Control #	Rev. Date:	Title:	Effective Date: 10/16
A 5.2	10/186	REVIEW OF CLIENT DEATH FOR ADULT MENTAL HEALTH AGENCIES	Next Review Date: 10/2018

1.0 POLICY:

It is the policy of the Division to review certain cases in which people receiving services expire. Clients who expire while receiving services in hospital inpatient units will be reviewed according to ~~Division Policy #4.054~~DPBH CRR 1.3 Sentinel Events.

2.0 PURPOSE:

The purpose of this review is to assess the care provided and make recommendations for improvements to care systems thereby reducing risk for others receiving services. Recommendations stemming from these reviews will be used to promote quality care at all agencies.

3.0 SCOPE: Clinical Services Branch

~~Performance Improvement: Review of Client Death for Adult Mental Health Agencies~~

4.0 DEFINITIONS: N/A

5.0 REFERENCES:

5.1 DPBH Policy CRR .014 Risk Management and Reporting Serious Incidents
5.2 DPBH CRR 1.14 Root Cause Analysis and attachments
5.3 DPBH CRR 1.13 Sentinel Events

~~5.0~~ 6.0 PROCEDURE~~RE:~~

~~5.1~~ ~~Applicability of Root Cause Analysis Procedures:~~

~~5.1.1~~ 6.1 In order to most efficiently use the resources of the State of Nevada, review activities are adjusted according to the circumstances of the death and the extent of services the person was receiving.

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5.1.25.1.1 Any deathincident in which thewhile the person who died was currently receiving round the clock services from a Division Adult Mental Health agency or a suicide within 72 hours of discharge from such a setting is subject to Policy Policy 1.13 #4.054 Sentinel Events.

5.1.2 Outpatient clients who commit suicide or die in circumstances that are unclear will be analyzed using a root cause analysis type process.

5.1.3 Outpatient clients who commit suicide in a state facility or on state property will be reported to the Sentinel Event Registry.

5.1.4 Outpatients who die accidentally, by natural causes, from disease process orprocess or accidents unrelated to their mental illness will be reviewed by a designated staff person and referred to the more extensive root cause process only if deemed necessary by the Agency Director, State Psychiatric Medical DirectorMedical Director, or Division Administration.

5.2 Immediate action upon receipt of notification of death:

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5.2.15.1.5 Immediately, and in no event later that one (1) hour after receipt of notification of a death, the Agency Director or designee will secure and/or direct to be secured the client's complete, original clinical records to the custody of the Director of Health Information Services or applicable staff designated by the agency Director.

5.2.25.1.6 A Serious Incident Report (SIR) will be completed, per Division Policy CRR .014 #4.003 Reporting of Serious Incidents. The following information will be included in the SIR:

5.2.2.15.1.6.1 What is the reported time, date and reported/apparent cause of death?

5.2.2.25.1.6.2 Note if the coroner was contacted, if the information is available.

5.2.2.35.1.6.3 Where was the client found, if the information is avialableavailable?

5.2.2.45.1.6.4 Who found the client, if the information is avialableavailable?

5.2.2.55.1.6.5 Was there a history of suicide or assaultive symptoms? Give analysis of care specific to suicide or assaultive symptomatology for the last six months.

5.2.2.65.1.6.6 If the client missed appointments during the past six months, was appropriate follow-up done?

5.2.2.75.1.6.7 Give a summary of the client's contact with the Agency with special emphasis to services provided within the last six months, ifmonths if the information is avialableavailable.

5.2.2.85.1.6.8 Were any medical conditions present? If so, describe contacts with the medical provider during the last six months of care relative to the condition.

5.2.2.95.1.6.9 Describe interaction between Division programs and all non-Division community based programs for the past six months.

5.2.2.105.1.6.10 Was grief counseling offered to the family? If not, give reasons.

5.2.35.1.7 The Agency Director, the AgencyStatewide Quality Assurance Performance Improvement Manager or the Agency Medical Director or theiror their designees may refermay refer the case for root cause analysis.

5.2.4 Upon notification of death, the the Agency Director of Health Information Services or appropriateor appropriate staff will request a copy of the death certificate, Coroner's report, and toxicology report. Upon receipt these reports will become a part of the permanent medical record

5.2.55.1.8 The Agency Director may request that an agency debriefing team hold a debriefing meeting with the treating clinical staff team. The purpose of this meeting is to provide emotional support to staff, not to investigate the death. The coordinator of the debriefing will report to the Agency

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Director the time and date of the debriefing and the number of people participating.

~~5.2.6 Root Cause Analysis (RCA) Team – Structure:~~

~~5.2.6.1 The Root Cause Analysis Team is flexible based on the expertise required by the circumstances of each case. This also allows the agency to develop depth in the skills required to conduct such analysis.~~

~~5.2.7 Agency Medical Directors shall appoint a facilitator to the Root Cause Analysis Team. The facilitator must be someone who has received training on the root cause analysis process. The facilitator's responsibilities include but are not limited to the following:~~

~~5.2.7.1 Facilitate the root cause analysis process.~~

~~5.2.7.2 Ensure the collection of all necessary materials (i.e., medical records, police reports, policies, equipment).~~

~~5.2.7.3 Provide involved staff with information on the root cause analysis process and generally prepare team for the process.~~

~~5.2.7.4 Ensure that a report on each review is sent to the Agency Director and Medical Director.~~

~~5.2.8 The Director of Health Information Services or appropriate staff of the Division agency, from which the client was receiving services, will serve as technical consultant in reviewing the clinical record for completion and adherence to agency standards regarding records.~~

~~5.2.9 The Director of Performance Improvement for each Division agency (or their designee), from which the client was receiving services, shall be a consultant to the team for specific policy, procedure, external standards and PI monitoring features.~~

~~5.2.10 A Pharmacist will be appointed by the Agency Director to consult with the Root Cause AnalysisTeam. Agencies that do not have a staff pharmacist may request assistance from an agency that does by making such a request to the Statewide Pharmacy Director.~~

~~5.2.11 The remainder of the committee will consist of at least three members of the staff representative of the positions involved in the treatment of the client including a physician.~~

~~5.3 Root Cause Analysis Team – Procedure:~~

~~5.3.1 All deaths on open clients ruled suicides are to be referred for Root Cause Analysis. Deaths due to other circumstances may be referred to the committee at the discretion of the the Agency Director, the Statewide Quality Assurance and Performance Improvement Manager and the Agency or Statewide Medical Director.~~

~~5.3.2 The team is to be convened as soon as practicable after the death but in no case later than six weeks after the death.~~

~~5.3.3 The review will be conducted as a root cause analysis. The purpose of the review is to establish any system improvements that will reduce risk of future similar outcomes. The review should include the following steps:~~

~~5.3.3.1 Event investigation;~~

~~5.3.3.2 Event reconstruction and analysis;~~

~~5.3.3.3 Review of the chart review;~~

~~5.3.3.4 Recommendations stemming from chart review;~~

~~5.3.3.5 Identification of root causes and contributing factors;~~

~~5.3.3.6 Development of action plan; and~~

~~5.3.3.7~~5.1.8.1 ~~Report of findings~~.

~~5.4 Root Cause Analysis Team – Report:~~

~~5.4.1 The report is to be sent to the Agency Director and the Agency and Statewide Medical Director. The report must include the following:~~

~~5.4.1.1 Factual narrative of the event;~~

~~5.4.1.2 Description of the investigation and analysis process;~~

~~5.4.1.3 Factors contributing to the event;~~

~~5.4.1.4 Findings; and~~
~~5.4.1.5 Recommended action plan~~

~~5.4.2 The report should de-identify individuals using only coded labels (i.e. nurse1, tech2, CSW1 etc.)~~

~~5.4.3 The report is to be delivered to the Agency Director and the Statewide Medical Director no more than thee (3) days after the Root Cause Analysis is completed.~~

~~5.5 Root Cause AnalysisTeam – Follow Up and Closure:~~

~~5.5.1 The Agency Director is responsible for ensuring the initiation and tracking of the action plan.~~

~~5.5.2 The Agency Director is responsible for submitting a follow-up SIR within one week of receiving the report to the Statewide Medical Director and the Division Administrator.~~

~~5.5.3 The Statewide Medical Director will review the report and comment within two weeks and shall forward any additional recommendations to the Agency Director, Division Administrator or designee and appropriate DAG.~~

~~5.5.4 If The Statewide Medical Director makes additional recommendations, the Agency Director will respond within two weeks of the Statewide Medical Director's request.~~

~~5.5.5 Upon implementation of all action plans, the Agency Director may submit a request to Division Administrator for review and closure.~~

~~5.5.6 The Root Cause Analysis process shall not exceed 25 days, with the exception of cases involving unusual and extenuating circumstances that warrant additional time.~~

~~5.5.7 The Deputy Administrator will recommend closure of the incidents.~~

~~5.5.8 Agency Director will ensure that all action plans are completed and the results of such plans are reported to Agency and Division Leadership and the Executive Committee of the Medical Staff, when applicable.~~

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5.65.2 All incidents of client suicides and unusual client deaths that meet the requirements of a Sentinel ~~will~~Event will be referred by the Division Deputy Administrator to the Commission on Behavioral Health~~for Mental Health~~ for review.

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5.75.3 The review, report and action provided pursuant to this policy is a performance improvement function of the Division agencies, undertaken to help assure appropriate quality services to Division clients. As such, the performance improvement privilege attached to the actions of the committee, Clinical Supervisors, Agency Directors, and Division Administrators, all documents, notes, conversations or discussions by the committee reviewed or made in the course of its exercise of its function are privileged and not subject to disclosure.

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~~5.8 Each Division agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency's policy manual.~~

~~5.9 Root Cause Analysis Team – Follow Up and Closure:~~

~~5.9.1 The Agency Director is responsible for ensuring the initiation and tracking of the action plan.~~

~~5.9.2 The Statewide Medical Director will review the report and comment within two weeks and shall forward any additional recommendations to the agency Director, Division Administrator or designee and appropriate DAG.~~

~~5.9.3 If the Statewide Medical Director makes additional recommendations, the Agency Director will respond within two weeks of the Statewide Medical Director's request.~~

~~5.9.4 Upon implementation of all action plans, the Agency Director may submit a request to Division Deputy Administrator for review and closure.~~

~~5.9.5 The Root Cause Analysis process shall not exceed 45 days, with the exception of cases involving unusual and extenuating circumstances that warrant additional time.~~

~~5.9.6 The Deputy Administrator will recommend/approve closure of the incidents.~~

~~5.9.7 The Agency Director will ensure that all action plans are completed and the results of such plans are reported to Agency and Division Leadership and the Executive Committee of the Medical Staff, when applicable.~~

~~5.10 All incidents of client suicides and unusual client deaths will be referred by the Division Deputy Administrator to the Commission for Mental Health and Developmental Services for review.~~

~~5.11 The review, report and action provided pursuant to this policy is a performance improvement function of the Division agencies, undertaken to help assure appropriate quality services to Division clients. As such, the performance improvement privilege attached to the ations of the committee, Clinical Supervisors, Agency Directors, and Division Administrators, all documents, notes, conversations or discussions by the committee reviewed or made in the course of its exercise of its function are privileged and not subject to disclosure.~~

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6.0 ATTACHMENTS: N/A

7.0 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.

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EFFECTIVE DATE: 12/31/97
DATE REVISED: 11/27/02, 1/28/03, 7/07/03, 11/18/03, 5/28/07, 10/16

Control #	Rev.	Type	Title	Effective Date	Page
BHO-003	~~2~~		Behavioral Health Outpatient (BHO) Service Delivery	11-15-2016	1 of 11

1.0 POLICY

The Division of Public and Behavioral Health Clinical Services Branch will ensure timely access to outpatient behavioral health services under an established statewide service delivery model. This model is based on an integrated system of care that meets the individually assessed biopsychosocial needs of individuals served. The provision of services is based on medical necessity, clinical~~ly~~ appropriateness, and the emergent, urgent, and ~~stabilization~~ routine needs of each ~~client~~individual ~~consumer~~ in conjunction with their goals and choices. ~~Individuals~~ Consumers will be offered entry into any service needed, regardless of the point of contact. All services will be coordinated across the continuum of care and will be provided under this policy and according to each of the following BHO policies: BHO-004: Medication Clinic Services; BHO-005: Outpatient Counseling and Rehabilitative Mental Health (RMH) Services; and BHO-006: Service Coordination/Case Management Services.

~~Individuals~~ Consumers may receive services in conjunction with or independent of other services. Services are based on an on-going review of admission, continuing stay, and discharge criteria for each program. All services will be provided according to the Division's Quality Assurance Strategic Plan and according to the most recent edition of the relevant Medicaid Services Manuals (MSM) to include Chapters 100, 400, 600, 1900, 2500, 3400, 3600 and 3800 and the MSM Addendum.

2.0 PURPOSE

The DPBH Clinical Services ~~Division will~~Branch will ensure effective and systematic compliance with Federal, State and Division policies through uniformity in the access, provision and documentation of all outpatient behavioral health services. In addition, the purpose of this policy is to establish a standardized statewide system of care that is ~~in compliance with~~compliant with applicable regulations. The standardized statewide system of care ensures the provision of all services, supports the mission of the Division, and is provided under the following guiding principles:

2.1 Services will be provided using evidence-based practices and protocols and will be evaluated based on outcomes;

2.2 Program structures, milieu, staffing, and training relative to co-occurring disorders will be integral to all services; and

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2.3 Services will incorporate the belief that family education and support, recovery support, self-help, person/family-centered services and peer-delivered services are important components of the statewide system of care.

3.0 SCOPE: DPBH Clinical Services Branch ~~This policy applies to the Division's behavioral health agencies and programs providing outpatient behavioral health services.~~

4.0 DEFINITIONS

4.1 Assessment: the act or process of assessing or evaluating and documenting the medical necessity of an ~~individual's~~ consumer's need for behavioral health services and the types of treatment needed for stabilization or improved functioning. A comprehensive biopsychosocial behavioral health assessment includes components as required by Medicaid and is completed by a Qualified Mental Health Professional (QMPH) deemed competent to make such an assessment.

4.2 Behavioral Health Screening: a process completed and documented by a trained Qualified Mental Health Associate (QMHA) or a QMHP to determine status and eligibility for a behavioral health program.

4.3 Care Coordination: a formal documented process that ensures ongoing coordination of services on behalf of individuals served. Care coordination includes facilitating communication and referral between the individuals and entities that are providing care for the ~~individual~~consumer. Care coordination includes promoting continuity of care by creating linkages to and monitoring of transitions between programs and intensities of services provided. Care coordination is a required component of all DPBH services and includes an established procedure for referrals to all outside providers to include but not limited to Substance Abuse Prevention and Treatment Agency (SAPTA) providers, primary care providers, and Community Health Nursing (CHN) programs.

4.4 Co-Occurring Disorder: the existence of at least two disorders, one of which is a substance abuse ~~disorder~~disorder, and another is relating to mental illness. Treatment plans for ~~individuals~~ consumers with co-occurring disorders will ensure that stage-specific and clinically appropriate services are prescribed and provided concurrently, and will continue at the needed intensity, regardless if the ~~individual~~ consumer is actively using substances or exhibiting psychiatric symptoms. All ~~individuals~~ consumer will be screened/assessed for substance use disorders using ~~valid evidence based~~evidence-based instruments. Co-occurring disorder treatment will be formally coordinated with non-DPBH providers and provided following the guidelines listed below in all levels of care, across all agencies, and throughout all phases of the recovery process (e.g., engagement, screening, assessment, treatment, rehabilitation, discharge planning, and continuing care):

4.4.1 Co-occurring (mental health and substance abuse) disorders are common ~~in our system of care therefore co-occurring disorders~~ staff are expected to

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recognize and treat ~~and~~ individuals~~individuals~~ with co-occurring disorders ~~are met with a welcoming treatment environment;~~ according to the standard of care.

4.4.2 Both mental health and substance use disorders are to be diagnosed and treated simultaneously;

4.4.3 Service provision of integrated treatment includes documentation of the coordination of care;

4.4.4 Integrated care must be accomplished by preserving and capitalizing on the values, philosophies, and core technologies of both mental health and addiction treatment fields;

4.4.5 Alcohol or substance use level, presence of active use, and/or length of abstinence will not be a barrier to mental health assessment, treatment or case management services;

4.4.6 Relapse or non-adherence to treatment is not an automatic cause for termination from services; and

4.4.7 All Division staff working with individuals with co-occurring disorders will participate in orientation, and on-going training with curricula specific to co-occurring disorders and treatment. In addition, all clinical staff will be trained in and integrate the Screening, Brief Intervention and Referral Treatment (SBIRT) methodology.

4.5 **DPBH Templates**: standardized forms designed as tools to ensure all clinical documentation meets prescribed regulations. DPBH staff is required to appropriately document and claim all billable services using approved forms if the format is not available in Avatar.

4.6 **Discharge Criteria**: the diagnostic, behavioral, and/or functional indicators that constitute the ~~sought after~~sought-after goals and outcomes of the interventions provided that must be met to complete services. Discharge criteria are developed as part of the discharge planning process.

4.7 **Discharge Planning**: the process of preparing for the completion of services which begins at the time of admission. Discharge planning is designed to ensure continuity of care and access to needed support services during and upon completion of services.

4.8 **Discharge Summary**: written documentation of the last service contact with the ~~individual~~ consumer which includes a concise synopsis of all services provided, the reason for discharge, current level of functioning, and recommendations for further treatment.

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4.9 **Documentation**: all ~~client~~ consumer records shall reflect professional, respectful and accurate clinical presentation of that person~~e individual~~. Records must be chronological, current (within one business day), objective, specific and concise. All billable services must be documented according to policy using the required template or format. When corrections are necessary to rectify errors or inaccuracies, staff will contact the AVATAR Helpdesk for assistance. When information has been omitted, the append function must be used to insert the added information. Late entries must be labeled as such.

4.10 **Dually Diagnosed**: ~~individuals~~ consumers with both an intellectual disability and a behavioral/mental health disorder. Treatment will be coordinated with the Aging and Disability Services Division (ADSD) ~~in order to~~to ensure the provision of high quality collaborative services that comprehensively address treatment needs, avoid duplication of services and billing errors, and maximize continuity of care and security for each ~~individual~~ consumer within their community.

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4.11 **Episodic Care**: an approach to the provision of services that responds to the medically necessary and clinically appropriate needs of an ~~individual~~ consumer for a specified course of treatment. Episodic care addresses identified and ~~client~~consumer-specific goals within the recovery-oriented system of care.

4.12 **Functional Impairment**: difficulties that substantially interfere with or limit a~~n individual~~ consumer from achieving or maintaining safety, housing, employment/benefits, relationships, or education~~, relationships or safety~~. Functional impairments are documented and included in the biopsychosocial comprehensive assessment.

4.13 **Initial Screening**: initial screenings identify current crisis and/or need for immediate assistance. At Point of Entry, all ~~individuals~~ consumers will receive an initial screen for risk of harm to themselves or others.

4.14 **Intake**: initial collection of information from a potential ~~client~~ consumer which includes primarily demographic, financial, and insurance information. This step may be completed by non-clinical staff such as an administrative assistant or support staff.

4.15 **Integrated Care**: a system of care, which uses collaboration with State, Division and community partners to provide services, based on meeting the biopsychosocial needs of ~~individuals~~ consumers with behavioral/mental health disorders. Integrated care, at a minimum, includes the coordination of care with primary/medical care providers, co-occurring disorders and dual diagnoses treatment programs/providers, and community health nursing programs. Integrated care services must be seamless for the ~~individual~~ consumer incorporating a 'no wrong door' approach to receiving services.

4.16 **Medical Supervision**: the required documented oversight, which determines the medical appropriateness of the behavioral/mental health program and services. Medical supervision must be documented at least annually and at all times, when determined medically appropriate, based on review of circumstance. Medical supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided and may be provided through on and offsite means of communication.

4.17 **Mental Illness**: a clinically significant disorder of thought, mood, perception, orientation, memory or behavior which seriously limits the capacity of a person to function in the primary aspects of daily living including, without limitation, personal relations, living arrangements, employment and recreation. Note: treatment/service requirements and diagnostic criteria can be found in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) ~~-5~~, relevant Nevada Revised Statues (NRS) and/or MSM Chapter.

4.18 **Orientation**: prior to receiving services, an introductory overview provided to inform ~~clients~~ consumers about available services, programs and processes which includes a description of the individual's role and responsibilities. The goal of orientation is to enhance the informed consent process and promote ~~client~~ consumer's involvement. Orientation is to be welcoming, empathetic and encouraging as it is the foundation for hope. Orientation is an integral part to the assessment/intake process and may be provided one-on-one or in a group but must not be used as a test for eligibility/readiness to receive services.

4.19 **Person-Centered Planning**: an approach that focuses on the person's goals, desires, strengths, and needs for support in the provision of services. Services are individualized in partnership with all persons served to ensure that they and their families can select and direct meaningful and informed interventions. Services are outcome-based and are designed to maximize each ~~client individual's~~consumer's independence, capabilities and satisfaction.

