**Purpose:** The goal of this policy is to outline the components of a Quality Management Plan for Community Healthlink.

**Definitions:**
- **CPO:** Clinical Policy and Operations Committee
- **Quality Management Plan:** The Quality Management Plan is the agency-wide blueprint that describes the actions and processes to which our organization is committing itself with regard to ensuring high quality program operations and treatment outcomes. The actions and processes in the plan are designed to:
  - ensure efficient program operations;
  - improve treatment outcomes for the clients served; and
  - Achieve the mission of the Agency.

**Policy:**
1. The Quality Management Director is responsible for the development of a comprehensive Quality Management Plan.
2. The CPO is responsible for the implementation of the Quality Management Plan and all performance improvement initiatives within the organization.
3. The CPO will meet on a regular basis and will use this Plan as a guideline for quality issues.

**Responsibility:** The Quality Management Director

**Procedures:**
The Quality Management Plan will have the following components:

**II. Performance Measurement**
The goal of performance measurement is to understand current performance *and its causes* so that improvement actions can be planned and implemented and *better results* can be achieved. Ongoing, reliable, and valid measurement provides performance information that allows an organization to:

- have continuous access to objective data that support its claims of quality;
- receive and respond to early warnings of performance problems;
- verify the effectiveness of corrective actions;
- highlight areas of outstanding performance; and
- Compare its performance to that of other organizations.
Traditional quality improvement literature identifies three fundamental purposes for conducting performance measurement: assessment of current performance, demonstration and verification of performance improvement, and control of performance. All programs have performance measurement goals that are measured throughout the year.

Measurement is a key function in the implementation of an effective quality management plan. The following activities are designed to obtain data on specific areas of performance. Once the data is collected, the CPO will be responsible for analyzing the data, identifying improvement priorities, and overseeing performance improvement activities. Other measurement mechanisms will include:

**Client Satisfaction Surveys**

a. Client satisfaction surveys will be conducted on an annual basis. The CPO is responsible for ensuring that surveys are conducted and is charged with assisting in the survey process.

b. Results from satisfaction surveys will be reported to the Executive Management Team (EMT) and other Committees.

**Staff Satisfaction Surveys**

The survey will be conducted periodically and will be coordinated by the CPO.

### III. Performance Improvement

1. The Director of Quality Management and the CPO will serve to support the teams in the quality process and will maintain a record of the performance improvement projects.
2. The progress and the results of performance improvement projects will be shared with the staff and clients involved with the process.
3. The results of the client satisfaction surveys will be reviewed with family members on an annual basis. The format of this review will be focus groups.

### IV. Staff Training

1. Training is recognized as a key component to a successful quality management program. The training program design is based on this statement.

2. All Agency employees receive training in quality management to provide them with knowledge of quality management principles and techniques that are designed to improve program operations and treatment outcomes. Community Healthlink will provide training on client driven approaches and outcomes. The Director of Quality Management will coordinate the training.

3. Programs that require topic-specific quality management and performance improvement training will receive this training on an ongoing basis.
Purpose: To outline the processes of:

- Evaluating clinical care of individuals served by CHL;
- Conducting peer review with consideration of liability and the discoverability of information;
- Identifying opportunities to improve care processes; and
- Ensuring compliance with external reporting requirements.

This policy was designed to correspond with CHL’s general incident reporting system.

Definitions:

**Major incident/sentinel event:** Deaths or permanent impairment of bodily functions that are not expected as a result of the patient's condition upon presentation – these incidents require reporting to the Commonwealth of Massachusetts Board of Registration in Medicine

**Critical incidents:** Serious suicide attempts, serious medication complications from treatment, serious boundary issues/ethics violations, criminal behavior (primarily felonies) on property operated by CHL, neglect/abuse, restraint or seclusion practices not in accordance with applicable regulations, and other unanticipated adverse outcomes

**Quality Assurance/Patient Care Assessment Committee:** A medical peer review committee, as defined by 243 CMR 3.02, and consistent with M.G.L. c. 112, ss. 1 and 204, that is created by the bylaws at the governing board level of a health care facility and which includes among its members not less than one governing board member, and other senior personnel essential to the quality of patient care.

**Patient Care Assessment Coordinator:** A qualified physician or non-physician designated by a health care facility to implement and coordinate the facility's Qualified Patient Care Assessment Program established pursuant to the requirements of 243 CMR 3.00.

Policy:

1. CHL has established multiple committees that maintain the responsibility for the oversight of the systems of care in their specified area. The following committees have been charged with specific oversight functions.

   a. Morbidity and Mortality Committee
   b. Pharmacy and Therapeutics Committee
   c. Environment of Care Committee
   d. Infection Control Committee
   e. Executive Management Team
   f. Clinical Review Committee
   g. Residential Rounds
   h. Quality Council Meeting (Leominster)
i. Outpatient Staff Meetings
j. Clinical Teams
k. Utilization Review/ Utilization Management Meetings

2. The Morbidity and Mortality Committee will review all outcomes that meet the criteria for a major incident. This Committee will ensure that reporting requirements are fulfilled.

3. The other oversight committees are responsible for reviewing critical incidents and other incidents. Refer to the Committee functions statements for their specific responsibilities and objectives.

**Responsibility:** Committee chairs, Director of Quality Management

**Procedures:**

**A. Guidelines for Conducting Peer Review**

1. To apply the peer review privilege to activities within the aforementioned committees, the activity should be identified as “peer review” prior to the beginning of the discussion.

2. Reports and other records of the activities identified as peer review should be identified/ labeled as “Confidential-Peer Review Material” to ensure protection provided by the peer review statute.

3. Minutes from peer review activities must be written in a factual, objective manner.

4. In the event that a Committee meeting includes both peer review and non-peer review activities, it is required that documentation be separate according to peer review status. (Meeting minutes and other documentation should not include both peer review and non-peer review activities).

5. Any written materials utilized for discussion during a peer review process will be collected at the end of the meeting and destroyed.

6. According to the Board of Registration in Medicine, a health care facility has no legal justification for withholding the results of quality assurance investigations, however, peer review committee proceedings are protected under the peer review privilege.¹

**B. Evaluating Causation and Planning Improvement (Major Incidents)**

1. The purpose of evaluating causation and planning for improvement is to understand how and why the event occurred and to design systems to prevent future reoccurrence of similar events.

2. It is important to note that the purpose of this process is to assess the systems that were involved, not the people.

¹ Supreme Judicial Court, Beth Israel Hospital Association v. Board of Registration in Medicine, (1987)
3. A written protocol outlined by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) for conducting root cause analyses will be utilized when reviewing major incidents. The steps of this process will involve:

- team assignment,
- defining the event,
- identifying proximate and underlying causes,
- collecting related data,
- designing and implementing interim change (risk containment),
- conducting root cause analyses,
- and communicating findings.

C. Reporting

1. All events are reported to the Risk Manager through the incident reporting system. Programmatic guidelines on response and immediate external reporting requirements are managed at the local level.

2. Major incident reports are reported to the Risk Manager or designee within 48 hours of the event. The Risk Manager will coordinate the root cause analysis process, and will ensure compliance with external reporting requirements.

3. Major incidents will be reported to the Board of Registration in Medicine on a quarterly basis as defined per guidelines promulgated by the Board of Registration in Medicine.

4. The Risk Manager will coordinate communication with governance (Board of Directors) and senior leadership.
Purpose: To outline the goals of CHL’s treatment planning and utilization review process.

Definitions:

Policy:
1. Initial treatment plans shall be prepared by a clinician with the participation of multidisciplinary team within three client visits.
2. All treatment plans will be reviewed with the client to insure a full understanding of the goals of treatment and the interventions included in the treatment plan. All treatment plans will be signed by the client to confirm that they understand and concur with the content (except in those instances where the policy of informed consent applies). Family members or other significant others involved in treatment will be included in the treatment planning process as is deemed appropriate, and within the clients’ right to privacy and confidentiality.
3. The treatment plan shall be reviewed no less than every 90 days and revised as necessary by the primary clinician.
4. The initial treatment plan shall include:
   a. Date
   b. Statement of problems and needs to which treatment is addressed.
   c. Treatment goals, with time limits, stated in measurable terms.
   d. Evidence of client involvement in treatment formulation.
   e. Defined staff responsibility.
   f. Signature(s) of staff involved in preparation of the plan.
   g. Evidence of contact (written) with the client’s PCP
5. Within 45 days of the implementation of the treatment plan, and at the termination of treatment, each case shall be reviewed by a multi-disciplinary utilization review committee. The UR process shall be determine and document:
   a. That the diagnosis is appropriate and adequately documented.
   b. That the treatment plan is appropriate and that it specifies methods and duration of the plan, and that the plan has been modified as appropriate to reflect changes in the client’s condition.
   c. That the treatment plan has been/is being carried out.
   d. That the medical/medication consultation is occurring if needed.
   e. That, base don progress toward achievement of short and long term goals, treatment shall be continued, modified, or terminated.
   f. That when a client misses appointments, drops out, or terminates treatment, or is terminated, that adequate follow-up, closure, or other appropriate action has occurred.
6. A record of the review shall be maintained in the Health Information Management Department.
7. Maximum acceptable time for the completion of the review shall be no more than 45 days.
8. Each entry must be dated.

Responsibility: All Clinicians.
Procedures:

1. Initial Treatment Planning: All treatment plans must be reviewed by a multi-disciplinary team. These teams are selected and report to the Division Director. The treatment plan must contain the signatures and disciplines of each member, and the date the plan was reviewed.

2. Initial Utilization Review:
   a. No later than 45 days after the multi-disciplinary treatment planning meeting, the initial utilization review shall be scheduled by the administrative assistant or other designated person.
   b. As soon as the initial UR is scheduled, the unit shall notify the UR coordinator (or designee) who will prepare a UR log containing the following information: Client name, number, unit and therapist, date(s) ongoing UR is due.

3. The initial UR shall be completed by a multi-disciplinary team and documented on the UR continuation worksheet which shall be signed by the UR team. The therapist may not perform UR on their own cases.

4. If there are no comments, the UR sheet shall be signed by the clinician and returned to clerical staff for filling with Health Information Management.

B. Discontinuation Review: See policy 6-15 (Closing Clinical Records) for more details:

1. Within 30 days of closing by the therapist, the closed chart shall be reviewed by the UR team and documented on the UR discontinuation worksheet that shall be signed by each member of the UR team.

2. If there are recommendations, these shall be reviewed and acted upon by the appropriate person, or appealed as per procedure B5.

3. Discontinuation UR worksheets shall be filed in the chart, and the closing procedures shall be followed.
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Policy and Procedure Manual

Section: 5 General Clinical  |  Policy Number: 5-04-7  |  Effective Date: 2/28/00
Title: Incidents and Accident Reporting and Investigations  |  Review Date: 7/1
Scope:  |  Originated: 2/25/99
References: DPH, DMH, DPPC, DCF, DEEC
Revised: 8/26/02, 7/11/05, 2/1/06, 12/4/06, 9/17/07, 2/27/08, 8/28/08, 10/31/08

Purpose:

Community Healthlink strives to ensure the timely reporting, documentation and review of incidents. Tracking and assessment of incidents serve to:

- Safeguard our clients human rights,
- maintain the safest possible environment,
- prevent future unsafe conditions, accidents, injuries, etc.,
- ensure administrative intervention as indicated or required, and
- identify areas in need of improvement.

The purpose of this policy is to ensure that all staff understand and follow Community Healthlink’s internal and external reporting requirements.

If a program has funding, accrediting or licensing from any state agency, the reporting requirements of that agency must also be followed (e.g. Department of Public Health, CARF). The following is a list of Community Healthlink payers, regulatory agencies and accrediting bodies.

- Department of Mental Health (DMH)
- Department of Mental Retardation (DMR)
- Massachusetts Behavioral Health Partnership (MBHP)
- Department of Children and Families (DCF)
- Disabled Person’s Protection Commission (DPPC)
- Executive Office of Elder Affairs (EOEA)
- Department of Public Health (DPH)
- Department of Early Education and Care (DEEC – formally OCCS)
- Medicaid HMO’s including NHP, Network Health, Fallon and BMC Healthnet
- Bureau of Substance Abuse Services (BSAS)
- Commission on Accreditation of Rehabilitation Facilities (CARF)

Please refer to Appendix I for a complete list of Community Healthlink programs funded by the state Departments requiring incident reporting.
1. Organizational Expectations And Usage Of Incident Reporting Data

Program staff are expected to submit a complete and accurate incident report to their supervisor on a timely basis. Incident reports must be submitted for any event or situation which occurs in a CHL program or concerning a CHL consumer that meet specified criteria for all critical and non-critical incidents (See Definitions/Criteria for Reporting of Incidents). Incident Reports provide information regarding events and situations which occur in our programs and/or to our clients that can assist CHL in making needed improvements.

All CHL programs in which there is an occurrence that meets the definitions/criteria in Section 2 must report the occurrence as an incident to CHL’s Compliance Officer. DMH and DMR funded programs must report when there is an occurrence that meets the definitions/criteria in Section 2 to their respective funding agencies and to CHL’s Compliance Officer. Other funded/licensed programs may also need to report to their respective agencies and should refer to Section 7 Additional Responsibilities for this information.
The Compliance Department receives copies of all incident reports and manages incident reporting data. It is the responsibility of the Compliance Department to:

- Review and log incidents and investigations into the Incident and Investigations Database;
- Notify the division’s Vice President, CEO and Legal Counsel when necessary;
- Provide incident report data to Senior Managers and CPO and assist them in identifying patterns and trends;
- Coordinate and track external investigations and provide assistance to Division Directors and Vice Presidents as needed with the investigation process;
- Coordinate internal investigations;
- Provide assistance to Programs in completing incident reports;
- Provide training to Programs on incident reporting policies and procedures;
- Support Quality Teams (Clinical Councils) and provide them with incident reporting data for their review; and
- Support CHL Human Rights Committee, and provide them with information on all incidents that result in investigations involving clients’ human rights.

2. Definitions/Criteria for Reporting of Incidents

**Incident** - An event or situation which occurs in a CHL program or concerning a CHL consumer that is unusual or out of the ordinary and meets the criteria as specified below is an incident. The event may be a health and safety issue, a human rights issue, a consumer emergency or any other situation that may be considered out of the ordinary. (When in doubt if an event is an incident, staff are encouraged to discuss the situation with their supervisor, who may consult with the Compliance Department). There is no time limit on reporting incidents. If a client refers to a past incident, staff are still required to report it for investigation.

**CHL Reporting**

**Critical Incidents:**
A critical incident is an event or situation as described above that meets one of the following criteria:

- All deaths
- Serious injury that requires any medical treatment beyond first aid. This includes being transported to an acute care hospital
- Any non-serious injury/condition resulting in unplanned transportation and admission at an acute care hospital
- A suicide attempt/gesture that involves an injury requiring medical treatment
- Any sexual assault by or upon a consumer or an alleged sexual assault by or upon a consumer
- A medical emergency
- An incident involving a weapon
• Abuse, actual or alleged, by a caretaker or staff member toward a client
• Any assault toward a client
• Seclusion
• Mechanical or chemical restraints
• Substance related incident (alcohol, legal and illegal drugs, other substances)
• Sexual activity of minors in a CHL program
• Any arrest for a felony including, but not limited to, arson, rape, murder, sexual assault or attempted assault (see Appendix for a list of felony examples)
• Any crime committed at a residence by a consumer or upon a consumer – even prior to arrest
• Any consumer who becomes a victim of a felony
• Any unaccounted for absence of a consumer who is under 18
• Any client in a DMH funded program who is absent for more than 4 hours
• Any unaccounted for absence of an adult consumer from a residence considered at risk to self or others
• Major damage or threat to the physical plant leading to relocation of consumers
• Unscheduled situations that result in the temporary evacuation of a program or facility, such as a toaster-caused fire resulting in fire department response
• Any restraint of a consumer
• Exposure incidents of consumer *
• Staff injury
• Facility related such as damage to a program or van

(*) Note: When staff have been exposed to blood or other potentially infectious material in their eye, mouth, mucous membranes, non-intact skin or parenteral (needle sticks) contacts, staff must also contact Infection Control at 508-438-5572. For more information see P&P 9-07.

Note: When a staff person is involved in an automobile accident while working, in addition to the CHL incident report (and any state reporting if it involves a client), staff must also contact Human Resources.

Critical Incident Notification:
• Staff should contact their Program Director immediately following a critical incident. Program Directors must then immediately notify the Division Director/Designee.
• The Program Director/Supervisor or manager on call is responsible for assisting staff in following internal program protocols regarding emergencies.
• The Division Director/Designee must report critical incidents in DMH/DMR funded programs by telephone to DMH/DMR within two hours, or as soon as possible after the situation is stabilized, whichever is sooner. See the Appendix for phone numbers.
• The Program Director/Supervisor or manager on call should identify which staff will be responsible for contacting family members/guardians as appropriate and members of the consumer’s treatment team.
If funded by DMH or DMR, the Division Director, or designee, must report critical incidents by telephone to DMH within 2 hours or as soon as possible after the situation is stabilized.

- During regular business hours call:
  DMH – Site Director
  DMR – Area Office
- After hours, on holidays or on weekends, call:
  DMH - The Administrator On-Call
  DMR – Area Director/Designee

If the incident involves suspected or observed abuse of a child, a disabled adult or an elder the incident must also be immediately reported to the appropriate agency (DCF, DPPC or the Office of Elder Affairs) by the staff person who witnessed the abuse or neglect, or by the Program Director. See Mandated Reporting Section 10 for reporting guidelines.

**Submitting the Incident Report:**

The CHL incident report must be completed immediately and faxed to the Compliance Officer. Written incident reports (CHL, DMR/DMH) must be submitted within 24 hours for critical incidents. See Appendix for Fax Numbers.

**Non-Critical Incidents**

Non-critical incidents are events or situations that meet one of the following criteria:

- Self-injurious and behavioral incidents resulting in a non-serious injury
- Any injury requiring contact with a medical professional and/or first aid, but not requiring admission to an acute care hospital
- Any non-serious injury of unknown origin
- Physical altercations
- Minor injury to clients
- A suicide attempt or gesture not resulting in serious injury and/or medical attention
- Suicidal ideation
- Actual or potential emotional harm
- Human Rights violation
- 51A filed with DCF
- Section 12 issued
- Unusually threatening behavior
- Situations that compromise the safety of consumers
- Unusual damage, loss or theft
- Non-felony arrests
- Minor fires or other damage to the program site
- Violations of health and safety standards
- Minor alcohol use/intoxication
- Non-critical incidents that involve police or fire departments
- Fire alarm or fire drill problems that does not initiate a fire department response
• Medication Occurrence - A breach in one of the “five rights”. The five “wrongs” are: wrong individual, wrong medication, wrong time, wrong dose, wrong route. (For more information on Medication Occurrence Reporting Requirements, refer to CHL Medication Administration Policy "MAP" Manual)

**Note:** 1) Any medication error by MAP trained staff as defined in the CHL Medication Administration Program (MAP) Manual, requires a Medication Occurrence Report, but not an Incident Report unless the error results in follow-up medical treatment, injury, harm or death to the consumer. Refer to CHL MAP Manual.

