed above by 4.7 Utilization Review.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>16 of 22</u>

8.5 Each agency designates a staff person who oversees these reviews and generates any reports requested. Storage of Supervisory and Peer Reviews, records of any corrective action, and records of clinical or direct supervision of staff regarding the recipient will be at a location outside of the recipient's case file (Avatar) to be determined by each agency.

**7.09.0 ATTACHMENTS**

- A. Sample Case Management Assessment of Needs template
- A.B. Sample Case Management Care Plan template
- B.C. Sample Case Management Progress Note template
- D. Sample Case Management Discharge Summary template
- E. Sample Case Management Records Review Checklist

**8.010.0 REFERENCES**

Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 440.169, Case Management Services (42 CFR 440.169). This federal regulation defines what the purpose of case management services is, defines what the activities comprising case management services are, and defines and allows for targeted case management services to be provided to specific targeted groups specified by the State plan.

Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 441.18, Case Management Services (42 CFR 441.18). This federal regulation explains what the requirements regarding the provisioning of case management services are, what the requirements for the documentation of case management services are, what the requirements for defining target groups are, and provides examples of direct services which are excluded from being reimbursed as case management services.

Nevada Medicaid State Plan, Supplement 1 to Attachment 3.1-A. This document helps implement 42 CFR 440.169, and 42 CFR 441.18. It indicates the frequency of assessments and monitoring, defines the groups in the State of Nevada eligible to receive targeted case management services, and defines the provider qualifications for those targeted groups.

Nevada Medicaid Services Manual (MSM), Chapter 2500, Case Management. This document is a compilation of the regulations adopted by the State of Nevada that, in conjunction with MSM Chapter 100 and the MSM Addendum, implements 42



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<b><u>Control #</u></b>	<b><u>Rev.</u></b>	<b><u>Type</u></b>	<b><u>Title</u></b>	<b><u>Effective Date</u></b>	<b><u>Page</u></b>
<b><u>BHO-006</u></b>	<b><u>23</u></b>		<b><u>Behavioral Health Outpatient (BHO) Case Management</u></b>	<b><u>0709-01-2018</u></b>	<b><u>17 of 22</u></b>

CFR 440.169, and 42 CFR 441.18. It defines what the targeted groups are to which targeted case management services may be provisioned in the State of Nevada, and defines what additional requirements must be met regarding the delivery of case management services.

**Billing Manual for Nevada Medicaid and Nevada Check Up.** This manual provides the general procedures for the reimbursement of medically necessary services by Nevada Medicaid, such as case management, and is used in concert with the MSM.

**Provider Type 54 Billing Guide.** This guide provides specific procedures and requirements for the billing and reimbursement of targeted case management services. It is used in concert with the MSM and the Billing Manual for Nevada Medicaid and Nevada Check Up.

**Nevada Revised Statutes, Title 39 Mental Health, Chapter 433 (NRS 433), 433A, 433B, 433C, and 435.** When consumers in the defined target groups of Serious Mental Illness (SMI), Non-Serious Mental Illness (Non-SMI), Severe Emotional Disturbance (SED), or Non-Serious Emotional Disturbance (Non-SED) receive targeted case management services, these State statutes also become relevant to the delivery of case management services.

**Nevada Administrative Code, Chapter 433 (NAC 433) and 436.** When consumers in the defined target groups of Serious Mental Illness (SMI), Non-Serious Mental Illness (Non-SMI), Severe Emotional Disturbance (SED), or Non-Serious Emotional Disturbance (Non-SED) receive targeted case management services, these State regulations also become relevant to the delivery of case management services.

**Division of Public and Behavioral Health (DPBH), policy BHO-003 Service Delivery Model.** This policy describes how outpatient mental health services, including case management, will be implemented DPBH and its agencies.

**Division of Public and Behavioral Health (DPBH), policy BHO-005 Outpatient Counseling & Rehabilitative Mental health (RMH) Services.** This policy describes the criteria for a Qualified Mental Health Associate (QMHA) and a Qualified Mental Health Professional (QMHP) for DPBH and its agencies.