4.20 **Progress Note**: the written documentation of a treatment, intervention or case management service provided. All progress notes reflecting a billable service must be sufficient to support the service provided and must document the amount, scope, duration and provider of the service. All progress notes must be completed within one (1) business day of the service provided using an approved DPBH template or format.

4.21 **Provider Type:** the Medicaid designated group of service providers that operate primarily under specific and distinct Medicaid Services Manuals (MSM). DPBH-Behavioral Health operates three provider types:

4.21.1 **Medication Clinic** - Provider Type 14, MSM Chapter 400; Provider Type 20, MSM Chapter 600. Medication management is prescribed on a ***Plan of Care***;

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4.21.2 Outpatient Counseling/RMH Services - Provider Type 14, MSM Chapter 400. Treatment and services are documented on ~~a ***Treatment***~~a Treatment ***Plan***; and

4.21.3 Service Coordination/Targeted Case Management - Provider Type 54, MSM Chapter 2500. Services are specified on a ***Care Plan***.

4.22 Setting: the environment in which services are provided. All services are to be provided in the least restrictive, most normative environment possible. Settings may include telehealth, a medical professional clinic/office, within a community environment, while in transit and/or in the ~~individual's~~ consumer's home.

4.23 Service Coordination/Case Management Services: services to assist ~~individuals~~ consumers in gaining access to needed medical, social, educational, and other support services including housing and transportation.

4.24 Telehealth: the use of a HIPAA-compliant telecommunications platform to substitute for approved in-person clinical services. Services are provided to a ~~client~~ consumer at a different location than the provider. Telehealth includes audio-visual forms of communication and does not include a standard telephone call, email, instant messaging or facsimile.

4.24.1 Telehealth Originating Site: the location where a ~~client~~ consumer is receiving telehealth services in Nevada.

4.24.2 Telehealth Distant Site: the location where a provider of health care is providing telehealth services to a ~~client~~ consumer located at the originating site. The distant site provider must be an enrolled Medicaid provider.

4.25 Utilization Management: a prospective approach to the provision of services that ensures ~~an individual~~a consumer receives the appropriate levels and amounts of services based on medical necessity, clinical appropriateness, and quality of care while managing the costs of services provided. Utilization management is based on effective discharge planning and encompasses efficiency in the provision of services to ensure services are provided according to established Division policies and Agency procedures.

4.26 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 Division policies and Agency procedures.

4.27 Warm Hand-Off: an approach to good customer service which includes a streamlined, effective, seamless manner that ensures clients are effectively linked and engaged with other providers.

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5.0 REFERENCES:

5.1 Nevada Revised Statues (NRS) 433, 433A, 433B, 435 and 436

5.2 Nevada Administrative Code (NAC) 433 and 436
5.3 Medicaid Services Manual (MSM) Chapters 100, 400, 600, 1900, 2500, 3400, 3600 and 3800 and the MSM Addendum (this policy is based on the most recent editions of these chapters as of the date of approval and includes these chapter references).

6.0 PROCEDURE:

~~5.0~~ 6.1 POINT OF ENTRY

Entry Services is the access point of admission into outpatient services.

6.1.1 Entry Services function to screen individuals for risk and, in the case of a hospital facility, emergency services. ~~In addition,~~

6.1.2 Entry Services includes a process to determine DPBH program eligibility and provide access to care or formal referral to a more appropriate program/service.

~~**5.1.1**~~ Entry Service programs do not provide treatment, however, in the case of urgent/emergent needs Entry Services staff coordinates immediate assistance and expedited access to care.

6.1.3 While regionally the names of the entry into services may differ (e.g., Counseling and Assessment Referral Services - CARS, etc.), the function is the same statewide.

6.1.4 Entry Services staff will make every effort to link all individuals to appropriate resources including a warm hand-off, whether eligible for State agency services or not, and document the rationale and disposition of the referral in the electronic medical record.

~~5.2~~6.2 Process:

~~**5.2.1**~~**6.2.1 By Phone:** ~~individuals~~ consumers calling Entry Services to request assistance are greeted and asked if they are in crisis or need immediate assistance. If they indicate they are in crisis or need immediate assistance or if they appear to be in crisis (e.g., excessive tearfulness, highly angry or seem confused and frantic) they are to be immediately transferred to a QMHP or designated QMHA. For non-urgent requests, the individual is directed to the nearest mental health clinic.

~~**5.2.2**~~**6.2.2 In Person:** ~~individuals~~ consumers presenting to a DPBH outpatient program for services are welcomed and asked if they are in crisis or need immediate assistance.

~~**5.2.2.1**~~**6.2.2.1** If the ~~individual~~ consumer indicates they are a risk to themselves or ~~others, or~~others or provides any other type of verbal or non-verbal response (e.g., excessive tearfulness, agitation, pacing) that might suggest the need for an immediate assessment for risk, they receive a behavioral health screen within 15 minutes by a

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QMHP or designated QMHA. If the individual is in crisis consistent with the requirements of a legal hold, a legal hold is initiated following NRS, Division policies, and Agency procedures.

~~5.2.2.2~~6.2.2.2 If the ~~individual consumer's~~consumers indicates they are not in crisis and do not need immediate assistance, the individual is provided an intake packet which includes a brief risk questionnaire to complete and offered assistance as needed (e.g., interpreter, verbal instructions) or, upon request, given the paperwork to complete and return.

~~5.2.2.3~~6.2.2.3 Upon receipt of the intake packet, Entry Services staff opens the individual in Avatar and coordinates the ~~consumer's individual's~~consumers' admission into the assessment phase of the requested services/program according to relevant Agency procedures. In addition, Entry Services staff ensure individuals are provided the crisis call number and appropriate community resources with written contact information.

~~5.2.3~~6.2.3 If it is determined the ~~individual~~ consumer is to be referred to a more appropriate provider, the Entry Services staff ensure a warm hand-off and document the referral in Avatar.

~~6.0~~ 6.3 ELIGIBILITY

The ~~Division~~ DPBH Clinical Services Branch serves all people in Nevada with a behavioral/mental health disorder in need of services that are not available or accessible in the community or private sector.

6.3.1 To be eligible for services, ~~an individual~~a consumer must meet diagnostic and impairment criteria in ~~at least~~ one of the following four general categories (see full definitions in the MSM Chapters 400 and 2500 and the MSM Addendum) and must have the legal capacity to request and consent to services (except in the case of an emergency) or have the consent of a legal guardian.

Non-Serious Mental~~ly~~ Illness (Non-SMI)~~:~~ ~~individual 18 years or older with:~~

6.3 ~~A current International Classification of Diseases (ICD) diagnosis from the current Mental, Behavioral, Neurodevelopmental Disorders section (codes F01 thru F99, excluding dementia, intellectual disabilities, or primary diagnosis of an addiction disorder (codes F10 thru F19, and F63)), including codes Z55 thru Z65, R45.850 and R45.851, which does not meet SMI criteria;~~

~~Significant life stressors that impair functioning; and~~

~~6.1~~ ~~A significant life stressors who has a DSM mental health diagnosis, including V-codes diagnosis (excluding dementia, intellectual disability or primary diagnosis of a substance abuse disorder, unless these are co-occurring) and a Level of Care Utilization System (LOCUS) Level I or II of 1 or 2.~~

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Non-Severely Emotionally Disturbanceed (Non-SED):: individual under age 18 with:

A current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section (codes F01 thru F99, excluding dementia and intellectual disabilities), which does not meet SED criteria;

Codes Z55 thru Z65, R45.850 and R45.851 as listed in the current ICD, which does not meet SED criteria; and

A Child Adolescent Service intensity Instrument (CASII) Level of 0, 1, 2, or above.

6.2 significant life stressors, who has a DSM mental health diagnosis or V code diagnosis that does not meet SED criteria (excluding dementia, and intellectual disability, or a primary diagnosis of a substance abuse disorder, unless these conditions are co-occurring), and have a Child and Adolescent Service Intensity Instrument (CASII) Level I or II.

6.36.4 Seriously Mentally Illness (SMI): individual 18 years or older who currently, or at any time during the past year (continuous 12 month period) have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the current ICD Mental Behavioral, Neurodevelopment Disorders section (codes F01 thru F99, excluding substance abuse or addictive disorders, irreversible dementias as well as intellectual disabilities, unless they co-occur with a serious mental illness that meets current ICD criteria)DSM (excluding substance abuse or addictive disorders, irreversible dementias as well as intellectual disability, unless they are co-occurring) that has resulted in a functional impairment which substantially interferes with or limits one or more major life activities;, hinders them from achieving or maintaining safety, housing, employment/benefits, relationships, or education relationships or safety; and have a LOCUS score of Level III3 or above.; or

6.46.5 Severely Emotionally Disturbedance (SED): individual age 4 and up to age 18 who currently or at any time during the past year (continuous 12 month period) has a diagnosable mental, behavioral or diagnostic criteria that meets the coding and definition criteria specified in the current ICD Mental Behavioral, Neurodevelopment Disorders section (codes F01 thru F99, including those of biological etiology; and excluding substance abuse or addictive disorders, irreversible dementias, as well as intellectual disabilities and Z codes, unless they co-occur with another severe emotional disturbance that meets current ICD criteria) DSM (excluding V codes, substance abuse or addictive disorders, irreversible dementias as well as intellectual disability, unless they are co-occurring) that results in functional impairment which substantially interferes with or limits the child's or /adolescent's role or functioning in family, school, or community activities; and hinders them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills; and hashave a CASII score of Level 3III or above.

7.0 6.6 PROGRAMS

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6.6.1 DPBH outpatient services may be provided in conjunction with or independent of other services and include the following three service programs:

6.6.2 OUTPATIENT COUNSELING/REHABILITATIVE MENTAL HEALTH ~~7.1~~ (RMH) SERVICES

6.6.2.1 Services include individual, family and group therapy, psychosocial rehabilitation, basic skills training, peer support services, day treatment, program for assertive community treatment (PACT), and crisis intervention.

6.6.2.2 Services are based on the case formulation established by a comprehensive biopsychosocial assessment.

6.6.2.3 All outpatient/RMH services are prescribed on a current Treatment Plan that is jointly developed with and signed by the individual served. Treatment Plans are updated every 90-days as part of the intensity of needs determination (i.e. LOCUS or CASII).

~~7.2~~ 6.7 MEDICATION CLINIC SERVICES

Services include psychiatric and nursing assessments, medication management, and medication training and support. Services are based on an on-going review of psychiatric symptoms, treatment history and Plan of Care, and in coordination with an ~~individuals'~~ consumers' primary care provider.

~~7.3~~ 6.8 SERVICE COORDINATION/CASE MANAGEMENT SERVICES

Service Coordination/Case Management Services, also known as Targeted Case Management (TCM), are services that assist eligible individuals in gaining access to needed medical, social, educational, and other support services including housing and transportation. Service coordination is based on the assessed case management needs of the ~~individual~~ consumer in a specific target group and according to the established person-centered Care Plan. Case reviews and inter-disciplinary team collaboration QMHP

~~8.0~~ 6.9 CLINICAL RECORDS

6.9.1 In accordance with applicable ~~Division~~ DPBH Clinical Services Branch policy(ies) related to clinical records standards, ~~A~~all consumer~~client~~ records shall reflect professional, respectful and accurate clinical presentation of the individual.

6.9.2 Records must be chronological, current (within one business day), objective, specific and concise.

6.9.3 Billable services must be documented according to policy using the required template or format.

6.9.4 When corrections are necessary, staff will contact the Division Helpdesk for assistance and follow instructions.

6.9.5 When information has been omitted, the append function must be used to insert the added information. Late entries must be labeled as such. Please see the applicable Division Policy IMRT 2.1 Basic Documentation Guidelines for Medical Records~~policy for additional information about documentation in the clinical record. In addition:~~

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~~**8.1** When client abuse is observed or reported, facts relative to the abuse must be documented in the record, including action taken by the staff.~~

~~**8.2** Records must contain only approved acronyms or abbreviations.~~

~~**8.3** Clinical records shall not contain:~~

~~**8.3.1** Remarks that are critical of treatment carried out by others, that may indicate bias against an individual or that are unprofessional.~~

~~**8.3.2** Personal identification of another individual/client. When reference must be made about other individual/client, initials, the AVATAR record number or some other form of identification, such as "male peer," "roommate," "mother," and so forth are to be used.~~

~~**8.3.3** Entries labeled as "medication errors" or "serious incidents." In such case, the information shall be documented in the record with the description of the event, remedial actions taken and the individual's condition following the event. Opinions or conclusions relative to the event must not be included in the entry. When a separate incident report is completed, this must be submitted according to Division policies and not be referenced in the clinical record.~~

~~**8.3.4** Staff opinions or non-clinical conclusions.~~

REFERENCES

~~Nevada Revised Statues (NRS) 433, 433A, 433B, 435 and 436~~
~~Nevada Administrative Code (NAC) 433 and 436~~
~~Medicaid Services Manual (MSM) Chapters 100, 400, 600, 1900, 2500, 3400, 3600 and 3800 and the MSM Addendum (this policy is based on the most recent editions of these chapters as of the date of approval and includes these chapter references).~~

7.0 ATTACHMENTS: N/A

8.0 Implementation of Policy:

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

APPROVED BY THE DPBH ADMINIDTRATOR:
APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:

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Control #	Rev.	Title:	Effective Date: 04/21014
BHO-004		Medication Clinic Services	Next Review Date

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1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) ensures timely access to medication clinic services under an established statewide service delivery model. This model is based on an integrated system of care that meets the individually assessed biopsychosocial needs of individuals served. The provision of services is based on medical necessity and the emergent, urgent, and stabilization needs of each individual in conjunction with their goals and choices. Individuals will be offered entry into any service needed, regardless of the point of contact. All care will be coordinated and services will be provided under this policy and BHO-003: Service Delivery.

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 behavioral health services. The purpose of this policy is also to establish policy for compliance with applicable accreditation agencies (e.g. Centers for Medicare and Medicaid Services also known as CMS).

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3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

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4.1 **Examination**: the physical aspect of a psychiatric or nursing assessment.

4.2 **Health Questionnaire**: a tool completed by an individual and used by Registered Nurses RN's) to assist in the evaluation of the physical health concerns as reported by the individual. Reported health issues become integral as a focus in coordination of care and is the basis for development of the nursing care plan.

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4.3 **Medication Clinic (MC) Assessment**: the assessed biopsychosocial needs of an individual which determines the medication clinic plan of care and the nursing care

plan. Information is obtained from direct examination, clinical interview and can also be obtained through an AVATAR clinical record review, and/or from outside medical providers.

4.4 **Medication Clinic (MC) Plan of Care**: a plan of medication treatment services to be provided to an individual. This plan is documented on the medical staff progress note each time an individual is provided a billable treatment service by a medical staff. The MC Plan of Care is reviewed, updated and documented in the plan section of each progress note at each clinical visit.

4.5 **Nursing Care Plan**: a plan for nursing services which are based on the assessed nursing care needs of the individual and in support of medical staff services. The Plan is reviewed, updated and documented in the plan section of each nursing progress note at each clinical visit.

4.6 **Pain Assessment**: the assessed level of self-reported pain of an individual that contributes to reduced functioning and/or coping, or exacerbates a behavioral health disorder, and is addressed in the nursing care plan.

~~4.6~~

5.0 REFERENCES:

5.1 NRS 433, 433A, 433B, 435 and 436
5.2 NAC 433 and 436
5.3 Medicaid Services Manual Chapters 100, 600, 3400 and 3600 and the MSM Addendum

Note: this policy is based on the most recent editions of the MSM chapters as of the date approval and includes chapter references.

6.0 PROCEDURE:

6.1 Medication Clinic services will be provided according to the most recent Medicaid Services Manual, Chapter 600, Physician Services:

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https://dhcfp.nv.gov/MSM/CH0600/MSM%20Ch%20600%20FINAL%209-12-13.pdf .

6.1.1 Individuals may receive medication in conjunction with or independent of other services.

6.1.2 Services are based on an on-going review of psychiatric symptoms, treatment history and in coordination with an individuals' primary care provider, when appropriate.

6.1.3 If an individual does not have a primary care provider, every effort will be made to encourage and link the individual to available resources.

6.2 Eligibility

6.2.1 Admission criteria - Eligibility for Medication Clinic Services is based on the medical necessity for medication clinic services and meeting criteria in one of the following categories:

6.2.1.1 Non-Seriously Mental Ill (Non-SMI) Adults

6.2.1.2 Non-Severely Emotionally Disturbed (Non-SED) Children

6.2.1.3 Seriously Mental Ill (SMI) Adults

6.2.1.4 Severely Emotionally Disturbed (SED) Children

6.2.1 Continuing stay criteria: Must meet all of the following:

6.2.1.1 Continues to meet admission criteria.

6.2.1.2 Services are not available, accessible, or appropriate in the community or private sector.

6.2.1.3 MC Plan of Care and goals are established.

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6.3 Discharge/Exclusionary criteria: Must meet at least one (1) of the following:

6.3.1 No longer meets the admission and continuing stay criteria.

~~6.3.2 Has been admitted into a psychiatric hospital, IMD or nursing facility with an anticipated length of stay to exceed 30 days.~~

~~6.3.3~~6.3.2 The individual or their legal representative chooses not to participate in the program or is non-compliant with agreed upon treatment.

~~6.3.4~~6.3.3 The individual has been linked/referred to an available community resource and the transfer of care has been confirmed.

6.4 Services: Based on medical necessity and individually assessed needs of the client.

6.4.1 Services are provided as prescribed in a MC Plan of Care by a medical staff prescriber and as documented in the nursing care plan.

6.4.2 All services provided and the coordination of care must be documented in individual's electronic medical record.

6.4.3 Services include:

6.4.3.1 Behavioral Health Screen – A screen to determine eligibility for services.

6.4.3.1.1 All individuals presenting to the medication clinic who are identified being at risk of harm to themselves or others and/or present with any other type of verbal or non-verbal response (e.g., excessive tearfulness, agitation, pacing) that might suggest the need for an immediate assessment, will receive a behavioral health screen by an RN or clinician as soon as possible and no longer than 15 minutes.

6.4.3.1.2 If the individual is in crisis consistent with the requirements of a legal hold, a legal hold will be initiated following Division policies and procedures.

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6.5 Evaluation and Management (E/M) Services: a medical service provided by a medical staff prescriber to assess the psychiatric needs of an individual.

6.5.1 E/M services include a determination of the level of complexity of the assessed needs.

6.6 Injection: under medical staff supervision a "therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular."

6.7 Medication Training and Support: provided by an RN to monitor compliance, side effects, to provide education and support, and to coordinate requests to a DPBH medical staff prescriber for changes in medication(s).

6.8 Pharmacy Support Services: assist individuals to improve their understanding of their prescriptive medications prescribed by a DPBH medical staff prescriber. The intent is to broaden the individual's understanding of the importance of medication self-administration thereby improving self-sufficiency and promoting greater medication adherence.

6.9 Psychiatric Evaluation: an evaluation to determine psychiatric diagnosis(es).

6.9.1 New individuals requesting medication clinic services will receive a psychiatric evaluation. If an existing psychiatric evaluation is available, less than a year old, then a review and/or an update of their recent psychiatric evaluation is done.

6.9.2 Adults who have not received an evaluation within two (2) years and children/adolescents who have not received an evaluation within one (1) year prior to receipt of services will receive a new evaluation.

6.9.2.1 Prescribers will utilize any current evaluation available including those submitted by an outside provider (in the case of a client transfer), in order to complete, review and/or update a Psychiatric Evaluation/Update.

6.9.2.2 Consumers with uninterrupted care can have a reviewed/updated evaluation combined with a psychiatric symptoms checklist, completed in the progress note section of AVATAR.

6.9.2.3 Previous consumers with a break in service less than one (1) year, can also have an updated psych evaluation completed in the progress note as an extended visit.

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6.9.2.4 Consumer's new to the clinic from other programs or clinics with a current psych evaluation under two (2) years can also be updated in the progress notes.

6.9.2.5 The medical staff may determine at any time based on acuity, new consumer status, or other changes to schedule a new psychiatric evaluation.

6.9.2.6 All medical staff psychiatric evaluation updates completed in the progress notes must also update the diagnosis section in AVATAR.

6.10 Nursing Assessment: Individuals receiving medication services will receive a nursing assessment or review and/or update of their current AVATAR assessment.

6.10.1 All nursing services are provided under medical supervision and are based on the assessed needs of the individual served.

6.10.2 All nursing staff will utilize any current assessments available including those submitted by an outside provider (in the case of a client transfer), in order to complete, review and/or update a Nursing Assessment.

6.10.3 A reviewed/updated nursing assessment combined with medical necessity and clinical judgment will be the basis for all nursing services.

6.10.4 Nursing assessments may be provided on the same day, prior to an evaluation and management medical staff visit, or independent of that visit.