**Note:** 2) Medication errors, by non-MAP trained staff, i.e. physicians or nurses, need to be documented on a CHL Incident Report form and submitted to Compliance.

• Medication Loss- If medication is missing DPH requires a Drug Incident Reporting Form (See Section 8.1) be faxed to DPH-Drug Control Program (617-524-8062) within 24 hours of discovery. An Incident Report is also required.

**Non-critical incidents Reporting**

• Staff should complete a written CHL incident report and submit to his/her Program Director/Supervisor within 24 hours after a non-critical incident. The Program Director/Supervisor must submit the completed report to the CHL Compliance Officer by the **next business day**.

• DMH: The Division Director/Designee must submit a written incident **report within 5 days** to DMH

• DMR: The Division Director/Designee must submit a written incident **report within 24 hours** to DMR.

**Staff Related Incidents**

Staff related incidents include:

- Criminal acts
- Medical emergencies
- Actual or potential harm – actual harm must also be reported to Human Resources.
- Work Related Injuries – must be reported to Human Resources
- Infectious Material Exposure
- Breach of Confidentiality

**Reporting of Staff related Incidents:**

All of the above require an incident report to be submitted. For work related injuries, staff are also required to contact Human Resources at 508-421-4335.

**Facility Related Incidents:**

Facility related incidents include the following:

- Disaster Plan implementation
- Program or facility deemed uninhabitable or dangerous
- Fire hazard of life safety hazard
- Theft
- Significant destruction of property
Vehicle damage

Facility Related Incident Reporting:
All of the above require a CHL incident report to be submitted. If non-urgent maintenance is required, please complete a maintenance request form. Forms are available by calling 508-860-1124. For urgent maintenance needs please call the Facility’s Director at 508-860-1123.
3. DMR Funded Programs and DMR Clients:

DMR REGULATIONS REQUIRE THAT ALL INCIDENTS ARE REPORTED WITHIN 24 HOURS. Please remember to also file a CHL incident form.

All incidents involving individuals served by CHL program which result in any of the following shall be reported to DMR:

1. **Unexpected/Suspicious Death** – Any death that is sudden, unanticipated or suspicious. This excludes any expected, foreseen or imminent death from natural causes.
   - **Accidental** – Any death resulting from accidental causes, such as the result of a car accident or choking incident.
   - **Suicide** – Any death resulting from a conscious act to take one’s own life.
   - **Unusual Circumstances** – Any suspicious death, such as one resulting from foul play or a drug overdose.
   - **Other Unexpected/Sudden Death** – Any other unexpected or unanticipated death that does not fit into another secondary incident type.

2. **Suicide Attempt** – A serious, intentional, voluntary attempt to take one’s own life. This would include an incident that might not in and of itself cause death, if the intention was to take one’s own life. This would not include self-injurious behavior unless that behavior was attempted in order to take one’s own life.
   - **First Known Attempt**
   - **Repeat Attempt**

3. **Unexpected Hospital Visit** – This category is for an unplanned emergency visit to an acute care medical or psychiatric hospital for the purpose of evaluation and treatment of an immediate medical or psychiatric concern. This would not include a hospital visit that is part of routine care, scheduled visit or medical treatment protocol, such as a protocol for replacing a feeding tube, even though the timing for this visit may not be planned, but is an expected step in an individual’s medical treatment.
   - **Medical Hospitalization** – This category would be used only when an individual is admitted as an inpatient to the hospital for medical treatment as a result of the unexpected hospital visit. It would not be used if the individual is only seen and treated in the emergency room, even if the time spent in the emergency room is extensive.
   - **Psychiatric Hospitalization** – This category would be used only when an individual is admitted as an inpatient to the hospital for psychiatric treatment as a result of the unexpected hospital visit.
   - **E.R. Visit** – This category would be used when any assessment and/or treatment provided is through the emergency room as a result of the unexpected hospital visit, regardless of the amount of time spent in the emergency room.
   - **Emergency Services Team Evaluation** – Emergency psychiatric evaluation that is not part of a regular intervention outlined in an individual’s behavior plan.

4. **Near Drowning** – Any water incident that almost results in the individual’s drowning and requires emergency response.
   - **Bathtub**
   - **Swimming Pool**
   - **Other Body of Water**
5. **Assault** – This category includes intentional physical attacks that cause or may cause severe physical or emotional harm to an individual. Incidents in this category would always be considered major incidents because of the possible serious consequences that could result from the attack.
   - **Sexual Assault – Alleged Victim** – This category is used when an individual is the alleged victim of any unwanted sexual advance such as exposing oneself in a sexual way, inappropriate sexual touching and up to and including rape.
   - **Sexual Assault – Alleged Perpetrator** – This category is used when an individual is the alleged perpetrator of any unwanted sexual advance such as exposing oneself in a sexual way, inappropriate sexual touching of another person and up to and including rape.
   - **Physical Assault – Alleged Victim** – This category is used when an individual is the alleged victim of a serious physical attack with such force to cause or potentially could have caused serious injury. An example would be if someone grabs the individual around the throat and is in danger of choking but for the intervention of staff.
   - **Physical Assault – Alleged Perpetrator** – This category is used for the alleged perpetrator when an individual physically attacks someone with such force as to cause or potentially could have caused serious injury. An example would be an individual grabbing someone around the throat with a danger of choking but for the intervention of staff. Another example would be an assault on staff that causes injury requiring medical treatment.

6. **Missing Person** – Any individual who is missing and considered to be at risk. This could include someone who is missing for any period of time, if considered in immediate jeopardy, or someone who is missing for more than 24 hours without prior arrangement, unless the person’s ISP Team specifies that an individual could safely be out of contact for a period of time longer than 24 hours.
   - **Law Enforcement Contacted**
   - **Law Enforcement Not Contacted**

7. **Medical Treatment Resulting From Injury** – This category is appropriate when there is medical treatment generally beyond first aid. This would include life saving interventions such as the Heimlich maneuver and CPR. This category also includes wound closure by a medical professional or other treatment provided in a health care practitioner’s office or on site by agency medical personnel (RN, LPN, etc.). This would also include evaluation of a possible injury by emergency personnel in response to 911 or consultation with poison control even if the individual were not transported to an emergency room.

8. **Fire** – Any incident involving a fire in an individual’s environment that requires active involvement of fire personnel or equipment.
   - **Intentional – Started By Individual** – this category would be used when an individual receiving services purposely starts a fire, such as making a conscious decision to burn papers or material in their home.
   - **Intentional – Not Started By Individual** – this category would be used when someone other than an individual receiving services purposely starts a fire in the individual’s environment.
   - **Accidental – Started By Individual** – this category would be used when an individual receiving services starts a fire accidentally, such as causing a grease fire in the kitchen or toast catching on fire that requires intervention by fire personnel.
   - **Accidental – Not Started By Individual** – this category would be used when someone other than an individual receiving services accidentally starts a fire, such as a staff person causing a grease fire in the kitchen or toast catching on fire that requires intervention by fire personnel.
   - **Fire of Unknown Origin**
9. **Suspected Mistreatment** – This category includes any intentional or negligent action or omission that exposes an individual to a serious risk of physical or emotional harm. This category could be used both if the perpetrator of the suspected mistreatment is a staff person, person from the general community or another individual receiving services, as long as the suspected mistreatment is determined to expose an individual to a serious risk of physical or emotional harm. If the alleged perpetrator is another individual, there should be a pattern of occurrences that meet the threshold of suspected mistreatment, whereas if the alleged perpetrator is a staff person, one occurrence of a reportable event in this category should be reported.

- **Alleged Victim of Psychological Abuse** – This category includes acts other than verbal, which may inflict serious emotional harm, invoke fear or humiliate, intimidate or demean an individual or potentially seriously damage an individual’s self respect. An example would be a housemate regularly not letting an individual into the family room to watch TV with others so that the individual is afraid to come into the room. Another example would be if a staff person hides something of value from the individual as a way of making fun of or intimidating the individual.

- **Alleged Victim of Verbal Abuse** – This category includes verbalizations that may inflict serious emotional harm, invoke fear or humiliate, intimidate or demean an individual or potentially seriously damage an individual’s self respect. An example would be a staff person or a housemate who always makes fun of an individual, telling him to shut up or calling him names, which makes the individual very nervous and afraid to talk or be comfortable in his own home.

- **Alleged Omission – Failure To Provide Needed Supports** – This category is used for failure to provide services and supports determined to be necessary or otherwise required by law, regulation or contract. An example would be staff not following doctor’s orders and providing needed treatment to ensure timely resolution of a medical condition.

- **Alleged Omission – Failure To Provide Needed Supervision** – This category is used for failure to provide supervision determined to be necessary or otherwise required by law, regulation or contract. An example would be a staff person leaving an individual who need ongoing supervision alone in a van while going into a store.

10. **Physical Altercation** – This category would be used when there is a physical encounter from one individual receiving services to other individual(s) receiving services or to staff that causes some emotional distress or minor physical injury requiring no more than first aid intervention. Examples could include one individual receiving services pushing a peer and grabbing her snack, or punching or slapping a housemate with no observable injury.

- **Individual to Individual – Victim**
- **Individual to Individual – Perpetrator**
- **Individual to Staff**

11. **Property Damage** – This category includes intentional damage to or destruction of property that is typically of more than $200 but less monetary value but significant personal value to the owner. For example, a pen would not typically reach the threshold for reporting, but if the pen had been a gift from a favorite relative that had died and the destruction caused significant distress, it would be reportable.

- **Damage of DMR/Provider Property** – This category includes damage to property that is owned by DMR or the provider. It would not include communal property in a home that is owned by other individual(s) living in the home. An example would be damage to a television set that is owned by the provider.

- **Damage of Personal Property** – This category includes property that is solely an individual’s own property. An example would be damage to a television set that is the property of the individual committing the damage.
· **Damage of Public/Community Property** – This category includes property in the community at large. Examples would include damage to a neighbor’s property or other community sites such as restaurants or stores.

· **Damage of Another Individual’s Property** – This category includes property owned solely or in part by other individual(s). An example would be damage to a television set that is owned solely or in part by a housemate.

12. **Theft** – Unlawful taking of money, other financial assets and/or personal property that is reported to DPPC and/or law enforcement.
   · Alleged Victim
   · Alleged Perpetrator

13. **Other Criminal Activity** – Criminal activity not included under incident type of theft or property damage, such as identity theft or drug possession.
   · Alleged Victim
   · Alleged Perpetrator

14. **Transportation Accident** – This category would be used for traffic accidents where there was a potential for serious harm or that identifies safety needs for an individual. It would not include minor fender benders. The secondary category would be chosen based on where the individual was during the accident.
   · **DMR Funded Transportation** – This category includes transportation typically to and from an individual’s day support. This would include both blended rate and brokered transportation.
   · **Provider Transportation** – This category includes transportation by staff of the provider of services using a vehicle owned by the agency.
   · **Public Transportation** – This category includes all forms of public transportation including bus, train, cabs, etc.
   · **Private Vehicle** – This category includes any privately owned vehicle including a staff person’s own car.
   · **Pedestrian** – This category is used if an individual was a pedestrian injured in a traffic accident.
   · **Recreational Vehicle** – This category is used if an individual was a passenger in a recreational vehicle, such as a boat, at the time of the accident.
   · **Bicycle** – This category is used if an individual was riding a bicycle at the time of the accident.
   · **Other**

15. **Emergency Relocation** – Individual(s) relocation on an emergency basis for more than 24 hours due to fire, local disaster, weather conditions, or as a result of immediate eviction.

16. **Unplanned Transportation Restraint** – The use of physical holding or a mechanical device to keep an individual safe during transportation that has not been planned for in the individual’s ISP. A restraint form is not required in these circumstances, however, an Incident Report is required if the intervention is not written into the individual’s ISP.

17. **Other** – This category covers incidents that do not easily fit into one of the other incident types.

   · **Staff Involvement with Law Enforcement** – This category includes situations where a staff person is involved with law enforcement related to an unlawful activity of the staff person and not relating to individuals served. An example would be if the police arrests a staff person for drug possession. An incident report is submitted if this arrest directly affects an individual receiving supports, such as individuals being upset at seeing a staff person arrested.
· **Behavioral Incident In The Community** – This category is used for an unusual incident in the community that draws attention to the individual by the community at large. An example would be an individual needing to be restrained while in the community and the incident was observed by members of the community at large.

· **Behavior Incident Involving Law Enforcement** – This category is used when law enforcement presence is needed because an individual is out of control and cannot be managed by staff. This incident could occur in the community or at the program site.

· **Ongoing Or Escalating Series Of Events** – This category is used when there are a series of events, each of which do not individually constitute an incident, but when viewed holistically, are a pattern that should be reported and addressed. An example would be an individual who is starting to fall frequently. Although there is no injury, staff are feeling these falls may be an indication of something changing for the individual that the ISP Team should look at.

· **Community Complaint** – This category is used for a complaint by a community member. An example is a complaint made by a neighbor about noise from individuals in a residential home.

· **Other** – This category is used for incidents that do not fit another incident type. This category should rarely be used because most incidents that are reportable would likely fit into one of the other categories.

Where an individual served by the program has a physical injury of unknown origin requiring medical treatment beyond routine first aid, the staff person first observing the injury shall complete and file the incident report.

(a) The incident report in this instance shall indicate that the injury is of unknown origin.

(b) The incident report for an injury of unknown origin shall address the elements listed in 115 CMR 9.16(3), but shall address these elements in terms of the discovery of the injury rather than in terms of the occurrence of an incident.

If the reporting staff person or head of the provider has reasonable cause to believe that serious physical or emotional injury of an individual served resulted from abuse or neglect, whether by act or omission, including non-consensual sexual activity, he or she shall also:

(a) immediately call the DPPC and file a complaint under M.G.L. c. 19C, where the suspected victim of the abuse is 18 years of age or older, but under 60 years of age.

(b) immediately call the Department of Children and Families and file a report under M.G.L. c.119, § 51A, where the suspected victim is under 18 years of age.

(c) immediately call the Department of Elder Affairs and file a report under c.19A, § 15, where the suspected victim is 60 years of age or older.

(d) immediately call the Department of Public Health and file a report under M.G.L. c. 111, § 72G, where the suspected victim resides in a nursing home or similar establishment required to be licensed or certified by the Department of Public Health.

Where the head of the provider has reasonable cause to believe that a felony has been committed in connection with an incident under 115 CMR 9.16(1), he or she shall file a report with the local police and district attorney. Staff will consult with the Compliance Officer in these matters before contacting the police or DA’s office.
**Incident Notification:**
In accordance with DMR regulation, family members/guardians are to be notified of incidents within 24 hours. In addition, program staff will ask individuals who are their own guardian if they want to see their incident reports and if they want their family to be notified of incidents.

- **Guardians of Individuals:**
  Upon an individual’s intake into a program, guardians are asked to sign an Incident Notification Request Form. This form asks guardians if they wish to exercise one of the following options:
  - Request copies of all incidents reports;
  - Request verbal notification, only, of all incidents; and,
  - Request verbal notification and a copy of all incident reports.

- **Individual who is his/her own guardian**
  Individuals will be asked if they want his/her family notified by requesting that they complete the Incident Notification Request Form. If the individual requests, and documents on the Incident Notification Request Forms that his/her family not be notified the individual’s wishes will be respected.

  EXCEPTION: If the individual is involved in a serious incident involving injury or hospitalization, the family will be notified. Individuals will also be asked if they want to see all of their incident reports and have staff explain the reports to them.

**Reporting Deaths of DMR Clients**
All deaths of individuals, regardless of cause, and regardless where the individual resided immediately prior to death, shall be reported to the Office of the General Counsel in the manner directed by that office.

Any Department or provider employee having reason to believe that an individual died a medicolegal death shall:
(a) file a complaint under 115 CMR 9.06 and 9.16; and
(b) notify the Medical Examiner, unless he or she has already taken jurisdiction of the case, who is required to inquire into the cause and circumstances of death and to take custody of the dead body if he or she is of the opinion that death may have resulted from violence or unnatural causes.

**Submitting Incident Reports: HCSIS**
The Department of Mental Retardation uses an electronic reporting system called HCSIS (Home and Community Services Information system). Incidents must be reported using HCSIS. For detailed instructions on how to use the system, please go to the DMR web page at www.mass.gov
4. DMH Funded Programs and DHM Clients

The following are incidents (Category I) that must be reported to DMH immediately:

1. medicolegal death:
   a. any death required by M.G.L. c. 38, § 3, to be reported to the Medical Examiner (which is most)
   b. a death in which the Medical Examiner takes jurisdiction.
2. sexual assault or abuse (actual or alleged);
3. any unaccounted for absence from a DMH-contracted day or residential program of a child who is under 18;
4. physical assault or abuse (actual or alleged);
5. serious injury resulting in hospitalization;
6. attempted suicide which results in serious physical injury;
7. arrested for a felony;
8. restraint or seclusion practices not in accordance with Department regulations which result in serious physical injuries; or
9. if the Compliance Officer believes that a complaint is sufficiently serious or complicated as to require an investigation by the Office of Investigation even though it does not involve one of the categories listed.

The following are incidents (Category II) that must be reported to DMH within 24 hours:

1. A non-medicolegal death;
2. Any absence without leave from a DMH funded program;
3. Serious injury;
4. Unscheduled events that result in the temporary evacuation of a program or facility, such as a fire; or
5. All suicide attempts/gestures (with intent to harm self).

Staff Procedures:

1. Notify your supervisor. If your supervisor is not available, continue up the chain of command until you reach someone.
2. Complete an incident form.
3. Complete (Manager) a DMH incident form. These should be reviewed by your supervisor or a senior staff person before being sent to DMH. Attach a copy of the DMH incident report to the CHL incident report.
4. The incident report and the copy of the DMH incident report should be faxed the CHL Compliance Officer 508-860-1115 immediately.

DMH Phone Numbers:

Category I incidents:
• Report immediately by phone to 508-368-3838. After hours call 508-368-3300.
• Fax written report no later than next business day to: 508-363-1500.

Category II incidents:
• Report no later than the close of business on the next day by phone.
• Fax written report no later than next business day.
5. Programs Licensed by the Department of Public Health (DPH)

These procedures are for DPH funded programs and are in addition to CHL reporting requirements.

