

Program Supervisors

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ACCEPTABLE TREATMENT MODALITIES

Policies & Procedures



SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Acceptable Treatment Modalities
EFFECTIVE DATE:	12/2005
REVISION DATE:	5/2013

POLICY

Davis Behavioral Health mental health and addictive disorders professionals will be familiar with those treatments that have been accepted as preferred or promising practices. These treatments will be available whenever agency resources allow. Unusual practices, which deviate from preferred treatment, will be employed only when they have been reviewed by the clinical supervisor and are considered to be promising and consistent with standards of care.

PURPOSE

To ensure that the treatment being delivered by the clinicians at DBH is high in quality and is consistent with preferred practices.

PROCEDURES

- 1.0 Standard theoretical approaches and treatment modalities are encouraged consistent with the comprehensive continuum of mental health and substance abuse services.
- 2.0 The therapeutic modalities utilized need to be clearly evidenced in the clinical record as to the medical necessity of that service.

While a broad range of theories and modalities is encouraged, the appropriate match of client problems with the most effective preferred or promising treatment approach in the least restrictive setting is the paramount consideration following an adequate assessment. What is best for the client cannot be compromised by what is the most rewarding or comfortable for the therapist.

- 3.0 Some unique therapies may have scientific validity but create significant issues of community disapproval with questions regarding evidence-based efficacy or promising practice. Clients requesting such therapies may be referred to an appropriate treatment setting outside of DBH. All therapy practiced at DBH will conform to those methodologies for which they have training and experience and are approved by their respective licensing bodies.
- 4.0 DBH will follow the Utah Behavioral Healthcare committee/Utah State Division of Substance Abuse and Mental Health "Preferred Practice Guidelines" for assessment and treatment.

- 5.0 Whenever doubt exists in the therapist's mind regarding a potential non-standard treatment, several steps can be taken:
- A. Consultation should be sought with a Program Coordinator and Program Director.
 - B. Under direction of the Program Director a clinical staffing may be directed.
 - C. In ALL non-standard treatment situations the Program Director will consult with the Clinical Leadership Team.
 - D. The Program Director will keep the Clinical Leadership Team informed of ALL non-standard treatments approved.
- 6.0 All clinical service staff will become familiar with the Utah Public Mental Health System Preferred Practice Guidelines during Employee Orientation.

Governing Authority

This policy was developed in accordance with the Department of Health Medicaid Provider Contract.

Policy

Davis Behavioral Health (DBH) will provide timely access to care for all clients qualifying for services. DBH will utilize an Electronic Health Record (EHR) for tracking, monitoring, calculating, and reporting adherence to performance standards for the first face-to-face appointment for initial contacts made during regular business hours.

An initial contact is defined as a Medicaid enrollee requesting services for a new episode of care.

Procedure

1. DBH will adhere to performance standards as outlined by the Department of Health Medicaid Provider Contract.
 - a. If based on the initial contact it appears the enrollee has an emergency, a qualified mental health worker from DBH will respond to the enrollee within 30 minutes. If DBH determines that the enrollee has an emergency, DBH offers face-to-face emergency services within one hour from the time of the initial call or within a time frame mutually agreed upon by the enrollee or his or her agent and DBH.
 - b. If it is determined during the initial contact that the enrollee required urgent care, DBH will offer face-to-face covered services within a maximum of five working days of the initial contact. DBH will also provide appropriate information regarding emergency services to the enrollee with instructions to contact DBH if more immediate services are needed.
 - c. If it is determined during the initial contact that the enrollee requires non-urgent care, DBH will offer face-to-face covered services within 15 working days of the initial contact.
2. DBH intake will utilize the intake form located in Credible to capture required information. The following elements will be captured in the system:
 - a. Enrollee name, birth date, Medicaid ID, episode and intake date.
 - b. Whether emergency face-to-face service was provided within the required time frame and, if not, the reason.
 - c. Whether DBH sent a Notice of Action letter if DBH was unable to provide the initial face-to-face service within the required time frame and the enrollee was not satisfied with waiting beyond the required time frame.
 - d. The date and time of the first scheduled face-to-face appointment.
 - e. Whether information on emergency services was given to the enrollee with instructions to contact DBH if more immediate services were needed.
 - f. The status of scheduled face-to-face appointment.
3. Measuring and monitoring timely access standards for the first face-to-face appointments.

- a. New Medicaid clients are entered into the EHR intake form. Clients are classified by level of urgency and payer type.
 - b. Client appointments are scheduled using Credible calendar.
 - c. In the event that data changes, corrections, exclusions or inclusions occur, assigned DBH employees will document those changes on the intake form by editing the record.
 - d. Tracking and monitoring of the access to care data is conducted monthly by the Main Street Clinic office manager to assure accuracy in the data entry (reviewing all dates, Medicaid IDs, if appointments were offered within standard etc.). The office manager will communicate findings back to Intake for correction.
4. Procedures used for calculating and submitting the performance measures report to UDOH.
 - 1) All calendar year access to care data (information from the Credible intake form system) is compiled into one excel spreadsheet by the data manager.
 - 2) Utilizing Credible reports, initial contact data is separated into areas of Emergency, Urgent, and Non-urgent.
 - 3) Calendar year initial contact data is totaled by those who have met the standard of care and those who have not met the standard of care in each of the three categories (Emergency, Urgent, and Non-urgent).
 - 4) Information gathered is then entered in both the qualitative and quantitative sections of the Performance Measures Annual Report (PMAR) form by the data manager and submitted to the Corporate Compliance Officer for review.
 - 5) The Corporate Compliance Office reviews the PMAR and compares it with the initial contact data for accuracy.
 - 6) The PMAR is then submitted by the Corporate Compliance Officer.
5. Enrollees who are placed on a waiting list for non-urgent care are queued in accordance with established criteria that treat like individuals in like circumstances similarly.
 - a. If an appointment time for outpatient services is not immediately available within the required non-urgent time frame, the enrollee or his/her agent will be contacted with an available date and time not less than 24 hours before the required time frame lapses.
 - b. DBH will place an enrollee on a waiting list only after providing an initial mental health evaluation and only if there is agreement between enrollee or the enrollee's agent and DBH that the need for general outpatient services is not urgent.
 - c. The enrollee, regardless of diagnosis or treatment needs, is given a follow-up appointment not to exceed 20 working days from the date of placement on the waiting list.
 - d. If the enrollee is placed on waiting list for specialty services (e.g., specialized therapy groups, psychosocial rehabilitation groups or programs, etc.) or for services with a specific provider, DBH offers or provides other needed outpatient services in the interim.
 - e. Enrollees may remain on waiting lists for specialty services or for services with specific providers until openings become available as long as other appropriate outpatient services are offered or provided in the interim.

- f. If the enrollees (or their representatives) do not want other outpatient services in the interim, DBH documents the services that were offered and the enrollee's (or his or her representative's) decision.
 - g. All enrollees will receive education about how to access emergency services.
- 6. Monitoring access to care
 - a. The Executive Leadership Team will run the access to care report from the Credible data base weekly.
 - b. The corporate compliance officer will notify the clinical director anytime the non-urgent requests for services exceed ten (10) business days.
 - c. The clinical director will take corrective action when necessary to adjust clinical capacity or individual assignments to ensure timely access to care.
 - d. The corporate compliance officer will review access to care data by quarter with the QAPI committee.

ACCOUNTING FOR DISCLOSURES

SECTION:	<u>HIPAA</u>
PAGE:	<u>1 of 2</u>
SUBJECT:	<u>Accounting for Disclosures</u>
EFFECTIVE DATE:	<u>8/2017</u>
REVISION DATE:	<u> </u>

Clients have a right to receive an accounting of disclosures of PHI made from their electronic record, which were not related to treatment, payment, and health care operations, or pursuant to an authorization.

Davis Behavioral Health (DBH) personnel will maintain a *Record of PHI Disclosures* in the client file to record all appropriate disclosures. Information on the *PHI Disclosure form* must be maintained for at least six years. Each disclosure will be logged by the person who made the disclosure.

Disclosures of PHI which are not related to treatment, payment, and health care operations, or pursuant to an authorization must be approved by the compliance officer.

PROCEDURES

1. Recording Disclosures: When a disclosure of PHI meeting the policy criteria has been approved by a supervisor, compliance officer or designee, or when an accidental or illegal disclosure has been discovered:
 - A. Record the disclosure at, or as close to the time of, the disclosure of discovery as possible on the PHI Disclosure to be Include in Client's Accounting form.
 - B. Enter all information required.
 - C. Enter the following types of disclosures of PHI (not all-inclusive):
 - 1) Reporting for public health requirements:
 - Poison control
 - Accidental deaths
 - Vaccination reactions
 - 2) Reporting abuse or neglect
 - Of children, the elderly, or mentally disabled persons
 - 3) Reporting for health oversight activities such as CDC, FDA, DEA, etc.
 - Illnesses, injuries or deaths due to medical devices
 - Required tracking of FDA-regulated products
 - Injury caused by discharge of firearms
 - Disaster relief activities
 - Outside auditors
 - 4) For limited law enforcement purposes:
 - Identification and location purposes
 - Crime reporting and investigation

- 5) For services and processes related to decedents, including:
 - Funeral directors, coroners, and medical examiners
 - Organ, eye, and tissue donation organizations
- 6) To avert serious threats to health or safety
- 7) For specialized government functions
 - Military and veteran's activities
 - VIP protective services
 - Medical suitability (public officials)
- 8) Workers Compensation disclosures not authorized by the client
- 9) Known accidental and/or illegal disclosures

2. Responding to Requests for Accounting of Disclosures

- A. When a written Request for Accounting of Disclosures is received, verify the identity of the requestor, and if not the client, the relationship of the requestor to the client and their authority to receive the accounting. Record the request on the Accounting of PHI Disclosed by DBH form.
- B. If any disclosures have been recorded on a paper Record of PHI Disclosures form in the client's medical record, attach a copy of the Record of PHI Disclosures form to the original Request for Accounting of Disclosures, and forward both to the compliance officer. If there is no Record of PHI Disclosures form in the client's medical record, send only the Request for Accounting of Disclosures form.
- C. The compliance officer will coordinate the response to the request.
- D. Maintain a copy of the response, when received, in the client's medical record.

3. Grounds for temporary suspension of right to receive an accounting:

- A. DBH must temporarily suspend a client's right to receive an accounting of disclosures made to a health oversight agency or law enforcement official upon request by the agency or official.
 - B. Such requests should be made in writing; however, if the request is made orally, DBH must document the statement, including the identity of the agency or official making the statement.
 - C. Temporary suspensions should be limited to no longer than 30 days from the date of the oral statement, unless a written statement is submitted during that time.
4. Fees for provision of accounting. DBH must provide the first accounting to a client in any 12-month period without charge. The fees for subsequent accountings will be \$15.00. If a client requests a review of their records with their clinician, the fees for accounting should be calculated at an hourly rate, to include all persons involved in compiling the requested information, but not to exceed \$50.00.
 5. Accounting for disclosures during research. Researchers who disclose protected health information to individuals or entities outside of DBH are responsible for tracking all disclosures that were not related to treatment or health care operations and which were not authorized by the client.

Advance Health Care Directives

SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Advance Directives
EFFECTIVE DATE:	6/2009
REVISION DATE:	10/2015

POLICY

Davis Behavioral Health (DBH) will provide adult patients with written information about Advance Health Care Directives and will also provide education on the advance directive process. DBH will honor a client's Advance Directive for psychiatric care when those preferences are medically appropriate and in a form consistent with UCA-62A-15-1004. DBH will encourage clients to use Advance Health Care Directives and will provide resource support for consumer advocates by providing training and consultation on Advance Directives. The decision to provide care to any client is not conditioned on whether they have executed an Advanced Directive. No treatment discrimination or bias is appropriate or allowable for reasons incident to Advanced Directive instructions.

PURPOSE

Advance Health Care Directives are a written statement of a client's wishes for treatment in the event that he/she lacks capacity to make a health care decision. The directive is written at a time when the client is competent, as verified by a family member or friend who serves as an "attorney-in-fact." The purpose is to give the client decision-making ability at a time when he/she is competent so that treatment can follow their wishes in the event he/she becomes impaired and is not competent. The Advance Health Care Directive also serves the treatment personnel of DBH who will use the written statement to determine the treatment preferences of the client.

PROCEDURE

- 1.0 Intake will provide adult patients with written materials and provide a brief explanation of advance directives upon request.
 - 1.1 DBH will provide education on Advance Health Care Directives on an individual basis when requested, on the DBH website and/or in a group setting made available to the community at large. DBH will also provide education to intake and clinical staff regarding the DBH Advanced Directive policy, purpose and procedures as provided herein.
 - 1.2 DBH will notify enrollees that there is one form for mental health and medical Advance Directives. Once an enrollee has filled it out, a copy needs to go to all their providers, including physical health care providers and DBH.

- 1.3 DBH will update written materials to be provided to enrollees and notify all clients with an Advance Directive of any changes in state law regarding Advanced Directives as soon as possible, but no later than 90 days after effective date of the change.
- 2.0 DBH staff will request a copy of a client's Advance Health Care Directive when the client indicates that he/she has completed a directive. This directive will be placed in the DBH clinical record and thereby be made available to all treating clinicians. Attention will be drawn to the directive by means of a prominent alert notice added to the face page of the client record..
- 3.0 In the event that the client becomes impaired by a mental illness to a degree that he/she could be termed not competent, the primary service coordinator will verify the existence of a current Advance Health Care Directive. At that time, the primary service coordinator will contact the designated attorney-in-fact.
- 4.0 The attorney-in-fact will make the determination of when the terms of the Advance Health Care Directive should be implemented. The defined psychiatric and environmental interventions specified in the Advance Health Care Directive will be incorporated into the DBH treatment plan *to the extent that resources allow and within standards of reasonable medical care.*
- 5.0 Because of potential conflicts in decision making, and as set forth in Utah statute, DBH personnel will not direct the development of an Advance Health Care Directive, nor will they serve as any client's attorney-in-fact.
- 6.0 If a client is currently competent, the current desires of that client concerning treatment supersede any previously expressed preferences in the Advance Health Care Directive.
- 7.0 The client may revoke an Advance Health Care Directive at any time that he or she is competent to do so. The wish to revoke the directive should be indicated in writing. When this indication is made, the Advance Health Care Directives may be removed from the client's clinical record. At this time, the revocation request and a clinical note indicating the rescission of the Advance Health Care Directive will be placed in the record.

ASSESSMENT, RECOVERY PLANNING AND TREATMENT

SECTION:	Clinical
PAGE:	1 of 2
SUBJECT:	Assessment, Recovery Planning & Treatment
EFFECTIVE DATE:	8/2007
REVISION DATE:	5/2013

Policy: Clinical treatment will be provided in a way that ensures the clinical needs of the client are primary. Treatment will be based on a) an on-going assessment that substantiates medically necessary treatment and b) a written Recovery plan that is negotiated with client and that guides treatment. When appropriate, the client's family and/or other natural supports will be involved in the assessment, treatment and recovery planning process.

Purpose:

DBH supports individuals in their Recovery from addiction and mental illness throughout their Recovery. This means addressing an entire continuum of services including: early identification, early intervention, stronger client engagement, improved person-centered assessment, planning and treatment and establishing a system of supports for continuous recovery management after traditional treatment is concluded.

Procedures:

1. ENGAGEMENT

- The focus of engagement is on the immediate/pertinent needs of the client
- Clinicians establish rapport with clients
- Clients can expect to gain something (Relief, clarity, answers, hope) from the initial (engagement) session
- Clinicians check that client's needs are being met.
- Clinicians gather and document relevant information in an organized way.
- Clinicians make recommendations and negotiate with the client and respect their choices.

2. ONGOING ASSESSMENT

- Assessment information is kept current
- Clinicians gather comprehensive relevant assessment information based on the client's concerns, in an ongoing manner as part of the treatment process
- Assessment includes an ongoing focus on strengths and supports that aid in their recovery.
- Assessment includes identifying those things that motivate the client (Life Goals) and how those motivations have been impeded (Barriers) by mental illness and/or addiction.
- Assessment information is organized coherently and available in a readable, printable format.
- Initial assessments will be completed within 5 working days of first client contact.

3. ONGOING TREATMENT/Recovery PLANNING

- The client is involved in ongoing and responsive recovery planning
- Plans incorporate strategies based on the client's strengths and motivations.
- Where possible, the plan represents a negotiated agreement.
- The plan supports medical necessity and is kept current and up to date.
- Short term goals/objectives are measureable, achievable and within a timeframe.
- Planning anticipates developing and maintaining independence as part of recovery and discharge from the acute episode of treatment.

4. TREATMENT

- a) Treatment is individualized dynamic and adjusts according to feedback and concerns of the client
- b) Treatment is recovery focused and based on outcome, sound practice and evidence.
- c) Family and other informal and natural supports are involved as appropriate and as approved by the client.
- d) Treatment documentation should be done collaboratively when possible and within 24 hours in other circumstances.

Audio/Video Recording of Therapy Sessions

SECTION:	HIPAA
PAGE:	1 of 2
SUBJECT:	Audio/Video Recording of Therapy Sessions
EFFECTIVE DATE:	1/2015
REVISION DATE:	

PURPOSE

Audio/video recording of treatment sessions may be conducted by approved staff for the purpose of training members of the clinical team. The intent of allowing such recording is to improve the clinical skills of treatment team members, thereby ultimately improving the outcomes for clients. Any other use or intent associated with the audio/video recording of sessions is prohibited.

POLICY

Any audio/video recording of treatment sessions will be conducted under the clinical management of Davis Behavioral Health and will be stored only in a secure location on the DBH server. A recording may only be made in strict compliance with the following:

- 1) A recording shall comply with all state and federal laws, rules, and regulations including, but not limited to, compliance with HIPAA and 42 CFR Part 2.
- 2) A recording may only be made after a client has been fully informed of the purposes of the audio/video recording of treatment sessions. The client shall be advised that there is no obligation to consent to the audio/video recording. The client may decline to participate in an audio/video recording without duress or fear of consequence. Once the client has been thus informed, the client shall sign the proper consent form.
- 3) If the client is under the age of 18, a parent or legal guardian must also sign the consent form.
- 4) If the client is under the age of 8 a parent or legal guardian may sign on behalf of the client.
- 5) The recording shall not be removed from DBH premises. If the recording is conducted at a location other than on DBH premises, it shall be promptly submitted to DBH for proper storage.
- 6) Recordings older than 120 days shall be deleted from the secure server site.

PROCEDURES

The audio/video recording of treatment sessions and the storing of those recordings shall be effectuated by the following procedures:

- 1) A clinical supervisor requests that an audio/video recording be made or has authorized the clinician to make the recording.

- 2) The client whose session will be recorded is informed of the purposes of the recordings, how the recordings may be used, and signs the consent form for the recording of treatment sessions without duress or fear of consequence.
- 3) If applicable, the client also signs an authorization allowing non-treating staff members to view the recordings for purposes of training.
- 4) The session is reviewed prior to and/or training at DBH.
- 5) The recorded session shall be kept for 120 days from the date of the initial recording. After 120 days, the recording shall be deleted by the clinical supervisor.

MILEAGE REIMBURSEMENT

SECTION:	Financial
PAGE:	1 of 2
SUBJECT:	Mileage Allowance
EFFECTIVE DATE:	5/07
REVISION DATE:	2/2012

POLICY

Davis Behavioral Health will reimburse employees using personal vehicles for actual miles driven to conduct agency business. Employees will be reimbursed at a rate established by the DBH Finance Department using a formula derived from IRS business and charitable reimbursement rates.

PURPOSE

To establish a comprehensive policy regarding auto mileage allowances, provide for periodic adjustment of the allowance amount, and to establish reimbursement procedures for employees and volunteers.

PROCEDURES

1.0 In order to receive an auto mileage reimbursement, procedures must be followed.

1.1 The requestor must be an employee or volunteer of Davis Behavioral Health and be recommended for mileage reimbursement by his/her supervisor, based on expected out-of-office responsibilities.

1.2 An employee must have a valid Utah driver's license and insurance when driving a vehicle on agency business. An employee must be able to provide proof of the same, if requested to do so by a supervisor or administrator.

1.3 An employee whose driving privilege is revoked or whose automobile liability insurance is not in effect may not drive in the line of duty for the agency.

1.4 Supervisors will verify the accuracy of the mileage report and approve the reimbursement request.

2.0 Mileage Allowance

2.1 Employees shall be reimbursed at the approved rate for miles driven in private vehicles on agency business.

2.2 Reimbursable mileage begins at the first location where work for the agency is performed.

2.3 The Finance Department shall be responsible for processing legitimate reimbursement requests under this policy.

2.3.1 To receive mileage reimbursement under this policy, the employee must submit a Travel Reimbursement Request Form.

2.3.3 If any reimbursement is due upon an employee's termination from eligibility under this policy, or termination from employment, the employee is responsible to submit a Travel Reimbursement Request Form for processing.

2.4 Davis Behavioral Health may withhold payment of mileage reimbursement if such payment is in violation of this policy.

3.0 Accident Procedure

3.1 In the event that an employee is involved in an automobile accident while on agency business in his/her private vehicle, an Incident Report must be filed with the Corporate Compliance Officer.

BREACH OF PERSONAL INFORMATION

SECTION:	HIPAA Policies
PAGE:	1 of 4
SUBJECT:	Breach of Personal Client Information
EFFECTIVE DATE:	9/2017
REVISION DATE:	

POLICY

Federal law requires that under certain circumstances, Davis Behavioral Health (DBH) clients must be notified when a breach of protected data has occurred (unauthorized acquisition). DBH will report privacy breaches and will do all in its power to correct or ameliorate further privacy breaches.

PROCEDURES

1. Unauthorized acquisition or disclosure of private data to persons without a "need to know" is considered a privacy breach. This could include: discussing private data in public places, leaving documents containing private data unattended in public places, posting private data on unsecured websites, sending PHI in emails outside DBH, "misplacing" or otherwise losing unencrypted Protected Health Information (PHI), or Personal Identification Information (PII) stored on removable computer media, etc.
2. The term "breach" does not include:
 - A. Any unintentional acquisition, access, use, or disclosure of protected health by an employee or individual acting under the authority of a covered entity or business associate if:
 - 1) Such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with the covered entity or business associate; and
 - 2) Such information is not further acquired, accessed, used, or disclosed by any person; or
 - B. Any inadvertent disclosure from an individual who is otherwise authorized to access protected health information at a facility operated by a covered entity or business associate to another similarly situated individual at same facility; and
 - C. Any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization by any person.
3. The following disclosures may be considered a privacy breach (as determined by the completion of the Privacy Incident Tracking Report);
 - A. Accidental Disclosures: Accidental disclosures are considered Privacy Incidents and must be reported unless:
 - 1) Such information is not further acquired, accessed, used, or disclosed by any person or

- 2) Any inadvertent disclosure from an individual who is otherwise authorized to access protected health information at a facility operated by a covered entity or business associate to another similarly situated individual at same facility; and
 - 3) Any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization by any person.
- B. Incidental Disclosures - If a workforce member is taking reasonable precautions and another individual happens to see or overhear private data that the workforce member is using, the workforce member will not be held liable for that disclosure and usually does not need to report it as an incident.
- C. Intentional disclosures - Intentional disclosures are Privacy Incidents that may result in disciplinary action. They may also result in personal liability, either in civil or criminal legal action.
4. DBH will take the following steps when they learn that "unsecured" Protected Health Information (PHI) of the client's has been subjected to unauthorized access, use or disclosure.
- A. DBH will conduct a Risk Assessment and determine to what degree the breach may have affected the client or clients.
- B. If it is determined that a client's PHI was, or is reasonably believed to have been, acquired by an unauthorized person and that the information could be used for fraudulent purposes, DBH will make reasonable efforts to notify any affected persons according to the guidelines below.
- C. Notification Requirement (see links below):
- Notification of Individuals (45 CFR 164.404)
 - Notification to the Media (45 CFR 164.406)
 - Notification to the Secretary (45 CFR 164.408)
 - Notification by a Business Associate (45 CFR 164.410)
 - Law enforcement delay (45 CFR 164.412)
 - Administrative requirements and burden of proof (45 CFR 164.414)
- D. Notice to client(s) is required when computerized data containing personal information, that is unencrypted, is breached. Personal information includes: First name or first initial and last name in combination with (1) Social Security number; (2) drivers license number or identification card number; or (3) financial account number or credit or debit card number, in combination with and linked to any required security code, access, code, or password that would permit access to the person's account.
- E. Notice is not required if an investigation reveals that the misuse of personal information for identity theft or fraud purposes has not occurred, or is not reasonably likely to occur.

Procedures for Staff

1. Unauthorized Disclosures - If an unauthorized disclosure or acquisition of private data occurs or is suspected to have occurred, or a record is misplaced or stolen, the procedures below will be followed
 - A. Step in to correct the situation, if possible. For example: interrupt an improper chat in the copy room; rescue a document left in a public place; or lock up an area with access to private data.
 - 1) If the breach involves misplaced or stolen records containing private data, staff will do the following:
 - a) If every effort has been made to retrieve a lost record and it has been determined that retrieval is unlikely. Notify the corporate compliance officer.
 - b) If a record that was believed to be lost or was known to have been stolen is later recovered, notify the corporate compliance officer.
 - 2) If the breach involved a computer system containing private data, staff will take immediate steps to secure the affected system and restore data, as appropriate.
 - 3) Report the breach, along with their contact information, immediately to their supervisor and the DBH compliance officer by the end of the workday.
 - 4) The corporate compliance officer will investigate and document the incident on the Privacy Incident Tracking Report. The report should include the following information:
 - Date, time, and location of the incident (time may be estimated; location should be the location where the incident occurred).
 - The nature of the violation: a clear description of what happened and how, if known.
 - Type of private data involved: paper records, electronic records, or other type of data.
 - Other persons involved: names, titles, contact information, and how they were involved.
 - Any immediate harm known or observed: was data disclosed, altered, damaged, or destroyed? Was DBH/client aware?
 - Immediate corrective actions already taken: for example, documents or computer equipment were secured, accidental recipient of PHI was asked to return or destroy the data, email was retracted, etc.
2. Inappropriate Disclosures (information mailed or faxed to an incorrect address or wrong individual):
 - A. Make every effort to retrieve the information that was sent (have it mailed back or hand-carried), or get assurance from the recipient that it was destroyed. Document these efforts and the results on the HIPAA Privacy Incident Report form in the EHR.