6.10.5 Completed nursing assessments will include a nursing care plan based on identified client biopsychosocial needs.

6.11 Locus/Cassi Assessments: Completed at the time of Behavioral Health Screening and every ninety (90) days thereafter by clinician, or RN if open to medication clinic only. (Per Medicaid Regulations)

Control #	Rev.	Title:	Effective Date: 04/21014
BHO-004		**Medication Clinic Services**	**Next Review Date**

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

Control #	Rev. Date:	Title:	Effective Date: 07/06
CRR 2.2	~~9~~8/2018~~1~~	CULTURAL COMPETENCE	Next Review Date: 9/2020 ~~(2)~~

1.0 POLICY:

The Division of DPBH and each Division agency will work with other agencies across Nevada to develop, promote, and maintain a culturally and linguistically competent system of care for all individuals within their community.

2.0 PURPOSE:

To ensure that s~~S~~ervices are centered on each client~~person~~'s needs and clients~~people~~ are not denied services based on race, color, national origin, religion, gender, sexual orientation, age, or disability and; ~~.~~

To provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

3.0 SCOPE: Clinical Service Branch

4.0 DEFINITIONS:

~~4.0~~ 4.1 Culture is the sum of values, beliefs, attitudes, language, symbols, rituals, behaviors and customs that are unique to a group and passed from one generation to the next.

4.2 Cultural Competence – the ability to understand and respond effectively to the individual needs of a client brought to the health care encounter. This may be based on culture, language, gender, gender identity and other factors.

4.3 Discrimination - Differential treatment of a person because of group membership, such as sexual, gender, gender identity or minority statu

5.0 REFERENCES:

5.1 The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care: A Roadmap for Hospitals.
5.2 Inside the Joint Commission; November 17, 2014/Volume 19, Issue 22.
5.3 DPBH Clinical Service Policy CRR 1.1 Client Rights
5.4 ADSD

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CRR 2.2	~~98~~/2018~~1~~	CULTURAL COMPETENCE	Next Review Date: 9/2020 ~~(?)~~

~~5.0~~6.0 PROCEDIRES:

~~5.1~~6.1 The Division ~~of~~ DPBH and each agency, ~~working alone or in concert with other agencies,~~ shall promote culturally competent services based on the Office of Minority Health CLAS ~~and~~Standards and have mechanisms in place for ongoing monitoring. People that are currently receiving services have access t~~o~~:

6.1.1 Effective, equitable, understandable and respectful care from all

~~5.1.1~~ staff members

6.1.2 Offer competent l~~L~~anguage assistance services at any point of contact, when needed and avoid the use of untrained individuals, minors and family members

~~5.1.2~~6.1.3 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

~~5.1.3 Understandable individual-related materials and signage~~

6.1.4 ~~5.1.4~~ Information about rights and grievance processes in their preferred language

6.1.5 Non-discrimination in service delivery

6.2 Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

6.2.1 Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

6.2.2 Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

6.3 Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.

6.4 Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities

6.5 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

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6.6 Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

6.7 Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

6.8 Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

6.9 Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

~~For persons in Nevada communities that may not be receiving services, accessibility, within funding limitations, is promoted by:~~

6.10 For persons in Nevada communities that may not be receiving services, accessibility, within funding limitations, is promoted by:

6.10.1 Identifying diverse population groups in the service area, including, but not limited to, children, older adults, ethnic minorities, persons with disabilities, and blind or ~~hearing impaired~~hearing-impaired individuals;

6.10.2 Determining and addressing any disparity in access and utilization of services;

6.10.3 Developing outreach strategies to diverse communities;

6.10.4 Recruiting and retention strategies to attract and ~~developculturally~~develop culturally competent staff;

6.10.5 Obtaining input and consultation from diverse groups in its service area (e.g., advisory committees, focus groups, key minority informants, and directed surveys).

6.10.6 Working collaboratively with local diverse groups to review service delivery to individuals, families and communities;

6.10.7 Providing regular quality monitoring with indicators that evaluate both the quality and outcomes of services with respect to culturally diverse populations;

6.11

~~5.1.5~~

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Control #	Rev. Date:	Title:	Effective Date: 07/06
CRR 2.2	~~9~~8/2018~~3~~1	CULTURAL COMPETENCE	Next Review Date: 9/2020 ~~(2)~~

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~~5.2~~1.1 ~~For persons in Nevada communities that may not be receiving services, accessibility, within funding limitations, is promoted by:~~

~~5.2.1~~1.1.1 ~~Identifying diverse population groups in the service area, including, but not limited to, children, older adults, ethnic minorities, persons with disabilities, and blind or hearing impaired individuals;~~

~~5.2.2~~1.1.1 ~~Determining and addressing any disparity in access and utilization of services;~~

~~5.2.3~~1.1.1 ~~Developing outreach strategies to diverse communities;~~

~~5.2.4~~1.1.1 ~~Recruiting and retention strategies to attract and developculturally competent staff;~~

~~5.2.5~~1.1.1 ~~Obtaining input and consultation from diverse groups in its service area (e.g., advisory committees, focus groups, key minority informants, and directed surveys).~~

~~5.2.6~~1.1.1 ~~Working collaboratively with local diverse groups to review service delivery to individuals, families and communities;~~

~~5.2.7~~1.1.1 ~~Providing regular quality monitoring with indicators that evaluate both the quality and outcomes of services with respect to culturally diverse populations;~~

~~5.2.8~~6.11.1 Utilizing multi-faceted approaches to assess satisfaction of diverse individuals, families, and communities and developing performance improvement initiatives based on findings;

~~5.2.9~~ Monitoring service delivery to diverse individuals~~;~~

~~5.2.10~~6.11.2 Ensuring identification of minority responses in the tabulation of individual surveys;

~~5.2.11~~6.11.3 Ensuring that person's and families' cultural preferences are assessed and included in the development of treatment plans; and

~~5.2.12~~6.11.4 Reviewing other information, goals and strategies that the Division may consider relevant.

~~5.3~~6.12 Employee orientation, training and continuing education activities will reflect specific and/or integrated components that address cultural competence.

~~5.4~~ Employee orientation related to cultural competency occurs within six (6) months of hire and ~~annual~~ cultural competency training of employees, either within an DPBH agency or contracted provider occurs annually through NvElearn~~.~~

6.13 The preferred Course is the Cultural Competency/Kultur Competence/Competencia Cultural (Aging and Disability Division in collaboration with DPBH and SNAMHS) in NvElearn.

~~5.5 The Division, each DPBH agency and contracted provider shall periodically analyze available data to evaluate the impact of the service delivery system in minimizing disparity among all services recipients as well as evaluate the cultural and linguistic needs of the population served and ensure service capacity to meet those needs.~~

~~5.6 The Division of DPBH shall annually evaluate the impact of activities undertaken towards developing a culturally competent service delivery~~

~~6.0~~7.0 ATTACHMENTS:

7.1 CLAS Standards; OMH Website HHS.gov ~~N/A~~

~~7.0~~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: 07/14/06
REVISED / REVIEWED DATE: 01/02/07, 01/02/10, 08/23/11
SUPERSEDES: POLICY#: 4.067 CULTURAL COMPETENCE
APPROVED BY DPBH ADMINISTRATOR: 08/25/11
APPROVED BY DPBH COMMISSION: 07/14/06, 09/16/11

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CLAS Standards from OMH Website HHS.gov

Principal Standard

1) Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

CLAS Standards from OMH Website HHS.gov

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.

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 DPBH Release of Protected Health Information Consent Form, English
7.2 DPBH Release of Protected Health Information Consent Form, 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:

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
RELEASE OF PROTECTED HEALTH (PHI) CONSENT FORM

Name: _____ Date of Birth: _____SS #: XXX-XX-_____
Street Address: _____City: _____State: _____ Zip: _____
Phone #:_____Alt. #: _____

I authorize the following Agency to release my Protected Health Information (PHI) for the specified dates:

- ☐ **LAKE'S CROSSING: Dates of Service: _____**
- ☐ **NNAMHS: Dates of Service: _____**
- ☐ **RURAL HEALTH CLINIC Dates of Service: _____**
- ☐ **SNAMHS: _____Rawson-Neal _____ Stein_____ Medication Clinic Dates: _____**
- ☐ **OTHER: _____ Dates: _____**

INFORMATION TO BE RELEASED: **(Individual MUST INITIAL each item of information to be released)**

_____ Psychiatric/Drug/ Alcohol Information		**_____HIV/AIDS Information**
_____Consultation Reports	_____History & Physical Exam	_____Treatment Plans
_____Diagnosis (psychiatrist)	_____Discharge Summary	_____ Outpatient Counseling
_____Psychiatric Evaluation	_____Medication Records	_____ Service Coordination
_____Psychological Assessment	_____ Progress Notes	_____ Case Management
_____General Summary Letter Only	_____ Nursing Notes	_____ Lab / EKG Results

_____Other (Specify):_____

RELEASE TO:
Name/Agency (Recipient Name): _____ Phone#: _____
Street Address: _____City: _____State: _____ Zip: _____

MUST BE INITIALED: _____Written Disclosure _____Verbal Disclosure _____Transmitted electronically_____
Electronic transfer/E-mail address: _____Fax #: (If different from above) _____

PURPOSE OF RELEASE:
_____ Continuation of Care _____ Self/Personal
_____ Insurance Specify Purpose: _____
_____ Legal

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations. Any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Re-disclosure of information pertaining to identification of an individual as having been diagnosed, treated, or referred for treatment for a substance use disorder is prohibited.

Consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the individual's or authorized representative's signature and the date of the signature. The authorized representative signing for the client must submit a copy of the legal document(s) granting this authority.

This authorization for the Release of Medical Information waives any and all rights that the individual now has or in the future may have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of the completed "Authorization for the Release of Protected Health Information."

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization expires_____ days from the date of signing (but no longer than 365 days) or upon case closure, whichever occurs first.
A PHOTOCOPY, FACSIMILE OR ELECTRONIC SUBMISSION OF THIS FORM IS AS VALID AS THE ORIGINAL

Client or Legal Representative Signature: _____ Date: _____
Relationship to Client: _____ Witness Signature: _____

Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork with this request)

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
RELEASE OF PROTECTED HEALTH (PHI) CONSENT FORM

REVOCATION:

I hereby revoke the authorization given on the reverse side of this page

_____Date/Time_____

Signature of Patient

_____Date/Time_____

Signature of Guardian/Representative (Legal documents required)

_____Date/Time_____

Signature of Witness

División de Salud Pública y Comportamiento
Autorización para Compartir Información de Salud

Nombre: _____ Fecha de Nacimiento: _____SS #: XXX-XX-_____
Direccion: _____Ciudad: _____Estado: _____ Zip: _____
Telefono #:_____Alterno #: _____
El propósito de liberación:

- ☐ LAKE'S CROSSING: FECHA(S) DE SERVICIO DE: _____
- ☐ NNAMHS: FECHA(S) DE SERVICIO DE: _____
- ☐ RURAL HEALTH CLINIC - FECHA(S) DE SERVICIO DE: _____
- ☐ SNAMHS: _____Rawson-Neal _____ Stein_____ Medication Clinic Fechas: _____
- ☐ OTRA: _____ Fechas: _____

Información que será liberada: (El individuo debera poner sus INICIALES AL LADO DE CADA ARTICULO de informacion que debe ser liberar)

_____ Información de Psiquistrica / Droga / Alcohol		_____Información sobre el SIDA y VIH
_____ Reporte de consulta	_____Historial medico y examen físico	_____ Plan de tratamiento
_____ Diagnostico psiquiátrico	_____ Sumario de tratamiento	_____ Servico de Coordinacion
_____ Evaluación psiquiátrica	_____Resume de Alta	_____ Manejo de Casos
_____ Evaluacion psicologica	_____ Medicamento	_____ Notas de Enfermeria
_____ Carta de información general únicamente	_____ Historial de tratamiento medico	_____ Laboratorio/ Analisis

_____ Otra (sea especifico/a) _____

INFORMACION SERA LIBERADA A:
Nombre/Agencia: _____Telefono#:_____
Dirección: _____Ciudad: _____Estado: _____ Zip:_____

DEBE SER RUBRICADO: _____Informacion Escrita _____Informacion Verbal ----------Transferencia Electronica / FAX

Proposito de la Liberacion:
_____ Continuacion de la atencion _____ Self/Personal
_____ Aseguransa Especificar el proposito_____
_____ Legal

Información Para Autorización De El Paciente

Estatuas del estado y federal, leyes, y regulaciones incluyendo Estatuas revisadas de Nevada y titulo 42 del código de regulaciones federales y HIPAA protege la confidencialidad de información medica, psiquiatrita, y de abuso de substancia. Estas estatuas, leyes, y regulaciones requieren que el individual de informada autorización, antes de que soltemos cualquier información de salud, o registro de hospital, con respecto a cómo este explicado en las estatuas, leyes, y regulaciones.

Una autorización para soltar información seria valida solo cuando indique: (1) Quien soltaría la información (2) Quien recibirá la información (3) El propósito de usar la información (4) Específicamente cual información seria soltada (5) Cuando se vencería la autorización. La autorización debe contener la firma y fecha del individual o representador autorizado. El representador autorizado que firma por el cliente debe de presentar una copia de los documentos legales que garantiza esta autoridad.

Esta "autorización para soltar información de registro" renuncia cualquier y todos los derechos que el individual ahora tiene o tendrá en el futuro para llevar acción legal en contra de la persona/ o facilidad que causa daños y perjuicios directo o indirecto a causa de soltar la información o otra información confidencial. Al pedido, el individual podrá recibir una copia de la completada "autorización de información.

Esta autorización es efectiva inmediatamente y es sugerida a revocación en escrito a cualquier hora, con la excepción a medida que ya hayamos tomado acción el la dependencia al respecto. De otro modo esta autorización se vencerá 365_ días de la fecha que fue firmada (pero no mas de 365 días) o hasta que se cierre el caso, cualquiera que ocurra primero. Solo la firma original del individual que servimos o la firma de su guardián serán honradas.

Firma del Cliente/del Guardian: _____ Fecha: _____
Parentesco al Cliente: _____ Firma del Testigo: _____Fecha: _____
Los tutores y los representantes del poder duradero deben incluir una copia de la documentación aplicable con esta solicitud.

COPIAS $ .60 POR PÁGINA

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
RELEASE OF PROTECTED HEALTH (PHI) CONSENT FORM

REVOCACION:

I hereby revoke the authorization given on the reverse side of this page
Por la presente revoco la autorizacion dada en el reverse de esta pagina

_____Date/Time_____
Signature of Patient (Firma del paciente) Fecha / Hora

_____Date/Time_____
Signature of Guardian/Representative (Legal documents required)
Firma del tutor o representante (documentos legales requieridos)

_____Date/Time_____
Signature of Witness (Firma del testigo) Fecha / Hora

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 <u>one (1) hour</u> 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:

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:

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Public and Behavioral Health (DPBH)

Health Insurance Portability and Accountability Act (HIPAA)
CONFIDENTIALITY AGREEMENT

For Employees, Contractors, Temporary Workers, Students, Interns, Externs, Voluntary Workers or Other Workforce Members as defined by the Division

I acknowledge that during the course of performing my assigned duties at the Division I may have access to, use of, or disclose information which is protected by federal and state law. I hereby agree to consider this information as confidential and handle such information in a confidential manner at all times during and after my employment and commit to the following obligations:

A. I will use and disclose information received only in connection with and for the purpose of performing my assigned duties.

B. I will request, obtain or communicate information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more information than is necessary to accomplish my assigned duties.

C. I will take reasonable care to properly secure all information on my computer and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off my computer or use a password protected screensaver in order to prevent access by unauthorized users. All information I transmit by email, fax or other electronic means will be secured in accordance with Department and Division guidelines.

D. I will not disclose my personal password(s) to anyone. I will not record or post passwords in an accessible location and will refrain from performing any tasks using another person's password.

E. I will use and disclose information solely in accordance with HIPAA Privacy and Security Rules. I also agree to comply with any Division HIPAA Training requirements.

F. I will immediately report any unauthorized use or disclosure of any information of which I become aware to my supervisor or the Division's HIPAA Privacy Officer.

G. If I am a supervisor/manager, I acknowledge I am responsible to ensure all employees, contractors, temporary workers, students, interns, externs, voluntary workers or any other workforce member under my supervision, signs the Division's HIPAA Confidentiality Agreement, and completes all required training.

I understand and agree my failure to fulfill any of the obligations set forth in the Agreement and/or my violation of any terms of this Agreement may result in my being subject to appropriate disciplinary action, up to and including termination of employment in accordance with the Rules for State Personnel Administration (NAC 284) and the State of Nevada Department of Health and Human Services Incompatible Activities – Prohibition and Penalties.

I understand, if my Division is a covered entity or I work in a covered component of the Divison, the civil monetary and/or criminal penalties for misuse or misappropriation of protected health information outlined in the Health Insurance Portability & Accountability Act (HIPAA) can be levied against me personally as well as the Division. Civil penalties can range from $100 per violation to a current annual maximum of $1.5 million or as determined by federal or state law depending on the type of violation. Criminal penalties can also be imposed.

My signature below acknowledges I have read and understand the Division of Public and Behavioral Health (DPBH) and the Health Insurance Portability and Accountability Act (HIPAA) Confidentiality Agreement. Should I have any questions, I will ask my supervisor or the Division's HIPAA Privacy Officer.

_____	_____
Signature	Date
_____	_____
Print Name	Agency, Bureau, Program, or Unit

Employment Status:

- ☐ Employee
- ☐ Contractor
- ☐ Intern/Extern
- ☐ Student
- ☐ Volunteer
- ☐ Temporary Worker
- ☐ Other (Specify) _____

Control #	Rev.	Title:	Effective Date: 10/16
GOV 1.1	10/18 ~~New~~	CLINICAL SERVICES HOSPITAL GOVERNING BODY POLICY	Review Date: 10/20 ~~18~~

1.0 POLICY

The Division of Public and Behavioral Health (DBPH) in accordance with Nevada Revised Statutes NRS 449.0302 and NAC 449.286 has an established Governing Body that is legally responsible for the conduct of DBPH Inpatient Facilities. One Governing Body may be responsible for all DBPH inpatient facilities regardless of differing CMS Certification Numbers

2.0 PURPOSE

To define procedures that guide the process of DBPH inpatient facility governance and to define the shared and unique responsibilities of Hospital Administration, Medical Staff Leadership and the Governing Body.

3.0 SCOPE: Division wide, including all DBPH run inpatient facilities.

4.0 DEFINITIONS

4.1 Governing Body (NRS 440.0302 and NAC 449.286) - the person or group of persons, including a board of trustees, board of directors or other body, in whom the final authority and responsibility is vested for conduct of a hospital.

5.0 REFERENCES:

5.1 NRS 440.0302
5.2 NAC 449.286
5.3 TJC LD.02.02.01 EP1

~~5.0~~6.0 PROCEDURES

~~5.1~~6.1 The Governing Body will:

~~5.1.1~~6.1.1 Include a member or members of the hospital's medical staff
~~5.1.2~~6.1.2 Identify those responsible for the provision of care.
~~5.1.3~~6.1.3 Hold meetings at least quarterly and more frequently when needed.

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~~5.1.4~~6.1.4 Adopt a workable set of bylaws which must be in writing and available to all members.

~~5.1.5~~6.1.5 Establish and follow processes ~~mechanisms~~ for formal approval of policies, bylaws, rules and regulations of the medical staff and its departments in the hospital.

~~5.1.6~~6.1.6 Participate in the appointment of a qualified Chief Executive Officer (hospital administrator) using as its criteria the actual experience, nature and duration, or similar field, of the appointee.

~~5.1.7~~6.1.7 A member of the Governing Body may participate in the hiring panel for the Chief Executive Officer (Hospital Administrator).

6.1.8 Determine, in accordance with state law, which categories of practitioners are eligible for appointment to the medical staff.

6.1.9 Approve appointment of members of the medical staff after considering the recommendations of the existing medical staff.

6.1.10 Review written and verbal reports from the medical staff highlighting the quality of care which the medical staff provide to patients.

6.1.11 Ensure the criteria for selection of medical staff includes individual competence, training, experience and judgment.

6.1.12 In conjunction with senior managers and leaders of the organized Medical Staff work together to define in writing conflicts of interest involving leaders that could affect safety and quality of care, treatment and services.

~~5.1.8~~

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~~5.1.9 Appoint members of the medical staff after considering the recommendations of the existing medical staff.~~

~~5.1.10 Ensure that the medical staff has bylaws.~~

~~5.1.11 Approve medical staff bylaws and other medical staff rules and regulations.~~

~~5.1.12 Review written and verbal reports from the medical staff highlighting the quality of care which the medical staff provide to patients.~~

~~5.1.13 Ensure the criteria for selection of medical staff includes individual competence, training, experience and judgment.~~

~~5.1.14~~6.1.13 The Governing Body will assure that every patient is under the care of:

~~5.1.14.1~~6.1.13.1 A ~~doctor of medicine~~Doctor of Medicine or osteopathy

~~5.1.14.2 A clinical psychiatrist~~ A Physician Assistant.

~~5.1.14.3~~6.1.13.2 Advanced Practice Registered Nurse (APRN)

~~5.1.15~~6.1.14 Patients are admitted to the hospital only ~~on the recommendation~~ by the order of a licensed practitioner, permitted by the state to admit patients to a hospital.