1a) Reportable Incidents for:

- Fire
- Suicide
- Serious Criminal acts
- Pending or actual strike by its employees, and contingency plans for operation of the clinic

The incidents listed above must be reported immediately to DPH when they occur at a program site and seriously affect the health and safety of consumers.

- Medication Loss

Incidents of this type require a faxed report to DPH/DCP within 24 hours.

1b) Reportable Incidents for:

**Early Intervention Programs**

- Injury
- 51A Mandated Reports

The incidents listed above must be reported immediately to DPH

Any injury that requires first aid or any other emergency care, must be reported within 24 hours to the child's parent and a copy of the report kept in the child's file.

2) DPH Reporting Procedures

The following procedures are to be followed in the reporting of all incidents to DPH:

- Notify DPH immediately by telephone of any death resulting from incidents, medication errors, abuse or neglect:

  **Department of Public Health**
  **Division of Health Care Quality**
  **Tel. Number (617) 753-8000**

- The staff person(s) involved makes an immediate telephone report to the Program Director or designee, who notifies the Division Director.

- The involved staff member must complete an Incident Report Form using either CHL Incident Reporting Form or the Funder’s reporting form for reporting to DPH. Be sure to note on the fax cover sheet that the form has already been submitted to the funder.
• The completed form must be reviewed by the Program Director/Supervisor.

• The Program Director/Supervisor faxes/emails the completed form to the Division Director/Designee.

• The Division Director/Designee reviews and signs the Incident Report.

• The Program Director or designee will fax an incident report form to DPH Office within seven days.

**DPH Fax Number: 617-753-8165**

A copy of all incident documentation must be sent to the CHL Compliance Department as soon as it is sent to DPH.

3) **Programs Providing Medication Administration Only:**

Residential Programs

• Medication Occurrences – Any medication error as defined in the CHL Medication Administration Program Manual (MAP), requires a Medication Occurrence Report, but not an Incident Report unless the error results in follow-up medical treatment, injury, harm or death to the consumer.

• Refer to the MAP Manual for reporting procedures.

• Medication Loss- a DPH/Drug Incident Report needs to be completed and approved by the Division Vice President who will submit it to DPH and Quality Management.

• Division Directors/VPs/Designees must submit a copy of all Medication Occurrence Reports to Compliance Department.


5.5 **Programs Licensed by the Department of Early Education and Care (EEC)**

At the present time the following programs is licensed by DEEC:

• Burncoat Family Center
• Together for Kids

DEEC requires the following:

A. Regulation 3.04(3)(f) requires every provider to have a written plan for the filing of 51A’s. (see section 10 – Mandated Reporting).

B. Regulation 3.04(3)(g) requires every provider to have a written plan for the notification of DEEC as well as any other agency (DOE, DMH, etc.) when a 51A is
filed. CHL staff will immediately notify their supervisor and the program Director in the event of a significant event as outlined in section C below. The Program Director or her designee shall immediately report the incident to EEC as well as CHL’s Compliance Department.

C. Regulation 3.04(5) requires providers to notify DEEC in the event of:
   • Evacuation of the facility
   • Initiation of civil, criminal or administrative action against the provider
   • Serious accident involving a resident
   • Serious injury of a resident involving hospitalization
   • Death of a resident
   • Incident involving firearms or dangerous weapons
   • Fire
   • Inability to renew building, health or fire inspections
   • A substantial change in the program (physical plant, staffing, administration, population, policies)

D. Regulation 3.04(3)(e) requires an Internal Investigation by the provider of an allegation of abuse or neglect or a serious incident involving a resident within the program. This investigation must be completed regardless of whether DCF screens in the 51A.

E. All DEEC reportable incidents must be reported to the Compliance Department. The Compliance Department will be responsible for initiating any internal investigation.

DEEC: Call in reports to 508 798-5180. Fax reports to: 508 798-5181

If an incident occurs that needs to be report, staff should complete the EEC Incident report form.

6. Debriefing Meeting following a Critical Incidents
The Program should hold a meeting as soon after the critical incident as is possible when deemed appropriate by the supervisor or Division Director. The meeting should include staff who were directly involved in the incident or staff that may be impacted by the incident. When meetings are not possible due to scheduling, the supervisor must identify other means to communicate with all relevant staff. The purposes of this debriefing meeting are to:
   • Review all circumstances relating to the incident
   • Identify support needs of staff and related consumers
   • Identify ways to minimize recurrence of similar incidents
   • Plan for ongoing support, training, education to staff and/or consumers as needed

7. Additional Responsibilities Regarding Critical Incidents
Consumer Deaths:

- **Immediately**: If any consumer who is considered a disabled person between the ages of 18 and 59, regardless of the cause, dies, DPPC requires that the program notify DPPC immediately of the death. Notification is made by calling the DPPC Hotline at 1-800-426-9009.

- **By the next business day**: Within 24 hours of the death, the program must submit: A written death report to DPPC and an Incident Report or Client Death Report with copy of DPPC death report to Compliance. Copies of all submissions must be sent to the Compliance Officer.

- **Within two weeks**: DMH - The Deceased Client Profile must be completed and sent to the Area Site Director.

Exposures:

**By the Next Business Day**: In addition to an Incident Report, if an employee has been exposed (See Infection Control Manual, Exposure Policy), an incident form must be submitted to Compliance within twenty-four hours of the incident. Compliance will forward a copy to Human Resources. Staff must also complete the CHL’s Compensation Report that is submitted to Human Resources within twenty-four hours of the incident.

MBHP and Medicaid HMO Reporting
The following require reporting of incidents:

**MBHP**:

MBHP requires that:

- All 24-hour level of care providers (e.g., Inpatient, Acute Residential Treatment, Transitional Care Unit, Crisis Stabilization Unit) must report all Category I and Category II Incidents that involve covered individuals and uninsured DMH clients.

- Non 24-hour level of care providers (e.g., Outpatient facilities, Community Support Programs, Family Stabilization Teams) need only report deaths of MassHealth covered individuals or uninsured DMH clients.

Definitions:

- **Covered Individuals**: MassHealth Members who are eligible to receive Covered Services under the Behavioral Health Program, including PCC Plan Enrollees and Children in the Care and/or Custody of the Commonwealth. Covered Individuals may also be DMH Clients.

- **DMH Clients**: individuals who are identified by the Division as determined by DMH to be eligible for and who do receive DMH Continuing Care Services. DMH Clients may be Covered Individuals or Uninsured DMH Clients.
• **Uninsured DMH Clients:** DMH Clients who are not eligible for MassHealth and who do not have any health insurance coverage.

**MBHP Reporting and Requirements:**

• All incidents must be faxed to the Quality Management Department of the Partnership at (617) 350-1981 within 24 hours. A copy of the form, along with a CHL Incident Report form, should be sent to the CHL Compliance Officer.

• The incident report must be either printed legibly or typed. Report Forms that are illegible because of poor handwriting or fax quality will not be accepted.

  *Note: The Partnership has an electronic form available for your convenience. Please contact the Quality Coordinator for Incident Reporting, at (617) 350-1941 to request the electronic form. This e-form must be faxed to the Partnership and not e-mailed.*

**Definitions of Reportable Incident Categories:**

**Category I**

1. **Death:** all deaths of a covered individual or uninsured DMH client of any cause

2. **Absence Without Authorization (Covered individuals and uninsured DMH clients who are committable or are under the age of 18):** any AWA, or absence beyond authorized leave, from a facility involving covered individuals and uninsured DMH clients who are admitted or committed to the facility under M.G.L. Chapter 123, Sections 7&8, 10&11, or 12, and who are a danger to self or others. These statutes apply to commitment and retention of dangerous persons, voluntary admissions, and the emergency restraint of dangerous persons. AWA incidents must also be reported on covered individuals and uninsured DMH clients who are admitted under M.G.L. Chapter 123, Sections 15, 16, 17, or 18, which includes competency to stand trial and the hospitalization of mentally ill prisoners. AWAs must also be reported on covered individuals and uninsured DMH clients who are under 18.

   *Note: AWA incidents differ from a discharge that occurs Against Medical Advice (AMA).*

3. **Any sexual assault or alleged sexual assault where the covered individuals or uninsured DMH client is either the alleged perpetrator or the alleged victim:** any assault to or by covered individuals and uninsured DMH clients that is sexual in nature, such as any touching or fondling that is physically forceful or forced penetration; sexual contact between patients, whether consensual or not, when at least one of the patients is a covered individual or uninsured DMH client; sexual contact between staff and covered individuals or uninsured DMH clients, whether consensual or not.

4. **Serious injury/medical emergency requiring transport and admission to an acute care facility:** injury or medical condition requiring medical treatment more intensive than first aid that is provided off the psychiatric unit and requiring medical hospitalization.
5. **Violations or alleged violations of DMH restraint and seclusion regulations:** any restraint or seclusion that is administered outside the purveyance of DMH licensing and operational standards for restraints and seclusions 104 CMR, Section 27.12.

**Category II**

1. **Absence Without Authorization (Covered individuals and uninsured DMH clients who are not committable and are over the age of 18):** any covered individuals and uninsured DMH clients who do not meet the criteria in Category I and are determined through their clinical presentation to be AWA, or absent beyond authorized leave. Also, any covered individuals or uninsured DMH client who has not returned to the facility by the midnight census, unless otherwise indicated by his or her treatment plan.

   *Note: AWA incidents differ from a discharge that is Against Medical Advice (AMA).*

2. **Any physical assault or alleged physical assault to or by covered individuals and uninsured DMH clients:** physical aggression to or by covered individuals or uninsured DMH clients, either directed to or exhibited by another patient that exceeds normative clinical behavior addressed in the treatment plan. Includes hitting, kicking, and/or use of a weapon. Also includes staff mistreatment of covered individuals or uninsured DMH clients, and any physical aggression that produces tissue damage.

3. **Serious injury/medical emergency requiring transport to an acute care facility for ambulatory treatment and release:** injury involving a covered individual or uninsured DMH client requiring medical treatment more intensive than first aid that is provided off the psychiatric unit but that does not require admission to a hospital.

4. **Unscheduled event that results in the evacuation of a program:** any event that occurs whereby all the patients on the unit must be evacuated, such as fire, unsafe air quality, flooding, or serious threats against the facility.

5. **Other:** any other occurrences that adversely affect covered individuals and uninsured DMH clients’ care and which, in the judgement of the facility staff, require notification. Some examples of incidents that may be reported under this category are:

   a. **Public health hazard:** any introduction of extraordinary elements into the environment that could be considered hazardous to the community, such as food contamination or lice infestation that causes a major disruption to the unit and results in medical treatment or hospitalization of covered individual(s) or uninsured DMH client(s)

   b. **Medication errors:** any medication error whether through omission, duplication, incorrect dosage, order missing, incorrect patient, packaging/labeling, transcription, incorrect drug, incorrect time, or covered individuals or uninsured DMH clients “cheeking” medications that results in the need for urgent or emergent medical treatment and/or admission to an acute care facility.
c. **Riot:** any organized or other significant event on the unit that causes disruption to the milieu and that could result in a potentially harmful situation for covered individuals and uninsured DMH clients.

**Network Health:**
Network Health has the same reporting requirements as MBHP, but you must use Network Health’s reporting form. The form can be found in the Appendix. All forms should be faxed to 888-977-0776. A copy of the form should also be sent, along with CHL’s incident report form, to the Compliance Officer.

**NHP and Fallon:**
For NHP and Fallon the following procedures apply:

Beacon providers are required to contact the UR Clinician, ICM Clinician, or after-hours UR Clinician by phone **on the day of the incident** and report the following:

- Member Demographics
- A description of the incident that allows for the determination that either a Sentinel Event or an Other Reportable Incident has occurred.
- In the case of a Sentinel Event, the steps the provider has taken to ensure the safety of the member.

In addition, the Beacon network provider is required to fax a copy of the Provider Incident Report Form to Beacon’s Ombudsperson at (781) 994-7642.

**Sentinel Events**
1. **All Medicolegal Deaths**
   - Any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction.
2. **Any Absence Without Authorization (AWA) involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others.**
3. **Any serious injury resulting in hospitalization for medical treatment.**
   - A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted.
4. **Any sexual assault or alleged sexual assault.**
5. **Any medication error or suicide attempt that requires medical attention beyond general first aid procedures.**
6. **Any physical assault or alleged physical assault by a staff person against a member.**
7. **Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for members.**

**Other Reportable Incidents**
1. Any non-Medicolegal death.
2. Any absence without authorization from a facility involving a Member who does not meet the criteria for a Sentinel Event as described above.

3. Any physical assault or alleged physical assault by or against a Member that does not meet the criteria of a Sentinel Event.

4. Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization.
   • A Serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted.

5. Any unscheduled event that results in the temporary evacuation of a program or facility such as a small fire that requires fire department response.

For additional information including the updated Adverse Incident Report Form, please visit Beacon’s new Website at www.beaconhealthstrategies.com.

8. Restraints and Holds/Escorts
Restraints are only allowed in the following Community Healthlink programs:
   • Burncoat Family Center;
   • Lipton Academy; and
   • After School Program

If a restraint is used, a CHL Restraint Incident Form must be completed and forward to the Compliance Officer. See P&P 9-12 for more information.

9. Completing The Incident Report
It is expected that the staff person first observing the incident will complete the incident form. Please remember that DMH, DMR, DPPC, MBHP, Network Health, Fallon and NHP all use different forms. The forms are all located in the Appendix of this P&P.

Begin with an Incident Report Form that is clean and not cut off on the edges, it is best to print out a copy from your computer for each time you need an Incident Report Form. Ensure that the Incident Report includes:

Page 1 –
   • Indicate which type of incident occurred. Be sure to check all that apply. If you are uncertain how to classify an incident, use #24, Other.
   • Client MIS (Medical Record Number), Name and Date of Birth are all required.
   • Date and time of the incident
   • Gender and medications
   • Center/Division

Page 2
   • Indicate in the top box any state agencies that the client may be involved with. Even if the incident does not meet the criteria for reporting to that state agency.
   • Description – Describe the incident step-by-step. Be sure to include the initials and ID numbers of other client’s involved, and the names and roles of all staff involved and/or that witnessed the incident. If you need more room, please attach additional pages.
• Initial Report made to: List the name of the supervisor or on-call that you first reported this incident to, and the date and time of notification.

• Staff Intervention – Answer all of the following questions completely.
  • What measures were taken to ensure a safe environment? Explain.
  • If there was any exposure to bodily fluid, what universal precautions were used (If an exposure occurred, be sure to notify Infection Control as well).
  • Was First Aid administered? Explain.
  • Was Medical Attention required? Explain.
  • What other interventions were required? Explain.
  • Urgent Event Form Completed?
  • Other Information

Be sure to sign, print your name, job title and program name, as well as the date completed.

Page 3 – Supervisory Review
• The supervisor should indicate all persons notified and their contact information.
• Resolution of Incident/Accident: The supervisor should say how this incident was resolved, what the outcome was.
• Summary of Action: The supervisor should describe what steps were taken to ensure the safety of the clients, and to ensure that the incident would not occur again.
• Summary of Actions Anticipated within 7 Days of the Incident: What actions will be taken to ensure that type of incident does not re-occur? This may include additional training, staff meetings, debriefings, a corrective action plan etc.
• Supervisors should sign and date the report and fax to the Compliance Officer at 508-860-1115.
10 MANDATED REPORTING

Vulnerable members of our society who suffer from abuse and neglect are not always able to report the abuse inflicted upon them. So, it is important for all CHL staff who work with children, disabled persons and the elderly to know how, when and where to report incidents of abuse and neglect. Reporting abuse to the proper agency will not only help the person who has suffered abuse in that particular situation but will also send out a broader message to everyone that mistreatment will not be tolerated or ignored. Massachusetts law mandates that certain caregivers must report incidents of abuse to the appropriate Massachusetts human service and law enforcement agency. Such caregivers are called Mandated Reporters. All staff must comply with the Massachusetts laws that protect children, disabled persons and elders from abuse. The mandated reporting laws can enforce fines up to $1,000 for non-compliance. Mandated reporting laws also provide confidentiality and protection for staff reporting abuse.

Mandated reporters are required under the law to report abuse/potential abuse as defined below.

**Mandated Reporters:**

- **Disabled Persons** - All CHL employees

- **Children** - CHL employees who are licensed professionals and all CHL employees working in programs that provide services to children.

- **Elderly People** - CHL employees who are licensed professionals and all CHL employees working in programs that provide services to elderly people.

- **Citizens in Long-Term Care Facilities** - CHL employees who are licensed professionals and CHL employees working in programs providing services to people living in a nursing home, rest home, or intermediate care facility for people with mental retardation.

If a CHL employee is not a mandated reporter, but in his/her professional capacity has reasonable cause to believe that a child, disabled person, or elderly person is suffering abuse or neglect, s/he can still file a report with the correct state agency. S/he should discuss the situation with her/his supervisor regarding filing a report as a non-mandated reporter.

**Mandate Reporter Requirements**

- Staff should contact their Program Director or Supervisor immediately following any serious or critical incident. If off-hours, the emergency on-call system should be used.
• The staff person who receives the information about abuse or neglect must report the allegation(s) to the appropriate agency(ies).

• A telephone report must be made as soon as possible to the appropriate agency.

• A written report must also be completed within 48 hours of the telephone report. In addition to mandated reporting, as listed above, incident reports also must be filed with the funder/licenser if the incident meets the specified criteria.

**Telephone Reporting Numbers**

- **Disabled Persons Between the ages of 18 and 59**
  Call the Disabled Person’s Protection Commission (DPPC)
  1- 800- 426- 9009

- **Children Under the age of 18**
  Call the Department of Children and Families. The Hotline will refer you to the correct DCF Area Office
  **24-Hour Hotline: 1- 800- 792- 5200**

- **Elderly People Over the age of 59**
  Call the Executive Office of Elder Affairs
  1- 800- 922- 2275

- **Citizens in Long-Term Care Facilities**
  Call the Department of Public Health/Division of Health Care Quality.
  **Business Hours: 1- 617- 727- 5860**
  **24-Hour Hotline: 1- 800- 462- 5540**

**CHL Reporting Requirements:**
Once the mandated report has been made all staff are required to maintain the confidentiality of all parties involved. Information concerning the fact that a report was filed and/or the content of the report must be kept strictly confidential. Staff should consult their Program Director or Supervisor immediately if inquiries regarding a report are made. If such a situation arises off-hours the emergency on-call service should be used.

An employee is required to cooperate with a DCF or DPPC investigation after making a mandated report of abuse or neglect. If staff receive telephone inquiries about the mandated report the only information they may provide must pertain to the alleged abuse or neglect.