- B. Log the disclosure into the client file in the EHR.
 - C. Indicate on the Privacy Incident Report form whether DBH (or DBH's legal representative) is aware of the disclosure or not. If the affected individual is unaware of the incident, the Compliance Office will either inform them or instruct the responsible department to do so.
3. After investigation, if notification of affected persons or mitigation is required, departments and/or individuals involved in the privacy breach may be asked to assist with the notification process and/or in mitigating the harmful effects.

REFERENCES: HIPAA Regulation: 45 CFT § 164.530 (e) and (f) (Sanctions and Mitigation)

CELL PHONE POLICY

SECTION:	<u>Administrative</u>
PAGE:	<u>1 of 4</u>
SUBJECT:	<u>Cell Phones</u>
EFFECTIVE DATE:	<u>10/2009</u>
REVISION DATE:	<u>4/2019</u>

PURPOSE

To establish guidelines for the use of cell phones when conducting DBH business. DBH issues individual cell phones to employees who are required to be in close contact with the company at all times or working with clients in the community. Employees not issued a "company phone" may be provided a monthly stipend for work related calls made from personal cell phones. While cell phones are a necessary tool for doing business, we require that our employees follow the guidelines listed in this policy in order for the company to provide the most cost-effective program.

GENERAL STATEMENT

Employees may be eligible for company paid cell phones, or a monthly stipend for their personal cell phones based on certain criteria. All DBH issued phones and monthly stipends must be approved by the Executive Leadership Team (ELT). Inclusion in the program is based on the role or function of the employee and responsibility as determined by ELT. All employees will need to follow the guidelines listed below.

1. COMPANY PROVIDED CELL PHONES & OTHER MOBILE DEVICES

- Where job or business needs demand immediate access to an employee who otherwise would be difficult to reach, or demand the employee to have immediate access to clients, DBH may issue a cell phone. (For a list of positions that require a DBH cell phone, or stipend, see Section 5 of this policy.)
- All company provided cell phones or mobile devices are the property of DBH. Employees must comply with company requests to make their company-issued cell phone available for any reason, including upgrades, replacement, or inspection. Employees who leave DBH for any reason must return their company-issued cell phone to the Human Resource Manager.
- The company reserves the right to publish the cell phone numbers in order to make the employee more accessible for business needs.
- All equipment must be obtained through the Human Resource Manager. Failure to follow this policy will result in exclusion from the program or a reduced reimbursement.
- Any negligent damage will be the employee's responsibility to repair or replace.

2. COMPANY CELL PHONES STIPEND

- In cases where an employee's regular job does not require them to be in close contact with the company at all times but the employee on occasion uses his or her personal cell phone for work purposes, that employee may be eligible for a cell phone stipend.
- All stipend requests must be approved by ELT if they fall outside the positions listed in Section 5.
- Stipend recipients must complete the cell phone stipend agreement form.

- By agreeing to receive a stipend, employees understand their phone number may be listed on the DBH internal website (for employee use only).

3. CELL PHONE ETIQUETTE

- While at work employees are expected to exercise the same discretion in using personal cell phones or other mobile devices as is expected for the use of company phones.
- Excessive personal calls during the workday can interfere with employee productivity and be distracting to others. Phones should be set on vibrate, or turned off, especially during meetings. Employees are encouraged to minimize the number of personal calls during work time.
- DBH will not be liable for the loss or damage to personal cell phones brought into the workplace, even if the employee is receiving a stipend.

4. CELL PHONE SAFETY

- Employees whose job responsibilities include regular or occasional driving are not allowed to use their cell phone or mobile device while driving. Safety must come before all other concerns.
- Employees whose job responsibilities do not specifically include driving as an essential function but use a cell phone or mobile device for business use, are also expected to abide by the provisions above.
- Employees are prohibited from using cell phones for work-related matters while driving. If the employee needs to make a call or receives a call while driving, they should pull over safely and stop the car.
- Under no circumstances are employees allowed to place themselves or others at a safety risk to fulfill business needs.
- Employees may use hands-free equipment to make or answer calls while driving without violating this policy. However, safety must always be the priority. DBH expects employees to keep these calls brief. If, because of weather, traffic conditions, or any other reason, employees are unable to concentrate fully on the road, they must either end the conversation or pull over and safely park the vehicle before resuming the call.

5. POSITIONS REQUIRING A DBH CELL PHONE OR STIPEND

The following positions are approved and may be provided a DBH cell phone or stipend. All exceptions to this list must be approved by ELT.

- Member of the Executive Leadership Team
- Program Directors
- Program Supervisors
- Mobile Crisis Outreach (MCOT) and Stabilization and Mobile Response (SMR) Teams
- Case Managers, FRF, Peers, IPS, RSS who work with clients in the community (office-based case managers will not be eligible).
- Prescribers who provide on-call services
- Office Manager
- Maintenance Team
- Hospitalization Coordinator

6. LOST, STOLEN OR DAMAGED CELL PHONES

- It is the responsibility of the employee to protect the phone from damage. In the event that a DBH-issued phone is damaged, lost or stolen, the employee will contact the Human Resources Manager to discuss repair/replacement options.

7. PURCHASING AND UPGRADES OF DBH CELL PHONES

- For DBH employees eligible for a DBH provided cell phone as described in section 5, the employee will be allotted a \$250 allowance toward the purchase of a phone at the time of hire and when they become eligible for an upgrade. Requests for phones costing more than the allotted \$250 will require the employee to pay the difference. Payment for the additional cost of a phone above the allotted amount will need to be provided to the finance office at the time the phone is ordered.
- DBH will provide a case, screen protector, and car charger for all new lines. The cost for these items does not count towards the device allowance.
- Upgrades may be provided every 2 years.

CELL PHONE STIPEND AGREEMENT

Employee Name: _____ Stipend Start Date*: _____
Job Title: _____ Monthly Stipend Amount (select one):
Dept Name: _____ **Occasional Regular Power Use**
Org: _____ Cost ___\$25 ___\$50 ___ up to \$80
Cell Phone #: _____ Cellular Carrier: _____
Business Purpose: _____

*Stipend payment should begin with the start of the next month.

POLICY SUMMARY

Employees who hold positions that include the need for a cell phone may receive a cell phone stipend to reimburse for business-related costs incurred when using their personally-owned cell phones. The stipend will be considered a non-taxable fringe benefit to the employee. The level of cash subsidy (stipend) will be determined by a person's job duties as it relates to cell phone use and access. DBH will review and set the amounts to be provided for stipends and reimbursement on an annual basis. For more information, refer to the *Cell Phone Stipend Policy*.

Employee Responsibilities

Recipients of a cell phone stipend have the following responsibilities:

- Purchase cellular phone service and equipment and assume responsibility for vendor terms and conditions. The employee is responsible for plan choices, service features, and calling areas that meet the requirements of the job and the area of service the stipend is intended to cover (work, travel, home). This includes termination clauses, and paying all charges associated with the cellular service and device.
- Report any job function changes that eliminate or significantly reduce the business need for a cell phone to your supervisor within 5 business days of this change. Also, if the employee reduces service levels in the wireless contract below the reimbursed amount, the same communication expectations exist.
- Avoid using the cellular phone for work related purposes while operating a motor vehicle, or in other dangerous situations.
- Comply with all Federal and State data maintenance and protection laws (e.g., HIPAA, record retention requirements, etc.), as well as all DBH policies, including those pertaining to data security, acceptable computing use, and email.

EMPLOYEE CERTIFICATION

By signing below, I certify that I have read, understand, and agree to the Cell Phone Stipend Policy and my responsibilities under the policy.

Employee Signature

Date

Human Resources Signature

Date

CLINICAL SUPERVISION

SECTION:	Clinical
PAGE:	1 of 2
SUBJECT:	Clinical Supervision
EFFECTIVE DATE:	12/2005
REVISION DATE:	10/2011

Policy

Clinical Supervision will be provided to all clinical service providers at Davis Behavioral Health. The supervision will provide support and direction in contending with problematic client symptoms and behaviors, best methods for providing approved treatments, practice management, accuracy of assessments, and adequacy and timeliness of documentation.

Purpose

Supervision is essential for the support of the clinician and for the accomplishment of the due diligence responsibilities of the organization. The intent of this standard is to ensure that all service providers are provided with appropriate support and direction.

Procedure

1. Each clinical service provider will be assigned a clinical supervisor. In most cases, the clinical supervisor will be the primary organizational supervisor for that employee. In some cases, the clinical supervisor may be assigned in addition to the organizational supervisor.
2. Clinical supervisors will be familiar with the quality of the clinical work of their supervisees. This includes a knowledge of the quality of the supervisee's
 - a. Assessment and (when applicable) diagnostic abilities.
 - b. Therapeutic engagement skills
 - c. Knowledge of preferred practices and approved treatments.
 - d. Documentation practices.
 - e. Practice management ability.
3. Clinical supervisors will conduct reviews of the quality of their supervisee's services at least quarterly. This review will consist of any of these activities:
 - a. Participation in the peer review process.
 - b. Review of clinical assessments, treatment plans, and progress notes.
 - c. Review of productivity against expectations.
 - d. Review of scheduling activities and practice management approach.
 - e. Personal supervision meeting.
4. Clinical supervision will result in a supervisory assessment of the treatment effectiveness of the service provider, and the degree of success in meeting his or her individual performance goals.
5. Feedback will be given continuously to the supervisee in a manner that enhances his or her practice skills, and assists in the level of organizational support that they experience in their role.

6. Regular, individual supervision will be provided in cases in which:
 - a. The service provider requires supervision because of training or licensure requirements.
 - b. The service provider requests such supervision due to unique client or provider circumstances.
 - c. The service provider is experiencing difficulties in therapy application, practice management, or documentation.
7. Team meetings will be incorporated into the supervision process. Staff meetings with licensed colleagues will be accessible for the presentation of clinical cases and group supervision.
8. Documented, formal clinical supervision will result in a productivity credit or other compensation.

OFFICE OF LICENSING CODE OF CONDUCT AND CLIENT RIGHTS

STATEMENT OF PURPOSE

The Office of Licensing is statutorily required to monitor minimum standards in safety and client care in the programs we license. Our rules are designed to ensure the physical safety of programs and guard against abuse, neglect, mistreatment, harm, exploitation or fraudulent behavior. This Code of Conduct outlines minimum client rights and program conduct standards that protect clients and promote the public trust across all categories of DHS Licensure.

DEFINITIONS R501-1-1

(for reference in the following code of conduct rule)

(1) "**Abuse**" includes, but is not limited to: (a) attempting to cause harm; (b) threatening to cause harm; (c) causing non-accidental harm; (d) unreasonable or inappropriate use of a restraint, medication, confinement, seclusion or isolation that causes harm; (e) sexual exploitation, as defined in 78A-6-105; (f) sexual abuse, including sexual contact or conduct with a client, or as defined in 78A-6-105; (g) a sexual offense, as described in Title 76 Chapter 5; or (h) domestic violence or domestic violence related to child abuse. (i) "Abuse" does not include the reasonable discipline of a child, or the use of reasonable and necessary force in self-defense or the defense of others, as such force is defined in 76-2-4.

(6) "**Critical Incident**" means an occurrence that involves: (a) abuse; (b) neglect; (c) exploitation; (d) death; (e) an injury requiring medical attention beyond basic first aid; (f) an injury that is a result of staff or client assault, restraint or intervention; (g) the unlawful or unauthorized presence or use of alcohol or substances; (h) the unauthorized departure of a client from the program; (i) outbreak of a contagious illness requiring notification of the local health department; (j) the misuse of dangerous weapons; or (k) unsafe conditions caused by weather events, mold, infestations, or other conditions that may affect the health, safety or well-being of clients.

(8) "**Exploitation**" includes, but is not limited to: (a) the use of a client's property, labor, or resources without the client's consent or in a manner that is contrary to the client's best interests, or for the personal gain of someone other than the client; such as expending a client's funds for the benefit of another; or (b) using the labor of a client without paying the client a fair wage or without providing the client with just or equivalent non-monetary compensation, where such use is consistent with therapeutic practices; or (c) engaging or involving a client in any sexual conduct; or (d) any offense described in 76-5-111(4) or Section 76-5b-201 and 202.

(10) "**Fraud**" means a false or deceptive statement, act, or omission that causes, or attempts to cause, property or financial damages, or for personal or licensee gain. Fraud includes the offenses identified as fraud in Utah Code Title 76 Chapter 6.

(11) "**Harm**" means physical or emotional pain, damage, or injury

(15) "**Licensee**" is defined in 62A-2-101 and includes the person or persons responsible for administration and decision making for the licensed site or program. The term licensee may be used to describe a person or entity that has caused any of the violations described in 62A-2-112 that are related to the human services program.

(18) "**Mistreatment**" means emotional or physical mistreatment: (a) emotional mistreatment is verbal or non-verbal conduct that results in a client suffering significant mental anguish, emotional distress, fear, humiliation, or degradation; and may include demeaning, threatening, terrorizing, alienating, isolating, intimidating, or harassing a client; and (b) physical mistreatment includes: (i) misuse of work, exercise restraint, or seclusion as a means of coercion, punishment, or retaliation against a client, or for the convenience of the licensee, or when inconsistent with the client's treatment or service plan, health or abilities; (ii) compelling a client to remain in an uncomfortable position or repeating physical movements to coerce, punish, or retaliate against a client, or for the convenience of the licensee; (iii) physical punishment.

(19) "**Neglect**" means abandonment or the failure to provide necessary care, which may include nutrition, education, clothing, shelter, sleep, bedding, supervision, health care, hygiene, treatment, or protection from harm.

(23) "**Penalty**" means the Office's denying, placing conditions on, suspending, or revoking a human services license due to noncompliance with statute or administrative rules, may include penalties outlined in 62A-2-112. A penalty does not include corrective action plans as used in this rule.

(31) "**Staff**" means direct care employees, support employees, managers, directors, supervisors, administrators, agents, volunteers, owners, and contractors.

(33) "**Violation**" means an act or omission by the licensee, or any person associated with the licensee, contrary to any administrative regulation, or local, state, or federal law applicable to the program.

R501-1-12-1 Licensing Code of Conduct and Client Rights.

(1) Licensees and staff shall:

(a) accurately represent services, policies and procedures to clients, guardians, prospective clients, and the public;

(b) create, maintain, and comply with a written policy that addresses the appropriate treatment of clients, to include the rights of clients as outlined in this section;

(c) not abuse, neglect, harm, exploit, mistreat, or act in a way that compromises the health and safety of clients through acts or omissions, by encouraging others to act, or by failing to deter others from acting;

(d) not use or permit the use of corporal punishment and shall only utilize restraint as described in R501-2;

(e) maintain the health and safety of clients in all program services and activities, whether on or offsite;

February 2017

- (f) not commit fraud;
- (g) provide an insurer the licensee's records related to any services or supplies billed, upon request by an insurer or the Office;
- (h) require that any licensee or staff member who is aware of, or suspects abuse, neglect, mistreatment, fraud, or exploitation shall ensure that a report is made to the Office and applicable investigative agencies as outlined in R501-1-10-2, and in compliance with mandatory reporting laws, including 62A-4a-403 and 62A-3-305;
- (i) any licensee or staff member who is aware of, or suspects a violation of this rule, shall ensure that a report is made to the Office of Licensing at **801-538-4242** or directly to the licensor of the specific program or site; and
- (j) provide services and supervision that is commensurate with the skills, abilities, behaviors, and needs of each client.

501-1-10(d): Critical incidents (as defined herein) shall be reported by the program to the Office of Licensing by the end of the following business day, to legal guardians of involved clients, and to any other agencies as required by law, including: (i) Child and Adult Protective Services; or (ii) Law Enforcement

501-1-12-2 Clients have the right to:

- (a) be treated with dignity;
- (b) be free from potential harm or acts of violence;
- (c) be free from discrimination;
- (d) be free from abuse, neglect, mistreatment, exploitation, and fraud;
- (e) privacy of current and closed records;
- (f) communicate and visit with family, attorney, clergy, physician, counselor, or case manager, unless therapeutically contraindicated or court restricted;
- (g) be informed of agency policies and procedures that affect client or guardian's ability to make informed decisions regarding client care, to include:
 - (i) program expectations, requirements, mandatory or voluntary aspects of the program;
 - (ii) consequences for non-compliance;
 - (iii) reasons for involuntary termination from the program and criteria for re-admission; (iv) program service fees and billing; and

(v) safety and characteristics of the physical environment where services will be provided.

501-12-3 clients shall be informed of these rights and a copy signed by the client or guardian shall be maintained in the client file record.

R501-12-4 requires that **licensees shall train all staff annually on agency policies and procedures, Licensing rules, and the Licensing Code of Conduct. A document verifying this training shall be individually signed and dated by the trainer and staff member and maintained in the staff personnel file.**

The following acknowledgment and signature section may voluntarily be adopted for use by programs in order to comply with rule. If programs opt not to use this specific form, it is expected that they create something comparable. OL recognizes the need for flexibility for programs to document proof of training when HR and recording practices aren't conducive to hard-copy files, please discuss with your licensor if necessary.

ACKNOWLEDGMENTS

- I have read and been provided with a personal copy of the OL Code of Conduct and Client Rights rule.
- I understand this Code of Conduct and Client Rights rule and I agree to comply with it.
- I have been trained and understand agency policies and procedures and agree to comply with them
- I have been trained and understand Licensing rules and agree to comply with them
- I had the opportunity to ask questions and received clarification about the Code of Conduct and Client Rights, Agency Policies and Procedures and Licensing rules.
- I am aware of my responsibility to report any violations of this Code Rules to the Office of Licensing to the program licensor or to the highlighted phone number listed in section 1(i).

Employee Signature_____

Date_____

Printed name of Employee_____

- I provided a personal copy of the OL Code of Conduct and Client Rights rule to this employee.
- This employee has been provided training on Agency policies and procedures and Licensing rules.
- I offered this employee the opportunity to ask questions and provided clarification to all questions.

Trainer Signature_____

Date_____

Printed name of Trainer_____

Program/Site Name_____

CODE OF ETHICS

Policies & Procedures



SECTION:	Administrative Policies
PAGE:	1 of 5
SUBJECT:	Code of Ethics
EFFECTIVE DATE:	12/2005
REVISION DATE:	2/2012

POLICY

Davis Behavioral Health holds the Management Team to the highest level of moral advocacy and integrity. All members of the Management Team are required to annually pledge their commitment to this Code of Conduct.

PURPOSE

The purpose of the Code of Ethics is to serve as a guide for conduct for members of the Management Team. It contains standards of ethical behavior for Management Team members in their professional relationships. These relationships include consumers and others served, colleagues, payers, regulatory agencies, employees, the community and society as a whole. The Code of Ethics also incorporates standards of ethical behavior governing personal behavior, particularly when that conduct directly relates to the role and identity of the Management Team members and their representation of Davis Behavioral Health.

The fundamental objectives of the Management Team are to enhance overall quality of life, dignity, and well-being of every individual eligible for services at Davis Behavioral Health, and create a more equitable, accessible, effective and efficient behavioral healthcare system.

Management Team members have an obligation to act in ways that will merit the trust, confidence and respect of other members, staff, consumers, and the general public. Therefore, Management Team members should lead lives that embody an exemplary system of values and ethics.

In fulfilling their commitments and obligations to consumers served, members function as moral advocates. Since every administrative decision affects the health and well being of both individuals and the community, Management Team members must carefully evaluate the possible outcomes of their decisions. Management Team members must work to safeguard and foster the resources, rights, interests and prerogatives of consumers that we serve. The role of the moral advocate requires that Management Team members speak out and take all actions necessary to promote a cultural climate which embraces consumer rights, quality of care, and proper utilization of resources to fulfill, faithfully, our public stewardship.

PROCEDURES / STANDARDS

1.0 Standards to the administration of Davis Behavioral Health.

The Management Team member shall:

- 1.1 Uphold the values, ethics and mission of Davis Behavioral Health;
- 1.2 Conduct all personal and professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect well upon Davis Behavioral Health.
- 1.3 Comply with all laws and contractual obligations binding Davis Behavioral Health;
- 1.4 Maintain competency, knowledge, and proficiency in behavioral health management / administration by implementing a personal program of assessment and continuing professional / leadership development;
- 1.5 Avoid the exploitation of professional relationships for personal gain, convenience or comfort;
- 1.6 Use this Code to further the interests of Davis Behavioral Health and not for self-interested purposes;
- 1.7 Respect professional, organizational, and fellow member confidences;
- 1.8 Enhance the dignity and image of Davis Behavioral Health through positive public and employee interactions; and
- 1.9 Refrain from participating in any activity or behavior that demeans the credibility and dignity of fellow members and Davis Behavioral Health.

2.0 Standards and responsibilities to consumers or others served, to the organization and to employees

2.1 Standards and responsibilities to consumers or others served.

The Management Team member shall, within the scope of his or her authority:

- 2.1.1 Work to ensure the existence of a process to evaluate the quality of care or service rendered;
- 2.1.2 Avoid practicing or facilitating discrimination and institute safeguards to prevent discriminatory organizational practices;
- 2.1.3 Work to ensure the existence of a process that will advise consumers or others served of the rights, opportunities, responsibilities, and risks regarding available services;

- 2.1.4 Work to provide a process that ensures the autonomy and self-determination of consumers or others served;
 - 2.1.5 Work to ensure the existence of procedures that will safeguard the confidentiality and privacy of patients or others serviced; and
 - 2.1.6 Work to ensure the most efficacious utilization of resources.
- 2.2 Standards and responsibilities to the organization.

The Management Team member shall, within the scope of his or her authority:

- 2.2.1 Provide services consistent with available resources and work to ensure the existence of resource allocation process that considers ethical ramifications;
 - 2.2.2 Conduct cooperative and collaborative activities in ways that improve services;
 - 2.2.3 Lead the organization in the use and improvement of standards of administration, management and sound business practices;
 - 2.2.4 Respect the customs and practices of consumers or others served, consistent with the organization's mission; and
 - 2.2.5 Be truthful in all forms of professional and organizational communication, and avoid disseminating information that is false, misleading, or deceptive.
- 2.3 Standards and responsibilities to employees.

Management Team members have an ethical and professional obligation to employees or the organizations they manage that encompass but are not limited to:

- 2.3.1 Working to create a working environment conducive for underscoring employee ethical conduct and behavior;
- 2.3.2 Working to ensure that individuals may freely express ethical concerns and providing mechanisms for discussing and addressing such concerns;
- 2.3.3 Working to ensure a working environment that is free from harassment, sexual and other; coercion of any kind, especially perform illegal or unethical acts; and discrimination on the basis of race, creed, color, sex, ethnic origin, age, or disability;
- 2.3.4 Working to ensure a working environment that is conducive to proper utilization of employees' skills and abilities;

2.3.5 Paying particular attention to the employee's work environment and job safety; and

2.3.6 Working to advocate use of grievance and appeals mechanisms.

3.0 Conflicts of Interest

A conflict of interest may be only a matter of degree, but exists when the Management Team member:

3.1 Acts to benefit directly or indirectly by using authority or inside information, or allows a friend, relative or associate to benefit from such authority or information.

3.2 Uses authority or information to make a decision to intentionally affect the organization in an adverse manner.

The Management Team member shall:

3.2.1 Conduct all personal and professional relationships in such a way that all those affected are assured that administrative / management decisions are made in the best interest of the organization and the individuals served by it;

3.2.2 Disclose to the CEO and appropriate authority any direct or indirect financial or personal interests that pose potential or actual conflicts of interest;

.2.3 Accept no gifts or benefits offered; and

3.2.4 Inform the CEO and appropriate authority and other involved parties of potential or actual conflicts of interest related to appointments or elections to boards or committees inside or outside Davis Behavioral Health.

4.0 Standards and responsibilities to Davis County

The Management Team member shall:

4.1 Work to identify and meet the behavioral health needs of eligible residents of Davis County;

4.2 Work to ensure that all eligible consumers have reasonable access to services;

4.3 Participate in public dialogue on policy issues and advocate solutions that will improve health status and promote quality behavioral health care;

4.4 Consider the short-term and long-term impact of administrative / management decisions on both Davis County and on society; and

- 4.5 Provide prospective consumers with adequate and accurate information, enabling them to make enlightened judgments and decisions regarding services.

5.0 Standards and responsibility to report violations of the Code

A member of the Management Team who has reasonable grounds to believe that another member has violated this Code has a duty to communicate such facts to the CEO and then to the Corporate Compliance Officer.

Pledged this _____ day of _____, _____
month year

Name Position

DAVIS BEHAVIORAL HEALTH
CONSUMER RIGHTS STATEMENT

SECTION:	<u>Administrative Policies</u>
PAGE:	<u>1 of 3</u>
SUBJECT:	<u>Consumer Rights Statement</u>
EFFECTIVE DATE:	<u>6/2006</u>
REVISION DATE:	<u>5/2017</u>

As a consumer of services at Davis Behavioral Health, including consumers who are enrolled in the Prepaid Mental Health Plan, you have the right to:

- Be treated with respect and dignity
- Have access to DBH's 24-hour crisis services (801-773-7060)
- Have your privacy protected, including receiving a copy of our Notice of Privacy Practices
- Get information on all treatment options presented in a manner that is understandable to you
- Take part in treatment decisions regarding your mental health care, including the right to refuse treatment
- Be free from restraint or seclusion if it is used to coerce (force), discipline or used as a reaction (to retaliate), or for convenience, as specified in federal regulations on the use of restraint and seclusion
- Get a copy of your medical record and, if appropriate, ask that it be amended or corrected when allowed by federal law
- Be asked for written authorization before any interviews are audio or video taped
- Get mental health care regardless of your race, color, national origin, disability (mental or physical), gender, religion or age in the admission, treatment or participation in DBH programs, services and activities. If you have questions or feel you have been treated unfairly or discriminated against for any reason, you may contact the Client Relations Officer, Shelly Tanner, at 801.336.1800.
- Discuss any dissatisfaction with your therapist, your therapist's supervisor, or the program supervisor. You also have the right to file a consumer grievance with the Client Relations Officer, Shelly Tanner, by calling 801.336.1800.