~~5.1.16~~6.1.14.1 A ~~doctor of medicine~~Doctor of Medicine or~~,~~ osteopathy ~~or psychiatry~~ is on duty or on call at all times.

6.1.15 A ~~doctor of medicine~~Doctor of Medicine or~~,~~ osteopathy~~, psychiatry and/or and APRN~~ is responsible for the care of each patient with respect to the medical or psychiatric problem that a present on admission or develops during the hospitalization

~~5.1.17~~ 6.1.17 ~~,~~**A PA or an APRN is responsible for the care of each patient with respect to the medical or psychiatric problem that a present on admission or develops during the hospitalization as qualified and approved for practice by their respective State Board.**

~~5.1.18~~ 6.1.18 Meetings of the Governing Body shall be to:

~~5.1.18.1~~ 6.1.18.1 Evaluate the conduct of the hospital, including the care and treatment of patients.

6.1.18.2 The Governing Body shall take necessary actions

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~~5.1.18.2~~ ~~sufficient to~~sufficient to correct noted problems.

6.1.18.3 A record of all governing body proceedings which reflects all business conducted, including findings, conclusions and recommendations, shall be maintained for review and analysis.

~~5.1.18.3~~

~~5.1.18.4~~ 6.1.18.4 Take all appropriate and necessary action to monitor and restore compliance when deficiencies in the hospital's compliance with statutory and/or regulatory requirements are identified, including but not limited to monitoring the hospital administrator's submission and implementation of all plans of correction.

~~5.1.18.5~~ 6.1.18.5 Shall be responsible for the quality of patient care services, for the conduct of the agencies and for ensuring compliance with all Federal, State, and Local law.

~~5.2~~6.2 Medical Staff will:

~~5.2.1~~6.2.1 Ensure that the medical staff is accountable to the Governing Body for the quality of care provided to the patients.

~~5.2.2~~6.2.2 Ensure that under no circumstances is the accordance of medical staff membership or professional privileges dependent solely upon certification, fellowship or membership in a specialty body or society.

~~5.2.3~~6.2.3 Ensure that when telemedicine services are furnished to patients through an agreement with a ~~distance site~~ facility~~hospital~~.~~,~~ T~~t~~he agreement is written and that it specifies that it is the responsibility of the Governing Body of the ~~distance~~ receiving ~~site~~ facility ~~hospital~~ to meet the requirements in sections (A)(1) through (A)(8) of this section with regard to the ~~distance site~~originating facility~~hospital~~'s physicians and practitioners that are authorized to provide telemedicine services.

~~5.2.3.1~~6.2.3.1 The Governing Body of the facility~~hospital~~ whose patients are receiving telemedicine services may in accordance with CFR 482.33(A)(3) grant privileges based on its medical staff recommendations that rely on information provided by the ~~distance~~ originating site ~~hospital~~facility.

~~5.2.4~~6.2.4 Ensure that when telemedicine services are provided to patients through an agreement with ~~a~~an originating~~distance~~-site telemedicine

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entity, the written agreement specifies that the originating ~~distance~~ site telemedicine entity is a contractor of services.

~~5.2.4.1~~6.2.4.1 The contractor furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including but not limited to the paragraphs of this section with regard to the distance-site's medical staff.

~~5.2.4.2~~6.2.4.2 The originating~~distant~~ site's medical staff providing telemedicine services may be granted privileges based on the facility's ~~said hospital's~~ medical staff recommendations;

~~5.2.4.3~~6.2.4.3 Staff recommendations may rely on information provided by the distance-site telemedicine entity.

~~5.3~~6.3 The Chief Executive Officer is/will:

~~5.3.1~~6.3.1 Assume responsibility for management of the hospital and for providing liaisons among the governing body, medical staff, nursing staff and other departments, units or services of the hospital.

~~5.3.2~~6.3.2 Keep the governing body fully informed of the conduct of the hospital through regular written reports.

~~5.3.3~~6.3.3 Ensure that the hospital has an overall institutional plan which includes an annual operating budget that is prepared in accordance with generally accepted accounting principles (GAAP)

~~5.3.3.1~~6.3.3.1 The annual budget must include anticipated income and expenses.

~~5.3.3.2~~6.3.3.2 The hospital is not required to identify item-by-item components of each anticipated income or expense.

~~5.4~~6.4 Contracted Services – The Governing Body is responsible for services ~~whether or not~~whether they are provided by contractors. The Governing Body ensures that contractor services comply with all applicable conditions of participation and standards.

~~5.4.1~~ 6.4.1The Governing Body must ensure that the Organized Medical Staff oversee services performed under a contract. ~~are provided in a safe and effective manner via the Medical Director.~~

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~~6.0~~7.0 ATTACHMENTS: N/A

~~7.0~~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: 10/2016
REVIEW DATE:
APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH: 10/16

Control #	Rev. Date:	Title:	Effective Date: 02/1992
IMRT 2.1	11/2013	Basic Documentation Guidelines for Clinical Medical Records	Next Review Date:

1.0 POLICY:

The Division of Public and Behavioral Health will establish and maintain ~~uniform~~ consistent clinical record documentation procedures in accordance with regulating entities

2.0 PURPOSE:

To establish and maintain basic documentation guidelines for the Division of Public and Behavioral Health, healthcare facilities~~.~~

3.0 SCOPE:

DPBH- Clinical Services Branch~~Division Wide~~

4.0 DEFINITIONS:

4.1 Clinical Records, aka Medical Records/Health Records/Medical Chart/Medical File~~N/A~~

4.1.1 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

.4.1.2

Clinical D~~d~~ocumentation (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.

4.1.3 The keeper of all chart forms is defined as the Director of Health Information Services or designee. This individual shall keep an electronic copy of all agency-wide and medical record forms and collaborate with the Avatar Change Committee.

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Control #	Rev. Date:	Title:	Effective Date: 02/1992
IMRT 2.1	11/2013	Basic Documentation Guidelines for Clinical Medical Records	Next Review Date:

5.0 REFERERNCES:

5.1 The Joint Commission - Record of Care
5.2 CMS 482.24 Standard: Content of Record
5.3 CMS - Complying with Medical Record Documentation Requirements

~~5.0~~6.0 PROCEDURE:

~~5.1~~6.1 Entries in the ~~consumer~~ patients' medical record shall be:

~~5.1.1~~6.1.1 Accurate – Document the facts as observed or reported~~.~~; accurate and authenticated entries to promote uniform documentation standards. e.g., not limited to statement of general appearance including obvious "bruising" or "injury."

~~5.1.2~~6.1.2 Timely – Record significant information at the time of the ~~event,~~event. ~~as D~~delays are inappropriate and can result in inaccurate or incomplete information~~,. e.g., not limited to all restraint and seclusion documentation including physician orders, routine staff observation, and the standard seclusion and restraint documentation packet.~~ All documentation should be completed in a timely manner. Any late entries must be documented as such.

~~5.1.3~~6.1.3 Objective – Record the facts and avoid conclusions. Professional opinion must be phrased within the scope of practice for that profession. Written description of any event or any unusual event that leads to the transfer to a hospital or other facility or prior level of care should all be documented.

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~~5.1.4~~6.1.4 Specific, concise and descriptive – The medical record is a clinical communication tool and record entries should be detailed (not generalized), brief and meaningful without sacrificing essential facts, and thoroughly described observations and other pertinent information. Include specific patient quotes in medical record entries.

~~5.1.5~~6.1.5 Consistent – Entries should not be contradictory.

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~~5.1.6~~6.1.6 Comprehensive – Record significant information relative to a ~~consumer's~~ patient's condition and course of treatment. Documentation should reflect pertinent findings, services rendered, changes in the condition and the response to treatment. Information in the health record should include all medication administration information, ~~both~~ oral and intramuscular~~,~~; including physician orders, justification for the initial medication administration, the first dose review and effectiveness, any changes of increasing or decreasing dosage, including all related services or treatment provided.

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~~5.1.7~~6.1.7 Legible – All entries should be neat and readable by other persons.

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~~5.2~~6.2 ~~Consumer medical~~ Patient health record entries must include both the date and time of the entry and be authenticated by the individual making the entry. All evaluations/examinations must include the date and time the service was rendered. When information is transcribed, the date dictated and date transcribed is included along with the initials of the author and transcriptionist.

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~~5.3~~6.3 All entries will be made using the Electronic Health Record (EHR)~~the Clinical Work Station (CWS) electronic medical record;~~ unless the function is not available for entry, e.g. labs.

~~5.4~~6.4 Remarks that are ~~criotical~~ critical of treatment carried out by others that may indicate bias against a consumer or that are unprofessional should not appear in the medical record.

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~~5.5~~6.5 Medical record entries ~~should~~ will be maintained in chronological sequence. Electronic progress notes will be maintained unless the EHR is not available. During down-time, down time procedures will be followed. Lines or spaces should not remain vacant between record entries on a paper progress notes. A single line should be entered in the blank space. Do not line out vacant lines or physician order sheets.

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~~5.6~~6.6 When corrections are necessary to correct recording errors or inaccuracies in the EHR, the following procedures ~~should~~ will be followed:

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~~5.6.1~~6.6.1 The recording individual must use the APPEND function of ~~CWS~~ Avatar to add the correct or omitted information to a progress note.

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~~5.6.2~~6.6.2 If incorrect information is entered in an assessment, the recording individual must use the edit function to correct the error.

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~~5.6.3~~6.6.3 Late entries must be identified as a "late entry" with the actual date and time the entry was made. The date and time that the entry should have been made must also be documented.

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~~5.6.4~~6.6.4 In the event that a note is entered into the incorrect medical record, the note will be voided form the incorrect medical record. The recording individual will enter the note into the correct medical record. The person will notify the billing contact at their agency. The billing staff will ensure that the void is reconciled ~~to~~ so as not to generate an erroneous charge.

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~~5.7~~6.7 Entries in the ~~consumer~~ patient record should not personally identify another consumer. When reference must be made about other ~~consumers~~ patients, use initials, ~~consumer~~ patient record number, or some other form of identification such as "male peer," "roommate," "mother," etc.

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~~5.8~~6.8 Unusual occurrences, medication errors, or incidents should be recorded but not labeled as such in the medical record. They shall include a description of the event, remedial actions taken and the ~~consumer's~~ patient's condition following the event. Opinions or conclusions relative to the event should not be included in the record entry. When a separate incident report is completed, this should not be referenced in the ~~consumer~~ patient's record. Incident reports will not be filed in the medical chart.~~record~~.

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~~5.9~~6.9 When ~~consumer~~ patient abuse is observed or reported, facts relative to the abuse should be documented in the ~~consumer~~ patient record, including action taken by the staff~~.~~ (see 5.7). Staff opinions or conclusions should not be included in the record entry.

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~~5.10~~6.10 Use only agency approved abbreviations when documenting in the medical record. ~~Banned abbreviations re never to be used.~~

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~~5.11~~6.11 For each bill generated from a service provided, there must be a corresponding progress note completed by the provider describing in detail the billable service.

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~~5.12~~6.12 In the event ~~that~~ duplicate records are determined to be for one person (record merge), Health Information Services will notify Information Technology to process the record merge to include both the ~~CWS~~ Avatar and WORx portions of the record to ensure that the most accurate record is maintained for the client.

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~~5.13~~6.13 Quality Assurance Measures: Management reports will be generated to monitor the use of the void function by individual providers and follow-up as indicated.

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~~6.0~~7.0 ATTACHMENTS:

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Avatar Change Request Form~~N/A~~

~~**7.0 REFERERNCES:**~~

~~The Joint Commission – Record of Care~~

~~CMS 482.24 Standard: Content of Record~~

~~CMS N/A – Complying with Medical Record Documentation Requirements~~

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 02/07/92
Revised/Review Date: 7/7/00; 5/11/01; 9/26/01; 12/4/01; 10/13/06; 11/19/07; 11/15/13
Effective Date: 2/7/92
Approved by Administrator: 11/15/13
Supersedes: #4.030 – Basic Documentation Guidelines for Medical Records
Approved by Commission: 11/1/5/13

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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
HEALTH INFORMATION SERVICES DEPARTMENT
"DO NOT USE" ABBREVIATION LIST

Do No Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (international Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d. (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or pre-printed forms.

***Exception**: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.*

Additional Abbreviations, Acronyms and Symbols
(For possible future inclusion in the Official "Do Not Use" List)

Do Not Use	Potential Problem	Use Instead
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for U (units) when poorly written	Write "mL" or "ml" or "milliliters" ("mL" is preferred)
μg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "micrograms"

Δ	Change
# X =	Number of times
Ψ	Psychiatric
Ψ Rx	Psychotropic Medication
0 X # y	none for numbers of years
%	Percentage, percent
&	And
+	Positive
-	Negative
↓	Decreased, decrease ~~Decreased~~
↑	Increased, increase
"	Inches, inch
#	Number, pound, weight
# x =	Example 2 x is two times
#0 x # y	Example – none for number of years
lbs	Pounds
x	Times
1	Primary

For more Error Prone Abbreviations go to the Institute for Safe Medication Practices website: http://www.ismp.org/Tools/errorproneabbreviations.pdf (copy and paste into your browser).

Control #	Rev.	Title	Effective Date
SP 2.08		Student Participation in Client Evaluation and/or Treatment	Next Review Date

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1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health (DPBH) to ensure that clients are not ~~inappropriatelly~~inappropriately involved with student observers.

2.0 PURPOSE:

Create teaching/learning experiences for future health care employees.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: ~~N/A~~

4.1 Medical Staff: Medical Staff members include, physicians, advance practice registered nurses and physician's assistants who are licensed, credentialed and privileged to perform patient care duties within their scope of practice for the Division of Public and Behavioral Health.

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5.0 REFERENCES:

6.0 PROCEDURE:

6.1 Each Division agency that~~which~~ has a program using student observers or service providers shall ensure that the involvement of such individuals is clinically appropriate.

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6.2 Each division agency that ~~which~~ has a program using student observers or service providers shall develop specific written procedures that require review and approval of student involvement by DPBH professionals having primary responsibility for the client's treatment.

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Control #	Rev.	Title	Effective Date
SP 2.08		Student Participation in Client Evaluation and/or Treatment	Next Review Date

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6.3 Informed consent allowing student observers ~~of the client is required before a student observer or service provider interacts with the client.~~ is included in the general consent package that each patient acknowledges on admission into DPBH Clinical Services Branch facilities.

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6.4 When students enter the exam room with Medical Staff, they will be introduced to the client as a student observer.

6.4.1 Consent is included the general consent and need not be repeated here, however if the client states that they do not want the student to be present, this must be honored.

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6.4.2 The student's presence will be document in the progress notes.

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6.5~~4~~ Students accepted for practicums, internships, or other related experiences within DPBH Clinical Service Branch~~division~~ agencies must be ~~ensure that students accepted for such involvement are~~ affiliated with an institute of higher learning or registered with a licensing board to practice under supervision and with whom the state has a training site agreement.

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7.0 ATTACHMENTS: None

8.0 IMPLEMENTATION OF POLICY:

~~8.0~~

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

EFFECTIVE DATE: 4/30/1998
DATE RE~~re~~VISED: 02/04/99
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:

Control #	Rev.	Title	Effective Date
SP 2.08		Student Participation in Client Evaluation and/or Treatment	**Next Review Date**

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Control #	Rev:	Title:	Effective Date:
SP 4.14		Outpatient Psychotherapy/Counseling Case Review/Medication Clinic	12/31//97 Next Review Date

1.0 POLICY:

To review the length of treatment for all clients receiving outpatient psychotherapy/counseling services/service coordination services or medication clinic services.

2.0 **PURPOSE**:

To ensure that the length of treatment and services for all outpatient clients is appropriate.

3.0 SCOPE: Clinical Branch Services

4.0 DEFINITIONS:

4.1 Interdisciplinary Team means a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient.

4.2 Multidisciplinary Team means a group of health care professionals where each **team** member uses his or her own expertise to develop individual care goals. Multidisciplinary teams may not work in a coordinated fashion toward a common goal for the patient.

5.0 REFERENCES: N/A

6.0 PROCEDURE:

6.1 All outpatient cases receiving psychotherapy/counseling/case management or medication clinic services must be reviewed at intervals of 90 days or 12 psychotherapy/counseling sessions, whichever is shorter, to determine the need for continuing treatment.

6.2 The review must be conducted by an Interdisciplinary Team who must review the case directly.

6.2.1 Input from the person receiving services, regarding the need for continued services, is required and must be considered.

6.2.1 Documentation of this review must be entered into the client's clinical record.

Control #	Rev:	Title:	Effective Date:
SP 4.14		Outpatient Psychotherapy/Counseling Case Review/Medication Clinic	12/31//97 Next Review Date

6.3 The criteria for documented need to continue services should not be restricted to any partial or theoretical orientation, but should be concerned with the client's level of functioning and the progress made to date.

6.4 If there is no documented need for continuous treatment, or if there is no contact from the client for 90 days, the case must be closed.

6.5 If an agency wishes to establish a different interval for review of cases than the interval in this policy, the agency administrator shall submit such request to the Division Administrator.

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: 12/31/97
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev.	Title	Effective Date: 7/1/97
SP 4.16	7/1/99	**Training Policy**	
			Next Review Date: 7/1/99

1.0 POLICY:

It is the policy of the Department of Public and Behavioral Health (DPBH) to ensure that specific training and development opportunities are provided to help employees perform their work in the most effective way and adapt themselves to changing treatment technology.

While it is the responsibility of each employee to improve his or her own professional competence, the Division will complement these efforts where training can be of direct benefit to the agency. Training will be provided to Division employees without regard to race, color, national origin, sex, religion, age disability or rank.

2.0 PURPOSE:

~~2.0~~ To provide guidelines regarding required training for all employees

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

~~4.0~~ 4.1 Direct Care Employees

5.0 REFERENCES:

5.1 NRS 289.510 and NAC 289.160

5.2 NRS 284.498

~~5.0~~6.0 PROCEDURE:

~~5.1 Division Training Officer~~

~~The administrator will appoint a Division employee to serve as Division Training Coordinator. The responsibilities of this appointment shall be incorporated into the appointees work performance standards. These responsibilities include the following:~~

- ~~Chair the Division Training Committee,~~
- ~~Facilitate meeting of Division Training Committee.~~
- ~~Collect quarterly reports from agency training coordinators,~~
- ~~Develop quarterly reports for submission to the Administrator of DPBH,~~

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- ~~Research and identify resources for professional workshops sponsored by the Division.~~
- ~~Oversight of Division's training budget~~

~~5.2~~ 6.1 Agency Training Coordinator

Each agency manager ~~director administrator?~~ will appoint a staff person or persons to serve as the agency training coordinator.

6.1.1 The responsibilities of this appointment shall be included in the appointees' work performance standards.

6.1.2 This appointment includes the following responsibilities:

- ~~6.1.2.1 Represent the agency at the Division Training Committee,~~
- Facilitate the development of the agency's training plan,
- 6.1.2.2 Develop and submit the agency's quarterly training reports,
- 6.1.2.3 Oversee the tracking of training activities at the agency,
- 6.1.2.4 Coordinate the agency training requests and approval process.
- 6.1.2.5 Oversee the agency training budget and spending.

~~5.3 Training Committee~~

~~The Division shall maintain a statewide training committee to monitor the development and implementation of agency and Division training plans, as well as the expenditure of training monies.~~

~~5.3.1 The statewide training committee shall be composed, for voting privileges, of the training coordinator from each Division agency, a representative of the planning and evaluation Unit, and the Division Training Officer. Other individuals with interest in training may attend the meeting, but do not have voting privileges.~~

~~5.3.2 The committee shall meet at least once every quarter to discuss and monitor development and implementation of training plans for technicians/forensic specialist, professional staff, case management staff, quality assurance and program evaluation staff and support staff to ensure that legislatively mandated training is being carried out and monies are appropriately allocated and expended.~~

~~5.3.3 The committee shall develop, monitor and update, as necessary, a statewide training plan, in which all agencies and the Division participate.~~

~~5.4~~ 6.2 Program

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			Next Review Date: 7/1/99

6.2.1 Each agency manager ~~administrative officer~~, ~~working with the Division Training Coordinator, shall~~ will conduct a biannual training needs assessment in the agency prior to the biannual budget preparation.

6.2.2 Based on the assessment a training plan:

6.2.2.1 ~~,~~ include an estimate of costs associated with training will be developed and submitted.

6.2.2.2 The training plan and cost estimates shall include specific goals for each category of employee below.

6.3 All Staff

6.3.1 Required training on hire and annually

6.3.1.1 HIPAA Awareness

6.3.1.2 Client Rights

6.3.1.3 Cultural Competencey

6.3.1.4 KnowBe4 (Nevada Information Security Awareness)

6.3.2 Required training on hire with periodic intervals

6.3.2.1 Sexual Harrassment Prevention

6.3.2.2 Defensive Driving

~~5.4.1~~ 6.3 Technician/Forensic Specialist

6.3.1 The primary vehicle for training mental health technician/forensic specialist staff members is the Technician Certification Program established by the Division and the legislature to be conducted by the community college system.