If an employee receives a phone call from a DCF or DPPC investigator about an allegation of abuse or neglect that was made by someone else, s/he may only disclose
information to the investigator if the employee has a signed, written release from the consumer. To do otherwise, even to a DCF/DPPC investigator would violate laws and regulations on client confidentiality. An employee must also confirm the caller’s identity. A simple way to confirm the identification of a caller is by asking for the caller’s name and telephone number and calling him/her back.

- The Program Director/Designee must inform Division Directors any time a Mandated Report has occurred. Notification must occur within three hours of filing the report or, if off-hours, at the start of the next business day.
- The Division Director informs CHL’s Compliance Officer whenever a Mandated Report has been submitted to an outside agency, and submits a copy of the report along with a CHL incident report.
- Allegations of staff abuse or neglect are responded to immediately. In incidents involving sexual or physical abuse the accused staff person shall be immediately removed from all direct care responsibilities pending the outcome of an investigation. The supervisor should immediately contact Human Resources and the Compliance Officer.
- As needed, the Division Director may seek consultation from the Compliance Officer and/or Executive Management on mandated reporting requirements and confidentiality issues.

**Disabled Person’s Protection Commission (DPPC)**

DPPC was established in 1987 to provide for the protection and investigation of instances of abuse and neglect of disabled persons.

**Definitions:**

- **Disabled Person**
  A person between the ages of 18 and 59, inclusive, who is mentally retarded or otherwise mentally or physically disabled and as a result of the disability is wholly or partially dependent upon others to meet daily living needs.

- **Caretaker**
  The person or agency responsible for a disabled person’s health or welfare, whether in the same home as the disabled person, a relative’s home, a foster home or any day program or residential setting.

- **Abuse and Neglect**
  - A serious physical or emotional injury to a disabled person which results from an act or omission, including non-consensual sexual activity.
  - “ACT”: a caretaker’s intentional, reckless or negligent action.
  - “OMISSION”: a caretaker’s failure to take action to protect or provide for the daily living needs of a disabled person.
  - “SERIOUS PHYSICAL INJURY” includes, but is not limited to, death, brain damage, disfigurement, any non-trivial injury including but not...
limited to, fracture of a bone, skin bruising, intramuscular injury, puncture wound, abrasion, laceration, burn, bleeding, impairment of a bodily system or organ, excessive bedsores or similar condition, or harmful symptoms resulting from the use of medication or chemicals without informed consent or authorization; malnutrition or dehydration; unconsented touchings or unconsented sexual touching; sexual penetration or sexual exploitation.

- “SERIOUS EMOTIONAL INJURY” includes but is not limited to, a serious state of anxiety, fear, depression, withdrawal, or the development of post-traumatic syndrome, including but not limited to, symptoms resulting from being forced to engage involuntarily in sexual relations.

**Mandated Reporter Reporting Requirements Under DPPC**

Mandated reporters are persons who, as a result of their profession, have an opportunity to hear about or see abuse and, therefore, are required to report to DPPC. All CHL employees who, in their professional capacity, have reasonable cause to believe that a disabled person is suffering from a reportable condition of abuse or mistreatment are mandated by law to report it. Reasonable cause is a belief that it is more likely than not that a reportable condition of abuse exists.

In certain treatment relationships a competent disabled adult has the right to invoke a privilege of confidentiality. Massachusetts law states that under certain circumstances, the disabled person may request a licensed professional (i.e., licensed social worker, licensed psychologist, or psychiatrist) not to make a report of abuse or neglect to DPPC. Generally, this provision only applies to the above licensed professionals and does not apply to non-licensed staff. There is no privilege of confidentiality under this provision if the disclosure of abuse or neglect is made in public setting with other people present. Therefore, all parties in witness to the allegations are mandated reporters under the law. If a client requests that a staff person not report to DPPC, staff must consult first with the Compliance Officer.

Chapter 19C contains a criminal penalty for persons who discharge, discipline, threaten or discriminate in any way against reporters or persons who provide information regarding abuse of a disabled person to the Commission or agencies within the Executive Office of Human Services.

**DPPC Screening and Investigation Procedures**

*Screening of reports*

Once the report is made, DPPC determines the urgency of the situation.

- An emergency situation: When there is imminent danger of further abuse and requires immediate (within 24 hours) investigation and implementation of protective services.
• A non-emergency situation: When there is no imminent danger of further abuse to the victim. In this type of situation the investigation must be completed within 10 days.

Investigation of Reports

The DPPC will either conduct the investigation itself or refer the report of abuse to the appropriate state agency (usually the Department of Mental Health, the Department of Mental Retardation or the Massachusetts Rehabilitation Commission). The state agency conducts the investigation under DPPC monitoring.

If the abuse situation has also become a law enforcement matter, the DPPC may delay or defer the 19C investigation, but in such cases the DPPC is required to monitor the law enforcement investigation.

Elements of Investigations
Each investigation is required to include the following elements:
• A visit to the site of the abuse
• An interview with disabled person who is alleged to have been abused
• An interview with the person alleged to have been the abuser
• Gathering of pertinent facts
• Evaluation of the risk of further abuse to disabled person(s) at the location
• If the allegation of abuse is substantiated, recommendations for protective services to respond to the abuse and protect the disabled person.

All staff must notify the Compliance Officer immediately if they are asked to participate in a DPPC investigation, before any information is given to DPPC.

Additional Responsibilities Relating to Consumer Deaths

• If any consumer between the ages of 18 and 59, regardless of the cause, dies, DPPC requires that the program notify DPPC and the local police department immediately of the death.

• Notification is made by calling the DPPC Hotline at 1-800-426-9009.

• Within 24 hours of the death, the program must submit a written death report to DPPC.
Department of Children and Families (DCF)

DCF provides protective services and investigations of allegations of abuse/neglect and services for prevention of abuse and neglect of children in Massachusetts. Children are all persons under the age of 18. See P&P 6-13-1 for more information on 51A’s.

Definitions

- **Children**
  All persons under the age of 18.

- **Caretaker**
  A “caretaker” includes a child’s parent, step-parent, guardian, any other household member entrusted with the responsibility for a child’s health or welfare, and any other person entrusted with the responsibility for a child’s health or welfare, whether in the child’s home, a relative’s home, a school setting, a day care setting including babysitting, a foster home, a group care facility, or any other comparable residential setting.

- **Abuse and Neglect**
  According to Massachusetts law and Department of Children and Families regulations (110 CMR, section 400):
  
  **Abuse includes:**
  
  - The non-accidental commission of any act by a caretaker which causes or creates substantial risk of harm or threat of harm to a child’s well-being
  
  - The commission of a sex offense against a child as defined by the criminal laws of the Commonwealth.

  **Neglect includes:**
  
  - Failure by caretaker, either deliberately or through negligence, to take actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision or other essential care
  
  - Physical dependence of a child upon an addictive drug at birth.

  **Serious physical injury includes:**
  
  - Any non-trivial injury, death, malnutrition, and “failure to thrive.”

  **Serious emotional injury includes:**
  
  - An extreme emotional condition such as a severe anxiety, depression or withdrawal.

Mandated Reporter Reporting Requirements Under DCF

Mandated reporters are persons who, as a result of their profession, have an opportunity
to hear about or see abuse and, therefore, are required to report to DCF. Any licensed professional or person employed by a CHL program providing services to children, who, in his/her professional capacity, has reasonable cause to believe that a child is suffering from a reportable condition of abuse or neglect, is mandated by law to report it. Reasonable cause is a belief that it is more likely than not that a reportable condition of abuse exists.

The Department of Children and Families (DCF), under Massachusetts law, requires mandated reporters to immediately make an oral report when, in their professional capacity, they have reasonable cause to believe that a child under the age of 18 years is suffering serious physical or emotional injury as a result of abuse or neglect by a caretaker, including sexual abuse, or from neglect including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth. A written report must then be completed within 48 hours of making the oral report and should be sent to the appropriate DCF Area Office.

During the course of a 51A investigation, any person who is a mandated reporter and who has information which he/she believes might aid the Department in determining whether a child has been abused or neglected, upon request by the Department, shall disclose the relevant information to the Department. The person who disclosed the information would not be liable in any civil or criminal action and is protected against any discriminatory or retaliatory actions.

If staff have any questions concerning a DCF investigation, they should talked to their supervisor or the Compliance Officer.

Any allegation and/or DCF investigation against a CHL staff person or program must immediately be reported to the Division Vice President as well as the Compliance Officer.

**Department of Children and Families Investigation Procedures**

If the social worker that takes your report determines that there may be reasonable cause to believe that a child is abused or neglected, according to the above definition, DCF will assign a social worker to investigate the report. The investigation includes a home visit during which the social worker meets and talks with the child and caretaker. If the intake social worker has determined that the situation is an emergency, the investigation is completed within 24 hours of receipt of the report. All other reports are investigated within ten days.

If the investigating social worker determines there is reasonable cause to believe that the child in question is abused or neglected the Department will provide the family with services to reduce the risk of harm to the child. If the child is not abused or neglected but the family appears to be in need of services, the social worker may offer the family services on a voluntary basis. It is important to note that if the Department determines that a child has been sexually abused, sustained serious injury or has died as a result of abuse or neglect, the Department must notify the District Attorney. The District Attorney has the authority to file criminal charges, as does the police chief in the town where the
child resides.

Executive Office of Elder Affairs (EOEA)
EOEA is responsible for overseeing the protection and investigation of instances of abuse and neglect of elder persons. An elderly person is anyone who is 60 years of age or older. Definitions

- **Elder**
  A person 60 years of age and older.

- **Caretaker**
  The person or agency responsible for the elder's health or welfare, whether in the same home as the elder person, a relative’s home, a foster home, or any day program or residential setting.

- **Abuse and Neglect** -
  - A serious physical or emotional injury to an elderly person which results from an act or omission, including non-consensual sexual activity.
  - “ACT”: A caretaker’s intentional, reckless, or negligent action.
  - “OMISSION”: A caretaker’s failure to take action to protect or provide for the daily living needs of a disabled person.
  - “SERIOUS PHYSICAL INJURY”: Includes, but not limited to, death, brain damage, disfigurement, any non-trivial injury including but not limited to fracture of a bone, skin bruising, intramuscular injury, puncture wound, abrasion, laceration, burn, bleeding, impairment of a bodily system or organ, excessive bedsores or similar condition, or harmful symptoms resulting from the use of medication or chemicals without informed consent or authorization; malnutrition or dehydration, unconsented touchings or unconsented sexual touching, sexual penetration or sexual exploitation.
  - “SERIOUS EMOTIONAL INJURY”: Includes but is not limited to, a serious state of anxiety, fear, depression, withdrawal, or the development of post-traumatic syndrome, including but not limited to, symptoms resulting from being forced to engage involuntarily in sexual relations.

Mandated Reporter Reporting Requirements Under the Elder Abuse Act

Mandated reporters are persons who, as a result of their profession, have an opportunity to hear about or see abuse and, therefore, are required to report to EOE. Any licensed professional or person employed by a CHL program providing services to elderly persons, who, in his/her professional capacity, has reasonable cause to believe that an
elderly person is suffering from or has died as a result of abuse, is mandated by law to report it. Reasonable cause is a belief that it is more likely than not that a reportable condition of abuse exists.

If you believe an elderly person has been abused and/or neglected:
- **Immediately** - Call **1-800-922-2275**, the Massachusetts Executive Office of Elder Affairs
  
  - This law does not cover individuals in nursing homes, rest homes or other facilities licensed by the Department of Public Health.(See Section 5.1.2 Department of Public Health)

**Elder Abuse Investigation Procedures**

- The investigation will be held by the local elder service agency.

- This law does not cover individuals in nursing homes, rest homes or other facilities licensed by the Department of Public Health.

**Department of Public Health (DPH)**

All CHL employees working in programs providing services to people living in a nursing home, rest home, or DPH licensed intermediate care facility for people with mental retardation are mandated to report abuse, neglect, mistreatment, or misappropriation of a patient’s property to DPH. If any CHL employee has reasonable cause to believe that a person living in one of these facilities is suffering from such abuse or mistreatment, it should be reported. However, only CHL employees providing services to people living in one of the above programs are considered mandated reporters.

- DPH is responsible for the overall health of all citizens and regulates nursing homes, rest homes, and intermediate care facilities for the mentally disabled.

- To Report Nursing Home Abuse/Neglect Call:
  
  **Department of Public Health**
  
  **1-800-462-5540**
11. Program Funders

**DMH Funded Programs:**

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<tr>
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Last Update: 1/25/06
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Last Updated: 2/27/08
Appendix:
Incident Phone and Fax Numbers:

**CHL Compliance Officer:**
Phone: 508-860-1163  Cell: 508-981-4156  Fax: 508-860-1115

**DMH:**
Worcester: Day Phone: 508-368-3838 After Hours: 508-368-3300 Fax: 508-363-1500
North County: Day Phone: 978-353-4400 Fax: 978-348-1275

**DMR:**
Worcester: (508) 792-7545, Fax: (508) 792-7587
North County: (978) 342-2140 Fax: (978) 342-3313

**DPPC:** Phone: 1-800-426-9009

**DCF:** 800-792-5200

**DPH:** Phone: 617-753-8000  Medication Loss- Fax DPH/Drug Incident Report (617-524-8062).

**Executive Office of Elder Affairs:** 800-922-2275

**MBHP:** Phone: 617-350-4038  Fax: 617-350-1981

Network Health:  Phone: 888-257-1985  Fax: 888-977-0776

**NHP/Fallon/Beacon Health Strategies:**  Phone: 781-994-7500  Fax: 800-414-2820
**Attachments:**
- CHL Incident Form
- DMH Incident Form
- CHL Restraint Form
- Medication Error Report
- DPPC Death Report

All reports can be found at: CHL/Public/Incidents
Purpose: Community Healthlink is committed to continuous quality improvement, to full and open examination of problems and adverse events in a non-blaming, team educating fashion. At the same time, all staff must be vigilant regarding appropriate confidentiality and liability risk management.

Definitions:

Policy: With regard to examination of serious incidents and adverse events, the following policies and procedures will be followed:

Responsibility: CEO, VPO, Division VP's

Procedures:

1. A staff member who witnesses or is informed of a serious incident or adverse clinical event must immediately telephone his/her supervisor or program director to report the event. If that person is unavailable, he/she must contact the Vice President for his/her Division, or the Vice President of Operations (VPO) or the Chief Executive Officer (CEO) to report the matter. A written incident report must be prepared and submitted to the VPO, with copies to the program director and Vice President of the Division, within 24 hours in most cases. Serious incidents must be reported within 2 hours or as soon as possible, whichever is shorter.

2. The Division Vice President, or their designee in their absence, will determine whether the incident must be reported to an external contracting agency or licensing authority and, if so, is responsible for assuring that the report is filed. In making this determination, he/she may consult with the VPO or CEO.

3. The VPO or CEO will determine whether an internal investigation will be conducted and, if so, will appoint an investigator. Internal investigations should be completed within 10 days of the initial report, unless extenuating circumstances exist.

4. In the case of clinical events, the Director of Quality Management and the Chief Medical Officer will receive copies of the incident report and will arrange for appropriate reviews (i.e., Quality Council, Morbidity and Mortality Committee, Clinical Policy and Operations).

5. Requests by clients for information about the incident will be handled by the program director involved, with consultation as needed from the Division Vice President.

6. Requests by family members for information will be handled by the program, consistent with standard procedures about permission from the client.

7. Requests by outside parties—including regulatory agencies, purchasers, attorneys, etc.—for information, reviews, or investigation are to be referred to the CEO or, in his/her absence, the VPO. Community Healthlink will review requests and comply with the requirements of applicable law, regulation or specific contracts. Access to information will generally be restricted to agencies that pay for or license the specific service to be reviewed. An agency that, for example, purchases outpatient treatment may review outpatient clinic records, but not the records of residential services that they do not pay for. Requests by outside agencies to participate in meetings with CHL staff and clients’ family members shall generally not be granted. CHL staff may not participate with external agencies in any discussions or meetings to review an incident or adverse event without the explicit permission of the CEO or, in his/her absence, the VPO.
Purpose: To ensure that each client is included in the decision making process and is informed of all aspects of proposed treatments.

Definitions:

Policy:
1. All clients will be given a clear and concise explanation of the information in the procedure below.
2. To constitute informed consent, the client must be given the opportunity to review the material, and ask questions about the material presented to them.

Responsibility: Director of Quality Management and Training

PROCEDURE: Individuals are given a clear and concise explanation of:
- their condition
- proposed interventions, treatment and/or medications;
- the potential benefits, risks and side effects of proposed interventions, treatment, and/or medications;
- problems related to recovery;
- the likelihood of success;
- any significant alternative medications, treatments, and/or interventions;
- the individual’s right, to the extent permitted by law, to refuse medications, treatments and/or interventions.
- The clinician treating the client shall include client in the treatment decision making process and shall inform client of all proposed treatments. Clinicians shall document in progress notes client’s involvement in treatment planning and agreement with plan. The clinician shall additionally provide client with guidelines regarding rights to confidentiality of information disclosed and limits to those rights.

Please see attached Consent form:
Client Name: ____________________________  MR #: ____________________________

**Informed Consent**

I, ____________________________________________________ agree and understand the following:

---

**Initials**

I am legally entitled to give permission for my child/myself to be given medical treatment in case of an accident within the facility.

I authorize Community Healthlink (CHL) to release to all payers, whether an insurance company, Medicaid, or a state agency, the information necessary for billing for services provided to me and/or my family. Further, I authorize any and all payers to pay directly to CHL, all benefits, if any, otherwise payable to me for services provided by CHL. I understand that if co-payments are required they are my responsibility and will be paid at the time of my appointments. I further understand that any deductibles required by my insurance company are also my responsibility. I understand that if I do not make payments, CHL may end all treatment to me and/or my family and take whatever action may be necessary to recover overdue payments. If any problems arises that prevents me from making timely payments I understand that I can speak with ____________________. Payments will not exceed the usual and customary charges of CHL.

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**Initials**

I understand the limits of my insurance company as follows:

A. A deductible of __________, that must be paid by myself before my insurance company will pay anything towards treatment.

---

**Initials**

B. Maximum benefits of _______________ per calendar year/fiscal year.

---

**Initials**

C. My co-payment is ___________ that I agree to pay at the time of my appointment.

---

**Initials**

D. My sliding fee of ________________ will not be available to me until all insurance benefits are used.

---

**Initials**

I have received a copy of Community Healthlink’s (CHL) Client Information pamphlet that describes my rights as a client, the limits of confidentiality, how to make a complaint, CHL's payment policy, and missed appointment policy. I know who the Human Rights Officer is and how to access him/her if I feel that my rights have been violated. I have heard and understand the procedure for making a formal complaint and have been given the name and phone number of my contact person and their supervisor.

---

**Initials**

I have received CHL's Privacy Notice.