**Social Security Act (SSA), Chapter 1905(g)(1)**



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>18 of 22</u>

~~Deficit Reduction Act of 2005, Section 6052, Reforms of Case Management and Targeted Case Management  
42 CFR, 440.169, Case management services  
42 CFR, 441.18, Case management services  
Nevada Revised Statutes (NRS) 433, 433A, 433B, 435 and 436  
Nevada Administrative Code (NAC) 433 and 436  
Nevada Medicaid Services Manual (MSM) Chapter 2500 Case Management; and the MSM Addendum  
Nevada Medicaid State Plan, Supplement 1 to Attachment 3.1 A  
DPBH Policies — BHO-003: Service Delivery; — BHO-005: Outpatient Counseling & Rehabilitative Mental Health (RMH) Services~~



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO) Case Management</u>	<u>0709-01-2018</u>	<u>19 of 22</u>

**11.0 IMPLEMENTATION OF POLICY**

EFFECTIVE DATE:

REVIEWED / REVISED DATE:

SUPERSEDES: 3.002 Service Coordination Services, and 4.047 Utilization and Quality Review for Service Coordination for Mental Health Agencies.

APPROVED BY DPBH ADMINISTRATOR:

APPROVED BY DPBH COMMISSION:

With Policy 4.047 apparently mostly finalized, I tried to take another crack at BHO-006 and incorporate some of the comments from 4.047 into it. I have attached an updated revision for your review.

One of the big sticking points was where in Avatar to document certain elements. Throughout the policy, I have removed references that stated a particular element needed to be documented using a particular Avatar module (I hope I caught them all).

Additionally, I have made the following changes:

As various elements got moved around, I also tried to move around the existing comments so that they ended up in a relevant place.

At 1.0, I still prefer the original wording instead of Laura's revision. Something went wrong in my version and some of the original wording apparently got deleted without track changes on. The only way I could fix this was to re-insert the missing text and then delete it. But then I was unable to show my revisions to the original text.

At 4.2, I have added the timeframes allows for initial assessment and reassessment per Nevada Medicaid State Plan, Supplement 1 to Attachment 3.1-A which deals with Case Management.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<b><u>Control #</u></b>	<b><u>Rev.</u></b>	<b><u>Type</u></b>	<b><u>Title</u></b>	<b><u>Effective Date</u></b>	<b><u>Page</u></b>
<b><u>BHO-006</u></b>	<b><u>23</u></b>		<b><u>Behavioral Health Outpatient (BHO) Case Management</u></b>	<b><u>0709-01-2018</u></b>	<b><u>20 of 22</u></b>

At 4.3, I have moved around and clarified the language of timeframes for Care Plans.

At 4.5, I have changed the reference from the MSM Addendum to MSM Chapter 2500.

At 4.6, I have moved the stuff about **Diagnostic Summary** from elsewhere to here, and re-labeled it as **Eligibility Summary** because I think that more accurately reflects what it's TCM function is, and why I think it should be included.

At 4.6.3, I have re-labeled the SMI/SED determination section to **Target Group Determination** because I think that more accurately reflects what it's TCM function is.

At 5.3.2, I added the No Contact provision from policy 4.047.

At 6.1, the Chapter 100 medical necessity requirements were moved to here.

At 6.2, I added language from the Billing guide about PARs.

As a result of moving other parts into section 4.6, section 7.1 thru 7.5 have been revamped (and somewhat simplified).

At 7.5.1, I have proposed a way to comply with NRS 434.494(2).





**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

<u>Control #</u>	<u>Rev.</u>	<u>Type</u>	<u>Title</u>	<u>Effective Date</u>	<u>Page</u>
<u>BHO-006</u>	<u>23</u>		<u>Behavioral Health Outpatient (BHO)</u>	<u>0709-01-2018</u>	<u>21 of</u>
			<u>Case Management</u>		<u>22</u>

At 7.6, I have simplified this section because much of the detail is already covered in BHO-003.

At 7.6.1 and 7.6.2, I have inserted content from policy 4.047.

At 7.7, I have reworded the section. The only relevant requirements for a discharge plan I could find were from Chapter 400. I have included them here because Kathryn Baughman insisted that BHO-006 contain this provision even though it is not part of Chapter 2500. Regardless, it makes sense to plan for discharge from TCM services upon admission to services.

At 9.0, I have added "Sample" to the attachments, to indicate that they are optional.

At 10.0 I have revamped and annotated the references to demonstrate how/why they are relevant to the policy.

At 11.0, I have added the Implementation of Policy section that has since become standard for all Division policies.

I have also attached a draft Care Plan template for attachment B for your consideration. The intent of that template is:

1. To be an OPTIONAL tool to help gather the information needed to transcribe into an Avatar Care Plan.
2. To address the Chapter 2500 required elements.
3. To be as intuitive and simple as possible without being over-engineered (I tend to over-engineer things).