6.3.1.1 This certification is primarily a progression reqirement [five (5) credits from Tech I to Tech II and five (5) credits from Tech II to Tech III]~~, but it~~

6.3.1.2 The certification is also the primary clinical training prograom for technicians/forensic specialists.

6.3.1.3 All technician/forensic staff members are required to complete the program within two (2) years of their hire date [half time staff within four (4) years of their hire date].

6.3.1.4 The employee's progress through the certification program shall be tracked in the employee's annual appraisal under "Developmental Plan and Suggestions."

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6.3.1.5 If the employee does not comply with the provisions for certification within the frame indicated, and there are no extenuating circumstances, as enumerated in NAC 433, they~~he or she~~ shall receive a "must improve" for the "Developmental Plan and Suggestions" category of the evaluation, until the certification is completed or the individual is dismissed.

6.3.1.5 There is no "grand-fathering" in this program.

6.3.1.6 In each quarterly report, the training office ~~agency directed~~ wis~~sha~~ll submit a list of employees who are not certified on the "Individual Training Report" form. [Attachment A]

~~The following classes serve as the core curriculum of the certification program and all staff members must complete them before they can be certified:~~

- ~~Role of the Technician in DPBH~~
- ~~Introduction to Therapeutic Interventions~~
- ~~Advanced Therapeutic Interventions or Application of Learning Theory~~
- ~~Assaultive Behavior Intervention~~

6.3.2 Additional classes within the DPBH series, as approved by the agency, shall be taken as electives to complete the requisite 150 hours (10 credits) required for certifications.

6.3.3 The agency director~~y~~, working with the training coordinator, and the technician/forensic specialist supervisor is responsible for tracking the progress of each technician/forensic specialist staff member in his or her progress through the certification program using the "Technician Certification Record" [Attachment B]. ~~An updated copy will be included in the Quarterly Report to the Division training officer.~~

6.3.4 Once certified, the technician/forensic specialist staff member must maintain their ~~his or her~~ certification by completing 20 hours of continuing education units every two (2) years following the date on which initial certification was issued.

6.3.5 Each agency will approve CEU training that is commensurate with the employee's responsibilities within the agency ~~and defensible before the training committee.~~

6.3.6 -Employees failing to meet the CEU requirements will receive a "must improve" for the developmental plan and suggestions" category of the evaluation, until the certification is completed, the employee terminates or the individual is dismissed.

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~~Once certified, the technician/forensic specialist staff member must maintain his or her certification by completing 20 hours of continuing education units every two years following the date on which initial certification was issued. Each agency will approve CEU training that is commensurate with the employee's responsibilities within the agency and defensible before the training committee. Employees failing to meet the CEU requirements will receive a "must improve" for the developmental plan and suggestions" category of the evaluation, until the certification is completed, the employee terminates or the individual is dismissed.~~

6.3.7 The agency director is responsible for ensuring that the provisions of NRS 433.279, as detailed in NAC 433, regarding the technician certification program are adhered to in their~~his or her~~ agency. ~~The Division training committee shall monitor the technician/forensic specialist certification program established through the community colleges to ensure the quality of the training.~~

~~5.4.2~~ 6.3.8 Forensic Specialists

6.3.8.1 In addition to meeting the requirments of the Technician Certification Program, n~~N~~ew Forensic-I Specialists are also required to attend the Peace Officer Standards and Training (POST) Academy within their first year after hire to meet the requirements of a Category III Peace Officer; NRS 289.510 and NAC 289.160.

6.3.8.2 The POST Academy requires that Forensic Specialist I cadets complete the following with Category III scores:

6.3.8.2.1 A physical agility test;

6.3.8.2.2 Fire Arms proficiency; and an

6.3.8.2.3 Academic test at the end of the Academy.

6.3.8.3 The Forensic Specialist I, II and III must also complete 12 hours of agency prescribed training annually including an approved system of de-escalation and defensive tactics ~~(CPART)~~ and to retain their Category III Certification.

~~5.4.3 Professional:~~

~~The Division training committee is charged with the responsibility of completing a plan for the division sponsored workshops on topics drawn from the needs assessment survey of professional staff members. This plan is to be incorporated into the Division comprehensive training plan. It shall be the responsibility of the Division training officer, working with the committee, to~~

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~~research and identify resources for workshop training and complete contractual arrangements with workshop providers.~~

~~5.4.4~~ 6.4 Service Coordinators:

6.4.1 For purposes of training any staff member who functions as a service coordinator or at least ½ of their FTE is devoted to service coordination (Rural Clinics), will be defined as a service coordinator.

6.4.2 These individuals will be included in the service coordinator section of the agency training plan.

~~5.4.5~~ 6.5 Support Staff

6.5.1 The agency shall ensure that the training needs identified by support staff on the needs assessment are included in the agency training plan.

~~5.4.6~~ 6.6 Supervisory Staff

6.6.1 Any staff member responsible for the direct supervision of any other staff member shall complete 40 hours of supervisory training, in addition to Equal Employment Opportunity (EEO) and alcohol and drug t~~T~~esting p~~P~~rogram, from the classes listed below that are offered by the state Personal Training, or the equivalent.

- 6.6.1.1 Work Performance Standardss
- 6.6.1.2 Disciplinary Procedures
- 6.6.1.3 Elements of Supervision
- 6.6.1.4 Employee Appraisal
- 6.6.1.5 Essentials of Management
- 6.6.1.6 Handling Grievances
- 6.6.1.7 Sexual Harassment in the Work Place
- 6.6.1.8 Supervisor's safte~~r~~y Training

6.6.2 NAC 284.~~,~~498 specifies training concerning the preparation of a report on

6.6.2.1 performace [documentation of completion to be sent to personnel records section, department of personnel],

6.6.2.2 a drug-free workplace, and equal employment opportunity [at least six (6) hours of training on this subject].

6.6.2.3 Training for new supervisors is to be completed within six (6) months of being appointed to a supervisory position~~.~~ ~~Supervisors are encouraged to take all classes.~~

6.6.2.4 Classes need not be repeated should an individual accept a new appointment.

~~5.5~~ 6.7 Other Training Requirements

6.7.1 Any staff ~~member~~ hired by the Division shall have completed the State Personnel training "Sexual Harassment in the work place", or the equivalent, within six (6) months of his/her hire date.

6.7.2 Any staff Hired by the Division shall complete all mandatory state training requirement.

6.7.2 Agencies whose policies require that direct-care staff be certified in CPR and First Aid must have documentation of this training in the employee's personal jacket.

6.8 All Division direct care employees are to receive training on the following Clinical Services Branch ~~Division~~ policies

- 6.8.1 DPBH CRR 1.1 ~~#2.001~~ Client Rights
- 6.8.2 #2.003 Abuse or Neglect of Clients
- 6.8.3 ~~#2.005~~ DPBH CRR 1.3 ~~Restraint/~~Seclusion/Restraint ~~-~~of Clients
- 6.84 DPBH CRR 4.29 ~~#4.029~~ Suicide Risk Assessment Procedure

~~5.6~~ Tracking and Reporting

~~5.6.1~~ Each agency director is responsible for tracking mandated training in a manner that allows required reports to be generated.

~~5.6.2~~ Each agency director, working with the training coordinator, shall submit a quarterly report of training to the division training officer. The report shall be in the format established by the Division

~~5.6.3~~ The Division training officer shall submit a quarterly report to the division administrator regarding the training conducted and the progress made by each agency towards the training goals laid out in the training plan.

~~5.7~~ Procedures for employee requesting training

~~5.7.1~~ Training request forms must be fully completed by the requesting staff member, including signature. Once completed the form is submitted to the requesting employees' direct supervisor for approval.

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~~5.7.2~~ All training request must be submitted on the appropriate form.

- Training sponsored by the Department of Personnel must be submitted on a TR-17 Form.
- All other training request must be submitted on the Department of Human Resources HR-1 form
- All out-of-state training request must include a completed out-of-state travel request form. Out-of-state- training request require the approval of the Division administrator and the Department of Human Resources. Appropriate verifying documentation must accompany the request. Departure without such approval will be entered as leave without pay or compensatory or annual leave if those resources are available.

~~5.7.3~~ The supervisor must access the request based on the appropriateness of the training requested and coverage and administrative leave considerations. If approved the supervisor then submits the request to the agency training coordinator.

~~5.7.4~~ The training coordinator must then assess the training based on appropriate and availability of funds. If approved, the training coordinator then submits the request to the agency director.

~~5.7.5~~ Finally, the agency director must assess the training request. If approved the director returns the approved form to the training coordinator who will notify the requesting employee and forward the request to the business manager so that funds may be encumbered.

~~5.7.6~~ If, at any stage, the request for training is not approved, the form is to be returned to the employee request the training, through the chain of command, with a comment as to why the training was disapproved in the comment box on the form.

~~5.8~~ Employee responsibilities and limitations

~~5.8.1~~ It is the responsibility of the employee to provide verification to the agency training coordinator upon completion of any training. This verification can be a certificate of completion, an agency training verification form signed by the trainer, or other formal documentation verifying that the employee completed the training. Failure to submit proper verification may result in the absence being recorded as leave without pay (LWOP)

~~5.8.2~~ Employees are to identify approved leave on time sheets in accordance with existing policy and procedure.

~~5.8.3~~ To be reimbursed for cost of training, an employee must have prior approval and submit verification of cost and successful completion of the training to the agency training coordinator, who will forward these documents to the business office. Reimbursements cannot be made without verification.

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~~5.8.4~~ The training request procedure shall be completed before the training occurs. Neither the agency nor the Division is responsible for granting leave or reimbursement for training request made after the fact.

~~5.8.5~~ No more than twenty-four [24] hours of release time per staff member per fiscal year may be granted for job related training without the approval of the Division administrator or designee. This twenty-four [24] hour limit does not include agency or Division required or sponsor training, travel time to and from training, or thr required hours of supervisory or managerial training, required safety training, or P.O.S.T. or Technician Certification training.

~~5.9~~ Fiscal procedures

~~5.9.1~~ Each agency shall manage the training allocation as a budget line item. The procedure for encumbering and paying of training monies is the responsibility of agency or regional business managers. Agency business managers are responsibility for including training expenditures as part of the monthly operating statement for the agency to the Division.

~~5.9.2~~ The agency director and the agency training coordinator shall establish fund distribution for each category based on the training needs assessment and training plan.

5.10 Each Division agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency policy manual.

7 REFERENCES:

NRS 433.279
NAC 433
~~6.0~~ NAC 284.498

8 ATTACHMENTS:

"Individual Training Report" form. [Attachment A]
Technician Certification Record" [Attachment
~~7.09~~ B].

~~8.0~~10 IMPLEMENTATION OF POLICY:

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

ADMINISTRATOR

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EFFECTIVE DATE: 7/1/97
REVISION DATES: 11/06/00; 12/19/01; 02/05/02; 03/07/02
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:

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Division of Mental Health and Developmental Services
Policy #4.016 – Training Policy
Attachment A

MENTAL HEALTH AND DEVELOPMENTAL SERVICES
TECHNICIAN/FORENSIC CERTIFICATION PROGRAM

INDIVIDUAL TRAINING REPORT

I, _____, Director of _____, verify that, with the exception of those
(print or type agency director's name) *(print or type agency name)*
listed below, all technician/forensic staff within this agency have been certified through the Technician/Forensic Specialist Certification Program and have met the continuing education requirements established by Division Training Policy and NRS 433.279.

TECHNICIANS/FORENSICS WHO ARE NOT CERTIFIED:

NAME	SOC. SEC. #	REASON NOT CERTIFIED:	PLAN FOR CERTIFICATION:

CERTIFIED TECHNICIANS/FORENSICS WHO HAVE NOT MET CONTINUING EDUCATION REQUIREMENTS:

NAME	SOC. SEC. #	REASON NOT CERTIFIED:	PLAN FOR CERTIFICATION:

A copy of this form shall be submitted to the Division Training Officer within 15 days of the end of the fiscal year. Use additional pages as necessary.

_____ _____

Agency Director Date

Control #	Rev. Date:	Title:	Effective Date: 12/1997
SP 4.18 (4.018)	09/2007	Civil Admission Criteria and Process for Consumer Admission	Next Review Date:

1.0 POLICY:

It is the policy that psychiatric inpatient admissions be based on established criteria and statute.

2.0 PURPOSE:

This policy specifies procedures for admitting consumers to state psychiatric inpatient facilities both civil and forensic while ensuring their safe and legal treatment.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Person with Mental Illness (NRS 433A.115) means any person whose capacity to exercise self-control, judgment and discretion in the conduct of the person's affairs and social relations or to care for his or her personal needs is diminished, as a result of a mental illness, to the extent that the person presents a clear and present danger of harm to himself or herself or others, but does not include any person in whom that capacity is diminished by epilepsy, intellectual disability, dementia, delirium, brief periods of intoxication caused by alcohol or drugs, or dependence upon or addiction to alcohol or drugs, unless a mental illness that can be diagnosed is also present which contributes to the diminished capacity of the person.

4.1.1 A person presents a clear and present danger of harm to ~~themself~~themselves if, within the immediately preceding 30 days, the person has, as a result of a mental illness:

4.1.1 ~~-~~Acted in a manner from which it may reasonably be inferred that, without the care, supervision or continued assistance of others, the person will be unable to satisfy their need for nourishment, personal or medical care, shelter, self-protection or safety, and if there exists a reasonable probability that the person's death, serious bodily injury or physical debilitation will occur within the next following 30 days unless he or she is admitted to a mental health facility pursuant to the provisions of NRS 433A.115 to 433A.330, inclusive, and adequate treatment is provided to the person;

4.1.3 Attempted or threatened to commit suicide or committed acts in ~~furtherance of~~furtherance of a threat to commit suicide, and if there exists a reasonable ~~probability that~~probability that the person will commit suicide unless he or she is admitted to a mental health facility pursuant to the provisions of NRS

433A.115 to 433A.330, inclusive, and adequate treatment is provided to the person; or

4.1.4 Mutilated himself or herself, attempted or threatened to mutilate himself or herself or committed acts in furtherance of a threat to mutilate himself or herself, and if there exists a reasonable probability that he or she will mutilate himself or herself unless the person is admitted to a mental health facility pursuant to the provisions of NRS 433A.115 to 433A.330, inclusive, and adequate treatment is provided to the person.

4.1.5 A person presents a clear and present danger of harm to others if, within the immediately preceding 30 days, the person has, as a result of a mental illness, inflicted or attempted to inflict serious bodily harm on any other person, or made threats to inflict harm and committed acts in furtherance of those threats, and if there exists a reasonable probability that he or she will do so again unless the person is admitted to a mental health facility pursuant to the provisions of NRS 433A.115 to 433A.330, inclusive, and adequate treatment is provided to him or her.

4.2 Legal 2K – an application for emergency admission

4.3 Types of admission to Mental Health Facilities
~~4.4.1 Voluntary~~4.4.1 Voluntary
~~4.4.2 Emergency~~4.4.2 Emergency
~~4.4.3 Involuntary~~4.4.3 Involuntary

5.0 PROCEDURE:

5.1 ~~Division psychiatric~~Division psychiatric ~~facilities provide~~facilities ~~full~~provide full ~~service treatment~~service treatment to people with mental illness who are capable of participating in a treatment program, including inpatient and psychiatric emergency care in Rapid ~~Stabalization~~Stabilization Units (RSUs) .

5.2 Division forensic mental health service provide a range of services to individuals in the criminal justice system including assessment and treatment to competency.

5.3 Inpatient civil psychiatric facilities shall accept for admission individuals who ~~are referred~~are referred pursuant to NRS 433A.150, voluntary, emergency, or involuntary admissions.

5.4 Forensic ~~facilities shall~~facilities shall accept consumers referred under NRS 178 and administrative transfers.

5.5 DPBH clinical services inpatient Units, have no acute detoxification, maternity (including ~~post partum~~post-partum), surgical or medical capabilities, child, and adolescent capabilities. The Mobile Crisis team and admissions department will ~~determine~~ screen for exclusion criteria as listed in 5.5.1-5.5.6 and 5.6.1 as well as medical condition complexity that exceed the agency's' capacity to provide proper care. ~~service exclusion criteria to include~~:

- 5.5.1 Individuals only diagnosed with organic brain syndromes;
- 5.5.2 Individuals with repeated utilization reviews and diagnosis indicating malingering behaviors; ~~ie.~~i.e.) a lone diagnosis of a personality disorder
- 5.5.3 Individuals diagnosed with primary diagnosis of substance abuse with repeated refusal to engage in a residential or outpatient treatment programs.
- 5.5.4 Individuals with known infectious diseases.

5.6 The primary diagnoses of record shall be consistent with the Diagnostic and Statistical Manual of Mental Disorders –V (D.S.M. V) & (ICD – 10 – CM).

- 5.6.1 The following Diagnoses shall not be utilized as the primary diagnosis for admitting individuals to inpatient services:
  - 5.6.1.1 Alcohol Use Disorder
  - 5.6.1.2 Substance ~~Ab~~U~~u~~se Disorder
  - 5.6.1.3 Adjustment Disorder
  - 5.6.1.4 Malingering
  - 5.6.1.5 Personality Disorder
  - 5.6.1.6 Academic Problem
  - 5.6.1.7 Acculturation Problem
  - 5.6.1.8 Age Related Cognitive Decline
  - 5.6.1.9 Autism Spectrum Disorder
  - 5.6.1.10 Major and Minor Neurocognitive D~~d~~isorders
  - 5.6.1.11 Intellectual and/or Developmental Disabilities (Individuals cooperatively served by DH~~PB~~H agencies shall have the permission of the Medical Director)
  - 5.6.1.12 Z~~V~~-codes in general for primary diagnosis.
- 5.6.2 These diagnoses may, however, be secondary to another acceptable primary D.S.M. 5~~V~~ / ICD – ~~9~~/10 - CM Psychiatric Diagnosis.

5.7 The usual route of admission to civil units will be through the Rapid

~~Stabalization~~Stabilization Unit (RSU).

5.8 Admission to the forensic unit occurs only via a court order per NRS 178 or Administrative Transfer approved by the DPBH Administrator.

5.9 Division agencies shall use the proper form pursuant to NRS 433A.130 for consumers admitted under emergency hospitalization. If the referring agency does not have the appropriate form, the Division agency will provide the necessary forms. Every effort shall be made to assist the referring agency with admission standards before a consumer is denied admission.

5.10 Forensic facilities do not accept emergency admissions.

5.11 Individuals who present at admission will be assessed and processed by the DPBH admission staff in a timely and courteous manner.

5.11.1 Each Division agency will develop a quality assurance tracking system that ~~–~~will be able to track how long it takes individuals to be evaluated and admitted or refused admission.

5.11.2 The quality assurance system shall include a consumer satisfaction survey.

5.11.3 In the case of forensic facilities, this survey shall include periodic surveys of the courts.

5.12 Consumers admitted to DPBH facilities, pursuant to NRS 178, 433A.150, 433A.310, are to be closely supervised and monitored to prevent escape or elopement from any and all activities.

5.12.1 Agencies will develop/implement the necessary protocols and procedures that address staff duties and responsibilities regarding consumer escapes, elopements or conditional leave.

5.13 No Division-employed Medical ~~psychiatrist~~Staff may refuse to admit an individual who is being referred for emergency admission only if ~~unless~~ the referring physician is contacted and the case is discussed.

~~5.13.1 If~~5.13.1 If the referring physician is not available, the referring facility will be contacted and the case will be discussed and/or confirmation will be made that all documentation and/or information has been received from the sending facility. This procedure must be documented.

5.14 No consumer referred on a court order will be denied admission.

5.14.1 If the admission staff or agency director feel that the court order is clinically inappropriate or that the court order ~~is in conflict with~~conflicts with Nevada Revised Statutes or existing cooperative transfer agreements, they should contact the Division Administrator.

5.14.2 The Division Administrator shall refer the matter to the Deputy Attorney General for a legal opinion.

5.14.3 In no instance shall any agency violate or fail to comply with the court order which has been issued.

5.14.4 Forensic facilities shall admit consumers in the sequence the court order was filed, as well ~~as, based~~as, based on consideration of acuity.

5.14.4.1 Consumers shall not be admitted to forensic facilities in excess of the allotted bed census.

5.15 Agencies or programs who are referring consumers for inpatient services shall establish policy and procedures that ensure forms are properly completed, evaluations are conducted, treatment plans are enacted and clinical progress notes are faxed to the admission office.

5.16 Each agency who receives crisis calls after normal working hours shall establish appropriate procedures to ensure that calls are expeditiously handled. Procedures should include provisions for a telephone service log, follow-up intervention, staff training, etc.

5.16.1 The telephone service log should include date and time of call, name of caller, staff time spent on call and staff member's name, ~~whether or not~~whether caller was homicidal or suicidal, and a brief statement of caller's problem and disposition of the case.

~~5.16.1~~

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5.17 Agencies shall ensure that any consumer who is being transferred by the police or sheriff's office receives priority admission service so that officers are not unduly delayed.