---

**Initials**

I understand that if I need to cancel a scheduled appointment, I will do so within 24 hours of the appointment. If I am being prescribed medication by a CHL physician or prescribing nurse I understand that failure to keep a scheduled medical appointment may mean that they will be unable to call in my medication prescription without first being seen by a CHL physician or prescribing nurse.

---

**Initials**

I understand that disclosure of personal information may be requested by a payer, whether an insurance company, Medicaid, or state agency, in order to process claims. I authorize the release of my records and/or am legally entitled to authorize the release of my child's record for claims payment. I understand that all payers are bound legally to keep information confidential.

---

I have read and understand the information listed above and authorize Community Healthlink to provide services to myself/my child/family.

---

**Signature of client, guardian, or authorized representative**  
**Date**

---

**Signature of Witness**  
**Date**
Purpose: To describe the function of the case conference and the mechanism by which they are held.

Policy:

1. Community Healthlink recognizes the importance of holding regular case conferences. Not only is the case conference a vital way of developing biopsychosocial understanding of the client, but it also represents an excellent teaching/supervisory opportunity for staff.

2. The purpose of the case conference includes: development of a treatment plan, coordinating of interagency services, developing a diagnostic formulation, and the planning of difficult cases.

3. A case conference is “called” by a clinician and then scheduled by his/her supervisor or program director.

4. The conference should be focused, and contain:
   a. purpose of the conference,
   b. brief background information, and
   c. key questions to be asked.

   All involved in the treatment should attend, as well as supervisors and other agency service providers.

5. Should a case conference involve clinicians or clients from more than one program the program directors from the respective programs should be responsible for coordinating the meeting.

6. The clinician who called the case conference is responsible for writing up the “findings” of the conference, as well as the recommendations. This note should be on a case conference note and placed in the client’s chart.

7. Refer to Policy 6-1 and 6-2 regarding issues of confidentiality during case conferences.

Responsibility: All clinical staff
Purpose: Discharge is a planned process that begins upon admission and continues throughout treatment. Discharge plans will include community supports, community agencies and family members. CHL will link consumers with follow-up services prior to discharge.

Definitions:

Policy:

1. If the client agrees, the clinician will meet with the family and/or significant others who have been involved in treatment and aftercare to receive follow-up instructions.

2. Clients will be linked with needed follow-up services prior to discharge.

3. The clinician will facilitate linkages between agencies and treaters and will ensure that appropriate staff are involved in discharge planning for each client.

4. For clients moved to a different level of care or another facility, the clinician will forward all pertinent clinical and administrative material prior to, or at the time of, transfer. With a valid authorization from the client, the provider will send a discharge summary to the new provider within two weeks, or as soon as possible. Substance Abuse and HIV related records must follow Federal and State Laws in regard to disclosure.

5. Appointments for referrals coming from inpatient or diversionary levels of care will be scheduled to occur as soon as possible in order to meet contract obligations.

6. When a CHL clinician or client determines that a transfer to another provider or clinician is appropriate, the decision process will be mutually inclusive of all involved parties, especially the client and/or guardian.

7. Whenever necessary, the CHL clinician will facilitate transfer to another source of care before terminating with the client. The provider will link the client to self-help and community support groups.

8. If a client fails to keep an appointment, before formally discharging the client, the clinician will document attempts to contact the client within 24 hours. Failed attempts to contact the client must also be documented in the medical record. If this is unsuccessful the clinician will make every effort to provide assistance for appropriate follow-up plans.

Responsibility: All clinical staff.
Purpose:

This policy outlines the rules and responsibilities of each major discipline (professional clinical position) at CHL.

Responsibility:

Policy developed by the CPO.

Programs at CHL are responsible for assuring that they have adequate professional staff to meet clinical needs and that professionals are working within their scope of discipline.

Note:

Each of the following pages outline a specific discipline.
**VOCATIONAL SPECIALIST:**

**Specific Roles and Responsibilities within the Agency:**

The role of the Vocational Specialist at Community Healthlink is to assist referred individuals in enhancing their level of community functioning via employment and educational opportunities. Such support includes assessment, case coordination, job development and job matching, job coaching, skills training, and educational referrals for such, benefits counseling and advocacy, and liaison, support, consultation and education for employers. The Vocational Specialist works with the individual to identify strengths, interests and limitations and to modify and intervene in the social environment on the individual’s behalf to promote positive employment outcomes.

**Specific Roles and Responsibilities as Part of A Multi Disciplinary Team:**

The Vocational Specialist works with the individual’s treatment team to identify ways in which the individual’s psychiatric symptomology may impact on his / her functioning in the workplace (i.e.: substance abuse, medication non-compliance, paranoia, etc.), learning style, interests and strengths. The Vocational Specialist attempts to identify barriers to the success of the vocational plan and work with the treatment team to minimize interference in vocational functioning as a result of psychiatric symptoms.

**Criteria Guiding A Referral for A Discipline Specific Assessment:**

1. The desire to work or receive education or training.
EXPRESSIVE THERAPY:

Specific Roles and Responsibilities within the Agency:

- Plan, implement and evaluate progress of Creative Arts Therapy groups.
- Supervise Expressive Art Therapy interns as appropriate per licensing requirements of student’s institution, and at the discretion of the Expressive Therapist.
- Perform discipline specific Expressive Art Therapy evaluations determined by the Expressive Therapist or recommended by the clinical team.
- Share outcome of creative process with team on an ongoing basis.
- Train other clinical/team members about the use of Expressive Art Therapy as part of a multi disciplinary treatment.
- Facilitate positive community exposure for client’s artwork as deemed appropriate by Expressive Arts Therapist in conjunction with clinical team and client.
- Share knowledge of creative process with team.
- Facilitate resolution of issues and skill acquisition using various modalities in a non-verbal creative process of self-expression.

Specific Roles and Responsibilities as Part of A Multi Disciplinary Team:

The Expressive Arts Therapist shares the creative process and outcome of a client’s artwork in team on an as needed basis and performs Expressive Art Therapy evaluations in specific modalities as determined by self or recommended by clinical team. The Expressive Therapist applies Expressive Therapy techniques to work on clinical issues with clients.

Criteria Guiding A Referral for A Discipline Specific Assessment:

- Clinical question that can be addressed best by an evaluation using a modality of Expressive Art Therapy.
- Client is able to participate in this type of diagnostic tool - talent/ability is not necessary.
LICENSED MENTAL HEALTH COUNSELOR:

Licensed mental health counselors have a Masters degree in psychology, Education, Counseling psychology or related field. LMHCs provide diagnostic evaluation and treatment of mental, emotional and substance abuse disorders to individuals, groups, couples and families. LMHCs apply psychological, sociological, human development and chemical dependency principles in their practice to assist clients in achieving more effective adjustment. LMHCs practice under the National Standards for Clinical Mental Health Counseling of the American Mental Health Counselors Association.

Specific Roles as Part of A Multi Disciplinary Team:

LMHCs provide psychotherapeutic services as described above as part of the MULTI DISCIPLINARY team similar to the services provided by other mental health professionals such as psychologists and social workers.

Criteria Guiding the Referral:

1. Client in need of diagnostic evaluation of mental or emotional disorder.
2. To provide treatment of problems of everyday life and/or psychopathology.
3. To provide psycho educational services to improve coping skills and level of functioning.
4. To provide individual, group or family consultations.
5. Specialized LMHCs provide cross-cultural, geriatric, child and adolescent, and substance abuse consultations.
6. To design and implement goal specific treatment plan with clients in collaboration with other members of the MULTI DISCIPLINARY team (i.e., social workers, nurses, psychologists, psychiatrists) according to agency policies and procedures.
7. Responsible for providing emergency evaluations and urgent care consultations.
8. Assess and arrange for hospitalizations as appropriate.
**NURSING**

**Specific Roles:**

1. Vital signs monitoring on clients and teaching other staff how to do vital signs.
2. Running Prolixin and Haldol Decanoate clinics and doing all injection medication for the agency.
3. Medication call ins for prescriptions through Urgent Care.
5. Running the Clozaril clinic for vital signs, assessment of medication side effects, and education involved with medications.
6. Health awareness education around medical conditions and emergency consultations involved in medical emergencies.

**Roles as Part Of A Nursing Team:**

Nursing is concerned with the client’s medical and psychiatric status and working towards “wellness” and symptom management. Nurses are involved in all areas of daily life from ADL training, to medication monitoring and administration. They act as health advocates as well as monitoring medical problems and helping refer clients to medical care.

At Community Healthlink (CHL) nurses staff the Prolixin and Haldol Decanoate clinics doing all injection medication for the agency. They pack medications for clients and teach the clients how to self medicate. Nurses arrange and run the Clozaril clinic where vital signs, education about illness, medication management and assessments are done.

Nurses call in prescriptions through Urgent Care. They monitor vital signs, do health awareness, education around medical conditions and emergency consultations around medical emergencies. They refer clients to PCP’s and work with them around medical concerns. They teach clients about their mental health illness. As a member of a multidisciplinary team, they report on the clients progress psychiatrically, create and present treatment plans, attend client specific meetings and work with other professionals to administer quality care psychiatrically and medically.

**Referrals:**

Referrals for nursing care would go through the teams, Urgent Care and individual doctors.
OCCUPATIONAL THERAPY:

Occupational therapy is concerned with an individual’s “ability to perform life tasks.” Life tasks refer to all of those activities one must be able to perform in order to meet his or her own needs and be a contributing member of a community. Thus occupational therapists are involved in helping clients learn to care for their personal needs such as grooming, shopping, and cooking; to maintain satisfactory interpersonal relationships; to participate in the world of work; to engage in satisfying recreational and vocational pursuits.

Specifically at Community Healthlink, the Occupational Therapist develops and facilities O.T. Groups to assess and/or increase skills to live independently. Occupational Therapists use purposeful activities to help individuals develop, relearn or maintain life skills. Purposeful activities are goal oriented and emphasize the idea of learning through doing. The environment is also in the domain of concern of Occupational Therapy. This refers to the physical environment in which an individual lives or is likely to live in the future. The role of a Certified Occupational Therapy Assistant (COTA/L) is to work in collaboration with the Occupational Therapist (OTR) to facilitate O.T. groups. Occupational Therapy Functional Evaluations are performed by an OTR, COTA/L and are able, under OTR supervision, to perform some Occupational Therapy Functional Assessments. Also at CHL, OTR / COTA/L train students and participate in research.

As a member of the multi disciplinary team, an OTR or COTA/L report information on an individual skill level and how it effects the client’s functioning. This would also include any adaptations needed in the environment to increase the client’s ability to function.

Referral for an OT Functional Evaluation would be appropriate when there are specific questions about the persons ability to function in the community, any safety concerns, or questions about a persons environment and any adaptations that are needed.
**PSYCHIATRISTS:**

Psychiatrists provide care through the evaluation, diagnosis, treatment planning and ongoing treatment of clients. This includes:

1. Evaluation of a client’s mental status and current level of function.
2. Determination of current level of risk of harm to self or others.
3. Assuring accuracy of the five axis diagnosis.
5. Review of medication side effects, other medication problems, and medications prescribed by other practitioners.
6. Provide psychoeducation regarding diagnosis and prognosis.
7. Discussing risks and benefits of current treatment and obtaining informed consent.
8. Initiating civil commitment / guardianship to provide the care and safety of those who are unable to consent to treatment and are at risk if possible.
9. Writing prescriptions and providing sample medications.
10. Monitoring appropriate lab tests.
11. Collaborating with primary care providers, other specialists, and making referrals when necessary.
12. Collaborating with staff from other facilities when providing consultative services.
13. Documenting all care clearly, in the medical record, reviewing data from other sources as well discharge summaries, physical exams, lab work, etc.

Psychiatrists work as part of a multi disciplinary treatment team to provide the appropriate level of care for each client. This includes review of and contribution to the overall treatment plan which involves regular meetings with non-medical staff. The psychiatrist informs and educates other staff regarding issues of overall client health, the relationship of psychosocial and biological problems, as well as the appropriate use of medications.

Criteria for making a psychiatric referral:

1. All outpatient clients referred to CHL who are currently taking psychiatric medication.
2. All clients who have been psychiatrically hospitalized, or who have frequently used emergency service during the past year.
3. All clients with an Axis I psychotic disorder.
4. All clients with other types of mental illness who have not adequately responded to psychosocial treatments alone within 3 - 6 months.
5. Clients with a primary diagnosis of substance abuse who have ongoing problematic symptoms of Axis I disorders after one month of sobriety.
6. Clients with a primary diagnosis of substance abuse who are not able to maintain complete sobriety due to possible coexistent mental illness that has not been recognized and treated.
7. All clients with significant risk of harm to self or others based on history or current level of function.
8. Direct request for an evaluation from the client or family.
9. Direct request from a primary care physician regarding advice about current or recommended medication treatment.
10. All appropriate clients who need evaluation for competency.
PSYCHOLOGIST:

Specific Roles And Responsibilities Within The Agency:

1. Conduct Psychological Assessments, which may include behavioral observation, clinical interview, and/or psychological testing.
2. Supervise non-licensed Psychology staff.
4. Apply knowledge of scientific research in order to identify scientifically validated procedures that help people change their thoughts, emotions, and behaviors.
5. Apply knowledge of research design, measurement theory, and statistics to the design and implementation of performance improvement projects.

Specific Roles And Responsibilities As Part Of A Multi Disciplinary Team:

The Psychologist applies his/her knowledge of psychological theories in order to advance the process of case formulation. S/he also assists the team in determining the need for psychological assessment and in interpreting the results of assessments previously conducted. S/he proposes scientifically validated interventions to achieve the treatment goals developed by the team.

Criteria Guiding A Referral For A Discipline Specific Assessment:

1. The articulation of a specific clinical question that can be addressed by psychological assessment techniques.
2. Addressing the referral question has a reasonable chance of leading to action that will benefit the client and will not be harmful or distressing to the client.
3. Client or guardian is informed about the purposes of the assessment and gives specific written consent for the assessment.
4. Referral question cannot be adequately addressed using other assessment methods.
SOCIAL WORKER:

Specific Roles And Responsibilities Within The Agency:

Social work seeks to enhance the psychosocial functioning of people utilizing a theoretical perspective of viewing both the clients and the community in which he/she lives as an interrelated system. Interventions to produce change in clients are directed at both the individual and the systems which impact upon them. Helping a client advocating to change the environment is a unique social work role whether or not intervention is done by the client or by the social worker as an independent advocate for change. Social work theory looks at individuals and systems as having developmental stages that are common to all individuals which possess challenges to our clients which are often complicated by trauma history, development disabilities, and/or mental illness. Social work in the agency is unique in its emphasis upon looking at fostering environment change as part of the overall client treatment planning. Social Workers have a bachelors or Master's degree in Social Work, and are licensed with the state to practice. Social Workers are guided in their practice by the Code of Ethics, created by the National Association of Social Workers.

Specific Roles And Responsibilities As Part Of A Multi Disciplinary Team:

Social work provides the perspective of looking at the client’s environment as a target for change in a multi disciplinary team. It will advocate for changes not only within the client’s immediate environment, but also within the larger community. Social workers advocate for changes within the agency itself if there are elements in service delivery that are hindering client growth.

Criteria Guiding A Referral For A Discipline Specific Assessment:

Social work as a profession encompasses work with a varied population of clients and presenting problems. Social workers are most often trained or have experience in one or more special fields of practice such as work with children, the elderly, developmentally disabled or mentally ill adults. They may have special expertise in substance abuse issues, domestic violence, sexual abuse, etc. They may also be proficient in a particular mode of treatment such a group work or family systems work. Therefore, a discipline specific assessment may take into account an area of specialization or particular mode of treatment deemed most appropriate for an individual client.

The following criteria that are a part of a client’s presenting problem are ones in which a social work therapist might be indicated:

1. Complex environmental issues that impact upon the client that require advocacy / interventions with other community supports.
CERTIFIED ALCOHOL COUNSELOR (CAC) / CERTIFIED DRUG ALCOHOL COUNSELOR (CADAC):

The CAC or CADAC are certifications that signify the counselor has a specialization in drug and alcohol treatment as recognized by the State of Massachusetts. The certification process is overseen by the Massachusetts Board of Substance Abuse Counselor Certification, Inc. In order to qualify for certification, the individual must meet specific criteria based on; hours of supervised substance abuse counseling experience, pass a written examination, pass an oral examination and have specific training in the 12 core functions of substance abuse counseling. CAC and CADAC individuals are recognized by the Massachusetts Behavioral Partnership (MBHP) as a reimbursable treatment provider within an agency.
Case Manager:

**Specific Roles And Responsibilities Within The Agency:**

1. Provide short term crisis management to homeless clients, particularly those with HIV/AIDS. Perform on site assessments, develop comprehensive service plans in collaboration with other components of the HOAP program. Arrange for community services to meet need; monitor delivery and appropriateness of services.

**Specific Roles And Responsibilities As Part Of A Multi Disciplinary Team:**

1. Work cooperatively with community to identify individuals or families who are homeless, mentally ill, or dually diagnosed.
2. Assess client needs and develop service plan utilizing appropriate program and community services. Services will be provided in a culturally and linguistically competent manner.
3. Monitor implementation of client service plans by scheduling outreach re-evaluating client progress and make recommendations for referral to other appropriate services or programs.
4. Provide short term case management support. Refer to other community services to assist clients on a long term basis.
5. Prepare and maintain client documentation, statistical reports, or other documentation as requested by supervisor.

**Criteria Guiding A Referral For A Discipline Specific Assessment:**

1. Homeless and or mental illness issues requiring intervention.
Nurse Practitioner and RN Clinical Specialist:

**Specific Roles And Responsibilities Within The Agency:**

1. Evaluation of and treatment of clients in need of mental health services. Ensuring that medical protocols and treatment plans are in place to meet client needs.

**Specific Roles And Responsibilities As Part Of A Multi Disciplinary Team:**

1. Provide mental health services including evaluation, diagnosis and treatment of mental illness within the serviced population.
2. Maintains working knowledge of current psychopharmacologic principles for treating mental illness.
3. Provide consultation and education to other staff and or family members
4. Participates in team meetings, case discussions and treatment planning sessions.

**Criteria Guiding A Referral For A Discipline Specific Assessment:**

1. Nursing or medical professional determination.
Residential Counselor:

**Specific Roles And Responsibilities Within The Agency:**

1. Functions as a member of the treatment team by assisting with the implementation of the substance abuse treatment services.

**Specific Roles And Responsibilities As Part Of A Multi Disciplinary Team:**

1. Assists in creating a safe therapeutic milieu by fostering a culture of recovery through interaction with clients.
2. Fosters client compliance with program expectations while delivering culturally sensitive treatment and care.
3. Provides basic education to clients through the use of didactic groups or video presentations.