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**BEHAVIORAL HEALTH POLICY**

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<b><u>Control #</u></b>	<b><u>Rev.</u></b>	<b><u>Type</u></b>	<b><u>Title</u></b>	<b><u>Effective Date</u></b>	<b><u>Page</u></b>
<b><u>BHO-006</u></b>	<b><u>23</u></b>		<b><u>Behavioral Health Outpatient (BHO) Case Management</u></b>	<b><u>0709-01-2018</u></b>	<b><u>22 of 22</u></b>

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

Control #	Rev.	Title	Effective Date:
CRR .014	9/2017	<b>Risk Management and Reporting Serious Incidents</b>	<b>9/2017</b>  <b>Next Review Date:</b> <b>9/2019</b>

**1.0 POLICY**

It is the policy of the Division of Public and Behavioral Health (DPBH) that serious incidents be reported to the Agency Director and Division Administrator or Designee and responded to appropriately, utilizing risk management techniques.

**2.0 PURPOSE**

In the interest of ensuring the safety and rights of the people receiving services, DPBH agencies have established a system for reporting incidents that may represent high risk situations. The purpose of this reporting is to ensure that appropriate safeguards are implemented, and all reportable serious incidents are handled and addressed appropriately.

**3.0 SCOPE** DPBH Clinical Services Branch

**4.0 REFERENCES**

4.13.1 DPBH Policy A 5.2 Review of Clients Death for Mental Health Agencies. Refer to this policy for reporting and follow-up procedures

~~4.13.2~~ DPBH Policy ~~CRR 1.13-4.054~~ Sentinel Events. Refer to this policy for reporting, follow-up procedures ~~and additional reportable sentinel event.~~

~~4.13.24.13.3~~ DPBH Policy A 51. Division Level II Incident Reports

~~4.13.34.13.4~~ Nevada Revised Statue (NRS) 618.378.

~~4.13.44.13.5~~ NRS 439.835

**5.0 DEFINITIONS:**

~~4.1-5.1~~ Patient Safety Officer (PSO) as used in this policy references NRS. 439.815 means a person who is designated pursuant to NRS 439.870.

5.2 Incident means an action, practice or situation that appears to be inconsistent with a

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

federal or state statute, rule or regulation of the Division or the Centers for Medicare and Medicaid Services or conditions and standards of or requirement for participation in Medicare or Medicaid. NRS 449.0046b Agency Level I Incident

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5.2.1 Agency Level I incident is an incident that represents risk at the agency level. These incidents are reported to the Agency Administrator to ensure that appropriate safeguards are implement within the agency/facility.

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5.2.2- Division Level II Incident is a serious incident that may represent a high risk to the safety of consumers or staff or liability to the State. Any client death and/or incident that meets the criteria of Sentinel event as defined by The Joint commission are Level II incidents. Such incidents are reported to the Administrator of the Division to ensure that appropriate safeguards are implemented, and all level II incidents are evaluated and addressed by the Division Incident Report Committee.

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**6.0 PROCEDURE**

6.1 A serious incident is an event that may represent a high risk to the safety of consumers or staff or liability to the State. Such incidents are reported to the Administrator the Division to ensure that appropriate safeguards are implemented and all serious incidents, whether at the Agency or Division level, are evaluated and addressed appropriately.

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6.2 A serious incident report (SIR) does not substitute for the normal documentation of events in a person's (both consumer and employee) service records.

6.2.1 Documentation of the details of the incident must be included in the progress notes. Progress notes must not include reference to the submission of a Serious Incident Report.

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6.2.2 All

documentation in the record must also be completed to include all follow-up

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activities identified and implemented.

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6.3 Level I Agency Incident Reports may be entered into the AVATAR Incident Tracking module from a written worksheet by staff at the Agency Manager's discretion.

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6.4 6.4 Level II Division Incident reports must be entered into Avatar by a QAS, a clinical staff person or a QAPI staff member. AAs do not enter Level II Incidents even

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

—with an SIR worksheet.

6.5 In addition to the SIR process, other reporting may be necessary depending on the type of incident. For example, abuse or neglect may require reports to protective services or law enforcement.

~~6.3~~ 6.3.1 The SIR does not substitute for required reports to law enforcement, protective services, Human Resources, Fleet Services or Risk management etc.