5.18 Agencies shall have COBRA procedures in place.

5.19 If after the evaluation process it is determined that the individual does not require hospitalization, an appropriate referral shall be made and documented.

6.0 ATTACHMENTS: N/A

7.0 REFERERNCES:

7.1	NRS -125C.0605	Adult defined
7.2	NRS 433A.115	Mentally ill person defined
7.3	NRS 433A.120	Types of admission
7.4	NRS 433.A130	Forms of admission
7.5	NRS 433A.140	Voluntary admission
7.6	NRS 433A.150	Emergency admission procedure

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: 12/31/97

DATE REVISED: 1/15/99; 4/3/00; 5/11/01; 5/16/02; 6/24/03; 7/1/03; 8/26/~~05; 9~~05; 9/27/07

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:

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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev.	Title	Effective Date:
SP 4.19	**New**	Over Dose Reporting Requirement	**Next Review Date**

1.0 POLICY:

Clinical Services Branch agencies will report drug overdoses or suspected drug overdoses pursuant to AB 474: Controlled Substance Abuse Prevention Act.

2.0 PURPOSE:

To provide guidance and direction

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS

4.1 **Overdose:** A condition including, without limitation, physical illness, a decreased level of consciousness, respiratory depression, coma, or death resulting from intentional or accidental consumption of a drug more than its prescribed or intended use.

4.2 **Drug:** A medication or substance scheduled as a schedule I, II, III or IV drug by the United States Drug Enforcement Agency.

4.3 **Provider of Healthcare:** A physician or nurse licensed in accordance with state law or a physician assistant licensed pursuant to Nevada Revised Statutes (NRS) Chapter 630 or 633.

5.0 REFERENCES:

5.1 **AB 474:** Controlled Substance Abuse Prevention Act

6.0 PROCEDURE:

6.1 No later than seven (7) days after discharge, a SNAMHS provider of healthcare who knows of or provides services to a patient who has suffered or is suspected of having suffered a drug overdose shall report each incident on the State of Nevada Overdose Reporting Form in its entirety.

6.2 Overdose reporting is required ***only if the primary reason for the patient visit/interaction is to address the patient overdose.***

6.2.1 ICD 10 codes related to the overdose or suspected overdose shall include one or more of the following and will be documented in the Overdose Reporting Form:

6.2.1.1 T40- Poisoning by, adverse effect of and under dosing of narcotics and psychodysleptics [hallucinogens]

6.2.1.2 T42- Poisoning by, adverse effect of and under dosing of antiepileptic, sedative- hypnotic and antiparkinsonism drugs

6.2.1.3 T43- Poisoning by, adverse effect of and under dosing of psychotropic drugs, not elsewhere classified

6.2.1.4 T41.1- Poisoning by, adverse effect of and under dosing of intravenous anesthetics

6.2.1.5 F55.3- Abuse of steroids or hormones

6.2.2 The completed Overdose Reporting Form shall be faxed to the Nevada Division of Public and Behavioral Health.

7.0 ATTACHMENTS:

7.1 Overdose Forms Fillable Attachment A

7.2 Overdose Reporting Frequently Asked Questions Attachment B

8.0 IMPLEMENTATION OF POLICY

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

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

Nevada Overdose Reporting Frequently Asked Questions

Who is required to report?

Per Nevada Administrative Code (NAC) 441A. 100, a "provider of healthcare" means a physician, nurse or veterinarian licensed in accordance with state law or a physician assistant licensed pursuant to Nevada Revised Statutes (NRS) Chapter 630 or 633.

Is a dentist required to report?

No, a healthcare provider of a discipline not listed in NAC 441A.100 is not required to report. For example, dentists are licensed pursuant to NRS Chapter 631, and therefore are not required to report.

What if a "provider of healthcare" is made aware that their patient overdosed previously (i.e. the overdose is not the primary reason for the current interaction with the patient)?

The provider of healthcare should only report the overdose if the primary reason for the visit is to address the overdose. This law is not intended to report on previous overdoses that the provider of healthcare was not addressing during the current interaction with the patient.

How do I report?

All reports will go the Division of Public and Behavioral Health via fax to 775-684-5999. If you are interested in establishing electronic reporting, please contact Julia Peek at jpeek@health.nv.gov. The form can be found prescribe365.nv.gov.

What if I do not have or collect some of the variables indicated on the form?

Please indicate that it is not collected or not available and submit the form with the information you do have.

What type of overdose is reportable?

As defined in the emergency regulations, a drug overdose or suspected drug overdose is reportable if the suspected drug is categorized as a schedule I, II, III, or IV drug by the United States Drug Enforcement Administration.

Does a hospice need to report?

Based on the intent of the overdose reporting, it is not intended to collect overdose data to identify individuals with a terminal illness who are receiving palliative medication at the end of life. In this case, the provider of healthcare need not submit a report.

How long are the emergency regulations in effect?

The emergency regulations (found here: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Resources/opioids/AB474-Emergency-Regulations.pdf) will be effective for 120 days, starting on Friday, January 19, 2018.

How can I provide input on the permanent regulations?

There are many opportunities to provide feedback on the permanent regulations.

- Small businesses can reply through January 24, 2018 to the small business impact survey on the DPBH website found here: http://dpbh.nv.gov/Resources/opioids/AB474-Regulations/.
- Any member of the public can provide feedback on the regulations at the public workshops planned for mid-February. These meetings will be posted on the DPBH website as well as the Nevada Public Notice Website found here: https://notice.nv.gov/.
- If you are unable to provide feedback in these mechanisms, you can provide written comments to Julia Peek, Deputy Administrator, Community Services at jpeek@health.nv.gov.

If multiple providers of healthcare treated the same patient during the overdose, are all of them required to report?

It is the intention of the law to receive one overdose report per patient. As noted in Section 3 of the emergency regulations, a medical facility in which more than one provider of healthcare may know of, or provide services to, a person who has or is suspected of having suffered a drug overdose shall establish administrative procedures to ensure that the health authority or Chief Medical Officer or his or her designee, as applicable, is notified. The facility should note in the procedure which provider of healthcare is required to report on behalf of that patient interaction.

Can a healthcare facility report on behalf of their providers of healthcare?

Yes, a weekly batched electronic report from the facility is the preferred method of reporting. If you are interested in establishing electronic reporting, please contact Julia Peek at jpeek@health.nv.gov.

1.0 POLICY:

It is the policy of the Department of Public and Behavioral Health (DPBH) to establish protocols for laboratory work-up on clients who are on psychotropic medications.

2.0 PURPOSE:

To monitor the appropriate laboratory evaluation of patients who are receiving psychotropic medications.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Chemistry Panel: (also called metabolic panel) includes Glucose test, Alkaline Phosphate, ALT (SGOT), AST (SGPT), BUN, Creatinine, Sodium, Potassium, Chloride, Calcium, Carbon Dioxide, Total Protein, Total Bilirubin, Albumin and Direct Bilirubin.

4.2 Lipid Panel includes: Total Cholesterol, Triglycerides, HL Cholesterol, VLDL Cholesterol calculated, and LDL Cholesterol calculated.

4.3 Thyroid Panel includes: Thyroxine (T4) Free Direct, Triodothyronine (T3) and Thyroid Stimulating Hormone (TSH).

4.4 Liver Function Test – includes Albumin, Alkaline Phosphatase, ALT (SGOT), AST (SGPT), Total Bilirubin, Direct Bilirubin and Total Protein.

4.5 Abbreviations:

- 4.5.1 Chem Panel – Metabolic Panel – Chemistry Panel
- 4.5.2 BUN – Blood Urea Nitrogen
- 4.5.3 IV – Intravenous
- 4.5.4 EKG – Electrocardiogram
- 4.5.5 UA – Urinalysis
- 4.5.6 CBC – Complete Blood Count
- 4.5.7 CR – Creatinine
- 4.5.8 PT/PTTT – Prothrombin Time/Partial Prothrombin Time
- 4.5.9 LFT – Liver Function Tests

5.0 REFERENCES: N/A

6.0 PROCEDURE:

6.1 All patients receiving medication for psychiatric or related conditions should undergo the following laboratory work-up:

6.1.1 EKG – any patient over 40 years of age if their history is positive for cardiovascular disease, diabetes, renal disease or hyopertension.

6.1.1 Chemistry Panel, UA

6.1.2 CBC with differential Tests listed in items B-C above do not need to be performed if:

6.1.3 The results of these tests are available before the medication is prescribed and were done in the last three months.

6.1.4 Results are obtained from another reliable facility that meet the above criteria and are available prior to treatment.

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EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

~~DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:~~

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4.5.6 CBC – Complete Blood Count

4.5.7 CR – Creatinine

4.5.8 PT/PTTT – Prothrombin Time/Partial Prothrombin Time

4.5.9 LFT – Liver Function Tests

5.0 REFERENCES: N/A

6.0 PROCEDURE:

6.1 All patients receiving medication for psychiatric or related conditions should undergo the following laboratory work-up:

6.1.1 Chemistry Panel, UA

6.1.2 CBC with differential, 4.51, 4.55 and 4.56 above do not need to be performed if:

6.1.2.1 The results of these tests are available before the medication is prescribed and were done in the last three (3)months.

6.1.2.2 Results are obtained from another reliable facility that meet the above criteria and are available prior to treatment.

6.2 Lab tests can be ordered concurrently with a prescription for psychotropic medication if clinically indicated.

6.2 CBCs, Chem Panels and UAs will be done at least annually and as clinically

indicated.

6.3 The following work-up and follow-up tests are indicated for specific groups of medications in addition to the general work-up as indicated in 4.52., 4.55 and 4.56

6.3.1 Lithium:

6.3.1.1 Pre-treatment work-up as in 4.52, 4.55 and 4.56

6.3.1.2 Thyroid panel within two (2) weeks of initiation of medication and yearly thereafter, or sooner if clinically indicated.

6.3.1.3 Serum Lithium level:

6.3.1.3.1 Within two (2) weeks after initiation of medication.

6.3.1.3.2 Recheck within three months and every six months thereafter.

6.3.1.3.3 Within (2-3) weeks after each change in dose.

6.3.1.3.4 Blood Urea Nitrogen and Creatinine at baseline and every six (6) months.

6.3.1.3.5 If Lithium toxicity is suspected, such as drowsiness, muscular weakness, ataxia, vomiting, diarrhea, or fever over 100 degrees:

6.3.1.3.5.1 Hold Lithium and refer the patient to appropriate level of medical care.

6.3.1.3.5.2 After lithium toxicity has resolved, restart lithium if appropriate or choose an alternative medication.

6.3.2 Carbamazepine:

6.3.2.1 Pretreat work-up, as in 4.52, 4.55, and 4.56

6.3.2.2 Serum Carbamazepine level:

6.3.1.3.2.1 Carbamazepine level and CBC with differential within two(2) weeks after initiation of treatment then every one (1) month for three (3) months and every six (6) months thereafter.

6.3.1.3.2.2 Within (2-3) weeks after each change in dose. If blood dyscrasia is suspected CBC with differential and LFT's will be rechecked.

6.3.1.3.2.3 Levels of other concurrent and anti-epileptic drugs will be obtained along with the Carbamazepine level.

6.3.3 Valproic Acid:

6.3.3.1 Pretreat work-up, as in 4.52, 4.55, and 4.56

6.3.3.2 Follow-up treatment work-up:

6.3.1.3.2.1 Valproic Acid level within two (2) weeks after initiation of treatment.

6.3.1.3.2.2 Valproic Acid level CBC with differential within two (2) weeks after initiation of treatment then every one (1) month for three (3) months and every six (6) months thereafter.

6.3.1.3.2.3 Within (2-3) weeks after each change in dose.

6.3.1.3.3.4 Levels of other concurrent and anti-epileptic drugs will be obtained along with the Valproic Acid level.

6.3.3 Clozaril: See division policy SP 4.15:

6.3.4 Antipsychotics Monitoring Protocol for Obesity and Diabetes:
6.3.5 Pretreatment work-up as in I, B through C
6.3.5.1 At Baseline, obtain Personal/Family History, Weight (BMI), Waist Circumference, Blood Pressure, Fasting glucose, Fasting Lipid Profile
6.3.5.2 If fasting glucose is greater than 126, order Hemoglobin A1C level and consider an internist referral for further medical management.
6.3.5.3 Thereafter, the Personal History is done annually; the Waist Circumference is done quarterly for the first year, and annually after the first year;
6.3.5.4 The Blood Pressure is done quarterly for the first year and annually after the first year;
6.3.5.5 the Fasting glucose is done quarterly for the first year and annually after the first year; the Fasting Lipid Profile is done one time at the end of the first quarter and every five (5) years after the end of the first quarter.
6.3.6 Each agency shall develop and maintain a monitoring system (chart review) to ascertain ongoing compliance with this policy.
6.4 Each division agency shall perform an annual evaluation of its client population load to determine cost estimates for compliance to this policy.
7.0.1 The cost estimate is to be used to plan lab budgets.

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: 04/30/98
REVISION DATE: 05/29/07
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:

~~**1.0 ATTACHMENTS:**~~

~~**2.0 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:~~

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Control #	Rev. Date:	Title:	Effective Date: 02/2002
SP4.47	08/2010	Utilization and Quality Review for Mental Health Agencies	Next Review Date: 08/2012

~~DIVISION OF PUBLIC AND BEHAVIORAL H~~

~~Control #~~	~~Rev. Date~~	~~Title~~	~~Effective Date~~	~~Page~~
~~4.047~~	~~08/2008~~	~~Utilization and Quality Review of Case Management Servicesfor Service Coordination for MH Agencies~~	~~08-01-2018~~	~~1 of 15~~

1.0 POLICY

It shall be the policy of ~~the~~ Clinical Services ~~Branch~~ to define and conduct utilization review on the consumer's case record when receiving ~~service coordination~~case management services from ~~mental health~~Division agencies.

2.0 PURPOSE

To provide guidelines for utilization review for consumers receiving ~~service coordination~~ case management services from ~~mental health~~ Division agencies.

3.0 SCOPE: Division Wide

4.0 DEFINITIONS:

4.1 **Utilization Review.** ~~is defined at the agency level as a "standardized review methodology to determine ongoing need for service."~~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. ~~consumer~~

4.2 ~~**Service Coordination**~~**Case Management** consists of services provided to consumers in order to assist that person in gaining access to medical, social~~rehabilitative~~, educational, and other support services including ~~financial, benefits,~~ housing and ~~, employment,~~ transportation~~, crisis intervention, and other support services to increase the consumers' level of independence over time~~ (refer to Division policy ~~#3.002~~ BHO-006).

~~Service Coordination is intended to enhance recovery and quality of life. Service Coordination decreases the need for additional, more costly services, such as: inpatient psychiatric hospitalizations, emergency room visits, and jail time, as well as decreases the~~

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~~likelihood of trauma, injury, or loss due to poor decision-making. Service Coordination also increases rehabilitation efforts and vocational activity, thereby decreasing the need for financial support, over time. Agencies must develop specific billable codes in accordance with Medicaid (or other insuring bodies).~~

4.3 **Targeted Groups for Case Management Services.** 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, a consumer must meet the diagnostic and functional impairment criteria for one of the following targeted groups defined by Chapter 2500 of the Nevada *Medicaid Services Manual*~~(MSM) Addendum (MSM) Chapter 2500~~:

4.3.1 Adults (individuals 18 years of age or older, Statewide) with a Serious Mental Illness (SMI).

4.3.2 Adults (individuals 18 years of age or older, Statewide) with a Non-Serious Mental Illness (Non-SMI).

4.3.3 Children and adolescents (individuals under age 18 years of age, in rural areas) with a Severe Emotional Disturbance (SED).

4.3.4 Children and adolescents (individuals under age 18 years of age, in rural areas) with a Non-Severe Emotional Disturbance (Non-SED).

4.4 **Intensity of Needs Determination.** This assessment helps demonstrate the consumer's level of functional impairment as part of demonstrating initial and ongoing eligibility for targeted case management services. This assessment is completed upon admission to case management services, and at least annually thereafter, or sooner if there is a change in the consumer's condition. The results of the Intensity of needs determination are documented in the consumer's case record. The consumer~~'~~s' intensity of needs are determined by

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using one of the following approved/recommended service intensity assessment instruments:

4.4.1 **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 (AACP) is approved by Nevada Medicaid to determine the intensity of needs.

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

5.0 PROCEDURE

~~5.1 Within the Division, Mental Health Agency Service Coordination is provided to two (2) target populations:~~

~~5.1.1 Children/Adolescents in the rural areas; and~~

~~5.1.2 Adults Statewide~~

~~5.2 Utilization review must accommodate the cyclical nature of the illness when assessing both frequency and duration of services.~~

~~5.2.1 Documentation in the individual consumer's medical record must reflect changes in, individual status and justify significant changes in frequency and/or duration of service coordination.~~

~~5.2.2 Both Severe Emotional Disturbance and Severe and Persistent Mental Illness are cyclical in nature.~~

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~~5.2.3 Consumers may progress and need less service coordination, but may experience episodic regressions in which their need for service coordination increases significantly for a brief period of time.~~

5.1 Documentation in the consumer's case record (Avatar) must (1) demonstrate initial and ongoing eligibility for case management services, (2) justify the frequency and quantity of case management services rendered, and (3) reflect and chronicle any changes in the consumer's status. The consumer's case record shall be reviewed to ensure that the following items are present and have been entered into the consumer's case record within 30 days of when they occurred:

5.1.1 **Eligible Diagnosis.** The consumer's case record shall contain documentation of the International Classification of Diseases (ICD) reason-for-encounter or diagnosis code(s) and description(s) that substantiate the initial and ongoing eligibility and medical necessity for case management services. If more than one qualifying ICD diagnosis is relevant to the consumer's case ~~managment~~management service 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.

5.1.2 **Functional Impairment**. The consumer's case record shall contain documentation of the results of an Intensity of Needs Determination, such as a LOCUS or CASII assessment, to help substantiate the initial and ongoing eligibility and medical necessity for case management services. Ongoing eligibility for case management services is demonstrated by the results of a LOCUS, CASII, etc. assessment that has not become more than 12 months old.

5.1.3 **Target Group Determination.** The consumer's case record shall contain documentation of the target group for which the consumer is eligible, such as SMI, Non-SMI, SED, Non-SED. This status should be updated by a QMHP at least

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annually and in conjunction with the ~~qualifying~~qualifying ICD diagnosis and the intensity of needs determination.

5.1.4 **Assessment of Needs.** The consumer's case record shall contain documentation of an assessment of case management needs. The needs identified in this assessment should be congruent with the qualifying ICD diagnosis, and demonstrate the medical necessity of case management services to assist the consumer in accessing any medical, social, educational, or other services. 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 consumer'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 actives.

Case Management Care Plan. The consumer's case record shall contain documentation of a case management care plan. The care plan is developed and periodically revised jointly with the consumer (and/or their legal representative). This document is based on the reason for referral to case management services, and the medically necessary assessed case management needs of the consumer for any medical, social, educational, or other services needed to regain societal integration and functioning. Pursuant to NRS 433.494(2), this plan must be thoroughly reviewed every ~~three months~~90 days. Evidence of this review is demonstrated by appending to the plan the outcomes, progress, and/or barriers experienced by the consumer towards achieving the goals and objectives listed in the plan, or by jointly developing a new care plan with the consumer (and/or their legal representative).

~~**Strengths.** Strengths are the existing strengths and resources the consumer already has. Strengths may also include and list progress the consumer has experienced.~~

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- ~~**Needs.** Needs are the identified resource/support needs of the consumer. Needs identify what is missing/lacking to help keep the consumer be 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 case management services and interventions provisioned. Needs must directly relate to reason for referral and reason for encounter codes (a.k.a. ICD diagnoses) that warrant initial and ongoing eligibility for services.~~
- ~~**Goals.** Goals reflect what the consumer wants to improve, and state the consumer's desired personal outcome(s). Goals must directly relate to the diagnosis and reason for referral/service encounter. Goals are focused, individualized, and based on the actual consumer's current life functioning. Goals 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.~~
- ~~**Action Steps (Objectives).** Action steps describe the details using easily understood language worded with a positive focus of what the consumer will do to improve the current "need" area, instead of a negative focus on the actions they need to stop. Action steps are measuable (i.e. action oriented) to verify/index consumer progress; achievable, meaning that the consumer is willing to follow through on the described action step and is capable of achieving it; and are realistic to the circumstances of the consumer.~~
- ~~**Interventions.** When included in the care plan, interventions indicate the additional specific **services** that will be put into place to meet the goal(s) and address the identified need(s), such as basic skills training (H2014), psychosocial rehabilitation (H2017), CBLA services, etc. Interventions specify the anticipated provider of each service, the anticipated amount (i.e. hours, units of service), scope (i.e. the daily,~~

~~weekly, or monthly frequency of services), type of service, and duration (i.e. anticipated end date) of services. For example: *ABC, Inc. will provide 20 hours per month of CBLA supervision, monitoring, and assistance for at least 90 days.*~~

~~**Diagnostic Summary.** This demonstrates the initial/ongoing eligibility for case management services, and thus includes (1) the qualifying ICD diagnosis code(s) and description(s) in order of treatment priority, ICD diagnosis date, name and credentials of ICD diagnosing QMHP; (2) the results of the intensity of needs assessment (i.e. LOCUS, CASII, etc.), date of assessment, and name and credentials of the assessing QMHA/QMHP; and (3) the consumer's current SMI, SED, etc. status, date of status determination, and name and credentials of the determining QMHP.~~

5.1.5 ~~**Discharge Plan.** The Discharge Plan includes: (1) the anticipated overall duration of case management services; (2) discharge criteria that identify and list the factors, criteria, and/or targets that will indicate that the consumer is ready and/or able to transition to a less restrictive level of care/services; (3) any required aftercare services anticipated; (4) the identified agency(ies) or independent provider(s) to provide anticipated aftercare services; and (5) a plan for assisting the consumer in accessing these anticipated aftercare services.~~

5.1.6 **Progress Notes.** The case management services, interventions, and contacts are documented ~~using the Progress Notes form~~ in Avatar. ~~-~~Each progress note for a reimbursable service must address a consumer's action step towards achieving the consumer's stated goals. See DBPH policy BHO-003 for additional requirements for progress notes.