**Criteria Guiding A Referral For A Discipline Specific Assessment:**
Demonstrated substance abuse problem.
#1097 Research Disclosures

Effective Date: 8/2/04

I. PURPOSE:
The purpose of this document is to provide direction for members of the UMass Memorial Medical Center (UMMMC) workforce regarding disclosures of protected health information for research purposes.

II. SCOPE:
This policy applies to all members of the UMass Memorial Medical Center workforce who have access to protected health information.

III. DEFINITIONS:

- **Authorized representative (for patient’s right to accounting purposes)**: A health care agent, guardian or authorized next-of-kin. A health care agent is an adult to whom authority to make health care decisions has been delegated under a health care proxy in accordance with M.G. L. c. 201D. A guardian is an individual appointed by a court to make decisions on behalf of an incompetent person. In the absence of a health care agent or guardian, the statutorily established order of next-of-kin is as follows: spouse, children of legal age, parent(s), sibling(s) of legal age, grandparent(s) and aunt/uncle/first cousin of legal age. Note that the authorized representative cannot authorize research unless the representative is the patient’s guardian and the order states that the guardian can consent to research.

- **Data Use Agreement**: A document that provides assurance that the limited data set recipient will only use or disclose the protected health information for purposes defined in the agreement, will use appropriate safeguards to prevent unauthorized use or disclosure, will report any unauthorized use or disclosure to the medical center, will ensure subcontractors agree to same restrictions and conditions, and will not identify or contact the individuals.

- **De-Identified**: Health care information that is stripped of all identifying information and unique characteristics or codes including: name; address, including street address, city, county, zip code, or equivalent geocodes; names of relatives and employers; birth date; telephone and fax numbers; e-mail addresses; social security number; medical record number; health plan beneficiary number; account number; certificate/license number; any vehicle or other device serial number; web URL; internet protocol (IP) address; finger or voice prints; photographic images; and any other unique identifying number, characteristic, or code. Age and some geographic location information may be included in the de-identified information, but all dates directly related to the subject of the information must be removed or limited to the year, and zip codes must be removed or aggregated (in the form of most 3-digit zip codes) to include at least 20,000 people. Extreme ages of 90 and over must be aggregated to a category of 90+ to avoid identification of very old individuals. Other demographic information, such as gender, race, ethnicity, and marital status are not included in the list of identifiers that must be removed.
- **Disclosure** – release, transfer, access to or provision of protected health information to a third party outside of UMMMC.
- **Institutional Review Board (IRB)** - a committee formally designated by an institution to review research involving human subjects, and to protect the welfare of human subjects recruited to participate in biomedical or behavioral research. The IRB approves the initiation of new research, conducts reviews of ongoing research, and approves an alteration or a waiver of the individual authorization.
- **Limited Data set** – protected health information that includes broad geographic information and dates (such as birth, death, admission, and discharge), but excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual: names, postal address information other than town or city, state, and zip code, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers and serial numbers, including license plate numbers, device identifiers and serial numbers, web universal resource locators (URLs), internet protocol (IP) address numbers, biometric identifiers, including finger and voice prints, Full face photographic images and any comparable images. A limited data set may be used or disclosed without authorization only for research, public health, or health care operations of another covered entity if it enters into a data use agreement with the limited data set recipient.
- **Protected Health Information** – all individually identifiable health information created, transmitted, received or maintained by UMMMC. This includes any information, including demographics, which identifies or could reasonably identify an individual, their health/condition, treatment or provision/payment for their health care.
- **Research** - systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
- **Review Preparatory to Research** – preliminary activities required to develop a research protocol and to determine whether a specific covered entity has protected health information of prospective research participants that would meet the eligibility criteria for enrollment into a research study.
- **UMMMC** - UMass Memorial Medical Center Worcester campuses including University, Memorial and Hahnemann.
- **Workforce** – all employees, contractors, volunteers, trainees (including medical students, interns, residents, allied health professional and business students), members of the medical staff including employed and private physicians, temporary employees, and other persons employed, credentialed or under the control of UMass Memorial Medical Center whether or not they are paid by the medical center.

**IV. RESPONSIBILITY:**
Members of the UMass Memorial Medical Center workforce who have access to protected health information are responsible for compliance with this policy.

**V. POLICY STATEMENT:**
All members of the UMass Memorial Medical Center workforce are required to follow this policy to ensure that proper documentation and approvals are in place before the disclosure can occur.
VI. **PROCEDURE:**

There are four situations when protected health information may be accessed by, or disclosed to, a researcher or research team. No protected health information (PHI) may be accessed by, or disclosed to, a researcher or research team except in these limited circumstances:

- Reviews Preparatory to Research
- Research on Decedent Information
- Research conducted pursuant IRB Waiver of Authorization
- Research conducted pursuant to patient Authorization.

The Office of Research must approve of reviews preparatory to research where study feasibility is being investigated and protected health information does not leave the medical center. The Institutional Review Board (IRB) must approve of all other research studies. The researcher must present appropriate attestation and/or IRB documentation, as noted below, before accessing or receiving PHI.

Researchers must also complete an “Accounting of Disclosures” form (attached), which allows UMMMC to comply with a patient’s right to an accounting of disclosures, *for each record accessed* unless:

- The patient has signed an authorization form, or
- The disclosure involves only de-identified data, or
- The disclosure involves only a limited data set and University of Massachusetts Medical School has executed a Data Use Agreement with UMMMC, or
- The number of records disclosed to the researcher is greater than 1000 and both the Office of Research and the UMMMC Director of Health Information Management approve a study summary. The summary must include the name of the protocol or research activity, a description of the purpose of the activity, criteria for record selection, description of PHI required, timeframe of the study, and the name, address, and phone number of the research sponsor. The summary is provided to patients who request an accounting of their PHI and who may have been involved in the study.

1. **Review Preparatory to Research**

   - The Office of Research must approve the data collection for review preparatory to research.
   - The researcher must be a faculty member at the medical school or a designee of a faculty member.
   - To access records other than his/her own patient records, the researcher must provide documentation attesting that the PHI is sought solely to prepare a research protocol, no PHI including photocopies will be removed from the medical center in the course of the review, and the PHI is necessary for research purposes. This form is available from the Office of Research.
   - Patient authorization is not required.
   - The researcher must complete an “Accounting of Disclosures” form for each record accessed unless the information accessed or disclosed is (a) a limited data set with an executed Data Use Agreement, (b) de-identified as defined previously, or (c) approved for a study summary by the Office of Research and Health Information Management.

2. **Decedent Research**

   - The IRB chair or designee must approve the research.
The researcher must provide UMMC with an “Exempt Letter” representing that PHI is sought solely for research on decedents and that the PHI is necessary for research purposes. The IRB chair or designee must sign this letter.

The researcher must complete an “Accounting of Disclosures” form for each record accessed unless the information accessed or disclosed is (a) a limited data set with an executed Data Use Agreement, (b) de-identified as defined previously, or (c) approved for a study summary by the Office of Research and Health Information Management.

3. **Patient authorization is waived by the IRB based on strict criteria to ensure data protection**
   - The IRB must approve the research.
   - The IRB must issue a “Waiver of Authorization” form including identification of the IRB, the date the waiver was approved, a statement that the waiver satisfies required criteria, a description of PHI needed, and a statement indicating whether the waiver was approved under normal or expedited review. The IRB chair or designee must sign the form.
   - The researcher must complete an “Accounting of Disclosures” form for each record accessed unless the information accessed or disclosed is (a) a limited data set with an executed Data Use Agreement, (b) de-identified as defined previously, or (c) approved for a study summary by the Office of Research and Health Information Management.

4. **Patient authorization is required to participate in the study**
   - The IRB must approve the research.
   - The chair or designee must sign the IRB approval form.
   - Since the patient must sign an authorization, this disclosure does not have to be captured in the patient’s request for accounting. Note that the authorized representative cannot authorize research unless the representative is the patient’s guardian and the order states that the guardian can consent to research.
   - The researcher must agree to notify Health Information Management, by forwarding the original authorization, if the patient agrees not to access research-related treatment records during the course of the study.

The following table summarizes the requirements.
## Research Disclosures: Summary Table

<table>
<thead>
<tr>
<th>Research Type</th>
<th>IRB Approval Required?</th>
<th>Documentation Required</th>
<th>Patient Authorization Required?</th>
<th>Capture in Accounting?</th>
</tr>
</thead>
</table>
| Preparatory   | No, but the data collection for review preparatory to research must be approved by Office of Research | ▪ Office of Research approval form  
▪ Researcher is a faculty member at the medical school or a designee  
▪ PHI is sought solely to prepare a research protocol  
▪ No PHI will be removed from the medical center in the course of the review  
▪ The PHI is necessary for research purposes | No | Yes, unless  
▪ Limited data set with an executed Data Use Agreement or,  
▪ De-identified data or,  
▪ Approved for study summary* (1000+ records).  
For study summary, researcher to provide:  
▪ The name of the protocol or research activity  
▪ A description of the purpose of the activity  
▪ Criteria for record selection  
▪ Description of PHI required  
▪ Timeframe of the study  
▪ Name, address, phone number of sponsor |
| Decedent      | Yes                    | ▪ Exempt Letter, signed by IRB chair or designee  
▪ PHI is sought solely for research on decedents  
▪ PHI is necessary for research purposes | No | Yes, unless  
▪ Limited data set with an executed Data Use Agreement or,  
▪ De-identified data or,  
▪ Approved for study summary (1000+ records). |
| Authorization Waived | Yes | ▪ IRB Waiver of Authorization form, signed by chair or designee  
▪ Identification of IRB and date waiver approved  
▪ Statement that waiver satisfies required criteria  
▪ Description of PHI needed  
▪ Statement that waiver was approved under normal or expedited review | No | Yes, unless  
▪ Limited data set with an executed Data Use Agreement or,  
▪ De-identified data or,  
▪ Approved for study summary (1000+ records). |
| Requires Patient Authorization | Yes | ▪ IRB form, signed by chair or designee.  
▪ Notification if patient has agreed not to access treatment records during the course of the study | Yes; HIPAA - compliant authorization may be combined with consent | No |
**VII. RESCISSION:**

This is a new policy that becomes effective upon issuance.

Developed By: Terry O’Brien, Privacy Officer 508-334-8096

Approved By: HIPAA Privacy & Security Committee
HIPAA Executive Steering Committee

Approved By: ________________________________ Phone number:

Approved By: Walter H Ettinger, Jr, MD Medical Center President 8/2/04
Signature Title Date
UMass Memorial Medical Center

ACCOUNTING OF DISCLOSURES*

Patient/Subject Name: ____________________________________________________

Medical Record #: ___________________    DOB:___________________

Information on the patient/study subject noted above was disclosed to the researcher listed below (or his/her designee) after approval was received for (check one):

☑ Data Collection for Review Preparatory to Research  ☐ Waiver of Authorization

Name of Researcher: ______________________________________________________

Department @ UMMS:________________________   Phone: ____________________

Brief Description of Information Disclosed:
___________________________________________________________________________________

Disclosure made by UMass Memorial Medical Center.

Date: __________________

*This Accounting of Disclosures form should be used by the researcher in the event of PHI disclosures in either of the following circumstances:

1) The researcher’s request to conduct Data Collection for Review Preparatory to Research has been approved by Research Subjects Office
2) The researcher’s Request for Waiver of Authorization has been approved by the IRB

After customizing this document with name and MR #, either place this form directly in the last section of the medical record (Incoming Letters and Reports) or send to:

Health Information Management
UMass Memorial Medical Center
55 Lake Avenue North
Worcester, MA. 01655
Purpose: To establish procedures for conducting research that is consistent with ethical care and human rights of clients and human subjects of research.

Definitions:

Policy: Community Healthlink, as a member of UMass Memorial Healthcare System, adheres to UMass Memorial's research policy.

Any complaints about research conducted by CHL should be handled by the Incident mechanism.

Responsibility: It is the responsibility to the lead researcher, their supervisor and the Division Vice President to ensure that all provisions of the UMass Memorial research policy are followed.

Procedure: Refer to UMass Memorial's Guidelines for the Protection of Human Subjects in Research, Version 2 Dated 9/00. Copies are available from the Vice President of Operations.

CHL also adhere to the provisions of the “Belmont Report” dated 4/18/1979 (see attached).
AGENCY: Department of Health, Education, and Welfare.
ACTION: Notice of Report for Public Comment.
SUMMARY: On July 12, 1974, the National Research Act (Pub. L. 93-348) was signed into law, thereby creating the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. One of the charges to the Commission was to identify the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects and to develop guidelines which should be followed to assure that such research is conducted in accordance with those principles. In carrying out the above, the Commission was directed to consider: (i) the boundaries between biomedical and behavioral research and the accepted and routine practice of medicine, (ii) the role of assessment of risk-benefit criteria in the determination of the appropriateness of research involving human subjects, (iii) appropriate guidelines for the selection of human subjects for participation in such research and (iv) the nature and definition of informed consent in various research settings.

The Belmont Report attempts to summarize the basic ethical principles identified by the Commission in the course of its deliberations. It is the outgrowth of an intensive four-day period of discussions that were held in February 1976 at the Smithsonian Institution's Belmont Conference Center supplemented by the monthly deliberations of the Commission that were held over a period of nearly four years. It is a statement of basic ethical principles and guidelines that should assist in resolving the ethical problems that surround the conduct of research with human subjects. By publishing the Report in the Federal Register, and providing reprints upon request, the Secretary intends that it may be made readily available to scientists, members of Institutional Review Boards, and Federal employees. The two-volume Appendix, containing the lengthy reports of experts and specialists who assisted the Commission in fulfilling this part of its charge, is available as DHEW Publication No. (OS) 78-0013 and No. (OS) 78-0014, for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Unlike most other reports of the Commission, the Belmont Report does not make specific recommendations for administrative action by the Secretary of Health, Education, and Welfare. Rather, the Commission recommended that the Belmont Report be adopted in its entirety, as a statement of the Department's policy. The Department requests public comment on this recommendation.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research

Members of the Commission

Kenneth John Ryan, M.D., Chairman, Chief of Staff, Boston Hospital for Women.

Joseph V. Brady, Ph.D., Professor of Behavioral Biology, Johns Hopkins University.
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Ethical Principles & Guidelines for Research Involving Human Subjects

Scientific research has produced substantial social benefits. It has also posed some troubling ethical questions. Public attention was drawn to these questions by reported abuses of human subjects in biomedical experiments, especially during the Second World War. During the Nuremberg War Crime Trials, the Nuremberg code was drafted as a set of standards for judging physicians and scientists who had conducted biomedical experiments on concentration camp prisoners. This code became the prototype of many later codes(1) intended to assure that research involving human subjects would be carried out in an ethical manner.

The codes consist of rules, some general, others specific, that guide the investigators or the reviewers of research in their work. Such rules often are inadequate to cover complex situations; at times they come into conflict, and they are frequently difficult to interpret or apply. Broader ethical principles will provide a basis on which specific rules may be formulated, criticized and interpreted.

Three principles, or general prescriptive judgments, that are relevant to research involving human subjects are identified in this statement. Other principles may also be relevant. These three are comprehensive, however, and are stated at a level of generalization that should assist scientists, subjects, reviewers and interested citizens to understand the ethical issues inherent in research involving human subjects. These principles cannot always be applied so as to resolve beyond dispute particular ethical problems. The objective is to provide an analytical framework that will guide the resolution of ethical problems arising from research involving human subjects.

This statement consists of a distinction between research and practice, a discussion of the three basic ethical principles, and remarks about the application of these principles.

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Part A: Boundaries Between Practice & Research

A. Boundaries Between Practice and Research

It is important to distinguish between biomedical and behavioral research, on the one hand, and the practice of accepted therapy on the other, in order to know what activities ought to undergo review for the protection of human subjects of research. The distinction between research and practice is blurred partly because both often occur together (as in research designed to evaluate a therapy) and partly because notable departures from standard practice are often called "experimental" when the terms "experimental" and "research" are not carefully defined.

For the most part, the term "practice" refers to interventions that are designed solely to enhance the well-being of an individual patient or client and that have a reasonable expectation of success. The purpose of medical or behavioral practice is to provide diagnosis, preventive treatment or therapy to particular individuals.(2) By contrast, the term "research" designates an activity designed to test an hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements of relationships). Research is usually described in a formal protocol that sets forth an objective and a set of procedures designed to reach that objective.

When a clinician departs in a significant way from standard or accepted practice, the innovation does not, in and of itself, constitute research. The fact that a procedure is "experimental," in the sense of new, untested or different, does not automatically place it in the category of research. Radically new procedures of this description should, however, be made the object of formal research at an early stage in order to determine whether they are safe and effective. Thus, it is the responsibility of medical practice committees, for example, to insist that a major innovation be incorporated into a formal research project.(3)

Research and practice may be carried on together when research is designed to evaluate the safety and efficacy of a therapy. This need not cause any confusion regarding whether or not the activity requires review; the general rule is that if there is any element of research in an activity, that activity should undergo review for the protection of human subjects.
Part B: Basic Ethical Principles

B. Basic Ethical Principles

The expression "basic ethical principles" refers to those general judgments that serve as a basic justification for the many particular ethical prescriptions and evaluations of human actions. Three basic principles, among those generally accepted in our cultural tradition, are particularly relevant to the ethics of research involving human subjects: the principles of respect of persons, beneficence and justice.

1. Respect for Persons. -- Respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy.

An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons' considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person's considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so. However, not every human being is capable of self-determination. The capacity for self-determination matures during an individual's life, and some individuals lose this capacity wholly or in part because of illness, mental disability, or circumstances that severely restrict liberty. Respect for the immature and the incapacitated may require protecting them as they mature or while they are incapacitated.

Some persons are in need of extensive protection, even to the point of excluding them from activities which may harm them; other persons require little protection beyond making sure they undertake activities freely and with awareness of possible adverse consequence. The extent of protection afforded should depend upon the risk of harm and the likelihood of benefit. The judgment that any individual lacks autonomy should be periodically reevaluated and will vary in different situations.

In most cases of research involving human subjects, respect for persons demands that subjects enter into the research voluntarily and with adequate information. In some situations, however, application of the principle is not obvious. The involvement of prisoners as subjects of research provides an instructive example. On the one hand, it would seem that the principle of respect for persons requires that prisoners not be deprived of the opportunity to volunteer for research. On the other hand, under prison conditions they may be subtly coerced or unduly influenced to engage in research activities for which they would not otherwise volunteer. Respect for persons would then dictate that prisoners be protected. Whether to allow prisoners to "volunteer" or to "protect" them presents a dilemma. Respecting persons, in most hard cases, is often a matter of balancing competing claims urged by the principle of respect itself.