~~6.46.6~~ The Deputy Attorney General will be notified of Level II Division Level Serious Incident Reports by Division Central Office.

~~6.56.7~~ In the event of a serious incident involving one or more Division consumers or staff, an agency of the Division or one of its contract service providers will follow the reporting procedure set forth below.

~~6.66.8~~ Process for reporting Serious Incident events will be by using the AVATAR Incident Tracking Module (AITM).

~~6.6.16.8.1~~ 6.6.16.8.1 All Serious Incident events will be reported by using AITM to include the designated reporting category. A detailed description of the event, including the names of witnesses, will be entered into AITM no later than the end of the first working day after the incident occurs.

~~6.6.26.8.2~~ 6.6.26.8.2 All follow-up notations, addendums and requests for closure will be completed in AITM.

~~6.6.36.8.3~~ 6.6.36.8.3 Any plan of correction, written statements, photographs or other documents related to the incident that cannot be documented in the follow-up notes will be scanned and submitted electronically to SIR Investigations email account.

6.8.4 All Serious Incident Events that are non-patient related (involving employees and/or non-patient person(s) (i.e. visitors, vendors)) will be addressed by following proper risk management protocol and reported to direct supervisors or onsite program managers as soon as possible

~~6.76.9~~ All DPBH Community Providers (SLAs, group homes, etc.) will be required to report incidents within one (1) hour of their discovery to their state contracting agency.

~~6.86.10~~ DPBH agencies will ensure that agency protocol and employee training for reporting SIRs are aligned.

~~6.96.11~~ DPBH agencies will train all staff on the reporting and completion of SIR protocols.

~~6.106.12~~ SAPTA's community treatment providers will be made aware of the policy for reporting serious incidents. SAPTA will be responsible for ensuring reporting and data collection compliance by their community providers.

~~6.116.13~~ Follow up reports of serious incidents are due within ten (10) days of the initial report using AITM

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

~~6.12~~6.14 Incidents are categorized as either Agency or Division. The determination regarding an incident is made by the Agency Director or their designee using the criteria provided in Attachment A.

~~6.13~~6.15 Attachment

~~6.13.16~~6.15.1 all work-related fatalities, and all work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours, per “Employer Responsibilities” [Occupational Safety and Health Administration](#). United States Department of Labor

~~6.14~~6.16 In the event of a non-patient, non-fatal employee injury or accident employees and supervisor (or his/her designee in the event of an absence) are to follow protocols set forth by the Department of Administration Risk Management. Supervisors will also contact and work with human resource management representative A “Risk Management Criteria for Determination of Incident Level” outlines criteria for establishing whether an event rises to a Level I (Agency incident) or Level II (Division Incident).

~~6.15~~6.17 Procedures regarding types of incidents:

~~6.15.16~~6.17.1 Death of a person receiving services in a 24-hour care setting (i.e., hospitals), deaths within seven (7) days of seclusion or restraints, and death within 72 hours of discharge is considered a Sentinel Event and handled in accordance with ~~CRR 1.13~~ ~~policy # 4.054~~ Sentinel Events. Refer to this policy for reporting, follow-up procedures and additional reportable sentinel events. Refer to policy #A 5.2 Review of Client Death for Mental Health Agencies.

~~6.15.26~~6.17.2 Death of a person currently open to community-based services or discharged within the last 30 days will be reported to Division Administration as an SIR.

~~6.15.36~~6.17.3 Reports of deaths also require the completion of additional questions regarding a death. Follow-up information is due within 30 days of the initial SIR report. Refer to policy #A 5.2 Review of Clients Death for Mental Health Agencies.

~~6.15.46~~6.17.4 In the event of an employee death or any accident or motor vehicle crash occurring during employment which is fatal to one or more employees or which results in the hospitalization of three or more employees must be reported by the employer orally to the nearest office Division within eight (8) hours after the time that the accident or crash is reported to any agent or employee of the employer, per Nevada Revised Statutes (NRS) 618.378. The appropriate Agency Director or their designee will notify OSHA within eight (8) hours of.



## DIVISION OF PUBLIC AND BEHAVIORAL HEALTH CLINICAL SERVICES

~~6.15.5~~6.17.5 In the event of an automobile accident involving a state car employee(s) and supervisor (or his/her designee in in event of an absence) are to follow protocols set-fourth by the Department of Administration Fleet Services Division.