The Medicaid Member Handbook can be located at dbhutah.org under "services."
If you are a consumer enrolled in the Prepaid Mental Health Plan, you also have the following rights:

- Get information on the Prepaid Mental Health Plan
- Get mental health services according to Davis Behavioral Health's access and quality standards

Client Initials _____

CONSUMER RESPONSIBILITIES

- Protect the privacy of other clients. This includes not divulging information about clients in group treatment, the content of the group treatment, or in any way identifying the members of the group.
- Arrive promptly for the scheduled appointments. If you are a parent/guardian and your child is in treatment, you are responsible to make the necessary arrangements for the child to come for the scheduled appointment
- Notify your therapist at least 24 hours in advance (if possible) if you are unable to make a scheduled appointment
- Pay your co-pay each time you receive services. If a third party payer (or insurance) is involved, you are also expected to promptly provide any necessary information (carrier, policy numbers, etc.) and to **obtain any prior approval necessary for payment of services**. At time of intake, the application for treatment has a release, which you sign; stating that any information needed to be provided to an insurance carrier for payment is being authorized.
- If your insurance company denies payment or otherwise does not pay, you may then become responsible for partial or full payment of services provided (depending on the reason for the denial)
- Inform the receptionist or business office if there are any changes in your financial situation, address or telephone number
- Telephone calls: A telephone call to your therapist or case manager is a billable service. You may be charged your co-pay for phone calls over five minutes.

Please initial all that apply:

- _____ I am aware of how to access DBH's 24-hour crisis service.
DBH has 24-hour emergency services seven days a week. Call 801.773.7060 to talk with a crisis worker. You can talk to a crisis worker in person, Monday – Thursday 8 AM – 8 PM or Friday 8 AM – 5 PM. Go to either of our clinics. A crisis worker will see you within one hour. After hours and weekends you can go to the Crisis Recovery Unit (CRU) at 2250 N 1700 W Layton, Utah 84041 and talk to someone.
- _____ I am aware of how to access alternative methods of transportation (for clients enrolled in the Prepaid Mental Health Plan)
- _____ I am aware of how to access DBH's grievance (complaint) process
- _____ I have received DBH's Medicaid Member Handbook
- _____ I have received DBH's Notice of Privacy Practices
- _____ I authorize DBH to serve and to obtain emergency care
- _____ I am aware of how to access alternative methods of transportation (for clients enrolled in the Prepaid Mental Health Plan)

Y N

Witness Signature	Date
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**Continuity & Coordination of
Client Employees & Clinical Services**

SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Continuity & Coordination of Client Employees
EFFECTIVE DATE:	10/2008
REVISION DATE:	6/2013

Overview:

Many barriers to successful employment may result from, or be exacerbated by, behavioral health issues. In addition, identification and consideration of employment opportunities and issues is important in the treatment of behavioral health disorders.

_Effective coordination of all care is dependent upon clear and timely collaboration and communication among the providers and facilities that care for patients.

_Effective communication allows better decision-making regarding treatment interventions, and decreases the potential for fragmentation of treatment and/or negative outcomes.

Therefore

Policy: Exchange of Information

Davis Behavioral Health requires that clinical providers, client employee specialists, job coaches, protective payees, case managers, and other providers caring for the same individual, share relevant information (as permitted by applicable confidentiality policies and laws) regarding the member's diagnosis and treatment as needed to ensure effective coordination of care.

Procedure:

Behavioral Health Providers Role and Supportive Employment Specialists Role:

Since Davis Behavioral Health consumers may initiate behavioral health services through self referral, Supportive Employment Specialists play a major role in ensuring that the appropriate exchange of information is coordinated.

_Client Employee Specialists are expected to routinely ask potential consumer employees to complete an authorization for release of information to the Recovery Coordinator (and other treating providers as appropriate for the individual situation) when being considered for employment.

_Similarly, treating behavioral health providers are expected to routinely ask consumers who are employed in DBH/DEO provided or referred services, to complete an authorization for release of relevant clinical information to the Employment Supervisor and/or Job Coach. Meetings with the treatment providers and Job Coach must include the consumer whenever possible. Documentation in the consumer's record will note the reason that the consumer was unable to attend the interdisciplinary meeting.

_The authorization forms must state clearly whether the employee/consumer agrees to or declines the release of information; the documents must be maintained in the treatment and/or employment records.

_If the consumer/employee consents to the release of information, the behavioral health provider or recovery coordinator is responsible for providing relevant information (including diagnosis, medication, and employment recommendations for hours worked, time of work and functional capabilities, and medication that may impair their workability) to the supportive employment specialists and such communication must be documented in the treatment record.

_Employment Specialists and Job Coaches are responsible to inform treatment providers of job expectations, including work hours, normal time schedules and travel or other job restrictions. Periodic updates are to be given whenever reasonably feasible, if significant changes in work effort or normal scheduling are anticipated.

CONTINUUM
OF
CARE

SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Continuum of Care
EFFECTIVE DATE:	12/2005
REVISION DATE:	5/2018

POLICY

It is the policy of DBH to provide medically necessary high quality, clinically appropriate and fiscally responsible services in the least restrictive setting. These services will be consistent with practices currently considered preferred practices or other prevailing community standards of practice and will be provided in a manner that is client/family friendly and, where possible, community based.

PURPOSE

To provide a full continuum of care for clients in the most clinically appropriate, high quality, cost efficient, and client friendly manner.

PROCEDURES

1.0 A continuum of services will be available and utilized where clinically indicated. These services include but are not limited to the following:

- 1.1 Twenty-Four Hour Emergency
- 1.2 Inpatient
- 1.3 Residential
- 1.4 Day Treatment
- 1.5 Outpatient
- 1.6 Psychotropic Medication Management
- 1.7 Psychosocial Rehabilitation
- 1.8 Case Management
- 1.9 Community Supports
- 1.10 Consultation and Education

2.0 DBH will admit clients to the least restrictive, most clinically appropriate program/service as determined by an assessment of clinical need.

3.0 Clients will not be required to stay at any level of care longer than is clinically indicated.

4.0 Clients may move from one program/service or level of care to another as is clinically indicated.

5.0 Clients will be expected to take an active role in their services and participate in all decisions made in their behalf.

- 6.0 Where clinically indicated and client approved community and natural supports will be coordinated and utilized in the rehabilitation/treatment process. This may require a formal written wraparound service and safety plan.
 - 6.1 To ensure client privacy, DBH requires appropriate releases be in place when coordinating care.
- 7.0 Each client is assigned a treatment coordinator who assesses needs and directs clinical intervention.

CORPORATE COMPLIANCE

SECTION:	Corporate Compliance
PAGE:	1 of 5
SUBJECT:	Corporate Compliance Policy
EFFECTIVE DATE:	1/28/2003
REVISION DATE:	12/2015

I. POLICY

Davis Behavioral Health Inc. (DBH) will consistently maintain the highest level of professional, legal and ethical standards in the conduct of its business. DBH places the greatest importance upon its reputation for quality patient care, honesty, integrity and high ethical standards.

II. PURPOSE

To achieve and sustain ethical practices through the actions and conduct of all personnel, including management employees of DBH, and to prevent fraud, waste, and abuse in health care. Employees and agents who ignore or disregard the principles of this Policy will be subject to appropriate disciplinary or contractual action. Employees, volunteers, contractors and agents of DBH must be knowledgeable of standards imposed by applicable federal and state laws and regulations that impact its documentation, coding, billing, and competitive practices, as well as day-to-day activities. Contractors and agents are responsible for having policies & procedures regarding the prevention of fraud, waste, abuse, and the False Claims act. In particular, and without limitation, this Policy prohibits DBH and each of its employees, agents, and Medicaid members from directly or indirectly engaging or participating in any of the following:

A. Improper Claims

Presenting or causing to be presented to Davis County, the State of Utah, and/or the United States Government or any other healthcare payor, a claim for an item or service that was not provided as claimed.

B. False Statement in Determining Rights to Benefits

Making, using, or causing to be made or used, any false record, statement or representation of a fact to determine rights to any benefit or payment under any healthcare program.

C. Conspiracy to Defraud

Conspiring to get a healthcare payor to pay or allow a false claim.

D. False Statement to Conceal Obligation to Pay

Knowingly using or causing to be used a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property.

E. Patient Dumping

Refusing to treat, transferring, or discharging any emergency patient without first providing for an appropriate mental health screening to determine whether or not an emergency condition

exists, and if it exists, stabilizing the condition or appropriately transferring the patient in accordance with policy.

F. Provision of Care to Contract-to-Contract Patients

Failing to provide covered services or necessary care to residents of Davis County or other patients when a contractual duty exists due to Medicaid or Medicare contracts, private insurance contracts, or direct service contracts.

G. Health Care Fraud/False Statements Relating to Healthcare Matters Executing, or attempting to execute, a scheme to defraud any healthcare benefit program.

H. Anti-Referral

Presenting a claim for reimbursement to any individual, third party payor, or other entity for health services because of a referral by a physician who has a financial relationship with DBH, unless the reimbursement is for health services that were provided within the physician's employment or contractual duties with DBH for service provided to a patient of DBH.

I. Anti-Kickback

Knowingly and willfully soliciting or receiving any remuneration in return for:

- a) referring an individual for services;
- b) purchasing any goods, facility, service, or item; or,
- c) offering or paying any remuneration in cash or in-kind to induce someone to refer an individual for services, or to purchase any goods, facility, service, or item.

J. Conflict of Interest

Using their position at DBH or any influence, power, authority or confidential information they receive in their position, or DBH time, equipment, property, or supplies for private gain.

K. Antitrust

Engaging in any activity, which is in restraint of trade or monopolizes interstate commerce.

L. Failure to Report Violations to Compliance Officer

Not promptly reporting any issues of non-compliance with the provisions of this Policy to the DBH Corporate Compliance Officer as described in Section V of this Policy.

III. PROCEDURE

A. The Compliance Officer

In an effort to ensure compliance with this Policy, the DBH Board of Directors is adopting a formal Compliance Program. To oversee and implement this program, DBH has appointed a Compliance Officer. The Compliance Officer will provide education and training programs for employees and volunteers, respond to inquiries from any employee regarding appropriate billing, documentation, coding and business practices, and investigate any allegations of possible impropriety.

B. Compliance Committees

The Compliance Officer will have one or more committees to advise and assist in the implementation of the Compliance Program. The current committee meets 2x a month and includes all members of DBH's executive leadership team. If another committee needs to be

established there will be consultation from the DBH executive team and may have one or more members, each of whom may have varying responsibilities within DBH.

C. Reporting by Compliance Officer

In general, recommendations from the Compliance Officer regarding compliance matters will be directed to the appropriate DBH officer or manager. In no case will DBH employees or managers endeavor to conceal any noncompliance.

D. Reporting Procedure

The Compliance Officer shall have an "open door" policy with respect to receiving reports of violations or suspected violations of the law or the Policy and with respect to answering any questions concerning adherence. Suspected or actual violations may be reported to the Compliance Officer by:

- (i) completing the Corporate Compliance Reporting Form and submitting it to the Compliance Officer via e-mail, inter-office mail, or registered mail;
- (ii) directly phoning the Compliance Officer on the dedicated, confidential Corporate Compliance phone line; or
- (iii) the Intranet; located under "Administrative Forms" on the DBH homepage.

E. Whistleblower Rights

All information being reported will be kept confidential to the full extent of the law. Under no circumstances shall the reporting of any such information or possible impropriety serve as a basis for any retaliatory action that may be taken against any employee, patient or other person making the report to the Compliance Officer, as long as such reporting was done in good faith. An individual who has personal knowledge and evidence of a fraud against the federal government can file a "qui tam" lawsuit on behalf of the government and, if successful, can receive a portion of any recovery. It is not sufficient for the whistle blower (also known as the "relator") to merely report the alleged fraud to the government; he or she must actually initiate a lawsuit by filing a complaint in federal district court in order to be eligible for "recovered funds". The complaint must be filed under seal (i.e., the contents of the complaint are not available to the public). The case will remain under seal while the government investigates the case, in order to allow the government to determine the strength of the charges. This confidentiality serves both to protect the whistleblower and the company while the case is being investigated. While a case is under seal, the government may conduct interviews and even issue search warrants, but it will not disclose the name of the whistleblower or the exact nature of its investigation.

F. Personnel Actions

Upon receiving a report of a suspected or actual violation, the Compliance Officer will take steps to ensure the appropriate investigation and resolution of the report. The Compliance Officer may also request immediate suspension of an employee with or without pay pending the completion of an investigation. In conjunction with the Executive Team and the Compliance Committee, the supervisor will prepare a corrective action plan to address and correct the identified problem. The compliance committee will monitor the implementation of the plan in consultation with the supervisor.

Any personnel actions taken will be in compliance with DBH policies and procedures. Any lost wages will be restored if the employee is exonerated. If the alleged violation was committed by the Chief Executive Officer, the Corporate Compliance Officer shall immediately consult with legal counsel and the Board of Directors to determine the appropriate action. If the alleged

violation was committed by the Local Mental Health Authority, the Corporate Compliance Officer shall immediately consult with the Davis County Attorney, legal counsel, Chief Executive Officer, and the Board of Directors.

IV. Educational Program

The Educational Program is intended to provide each DBH employee and volunteer with an appropriate level of information and instruction regarding ethical and legal standards including, without limitation, standards for documentation, pertinent laws, coding, billing and competitive practices, and with the appropriate procedures to carry out the Policy. DBH will make available appropriate educational and training programs and resources to ensure that all employees and volunteers are thoroughly familiar with those areas of law that apply to and impact upon the conduct of their respective duties. Education on the Corporate Compliance Policy will be provided to all employees at New Employee Orientation and at least annually thereafter. Ongoing training includes identification and explanation of unacceptable practices and improper activities; explanation of the legal penalties for improper activities and the institutional penalties for failure to comply; explanation of the Compliance program, its elements, investigation protocols, and reporting procedures; and client confidentiality. The Human Resources department will maintain a system to document the training received.

All training and educational materials will explain the obligation to report compliance issues and who to report them to. Education information and training will be available to board members, employees, contractors, and other affiliates of the organization. Training is mandatory for staff on at least an annual basis DBH will make every effort to provide appropriate compliance information to all employees and volunteers; it is not possible to anticipate every situation. Responsibility for compliance with this Program, including the duty to seek guidance when in doubt, rests with each DBH employee and volunteer.

V. Employee/Agent Obligations

A. Reporting Obligation: Employees and agents must immediately report to the Compliance Officer any suspected or actual violation (whether or not it is based on personal knowledge) of applicable law or regulations by DBH, any of its employees, or agents.

B. Acknowledgment Statement: Each employee as part of their new employee orientation or annual performance evaluation, or agent upon entering a contract, contract renewal or contract review must complete and sign an Acknowledgment Statement to the effect that they fully understand the DBH Compliance Program and acknowledge their commitment to comply with the Program as an employee or agent of DBH.

C. Employee Violation of Applicable Policy or Regulation: Violation of the Compliance Policy will be considered a violation of the DBH code of conduct. Violators will be subject to corrective action, up to and including termination of employment.

D. Agent Violation of Applicable Policy and Regulation: Violation of the Compliance Policy will be considered a breach of contract and the contract will be terminated for cause.

VI. Non-Employment or Retention of Sanctioned Individuals

DBH shall not knowingly employ any individual; accept as a volunteer or contract with any person or entity, who has been convicted of a criminal offense related to healthcare, or who is listed by a federal agency as debarred, excluded or otherwise ineligible for participation in

federally funded healthcare programs. In addition, until resolution of such criminal charges or proposed debarment or exclusion, any individual who is charged with criminal offenses related to healthcare or proposed for exclusion or debarment shall be removed from direct responsibility for, or involvement in documentation, coding, billing or competitive practices.

VII. Response to Reports of Violations

DBH shall promptly respond to and investigate all allegations of wrongdoing by employees, volunteers, contractors, individuals in the community, or agents, whether such allegations are received via telephone or in any other manner. Upon the discovery that a material violation of the law or of the Policy has occurred, DBH shall take immediate action to rectify the violation, to report the violation to the appropriate regulatory body if necessary, and to sanction the culpable employee(s) or agent. DBH will notify law enforcement if the case warrants this protocol.

VIII. Auditing and Monitoring

A. Importance of Auditing and Monitoring

It is critical, for compliance with this Policy, to conduct regular auditing and monitoring of the activities of DBH, its employees and contractors in order to identify and promptly rectify any potential barriers to such compliance. In addition to investigating specific complaints, the Compliance Officer will monitor ongoing agency operations and internal controls. In addition, the Executive Director may select specific areas for review based on recommendations from the Compliance Committee, Board of Directors, or other groups. The Compliance Committee and members of the Executive Team will work with the Compliance Officer in competing all monitoring activities.

The Compliance Officer will seek advice and consult with the DBH's legal counsel whenever a potential legal question is raised. The Compliance Officer will immediately report to the Executive Director and Legal Counsel any suspected criminal or civil violations of the law. The Executive Director, in consultation with Legal Counsel and the Compliance Officer, will refer the investigation to law enforcement, federal, or state authorities, as appropriate.

B. Regular Audits

Regular audits shall be conducted at the Board of Directors or Compliance Officer's direction. Such audits shall evaluate DBH compliance with this Policy and determine what, if any, issues exist. Such audits shall be designed and implemented to ensure compliance with this Policy and all applicable federal and state laws.

C. Duty to Report Potential Medicaid Fraud

If DBH becomes aware of potential fraud, waste, or abuse we will report the incident within 15 calendar days to the Office of Inspector General of Medicaid Services or The Medicaid Fraud and Control Unit (MFCU) and to the Department. If DBH becomes aware of potential enrollee fraud related to the enrollee's eligibility for Medicaid, we will report the incident to DWS. All other types of potential enrollee fraud or abuse will be made to the OIG.

D. Compliance with Applicable Fraud Alerts

The Compliance Officer shall regularly and periodically monitor the issuance of fraud alerts by the Office of the Inspector General of the Department of Health and Human Services.

E. Retention of Records and Reports

All records and reports created in conjunction with DBH adherence to the Regulatory Compliance Policy are confidential and shall be maintained by DBH.

This Regulatory Compliance Program has been adopted by the DBH Board of Trustees on the 28th day of January, 2003. First Revision effective on the 26th day of October, 2005, second revision effective on the 1st day of January, 2007, third revision on the 22nd day of June, 2010, fourth revision on the 26th day of October, 2011.

Crisis Intervention

SECTION:	Clinical
PAGE:	1 of 2
SUBJECT:	Crisis Intervention
EFFECTIVE DATE:	7/2010
REVISION DATE:	10/2015

POLICY

Davis Behavioral Health will provide crisis assessment and crisis intervention services for all persons who phone in or walk in to any DBH facility and who is in an emergent, psychiatrically unstable condition. This service will be provided 24 hours a day, seven days a week. Emergency services are available without preauthorization.

PURPOSE

Professional ethics require licensed mental health professionals to provide services to persons who are in an emergent situation irrespective of funding considerations if that professional is the first contact.

DEFINITION

DBH defines Crisis (Emergency) Services as inpatient or outpatient covered services furnished by a master's level (or higher) clinician who is qualified to furnish services required to evaluate and/or stabilize an emergency medical condition.

PROCEDURE

1. At least one DBH mental health professional will be identified as the crisis contact at all times of day, every day of the year.
 - a. These mental health professionals will be licensed to conduct psychotherapy, and will have knowledge of:
 - i. Appropriate use of community services.
 - ii. Crisis intervention techniques.
 - iii. Risk assessment.
 - iv. Procedures for involuntary hospitalization.
 - b. During the daytime office hours, a crisis back-up will be identified from the available professionals on staff to provide crisis services when the primary responder is unavailable or responding to other crises.
2. A DBH physician will be designated to be available to the crisis workers at all times for psychiatric consultation or hospital inpatient admission decisions.
3. The crisis service will provide, based on need, either telephone intervention services or face-to-face assessments. Face-to-face evaluations can occur at any DBH facility or can occur in the community depending on circumstances, including the needs of the client, the needs of the community, and various safety considerations. The determination

will prioritize the best interest of the client. If a face-to-face assessment is indicated, the assessment will include:

- a. An assessment of risk of harm to self or others.
- b. Crisis intervention.
- c. A crisis stabilization plan.
- d. Appropriate referral for
 - i. Medical screening (if necessary)
 - ii. Follow-up services
 - iii. Inpatient services

4. During non-office hours, a crisis line will be operated by the adult residential unit to make certain that live answering capability is maintained around the clock.

- a. The phone number of this crisis line will be given to all clients at the time of orientation to services.
- b. The residential unit personnel answering the crisis line will refer any emergency to the on-call crisis worker.
- c. The on-call crisis worker will contact the client within thirty minutes of the referral.

5. When the crisis evaluation indicates that hospitalization may be necessary, the crisis therapist is authorized to authorize up to the first 72 hours in the hospital. Any hospital that is desired by or most convenient for the consumer will be considered as a service provider.

Crisis Intervention Procedure Response for Backup

SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Crisis Intervention Procedure
EFFECTIVE DATE:	1/2015
REVISION DATE:	

In session, a client is having thoughts of harming themselves or others, or having other behaviors that are concerning the therapist:

Will the client commit to safety?

Yes

1. Complete Safety Plan (be sure to include removing any potentially dangerous objects from the individual's access).
2. Discuss the Safety Plan with family member or parent (if the client is a minor).
3. Encourage line of sight observation.
4. Discuss using the DBH crisis line in the evening if needed. You may also contact the evening crisis worker and request an outreach (support staff have the schedule of on-call crisis workers).

No

Ask support staff to contact crisis worker or you can try to contact him/her directly, however for logging purposes, it is beneficial to go through support staff.

DBH crisis worker will complete the risk assessment. The following are dispositions that may result from a risk assessment:

Provide in home support

More immediate or additional appointments by DBH providers

Archway (children and adolescent behavior issues)

DBH Receiving Center (ages 5-17)

CRU (adults)

Wellness Check

Hospitalization

Phone Calls

If a medical evaluation or possible hospitalization is needed, refer the client to the nearest hospital emergency room (ER). Each ER has its own crisis team and the respective crisis worker will complete their own evaluation. Key questions to ask: Does the client have transportation to the ER? Are family members or parents able and willing to safely transport the client to the hospital ER? If so, the family and/or client will take the individual to the hospital and ask to meet with a crisis worker in the ER.

If the client is unwilling, or cannot be transported safely, contact the local law enforcement agency and request a wellness check. When law enforcement arrives at the home, a “pink sheet” may be completed, which is the initiation of involuntary treatment and possible involuntary hospitalization.

*****As a general rule, DBH is not responsible to find a psychiatric bed in a hospital. All hospitalizations go through the hospital ER*****

1. Walk-In Crisis or Mobile Outreach

Even if the client has a therapist, support staff will contact the on-call crisis worker. During business hours, the primary daytime crisis worker is Ainsley Wall. If the daytime crisis worker is unavailable, the call will need to be handled by the backup crisis worker. The expectation is that the backup crisis worker will interrupt his/her activities (even if in session) to address the call. If the backup crisis worker does not respond appropriately, that person’s supervisor will be asked to handle the call. If this does not resolve the situation, contact Todd Soutor, Jan Pendley, Marty Hood, or Kristen Reisig to assist the client.

2. Not a DBH Client

If a non-DBH client walk-in crisis presents, support staff takes the same steps described above to contact a crisis worker. DBH responds in the same manner, regardless of the client’s address, funding source, or county of residence. The crisis worker is to assess the situation and determine the possible need for hospitalization. If hospitalization is not needed, determine if the client can/should go to a different agency (i.e., if the client is a Weber County resident, refer him/her to Weber Human Services or if the client has private insurance and DBH is not an in-network provider, refer him/her to insurance provider panel). Regardless of the referral, gather the client’s information including name, DOB, address, phone number, and insurance information (if face-to-face crisis) and ask an intake worker to open them in Credible. Document your note.

3. Referral Options

If Davis County Medicaid, refer to DBH for ongoing services. If out of county Medicaid, refer to the respective mental health center. If the client is uninsured, some services may be offered through the DBH Living Well Clinic—contact David McKay at extension 429. If the client has private insurance, he/she may be eligible for the after hours clinic or the client may contact their insurance company to see what benefits, services, and providers are available.

CRITICAL INCIDENTS/ SENTINEL EVENTS

Policies & Procedures



SECTION:	Administrative
PAGE:	1 of 2
SUBJECT:	Critical Incidents/Sentinel Events
EFFECTIVE DATE:	5/2005
REVISION DATE:	9/2011

POLICY

It is the policy of DBH to protect its clients, patients, property and staff from harm or threat of harm and, When possible, to act quickly and decisively at the point of occurrence to prevent or mitigate any harm or threat of harm. All critical incidents/sentinel events will be reviewed to determine the need for quality improvement activities on the part of the agency.

PURPOSE

To set up procedures to report, investigate and resolve where possible adverse incidents, which occur at DBH in order to insure safety of all consumers and staff.

PROCEDURES

1.0 Critical Incidents are those incidents that cause or threaten to cause physical and/or personal harm to clients, staff, and property.

Examples of critical incidents which are covered by this procedure are: threats of suicides, assaults, fire, theft, accidents, overdoses, self-destructive acts, missing or misused medication.

Sentinel events are those events that have resulted in the serious incapacitation or death of the consumer (suicide) or the serious incapacitation or death of another (homicide).

1.1 All critical incidents/sentinel events will be handled and stabilized to the extent possible at the point and time of the incident. Where needed, assistance should be obtained from the Program Director, the AOC, or from whomever the program director deems necessary.

1.2 In the event of a sentinel event, notification should be made to the AOC at the earliest available opportunity. The AOC has the responsibility for notifying the CEO and in-house legal counsel.

1.3 All sentinel events involving a death of an active client are required to be reported to the State Division of Mental Health and Substance Abuse. The corporate compliance officer is charged with the responsibility of making the mandatory report to the State Division of Substance Abuse and Mental Health. The corporate compliance officer is responsible for convening the Critical Incident/Sentinel Event Review Committee which is comprised of the medical director, a member of the Board of Directors, the corporate compliance officer, the

CEO, the clinical director, the program director, and legal counsel. The purpose of the review committee is two-fold:

- a.) to aid and support in the de-briefing of staff involved
- b.) to determine what, if any quality improvement actions might be recommended.

1.4 A licensed mental health professional, in the event of a critical incident, will determine:

- (a) If the client is currently stable,
- (b) What additional follow-up, if any, is necessary.
- (c) If the incident arises to a level that requires notification to the Program Supervisor. Within two regular working days after the incident is addressed and stabilized, the Program Supervisor will report the incident to the Program Director on the Incident Report Form. The Incident Report Form will not be entered into the clinical record of the client involved.