2. Beneficence. -- Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Such treatment falls under the principle of beneficence. The term "beneficence" is often understood to cover acts of kindness or charity that go beyond strict obligation. In this document, beneficence is understood in a stronger sense, as an obligation. Two general rules have been formulated as complementary expressions of beneficent actions in this sense: (1) do not harm and (2) maximize possible benefits and minimize possible harms.

The Hippocratic maxim "do no harm" has long been a fundamental principle of medical ethics. Claude Bernard extended it to the realm of research, saying that one should not injure one person regardless of the benefits that might come to others. However, even avoiding harm requires learning what is harmful; and, in the process of obtaining this information, persons may be exposed to risk of harm. Further, the Hippocratic Oath requires physicians to benefit their patients "according to their best judgment." Learning what will in fact benefit may require exposing persons to risk. The problem posed by these imperatives is to decide when it is justifiable to seek certain benefits despite the risks involved, and when the benefits should be foregone because of the risks.

The obligations of beneficence affect both individual investigators and society at large, because they extend both to particular research projects and to the entire enterprise of research. In the case of particular projects, investigators and members of their institutions are obliged to give forethought to the maximization of benefits and the reduction of risk that might occur from the research investigation. In the case of scientific research in general, members of the larger society are obliged to recognize the longer term benefits and
risks that may result from the improvement of knowledge and from the development of novel medical, psychotherapeutic, and social procedures.

The principle of beneficence often occupies a well-defined justifying role in many areas of research involving human subjects. An example is found in research involving children. Effective ways of treating childhood diseases and fostering healthy development are benefits that serve to justify research involving children -- even when individual research subjects are not direct beneficiaries. Research also makes it possible to avoid the harm that may result from the application of previously accepted routine practices that on closer investigation turn out to be dangerous. But the role of the principle of beneficence is not always so unambiguous. A difficult ethical problem remains, for example, about research that presents more than minimal risk without immediate prospect of direct benefit to the children involved. Some have argued that such research is inadmissible, while others have pointed out that this limit would rule out much research promising great benefit to children in the future. Here again, as with all hard cases, the different claims covered by the principle of beneficence may come into conflict and force difficult choices.

3. Justice. -- Who ought to receive the benefits of research and bear its burdens? This is a question of justice, in the sense of "fairness in distribution" or "what is deserved." An injustice occurs when some benefit to which a person is entitled is denied without good reason or when some burden is imposed unduly. Another way of conceiving the principle of justice is that equals ought to be treated equally. However, this statement requires explication. Who is equal and who is unequal? What considerations justify departure from equal distribution? Almost all commentators allow that distinctions based on experience, age, deprivation, competence, merit and position do sometimes constitute criteria justifying differential treatment for certain purposes. It is necessary, then, to explain in what respects people should be treated equally. There are several widely accepted formulations of just ways to distribute burdens and benefits. Each formulation mentions some relevant property on the basis of which burdens and benefits should be distributed. These formulations are (1) to each person an equal share, (2) to each person according to individual need, (3) to each person according to individual effort, (4) to each person according to societal contribution, and (5) to each person according to merit.

Questions of justice have long been associated with social practices such as punishment, taxation and political representation. Until recently these questions have not generally been associated with scientific research. However, they are foreshadowed even in the earliest reflections on the ethics of research involving human subjects. For example, during the 19th and early 20th centuries the burdens of serving as research subjects fell largely upon poor ward patients, while the benefits of improved medical care flowed primarily to private patients. Subsequently, the exploitation of unwilling prisoners as research subjects in Nazi concentration camps was condemned as a particularly flagrant injustice. In this country, in the 1940's, the Tuskegee syphilis study used disadvantaged, rural black men to study the untreated course of a disease that is by no means confined to that population. These subjects were deprived of demonstrably effective treatment in order not to interrupt the project, long after such treatment became generally available. Against this historical background, it can be seen how conceptions of justice are relevant to research involving human subjects. For example, the selection of research subjects needs to be scrutinized in order to determine whether some classes (e.g., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied. Finally, whenever research supported by public funds leads to the development of therapeutic devices and procedures, justice demands both that these not provide advantages only to those who can afford them and that such research should not unduly involve persons from groups unlikely to be among the beneficiaries of subsequent applications of the research.

Part C: Applications

C. Applications
Applications of the general principles to the conduct of research leads to consideration of the following requirements: informed consent, risk/benefit assessment, and the selection of subjects of research.

1. Informed Consent. -- Respect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them. This opportunity is provided when adequate standards for informed consent are satisfied.
While the importance of informed consent is unquestioned, controversy prevails over the nature and possibility of an informed consent. Nonetheless, there is widespread agreement that the consent process can be analyzed as containing three elements: information, comprehension and voluntariness.

**Information.** Most codes of research establish specific items for disclosure intended to assure that subjects are given sufficient information. These items generally include: the research procedure, their purposes, risks and anticipated benefits, alternative procedures (where therapy is involved), and a statement offering the subject the opportunity to ask questions and to withdraw at any time from the research. Additional items have been proposed, including how subjects are selected, the person responsible for the research, etc. However, a simple listing of items does not answer the question of what the standard should be for judging how much and what sort of information should be provided. One standard frequently invoked in medical practice, namely the information commonly provided by practitioners in the field or in the locale, is inadequate since research takes place precisely when a common understanding does not exist. Another standard, currently popular in malpractice law, requires the practitioner to reveal the information that reasonable persons would wish to know in order to make a decision regarding their care. This, too, seems insufficient since the research subject, being in essence a volunteer, may wish to know considerably more about risks gratuitously undertaken than do patients who deliver themselves into the hand of a clinician for needed care. It may be that a standard of "the reasonable volunteer" should be proposed: the extent and nature of information should be such as persons, knowing that the procedure is neither necessary for their care nor perhaps fully understood, can decide whether they wish to participate in the furthering of knowledge. Even when some direct benefit to them is anticipated, the subjects should understand clearly the range of risk and the voluntary nature of participation.

A special problem of consent arises where informing subjects of some pertinent aspect of the research is likely to impair the validity of the research. In many cases, it is sufficient to indicate to subjects that they are being invited to participate in research of which some features will not be revealed until the research is concluded. In all cases of research involving incomplete disclosure, such research is justified only if it is clear that (1) incomplete disclosure is truly necessary to accomplish the goals of the research, (2) there are no undiscovered risks to subjects that are more than minimal, and (3) there is an adequate plan for debriefing subjects, when appropriate, and for dissemination of research results to them. Information about risks should never be withheld for the purpose of eliciting the cooperation of subjects, and truthful answers should always be given to direct questions about the research. Care should be taken to distinguish cases in which disclosure would destroy or invalidate the research from cases in which disclosure would simply inconvenience the investigator.

**Comprehension.** The manner and context in which information is conveyed is as important as the information itself. For example, presenting information in a disorganized and rapid fashion, allowing too little time for consideration or curtailing opportunities for questioning, all may adversely affect a subject's ability to make an informed choice.

Because the subject's ability to understand is a function of intelligence, rationality, maturity and language, it is necessary to adapt the presentation of the information to the subject's capacities. Investigators are responsible for ascertaining that the subject has comprehended the information. While there is always an obligation to ascertain that the information about risk to subjects is complete and adequately comprehended, when the risks are more serious, that obligation increases. On occasion, it may be suitable to give some oral or written tests of comprehension.

Special provision may need to be made when comprehension is severely limited -- for example, by conditions of immaturity or mental disability. Each class of subjects that one might consider as incompetent (e.g., infants and young children, mentally disable patients, the terminally ill and the comatose) should be considered on its own terms. Even for these persons, however, respect requires giving them the opportunity to choose to the extent they are able, whether or not to participate in research. The objections of these subjects to involvement should be honored, unless the research entails providing them a therapy unavailable elsewhere. Respect for persons also requires seeking the permission of other parties in order to protect the subjects from harm. Such persons are thus respected both by acknowledging their own wishes and by the use of third parties to protect them from harm.

The third parties chosen should be those who are most likely to understand the incompetent subject's situation and to act in that person's best interest. The person authorized to act on behalf of the subject should be given an opportunity to observe the research as it proceeds in order to be able to withdraw the subject from the research, if such action appears in the subject's best interest.
Voluntariness. An agreement to participate in research constitutes a valid consent only if voluntarily given. This element of informed consent requires conditions free of coercion and undue influence. Coercion occurs when an overt threat of harm is intentionally presented by one person to another in order to obtain compliance. Undue influence, by contrast, occurs through an offer of an excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance. Also, inducements that would ordinarily be acceptable may become undue influences if the subject is especially vulnerable. Unjustifiable pressures usually occur when persons in positions of authority or commanding influence -- especially where possible sanctions are involved -- urge a course of action for a subject. A continuum of such influencing factors exists, however, and it is impossible to state precisely where justifiable persuasion ends and undue influence begins. But undue influence would include actions such as manipulating a person's choice through the controlling influence of a close relative and threatening to withdraw health services to which an individual would otherwise be entitled.

2. Assessment of Risks and Benefits.-- The assessment of risks and benefits requires a careful arrayal of relevant data, including, in some cases, alternative ways of obtaining the benefits sought in the research. Thus, the assessment presents both an opportunity and a responsibility to gather systematic and comprehensive information about proposed research. For the investigator, it is a means to examine whether the proposed research is properly designed. For a review committee, it is a method for determining whether the risks that will be presented to subjects are justified. For prospective subjects, the assessment will assist the determination whether or not to participate.

The Nature and Scope of Risks and Benefits. The requirement that research be justified on the basis of a favorable risk/benefit assessment bears a close relation to the principle of beneficence, just as the moral requirement that informed consent be obtained is derived primarily from the principle of respect for persons. The term "risk" refers to a possibility that harm may occur. However, when expressions such as "small risk" or "high risk" are used, they usually refer (often ambiguously) both to the chance (probability) of experiencing a harm and the severity (magnitude) of the envisioned harm. The term "benefit" is used in the research context to refer to something of positive value related to health or welfare. Unlike, "risk," "benefit" is not a term that expresses probabilities. Risk is properly contrasted to probability of benefits, and benefits are properly contrasted with harms rather than risks of harm. Accordingly, so-called risk/benefit assessments are concerned with the probabilities and magnitudes of possible harm and anticipated benefits. Many kinds of possible harms and benefits need to be taken into account. There are, for example, risks of psychological harm, physical harm, legal harm, social harm and economic harm and the corresponding benefits. While the most likely types of harms to research subjects are those of psychological or physical pain or injury, other possible kinds should not be overlooked. Risks and benefits of research may affect the individual subjects, the families of the individual subjects, and society at large (or special groups of subjects in society). Previous codes and Federal regulations have required that risks to subjects be outweighed by the sum of both the anticipated benefit to the subject, if any, and the anticipated benefit to society in the form of knowledge to be gained from the research. In balancing these different elements, the risks and benefits affecting the immediate research subject will normally carry special weight. On the other hand, interests other than those of the subject may on some occasions be sufficient by themselves to justify the risks involved in the research, so long as the subjects' rights have been protected. Beneficence thus requires that we protect against risk of harm to subjects and also that we be concerned about the loss of the substantial benefits that might be gained from research.

The Systematic Assessment of Risks and Benefits. It is commonly said that benefits and risks must be "balanced" and shown to be "in a favorable ratio." The metaphorical character of these terms draws attention to the difficulty of making precise judgments. Only on rare occasions will quantitative techniques be available for the scrutiny of research protocols. However, the idea of systematic, nonarbitrary analysis of risks and benefits should be emulated insofar as possible. This ideal requires those making decisions about the justifiability of research to be thorough in the accumulation and assessment of information about all aspects of the research, and to consider alternatives systematically. This procedure renders the assessment of research more rigorous and precise, while making communication between review board members and investigators less subject to misinterpretation, misinformation and conflicting judgments. Thus, there should first be a determination of the validity of the presuppositions of the research; then the nature, probability and magnitude of risk should be distinguished with as much clarity as possible. The method of ascertaining risks should be explicit, especially where there is no alternative to the use of such vague categories as small or slight risk. It should also be determined whether an investigator's estimates of the probability of harm or benefits are reasonable, as judged by known facts or other available studies.
Finally, assessment of the justifiability of research should reflect at least the following considerations: (i) Brutal or inhumane treatment of human subjects is never morally justified. (ii) Risks should be reduced to those necessary to achieve the research objective. It should be determined whether it is in fact necessary to use human subjects at all. Risk can perhaps never be entirely eliminated, but it can often be reduced by careful attention to alternative procedures. (iii) When research involves significant risk of serious impairment, review committees should be extraordinarily insistent on the justification of the risk (looking usually to the likelihood of benefit to the subject -- or, in some rare cases, to the manifest voluntariness of the participation). (iv) When vulnerable populations are involved in research, the appropriateness of involving them should itself be demonstrated. A number of variables go into such judgments, including the nature and degree of risk, the condition of the particular population involved, and the nature and level of the anticipated benefits. (v) Relevant risks and benefits must be thoroughly arrayed in documents and procedures used in the informed consent process.

3. Selection of Subjects. -- Just as the principle of respect for persons finds expression in the requirements for consent, and the principle of beneficence in risk/benefit assessment, the principle of justice gives rise to moral requirements that there be fair procedures and outcomes in the selection of research subjects. Justice is relevant to the selection of subjects of research at two levels: the social and the individual. Individual justice in the selection of subjects would require that researchers exhibit fairness: thus, they should not offer potentially beneficial research only to some patients who are in their favor or select only "undesirable" persons for risky research. Social justice requires that distinction be drawn between classes of subjects that ought, and ought not, to participate in any particular kind of research, based on the ability of members of that class to bear burdens and on the appropriateness of placing further burdens on already burdened persons. Thus, it can be considered a matter of social justice that there is an order of preference in the selection of classes of subjects (e.g., adults before children) and that some classes of potential subjects (e.g., the institutionalized mentally infirm or prisoners) may be involved as research subjects, if at all, only on certain conditions.

Injustice may appear in the selection of subjects, even if individual subjects are selected fairly by investigators and treated fairly in the course of research. Thus injustice arises from social, racial, sexual and cultural biases institutionalized in society. Thus, even if individual researchers are treating their research subjects fairly, and even if IRBs are taking care to assure that subjects are selected fairly within a particular institution, unjust social patterns may nevertheless appear in the overall distribution of the burdens and benefits of research. Although individual institutions or investigators may not be able to resolve a problem that is pervasive in their social setting, they can consider distributive justice in selecting research subjects. Some populations, especially institutionalized ones, are already burdened in many ways by their infirmities and environments. When research is proposed that involves risks and does not include a therapeutic component, other less burdened classes of persons should be called upon first to accept these risks of research, except where the research is directly related to the specific conditions of the class involved. Also, even though public funds for research may often flow in the same directions as public funds for health care, it seems unfair that populations dependent on public health care constitute a pool of preferred research subjects if more advantaged populations are likely to be the recipients of the benefits of research. Although practice usually involves interventions designed solely to enhance the well-being of a particular individual, interventions are sometimes applied to one individual for the enhancement of the well-being of another (e.g., blood donation, skin grafts, organ transplants) or an intervention may have the...
dual purpose of enhancing the well-being of a particular individual, and, at the same time, providing some benefit to others (e.g., vaccination, which protects both the person who is vaccinated and society generally). The fact that some forms of practice have elements other than immediate benefit to the individual receiving an intervention, however, should not confuse the general distinction between research and practice. Even when a procedure applied in practice may benefit some other person, it remains an intervention designed to enhance the well-being of a particular individual or groups of individuals; thus, it is practice and need not be reviewed as research.

(3) Because the problems related to social experimentation may differ substantially from those of biomedical and behavioral research, the Commission specifically declines to make any policy determination regarding such research at this time. Rather, the Commission believes that the problem ought to be addressed by one of its successor bodies.
Purpose: The goal of the risk management program is to identify potential risks, evaluate and analyze the potential exposure, create a plan for reducing or eliminating high and moderate risks, implement the plan(s), monitor the actions being taken to reduce risk, report on the results, and include risk reduction as part of the quality improvement activities.

Definitions: Critical Risk Assessment Tool (CRAT)

Policy: On a yearly basis the Compliance Committee will review and re-assess the Risk Matrix. During this review monitoring will be evaluated to ensure it is sufficient.

Procedures:
1. Departments are responsible for all monitoring functions related to risk reduction.
2. The Compliance Officer assumes overall responsibility for the risk reduction plan.