5.1.6.1 **No Commingled Services.** Documentation of one reimbursable Healthcare Common Procedure Coding System (HCPCS) service cannot be commingled with other HCPCS procedures/services within

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the same progress note. For example, documentation of a case management service cannot also include documentation of any other services such as Basic Skills Training (BST)/Psychosocial Rehabilitation (PSR) services, or non-reimbursable services such as transportation services, payee services, etc. within the same progress note.

5.1.6.2 **Inpatient/Incarceration.** Case management services provided while a consumer is hospitalized with an ~~inpatient~~inpatient status or is incarcerated are not reimbursable as outpatient case ~~managment~~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.

5.1.6.3 **Service Limits.** 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.

5.1.7 **Discharge Summary.** If the consumer has been discharged from case management services, the consumer's case record contains a discharge summary progress note. This progress note 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. 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

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summary must be given at the time of transition and followed with a written summary within seven (7) calendar days of the transfer.

5.1.7.1 **No Contact.** Any consumer who has not responded to attempts to contact them and/or see them face-to-face within 90 days is closed to case management services.

5.2 **Peer Reviews** of documentation are conducted monthly by each case manager 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. The Sample Case Management Records Review Checklist may be used for this (see attachment A).

5.3 **Supervisory Review** conducted by the supervisors of the case management staff should include establishing the consumer'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 consumer. Supervisor reviews should be conducted every six (6) months.

5.4 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 consumer will be at a location outside of the consumer's case record (Avatar) to be determined by each agency.

~~5.2.4 All consumers referred for admission to service coordination services with mental health agencies shall be assessed for appropriateness for service coordination services based on the criteria defining Severely Emotionally Disturbed (SED) and Severely Mentally Ill (SMI) consumers as outlined in Policy #3.002.~~

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~~5.2.5 All consumers must be re-assessed as to SED/SMI status every 90 days (at each treatment plan review) and any change in status should be documented in the individual consumer record (Avatar).~~

~~5.3 All consumers admitted into service coordination will be assessed using the LOCUS (Level of Care Utilization system) for adults and the CASII (Child and Adolescent Intensity Instrument) used for those under age 18 and will receive service coordination based on the results of this assessment.~~

~~5.3.1 The individual consumer must reach at least a level three (3) in order to receive service coordination services (see Policy #3.002 – Service Coordination Services).~~

~~5.3.2 Agencies may also choose to use additional assessment tools to initially determine functional impairment consumer.~~

~~5.3.3 Consumers will be re-assessed every 90 days consumer and all LOCUS/CASII scores will be recorded in AVATAR progress notes consumer and the LOCUS/CASII sheet place in the individual record~~

~~5.4 Utilization review for service coordination will include the following:~~

~~5.4.1 Treatment Plan Review~~

~~5.4.1.1 The treatment team at each mandatory nine (9) day review (NRS 433), should consumerconsumer assess SMI status and appropriateness of the frequency and expected duration of service coordination for each individual consumer.~~

~~5.4.1.2 This assessment will be documented in the individual consumer record as well as on the treatment plan. consumer consumer~~

~~5.4.1.3 Specialized services by a contract provider must be included in treatment plan reviews and staff must determine need for ongoing specialized services.~~

~~5.4.1.4 Medicaid requires prior authorization of services beyond a certain level. Prior authorizations are completed and a copy kept in the chart if services are thought to be needed at that frequency.~~

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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev. Date:	Title:	Effective Date: 02/2002
SP4.47	08/2010	Utilization and Quality Review for Mental Health Agencies	Next Review Date: 08/2012

Control #	Rev. Date	Title	Effective Date	Page
4.047	08/2008	Utilization and Quality Review of Case Management Servicesfor Service Coordination for MH Agencies	08-01-2018	11 of 15

5.4.2 Targeted Case Management Review

5.4.2.1 As a Medicaid provider, DPBH is required to conduct an annual audit of a valid sample (at least 5%) of Medicaid service coordination consumers to assure that documentation requirements are being met.

5.4.2.2 Division QA has developed a Medicaid approved review instrument and corresponding guide to be used for this review.

5.4.2.3 Each agency designates a staff person who oversees this review. Service coordination supervisors conduct the reviews.

5.4.2.4 A quarterly report is produced which outlines the results of the review and each agency is required to respond to findings with an "action plan" addressing any area needing remediation (having less than 85% compliance rate).

5.4.2.5 A 90-day "No Contact Report" is generated by Program Evaluation when requested by Clinical Program Manager for service coordination.

5.4.2.5.1 Any individual consumer who has not responded to attempts to contact them and/or see them face-to-face within 120 days is closed to services in service coordination.

5.4.3 Supervisory Review:

5.4.3.1 Should include establishing the individual consumer's continued eligibility reflected by a Level three (3) on the most recent LOCUS/CASH and consumers who receive service delivery hours significantly above or below what their clinical picture would indicate.

5.4.3.2 Supervisory review should be conducted every six (6) months and results forwarded with an action plan to the agency director or their designee.

5.4.3.3 Quarterly summaries shall be sent to agency Quality Assurance (QA) staff and/or other leadership staff as determined by the agency.

5.4.4 Peer Review:

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~~5.4.4.1 Conducted by each service coordinator on a monthly basis on peers' individual records to assess appropriateness of frequency of service coordination received and quality of documentation of service delivery in individual consumer record.~~

~~5.4.4.2 Documentation is reviewed to ensure it meets Medicaid standards.~~

~~5.4.4.3 Copy of all peer reviews will be given to the supervisor of service coordination (or other supervisory staff as determined by the agency) and reported in the agency leadership group.~~

~~5.4.4.3.1 The form must include space for correction plan and supervisor signature indicating supervisor has reviewed form and correction plan.~~

~~5.4.4.4 Supervisor will provide quarterly summaries of peer review findings to agency QA staff.~~

~~5.4.5 Storage of Supervisory and Peer Reviews will be at a location outside of the individual file consumer to be determined by each agency.~~

6.0 ATTACHMENTS

A. Sample Case Management Records Review Checklist

7.0 REFERERNCES

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

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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 the Nevada Medicaid State Plan, MSM Chapter 100, and the MSM Addendum, implements 42 CFR 440.169, and 42 CFR 441.18. It defines the targeted groups to which targeted case management services may be provisioned in the State of ~~Nevada, and~~Nevada and defines what additional requirements regarding the delivery of case management services must be met.

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 is 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). 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). 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-006 *Service Coordination*. This policy, in conjunction with DPBH policy BHO-003 *Service Delivery Model*, describes how to implement case management services for DPBH and its agencies pursuant to 42 CFR 440.169; 42 CFR 441.18; MSM Chapter 2500, Chapter 100, and the MSM Addendum; NRS 433; and NAC 433.~~Nevada Revised Statutes (NRS) 433~~

~~Nevada Medicaid Services Manual (MSM) Chapter 2500 – Case Management~~

~~DPBH Policy BHO-006: Case Management~~

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8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE: 08/2002
REVIEWED / REVISED DATE: 08/2010
SUPERSEDES: 4.047 Utilization and Quality Review for Service Coordination for Mental Health Agencies, dated 02/2002.
APPROVED BY DPBH ADMINISTRATOR: 09/2018
APPROVED BY DPBH COMMISSION: 04/19/2002; 09/2018

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Needs Goals Measurable Actions Condition/Status/Functioning Outcomes/Barriers/Progress Timeframes

CASE MANAGEMENT RECORDS REVIEW CHECKLIST

Review Date:		Review Period:	
Avatar #:		Reviewer:	

ADMISSION AND CONTINUING STAY CRITERIA (reference: NMSM 2502.6/7/8/9)	
☐ Yes ☐ No Diagnosis Date: 00/00/2018	**Mental Health Diagnosis.** Client's case record contains an eligible mental health diagnosis or re-diagnosis that has not become more than 12 months old. Primary Diagnosis Code & Description: Diagnosing Clinician's Name and Credentials:
☐ Yes ☐ No Rating Date: 00/00/2018	**Functional Impairment.** Client's case record contains a LOCUS (age 18 and older), CASII (age 6 thru 17), or ECSII (age 0 thru 5) rating that has not become more than 12 months old. Rating Score (#): Recommended Level of Care (#): Rating Clinician's Name & Credentials:
☐ Yes ☐ No Date of Determination: 00/00/2018	**SMI/SED**. Client's case record contains a determination or re-determination that has not become more than 12 months old, made by a Qualified Mental Health Professional (QMHP), of: Serious Mental Illness (**SMI**; age 18 and older), Non-Serious Mental Illness (**Non-SMI**; age 18 and older), Severe Emotional Disturbance (**SED**; age 0 thru 17), or Non-Severe Emotional Disturbance (**Non-SED**; age 0 thru 17).
DOCUMENTATION REQUIREMENTS	
☐ Yes ☐ No	**Case Management Assessment of Needs.** Pursuant to NMSM 2502.11.A; the client's case record contains an assessment of case management service/support needs that is not more than 12 months old.
☐ Yes ☐ No	**Case Management Plan**. Pursuant to NMSM 2502.11.B; the client's case record contains a Case Management Plan that is not more than 12 months old and addresses the service/support needs identified in the Case Management Assessment.
☐ Yes ☐ No	**Client's Own Words**. Pursuant to NMSM Addendum, section G, GOALS; to help demonstrate client involvement and agreement, all goals listed in the most recent Case Management Plan are in the client's own words (i.e. enclosed in quotation marks).
☐ Yes ☐ No	**Outcome-Based Action Steps**. Pursuant to NMSM Addendum, section O, OBJECTIVES; all action steps (objectives) listed in the most recent Case Management Plan are expressed in terms that provide measurable benchmarks/indices of progress.
☐ Yes ☐ No	**Timeliness.** Pursuant to Division policy BHO-003.4.9; the progress notes from the period reviewed were entered within one (1) working day of the date of service.
☐ Yes ☐ No	**Timeframes.** Pursuant to NMSM 2502.11A.5; the progress notes from the period reviewed include a specific date for the next anticipated service or contact (e.g. "by next Friday", "by 00/00/0000", etc.).
☐ Yes ☐ No	**Progress note references and addresses the plan's need, goal, and action step(s).** Of the progress notes from the period reviewed, those documenting a case management service (i.e. codes 622, 623, 626, and 627): 1. Are electronically linked to the need, goal, and at least one action step (objective) in a current (within the past 12 months) case management plan, or manually reference them within the body of the progress note, AND 2. Address the action step(s) to which it refers or is linked.
☐ Yes ☐ No	**Client Progress**. The progress notes from the period reviewed either: 1. Chronicle the outcomes (progress, lack of progress, or barriers to progress) experienced by the client from the services rendered to the client to help the client achieve their stated goal to meet their service need (per NMSM 2502.11A.3); AND 2. Chronicle the client's needs, condition, status, or functioning (per NMSM 2502.11.D.3).
☐ Yes ☐ No	**Service Level Warranted.** Pursuant to NMSM 2502.11A; the progress notes from the period reviewed justify the level or intensity of services being received. For ICBLA, LOCUS Level of Care is also at least 4.
☐ Yes ☐ No	**No Commingled Services.** Pursuant to NMSM 2503.1A.2; of the progress notes from the period reviewed, those documenting a case management service (i.e. codes 620, 621, 622, 623, etc.) do not also commingle excluded services within the same progress note (such as direct services, transporting clients, paying bills, etc.).
☐ Yes ☐ No ☐ N/A	**Inpatient/Incarcerated.** If any of the progress notes from the period reviewed document a case management service while the client was incarcerated or hospitalized, they use service code 955 instead of 620, 621, 622 or 623.
# Yes ____ # No____	**Tally of Yes and Tally of No Responses:**

Control #	Rev. Date:	Title:	Effective Date: 10/16
SP 5.1	9/2016	DPBH PASRR PROGRAM	Next Review Date: 10/18

1.0 POLICY:

It is the policy of the DPBH to provide oversight and authority to the Level II PASRR program pertaining to screening determinations, specialized services, and monitoring activities

2.0 PURPOSE:

Pursuant to federal regulations addressed in 42 CFR 483 the state mental health authority (SMHA) and state mental retardation authorities (SMRA) are responsible for oversight and administration of PASRR Level II functions. This policy pertains only to the DPBH portion of the PASRR program in its role as the SMHA. Described within this policy are common definitions, procedures and protocols which will guide all PASRR requirements and operations.

3.0 SCOPE:

Division Wide

4.0 REFERENCE:

42 Code of Federal Regulations (CFR) 483.108 to 483.136

5.0 PROCEDURE:

5.1 Common PASRR Definitions:

5.5.1 **PASRR** – Pre-Admission Screening and Resident Review. Before admission into a nursing facility a person must be screened to determine the presence of mental illness, intellectual and/or developmental disorders or a related condition. If such a condition exists, a further screening may be required to determine whether or not an individual may be placed in a nursing facility or another alternative setting.

5.5.2 **Medicaid** – Division of Health Care Financing and Policy (DHCFP) – Nevada Medicaid. The State Medicaid Authority (SMA) is responsible for the overall oversight and administration of the PASRR program.

5.5.3 **Level I** - Pursuant to 42 Code of Federal Regulations (CFR) 483.128 (a), the identification of individuals with a Mental Illness (MI) or Intellectual and/or developmental disorders (MR). The PASRR program must identify all individuals who are suspected of having MI or MR as defined in 42 CFR 483.102.

5.5.4 **Level II** – Pursuant to 42 CFR 483.128 (a), the function of evaluating and determining whether nursing facility (NF) services and specialized services are needed for individuals identified with MI or MR as defined in 42 CFR 483.102.

5.5.5 **PASRR II-B** – A PASRR II-B consumer is a person who has been screened as having mental illness, intellectual and/or developmental disorders or a related condition, and as a condition of being placed or allowing to remain in a nursing facility, requires PASRR Specialized Services. Additionally, if an individual in a nursing facility has a "significant status change" they are required to receive a PASRR screening.

5.5.6 **DPBH** – As defined by terminology used by the federal Centers for Medicare and Medicaid Services (CMS), the Nevada Division of Public and Behavioral Health (DPBH) is the state mental health authority (SMHA) in Nevada. DPBH is responsible for operation of state funded outpatient community mental health programs, psychiatric inpatient programs, and mental health forensic services.

5.5.6.1 Within mental health are five (5) agency service sites: Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), Rural Services – Mental Health Lake's Crossing Center and Stein Forensic Facilities. The final agency within DPBH is the Substance Abuse Prevention and Treatment Agency (SAPTA).

5.5.6.2 By Nevada state statute DPBH is responsible for planning, administration, policy setting, monitoring and budgeting development of all state funded Public and Behavioral Health programs.

6.1 Specialized Services

5.6.1 Pursuant to 42 CFR 483.120 (a), for mental illness, specialized services are specified by the state (mental health authority) which, combined with services provided by the nursing facility, results in the continuous and aggressive implementation of an individualized plan of care that:

5.6.1.1 is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professions;

5.6.1.2 prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitate supervision by trained mental health personnel;

5.6.1.3 is directed toward diagnosing and reducing the resident's

behavioral symptoms that necessitated institutionalization, improving his or her level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

5.6.1.4 Specialized Services Include but are not limited to:

5.6.1.4.1 Psychotherapy (individual/group/family)
5.6.1.4.2 Psychotropic Medications
5.6.1.4.3 Psychiatrist Follow-Up Services
5.6.1.4.4 Psychiatric Evaluation
5.6.1.4.5 Psychological Testing
5.6.1.4.6 Transitioning services, to assist in moving to a less restrictive environment
5.6.1.4.7 Monitoring and Advocacy
5.6.1.4.8 Other: _____

5.6.1.5 working with nursing facilities to provide or arrange for the provision of specialized services to all nursing facility residents with mental illness whose needs are such that continuous supervision, treatment and training by qualified mental health personnel is necessary.

5.6.2 Medicaid Cost Containment Vendor~~Hewlett Packard Enterprise Services~~, The Medicaid Quality Improvement Organization-Like (QIO-like) vendor contracted by DHCFP-Medicaid. ~~Hewlett Packard Enterprise Services~~ The Medicaid Cost Containment Vendor provides an array of fiscal agent, health care management and provider services. Among its array of contractual obligations to DHCFP-Medicaid, the Medicaid Cost Containment Vendor ~~Hewlett Packard Enterprise Services~~ is responsible for making nursing facility PASRR Levels I and II and Specialized Service determinations for Level II- related services – this is permitted through a "Delegation of Authority" Agreement DPBH has with DHCFP-Medicaid and the Mediciad Cost Containment Vendor~~Hewlett Packard Enterprise Services~~.

7.1 PASRR Program Requirements:

5.7.1 Pursuant to its being permitted by 42 CFR 483.106 (d) (2) (e), as the State's mental health authority DPBH delegates the responsibilities to the Medicaid Cost Containment Vendor ~~Hewlett Packard Enterprise Services~~ to perform PASRR Level II evaluations and determinations, including, when it determines to be clinically necessary due to the consumer's mental illness, specialized service determinations. The Medicaid Cost Containment Vendor ~~Hewlett Packard Enterprise Services~~ is responsible for:

5.7.1.1 Submitting copies of PASRR Level II determinations and evaluations/summary of findings to DPBH within three (3) business day of completion;

5.7.1.2 Informing nursing facility applicants or residents of individual PASRR determinations;

5.7.1.3 Maintaining a tracking system for all PASRR Level I and

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II determinations and submitting to DPBH a monthly report of PASRR II activities;

5.7.1.4 Participating with DPBH and DHCFP-Medicaid in providing necessary PASRR-related training to nursing facilities, hospitals and other relevant providers, and when necessary, DPBH staff; and

5.7.1.5 Participating in the Medicaid appeals process.

5.7.2 DPBH will cooperate in efforts to establish a relationship between nursing facilities, the Medicaid Cost Containment Vendor ~~Hewlett Packard Enterprise Services~~ and Medicaid necessary to comply with federally mandated PASRR requirements, including training, joint planning, access to records and exchange of information concerning individuals with mental illness, developmental disabilities or related conditions.

5.7.3 Upon receipt of PASRR Level II-B screening determinations from ~~the~~ the Mediciad Cost Containment Vendor ~~Hewlett Packard Enterprise Services~~, DPBH PASRR regional coordinators will create a hard copy file for each consumer determined to need mental health specialized services (PASRR II–B), which contains as a minimum:

5.7.3.1 PASRR II determination and evaluation;

5.7.3.2 NF notification and DPBH Specialized Services forms;

5.7.3.3 Documentation that identifies each specific mental health service(s) and specialized service(s) that are to be provided, the anticipated duration of each, and who is to provide each of these services;

5.7.3.4 Completed Quarterly PASRR Review forms; and

5.7.3.5 DPBH Central Office Communication forms (Attachments A and B).

Additionally, all Level II PASRR data will be collected and stored in both DPBH' data base and by DPBH agency hard copy files.

All PASRR Level II hard copy and electronic files are to be maintained in a secure location under the direction of the DPBH PASRR Manager and/or his/her delegate.

5.7.4 DPBH regional agency PASRR staff will assist nursing facilities with arranging, delivering and/or monitoring the provision of specialized services to all individuals who agree to receive and comply with such services, as required by the federal PASRR regulations. Each DPBH regional agency PASRR coordinator shall assume the following responsibilities for specialized services:

5.7.4.1 Within 30 days of being notified by the DPBH PASRR Program that a new PASRR II-B consumer is being added to their caseload, DPBH regional PASRR coordinators will provide an initial review of the consumer. Then, following the initial review, DPBH regional PASRR agency coordinators will conduct a quarterly consumer review every 90 days thereafter. This initial and quarterly

review, monitoring and documentation are to assure that the PASRR II-B consumers are receiving Specialized Services. Additionally, the DPBH PASRR Program must be notified by DPBH' Regional PASRR agency coordinators if there is a change in status warranting the consumer no longer requires PASRR services, or the consumer is no longer at the nursing facility (death or discharge to another setting). This review, monitoring and documentation compliance will be done by way of formal quarterly visits/reviews using the "DPBH PASRR II–B Quarterly Nursing Facility Review Form (Attachment C)."