1.5 The Program Director will determine:

- (a) Whether an investigation should be undertaken
- (b) If any procedures should be changed
- (c) If the file should be closed or reviewed by the Executive Leadership Team. If a review is indicated, the Program Director will send the Incident Report Form and recommendations to the ELT.

1.6 The Critical Incident/Sentinel Event Review Committee will review the Program Director's recommendations and make the following decisions:

- (a) Whether additional follow-up is necessary.
- (b) Whether further investigation is necessary.
- (c) Whether the incident should be reported to our insurance company, the corporate attorney, and/or governmental authorities.

CULTURAL COMPETENCY PLAN



Policies & Procedures



SECTION:	Human Resources
PAGE:	1 of 11
SUBJECT:	Cultural Competency Plan
EFFECTIVE DATE:	2017/18
REVISION DATE:	May 2018

Table of Contents

Commitment to Cultural Competence

Davis Behavioral Health, Inc. (DBH) believes that the pursuit of equality in healthcare must be in the forefront of all our efforts to serve the many individuals that seek our services. DBH places significant important on providing services that are of the highest quality available. In addition, DBH is committed to accommodating the unique needs of individuals and families who cultural perspectives and linguistic differences are significantly dissimilar from the main stream culture in Davis County, Utah.

CLAS Standards

DBH has adopted the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care as the foundation for implementing cultural competence as a core element in the delivery of services.

As defined by the U.S. Department of Health and Human Services Office of Minority Health, The National CLAS Standards aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

The National CLAS Standards are outlined below:

Principal Standard

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

Governance, Leadership and Workforce

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

3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

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

Engagement, Continuous Improvement and Accountability

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

Cultural Competency Work Plan

The DBH Executive Leadership Team (ELT) have the authority and responsibility to integrate cultural competence through all levels of the organization. The Human Resources Director has been specifically tasked with leading cultural competence effort, including the organization and direction of the DBH Cultural Competency Committee.

Cultural Competency Committee

Davis Behavioral Health has established a Cultural Competency Committee composed of a minimum of 4 individuals, including a Chair and three committee members. Responsibilities and assignments are delegated to all committed members.

The role of the Committee shall be:

- To promote cultural competency among staff and in all services provided by DBH

- To develop and recommend the annual Cultural Competency Plan to the Executive Leadership Team (ELT) and to make relevant recommendations to the Quality Assurance and Performance Improvement (QAPI) committee. The Cultural Competency Plan will be presented to ELT in the first executive each July
- Attend available statewide workshops and training
- Compile, maintain, and disseminate information on internal and external resources for staff serving diverse populations
- Coordinate with Human Resources Department to ensure that annual staff training pertaining to cultural competency is completed
- Served as primary contact and educators for all cultural competency issues or concerns that arise at DBH

Meetings

The Cultural Competency Committee will meet at least quarterly on a date determined by the committee. Special meetings may be called at the discretion of the Chair to conduct business within the scope of the standing rules and/or to carry out the annual plan.

A member of the Committee will be assigned to take minutes at each meeting and send follow-up communication to the other committee members.

Cultural Competency Plan

The Cultural Competency Plan is reviewed and/or updated annually and will include one or more of the following components:

- Goals and implementation
- Delivery of services
- Conflict and grievance resolution for consumers
- Strategic partnerships with local community groups
- Recruitment and retention of staff
- Legal considerations
- Cultural competency training

Goals and Implementation

To make the annual Cultural Competency Plan an effective tool for DBH, the Cultural Competency Committee will create 1-2 short-term and long-term goals each year during the review and revision process for the annual Plan. Short-term goals will be focused on areas that can be completed within the 12-month scope each plan, have relevant and practical applications for immediate improvement, and are attainable with available resources.

2017/18 Goals

Short-term Goals

1. Improve staff awareness of cultural competency by initiating cultural competency training.

Long-term Goals

Long-term goals will remain focused on DBH's efforts to meet the CLSW principle standards of providing high quality culturally competent services to persons with diverse cultural health beliefs, practices, and languages.

Delivery of Services

Treatment staff at DBH are encouraged to perform assessments, treatment, and discharge planning in what that, when possible, take into consideration holistic approaches, cultural beliefs and values, family and other natural support systems, community resources, and any communication barriers that may be present. DBH will use a system of care approach that encourages wraparound services that meet the needs of families and include those in a consumer's natural culture. DBH will promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Interpreters and Written Materials

DBH will make every effort to provide services to consumers in their preferred language. In the absence of qualified and competent bilingual staff, interpreters (language, ASL, etc.) may be offered to overcome communication barriers on an as needed basis. In such instances, interpreters are required to maintain confidentiality, while providing complete and accurate interpretation. Family members, particularly children, will not be used as interpreters in mental health assessments, treatment, or other situations where impartiality is critical. Additionally, the same interpreter should be utilized over the course of treatment, whenever possible. Please refer to Attachment I for the "Language Interpreter and Translator Code of Professional Conduct" used by DBH.

DBH will continue to comply with PMHP contract requirements to make interpreter services available to assist those with limited English proficiency to access services.

Interpreters may not be limited to prevalent languages in the catchment area, but shall apply to all non-English languages.

DBH will make interpretation services for all non-English languages available free of charge and notify members that oral interpretation is available for any all language and written translation is available in prevalent languages, including the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL). Further, DBH will instruct members how to access these services.

DBH Human Resources Department will include all non-English languages spoken by staff in the human resource information system (HRIS), which is currently administered by Paylocity. This information will be used to track potential internal interpreter sources.

A list of names and phone numbers of interpreters and staff fluent in a 2nd language will be kept on the internal DBH website.

DBH intake staff will complete the Clinical Information/Demographic Form as part of the intake process, whether consumers request and receive either interpreter services or services in a preferred language other than English.

DBH will provide written materials that are critical to obtaining services in prevalent non-English languages in its service areas. DBH has identified Spanish as the sole prevalent non-English language in its service area in which critical written material will be provided. Critical materials include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.

DBH agree to meet the following criteria for all written material:

- Use easily understood language and format
- Use a font size no smaller than 12 point
- Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency.
- Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, include written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.

Documentation

DBH will maintain documentation of activities conducted by the agency and its staff. When requested, DBH will submit the written cultural competency plan and or documentation of the activities to the State of Utah Department of Human Services.

Conflict and Grievance Resolution for Consumers

The DBH Cultural Competency Committee will collaborate with the Corporate Compliance Officer and Executive Leadership Team (ELT) to ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by consumers.

Strategic Partnerships with Local Community Groups

DBH staff members will strive to participate in community committees to ensure that the community needs are being met in a culturally sensitive manner. DBH believes that it is essential to gain trust by finding natural leaders from within the minority community as this helps clarify needs and how services need to be adapted to fit the needs of individuals.

Recruitment and Retention of Staff

The Cultural Competency Committee will work with the Human Resources Department to provide supervisors with resources related to the recruitment and retention of staff with diverse cultural and language backgrounds.

Conflict and grievance resolution processes will be addressed in a culturally sensitive manner to help identify, prevent, and resolve cross-cultural conflicts or complaints by staff or consumers.

Cultural competency training will be included in all new employee orientation meetings and material.

Legal Considerations

DBH complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45CFR part 91; the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

Title VI of the Civil Rights Act of 1964

Title VI declares that no person shall be subject to discrimination based on race, color or national origin under any program or activity that receives federal financial assistance.

What is the penalty for non-compliance with Title VI?

- Loss of federal funds
- Loss of future federal and state funding
- Subject to legal actions from NC DHHS, legal services organizations and private individuals.
- Possible “Informed Consent” issues which could lead to medical malpractice charges for both the public and private sector.

Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the Civil Rights Center.

Rehabilitation Act of 1973

The Rehabilitation Act of 1973, as Amended (Rehab Act) prohibits discrimination on the basis of disability in programs conducted by federal agencies, in programs receiving federal financial assistance, in federal employment and in the employment practices of federal contractors.

The standards for determining employment discrimination under the Rehab Act are the same as those used in Title I of the ADA; it protects “qualified individuals with disabilities.” An “individual with a disability” is a person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment or is regarded as having such an impairment. “Qualified” means the person satisfies the job-related requirements of the position he or she holds (or is applying for) and can perform its essential functions, with or without a reasonable accommodation.

Title IX of the Education Amendments of 1972

Title IX is a comprehensive federal law that prohibits discrimination on the basis of sex in any federally funded education program or activity. The principal objective of Title IX is to avoid the use of federal money to support sex discrimination in education programs and to provide individual citizens effective protection against those practices. Title IX applies, with a few specific exceptions, to all aspects of federally funded education programs or activities. In addition to traditional educational institutions such as colleges, universities, and elementary and secondary schools, Title IX also applies to any education or training program operated by a recipient of federal financial assistance.

Americans with Disabilities Act (ADA)

The landmark Americans with Disabilities Act (ADA) enacted on July 26, 1990, provides comprehensive civil rights protections to individuals with disabilities in the following areas:

Title I Employment

Business must provide reasonable accommodations to protect the rights of individuals with disabilities in all aspects of employment. Possible changes may include restructuring jobs, altering the layout of workstations, or modifying equipment. Employment aspects may include the application process, hiring, wages, benefits, and all other aspects of employment. Medical examinations are highly regulated.

Title II Public Services

Public services, which include state and local government instrumentalities, the National Railroad Passenger Corporation, and other commuter authorities, cannot deny services to people with disabilities participation in programs or activities which are available to people without disabilities. In addition, public transportation systems, such as public transit buses, must be accessible to individuals with disabilities.

Title III Public Accommodations

All new construction and modifications must be accessible to individuals with disabilities. For existing facilities, barriers to services must be removed if readily achievable. Public accommodations include facilities such as restaurants, hotels, grocery stores, retail stores, etc., as well as privately owned transportation systems.

Title IV Telecommunications

Telecommunications companies offering telephone service to the general public must have telephone relay service to individuals who use telecommunication devices for the deaf (TTYs) or similar devices.

Title V Miscellaneous

Includes a provision prohibiting either (a) coercing or threatening or (b) retaliating against the disabled or those attempting to aid people with disabilities in asserting their rights under the ADA.

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

Cultural Competence Training

DBH has established a robust cultural competence training program for staff to complete on an annual basis. Components of the program include:

- Annual review and acknowledgement of the cultural competency policy and cultural competency plan
- Twelve (12) individual video training modules to be completed annually
 1. TedxMileHigh – Bobby Lefebvre – Social Worker
 2. Cultural Humility
 3. Challenges & Rewards of a Culturally-Informed Approach to Mental Health
 4. Why Cultural Diversity Matters
 5. Everything You Wanted to Know About Culture
 6. What is Culturally Competent Healthcare?

7. Youth Cultural Competency
 8. An Emptiness in My Heart: Coping with Mental Illness in a Foreign Land
 9. Why Culturally and Linguistically Appropriate Services (CLAS) Matter
 10. Overview of CLAS Standards 1 of 2
 11. Overview of CLAS Standards 2 of 2
 12. What is Cultural Competence and Why is it Important?
- Voluntary completion of the Culturally Competent Care: A Cornerstone of Caring training offered by the U.S. Department of Health & Human Services Office of Minority Health is also encouraged for DBH employees.
 - This training provides up to nine (9) continuing education credits for licensed social workers at DBH.
 - <https://ccnm.thinkculturalhealth.hhs.gov/default.asp>

Participation and completion of the required annual training is logged in Paylocity, the Human Resource Information System (HRIS) utilized by DBH.

Attachment I – Interpreter Code of Ethics

Interpreter Code of Ethics

Language Interpreter and Translator Code of Professional Conduct

Accuracy

Interpreters/translators shall always thoroughly and faithfully render the source language message, omitting or adding nothing, considering linguistic variations in both source and target languages, conserving the tone and spirit of the source language message.

Cultural Sensitivity and Courtesy

Interpreters/translators shall be culturally competent, sensitive, and respectful of the individual(s) they serve.

Confidentiality

Interpreters/translators shall not divulge any information obtained through their assignments, including but not limited to information gained through access to documents or other written material.

Disclosure

Interpreters/translators shall not publicly discuss, report, or offer an opinion concerning matters in which they are or have been engaged, even when that information is not privileged by law to be confidential.

Proficiency

Interpreters/translators shall meet a minimum proficiency standard.

Compensation

The fee schedule agreed to shall be the maximum compensation accepted.

Interpreters/translators shall not accept additional money, compensation, or favor for services reimbursed under contract.

Non-Discrimination

Interpreters/translators shall always be neutral, impartial, and unbiased. Interpreters/translators shall not discriminate on the basis of gender, disability, race, color, national origin, age, socioeconomic or educational status, or religious or political beliefs, or sexual orientation.

Self-Evaluation

Interpreters/translators shall accurately and completely represent their proficiency, experience, and training.

Impartiality

Interpreters/translators shall disclose any real or perceived conflict of interest which would affect their objectivity in the delivery of service.

Professional Demeanor

Interpreters/translators shall be punctual, prepared, and dressed in a manner appropriate and not distracting for the situation.

Scope of Practice

Interpreters/translators shall not counsel, refer, give advice, or express personal opinions to individual for whom they are interpreting/translating, or engage in any other activities which may be construed to constitute a service other than interpreting/translating.

Reporting Obstacles to Practice

Interpreters/translators shall assess at all times their ability to interpret/translate. Should interpreters/translators have any reservations about their competency, they should notify the parties and offer to withdraw without threat of retaliation. Interpreter/translator may continue until more appropriate interpreters/translators can be secured.

Ethical Violations

Interpreters/translators should withdraw from service provision they perceive as a violation of any part of this Code. Any violation of the Code of Professional Conduct may cause termination of the contractual relationship.

Professional Development

Interpreters/translators should develop their skills and knowledge through professional training, continuing education, and interaction with colleagues and specialists in related fields.

I agree to abide by the Davis Behavioral Health, Inc. Interpreter Code of Ethics.

Name

Date

POLICY HANDBOOK
Davis Behavioral Health

No.	Policy	Effective Date:	Revision Date:
102	Employment Relationship	4/2/2007	-
103	Employee Acknowledgement	4/2/2007	-
201	Equal Employment Opportunities	4/2/2007	-
202	Employment Status and Categories	4/2/2007	3/29/2011
203	Personnel Information	4/2/2007	-
204	Discipline	4/2/2007	-
205	Performance Appraisals	4/2/2007	-
206	Promotions and Transfers	4/2/2007	-
207	Nepotism	4/2/2007	3/29/2011
208	Problem and Complaint Procedure	4/2/2007	-
209	Standards of Employee Conduct	4/2/2007	-
210	Confidentiality and Loyalty	4/2/2007	-
211	Use of Communication Instruments & Facilities	4/2/2007	-
212	Use of Cellular Phones and Other Wireless	4/2/2007	-
213	Conflicts of Interest	4/2/2007	-
214	BCI Screening	4/2/2007	-
215	Credited Service	4/2/2007	3/29/2011
300	Work Schedule	3/29/2011	3/29/2011
301	Attendance and Punctuality	4/2/2007	-
302	Paid Holidays	4/2/2007	3/29/2011
303	Vacation Benefits	4/2/2007	3/29/2011
304	Sick Leave Benefits	4/2/2007	3/29/2011
305	Family and Medical Leave	4/2/2007	-
306	Unpaid Leave	4/2/2007	-
307	Other Special Leaves	4/2/2007	-
308	Leave Donation	4/2/2007	3/20/2011
309	Employees Serving as Witnesses	4/2/2007	-
310	Protected Disabilities	4/2/2007	-
401	Payroll & Timekeeping	4/2/2007	-
402	Overtime	4/2/2007	-
403	Insurance Benefits	4/2/2007	9/22/2011
404	Educational Assistance	4/2/2007	-
405	Business Travel Expenses	4/2/2007	-

406	Garnishments	4/2/2007	-
407	401 (k) Pension/Profit-Sharing Plan	4/2/2007	-
408	Cafeteria Benefit Plan	4/2/2007	-
409	Employee Assistance Plan	4/2/2007	-
410	Employee References	4/2/2007	-
501	Sexual & Other Unlawful Harassment	4/2/2007	-
502	Drug & Alcohol Abuse	4/2/2007	-
503	Drug & Alcohol Testing Policy	4/2/2007	-
504	Solicitation	4/2/2007	-
505	Accuracy of Billing Records; False Claim Act;	4/2/2007	-
506	Dress Code	4/2/2007	-
507	No Smoking Policy	4/2/2007	-
508	Visitors	4/2/2007	-
509	Workplace Violence Prevention	4/2/2007	-
510	Identification Badges	4/2/2007	-
601	Terminations	4/2/2007	-
602	Layoffs - Reductions if Force	4/2/2007	-
603	Severance	4/2/2007	-
604	COBRA	4/2/2007	-

Employment Relationship

Policy No. 102

Effective Date: 4/2007

Review Date: 10/2015

This Employee Handbook is intended only as a helpful guide. Neither this Handbook nor any of its provisions are intended to bind DBH in any way beyond its sole obligation to pay wages earned and benefits vested through the employee's last day worked. No contract, either express or implied, respecting the procedures, terms, conditions, or duration of employment is created by this Handbook or any of the guidelines contained herein. Employment at DBH is on an at-will basis, which means that your employment may be terminated by you or by DBH at any time, for any reason or for no reason, with or without notice, and without any procedure or formality. The at-will nature of your employment is not affected by any of the guidelines of this Handbook and cannot be modified by any oral promise from any supervisor or DBH representative or by any other writing unless duly executed by the employee and the CEO of DBH.

DBH reserves the right to change, replace, withdraw, or deviate from any of the guidelines contained in this Handbook without prior notice. Employees may be asked to sign separate agreements covering such matters as alternative dispute resolution or protecting confidential and proprietary information of DBH. If you have any questions or wish to have further information about any particular guideline in this Handbook, please contact the Human Resource Director.

Employee Acknowledgement

Policy No. 103

Effective Date: 1/2007

Review Date: 10/2015

I acknowledge receipt of a copy of DBH's Employee Handbook. I understand that the guidelines contained in the Handbook are not a contract and impose no legal obligation of any kind on DBH. I further acknowledge that my employment with DBH is at will, and may be terminated by me or by DBH without prior notice, at any time, without any procedure or formality, for any reason or for no reason, and with DBH's sole obligation being payment of wages earned and benefits vested through the last day worked. I also understand that, should termination be the result of a reduction-in-force, DBH will select employees for termination based on DBH's present and future needs, as determined in the sole discretion of DBH, and any other factors DBH, in its discretion, finds relevant. DBH will implement the reduction in any manner that, in its judgment, best meets existing conditions.

I further acknowledge that all prior DBH guidelines and procedures, and also understand that DBH may change, replace, withdraw, or deviate from any or all of the guidelines contained in the Employee Handbook without prior notice. I further acknowledge my responsibility to read and follow any modifications or additions to the guidelines distributed to me for inclusion in my copy of the Employee Handbook without signing an additional acknowledgment of receipt of such additions or modifications. In the event of any conflict between this Acknowledgment and any other statements, oral or written, present or future, concerning the terms and conditions of employment, I understand and agree that the at-will relationship confirmed by this acknowledgment will control.

Date

Employee Signature

Printed Name

Equal Employment Opportunities

Policy No. 201

Effective Date: 4/2007

Review Date: 10/2015

DBH is an equal employment opportunity employer. DBH prohibits any discrimination based on race, gender, pregnancy, color, national origin, religion, age, disability, or any other status or characteristic protected by law. Discrimination is prohibited throughout all phases of your employment -- including being interviewed, hired, promoted, compensated, and provided benefits.

DBH forbids retaliation against anyone who reports prohibited discrimination. DBH's policy is to investigate any complaints of unlawful discrimination and to take any necessary corrective action, up to and including termination. It is also DBH's policy to ensure against and to take corrective action against any employees who harass, embarrass, or retaliate in any respect against anyone who has made a complaint regarding unlawful discrimination. Any complaints concerning unlawful discrimination or retaliation for having raised a complaint should be immediately directed to the Human Resource Director.

Employment Status and Categories

Policy No 202

Effective Date: 4/2007

Revision Date: 10/2015

Employment Status

Davis Behavioral Health, Inc. (DBH) classifies all employees as either *exempt* or *non-exempt* under the Fair Labor Standards Act (FLSA) and other State and Federal laws for payroll purposes.

Non-Exempt

Employees whose positions do not meet certain legal requirements necessary for exemption from the FLSA are classified as non-exempt. Non-exempt employees are paid overtime rates for all hours worked over 40 in a workweek. The workweek at DBH runs Friday through Thursday. Overtime pay is calculated at 1 ½ times the employee's base hourly rate. Non-exempt employees are paid for each hour worked.

DBH adheres to a strict policy of prohibiting off-the-clock work, as required by Federal and State employment law. Disciplinary action, up to and including termination of employment, may be initiated if an employee does not report work hours accurately on time records or if a manager or other employee instructs an employee to work off the clock. Any violations of this nature should be reported to the Human Resources Director immediately.

Employees are prohibited from working unauthorized overtime, as outlined in Policy 402 – Overtime.

Exempt

Employees whose positions meet the necessary legal requirements for exemption from the FLSA are classified as exempt. Such employees are exempt from the overtime provisions of the FLSA and do not receive overtime pay, even though they may work in excess of 40 hours in a workweek.

Exempt employees are paid on a salaried basis and are paid to do a job, regardless of hours worked. Exempt employees typically perform work that is executive, managerial, administrative, or professional in nature. DBH reserves the right, in its sole judgment, to determine whether or not an employee should be classified as exempt or non-exempt in accordance with the FLSA.

Categories of Employment

DBH recognizes four basic types of employment categories:

Full-time

DBH recognizes two (2) categories of full-time employees for the purpose of benefit program eligibility and participation:

1. **Regular full-time.** Regular full-time employees are those regularly scheduled to work at least 40 hours per week. Regular full-time employees may participate in the benefit programs for which eligibility requirements are satisfied.
2. **3/4 full-time.** Three-quarter (3/4) full-time employees are those regularly scheduled to work between 30 and 40 hours per week. 75% full-time employees may participate in the benefits programs for which eligibility requirements are satisfied. Premiums, holiday pay, vacation leave accrual, and sick leave accrual for employees in this category are pro-rated.

Part-time

Part-time employees are those who work less than 30 hours per week. Part-time employees who are regularly scheduled to work between 20 and 30 hours per week are eligible to receive 4 hours of holiday pay, as outlined in Policy 302 – Paid Holidays, and participate in the 401 (k) retirement benefit. Employees who are regularly scheduled to work less than 20 hours per week or who work on an as needed basis are not eligible to participate in the benefit programs or receive holiday pay.

Transitional

Transitional employees are those hired to participate in DBH supported employment programs. Transitional employment helps consumers who have no work history or previous work failures to access job placement and gain beneficial work experience. These jobs are usually designed for individuals with one or more barriers to employment (i.e., criminal history, homeless, substance abuse, mental illness, etc.). The goal of transitional employment is to give individuals work experience so they are able to transition into other jobs that will enhance their self-sufficiency. Transitional employment positions are temporary in nature and last between six (6) and twelve (12) months.

Temporary

Temporary employees are those hired for a specific task or for a specific length of time and are regularly scheduled to work at least 40 hours per week. Temporary full-time employees are not eligible for DBH's non-wage benefits, including paid vacation, sick, and holiday leave.

Independent Contractors

Individuals who have a formal independent contractor relationship with Davis Behavioral Health are not considered to be employees of the agency.

Change in Status

If a temporary employee is offered a regular full-time position and assumes that position without a lapse in employment, the length of service credit will begin on the date a regular full-time position is assumed.

Re-Employment

Individuals who obtain re-employment with DBH will be classified in one of the two following categories:

Re-hired Employees

Individuals who obtain re-employment with DBH will be classified as re-hired employees if they voluntarily terminate their employment or if they are laid off from employment and are re-employed more than 45 days after their termination date. Re-hired employees are considered new employees and will accumulate seniority and benefit eligibility from their most recent date of hire.

Reinstated Employees

Individuals whose employment is terminated in connection with a layoff or reduction in force, and who return to employment within 45 days after their termination date are considered reinstated employees. The seniority and eligibility for paid time off of a reinstated employee relates back to the reinstated employee's original date of hire. Eligibility for medical and other benefits of reinstated employees is determined in accordance with the governing provisions of the applicable medical or other benefit plan.

Personnel Information

Policy No 203

Effective Date 4/2007

Revision Date: 10/2015

Employment Application

The employment application is an important phase of the hiring procedure and becomes a part of your employee record. All information submitted on the application form is subject to verification. DBH reserves the right of immediate dismissal upon discovering misrepresentations or omissions on an employee's application.

Personnel Data Changes

Each employee is responsible to promptly notify DBH of any changes in the employee's personnel data. Personal mailing addresses, telephone numbers, number and names of dependents, individuals to be contacted in the event of an emergency and other such status reports should be accurate and current at all times. If any personnel data has changed since originally provided to DBH, the employee is obligated to notify the Human Resource Director.

Access to Personnel Files

DBH maintains a personnel file on each employee. The personnel file includes such information as the employee's job application, resume, records of training, documentation of performance appraisals and salary increases, and other employment records.

Personnel files are the property of DBH and access to the information they contain is restricted. Generally, only HR staff, supervisors and management personnel of DBH who have a reason to review information in a personnel file are allowed to do so. Employees who wish to review their own file should contact the Human Resource Director. With reasonable advance notice, and without imposing undue inconvenience, employees may be permitted to review their own personnel files in DBH's offices and in the presence of an individual appointed by DBH to maintain the files.

Discipline

Policy No. 204

Effective Date: 4/2007

Review Date: 10/2015

DBH's supervisors and managers are responsible for the discipline of persons whom they supervise. When an employee's attendance or performance becomes unsatisfactory, or when an employee engages in inappropriate conduct, DBH may provide the employee with notice of the concern and an opportunity to improve. However, DBH retains sole discretion to determine whether the misconduct or degree of unsatisfactory performance warrants immediate termination without notice. DBH's supervisors and managers have several discipline options available, which may include, but are not limited to, verbal warnings, suspensions without pay, or discharge. Different versions or combinations of these or other forms of discipline may be used. However, there is no plan, policy or procedure of "progressive discipline" which DBH is obligated to follow. Rather, any of the available forms of disciplinary options may be levied for any particular violation based upon DBH's discretion.