Scope: All programs
Risk Matrix:

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<th>Area</th>
<th>Risk</th>
<th>Risk Level</th>
<th>Plan to reduce or eliminate</th>
<th>Monitoring Mechanism</th>
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<tr>
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<tr>
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<tr>
<td>Compliance</td>
<td>Informed Consent</td>
<td>Low</td>
<td>Training</td>
<td>Chart review</td>
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<tr>
<td>Compliance</td>
<td>Adherence to HIPAA Privacy and Security</td>
<td>Low-Moderate</td>
<td>Training</td>
<td>Incident reporting, chart audits</td>
</tr>
<tr>
<td>Compliance</td>
<td>Storage of Medications</td>
<td>Low-Moderate</td>
<td>Training</td>
<td>Audits</td>
</tr>
<tr>
<td>Compliance</td>
<td>Transportation</td>
<td>Moderate</td>
<td>Check driving records, training, monitoring</td>
<td>Incidents Reporting, Yearly checks</td>
</tr>
<tr>
<td>Compliance, Human Rights Committee</td>
<td>Restraints</td>
<td>Moderate</td>
<td>P&amp;P, Human rights training, Corrective action plans, SOLVE training</td>
<td>Incidents Reporting, Human Rights Review</td>
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<tr>
<td>Compliance, Residential</td>
<td>Medication Administration</td>
<td>Moderate</td>
<td>P&amp;P, MAP Training and monitoring</td>
<td>Incidents Reporting, Human Rights Review</td>
</tr>
<tr>
<td>Credentialing</td>
<td>OIG Exclusion</td>
<td>Low</td>
<td>Monitoring</td>
<td>Yearly monitoring</td>
</tr>
<tr>
<td>Fiscal</td>
<td>Protection from Professional Liability Insurance</td>
<td>Low</td>
<td>Maintenance of professional liability coverage, contract review, risk reduction</td>
<td>Incidents reporting, audits</td>
</tr>
<tr>
<td>Fiscal</td>
<td>Fiduciary Responsibility of investments</td>
<td>Low-Moderate</td>
<td>Broker and CHL annual review</td>
<td>Investment Committee review</td>
</tr>
<tr>
<td>Fiscal</td>
<td>Financial Integrity</td>
<td>Low-Moderate</td>
<td>Budgeting, fund raising, grant writing, contract management, loan management, investment planning</td>
<td>Auditing and reporting</td>
</tr>
<tr>
<td>Food Services</td>
<td>Nutrition/Diet</td>
<td>Low</td>
<td>Training and Education</td>
<td>Incidents Reporting</td>
</tr>
<tr>
<td>Food Services</td>
<td>Storage of Food</td>
<td>Low</td>
<td>Training</td>
<td>Incidents Reporting (CHL and State)</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Avoiding Sexual Contact with Clients</td>
<td>Low</td>
<td>Training</td>
<td>Incidents reporting</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Managing the professional – client relationship</td>
<td>Low</td>
<td>Training</td>
<td>Incidents reporting</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Traumatic Event – Need for Critical Incident Debriefing or EAP services</td>
<td>Low-Moderate</td>
<td>EAP contracted services</td>
<td>Safety Minutes</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Workers Compensation</td>
<td>Low-Moderate</td>
<td>Training, safety, Work Life Committee,</td>
<td>Incidents Reporting, Reporting</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Improper staff conduct</td>
<td>Moderate</td>
<td>Screening at hire, CORI checks, training and monitoring</td>
<td>Incidents reporting</td>
</tr>
<tr>
<td>Infection Control</td>
<td>Infectious Disease</td>
<td>Low</td>
<td>Training, P&amp;P, Monitoring</td>
<td>Infection Control Monitoring, Committee, Incidents Reporting</td>
</tr>
<tr>
<td>Area</td>
<td>Risk</td>
<td>Risk Level</td>
<td>Plan to reduce or eliminate</td>
<td>Monitoring Mechanism</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>Infection Control</td>
<td>Needle Sticks</td>
<td>Low</td>
<td>Training, P&amp;P, Monitoring</td>
<td>Incident Reporting, IC Committee</td>
</tr>
<tr>
<td>IT</td>
<td>Computer Virus</td>
<td>High</td>
<td>Hardware and software deterrents, staff training, monitoring</td>
<td>IS monitoring, Incident reporting</td>
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<tr>
<td>IT</td>
<td>IT Disaster recovery</td>
<td>Low</td>
<td>Plan, testing of backups</td>
<td>Incident reporting</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Disposal of Hazardous materials</td>
<td>Low</td>
<td>Training, P&amp;P</td>
<td>Disposal monitoring system</td>
</tr>
<tr>
<td>Maintenance</td>
<td>General Safety and Upkeep</td>
<td>Low</td>
<td>Maintenance Request system</td>
<td>Annual report</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Storage of Hazardous Materials</td>
<td>Low</td>
<td>Training</td>
<td>Inspections (CHL and State)</td>
</tr>
<tr>
<td>Maintenance and Compliance</td>
<td>Building Regulatory Compliance</td>
<td>Low</td>
<td>Yearly building walk-through, utilizing DMH/DPH inspection sheets</td>
<td>Annual reviews</td>
</tr>
<tr>
<td>Physical Plan</td>
<td>Evacuation</td>
<td>Low</td>
<td>Drills, training, planning</td>
<td>Incident reporting</td>
</tr>
<tr>
<td>Physical Plan</td>
<td>Interruption of supplies and equipment</td>
<td>Low</td>
<td>Drills, planning</td>
<td>Incident reporting</td>
</tr>
<tr>
<td>Physical Plan</td>
<td>Relocation</td>
<td>Low</td>
<td>Drills, training, planning</td>
<td>Incident reporting</td>
</tr>
<tr>
<td>Physical Plant</td>
<td>Fire, bomb, flood,</td>
<td>Low</td>
<td>Drills</td>
<td>Fire drill log, Safety Minutes</td>
</tr>
<tr>
<td>Physical Plant</td>
<td>Physical Plant dangers</td>
<td>Low</td>
<td>Training, mock disaster drills</td>
<td>Incident reporting</td>
</tr>
<tr>
<td>Physical Plant</td>
<td>Snow</td>
<td>Moderate</td>
<td>Drills</td>
<td>Safety Minutes</td>
</tr>
<tr>
<td>Safety</td>
<td>Weapons/contraband</td>
<td>Low-Moderate</td>
<td>Searches, security</td>
<td>Incident Reporting</td>
</tr>
<tr>
<td>Safety</td>
<td>Building Access</td>
<td>Moderate</td>
<td>Security, Front desk staff, training, HR P&amp;P on return of property (keys)</td>
<td>Incident reporting</td>
</tr>
</tbody>
</table>
Community Healthlink  
Policy and Procedure Manual

<table>
<thead>
<tr>
<th>Section: 5 General Clinical</th>
<th>Policy Number: 5-18-1</th>
<th>Effective Date: 7/1/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Answering Service</td>
<td>Review Date: 7/1</td>
<td></td>
</tr>
<tr>
<td>Scope: Interactions and contracts with answering services</td>
<td>Originated: 7/1/01</td>
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</tbody>
</table>

Purpose: To establish a policy on the requirements of all Answering Services that CHL contracts with for after-hours and emergency phone coverage and to establish procedures for keeping the contracts up-to-date with practice.

Definitions:

Policy: All answering services contracting with CHL will follow the below specifications and contracts with answering services will include the following in the contract:

1. Main contact – This person will be the main contact for questions and problem resolution.
2. All calls should be answered within 20 seconds or 3 rings
3. Calls should be answered with the name of the location and a statement identifying the person as the answering service (for example, CHL answering service).
4. The answering service should always follow the directions for how to triage calls (see attached.)
5. The established plan for escalating calls should be followed (see attached).

Responsibility: Vice President of Operations, Division Vice Presidents, Managers

Procedures:

1. The Vice President of Operations will negotiate all contracts for answering services.
2. Any problems that are not resolved through normal customer service routes should be referred to the Vice President of Operations for resolution.
3. Any complaints about the answering services should be directed to the Vice President of Operations.
4. Each unit is responsible for guaranteeing that the directions for triaging and escalating calls are up to date.

Answering Service Procedures:

1. All calls should be answered within 20 seconds or 3 rings.
2. All calls should be answered by identifying the operator as “Answering Service” (e.g. “Worcester Youth Guidance Center Answering Service”).
3. All callers should be asked if this is an emergency before being put on hold.
4. If the call is an emergency, call should be triaged immediately.
5. Although the operator must use their judgement to decide if a call should be paged out to an on-call person, the following is a guide:

Calls that should not go to the clinician on - call:
• Employees calling in sick or late.
• Clients changing or canceling appointments.
• Personal calls for staff

Calls that should go to the clinician on-call:
• Calls in which the client states that the situation is emergent, urgent or a crisis.
• The client states that they must talk to their therapist or a clinician or the on-call clinician.
• The client requests to speak to a therapist.
• Calls in which the caller is confused, or otherwise impaired.

6. When a call is paged, the service will wait 5 minutes for the page to be answered. If there is no response, the service will repeat the page and wait another 5 minutes. If the second page is not answered, the service should call the home phone number of the person on call. If after another 5 minutes the on-call has not retrieved the message, then page the Administrator on Call (AOC).
7. If the AOC does not respond within 5 minutes, the service should then page Carolyn Droser at: 508-899-0828
8. The answering service must have the ability to handle calls from a TTY.
9. Answering service personnel will be trained in handling crisis calls.

CHL’s responsibilities:
1. CHL must furnish the service an up-to-date list of on-call staff, pager numbers, home phone numbers, as well as back-up Administrators on Call (AOC).
Purpose:
CHL is committed to creating programs and delivering services that are sensitive to cultural, ethnic or gender disparities. In addition, this policy is intended to meet the requirements of the Department of Public Health’s standards on Cultural and Linguistic Competence.

Definitions:

CLAS: Culturally and Linguistically Appropriate Services.

Culture is the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, and values of individuals and groups, all which may be influenced by race, ethnicity, religion, class, age, gender, gender identity, disability, sexual orientation, and other aspects of life upon which people construct their identities.

Cultural competence is a set of behaviors, attitudes, and policies that come together in a system, agency, or among individuals that enables effective delivery of services. Linguistic competence is the ability to communicate effectively with people, including those whose preferred language is not the same as the provider’s, those who are illiterate or have low literacy skills, and/or those with disabilities. It is important to remember that cultural and linguistic competence is a goal toward which all providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities. However, all providers should be involved in a continual process of learning, personal growth, experience, education, and training that increases cultural and linguistic competence and enhances the ability to provide culturally and linguistically appropriate services to all individuals. Culturally and linguistically appropriate services are services that:

- respect, relate, and respond to a client’s culture, in a non-judgmental, respectful, and supportive manner;
- are affirming and humane, and rely on staffing patterns that match the needs and reflect the culture and language of the communities being served;
- recognize the power differential that exists between the provider and the client and seek to create a more equal field of interaction; and
- consider each client as an individual, and do not make assumptions based on perceived or actual membership in any group or class.

Policy:
1. To ensure that consumers receive from all staff members, effective, understandable, and respectful care that is provided in a manner that is respectful of cultural, ethnic or gender differences.
2. CHL endeavors to implement strategies to recruit, retrain and promote at all levels of the organization a diverse staff and leadership that is representative of the demographic characteristics of the area.

3. As part of the on-going process of building cultural and linguistic competence, CHL will strive to develop:
   - a comfort with and appreciation of cultural and linguistic difference;
   - interpersonal behaviors that demonstrate and convey concern and respect for all cultures;
   - the comfort and ability to acknowledge the limits of personal cultural and linguistic competence and the skills to elicit, learn from, and respond constructively to relevant personal and cultural issues during service interactions; and
   - a commitment to increasing personal knowledge about the impact of culture on health and specific knowledge about the communities being served.

4. CHL will conduct on-going trainings that help build cultural and linguistic competence and may include traditional cultural and linguistic competency trainings, as well as a range of trainings that help build specific skills and knowledge to work and communicate more effectively with the communities we serve.

**Responsibility:** All managers, Director of Quality Management and Training

**Procedures:**

1. Managers will document discussion of cultural competency with each staff person at least once a year during performance review.
2. All CHL staff are provided with initial and annual training in cultural sensitivity.
3. CHL provides consumer literature in the languages that are commonly encountered in the service area.
4. CHL conducts ongoing self-assessments of Culturally & Linguistically Appropriate services. CHL programs will utilize the attached self assessment form from DPH.
5. CHL will maintain an up to date demographic, cultural and epidemiological profile of the community.
Specific Standards:

<table>
<thead>
<tr>
<th>DPH CLAS Standard</th>
<th>DPH Measure</th>
<th>CHL Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Programs shall recruit, retain, and promote a diverse staff that reflects the cultural and linguistic diversity of the community.</td>
<td>Programs will have a strategy on file to recruit, retain and promote qualified, diverse, and linguistically and culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of clients.</td>
<td>See P&amp;P 4-22</td>
</tr>
<tr>
<td>1.2 All staff shall receive on-going training and education to build cultural and linguistic competence and/or deliver culturally and linguistically appropriate services.</td>
<td>All staff members attend appropriate training at least one (1) time per year. Maintain copies of training verification in personnel file</td>
<td>Copies of training are maintained by program managers and in some cases, HR.</td>
</tr>
<tr>
<td>1.3 Programs shall understand the cultural and linguistic needs, resources, and assets of its service area and target population(s).</td>
<td>Programs will collect and use accurate demographic, epidemiological, and service utilization data in service planning for target population(s). Verified through Grantee site visit. Data maintained in a place that is easily accessible for review.</td>
<td>A bi-annual study is conducted and maintained by the VP of Operations. One measure must be to test for threshold languages.</td>
</tr>
<tr>
<td>1.4 Programs’ physical environment and facilities are welcoming and comfortable for the populations served.</td>
<td>Grantee site visit.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| 1.5 All programs must ensure access to services for clients with limited English skills. | Programs shall ensure access to services in one or more of the following ways (listed in order of preference):  
- Bilingual staff who can communicate directly with clients in preferred language;  
- Face-to-face interpretation provided by qualified staff or contract or volunteer interpreters;  
- Telephone interpreter services (for emergency needs or for infrequently encountered languages); or  
- Referral to programs with bilingual/bicultural clinical, administrative and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter. | When possible, CHL provides bi-lingual staff.  
When this is not possible, on site, or when necessary, off-site interpreters are used. |

1 Interpretation refers to verbal communication that translates speech from a speaker to a receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.
<table>
<thead>
<tr>
<th><strong>DPH CLAS Standard</strong></th>
<th><strong>DPH Measure</strong></th>
<th><strong>CHL Response</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6 Family and friends are not considered adequate substitutes for interpreters because of privacy, confidentiality and medical terminology issues. If a client chooses to have a family member or friend as their interpreter, the provider must obtain a written and signed consent in the client’s language. Family member or friend must be over the age of 18.</td>
<td>Family/friend interpretation consent form signed by client and maintained in client record.</td>
<td>Request client to sign ROI which contains the following, “I give the above named person permission to provide interpretation for me/my family with CHL.” This should be written in the client’s language.</td>
</tr>
<tr>
<td>1.7 Interpreters and bilingual staff, volunteers, and contracted providers must demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting and knowledge in both languages of the terms relevant to the services to be provided.</td>
<td>Resume and documentation of training in file; For interpreters, copy of certification on file at agency.</td>
<td>If not hired through a professional services that CHL contracts with, these documents must be maintained by HR.</td>
</tr>
<tr>
<td>1.8 Clients shall be informed of their right to obtain no-cost interpreter services in their preferred language.</td>
<td>Rights and responsibilities policy contains notice of the right to obtain no-cost interpreter services (see Standard 1.0).</td>
<td>Need to edit client rights.</td>
</tr>
<tr>
<td>1.9 Clients shall have access to linguistically appropriate signage and educational materials.</td>
<td>Programs must provide commonly used educational materials and other required documents (e.g., grievance procedures, release of information, rights and responsibilities, consent forms, etc) in the threshold language of all threshold populations. Programs that do not have threshold populations must have a documented plan for explaining appropriate documents and conveying information to those with limited English proficiency.</td>
<td>Documents currently available in English, Spanish and Vietnamese.</td>
</tr>
<tr>
<td>1.10 Programs shall conduct ongoing assessments of the program and staff’s cultural and linguistic competence.</td>
<td>Programs will integrate cultural competence measures into program and staff assessments (e.g., internal audits, performance improvement programs, patient satisfaction surveys, personnel evaluations, and/or outcome evaluations).</td>
<td>DH?</td>
</tr>
</tbody>
</table>

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2 A threshold population is a linguistic group that makes up 15% or more of a program’s clients and who share a common language other than English as a primary language. For example, if program XYZ serves 200 clients and at least 30 of them speak Haitian-Creole as a primary language, that group would be considered a threshold population for that program and Haitian-Creole would be considered a threshold language. Some programs may target multiple groups, and therefore, may have multiple threshold populations and threshold languages; some programs may have no threshold populations.
INSTRUCTIONS

DPH understands that agencies and programs will be in various stages of implementing the recommended federal CLAS standards. Points awarded for this section of the proposal will be for completeness only. The section is complete if you have rated yourself on every standard in Part B and completed Parts A and C. DPH will deduct points for incomplete responses.

Use Black or Blue Ink. Shorten if necessary to fit in spaces.

**Part A:**

- Agency has No Vendor Number yet

<table>
<thead>
<tr>
<th>RFR Number</th>
<th>Vendor Number</th>
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Agency Contact for CLAS Implementation:

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<th>First</th>
<th>Last</th>
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<th>Phone</th>
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<tr>
<th>Email</th>
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Program Contact for CLAS Implementation:

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<th>First</th>
<th>Last</th>
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<tr>
<th>Email</th>
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</table>

**Part B:** Rate the completeness, effectiveness, and institutionalization of CLAS implementation for your overall agency AND for the specific program for which you are requesting funds. Use the numbering from the scale below to rate the agency and program from 1-7, for each of the 8 components of the CLAS standards listed below. (Please use whole numbers. Put a number in each box.)

The following scale is to be used for assessment:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Implemented</td>
<td>Partly AND Actively Working to Improve</td>
<td>Complete AND Highly Effective</td>
<td></td>
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</table>

Increasing Use of Standard: More Complete, Effective and Institutionalized
<table>
<thead>
<tr>
<th>Component #</th>
<th>Agency Rating (1-7)</th>
<th>Program Rating (1-7)</th>
<th>Component of CLAS Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>Has a demographic profile that describes its service area/population accurately, including stable and changing race, ethnic and language groups</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>Ensures that agency/program participants are provided services respectfully and in manner consistent with their beliefs and culture, supported by written policies/procedures</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>Implements recruitment, retention and promotion procedures such that staff reflect the race, ethnic and linguistic diversity of the service area/population</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>Provides ongoing training in culturally and linguistically appropriate service delivery for staff at all levels and disciplines</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>Assures that limited English proficient individuals in the service area have language access, supported by written policies and procedures and high quality interpretation services</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>Ongoing, assesses its capacity, strengths and gaps in providing services to diverse racial and ethnic populations, and has a written plan to address identified gaps</td>
</tr>
<tr>
<td>7</td>
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<td></td>
<td>Collects data on participant/client race, ethnicity and language</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td>Has effective partnerships with agencies that target the diverse cultural groups in the service area/population</td>
</tr>
</tbody>
</table>

Part C: Select one of the 8 components for which you scored less than "4" and briefly describe what you will do to improve this year. (If you scored "4" or more for all components, choose one of your lower scoring components.):

Component # [ ] Please write or print legibly
Purpose:
To create a standardized format for all CHL direct care staff to use when creating their voicemail message.

Definitions:

Policy:
1. All CHL direct care staff that receive calls from clients should include at a minimum the following information in their voicemail message.
   a. Staff person's name
   b. Hours and days you work if not M-F, 9-5
   c. The statement, "If you are experiencing a life threatening emergency, please hang up and call 911 or go to the nearest hospital emergency department."
   d. If this is an urgent matter, please (insert your site's protocol here)
   e. For all other matters, please leave your name and number.
   f. If you will be on vacation or away from the office, leave a name and number of whom the client can call and when you will be away and when you will return.
2. For urgent matters, use the following protocols:
   a. WYGC: Answering service will pick up call after hours and page on-call.
   b. Worcester Adult Outpatient: Answering service will pick up call after hours and page on-call.
   c. North County (except Clinton): Answering service will pick up after hour calls and forward to ES when needed

Sample: Below is a sample message:
Hi, you have reached the confidential voicemail box for Jane Smith, Clinical Social Worker at Community Healthlink. If you are experiencing a life threatening emergency, please call 911 or go to your local hospital emergency department. Please note that I work Monday, Wednesday and Friday from 9-5. Please leave me a message and I will get back to you as soon as possible. If this is an urgent matter, please call the clinic's main number at 508-860-1260.

Responsibility: All managers and staff.

Procedures:

1. All staff that interact with clients shall include the above information in their voicemail.