~~6.15.6~~6.17.6 Agency Directors or designees will verbally notify the Division Administrator or Designee within thirty (30) minutes of becoming aware of any serious incident that may be considered high profile or of media interest. Outside of regular work hours (8AM-5PM), the Agency Director or designee will call the Division Administrator or Designee at home or on their cell phone.

~~6.15.7~~6.17.7 The Division Administrator or Designee will notify the Director of DHHS of a serious incident that may be considered high profile or of media interest. Outside of regular work hours, the Division Administrator or Designee will attempt to contact the Director or Deputy Director of DHHS. If the Director or Deputy Director of DHHS is unavailable, the assistant to the Governor will be contacted.

~~6.15.8~~6.17.8 In the event of theft of State property, law enforcement must be notified immediately. If confidential information, such as a consumer's name, is disclosed to law enforcement agencies, a formal denial of rights must be filed at the time such notification occurs. The DPBH HIPAA and Agency HIPAA Privacy officers must be notified.

~~6.16.18~~ Timeframes for Notification to Division of Level II Required

### Documentation

~~6.16.1~~6.18.1 Verbal Notification - Deaths (including suicide and homicide) occurring in a Division facility or Division-contracted 24-hour care setting must be verbally reported within one (1) hour to the Division Administrator, State Medical Director and the Division's Deputy Administrator of Clinical Services

~~6.16.2~~6.18.2 Avatar Inputting – Any patient serious incidents will be entered in Avatar within one (1) working day of the discovery of the serious incident.

~~6.16.3~~6.18.3 If the incident has been determined to meet the Sentinel Event Criteria as defined by NRS 439.835 and 439.805 staff shall follow mandatory reporting requirements of sentinel events as defined by NRS 439.835.

~~6.16.4~~6.18.4 An event is also considered sentinel if it is one of the following:

- 6.16.4.1 Suicide of any patient receiving care, treatment, services in an around-the-clock care setting or within 72 hours of discharge.
- 6.16.4.2 Abduction of any patient receiving care, treatment, and services



## DIVISION OF PUBLIC AND BEHAVIORAL HEALTH CLINICAL SERVICES

- 6.16.4.3 Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting, leading to death, permanent harm, or severe temporary harm to the patient.
  - 6.16.4.4 Rape or sexual assault (leading to the death, permanent harm, or severe temporary harm).
    - 6.16.4.4.1 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 on the premises of the hospital which includes oral, vaginal, anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ or object.
    - 6.16.4.4.2 One or more of the following must be met: Any staff witnessed sexual contact as described above, admission by the perpetrator that sexual contact, as described above occurred on the premises or sufficient clinical evidence obtained by the hospital to support allegations of sexual contact.
    - 6.16.4.4.3 Homicide of any patient receiving care, treatment, and services while on site at the hospital.
    - 6.16.4.4.4 Rape, assault of any patient (leading to death, permanent harm, or severe temporary harm).
  - 6.16.4.5 Homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital.
- 6.17 Data Collection
- 6.17.1 In addition to responding to serious incidents at their agency or Division level to assure they are responded to appropriately, serious incidents also provide a performance improvement opportunity for DPBH agencies with their overall services to their consumers.
  - 6.17.2 Data on incidents, both at the agency (Level I) and Division (level II) shall be collected, and analyzed for trends to determine opportunities for continuous performance improvement activities at each agency.
- ~~6.17.6.19~~ Each Agency of the Division may develop and implement their own written protocol, to implement the provision of this policy.

### 7.0 ATTACHMENTS:

- 7.1 [CRR .014 Risk Management and Reporting Serious Incidents Attachment A](#)





**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

EFFECTIVE DATE: 09/2017

DATE APPROVED BY DPBH ADMINISTRATOR: 9/2017

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH: 9/2017





**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

<b>Control #</b> CRR: 014	<b>Rev.</b> 1	<b>Title</b> Risk Management and Reporting Serious Incidents Attachment A	<b>Effective Date:</b> 09/2017 <b>Revision Date:</b> 09/2019	<b>Page</b> 1 of 6
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Incident	Definition	Level I (Agency)	Level II (Division)	Reporting method	Data Collection Points
<b>Consumer Death</b>	<p>Death of a Person Receiving Services in a 24-hour care setting</p> <p>Death of a person receiving services from a community based care program</p> <p>Death of a person closed from community based care within 30 days.</p>		<ul style="list-style-type: none"> <li>✓Suicide</li> <li>✓Homicide</li> <li>✓Accident with injury</li> <li>✓Death in a 24-hour care setting</li> <li>✓Death within 72 hours of discharge from 24-hour care setting</li> <li>✓Death occurring within seven days of seclusion or restraint</li> </ul>	<ul style="list-style-type: none"> <li>✓AVATAR Incident Tracking Module (AITM).</li> </ul>	<ul style="list-style-type: none"> <li>✓Deaths that qualify as a sentinel event.</li> </ul>