When an employee is subjected to discipline and feels that a mistake has been made, the employee may request review of the discipline by a higher level of DBH's management. Depending on the circumstances, DBH may, in its sole discretion, grant or deny the request for review. DBH has no obligation to permit review. However, if review of the discipline is allowed, DBH will typically discuss the matter with the employee and/or the supervisor or manager concerned. An employee who does not request review of discipline within two working days after receiving notice of discipline is deemed to have accepted the discipline issued as appropriate.

The discipline guidelines in this policy are not a contract and do not alter the at-will status of employment, nor do these guidelines create a requirement that employees be disciplined or terminated only for adequate or just cause. DBH reserves its right to use its sole discretion in determining what discipline is appropriate and in resolving any challenges to discipline.

Performance Appraisals

Policy No. 205

Effective Date 4/2/2007

Revision Date: 10/2015

The job performance of each employee may be formally evaluated at least once every year. The appraisal is normally conducted by your immediate supervisor. Its purpose is to provide a formal opportunity for your supervisor to evaluate your work and give you feedback. It also gives you a chance to express any concerns you have about your work with DBH. As important as this written performance appraisal is, it is not meant to substitute for on-going discussion between your supervisor and you about your performance.

Salary increases are not automatic with performance evaluations, but are based on several factors: your performance, changes in responsibilities, attendance and economic factors, among others.

If at any time you believe that your performance appraisal is overdue, you are responsible for setting up a review with your supervisor. Records of performance appraisals are generally maintained as part of your personnel file. Receipt of a favorable performance appraisal does not modify the at-will status of your employment relationship with DBH.

Promotions and Transfers

Policy No. 206

Effective Date: 4/2007

Revision Date: 10/2015

While DBH reserves the right to hire or promote at its discretion in order to meet changing business conditions and staffing needs, DBH prefers to fill vacant positions from within. Employees who are qualified and interested in a posted position should contact the Human Resource Director.

Promotion decisions may be made on the basis of the applicant's qualifications for the open position and on the recommendations of applicant's supervisors. Consideration may be given to such factors as seniority, past performance, creative ability, training, experience, cooperation, and initiative, among others. Employees currently on a formal corrective action or other disciplinary plan are considered to be ineligible for promotions and possibly transfers until terms and duration of the plan have been met successfully.

All positions at DBH are assigned pay grades, ranges, and starting wages. Employees who choose to apply or transfer to a position at DBH that falls in a lower pay grade may be compensated at a lower wage that fits the established compensation system. Wages may be adjusted for employees who are reassigned to a position with a lower pay grade due to disciplinary action. Employees who are reassigned to a lower paying position at the discretion of management may not have their wages reduced due to the new assignment.

Employment of Family Members

Policy No. 207

Effective Date: 4/2007

Revision Date: 10/2015

Davis Behavioral Health believes that close relationships within the work environment often gives rise to claims of favoritism, ill feelings, and suspicion by fellow workers. In order to avoid these concerns, no employee may hire or supervise, directly or indirectly, individuals in the following close relationships:

- Father	- Sister	- Father-in-law
- Mother	- Uncle	- Brother-in-law
- Husband	- Aunt	- Sister-in-law
- Wife	- Nephew	- Son-in-law
- Son	- Niece	- Daughter-in-law
- Daughter	- First cousin	- Cohabitant
- Brother	- Mother-in-law	

No prospective employee who has a close relationship with another employee at DBH will be hired without approval from the Executive Leadership Team (ELT).

Employees are required to disclose any relationship or circumstance which may be subject to this policy. A "Close Relationship Disclosure Form" must be submitted to the Human Resources Department to be stored in the employee's personnel file. Failure to comply with the required disclosure may constitute grounds for disciplinary action, up to and including termination of employment.

[Close Relationship Disclosure Form](#)

Problem and Complaint Procedure

Policy No. 208

Effective Date: 4/2/2007

Review Date: 10/2015

It is DBH's desire to provide pleasant working conditions and to make the work a rewarding experience. Employees are encouraged to communicate all questions, complaints and suggestions to their supervisor. If the matter cannot be resolved with the employee's supervisor, the employee is urged to report the matter to the Human Resource Director.

Standards of Employee Conduct

Policy No. 209

It is expected that employees will conduct themselves in accordance with high standards of fairness to each other and to DBH. Observing reasonable standards of conduct allows us to work together harmoniously and enables DBH to maintain efficient operations. It is important that all employees adhere to a consistent set of guidelines relative to, but not limited to, attendance at work, punctuality, and work performance. Failure to observe principles of good social and business practice is contrary to the best interest of all concerned. Therefore, employees not complying with the expected standards of conduct may be subject to disciplinary action, which may include involuntary termination with or without prior notice. Listed here are some of the major offenses to our conduct standards. The list is not all-inclusive. Any act contrary to prudent conduct on DBH premises is prohibited. These standards are not intended to alter the at-will status of your employment with DBH. Either you or DBH may terminate the employment relationship at any time with or without cause and with or without prior notice. DBH reserves the right to terminate any employment relationship without resorting to any formal or informal disciplinary procedure.

Personal Conduct

The following are examples of inappropriate personal conduct which may result in immediate discipline up to and including termination:

- *Fighting or engaging in horseplay on company premises.
- *Acting in such a manner or using language at work that is abusive, threatening or demeaning.
- *Stealing or willfully damaging employee or company property.
- *Removing or transferring company property without written authorization from the responsible manager.
- *Falsifying oral or written information.
- *Making entries on another employee's time card without supervisory approval.
- *Appearing on company premises while under the influence of narcotics, marijuana, alcohol or any illegal drug.
- *Possessing or appearing to possess or use firearms, explosive materials or any dangerous weapon while on company premises.
- *Possessing, selling or using alcoholic beverages or controlled substances on company premises.
- *Using company telephones unreasonably for personal matters.
- *Conducting personal business during work hours.
- *Gambling of any kind on the premises.

Job Conduct

The following are examples of inappropriate conduct which may result in immediate discipline up to and including termination:

- *Failing to perform work assignments or disobeying any direction given by your direct manager.
- *Failing to meet acceptable quality and quantity work standards.
- *Being absent without approval from work (this includes, but is not limited to, failure to return from leave of absence or paid time off when scheduled without notification), walking off the job or interfering with another employee's work.
- *Discourteous or rude conduct towards any co-worker, client, client's family members or direct support relationships, other treatment professionals, or suppliers that would affect the company's goodwill.

Safety

The following are examples of inappropriate conduct which may result in immediate discipline up to and including termination:

- *Performing an unsafe act on company premises, including parking lots, in a company vehicle or while engaged in company-sponsored/paid activities.
- *Failing to use safety devices provided or to adhere to safety regulation procedures, including using vehicles, equipment, machines or materials without approval
- *Using any company motor vehicles unsafely.
- *Failing to report any accident no matter how minor, to management;

Honesty

Dishonesty in your dealings with DBH, its officers, representatives or co-workers is grounds for termination. Because dishonesty is a broad category, it covers a wide range of behavior. Some specific examples of dishonesty include:

- *Software piracy or the use of unlicensed software.
- *Accessing a file server, internet or other repository of company information without a legitimate business purpose.
- *Submitting altered or falsified receipts for reimbursement from the travel reimbursement fund.
- *Not adhering to company policies.
- *Falsifying hours.

Miscellaneous

Engaging in any other behavior that is unethical, dishonest, immoral, reckless, damaging or disruptive to the conduct of business which may include, but not be limited to, the following:

- *Endangering employees because of known safety violations.
- *Disclosing confidential client or business information.
- *Engaging in willful, reckless or grossly negligent conduct that results in damage to company property or personal property on company premises.
- *Possessing, using, selling or being under the influence of intoxicants or any other non-prescribed mind-altering substance while on company property or while engaged in company-sponsored/paid activities.
- *Performing any immoral, indecent or other generally unacceptable act on company premises.
- *Repeating the same type of unsatisfactory employee performance or conduct that has resulted in a prior warning.
- *Displaying other intolerable conduct deemed to be equally as serious as the above.

Confidentiality and Loyalty

Policy No. 210

Effective Date: 12/2014

Confidentiality

Each employee is responsible for safeguarding confidential information obtained in connection with his or her employment. Employees may be required to sign a confidentiality agreement and/or non-compete agreement as a condition of employment or continued employment with DBH. From time-to-time, these agreements may be altered and DBH may ask that all existing employees cooperate in the execution of these agreements.

In the course of your employment, you may receive or be exposed to information regarding DBH, co-workers, clients, suppliers, vendors, margins, sales profits, business plans, financial information, and other information which DBH considers proprietary and/or confidential. You are required to maintain strict confidentiality with

respect to information pertaining to DBH's business and operations and any such information regarding its clients. Such information should not be discussed with anyone other than DBH's employees with a legitimate need to know.

Employees may not remove or make copies of any DBH records, reports or documents without prior management approval. Inappropriate disclosure of proprietary and/or confidential information or removal of records may result in disciplinary action up to and including dismissal, whether or not the employee personally benefits from the disclosure of such information.

Loyalty

Employees have an obligation to conduct business within guidelines that prohibit actual or potential conflicts of interest. This policy establishes only the framework within which DBH wishes the business to operate. The purpose of these guidelines is to provide general direction so that employees can seek further clarification on issues related to the subject of acceptable standards of operation. Contact the Human Resources Director for more information or questions about conflicts of interest. It is the duty of the employee to notify DBH if conflicts of interest occur.

Use of Communication Instruments & Facilities

Policy No. 211

Effective Date: 4/2007

Personal Use of Computers and Facilities

DBH equipment such as computers, printers, phones, copy machines, the Internet and other equipment are provided for legitimate business-related uses. The use of DBH equipment or resources for projects which result in personal gain, wages or pay is prohibited and may result in disciplinary action. This equipment may only be used for personal purposes or community service with your supervisor's permission. DBH's equipment and resources may not be used for personal reasons during the employee's regular working hours. You may use a personal computer after hours for personal purposes (i.e. papers for school, keeping a personal journal, etc.) if you have made prior arrangements for the use of a particular computer.

Outside Software and Games

All outside software (including shareware or other software brought in across the Internet) must be pre-approved by your immediate manager and must be work-related. Verification must be made that outside software is virus free before it can be installed on any company computer. Under no conditions will DBH condone the use of unlicensed or pirated software for any reason or at any time. Any employee that is found to have unauthorized software on their computer will face disciplinary action up to and including immediate termination.

Personal Telephone Use

Every employee should limit personal calls made from or received at DBH as much as possible. Unnecessary personal telephone calls during working hours are not only disruptive to your productivity, but in many cases are also disruptive to the people around you. If a personal call cannot be avoided, it should be as brief as possible. This includes calls made during your lunch break, as it is important not to tie up the phone lines for personal reasons. You are prohibited from receiving personal long distance calls on the 800 lines. Long distance calls for personal reasons should never be made unless approved by management and should be reimbursed to the DBH. Abuse of this policy can result in disciplinary action.

Monitoring of Communication Instruments and Facilities

DBH may provide employees with use of electronic and other information systems such as the telephone system, cellular telephone, computer system, e-mail, the Internet, voice mail, and other ("Communication Systems"). DBH's Communication Systems are intended for your use as a DBH employee for business-related purposes. However, DBH's confidentiality and business interests require DBH to reserve the right to access and, when appropriate, disclose information created or sent on, or deleted from its Communication Systems. You should therefore refrain from using DBH's Communication Systems for personal communications which you consider confidential.

With respect to the use of voice mail, e-mail and the Internet, DBH employees are prohibited from using unauthorized codes, passwords or other means to gain access to voice mail boxes or e-mail of others. All Communication Systems must be used in a professional and appropriate manner and with courtesy. Communicating on these Communication Systems should be treated the same as distribution of a written document. Rude, inappropriate or offensive messages with racial, sexual, religious or other harassing content are strictly prohibited.

Use of Cellular Phones and Other Wireless

Policy No. 212

Effective Date: 4/2007

The use of a cellular phone or other wireless device while driving may present a hazard to the driver, other employees, and the general public. All employees must take care to ensure the safe operation of company vehicles and the operation of private vehicles during work hours and while conducting business. DBH encourages the safe use of cellular phones and other wireless devices by employees who use such devices to conduct business for DBH.

Employees must follow all federal, state, and local rules and regulations concerning the use of cellular phones and other wireless devices while driving.

Employees should remember that while driving their primary responsibility is driving and obeying the rules of the road. Employees will need to take extra caution when using cellular phones while driving. It is strongly recommended that the employee safely pull off the road and come to a complete stop before using a cellular phone or other wireless device while driving.

Unless otherwise authorized, company provided cell phones must be used only for business purposes. In addition, employees should use a company provided cell phone only when a less costly alternative does not exist. Employees must fully reimburse DBH for any personal use of a company provided cell phone.

Violation of this policy may subject an employee to disciplinary action up to and including termination.

Conflicts of Interest/Secondary Employment

Policy No. 213

Effective Date: 4/2007

In order to preserve the common corporate interest in a continued, efficient and profitable operation and to protect DBH and its employees' reputation for integrity, a statement of policy is needed to:

- Define clearly the rights and responsibilities of DBH's employees in their direct or indirect business relationships with outside individuals, companies and organizations; and
- Establish an effective procedure for disclosure of transactions or situations in which there may be actual or potential conflicts with DBH's interests.

Definitions

Conflict of Interest

DBH defines a conflict of interest as any situation in which financial, professional, or personal interests, including the interests of immediate family members, may compromise one's professional judgment or professional or business obligations.

Conflicts of Interest can occur in one of three ways:

- **Dual Employment.** Conflicts of interest can occur when DBH employees and/or subcontractors are also employed by the State of Utah or by another of DBH's representatives.
- **Related-Party Transactions.** Conflicts of interest occur when DBH makes payments to a related party using money obtained from DHS/DSAMH through this contract. Conflicts of interest also occur when transactions, which affect the performance of this Contract, are made between DBH and a related party, whether or not payments are involved.
- **Independent Judgment Impaired.** Conflicts of interest occur when DBH's employees or subcontractors participate in any transaction on DBH's behalf and have a significant relationship of shared interest with another party to the transaction, which could affect a representative's ability or willingness to exercise independent judgment, and which may affect the performance of the Contract.

Statement of Policy

It is the policy of DBH to recognize and respect the rights of its employees to engage in outside financial, business or other activities which they may deem proper and desirable PROVIDED that: (1) such outside activities are legal; (2) such activities do not impair or interfere with the conscientious performance of DBH duties; (3) such activities do not involve the misuse of DBH's influence, facilities or other resources; and (4) such activities do not discredit the good name and reputation of DBH. Accordingly, for all business relationships with outside individuals and organizations and for all personal business undertakings, all DBH employees should:

- Act in accordance with the law, established DBH standards and their own good consciences.
- Consider the rights, interests and responsibilities of DBH, its subsidiaries, outside individuals and organizations and themselves.
- Protect professional reputations and the interests of DBH against actual or potential conflicting interests with outside parties.
- Not hold investments or any other direct or indirect financial interest in the business of a supplier or client of DBH, or in any enterprise to which financing accommodations are, or may be extended by DBH. (Investments are not intended to include ownership of securities in a publicly owned company if the investment by the employee or his/her immediate family is less than 1% of the outstanding stock of such company, except with respect to employees in a position to influence or affect the business relationship between the company and such publicly owned company). Investments in non-public, competing companies are prohibited.
- Avoid any attempt to preempt or usurp a corporate opportunity as, for example, to purchase or sell land or intellectual property rights in which DBH has or may have an interest.

- Avoid any interest in or relationship with an outside organization or individual having business dealings with DBH if this interest or relationship might tend to impair the ability of the employee to serve the best interests of DBH.
- Avoid doing business with a relative (or a company with which a relative is associated) on behalf of DBH unless the facts are disclosed and authorized approval is received in advance.
- Not accept any loan, gift or favor from a supplier or client or other source that has business relations with DBH. However, employees may accept gifts or favors of nominal value or casual entertainment that meet all standards of ethical business conduct.
- Not have a counseling practice in addition to their DBH employment to which clients may be referred from DBH.

Disclosure

This policy requires all DBH employees and subcontractors to submit a Conflict of Interest/Secondary Employment Disclosure Statement to the DBH Human Resources Department stating all existing, potential, and contemplated conflicts of interest that arise. This is to be submitted upon hire and when a conflict of interest arises (and prior to undertaking any activity that may raise potential conflict of interest). DBH Employees and subcontractors are required to submit an updated Conflict of Interest/Secondary Employment Disclosure Statement annually thereafter.

The Human Resources Director and Corporate Compliance Officer will review all disclosure statements for potential conflicts of interest. Factors being considered during this review include, but are not limited to, the following criteria:

- Whether the DBH employee or subcontractor or immediate family member is a party to, or may directly or indirectly benefit from, a proposed agreement or transaction involving DBH;
- Whether the DBH employee's or subcontractor's desire for, or expectation of, direct or indirect external economic advantage could distort a DBH activity;
- Whether the DBH employee or subcontractor or immediate family member is engaging in an activity, business, or transaction in which DBH is likely to engage;
- Whether the DBH employee's or subcontractor's outside activities may conflict with rights of, of their obligations to, DBH or DBH's clients;
- Whether there is an appearance of a conflict of interest.

Secondary Employment

DBH employees may hold outside jobs as long as they meet the performance standards of their job with DBH. All employees will be judged by the same performance standards and will be subject to DBH's scheduling demands, regardless of any existing outside work requirements. Any outside employment shall be disclosed to Human Resources Department on the Conflict of Interest/Secondary Employment Disclosure Statement. Similar to the guidelines established for reporting potential conflicts of interest, secondary employment is to be reported upon hire and when a conflict of interest arises (and prior to undertaking any activity that may raise potential conflict of interest).

If DBH determines that an employee's outside work interferes with performance or the ability to meet the requirements of DBH as they are modified from time to time, the employee may be asked to terminate the outside employment if he or she wishes to remain with DBH.

Outside employment that constitutes a conflict of interest is prohibited. Employees may not receive any income or material gain from individuals outside DBH for materials produced or services rendered while performing their jobs.

BCI Screening

Policy No. 214

Effective Date: 4/2/2007

The Department of Human Services, Office of Licensing requires all persons associated with DBH who have access to vulnerable adults or children to submit information for background clearances. All staff members with access to these protected populations must successfully pass an annual background screening in order to maintain their positions at DBH. The Human Resources Department or designated staff will initiate this action through notification of appropriate DBH supervisors and supply the necessary forms and instructions. DBH supervisors shall ensure their staff properly complete the forms and provide necessary documentation to the Human Resources Department in a timely manner.

When an employee is notified by the Office of Licensing that additional criminal background screening information is needed, such as fingerprinting, it is the responsibility of the employee to comply with all requirements and deadlines. Failure to provide the fingerprint card and fee within ten days may result in the application being denied, and the employee will not be eligible to participate in the program in any capacity until clearance procedures are completed. If not resolved, this may also result in termination of employment.

DBH will reimburse the processing fee paid to the Office of Licensing for a more extensive background screening. The employee is to complete an "In-State Travel and Expense Voucher," listing the expense in "Reimbursement for Other Expenses" and attach a receipt. The form is to be signed by the employee and the employee's supervisor and forwarded to Accounts Payable. The employee will be responsible to pay the fingerprinting charge.

Credited Service

Policy No. 215

Effective Date: 4/2007

Revision Date: 3/2011

Credited service is used to determine:

- Eligibility for accrual rates for Vacation and Sick Leave (refer to Policy 303 – Vacation Benefits)
- Calculation of service recognized for service awards

Credited service is calculated from the original date of hire. The original hire date for employees returning to work at DBH under the terms of re-hire or reinstatement is defined in Policy 202 – Employment Status and Categories.

One month of service is accrued for each calendar month you work as an active employee.

Absences resulting from leaves for military service or approved medical leave will not be considered a break-in-service and will count toward credited service.

Change in Status

When an employee has a change in status without a break-in-service, from part-time or temporary employment to regular full-time, the date of employment of the part-time or temporary position will be used as the basis for the credited service.

Credited Service for Employee Benefits

The service requirements for all benefit plans are defined by the individual plan documents. Whereas the original date of employment is used as the basis for determining credited service for vacation and sick leave benefits, the day an employee becomes eligible for benefit participation will serve as the start date for credited service for retirement and other benefits.

Work Schedules

Policy No. 300

Effective Date: 3/2011

Work schedules at Davis Behavioral Health are established to meet the needs of our consumers and the agency. Program Supervisors, with the approval of Program Directors, determine the specific schedules for their assigned departments.

Standard Work Week

The standard work week for timekeeping purposes is 12:01 am on Friday through 12:00 midnight on the following Thursday.

Standard Work Schedules

Davis Behavioral Health defines a standard work schedule as five (5) 8-hour shifts per week for regular full-time staff and five (5) 6 to 8-hour shifts per week for 75% full-time staff. Schedules for regular full-time and 75% full-time employees should not exceed five (5) days in a standard work week.

Shift Differential

Non-exempt employees who work at the Crisis Recover Unit (CRU), Men's Recovery Center (RMC), and Women's Recovery Center (WRC) are eligible to received shift differential pay as outlined below:

Shift	Start Time	End Time	Differential
Swing	5:00 pm	12:00 am	2%
Graveyard	12:00 am	6:00 am	3%

Shift differentials are added to the hourly wages for employees for all hours worked during the defined periods.

Alternative Work Schedules

Davis Behavioral Health may accommodate alternative work schedules (AWS) for its employees. DBH has determined that the following alternative work schedules may be available for its employees:

Schedule	Hours						Comments
	Day 1	Day 2	Day 3	Day 4	Day 5	Total	
4 x 10	10	10	10	10	--	40	
4 x 9; 1 x 4	9	9	9	9	4	40	
3 x 13 1/3	13 1/3	13 1/3	13 1/3	--	--	40	Residential Nurses Only

Individual employees may be permitted, with the consent of their supervisor and the approval of appropriate management to work alternative schedules. Approval of alternative work schedules for individual employees

will be based upon sound business judgment, consideration of the employee's job performance, special needs, employee's attendance and timeliness, and any disciplinary issues. Certain positions may not be eligible for an alternative work schedule due to program needs or the job duties assigned to the position.

Employee requests to work an alternative work schedule other than the three (3) schedules outlined above must be approved by members of the Executive Leadership Team (ELT).

Employees interested in working an alternative work schedule must complete an "Alternative Work Schedule Request Form" and submit it to their immediate supervisor. The form will then be submitted to the Program Director for review and approval. All approved alternative work schedule requests will go through a 90-day trial period after which the schedule will be reviewed and a decision made whether or not to continue the alternative schedule. No alternative work schedule will be implemented that results in an employee working less than the positions budgeted hours.

Employees on probation at DBH are not eligible to work an alternative work schedule until the probationary period is successfully completed.

Alternative work schedules are not an entitlement or right at Davis Behavioral Health.

Termination of Alternative Work Schedule

Alternative work schedules are subject to periodic review and may be subject to termination based on business needs and my performance. If possible, DBH will provide 30 days' notice in advance of ending or changing an arrangement, business needs permitting. In some instances, a resumption of the original work schedule may no longer be possible.

Lunch and Break Periods

Lunch

Program supervisors may require employees to take a non-compensated lunch period. When required, lunch periods should be between 30 minutes and one (1) hour in length. Lunch periods extending beyond one hour should be approved beforehand by the employee's immediate supervisor.

Breaks

Employees may take a 15-minute compensated break for every four (4) hours worked. Breaks cannot be used at the beginning or end of an employee's shift or accumulated to accommodate a shorter work day or longer lunch period.

[Alternate Work Schedule \(AWS\) Request Form](#)

Attendance and Punctuality

Policy No. 301

Effective Date: 1/2013

Excessive absenteeism causes problems in providing an adequate qualified workforce to meet DBH's work load. If you find it necessary to be absent from work, you must notify your supervisor as far in advance as possible, and under no circumstances later than the scheduled beginning of your work shift. If you are absent on consecutive days, you must call in each day of your absence to enable your supervisor to adjust the work

schedule of your department. A note from a medical provider is required on the third consecutive day an employee is absent from work due to illness. This note must be given to the employee's immediate supervisor, who will then forward it to the Human Resources Department to be added to the employee's personnel file.

If an employee is absent for two consecutive days without notifying his or her supervisor, the employee will be deemed to have voluntarily terminated employment with DBH.

Paid Holidays

Policy No. 302

Effective Date: 4/2007

Revision Date: 12/2018

Paid Holidays

Policy No. 302

Effective Date: 4/2007

Revision Date: 12/2013

Davis Behavioral Health provides eligible employees up to eleven paid holidays during the calendar year. The current paid holidays are:

- New Year's Day – **Premium Holiday**
- Martin Luther King Jr. Day (3rd Monday in January) – Regular Holiday
- Presidents' Day (3rd Monday in February) – Regular Holiday
- Memorial Day (Last Monday in May) – Regular Holiday
- Independence Day – **Premium Holiday**
- Pioneer Day – Regular Holiday
- Labor Day (1st Monday in September) – Regular Holiday
- Veterans' Day (November 11) – Regular Holiday
- Thanksgiving (4th Thursday in November) – **Premium Holiday**
- Day After Thanksgiving – Regular Holiday
- Christmas – **Premium Holiday**

Working on Holidays

Employees working in residential, day treatment and other departments at DBH may be required to work on a scheduled company holiday to provide continuous care for clients. Employees who meet the paid holiday benefit eligibility requirements outlined above and are scheduled to work on a paid holiday may submit an advance request for leave, but this does not guarantee leave will be granted. For employees required to work on company holidays compensation for the worked holiday is defined below:

Full-time and Part-time Non-exempt Employees

Premium Holidays

All employees required to work on a premium holiday will be compensated at double pay for all hours worked on the calendar day of the holiday, beginning at 12:00 am at the beginning of the holiday and terminating at 12:00 am at the end of the 24-hour period. In the instance when an employee's shift overlaps the start time and end time of a premium holiday, all hours worked outside of the 24-hour holiday will be compensated at the employee's regular pay rate.

Regular Holidays

All employees required to work on a regular holiday will be compensated at time and a half pay for all hours worked on the calendar day of the holiday, beginning at 12:00 am at the beginning of the holiday and terminating at 12:00 am at the end of the 24-hour period. In the instance when an employee's shift overlaps the start time and end time of a regular holiday, all hours worked outside of the 24-hour holiday will be compensated at the employee's regular pay rate.