5.7.4.2 Whenever possible, assist in developing the plan for specialized services- this is most often accomplished by being a member of the PASRR II-B consumer's nursing facility multi-disciplinary team, responsible for developing and monitoring the consumer's plan of care The consumer's DPBH regional agency PASRR coordinator will notify individuals identified as needing specialized services or alternate placement options and help to facilitate such services or placement.

5.7.4.3 For PASRR II-B consumers placed in out-of-state nursing facilities, DPBH PASRR Regional Coordinators, in lieu of performing onsite nursing facility quarterly visits, will utilize the Out-of-State Documentation Request for Nevada PASRR II-B Residents Quarterly Review (Attachment E) form.

5.7.5 DPBH' PASRR II-B consumers, regardless of location of the state, who are placed or reside in an out-of-state (OOS) nursing facility, will be assigned to the caseload of Rural Clinics (RC) RC will only be responsible for reviewing and monitoring the initial and ongoing (quarterly) reviews of OOS PASRR II-B consumers. If no other resources are available and the Specialized Services the OOS PASRR II-B consumer requires must be provided and/or financed by DPBH. The DPBH agency in the geographic area of Nevada the consumer was placed from to the OOS nursing facility is responsible for this action.

5.7.6 If a consumer requires specialized services, but is not eligible for SNF placement, DPBH PASRR agencies will participate fully with Medicaid staff and/or the nursing facility to arrange for appropriate services, including alternative placement elsewhere.

5.7.7 DPBH will complete and submit the "DPBH PASRR II-B Quarterly Report" to DHCFP-Medicaid.

5.7.8 DPBH will participate with Medicaid and the Medicaid Cost Containment Vendor ~~Hewlett Packard Enterprise Services~~ in an Appeals process for individuals adversely affected by PASRR Level II Determinations.

5.7.9 To comply with 42 CFR 483.106 (d) (2) (e) (i) which requires the State mental health authority to retain ultimate control and responsibility of PASRR Level II obligations, DPBH' Statewide PASRR Program Manager will conduct a periodic DPBH PASRR Program Compliance Review to a) verify the appropriateness of the Medicaid Cost Containment Vendor ~~Hewlett Packard Enterprise Services~~ PASRR Level II screening determinations and evaluations/summary of findings, b) verify that the consumer is receiving appropriate and clinically necessary specialized services as recommended by the PASRR Level II determination and 3) ascertain and verify the work responsibilities of the DPBH Regional Coordinators are being appropriately performed.

6.0 Attachments:

~~6.1 Attachment A: NURSING FACILITY (NF) PASRR II-B NOTIFICATION FORM (to be completed by Nursing Facilities)~~
~~SP 5.1 PASRR Program Attachment A~~
~~6.2 Attachment B: PASRR LEVEL II-B Communication Form (to be completed by the DPBH Regional PASRR Coordinators)~~
~~SP 5.1 PASRR Program Attachment B~~
~~6.3 Attachment C: DPBH PASRR II-B Quarterly Nursing Facility Review Form (to be completed by DPBH Regional PASRR Coordinators~~
~~SP 5.1 PASRR Program Attachment C~~
~~6.4 Attachment D: Nursing Facility PASRR II-B Specialized Services Resident Review Progress Note~~
~~SP 5.1 PASRR Program Attachment D~~
~~6.5 Attachment E: Out-of-State Documentation Request for Nevada PASRR II¬B Resident Quarterly Review~~
~~SP 5.1 PASRR Program Attachment E~~
~~6.6 Attachment F: PASRR Specialized Services Flow~~
~~SP 5.1 PASRR Program Attachment F~~
~~6.7 Attachment G: Sample Resident Care Plan: PASRR II-B Specialized Services (for persons with mental illness)~~
~~SP 5.1 PASRR Program Attachment G~~
~~6.8 Attachment H: Sample Resident Care Plan: PASRR II-B Specialized Services (for persons with developmental/intellectual disabilities)~~
~~SP 5.1 PASRR Program Attachment H~~

~~7.0~~6.0 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.

Attachment A

NURSING FACILITY (NF) PASRR II-B NOTIFICATION FORM
(To be completed by Nursing Facility)

RESIDENT NAME: _____

NF NAME: _____

NF DATE OF ADMISSION: _____

PASRR LEVEL II DETERMINATION: _____

DETERMINATION DATE: _____

NAME/TITLE OF NF STAFF PERSON COMPLETING FORM: _____

CURRENT STATUS (please check those that apply and fill in dates)

____ Resident Admitted to NF — Resident Admission Date:

____ Consumer Discharged from NF — Resident Discharge Date:

If known, where discharged to:

____ Consumer Death — Date of Death:

____ Other:

Additional Comments:

Please return this form to:
Attention: PASRR Administrative Assistant
Division of Public & Behavioral Health
6161 W. Charleston Blvd
Las Vegas, NV 89146
Phone: (702) 486-7121 Fax: (702) 486-5660

After receiving and entering the case in the ACCESS database, the Nevada State Division of Public and Behavioral Health PASRR Administrative Support person will send a copy of this form as notification to the appropriate Regional PASRR Coordinator, verifying specialized services monitoring and advocacy are required, and add the resident to the next PASRR Monthly report, so that the PASRR Regional Coordinator may commence the initial monthly visit, then quarterly visits thereafter.

Attachment B

PASRR LEVEL II B COMMUNICATION FORM
(To be copleted by DPBH agencies)

CLIENT NAME:

CLIENT SSN:

NF NAME:

NF DATE OF ADMISSION:

PASRR LEVEL II
DETERMINATION: IIB

DETERMINATION DATE:

DPBH AGENCY/REGION:

DPBH Agency Staff Completing Form:

CURRENT STATUS (please check those that apply)

☐ Specialized Services Required
Type of Service: ☐ Individual, ☐ Group and/or Family Psychotherapy; ☐ Psychiatrist Follow-Up Services; ☐ Monitoring and Advocacy; ☐ Transitioning services to assist in transitioning to a less restrictive environment.

MH ■ DS ☐

☐ Specialized Service Initiated Date Service Initiated: _____

☐ Specialized Services no longer required Date Discontinued: _____

☐ Client Discharge (from NF) Date of Discharge:

If known, where discharged to:

☐ Client Death Date of Death: _____

☐ Refused Services

☐ Unable to Locate

☐ No longer in service Area/Region

Additional Comments:

Please return this form to:
Attention: PASRR Administrative Assistant
Division of Public & Behavioral Health
6161 W. Charleston Blvd
Las Vegas, NV 89146
Ph: (702) 486-7121 Fax: (702) 684-5660

Attachment C

MHDS PASRR II-B QUARTERLY NURSING FACILITY REVIEW FORM
(To be completed by MHDS Regional PASRR Coordinators)

I. Demographic Information

Resident's Name:

Nursing Facility:

PASRR II-B Determination Date:

Date of MHDS PASRR Regional Coordinator's Review:

II. Specialized Services Recommended on Level II Determination (by Hewlett Packard Enterprise Services):

Mental Illness (MI)

- ☐ Psychotherapy (individual/group/ Family)
- ☐ Psychiatrist Follow-Up Services
- ☐ Monitoring and Advocacy
- ☐ Psychotropic Medications
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Transitioning services, to assist in moving to a less restrictive environment
- ☐ Other:

Mental Retardation and Related Conditions (MR/RC)

- ☐ Psychological Services
- ☐ School Referrals and Services
- ☐ Monitoring and Advocacy
- ☐ Day Services
- ☐ Transition Services, to assist in moving to a less restrictive environment
- ☐ Other:

III. Specialized Services Actually Being Provided:

Mental Illness (MI)

- ☐ Psychotherapy (individual/group/ Family)
- ☐ Psychiatrist Follow-Up Services
- ☐ Monitoring and Advocacy
- ☐ Psychotropic Medications
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Transitioning services, to assist in moving to a less restrictive environment
- ☐ Other:

Mental Retardation and Related Conditions (MR/RC)

- ☐ Psychological Services
- ☐ School Referrals and Services
- ☐ Monitoring and Advocacy
- ☐ Day Services
- ☐ Transition Services, to assist in moving to a less restrictive environment
- ☐ Other:

DO NOT PURGE *- One copy of this review form must be kept in the client's active medical record/chart at all times, including, if the PASRR II-B Resident is discharged and readmitted, and be carried over to the new medical record/chart. The other copy (original) will be kept/maintained by the MHDS PASRR II Reviewer.*

Resident Name: Review Date:

IV. Reviewer participated in the development and ongoing monitoring of Specialized Services the client receives from the NF:

Development? ☐ Yes ☐ No
Monitoring? ☐ Yes ☐ No

Please explain: (e.g., care plan team, IEP, etc.)

V. Resident's Care/Treatment Plan and Progress Notes (both) appropriately Addresses and Documents the Resident is Receiving Needed PASRR Specialized Services*? (Please be sure to specifically address each and every PASRR II-B specialized service (i.e., verify if it is being delivered, how often, including dates if possible, if the resident is benefiting from specialized service, etc.)*

VI. Does the MHDS PASRR Regional Coordinator recommend for the Resident any additional or different specialized services that may not have been previously recommended by Hewlett Packard Enterprise Services (HPES)?

☐ No ☐ Yes

If Yes, please document recommended or different specialized service:

Mental Illness (MI)

- ☐ Psychotherapy (individual/group/ Family)
- ☐ Psychiatrist Follow-Up Services
- ☐ Monitoring and Advocacy
- ☐ Psychotropic Medications
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Transitioning services, to assist in moving to a less restrictive environment
- ☐ Other:

Mental Retardation and Related Conditions (MR/RC)

- ☐ Psychological Services
- ☐ School Referrals and Services
- ☐ Monitoring and Advocacy
- ☐ Day Services
- ☐ Transition Services, to assist in moving to a less restrictive environment
- ☐ Other:

Comments:

DO NOT PURGE *- One copy of this review form must be kept in the client's active medical record/chart at all times, including, if the PASRR II-B Resident is discharged and readmitted, and be carried over to the new medical record/chart. The other copy (original) will be kept/maintained by the MHDS PASRR II Reviewer.*

Resident Name: Review Date:

VII. Is the Resident appropriate for possible discharge within the next 90 days, based on availability of services?

☐ Yes ☐ No

Yes or No, please explain:

VIII. MHDS Regional Coordinator's Review Summary:

1. Is the resident still appropriate at a PASRR Level II-B?

   ☐ Yes ☐ No

   If no, instruct the Nursing Facility to request a new PASRR Level I screening from Hewlett Packard Enterprise Services (HPES). The nursing facility must indicate that a new screening is necessary and that a new PASRR screening determination may be appropriate, and must forward supportive clinical documentation showing "significant status change."

2. Does the Resident still require the Specialized Services as indicated in section II (on page 1 of 2)?

   ☐ Yes ☐ No

   If no, the PASRR Regional Coordinator should recommend additional or different specialized services in VI above, or no specialized services at all.

3. Narrative Statement (e.g., what MHDS or the nursing facility may be working on or trying to arrange for the individual, whether specialized services, discharge from the nursing facility, on waiting list for community-based services, etc.):

MHDS Regional PASRR Coordinator (Print) MHDS Regional PASRR Coordinator (Signed) Date

DO NOT PURGE *- One copy of this review form must be kept in the client's active medical record/chart at all times, including, if the PASRR II-B Resident is discharged and readmitted, and be carried over to the new medical record/chart. The other copy (original) will be kept/maintained by the MHDS PASRR II Reviewer.*

Resident Name: Review Date:

Attachment D

NURSING FACILITY PASRR II-B SPECIALIZED SERVICES RESIDENT QUARTERLY PROGRESS NOTE (Social Services)

This Nursing Facility PASRR II-B Specialized Services Resident Quarterly Progress Note is to be completed in con junction with the resident's quarterly care plan update and/or general social services quarterly progress notes, and kept in the social services (or where other PASRR information is kept) portion of the resident's chart/medical record. Please be sure this document is carried over to resident's new chart if readmission occurs). In part, federal regulations at 42 CFR 483.120 and 483.126 require persons' screened and identified as needing specialized services (PASRR II-B) by the mental health authority or its agent as a condition to be admitted to a nursing facility, to receive specialized services identified in the PASRR II-B screening determination – receipt and provision of these specialized services by nursing facilities must clearly be documented.

I. Resident: _____ **PASRR II-B Determination Date:** _____

Nursing Facility: _____

II. PASRR Specialized Services recommended on PASRR Level II-B Determination (by Hewlett Packard Enterprise Services):

DPBH - Mental Illness (MI)

____ Psychotherapy (individual/group/ Family)
____ Psychiatrist Follow-Up Services
____ Monitoring and Advocacy
____ Psychotropic Medications
____ Psychiatric Evaluation
____ Psychological Evaluation
____ Transitioning services, to assist in moving to a less restrictive setting
____ Other: _____

ADSD – Intellectual Disabilities

____ Psychological Services
____ School Referrals and Services
____ Monitoring and Advocacy
____ Day Services
____ Transition Services, to assist in moving to a less restrictive environment
____Other: _____

III. PASRR Specialized Services Actually Being Provided:

DPBH Mental Illness (MI)

____ Psychotherapy (individual/group/ Family)
____ Psychiatrist Follow-Up Services
____ Monitoring and Advocacy
____ Psychotropic Medications
____ Psychiatric Evaluation
____ Psychological Evaluation
____ Transitioning services, to assist in moving to a less restrictive setting
____ Other: _____

ADSD – Intellectual Disabilities

____ Psychological Services
____ School Referrals and Services
____ Monitoring and Advocacy
____ Day Services
____ Transition Services, to assist in moving to a less restrictive environment
____Other: _____

***DO NOT PURGE** - One copy of this review sheet must be kept at all times in the client's active medical record/chart at all times, including, if resident is discharged and readmitted, carried over to the new medical record/chart.*

Resident Name: _____ Review Date: _____

IV. Plan of Care addresses and documents Resident is receiving PASRR II-B Specialized Services (e.g., at least one goal relates to and addresses the Resident's II-B Specialized Services).

Please specify below:

Resident Problem or Need	Care Plan Goal or Objective	Intervention by Nursing Facility Staff

V. Is the Resident appropriate for possible discharge within the next 90 days, based on availability of services?

_____ Yes _____ No

Why or Why Not: _____
_____
_____
_____
_____

VI. Final/Overall quarterly narrative summation of PASRR II-B Resident Specialized Services: *(be sure to specifically address each and every PASRR II-B specialized service, verifying if it is being delivered, how often, including dates if possible, if the resident is benefiting from specialized services, etc.)*_____
_____
_____
_____
_____
_____
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_____

In conjunction with Hewlett Packard Enterprise Services (HPES) PASRR II-B screening determination, I confirm that, as a condition of the Resident to be permitted to be placed or remain in this nursing facility, the resident is receiving provision of specialized services, and, as such, the resident's specialized services are addressed ongoing in the resident's Plan of Care.

_____ _____ _____
Nursing Facility Representative Signature **Title** **Date**

Resident Name: _____ Review Date: _____

Attachment E

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director, DHHS

JULIE KOTCHEVAR, PHD
Administrator, DPBH

IHSAN AZZAM, PHD, M.D.
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Southern Nevada Adult Mental Health Services
6161 W. Charleston Blvd., Las Vegas, NV 89146

Date:

To: **{Name of Nursing Facility PASRR Contact Person}**
{Name of Out-of-State Nursing Facility}

From: **{Name, Title and Location of Nevada Regional PASRR Coordinator**

RE: **{Name of Nevada PASRR II-B Nursing Facility Resident}**
Out-of-State Documentation Request for Nevada PASRR II-B Resident Quarterly Review

The above Nevada nursing facility resident has received a Nevada PASRR II-B screening determination, and is permitted to be admitted to, or remain in, your nursing facility, but only if he/she is receiving PASRR Level II-B Specialized Services.

Federal regulations at 42 Code of Federal Regulations (CFR) 483.116 and 483.120 require the state mental health (Division of Public and Behavioral Health) and state intellectual disabilities (Aging and Disabilities Services Division) authorities, to make determinations of the appropriate placement, and verify residents are receiving PASRR specialized services, as determined by Hewlett Packard Enterprise Services (HPES), the Nevada PASRR Program contractor.

As we are unable to conduct on-site reviews for our PASRR resident who is receiving care in your nursing facility, DPBH respectfully requests the following information for purposes of assisting us to conduct our quarterly reviews.
Please submit the following information no later than {list date}:

- ✓ Psychiatric eval/Psychiatric follow-up (provide last 90 days of the quarter being audited)
- ✓ Progress notes (provide last 90 days of the quarter being audited)
- ✓ Medication sheets and behavior monitoring sheets (provide last 90 days of the quarter being audited
- ✓ Social Services (last Quarterly Progress Notes)
- ✓ Nevada Nursing Facility PASRR II-B Specialized Services Resident Progress Note (Social Services) - Attachment D
- ✓ Most recent Resident Plan of Care
- ✓ Most recent MDS (approximately 10-pages).
- ✓ Any other information you deem relevant

Thank you very much for your cooperation and collaboration with providing this requested information in a timely manner. Out-of-state nursing facilities that do not provide this requested information timely are in violation of federal requirements. Additionally, non-compliance with this request could affect Nevada Medicaid payment to your facility.

Should you have any questions regarding this request please do not hesitate to contact the Nevada Statewide PASRR Coordinator, LaVonne Atkins (702) 486-4095 Latkins@health.nv.gov.

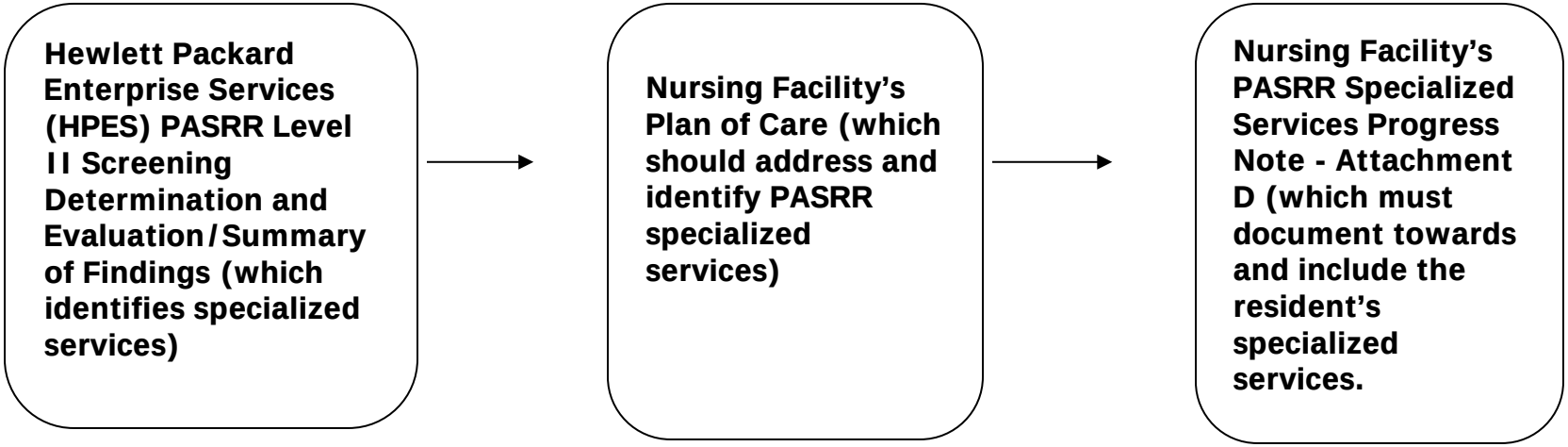
Thank you for your cooperation.

Sincerely,

Regional PASRR Coordinator

Attachment F

PASRR SPECIALIZED SERVICES FLOW



Attachment G

SAMPLE RESIDENT CARE PLAN FOR PASRR II-B SPECIALIZED SERVICES (Persons with Mental Illness)

Problem / Need	Goal / Objective	Approach / Intervention	Discipline
Resident has depression and psychosis, and has been identified in the PASRR II-B Screening Determination and Evaluation as requiring PASRR II-B Specialized Services	*Resident will receive the following PASRR-B specialized services as identified in his/her PASRR II-B screening determination and evaluation:* *1) Psychotropic Medications* *2) Psychiatric Follow-up* *3) Monitoring and Advocacy*	*The following provision of specialized services will be delivered, and by whom:* *1) <u>Psychotropic Medications</u>: The resident will receive his physician prescribed medication of Seroquel (list dosage, frequency, etc.) and Zyprexa (list dosage, frequency, etc.).* *2) <u>Psychiatric Follow-up</u>: The resident will receive at least quarterly follow-up from a psychiatrist or physician with monitoring his medications <u>or</u> the resident will receive weekly psychotherapy (whatever the case is)* *3) <u>Monitoring and Advocacy</u> – The resident will receive quarterly monitoring and advocacy visits and reviews (Attachment C) from his/her DPBH State PASRR Regional Coordinator*	*Social Services*