<p><b>Abuse/ Neglect</b></p>	<p><u>Abuse:</u> Willful infliction of pain or injury upon a person receiving services by anyone else – includes physical, sexual, mental, verbal abuse and exploitation</p> <p><u>Neglect:</u> Any omission to act that causes injury to a consumer or that places a consumer at risk of injury, including, but not limited to the failure to follow:</p> <p>1) an appropriate plan of treatment to which the consumer has consented,</p> <p>2) the policies of the facility for the care and treatment of consumer and</p> <p>3) standards of practice by professionals engaged in healthcare</p>	<p>✓ Allegation of abuse or neglect of a client by DPBH staff, or contract staff.</p>	<p>✓ An allegation of abuse, neglect or exploitation against DPBH staff or contract staff, <i>with substantiated evidence.</i></p> <p>✓ The incident poses a significant danger to the community</p>	<p>✓ AVATAR Incident Tracking Module (AITM).</p>	<p>✓ Abuse/Neglect/Exploitation by Levels I and II</p> <p>✓ Abuse allegations</p> <p>✓ Outcomes of inquiries resulting from allegations</p> <p>✓ Neglect allegations</p> <p>✓ Outcomes of inquiries resulting from allegations</p> <p><i>Abuse/neglect allegations that require reporting to authorities (e.g., CPS, EPS) must be documented in the consumer's medical record</i></p>
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Incident	Definition	Level I (Agency)	Level II (Division)	Reporting method	Data Collection Points
<b>Consumer Injury</b>	Injury due to: Accident Aggressive Behavior Self-Harm Trip or Fall Medication Error Restraint Auto Accident in State car or on state business Other Unknown Cause	<ul style="list-style-type: none"> <li>✓ Any injury that requires First Aid only</li> <li>✓ An accident that occurred on the ground of an DPBH facility</li> <li>✓ Defective equipment</li> <li>✓ An injury that resulted from DPBH staff error or negligence</li> </ul>	<ul style="list-style-type: none"> <li>✓ An injury as a result of DPBH staff or contract staff negligence that results in permanent physical or psychological impairment (or severe exacerbation of an existing psychological impairment).</li> <li>✓ Any injury resulting from the use of restraint</li> </ul>	AVATAR Incident Tracking Module (AITM).	Consumer Illness/Injury by: <ul style="list-style-type: none"> <li>✓ Levels I and II</li> <li>✓ Accident</li> <li>✓ Aggressive behavior</li> <li>✓ Self-Harm</li> <li>✓ Trip or Fall</li> <li>✓ Defective Equipment</li> <li>✓ Medication Errors</li> <li>✓ Injury or illness resulting from staff negligence</li> </ul>
<b>Consumer Behavior</b>	Suicidal Behavior (includes suicide attempts or completed suicides)	<ul style="list-style-type: none"> <li>✓ Suicidal threats and/or ideations with a plan and/or intent</li> </ul>	<ul style="list-style-type: none"> <li>✓ Suicidal behavior that results in permanent physical or psychological impairment.</li> <li>✓ Completed suicide</li> </ul>	<ul style="list-style-type: none"> <li>✓ AVATAR Incident Tracking Module (AITM).</li> </ul>	<ul style="list-style-type: none"> <li>✓ Suicides</li> </ul>

Incident	Definition	Level I (Agency)	Level II (Division)	Reporting method	Data Collection Points
<b>Consumer Behavior</b>	<p>Sexual Behavior exhibited by the Consumer in the 24 hour care setting</p> <p>Alleged Sexual abuse or assault</p>	<p>✓ Sexual behavior that is not a threat to others and does not involve a report to law enforcement or to an oversight agency in a DPBH facility (inpatient only)</p> <p>Examples: consensual sex, masturbation, rape allegation without supporting evidence.</p> <p>Sexual behavior that involves the threat to the safety of others or involves a report to law enforcement or to an oversight agency. Example – unwanted sexual advances/harassment</p>	<p>Rape or sexual assault, sexual coercion in a DPBH facility.</p>	<p>✓ AVATAR Incident Tracking Module (AITM).</p>	<p>✓ Incidents of rape, consensual sex, masturbation, unwanted sexual advances, sexual assault and coercion.</p>