Employees required to work on any company holiday who receive the holiday pay premium will not receive an additional paid day off at a later time for that holiday.

Full-Time Exempt Employees:

- No change in the rate of pay for the worked holiday.
- If **required** to work on a regular holiday, may "flex" the worked holiday to a different day.
- If **required** to work on a premium holiday, may "flex" the worked holiday to a different day and receive an additional paid day off.
- If opting to work on a holiday may do so with supervisor permission. Employee must "flex" the worked holiday to a different day.

Rescheduled holiday leave must be used during the fiscal year in which the regular holiday falls, ending June 30th each year. All rescheduling of holiday leave should be communicated to supervisors at the employee's earliest convenience.

Vacation Benefits

Policy 303

Effective Date: 4/2007

Revision Date: 3/2011

Vacation time off with pay is available to eligible employees to provide opportunities for rest, relaxation, and personal pursuits. Employees in the following employment classification(s) are eligible to earn and use vacation time as described in this policy:

- Regular full-time employees
- 75% full-time employees

The amount of paid vacation time employees receive each year increases with the length of their employment as shown in the following schedule:

	Regular Full-Time		75% Full-Time	
Year	Days per Year	Hours per Pay Period	Days Per Year	Hours Per Pay Period
0-5	13	4	9.75	3
6-10	16	4.92	12	3.69
11-15	19	5.85	14.25	4.38
16+	22	6.77	16.5	5.08

Employees classified as 75% full-time must work at least 60 hours per pay period to be eligible to accrue vacation leave. If an employee in this classification is approved to work beyond scheduled 60 hours, leave will be accrued on a per-hour basis per hours worked up to 80 hours in a pay period.

Credited service guidelines are outlined in Policy 215 – Credited Services.

Once employees enter an eligible employment classification, they begin to earn paid vacation time according to the schedule. They can request use of vacation time after it is earned. Employees who are on an approved "Leave of Absence" will not accrue paid vacation leave during that period of time. Accruals will resume once an employee returns from leave.

To take vacation, employees should request advance approval from their supervisors. Requests will be reviewed based on a number of factors, including business needs and staffing requirements.

Vacation time off is paid at the employee's base pay rate at the time of vacation. It does not include overtime or any special forms of compensation such as incentives, commissions, bonuses, or shift differentials.

As stated above, employees are encouraged to use available paid vacation time for rest, relaxation, and personal pursuits. In the event that available vacation is not used by the end of the calendar year, employees may carry unused time forward to the next calendar year. Unused vacation leave may accrue up to 360 hours. After the processing of the last pay check of the calendar year, any accrued and unused vacation leave in excess of 360 hours will be forfeited. The Human Resources Director may approve exceptions to forfeiture if business requirements do not allow the employee to use annual leave. Forfeiture of accrued vacation leave in excess of 360 hours will occur before conversion of accrued unused sick leave.

Upon termination of employment, employees will be paid for unused vacation time that has been earned through the last day of work.

Former employees rehired after military service or reinstated from reduction in force status shall assume the same eligibility for vacation accrual they had before their termination.

An employee cannot sell his/her vacation time back to DBH while they are still working.

To donate vacation time to another for use as sick leave (See policy 308).

Saturdays, Sundays, and legal holidays occurring during a period in which vacation leave has been granted shall not be charged against accrued vacation leave.

Sick Leave Benefits

Policy No. 305

Effective Date: 4/2007

DBH provides paid sick leave benefits to all eligible employees for periods of temporary absence due to illnesses or injuries. Employees in the following employment classification(s) are eligible to earn and use vacation time as described in this policy:

- Regular full-time employees
- 75% full-time employees

Eligible employees will accrue sick leave benefits at the rate of 12 days per year (1 day for every full month of service). Sick leave benefits are calculated on the basis of a "benefit year," the 12-month period that begins when the employee starts to earn sick leave benefits. Employees working less than forty (40) hours per week shall accrue sick leave on a prorated basis.

	Regular Full-Time		75% Full-Time	
	Days per Year	Hours per Pay Period	Days Per Year	Hours Per Pay Period
Accruals	12	3.7	8	2.775

Employees classified as 75% full-time must work at least 60 hours per pay period to be eligible to accrue sick leave. If an employee in this classification is approved to work beyond scheduled 60 hours, leave will be accrued on a per-hour basis per hours worked up to 80 hours in a pay period

Paid sick leave can be used in minimum increments of one hour. An eligible employee may only use sick leave benefits for an absence due to his or her own illness or injury, or that of a child, parent, or spouse of the employee.

Paid sick leave cannot be used for vacation or other related personal leave.

Employees who are unable to report to work due to illness or injury should notify their direct supervisor before the scheduled start of their workday if possible, but no later than one hour after normal starting time. The direct supervisor must also be contacted on each additional day of absence. If an employee is absent for three or more consecutive days due to illness or injury, a physician's statement may be provided verifying the disability and its beginning and expected ending dates. Such verification may be requested for other sick leave absences as well and may be required as a condition to receiving sick leave benefits. Before returning to work from a sick leave absence of 30 consecutive days or more, an employee may be asked to provide a physician's verification that he or she may safely return to work. Such proof shall be furnished within 5 calendar days of request.

Sick leave benefits will be calculated based on the employee's base pay rate at the time of absence and will not include any special forms of compensation, such as incentives, commissions, bonuses, or shift differentials. Employees who are on an approved "Leave of Absence" will not accrue paid sick leave during that period of time. Accruals will resume once an employee returns from leave. Unused sick leave benefits will be allowed to accumulate indefinitely.

Sick Leave Incentive Program

Employees who accrue and maintain 120 hours of sick leave will become eligible to participate in the sick leave incentive program. During a fiscal year in which an employee is eligible, one-third (1/3) of unused sick leave which accrued during the year (not the total accrued balance) may be converted to a corresponding amount of either pay or vacation leave after the processing of the last pay check of the year. After subtracting the converted sick leave, the remaining unused annual sick leave shall be accrued for future use. Conversion shall occur after vacation leave in excess of 360 hours has been forfeited.

Sick leave benefits are intended solely to provide income protection in the event of illness or injury, and may not be used for any other absence. Unused sick leave benefits will not be paid to employees while they are employed or upon termination of employment except as noted in the following:

Retirement

Employees who meet the retirement guidelines of the Utah State Retirement System and who apply and are approved to receive retirement payments or employees who terminate with ten (10) or more years of service with DBH shall be eligible to be paid for one-third (1/3) of all accrued unused sick leave. Employees discharged from DBH shall not be eligible for this benefit.

See Leave Donation Policy (308)

An employee whose status changes so that he/she is no longer eligible for sick leave shall have his/her balance maintained in their payroll file but shall not be eligible to use it. If the employee returns to a status eligible to receive sick leave, the balance will be restored and available for use.

Family and Medical Leave

DBH complies with the Family and Medical Leave Act of 1993, which protects employees' jobs and benefits in the event of a medical or family circumstance which requires the employee to take time off from work without pay. Family and medical leaves are granted as follows:

Eligibility

Employees are eligible for family and medical leave if they have been employed at least 12 months and have worked at least 1,250 hours in the 12-month period preceding the leave. Additionally, the employee must work at a DBH facility where at least 50 employees are employed by DBH within 75 miles of the facility.

Circumstances Permitting Family and Medical Leave

DBH will provide up to 12 weeks of leave without pay within any 12-month period to an eligible employee for any of the following reasons:

- * Birth of an employee's child (within 12 months after birth)
- * Adoption of a child by an employee (within 12 months after placement)
- * Placement of a child with the employee for foster care (within 12 months after placement)
- * Care of a child, spouse or parent having a serious health condition
- * Incapacity of the employee due to a serious health condition.

A "serious health condition" entitling an employee to FMLA leave means an illness, injury, impairment, or physical or mental condition that involves in-patient care or continuing treatment by a health care provider. Leaves may be limited to the duration of the serious health condition up to 12 weeks. DBH will require a physician to certify the necessity of any medical leave and DBH may require a second opinion concerning the need for a medical leave. When a second opinion is required by DBH, it will be obtained from an independent provider at DBH's expense. The "Medical Certification" form can be obtained from the Human Resources Department. Please return it as soon as possible, but no later than 15 days after DBH requests a certification. If you fail to return a requested certification, you may lose your protection under the FMLA and therefore be considered absent without a valid excuse.

DBH will grant intermittent or reduced-schedule leave if a health care provider certifies that it is medically necessary. Whenever possible, medical treatments should be scheduled so as not to disrupt DBH operations. To better accommodate your intermittent or reduced-schedule leave, we may temporarily transfer you to another job with equivalent pay and benefits.

Length of Leave

No leave or combination of leaves under this policy may exceed 12 weeks in a 12 month period. The 12 month period is the 12 month period measured forward from the date your first FMLA leave begins. Spouses who both work for DBH may be limited to a combined total leave of 12 weeks in the 12 month period for the birth or placement of a child or to care for a parent with a serious health condition.

Coverage

Eligible employees can take up to 12 weeks of leave each calendar year. Upon completion of leave, the employee will be allowed to return to the same position the employee held when leave commenced, or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment.

During an approved family or medical leave, the employee will not suffer loss of insurance benefits. The employee will be required to pay his/her share of the monthly insurance premiums which will be due on the first day of each month during the leave period. Should the employee elect not to return to work and continue working for at least 30 days after the medical or family leave has expired, the employee will be required to reimburse DBH for all insurance premiums paid during the FMLA leave. Upon return from an approved leave, the employee will return with the benefits and seniority they had before the leave commenced.

Employees are not permitted to work for another employer during family and medical leave without prior approval of DBH.

Leave Requests and Notice Requirements

To apply for family and medical leave, the employee must fill out specific forms and follow particular procedures. If you believe a family or medical leave is required, please contact the Human Resources Department to obtain appropriate forms and information so that your request for leave can be appropriately processed.

You must complete a written "Request for Leave" at least 30 days before you begin FMLA leave. This form is available from and must be returned to the Human Resources Department. If 30 days notice is not possible, you must notify us as soon as you can, no more than two business days after you learned that you would need leave. Otherwise, your leave may be delayed for 30 days following notice of your need for leave. For unexpected leave, you must contact your supervisor directly either before work or as soon after your starting time as possible. You must complete a "Request for Leave" form as soon as you can. If you are unable to give us notice yourself, a responsible person or family member must call.

If you are absent from work and do not comply with the procedures in this policy, we will apply our usual attendance policy rules. An unexcused absence may result in disciplinary action, up to and including termination.

While on leave, you must periodically contact your supervisor about your status, including your intent to return to work. A call-in schedule will be arranged after you notify your Supervisor of your need for FMLA leave. Failure to follow the schedule will result in discipline, up to and including termination.

Substitution of Paid Time Off

Earned paid time off must be used at the same time as your unpaid FMLA leave. Substitution of paid leave will be allowed to the extent the circumstances meet DBH policy requirements for use of that type of paid leave. If you are already receiving payment under workers' compensation or a temporary disability plan, you cannot use accrued paid leave at the same time. The use of paid time off and any other paid leave does not extend the 12-week maximum for FMLA leave.

Return from Leave

If leave is due to your own serious health condition, you must provide timely medical certification of fitness-for-duty before returning to work. Employment restoration may be delayed or denied if you fail to provide a fitness-for-duty certification.

If you do not return to work or contact the Human Resources Department within 24 hours of your agreed-upon return date, we will assume that you have voluntarily resigned.

Upon return from leave, you will normally be reinstated to the same job or a job with equivalent pay, benefits and working conditions. Please note, however, that you have no greater rights to a job when you return than if you had continued to work during the leave period. When you return from FMLA leave, you will have the same benefits you had when you began leave, minus any benefits used during leave.

If you are a key employee, we may deny you reinstatement if it will cause DBH substantial and grievous economic harm. A key employee is a salaried FMLA-eligible employee who is among the highest-paid ten percent of all DBH's workers within 75-miles of the employee's worksite.

Unpaid Leave

Policy No. 306

Effective Date: 4/2007

Taking a day off without pay may be allowed only in extremely exceptional circumstances when available PTO has been exhausted. Days without pay must be arranged through your supervisor in advance of use, and must be approved in writing by the Chief Executive Officer. Neglecting to get advance approval will result in the absence being treated as unexcused and may result in disciplinary action. Please be aware of the number of PTO you have accrued and allow a cushion for unplanned emergencies.

Other Special Leave

Policy No. 307

Effective Date: 4/2007

Military Leave

DBH employees who have military reserve obligations of less than two weeks will be given the appropriate amount of time off without pay to perform such duty. Employees with such military obligations may opt to use PTO for such absences.

DBH employees who are absent on military leave for a period of more than two weeks will be entitled to reemployment upon the conclusion of military leave as governed by the Uniform Services Employment and Reemployment Rights Act of 1994 and any other applicable law. An individual reemployed upon the conclusion of military leave does not lose any seniority credit earned for employment prior to the military leave.

Bereavement Leave

DBH full-time employees may receive up to five days of paid bereavement leave in the event of the death of an immediate family member and up to three hours for other relatives or close friends to travel, make funeral arrangements, and to attend the funeral services. An immediate family member is a spouse, child, parent, son or daughter-in-law, parent-in-law, grandchild, brother, sister or brother or sister-in-law or, with supervisor pre-approval, another person whose association with the employee was similar to such relationship.

Jury Leave

DBH full-time employees required to serve on a jury may, with proof of attendance, receive paid leave (less any amount received for jury service) for the period of jury service up to 5 days. Employees performing jury service

will continue to accrue credit for seniority and paid time off. No adverse employment action will be taken against any employee as a result of the employee's fulfillment of this important civic obligation.

Leave Donation

Policy No 308

Effective Date: 3/2011

Davis Behavioral Health established a leave donation program to help employees who have a short-term need and have used up all of their paid sick and vacation leave. Employees must complete a "Leave Donation Request Form" with their immediate supervisor to initiate the leave donation process. Request forms should be submitted to the Human Resources Director who will take the request to the Executive Leadership Team for approval.

The Human Resources Department will communicate approval/denial to the employee and will send an e-mail to all DBH employees requesting donations for all approved requests.

This policy is intended to allow employees to elect to provide additional support to an employee for a definable period of time until long-term disability or some other source of income can come into effect.

Only *vacation leave* hours may be donated to a specific individual for a specific event. Donated vacation leave is converted to sick leave when transferred to another employee. As outlined in Policy 304 – Sick Leave Benefits, sick leave benefits can only be used for an absence due to his or her own illness or injury, or that of a child, parent, or spouse of the employee. All Leave donations are transferred as hour units and do not carry a specific monetary value.

Employees can only donate leave when an approved request is in place. Employees cannot donate vacation leave that would normally be lost at the end of the calendar year unless it is possible for the donating employee to take the annual leave before the calendar year ends.

Employees must exhaust all personal accrued leave before leave donations will be available for use. Donations are directly associated with a specific event and time period. All unused leave donations will be returned to the donating employee(s).

[Leave Donation Request Form](#)

Employees Serving as Witnesses

Policy No. 309

Effective Date: 4/2007

All subpoenas or requests for expert witnesses, court appearances, depositions, document productions, etc. are to be presented to the Subpoena Officer for DBH. Only the Subpoena Officer of DBH will authorize staff to appear as witnesses after consulting with legal counsel.

Appearances of Behalf of DBH

DBH encourages employees to appear in court for witness duty when subpoenaed to do so. If employees have been subpoenaed or otherwise requested to testify as witnesses by DBH, they will receive paid time off for the entire period of witness duty and will be reimbursed for mileage at prevailing DBH rates. Witness and mileage fees paid to employees in connection with such appearance shall be remitted to DBH.

The subpoena should be shown to the employee's supervisor and the DBH Subpoena Officer immediately after it is received so that operating requirements can be adjusted, where necessary, to accommodate the employee's absence. The employee is expected to report to work whenever the court schedule permits.

In appropriate cases, DBH may charge an expert witness fee for appearances by DBH employee, which will include all travel time to and from the destination, appearance as witness, and incurred expenses. The fee will be determined by the President/CEO.

Requests which are not the result of a subpoena must be accompanied by sufficient information to allow DBH to bill for employee appearances.

Appearances for a Private Party of Interest

A request shall be made in writing to the Subpoena Officer of DBH to authorize an employee to act as an expert witness for a private party or interest. DBH will not pay remuneration to any employee for the time such employee spends with respect to act as an expert witness. Authorization to act as an expert for a non-DBH interest must be in writing. In the event a fee is received by the employee for time acting as an independent expert, such pay may be retained by the employee.

The employee must fully describe to the DBH Subpoena Officer the nature of the case, the opinions to be rendered, and the relation, if any, of the case to DBH employment. It is the employee's responsibility to insure that the DBH Subpoena Officer is fully informed of any potential conflicts of interest at the time authorization is requested.

Employees will be granted unpaid time off to appear in court as a witness when requested by a party other than DBH. Employees are free to use any available paid leave benefit to receive compensation for the period of this absence.

Protected Disabilities

Policy No. 310

Effective Date: 8/2012

Davis Behavioral Health is committed to complying fully with the Americans with Disabilities Act (ADA) and ensuring equal opportunity in employment for qualified persons with physical or mental disabilities. All employment practices and activities are conducted on a non-discriminatory basis.

Hiring procedures provide persons with disabilities meaningful employment opportunities. Pre-employment inquiries are made only regarding an applicant's ability to perform the essential functions of the position.

DBH will make reasonable accommodation(s) to the known physical or mental limitations of qualified applicants or employees with disabilities to enable them to perform the essential job duties, unless such accommodation(s) would impose an undue hardship on the operation of the agency. All accommodation requests will be made through the Human Resources office.

Qualified individuals with disabilities are entitled to equal pay and other forms of compensation (or changes in compensation) as well as in job assignments, classifications, organizational structures, and position descriptions. Leave of all types will be available to all employees on an equal basis.

DBH is also committed to not discriminating against any qualified employees or applicants because they are related to or associated with a person with a disability. The agency will follow any state or local law that provides individuals with disabilities greater protection than the ADA.

This policy is neither exhaustive nor exclusive. DBH is committed to taking all other actions necessary to ensure equal employment opportunity for persons with disabilities in accordance with the ADA and all other applicable federal, state, and local laws.

DBH reserves the right to make exceptions from any of the guidelines contained in this Handbook in order to implement or satisfy the reasonable accommodation requirements imposed by the Americans with Disabilities Act.

Payroll & Timekeeping

Policy No. 401

Effective Date: 4/2007

Payroll checks to all employees are distributed biweekly for the previous period. Payroll is distributed by direct deposit (wire transfer). Should payday fall on a holiday, checks will be issued the day before. Every effort is made to avoid paycheck errors. Please report any error to your supervisor or to the Payroll Office at once so that it can be corrected.

Hourly employees are required to record their hours manually. Federal and state laws require DBH to keep an accurate record of time worked in order to calculate employee pay and benefits. Time worked is all the time actually spent on the job performing assigned duties.

All employees are required to complete and turn in a bi-weekly time sheet by 9:00 a.m. on the Friday after the end of the pay period. Employees who have scheduled leave shall make arrangements to turn in their time sheet in advance of this deadline. Employees away due to illness or emergency shall contact their supervisor as soon as possible after the submission deadline.

Overtime work must always be approved, in writing, before it is performed. Employees are responsible to clearly communicate hours worked and leave taken and to have followed appropriate policies regarding overtime and leave. Payroll will only process those time sheets, which are submitted according to policies and procedures. Circumstances that are different from the usual work schedule must be explained in the "Comments" column.

Exempt employees must record approved PTO hours on time sheets.

Time cards must reflect your actual hours of work. Each employee is responsible for his/her own timecard. Employees may not record the start or stop time for another employee. Altering, falsifying, tampering with time records, or recording time on another employee's time record may result in disciplinary action, up to and including termination of employment.

It is the employees' responsibility to sign their time records to certify the accuracy of all time recorded. The supervisor will review and then sign the time record before submitting it for payroll processing. In addition, if

corrections or modifications are made to the time record, both the employee and the supervisor must verify the accuracy of the changes by initialing the time record.

Hours worked and leave taken will be reported to employees on a pay stub which will reflect the official records.

Overtime

Policy No. 402

Effective Date: 1/2015

From time-to-time, it may be necessary to have our employees work extra hours in order to meet a deadline or accomplish an important goal. Exempt employees do not receive overtime compensation (money or time) under normal circumstances. They are expected to work all hours necessary to perform their assigned duties.

If you fall into the category of non-exempt, you will receive overtime pay for all hours actually worked in excess of 40 during the work week. PTO or other leaves do not count as hours worked for purposes of overtime. No overtime is to be worked without prior approval from your direct Supervisor. Working overtime hours without proper authorization will result in disciplinary action up to and including termination.

Multiple Pay Rates

On occasion, employees may be approved to work in additional capacities at DBH that result in having multiple rates of pay. If an employee who has been approved to work in this manner works over 40 hours in a work week and becomes eligible for overtime earnings, the overtime will be calculated at one and a half times the regular rate associated with the job that caused the overtime to occur, as allowed under section 207 (g) (2) of the Fair Labor Standards Act ([29 CFR 778.419](#)). Please refer to the following example:

Regular earnings for full-time core position (Job A):

- \$15.00 per hour

Earnings for additional capacity (Job B):

- \$10.00 per hour (regular)
- \$15.00 per hour (overtime)

	Job A		Job B	
	Hours	Earnings	Hours	Earnings
Friday	8	\$120.00	--	--
Saturday	--	--	--	--
Sunday	--	--	--	--
Monday	8	\$120.00	12	\$180.00
Tuesday	8	\$120.00	--	--
Wednesday	8	\$120.00	12	\$180.00
Thursday	8	\$120.00	--	--
Total	40	\$600.00	--	\$360.00

Insurance Benefits

Policy No. 403

Effective Date: 4/2007

Revision Date: 9/2011

DBH provides several benefit programs to employees. The general terms of some of the benefit programs provided are outlined below. Keep in mind that the terms of all benefit programs are established and governed by the terms of the appropriate policy or plan. The information contained below is intended only to identify the general benefits available, but does not establish any of the terms or conditions of benefit programs. Any specific questions regarding the terms and conditions of benefit programs should be referred to the Payroll Department.

Medical Insurance

Davis Behavioral Health offers participation in the medical insurance program for the following classes of employees:

- Regular Full-Time – 40 hours per week
- 75% Full-Time – 30-39 hours per week

New employees joining DBH will be eligible for enrollment in the plan as of the Friday following the end of the previous pay period. DBH assists with payment of the medical insurance premium. Currently, premiums for the two eligible classes are as follows:

CLASS	DBH	EMPLOYEE
Regular Full-Time	82%	18%
75% Full-Time	58%	42%

Employees who reduce their hours below those assigned to their assigned class for two (2) consecutive pay periods will be reclassified to the lower class and premiums will be adjusted to the levels outlined above. In order to return to the previous class, the employee must work the required amount of hours for two (2) consecutive pay periods.

Dental Insurance

Davis Behavioral Health offers participation in the dental insurance program for the following classes of employees:

- Regular Full-Time – 40 hours per week
- 75% Full-Time – 30-39 hours per week

New employees joining DBH will be eligible for enrollment in the plan as of the Friday following the end of the previous pay period. DBH assists with payment of the medical insurance premium. Currently, premiums for the two eligible classes are as follows:

CLASS	DBH	EMPLOYEE
Regular Full-Time	50%	50%

75% Full-Time	25%	75%
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Employees who reduce their hours below those assigned to their assigned class for two (2) consecutive pay periods will be reclassified to the lower class and premiums will be adjusted to the levels outlined above. In order to return to the previous class, the employee must work the required amount of hours for two (2) consecutive pay periods.

Life Insurance

DBH provides a basic life insurance plan for full time employees and part-time employees who work at least 30 hours per week. This benefit pays two times the employees annual salary, rounded to the nearest \$1000. This benefit will begin to reduce at age 64 and further reduce as the employee becomes older. Additional supplemental and/or dependent life insurance coverage may also be purchased. Eligible employees may participate in the life insurance plan subject to all terms and conditions of the agreement between DBH and the insurance carrier.

Long-Term Disability

DBH provides a long-term disability benefit for its employees. Under the current plan contract, employees who are approved for long-term disability will receive 60% of their current wages after 90 days through the benefit provider while they remain eligible for the benefit. The employment status of employees who are approved to receive long-term disability benefits will be terminated once eligibility is met and/or FMLA leave is exhausted. For business purposes and the treatment of the consumers served by DBH, positions will not be held beyond this timeframe.

Employees who receive medical clearance to return to work may apply for current openings at DBH at that time.

Workers Compensation

Workers Compensation benefits are available to all employees who are injured on the job. The entire cost of the benefit is borne by DBH. All accidents must be reported to the Payroll Office immediately (no later than 24 hours after the occurrence). DBH must file a report with the State as soon as possible following the accident in order to not jeopardize payment of medical costs.

Unemployment Insurance

Taxes based on your pay are paid by DBH to provide partial income replacement for you in the event you are laid off or terminated through no fault of your own. If you quit work without cause or are terminated for just cause, you may be ineligible for unemployment benefits.

Social Security

Social Security taxes are paid partially by DBH and partially through deductions from your pay. In addition to providing some retirement income, the program helps your dependents in the event of your death and provides help with medical bills after retirement.

Educational Assistance

Policy No. 404

Effective Date: 4/2007

Updated: 4/2017

The skills and knowledge of DBH employees are critical to its success. DBH's educational assistance program

encourages personal development through formal education so that employees can maintain and improve job-related skills or enhance their ability to compete for reasonably attainable jobs within DBH.

DBH provides educational assistance to eligible employees who have completed 180 calendar days of service in an eligible employment classification as DBH funds are available. To maintain eligibility employees must remain on the active payroll and be performing their job satisfactorily through completion of each course. Employees in the following employee classification(s) are eligible for educational assistance:

* Full-time employees

*Part-time employees with a regular schedule of more than 30 hours per week

*Consulting professionals (with approval by the President and CEO)

Individual courses or courses that are part of a degree, licensing, or certification program must be related to the employee's current job duties or a foreseeable future position in the organization in order to be eligible for educational assistance. DBH has the sole discretion to determine whether a course relates to an employee's current job duties or a foreseeable future position. Employees should contact the Human Resource Director for more information or questions about educational assistance.

1. Full-time DBH employees who have been accepted into the DBH Educational Assistance Program will not receive payment for the practicum hours at DBH since the agency is paying a large portion of the tuition for the graduate program.
2. Participants are expected to continue their full-time positions at DBH and complete their practicum hours in addition to the required 40 hours of work.
 - a. Employees will maintain their status as a full-time, benefitted employee.
3. If participants would like to work a reduced or modified schedule compared to that they are currently working, they must submit an Alternative Work Schedule Request Form for approval (attached).
 - a. Any request that results in a reduction to the 40-hour full-time workweek will also influence benefits coverage, eligibility, and premiums. (i.e.: an approved request to work a 30-hour work week will result in insurance premiums and accruals moving to the 75%-full-time employee rates)

While educational assistance is expected to enhance employees' performance and professional abilities, DBH cannot guarantee that participation in formal education will entitle the employee to automatic advancement, a different job assignment, or pay increases.

Clinical staff and Support staff are eligible for DBH scheduled training to be arranged from time to time.

Funds available for individual training will be allocated at the beginning of the fiscal year (July 1 through June 30). Program Directors in consultation with the Human Resources Department will be responsible for determining how the money will be utilized best in promoting individual training at DBH, subject to budget requirements and other needs.

DBH personnel who attend workshops and use training funds may be asked to make in-service training presentations at quarterly general staff meetings and at training sessions held at the unit or program level.

Business Travel Expenses

Policy No. 405

Effective Date: 4/2007

DBH will reimburse employees for reasonable business travel expenses incurred while on assignments away from the normal work location. All business travel must be approved in advance by the employee's supervisor and

the Finance Department. Employees whose travel plans have been approved should make all travel arrangements through DBH's travel department.

Employees who are involved in an accident while traveling on business must promptly report the incident to their immediate supervisor. Vehicles owned, leased, or rented by DBH may not be used for personal use without prior approval.

When travel is completed, employees should submit completed travel expense reports within 30 days to their supervisor for approval and transmittal to the Finance Department. Reports should be accompanied by receipts for all individual expenses.

Garnishments

Policy No. 406

Effective Date: 4/2007

It is expected that each employee will meet his/her financial obligations without involving DBH. Wage attachments, garnishments, etc., are looked upon with disfavor. However, as required by applicable law, no employee will be discharged because earnings have been garnished in connection with any one judgment. The excessive amount of bookkeeping creates an unnecessary burden and additional expense for DBH.

DBH is required by law to honor any wage assignments served exactly as presented and will not enter into modifying agreements of any kind unless specifically instructed to do so by the court.

401(k) Pension/Profit-Sharing Plan

Policy No. 407

Effective Date: 4/2007

DBH has a 401 (k) profit sharing plan for full-time employees which has been established under the provisions of the Internal Revenue Code.

After you start work, and have completed the required eligibility requirements, you can enter the plan on the next entry date. To be eligible to become a participant in the plan, you must (i), have attained the age of 21, and (ii) work at least 20 hours per week (1,000 hours per year).

The terms of the 401 (k) profit-sharing plan are governed by the terms of the plan itself. The information contained in this Handbook is intended only to identify the general benefits available, but does not establish any of the terms or conditions of the plan. Any specific questions regarding the terms and conditions of the plan should be referred to the Payroll Office.

Employees who meet the retirement guidelines of the Utah State Retirement System and who apply and are approved to receive retirement payments or employees who terminate with ten (10) or more years of services with DBH shall be eligible to be paid for one third (1/3) of all accrued unused sick leave. Payout of this retirement incentive may be made as taxable income or deposited into an eligible retirement account. The standard one-third (1/3) conversion rate may be increased with Board of Directors approval to reward employees who are nearing retirement and have demonstrated increased loyalty to DBH during their years of service. Employees discharged from DBH shall not be eligible for this benefit.

Cafeteria Benefit Plan

Policy No. 408

Effective Date: 4/2007

DBH has a Cafeteria Benefit plan for full-time and part-time employees which has been established under the provisions of the Internal Revenue Code. The provisions allow each employee to choose from a menu of qualified benefits with the employee cost of selected benefits paid on a pre-tax basis. Examples of qualified benefits are health insurance, anticipated medical expenses, dependent child care and other insurance.

The terms of the Cafeteria Benefit Plan are governed by the terms of the plan itself. The information contained in this Handbook is intended only to identify the general benefits available, but does not establish any of the terms or conditions of the plan. Any specific questions regarding the terms and conditions of the plan should be referred to the Payroll Office.

Employee Assistance Plan

Policy No. 409

Effective Date: 4/2007

DBH cares about the health and well-being of its employees and recognizes that a variety of personal problems can disrupt their personal and work lives. While many employees solve their problems either on their own or with the help of family and friends, sometimes employees need professional assistance and advice.

Through the Employee Assistance Program (EAP), DBH provides confidential access to professional counseling services for help in confronting such personal problems as alcohol and other substance abuse, marital and family difficulties, and emotional distress. The EAP is available to all employees offering problem assessment, short-term counseling, and referral to appropriate community and private services.

The EAP is generally confidential and is designed to safeguard your privacy and rights. Information given to the EAP counselor may be released only if requested by you in writing. All counselors are guided by a Professional Code of Ethics.

Personal information concerning employee participation in the EAP is maintained in a confidential manner. No information related to an employee's participation in the program is entered into the personnel file.

There is no cost for employees to consult with an EAP counselor. If further counseling is necessary, the EAP counselor will outline community and private services available. The counselor will also let employees know whether any costs associated with private services may be covered by their health insurance plan. Costs that are not covered are the responsibility of the employee.

Information on EAP services is available through the Human Resources Director.

Generally, EAP will pay for up to 3 sessions with an appropriate mental health therapist who is not an employee of DBH, helping the employee to then take advantage of our insurance benefit for further needs.

Employee References

Policy No. 410

Effective Date: 4/2007

All requests for references must be directed to the Human Resource Director. No other manager, supervisor or employee is authorized to release references for current or former employees.

Sexual & Other Unlawful Harassment

Policy 501

Effective Date: 4/2007

DBH is committed to providing a work environment free of discrimination and unlawful harassment. Actions, words, jokes, or comments which exhibit disrespect or are demeaning to an individual's gender, race, ethnicity, age, religion, disability, veteran or marital status will not be tolerated.

DBH will not tolerate sexual harassment directed toward any person, irrespective of gender. Sexual harassment includes, but is not limited to, any of the following:

*Verbal, physical, or visual conduct of a sexual nature or suggestion which is unwelcome. Such conduct has the effect of unreasonably interfering with an individual's work performance, affects tangible job benefits, and may create an intimidating, hostile, or offensive work environment.

*Explicit sexual propositions, sexual innuendos, suggestive jokes, jokes about gender-specific traits, foul or obscene language or gestures, display of foul or obscene printed or visual material, and physical contact such as patting, pinching, or brushing against another's body.

*A circumstance where submission to or rejection of such conduct is used as the basis for decisions relating to employment.

*A circumstance where submission to or rejection of such conduct is a condition of employment, whether spoken or implied.

Examples of Sexual Harassment may include any of the following:

Verbal

Referring to an adult as a girl, hunk, doll, babe, honey, etc. or other demeaning terms

Whistling at someone; cat calls

Making sexual comments or innuendoes

Telling sexual jokes or stories

Asking personal questions about social or sexual life

Repeatedly asking out a person who is not interested

Loud, public, foul or abusive language

Non-Verbal

Looking a person up and down

Staring at someone

Displaying sexually suggestive visuals

Making sexual gestures with hands or body movements

Physical

Touching a person's clothing, hair or body

Giving a massage around the neck

Standing close or brushing up against a person

Grabbing

Pinching

Caressing

If you feel that you have been subjected to harassing conduct, contact the Human Resource Director immediately, or contact a member of management. Harassment is extremely serious misconduct, as is filing a

false statement that harassment has occurred, and may result in discipline, up to and including termination. Harassment may also subject the harasser to personal legal and financial liability.

DBH's practice is to fully investigate any complaints of harassment and to keep such complaints confidential to the extent practicable. However, DBH cannot promise anonymity to persons who report harassment. If DBH determines that sexually harassing conduct has occurred, appropriate remedial action may be taken up to and including termination.

DBH forbids retaliation in any form against anyone who has reported unlawful harassment. DBH will take corrective action up to and including termination against employees who harass, embarrass or retaliate in any respect against one who has made a complaint regarding unlawful harassment.

Drug & Alcohol Abuse

Policy No. 502

Effective Date: 4/2007

Sale, purchase, use, consumption, or possession of alcohol or a controlled substance or drug paraphernalia is prohibited during work hours or on DBH property, as is reporting to work under the influence of these substances so as to impair your ability to work. "Controlled substance" includes prescription drugs. Such drugs may be used only with a physician's prescription when your physician has granted you permission to use the drug at work. Violating this guideline may result in discipline up to and including termination.

DBH employees may be required to submit to appropriate drug testing during work hours, in accordance with DBH's Drug Testing Policies. Any failure or refusal to submit to testing, attempt to alter the result, or test results indicating an employee was working or on DBH premises under the influence of prohibited substances, or failure to report to management a violation or suspected violation of this guideline, warrants the imposition of discipline, up to and including termination.

DBH employees are required to notify DBH's Human Resource Director if they are convicted of any illegal drug violation within five days of such conviction. DBH asks all employees to make a good-faith effort to maintain a drug-free work place for the benefit of all concerned. DBH may periodically distribute information concerning drug education and awareness programs.

Solicitation

Policy No. 504

Effective Date: 4/2007

No employee is permitted to conduct any type of solicitation during working time including, for example, canvassing, collecting funds, soliciting pledges, circulating petitions, soliciting memberships in any organization or any other such activity undertaken for any purpose. Solicitations include but are not limited to efforts to raise or collect money for or support charitable or other causes, or to sell products or services.

No employee is permitted to distribute any non-company literature or other materials, such as leaflets, letters, petitions or any other written materials during working time or in working areas. As used in the guidelines, "working time" includes the time of the employees doing the soliciting or distribution and also the working time of the employee or employees to whom the soliciting or distributing is directed. No employee is permitted to distribute any such literature or other materials at any time in any DBH public area.

Persons not employed by DBH are not permitted, at any time or in any manner, on any DBH property to conduct any form of solicitation or to distribute any literature or other materials to any employee of DBH or to any visitor of DBH.

Accuracy of Billing Records; False Claim Act

Policy No. 505

Effective Date: 4/2007

Accuracy of Billing Records; False Claims Act; Whistle Blower Rights

It is the duty of every employee and contract provider engaged by DBH to help ensure that DBHs service and billing records are accurate in every respect.

The False Claims Act (31 U.S.C. 3729-3732) prohibits (1) knowingly presenting or causing to be presented to the Federal Government a false or fraudulent claim for payment; (2) knowingly using or causing to be used a false record or statement to get a claim paid by the Federal Government; (3) conspiring with others to get a false or fraudulent claim paid by the Federal Government; and (4) knowingly using or causing to be used a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the Federal Government. The False Claims Act is aimed only at fraud committed against the Government. It does not provide a remedy for waste or mismanagement that does not rise to the level of fraud. A company or individual that has made a false claim may be liable for triple damages, a civil fine of \$5,500 to \$11,000 per false claim, plus attorney fees.

Any DBH employee who has knowledge of any act that could constitute fraud in violation of the False Claims Act should report it immediately through the Silent Whistle link on the DBH homepage or through the DBH Corporate Compliance hotline.

An individual who has personal knowledge and evidence of a fraud against the federal government can file a qui tam lawsuit on behalf of the government and, if successful, can receive a portion of any recovery. It is not sufficient for the whistle blower (also known as the relator) to merely report the alleged fraud to the government; he or she must actually initiate a lawsuit by filing a complaint in federal district court. The complaint must be filed under seal (i.e., the contents of the complaint are not available to the public). The case will remain under seal while the government investigates the case, in order to allow the government to determine the strength of the charges. This confidentiality serves both to protect the whistleblower and the company while the case is being investigated. While a case is under seal, the government may conduct interviews and even issue search warrants, but it will not disclose the name of the whistleblower or the exact nature of its investigation.

An employee may not be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer in the terms and conditions of employment because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed the False Claims Act.

Utah also has a state False Claims Act (Section 26-20-1 et seq, Utah Code) that prohibits making or causing to be made a false statement or false representation of a material fact in an application for medical benefits or in determining rights to receive or continue to receive a medical benefit. The Act also prohibits soliciting, offering, paying, or receiving a kickback or bribe in connection with the furnishing of goods or services for which payment is or may be made in whole or in part pursuant to a medical benefit program, or paying or receiving a rebate of a fee or charge for referring an individual to another person for the furnishing of goods or services. Violations can result in civil and/or criminal penalties.

For more detailed information on DBHs policies and procedures related to detecting and/or preventing fraud, abuse and w

Dress Code

Policy No. 506

Effective Date: 4/2007

At all time you are expected to maintain appropriate standards of grooming, personal hygiene, and dress during working hours and on DBH property. All wearing apparel, personal grooming, and hygiene should not distract others or create a safety hazard to you or your co-workers. Your supervisor will answer any questions you have about appropriate dress or grooming for your department. All applicable federal or state safety and health laws pertaining to dress and grooming will be observed by each employee.

Casual Days

Each Friday will be a designated casual day. Employees may wear casual business wear on designated casual days. Casual business wear means clean, neat, professional clothing. It is never appropriate to wear stained, wrinkled, frayed, or revealing clothing to the workplace. If you are considering wearing something and you are not sure if it is acceptable, choose something else or inquire first.

Listed below is a general overview of acceptable casual business wear as well as a listing of some of the more common items that are not appropriate for the office. Obviously, neither group is intended to be all inclusive. Rather, these items should help set the general parameters for proper casual business wear and allow you to make intelligent judgments about items that are not specifically addressed.

Examples of acceptable casual business wear include:

- * Slacks
- * Jeans
- * Casual dresses and skirts
- * Casual shirts and blouses
- * Loafers
- * Deck shoes
- * Boots
- * Athletic shoes
- * Flats
- * Dress sandals

Examples of inappropriate clothing items that should not be worn on casual days include:

- * Warm-up or jogging suits and pants
- * Shorts
- * Short shorts
- * Spandex or other form fitting pants
- * Miniskirts
- * Tank tops
- * Halter tops
- * Visible undergarments
- * Baggy low-rider pants

No Smoking Policy

Policy No. 507

Effective Date: 4/2007

Revision Date: 5/2012

In accordance with the Utah Indoor Clean Air Act, DBH maintains nonsmoking facilities company wide. Smoking is not permitted within any building or permanent facility maintained by DBH. DBH may designate a smoking location out-of-doors to accommodate those who smoke during authorized breaks and lunch periods. In consideration of the therapeutic process, employees and contractors of DBH are not allowed to smoke with clients.

Visitors

Policy No. 508

Effective Date: 4/2007

To provide for the safety and security of employees and the facilities at DBH, only authorized visitors are allowed in the workplace. All visitors should enter DBH at the reception area. Authorized visitors will receive directions or be escorted to their destination. Employees are responsible for the conduct and safety of their visitors. If an unauthorized individual is observed on DBH's premises, employees should immediately notify their supervisor or, if necessary, direct the individual to the reception area.

Workplace Violence Prevention

Policy No. 509

Effective Date: 4/2/2007

Revision Date:

DBH is committed to preventing workplace violence and to maintaining a safe work environment. Given the increasing violence in society in general, DBH has adopted the following guidelines to deal with intimidation, harassment, or other threats of (or actual) violence that may occur during business hours or on its premises.

All employees, including supervisors and temporary employees, should be treated with courtesy and respect at all times. Employees are expected to refrain from fighting, "horseplay," or other conduct that may be dangerous to others. Firearms, weapons, and other dangerous or hazardous devices or substances are prohibited from the premises of DBH without proper authorization.

Conduct that threatens, intimidates, or coerces another employee, a client, or a member of the public at any time, including off-duty periods, will not be tolerated. This prohibition includes all acts of harassment, including harassment that is based on an individual's sex, race, age, or any characteristic protected by federal, state, or local law.

All threats of (or actual) violence, both direct and indirect, should be reported as soon as possible to your immediate supervisor or any other member of management. This includes threats by employees, as well as threats by clients, vendors, solicitors, or other members of the public. When reporting a threat of violence, you should be as specific and detailed as possible.

All suspicious individuals or activities should also be reported as soon as possible to a supervisor. Do not place yourself in peril. If you see or hear a commotion or disturbance near your work station, do not try to intercede or see what is happening.

DBH will promptly and thoroughly investigate all reports of threats of (or actual) violence and of suspicious individuals or activities. In order to maintain workplace safety and the integrity of its investigation, DBH may suspend employees, either with or without pay, pending investigation.

Anyone determined to be responsible for threats of (or actual) violence or other conduct that is in violation of these guidelines will be subject to prompt disciplinary action up to and including termination of employment.

DBH encourages employees to bring their disputes or differences with other employees to the attention of their supervisors or the Human Resources Director before the situation escalates into potential violence.

Identification Badges

Policy No. 510

Effective Date: 4/2007

When you commence employment with Davis Behavioral Health you will be issued employee identification badge that includes your photograph, name, and other identifying information. It identifies you as an employee of DBH and serves as your pass into our facilities and offices.

If you lose your ID, it is your responsibility to notify the Human Resources Department immediately so that arrangements can be made to cancel your lost badge, take another photograph of you, and issue you a new badge. The cost for an initial replacement badge will be borne by DBH; however, if you lose your ID more than once, it may be your responsibility to pay for a replacement badge.

The best protection for our workplace is conscientious, security-minded employees. If you observe anyone in our facilities without an ID or who appears to be engaging in suspicious activity, please notify your supervisor or human resources immediately.

Terminations

Policy No. 601

Effective Date: 4/2007

Nothing contained in this manual should be considered a contract or guarantee of employment. Employment at DBH is entirely on an at-will basis both for you and for DBH. Employees have the right to terminate employment at any time for any reason, and DBH has the same right. However, should you decide to leave DBH, when possible, we would like two weeks advance notice. Not only does this demonstrate professional courtesy, but it gives your supervisor the opportunity to adjust plans with the least amount of interruption to the company work schedules.

DBH will consider an employee to have voluntarily terminated his or her employment if the employee:

1. Elects to resign from DBH, or
2. Fails to return from an approved leave of absence on the date DBH specified, or
3. Fails to report to work without notice to DBH for two consecutive days.

If your DBH employment ends for any reason, you may be asked to participate in an exit interview. This interview is intended to give you an opportunity to communicate your views concerning your work with DBH. At the time of the interview, you are expected to return all DBH-furnished property, such as tools, equipment,

software, ID cards, keys, credit cards, documents and handbooks. Arrangement for clearing any outstanding debts with DBH and for receiving final pay also will be made at this time.

Layoffs - Reductions in Force

Policy No. 602

Effective Date: 4/2007

DBH reserves the right to terminate any employee because of changing business conditions, for any other reason, or for no reason. If a reduction in work force becomes necessary, DBH will select employees for termination based on DBH's present and future needs, as determined in the sole discretion of DBH. DBH will implement termination, whether or not part of a reduction in force, in the manner that best meets the requirements of DBH at that time. If a reduction in force becomes necessary, DBH may consider seniority, along with numerous other factors, including but not limited to skills, performance and staffing needs, in determining which employees will be laid off. Any employee who is laid off in connection with a reduction in force and who is recalled within 45 days after their termination date is considered a reinstated employee. The seniority and eligibility for leave accumulation of a reinstated employee relates back to the reinstated employee's original date of hire. Eligibility for medical and other benefits of reinstated employees is determined in accordance with the governing provisions of the applicable medical or other benefit plan. In determining former employees to be recalled from a layoff, DBH may consider the same variety of factors evaluated in selecting people for reductions in force.

Severance

Policy No. 603

Effective Date 4/2007

DBH employees have no entitlement to severance pay or compensation for accrued but unused PTO or paid leave upon termination. If, at its discretion, DBH decides to grant severance pay, such payments will be determined by DBH at the time of separation based on current business conditions and other factors.

Should DBH decide to offer severance pay or payment of accrued PTO to any employee, eligibility for receipt of such severance will require the employee to sign a legal release giving up the right to bring any legal action against DBH contesting the termination or any other aspects of the employment relationship.

If an employee is terminated for poor performance or violations of DBH guidelines, severance pay is generally not offered.

COBRA

Policy No. 604

Effective Date: 4/2007

The Federal Consolidated Omnibus Reconciliation Act ("COBRA") gives employees and their qualified beneficiaries the opportunity to continue health insurance coverage under DBH's health plan when a

"qualifying event" would normally result in the loss of eligibility. Some common qualifying events are resignation, termination of employment, or death of an employee; a reduction in an employee's hours or leave of absence; an employee's divorce or legal separation; and a dependent child no longer meeting eligibility requirements.

Under COBRA, the employee/beneficiary pays the full cost of coverage at DBH's group rates plus an administration fee. DBH provides each eligible employee with a written notice describing rights granted under COBRA when the employee becomes eligible for continued coverage under DBH's health insurance plan. The notice contains important information about the employee's rights and obligations.

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POLICIES & PROCEDURES

SUBJECT: Emergency Disaster Plan

PAGES: 2

SECTION: Administrative

EFFECTIVE DATE: 12/2005

REVISION DATE: 10/2011

PURPOSE

To ensure that Davis Behavioral Health has a written plan of action in the event of Disaster or Emergency..

POLICY

A. Each individual Unit shall have an *Emergency Preparedness and Disaster Plan*, which shall include fire evacuation plans, medical emergency plans, and floor plans indicating exits and the location of emergency equipment.

B. The *Emergency Preparedness and Disaster Plan* will be kept on file at the Administrative Office, and shall include copies of each individual unit's *Emergency Preparedness and Disaster Plan*.

C. All *Emergency Preparedness and Disaster Plans* will be reviewed by the Executive Leadership Team annually.

SCOPE

All Davis Behavioral Health Employees

PROCEDURES

1.0 The Facilities Director will develop an overall *Emergency Preparedness and Disaster Plan* for Davis Behavioral Health , which shall include:

1. Organizational response to internal and external disaster
2. Designation of Authority and Staff Assignments
3. Oversight and Review Procedures

2.0 Program Managers will develop individual unit Emergency Preparedness and Disaster plans that include:

1. Emergency information, including telephone numbers and location of emergency facilities
2. Fire and Evacuation Plans



POLICIES & PROCEDURES

SUBJECT: Emergency Disaster Plan

PAGES: 2

SECTION: Administrative

EFFECTIVE DATE: 12/2005

REVISION DATE: 10/2011

3. Medical Emergency Plans

4. Floor plans or diagrams indicating evacuation routes and exits

3.0 Copies of all Emergency Preparedness and Disaster Plans will be kept current, and on file in each Unit, and at the Administrative Office.

4.0 Each Unit will provide training for all staff, and in the day treatment programs and in housing, all tenants and participants shall be informed how to respond in the event of fire or emergency.

EMPLOYEES WITH INFECTIOUS DISEASE

SECTION:	Administrative
PAGE:	1 of 2
SUBJECT:	Employees with Infectious Disease
EFFECTIVE DATE:	12/2005
REVISION DATE:	9/2012

POLICY

Davis Behavioral Health employees will follow the infectious disease guidelines in the “procedures” section of this policy, in order to prevent the spread of common disease to other staff and clients.

PURPOSE

The purpose of this policy is to control and prevent the spread of communicable diseases from employees to other employees or clients. This will minimize health risks as well as maintain a disease free environment. The proceeding guidelines on communicable diseases will be followed to determine when an employee is free of a communicable disease and may return to work.

PROCEDURE

- 1.0 Employees should consult with their primary care provider or Health Department regarding receiving vaccinations as deemed appropriate. This may include, but is not limited to, Hepatitis A, Hepatitis B, Pertussis, Tetanus, Chicken Pox, and Influenza.
- 2.0 Employees with a respiratory illness will not work during the infectious stages (fever >100.5, rhinitis, sore throat)
- 3.0 If a supervisor identifies an employee with draining cold sores, boils, shingles, wounds, or with symptoms of communicable diseases such as coughing, fever, infections, vomiting, diarrhea, skin eruptions, etc., the employee should have no direct client contact, or work in food preparation.
- 4.0 An employee may NOT work during the known communicable periods at any of the Davis Behavioral Health sites for the following diseases:

Infectious Process	Duration of Restriction
Chicken pox	Until all vesicles have crusted and scabbed
Chicken pox exposure if you have not had chicken pox or been vaccinated	From day 10-21 post exposure
Diarrhea caused by Amebiasis, Cholera, Cryptosporidiosis, E. coli O-157, Giardia, Salmonella, Shigella	Employee may not work in food services if any vomiting or diarrhea illness, regardless of pathogen. Asymptomatic carriers are restricted from working in food services as well.
Draining wound caused by Staphylococcus aureus (both MRSA/MSSA)	Until draining wounds are covered, bodily fluids are contained, and the employee can observe good hygienic practices.
Hepatitis A	Until the fever is gone <u>and</u> at least 1 week after the onset of jaundice. Asymptomatic carriers are restricted from working in food services.