<p><b>Consumer Behavior</b></p>	<p>Acts or Threats of Violence made by or to a consumer, or other illegal behavior</p>	<ul style="list-style-type: none"> <li>✓ Aggressive or destructive act that does not involve a report to law enforcement or an oversight agency (not resulting in injury)</li> <li>✓ Targeting other consumers or employees</li> </ul> <p>Examples – pushing or hitting, throwing furniture</p>	<ul style="list-style-type: none"> <li>✓ An aggressive or destructive act or illegal behavior that involves a report to law enforcement or a complaint to an oversight agency (results in injury)</li> <li>✓ A consumer act that results in death, permanent physical or psychological impairment</li> <li>✓ Any injury (consumer or staff) resulting from assault by peer that requires hospitalization and/or medical attention beyond standard first aid</li> <li>✓ Incident poses a significant danger to the community</li> </ul> <p>Example – destroying property (\$500.00 or more), shooting someone, stealing drugs</p>	<p>✓ AVATAR Incident Tracking Module (AITM).</p>	<ul style="list-style-type: none"> <li>✓ Assaults against consumers</li> <li>✓ Assaults against employees</li> <li>✓ Destroying property</li> <li>✓ Weapons use</li> </ul>
<p><b>Incident</b></p>	<p><b>Definition</b></p>	<p><b>Level I (Agency)</b></p>	<p><b>Level II (Division)</b></p>	<p><b>Reporting method</b></p>	<p><b>Data Collection Points</b></p>
<p><b>Consumer Behavior</b></p>	<p>Consumer Absence or Elopement from a 24 hour care setting</p>	<ul style="list-style-type: none"> <li>✓ An absence from a provider group home less than 24 hours where law enforcement is not required</li> </ul>	<ul style="list-style-type: none"> <li>✓ An absence from a provider group home greater than 24 hours, or an absence that requires contact with law enforcement to file a <del>missing person</del> <b>missing person</b></li> <li>✓ An absence or elopement from a <b>24</b></li> </ul>	<p>✓ AVATAR Incident Tracking Module (AITM).</p>	<ul style="list-style-type: none"> <li>✓ Consumer absence or elopement from an inpatient facility</li> <li>✓ Consumers missing from residential setting and reported as missing person</li> </ul>

			<del>hour</del> 24-hour inpatient facility		
<b>Employee Incidents</b>	Auto accident in state car or on State business in personal car.	<ul style="list-style-type: none"> <li>✓ Auto accident that does not result in injury</li> <li>✓ Automobile accidents that results in injury requiring the employee to seek/received outpatient medical care.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Automobile accident that results in injury requiring the employee to seek/receive inpatient hospital medical care</li> </ul> <p>Note: An auto accident resulting in an employee and/or consumer injury or death, will be reported as injury or death.</p>	<ul style="list-style-type: none"> <li>✓ State Car – Fleet Services</li> <li>✓ Personal car-Risk Management</li> </ul>	<ul style="list-style-type: none"> <li>✓ Auto accidents resulting in injury</li> <li>✓ Auto accidents that do not result in an injury</li> </ul>
<b>Employee Incidents</b>	Internet and/or email misuse	<ul style="list-style-type: none"> <li>✓ Internet and email use not involving pornography</li> </ul>	<ul style="list-style-type: none"> <li>✓ Internet use involving pornography</li> <li>✓ Internet use involving illegal activity</li> </ul>	<ul style="list-style-type: none"> <li>✓ Administration and Human Resources</li> </ul>	<ul style="list-style-type: none"> <li>✓ Internet use not involving pornography</li> <li>✓ Internet use involving pornography</li> </ul>
<b>Employee Incident</b>	Confidentiality Breach	<ul style="list-style-type: none"> <li>✓ Any breach of a consumer's confidentiality</li> </ul>	<ul style="list-style-type: none"> <li>✓ A serious breach of <del>confidentiality reportable</del><u>confidentiality reportable</u> to the Office of Civil Rights (OCR)</li> </ul>	<ul style="list-style-type: none"> <li>✓ HIPPIA officers and Administration</li> </ul>	<ul style="list-style-type: none"> <li>✓ Breach of consumer responsibility</li> <li>✓ Co confidentiality that is reported to OCR.</li> </ul>
<b>Property Damage</b>	Property Damage	<ul style="list-style-type: none"> <li>✓ Minimal property damage– under <del>\$1000500</del></li> <li>✓ <del>Including human resource cost for repairs.</del></li> </ul>	<ul style="list-style-type: none"> <li>✓ Major Property Damage- <del>\$1000500</del> or more. <del>Including human resource cost for repairs.</del></li> </ul>	<ul style="list-style-type: none"> <li>✓ Administration</li> </ul>	<ul style="list-style-type: none"> <li>✓ Property damage under <del>\$1000500</del></li> <li>✓ Property damage <del>\$1000500</del> or more</li> </ul>

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**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

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<b>Control #</b>	<b>Rev. Date:</b>	<b>Title:</b>	<b>Effective Date: 04/2002</b>
<b>4.049</b>	<b>07/2007</b>	<b>Continuum of Care – Inpatient to Community Service Program – Mental Health</b>	<b>Next Review Date:</b>

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**1.0 POLICY:**

It shall be the policy of the Division of Public and Behavioral Health to provide continuity of care to all consumers in the mental health system.

**2.0 PURPOSE:**

The purpose of this policy is to provide guidelines for accessing mental health outpatient services for all consumers discharged from hospital/residential/forensic programs and Psychiatric Observation Units.

**3.0 SCOPE:** Clinical Services Branch

**4.0 DEFINITIONS:**

- 4.1 **LOCUS - Level of Care Utilization System;** The Level of Care Utilization System or LOCUS tool has been designed by the American Association of Community Psychiatrists (2009) to allow staff who work on inpatient hospital environments with patients with psychiatric problems (such as emergency departments, psychiatric sections of general hospitals or in psychiatric hospitals) to determine the level of care that an individual should receive.

**5.0 REFERENCES:**

- 5.1 American Association of Community Psychiatrists. (2009) LOCUS Level of Care Utilization System for Psychiatric and Addictions Services, Adult Version 2010. Retrieved on January 18, 2017 <http://cchealth.org/mentalhealth/pdf/LOCUS.pdf>
- 5.2 DPBH Policies and Procedures; DPBH Failure to Show Policy
- 5.3 SNAMHS Policies and Procedures
- 5.4 NRS 433

**6.0 PROCEDURE:**

Consumers receiving inpatient/institutional services will be assessed for referral to Division community services by the institutional treatment team. Consumers with Medicaid may be referred to available Medicaid programs.

- 6.1 The institutional treatment team and the consumer will complete a discharge LOCUS and review available options for follow-up outpatient services at the appropriate LOCUS specified Level of Service.
- 6.1.1 Staff and consumer will complete a release of information form that includes discharge summary, doctor's orders, and other relevant personal health information which is to be shared with the receiving program.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES**

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<b>Control #</b>	<b>Rev. Date:</b>	<b>Title:</b>	<b>Effective Date: 04/2002</b>
<b>4.049</b>	<b>07/2007</b>	<b>Continuum of Care – Inpatient to Community Service Program – Mental Health</b>	<b>Next Review Date:</b>

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- 6.2 When referring patients to services within the Division, the following procedures will apply:
- 6.2.1 A LOCUS will be completed prior to a forensic client being referred to a civil facility.
  - 6.2.1 A representative from the referring treatment team shall call the Division receiving site to obtain appropriate appointments for the consumer, or have the consumer's name placed on the waiting list;
  - 6.2.2 Should referring staff be unable to contact the site, the information shall be mailed to the appropriate agency. The consumer will be given contact information and instruction to contact the site office as soon as possible after discharge.
  - 6.2.3 The receiving site staff member shall note, on the information received from the referring agency, when the material is received and the clinician assigned to the case.
  - 6.2.4 The receiving site staff shall forward the information to the appropriate clinician.
  - 6.2.5 The information received from the referring agency will be included in the receiving agency's records.

6.3

- 6.3 To the extent possible, when referring patients to non-DPBH programs, staff will call the program to establish appointment times and/or assist the consumer in establishing contact with a staff at that program.

**7.0 ATTACHMENTS: N/A**

**8.0 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: 04/19/02

Revised/Review Date: 12/03/02; 05/15/03; 07/03/07

Approved by Commission: 04/19/02, 07/03/07