Impetigo	Until 24 hours after antibiotic treatment has been started, until sores are dried, or until sores can be covered with a bandage.
Influenza	Until fever has resolved
Lice	Until after the first treatment with a medicated head lice product, such as pyrethrin (Rid® and/or other medicated head lice product. Employee <i>must</i> be retreated in 7-10 days in order to kill remaining nits. Follow the manufacturer's directions carefully.
Measles	Until at least 4 days after the rash appears.
Mumps, active	Until at least 9 days after swelling first occurs or until swelling is gone.
Mumps exposure, if you have not had mumps or been vaccinated	Until at least 26 days after exposure, or until vaccinated.
Pink eye – conjunctivitis	For bacterial infections, 24 hours after treatment is started. For viral infections, until the watery, white or yellow discharge has ceased.
Resistant organisms colonized such as MRSA, VRE, others	No restriction necessary unless clearly implicated with disease transmission. If implicated, culture employee, restrict from work, treat, reculture. Employee may return to work when culture negative and clinically well. Routine culturing is not recommended.
Rubella	Until 7 days after the onset of rash.
Scabies	Until 24 hours after treatment is started.
Shingles	Until vesicles have crusted and scabbed.
Shingles exposure, if you have not had chicken pox or been vaccinated against chicken pox	From day 10-21 post exposure.
Strep Throat caused by Group A Streptococcus	Until 24 hours after antibiotic treatment is started.
Tuberculosis (TB)	Until symptoms have improved clinically (for example, they are coughing less and they no longer have a fever); and after compliant with an adequate treatment regimen for 2 weeks or longer and after three consecutive negative acid fast bacilli sputum smears collected in 8- to 24-hour intervals (at least one being an early morning specimen);
Diphtheria	Usually 4 days after initiation of antibiotic
Meningitis caused by Neisseria meningitis	Until adequately treated.
Typhoid Fever	Until stool cultures are negative
Whooping cough	Until 5 days after start of antibiotic therapy or until symptoms are no longer present.

www.cdc.gov
health.utah.gov
www.fda.gov

FAMILY INVOLVEMENT/ RELATIONSHIPS WITH ADVOCACY GROUPS

SECTION:	Clinical
PAGE:	1 of 1
SUBJECT:	Family Involvement/Relationships With Advocacy Groups
EFFECTIVE DATE:	12/2005
REVISION DATE:	5/2013

Policy

Clients of Davis Behavioral Health will be referred, whenever appropriate, to consumer/family advocacy groups, self-help groups, and other recovery-oriented community supports. Family members are actively encouraged to participate in a client's treatment and treatment planning (when consent is given by adult clients.)

Purpose

It is an operational value of Davis Behavioral Health that natural, community-based, familial, and peer-directed supports are preferable to institutional supports. Further, it is important that Davis Behavioral Health maintain a working partnership with advocacy groups and community partners.

Procedure

1. Community resources, as part of the natural environment of the client, will be used as the primary resource whenever feasible.
2. DBH clients will be considered for referral to self-help groups and other natural community supports. Referrals will be made, as appropriate, either concomitantly with DBH treatment; or in lieu of clinical treatment. Such local groups could include:
 - a. C.H.A.D.D.
 - b. Alcoholics Anonymous or other 12-step groups, such as Alanon/Alateen.
 - c. Vocational Rehabilitation
 - d. Veteran's Administration
 - e. Autism Supports
3. Clients and family members will receive a description of and contact information for available community supports such as Davis County NAMI, Allies with Families and/or a Family Resource Facilitator for peer support, family-to-family training, or consumer-to-consumer training. This information will be made available at first request for service and/or during intake procedures.
4. Adult clients will be asked, during the initial evaluation, if they are willing to have family members involved in the treatment and treatment planning process. This inquiry may include a discussion of involving family members at different levels, e.g., participating in a relapse prevention plan without being privy to the content of individual therapy sessions. Release-of-information forms will be written and signed consistent with the client's wishes.
5. During the initial evaluation, diligent efforts will be made to identify key family members and other key supports for DBH clients. These identified supports will be involved in the treatment planning process, as clinically indicated and as permitted by the client.
6. Efforts will be made to identify client interest in any culturally specific groups, e.g., communities of faith or ethnic advocacy/support organizations.

FATALITY REVIEW

SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Fatality Review
EFFECTIVE DATE:	6/2009
REVISION DATE:	7/2012

Policy

DBH will conduct a fatality review when a client death has occurred that is, or is possibly, attributable to suicide, homicide, or unusual circumstances not considered natural causes.

Purpose

The purpose of the review is a prospective analysis of 1) the service delivery system's performance and 2) the company's risk profile. The prospective nature of this review is to be distinguished from fault-finding or criticism of any individual or program. The products of the Fatality Review are: 1) recommendations for improved system performance in the future, and 2) identification of potential litigation exposure and recommended risk management. Comments and conclusions made as part of this process, as part of a morbidity/mortality review by a healthcare organization, have special protections under the law and are not "discoverable" during litigation.

Procedure

1. Upon learning of the death of a client, the primary provider will complete the Deceased Client Report and forward it to the Compliance Officer. The Compliance Officer will then request the Medical Examiners' Report in order to review the importance of a fatality review. This applies to active clients as well as clients who have been active at any time within the last two years.
2. If the nature and cause of death warrants a fatality review the fatality review will be convened by the Compliance Officer under the auspices of the Medical Director.
 - a. The review will include:
 - i. DBH Medical Director or designee
 - ii. Appropriate DBH Clinical Program Director
 - iii. Compliance Officer
 - iv. DBH treatment staff involved in direct provision of services to client at time of death.
 - v. Any relevant others based on need for information
3. The review will proceed according to the following investigational probes:
 - a. Probe #1: Is the known cause of death potentially attributable to

actions/inactions on the part of Davis Behavioral Health?

i. Death Due to Medical Condition

- Are the medications prescribed by DBH likely to have contributed to the medical risk to this client?
 - Were likely risks evaluated and documented?
 - Did the potential benefits of the treatment justify the prescribed treatment?
 - Were prescribed medications within standards of care?
- Were the medical evaluations that were provided, medically ordered, or were they requested and reviewed sufficiently in view of known risks?

ii. Death Due to Suicide

- Was the potential for suicide assessed/documented according to standards of care?
- Was the therapeutic response to identified risks within standards of care?
- What were the critical incidents in the life of the client preceding the suicide?
- Were there indications of escalating risk prior to the suicide?
- Are any service gaps identified within the Davis Behavioral Health service system that, if corrected, might have potential to improve detection or intervention prior to such events in the future?

b. Probe #2: What are the risks of litigation against Davis Behavioral Health regarding this event?

- What is Davis Behavioral Health's relationship to spouses, family members, and others significant to this client? Are there known threats of litigation or expressions of anger towards Davis Behavioral Health related to this death?
- Based on the previous review of Probe #1, what are the areas in which Davis Behavioral Health is vulnerable to litigation?
- Are there interventions that should be attempted with the family in order to provide support to them, and to enhance Davis Behavioral Health's relationship with those significant to the client?

c. Conclusions/Recommendations

- Are there recommendations for modification of:
 - Service system design,
 - Policies, or
 - Training/Supervision procedures?
- Are there actions steps recommended to prepare for or avert potential litigation?

d. Other Recommendations

**FEE
POLICY**

SECTION:	Financial
PAGE:	1 of 1
SUBJECT:	Fee Policy
EFFECTIVE DATE:	5/2010
REVISION DATE:	5/2014

PURPOSE

To charge for services based on verified ability to pay.

POLICY

Eligible patients will be assessed fees based on the Davis Behavioral Health Rate Schedule and/or Discounted Fee Schedule. Eligible patients are those not covered by Medicare, Medicaid, a contracting insurance company or a special contract. Services will not be denied based on the inability to pay.

PROCEDURES

- 1.0 Fee Setting & Collecting Procedures:
 - 1.1 All clients will be provided a written explanation of the fee policy at the time of their intake appointment.
 - 1.2 DBH will adhere to R523-1-5 regarding fee for services. All client fees, including drug court clients, will be based on the usual and customary rates established by our local authority or a negotiated contracted cost of services.
 - 1.3 Client's fees will not exceed the average cost of delivering the service.
 - 1.4 All fees assessed to clients, including upfront administrative fees, shall be reasonable as determined by the local authority
 - 1.5 All of DBH's programs will make a reasonable effort to collect outstanding fee charges and use an outside collection agency when appropriate.
 - 1.6 Individuals who indicate they are unable to pay for treatment or co-pays (and do not qualify for other funding sources) will be provided a Sliding Fee Application form. Once the form as been completed, the billing department will determine the applicants reduced fee based on the most recent Approved Fee Schedule and notify the applicant.
 - 1.7 Individuals who indicate that they are unable to make any payment or request fee balance forgiveness will be provided a Hardship Waiver Form to complete. Once completed, waiver forms must be returned to the finance department with requested income and expense documents attached for verification. A determination by the finance department will be made regarding the information provided on the form and communicated to the client.

GRIEVANCES

SECTION:	Grievance Process
PAGE:	1 of 3
SUBJECT:	Grievances
EFFECTIVE DATE:	
REVISION DATE:	10/2018

POLICY:

Davis Behavioral Health (DBH) will appoint a person to receive and be responsible for grievances. All grievances, as defined above, received by DBH will be directed to this individual for proper processing and handling.

A **grievance** is defined as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination, as “Adverse Benefit Determination” is defined in Davis Behavioral Health’s Adverse Benefit Determination policy. The term is also used to refer to the overall system that includes grievances and appeals handled by Davis Behavioral Health which includes access to the State Fair Hearing process.

PROCEDURE:

- 1.0 The Enrollee, his/her legally authorized representative (including the legal representative of a deceased enrollee’s estate) or a provider acting on behalf of the Enrollee as an authorized representative, may file a Grievance at any time.
- 2.0 The Grievance may be filed either orally or in writing.
- 3.0 DBH will give enrollees any reasonable assistance in completing required forms for submitting a written Grievance or taking other procedural steps. Reasonable assistance includes, but is not limited to, auxiliary aids & services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. From anywhere in Davis County the Enrollee may call toll-free (801)447-8887 and ask for the Grievance Officer. For TTY/TTD the Enrollee may call 711 or call 1-888-346-3162 for Spanish. If an Enrollee needs interpreter services or other assistance, the Enrollee may contact any DBH facility or call the Grievance Officer at (801)447-8887 and request an interpreter or other assistance.
- 4.0 DBH will acknowledge the receipt of the Grievance either orally or in writing in a format & language that is easily understood by the enrollee.
- 5.0 DBH will ensure that the individuals who make the decision on Grievances are individuals who:

- 5.1 Take into account all comments, documents, records, & other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
 - 5.2 Were not involved in any previous level of review or decision-making, if applicable to the nature of the Grievance.
 - 5.3 If deciding on a Grievance regarding denial of a request for an expedited resolution of an Appeal; or a Grievance that involves clinical issues, are health care professionals who have the appropriate clinical expertise, that is, they have the appropriate level of clinical licensure and expertise in treating the Enrollee's condition or disease.
 - 5.4 Grievances that involve quality of care concerns will be reviewed by our Clinical Director to ensure that appropriate measures are taken to resolve the grievance.
- 6.0 DBH will notify the affected parties of the disposition of the Grievance either orally or in writing in a format & language that is easily understood by the enrollee.
- 7.0 DBH will maintain complete records of all Grievances and submit semi-annual reports summarizing Grievances using reporting templates specified by the Utah Department of Health.
- 8.0 DBH will maintain documentation for **Oral** grievances including, but not limited to:
- 8.1 Date the oral Grievance was received and documented.
 - 8.2 The name of the person taking the oral Grievance.
 - 8.3 A summary of the nature of the Grievance, including the name of the Provider or other staff or individual involved/named in the Grievance, if it involves a person.
 - 8.4 Copies of written notices when extending the time frame for adjudicating oral Grievances when DBH initiates the extension.
 - 8.5 The date of resolution, and summary of the resolution of the oral grievance. This information may be documented in a written Notice of Grievance Decision if DBH chooses to inform the Enrollee of the Grievance decision in writing.
 - 8.6 The name of the individual(s) resolving the oral Grievance will ensure that the individuals who make the decision on grievances are individuals who were not involved in any previous level of review or decision-making, if applicable to the nature of the Grievance. Grievances that involve quality of care concerns will be reviewed by our Clinical Director to ensure that appropriate measures are taken to resolve the grievance. If the Grievance is regarding denial of a request for an expedited resolution of an Appeal or involves clinical issues, the title and credentials of the individual(s) who made the decision on the Appeal to demonstrate that they are individuals who:
 - a. were not involved in any previous level of review or decision-making and
 - b. are health care professionals who have the appropriate clinical expertise, that is, they have the appropriate level of clinical licensure

and clinical expertise as determined by the Utah Department of Health, in treating the Enrollee's condition or disease.

(If DBH chooses to inform the Enrollee of the Grievance decision in writing, the information in 8.6 above may be documented in the Notice of Grievance decision)

- 8.7 The date the Enrollee was notified of the grievance resolution and how the enrollee was notified (either orally or in writing). If the Enrollee was notified of the Grievance resolution in writing, DBH will maintain a copy of the written Notice of Grievance Decision.
 - 8.8 For oral Grievances not resolved within the required time frames, copies of Adverse Benefit Determination letters informing Enrollees that they may file an appeal.
 - 8.9 Any other pertinent documentation needed to maintain a complete record of all oral Grievances and to demonstrate that they were adjudicated according to the Contract provisions governing Grievances.
- 9.0 DBH will maintain documentation for written Grievances including, but not limited to:
- 9.1 Date the written Grievance was received.
 - 9.2 Date and method of acknowledgement (e.g. Orally or in writing).
 - 9.3 Copies of written notices when extending the time frame for adjudicating oral Grievances when DBH initiates the extension.
 - 9.4 The date of resolution and summary of the resolution. This information may be documented in a written Notice of Grievance Decision if DBH chooses to notify the Enrollee of the Grievance decision in writing.
 - 9.5 The name of the individual(s) resolving the Grievance to ensure that the individuals who make the decision on Grievances are individuals who were not involved in any previous level of review or decision-making, if applicable to the nature of the Grievance. If the Grievance is regarding denial of a request for an expedited resolution of an Appeal or involves clinical issues, the title and credentials of the individual(s) who made the decision on the Appeal to demonstrate that they are individuals who:
 - a. were not involved in any previous level of review or decision-making, if applicable to the nature of the Grievance, and
 - b. are health care professionals who have the appropriate clinical expertise, that is, they have the appropriate level of clinical licensure and clinical expertise, as determined by the Utah Department of Health, in treating the Enrollee's condition or disease.(If DBH chooses to inform the Enrollee of the Grievance decision in writing, the information in 9.5 above may be documented in the Notice of Grievance Decision)
 - 9.6 The date the Enrollee was notified of the grievance resolution. This information may be documented in the written Notice of Grievance Decision if DBH chooses to inform the Enrollee of the Grievance decision in writing.
 - 9.7 Copies of all written Notices of Grievance Decision to affected parties.

- 9.8 For written Grievances not resolved within the required time frames, copies of Notices of Grievance Decision informing Enrollees that they may file an Appeal.
- 9.9** Any other pertinent documentation needed to maintain a complete record of all written Grievances and to demonstrate that they were adjudicated according to contractual provision governing Grievances.

Davis Behavioral Health HIPAA Policies

Effective 4/14/03

Uses and Disclosures

Policy 1 Uses and Disclosures: For Treatment, Payment, and Health Care Operation

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the uses and disclosures of PHI from individuals with whom it has a direct treatment relationship.

Policy

Davis Behavioral Health will use and disclose PHI of clients for treatment, payment, and health care operations without obtaining explicit permission from those clients. However, Davis Behavioral Health will make our best effort to obtain a release of information from those clients in the areas of treatment and payment. We will not request an authorization to release information in the area of health care operations. Additionally, Davis Behavioral Health will make our best effort to obtain a written acknowledgement from each client that he/she has received a copy of our Privacy Notice prior to providing treatment.

Individuals seeking treatment have the right to request that Davis Behavioral Health restricts our uses and disclosures of their PHI for treatment, payment, and health care operations. Davis Behavioral Health is not obliged to agree to those restrictions, but, if we do, we must abide by them. Therefore, restrictions will not be granted without the express permission of the Privacy Officer who will evaluate an individual's request and determine:

1. If the restrictions are reasonable and
2. If it is possible to implement the restriction in our practice.

Should the request be granted, the Restriction Form will reflect the restrictions that have been allowed. See Policy 13 for complete information on Restrictions.

Davis Behavioral Health will, in all cases where a personal representative requests PHI on behalf of a client, consider the appropriateness of the request. In any case where Davis Behavioral Health elects not to treat a person as a legal representative, we will do so because:

1. Davis Behavioral Health has a reasonable belief that the individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or

2. Davis Behavioral Health, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the client's legal representative. In any such case, it is the policy of Davis Behavioral Health to document that decision in the medical record and inform the Privacy Officer.

Uses and Disclosures

Policy 2 Uses and Disclosures: Authorizations

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for obtaining authorization, from individuals with whom it has a direct treatment relationship, for any use and/or disclosure of PHI that is not covered by the consent requirement or is not otherwise permitted or required under the Privacy Rule.

Policy

Davis Behavioral Health will obtain a signed authorization that meets the standards of the Privacy Rules from individuals prior to using or disclosing PHI in those situations in which authorizations are required under the Rule. A copy of the authorization form presently in use in the Agency is found at the end of this policy.

Individuals seeking treatment have the right to refuse to provide authorizations for use and disclosure of their PHI. Davis Behavioral Health may not refuse to treat individuals who withhold their authorization except in the following circumstances:

1. Treatment is research-related for the use or disclosure of PHI for such research; or
2. The authorization is for PHI to be created in the course of treatment for the purpose of disclosure to a third party.

Clients may revoke an authorization at any time. The revocation must be in writing. Any actions that Davis Behavioral Health has taken in reliance on a client's consent will not be affected by the revocation. Davis Behavioral Health is not required, for example, to retrieve PHI that we have disclosed prior to the revocation. Should any employee be informed verbally that an individual has revoked an authorization provided to another entity, that employee should immediately inform the Privacy Officer

Davis Behavioral Health may amend the authorization form presently in use as long as it is written in plain language and the following elements are present in the amended authorization form:

1. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
2. The name or specific ID of the person(s), or class of persons, authorized to make the requested use or disclosure;
3. The name or other specific ID of the person(s), or class of persons, to whom Davis Behavioral Health may make the requested use or disclosure;
4. A description of each purpose of the requested use or disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose;
5. An expiration date or event that relates to the individual or the purpose of the use or disclosure. The statement “end of the research study”, “none”, or similar language is sufficient if the authorization is for a use or disclosure of PHI for research, including for the creation and maintenance of a research database or research repository.
6. The signature of the individual and the date. If signed by a personal representative, a description of the authority of that person to act for the individual must be provided.

Required Statements in the Authorization Form

In addition to the core elements listed above, an authorization must contain statements that put the individual on notice of all of the following:

1. The individual’s right to revoke authorization in writing and either:
 - a. The exceptions to the right to revoke along with a description of how to revoke; or
 - b. A reference to the Privacy Notice if Davis Behavioral Health’s Notice contains the information in a. above.
2. Davis Behavioral Health may only condition treatment (or payment by Davis Behavioral Health if applicable) on obtaining a signed authorization when:
 - a. It is providing research-related treatment and the authorization provides for the use or disclosure of PHI for such research; or
 - b. It is providing treatment solely for the purpose of creating PHI for disclosure to a third party and the authorization is for the disclosure of PHI to that third party.
3. The potential for PHI disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by the Privacy Rule.

An authorization that lacks any of these elements or statements is a defective authorization and will have no effect, therefore, Davis Behavioral Health requires that all of these elements or statements be in place in any authorization form version that may be developed in the future.

In any situation where the specificity of the request is inadequate to provide assurance that Davis Behavioral Health will disclose the correct information, the authorization should be considered defective.

In any situation where the relevant PHI will require extensive redaction, the individual will be given their entire record that he/she can redact prior to disclosure to the requestor of the information.

In any situation where Davis Behavioral Health has conflicts between two or more authorizations or other forms of legal permission in our possession for the same individual for the use and disclosure the same PHI, Davis Behavioral Health will attempt to obtain a new, conforming written authorization that resolves the conflict between the other documents. When a new authorization cannot be obtained, Davis Behavioral Health will rely upon the most restrictive form of permission in our possession.

Substance Abuse Providers

Federal regulations governing the confidentiality of substance abuse information (42 CFR, Part 2) are generally more restrictive than HIPAA and, therefore, Davis Behavioral Health will follow these regulatory requirements whenever the PHI of any client in a federally-assisted alcohol or drug abuse program is disclosed. In any of our federally-assisted alcohol or drug abuse programs, Davis Behavioral Health must always obtain specific authorization for each disclosure of client records or other information concerning a client unless one of the regulatory exceptions applies. See Policy 1, Uses and Disclosures (the section for Substance Abuse Providers). The authorization form (called a “consent” form in the substance abuse federal regulations) will meet the regulatory requirements incorporated in the Form attached to this Policy.

Davis Behavioral Health

Release of Information Authorization Form

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my individually-identifiable health information maintained by:

The Provider: Davis Behavioral Health:

Print Address

My health information may be disclosed under this Authorization to:

The Recipient [Person/Organization(s) receiving the information]:

Print Name

Print Address

Health information includes information collected from me or created by the Provider, or information received by the Provider from another health care provider, a health plan, my employer, or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

SECTION B: SCOPE OF USE OR DISCLOSURE

Check One:

Health information that may be used or disclosed through this Authorization is as follows:

- ☐ All health information about me, including my clinical records, created or received by the Provider. This information may include, if applicable: Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
- ☐ All health information about me as described in the preceding checkbox, **excluding** the following:

- ☐ Specific health information **including only**:

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are):

Check one:

- ☐ Specifically, the following purpose(s) :

; or

- ☐ This request for information to be used or disclosed has been initiated by the Client and the Client does not elect to disclose its purpose.

Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.

SECTION D: EXPIRATION

This Authorization expires in 90-days, unless otherwise noted here:

Insert applicable event or date – mm/dd/yy)

Note: If an expiration event is used, the event must relate to the Consumer or the purpose of the use or disclosure.

SECTION E: OTHER IMPORTANT INFORMATION

1. I understand that the Provider cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Davis Behavioral Health, except when I am (i) receiving research-related treatment or (ii) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from Davis Behavioral Health.
3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Privacy Office at Davis Behavioral Health. The address of the Privacy Office is 291 South 200 West, Farmington, UT 84025.
4. **This paragraph is only applicable to certain Authorizations to disclose health information for marketing purposes:** I understand that Davis Behavioral Health may, directly or indirectly, receive remuneration from a third party in connection with the marketing activities undertaken by Davis Behavioral Health.
5. Davis Behavioral Health hereby binds itself to safeguard the records and not re-disclose any medical records in violation of law.
6. I understand that if I am a drug and/or alcohol patient, that Davis Behavioral Health must obtain a specific authorization for each disclosure of my records except:
 - a. for internal program purposes;
 - b. for medical emergencies;
 - c. in response to court-ordered disclosure after I have had an opportunity to respond to the court;
 - d. when I have committed or threaten to commit a crime;
 - e. when the disclosure is for governmental audits or research purposes; or
 - f. when reporting is required under state law for child abuse.

Davis Behavioral Health Substance Abuse Redisclosure Notice **PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION**

- This notice accompanies a disclosure of information concerning a consumer in an alcohol or drug abuse treatment program, made to you with the consent of such consumer.
- This information has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purposes.
- The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumer.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature: _____ Date of signature: _____

Print client's full name: _____

When client is not competent to give consent, the signature of a parent, guardian, or other authorized legal representative is required.

Signature of legal representative: _____ Date of signature : _____

Print legal representative's name: _____

Optional: Photo I.D. # of Signator _____ Witness: _____

Uses and Disclosures

Policy 3 Uses and Disclosures: Opportunity for the Individual to Agree or Object

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for providing clients with an opportunity, in advance of the use or disclosure of PHI for

- a. Involving other people in the individual's care, or
- b. For notification about a client's location, general condition, or death to agree to that particular use or disclosure, to prevent it, or to restrict it.

Policy

Davis Behavioral Health will verbally inform each individual, during the intake process, of their right to prevent or restrict Davis Behavioral Health from

- a. Disclosing PHI about them to persons involved in their care; and
- b. Notifying persons about their location, general condition, or death.

The HIPAA Privacy Rules allows for Davis Behavioral Health to maintain facility directories. However, Davis Behavioral Health does not maintain a facility directory at any of our units. If asked, we will not confirm orally, in writing, or through any other medium that an individual is our current or former client.

With regard to clients who are present and have the capacity to make decisions, PHI may only be disclosed to people involved in their care (meaning relatives, friends, or community support people), if we:

1. Notify the client in advance of the anticipated disclosure and obtain their agreement to disclose;
2. Provide the clients with the opportunity to object to disclosures of PHI and the client does not express an opinion; or
3. Can, in the exercise of our professional judgment, infer from the circumstances that the client does not object to the disclosure of PHI.

With regard to clients who are not present or who are incapacitated or in an emergency situation, Davis Behavioral Health will disclose the minimum necessary PHI to persons involved in the client's care:

- 1) If the client is not a ward of the state or does not have a Advance Directive, court-appointed guardian, or other fiduciary, and
- 2) If Davis Behavioral Health determines in the exercise of our professional judgment that it is in the client's best interest.

It will be our policy, when disclosing PHI to persons involved in the client's care, to limit disclosures to PHI about the current circumstance. In addition, should the care provider believe, in the exercise of his/her professional judgment, that a disclosure of PHI might cause the client serious harm, the care provider may withhold PHI from the person involved in their care. Care providers should use their professional judgment about the scope of the person's involvement in the client's care (both to the length of time of that person's involvement and to the depth of disclosure of PHI that is appropriate) in a particular circumstance.

In disaster situations, no individual agreement will be required prior to disclosure of PHI to federal, state, or local agencies involved in disaster relief activities. This policy also applies to any private disaster relief organization that is authorized by law or their charters to assist in disaster relief efforts.

Uses and Disclosures

Policy 4 Uses and Disclosures: No Permission Required

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rule of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for responding to requests for disclosure of PHI in compliance with law and limited to the relevant requirements of the law that do not require the initial authorization or prior consent of the client.

Policy

Davis Behavioral Health has appointed a Privacy Officer, who is responsible for processing all requests for disclosures of PHI from external authorities in compliance with law and limited to the relevant requirements of that law. We recognize that we are not compelled to make disclosures by the Privacy Rule, but that we may do so without fear of further penalty under the Privacy Rule.

Disclosures of PHI, without permission or consent of the client, may or will (depending on the law and duty to report) occur under the following circumstances.

Public Health Uses: Disclosures of PHI may be made by Davis Behavioral Health without individual authorization to:

- 1) A public health authority authorized to receive PHI for the purpose of preventing or controlling disease, injury, or disability;
- 2) A public health authority or any other appropriate authority authorized by law to receive reports and do investigations of child abuse or neglect;
- 3) A person subject to FDA jurisdiction (who is responsible for the quality, safety, or effectiveness activities of a particular product) to collect/report adverse events, product defects, or biological product deviations, to track FDA regulated products, to enable product recalls, repairs, or replacement/look backs, or to conduct post-marketing surveillance;
- 4) A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition and who was authorized by law to be notified (typically in the conduct of a public health investigation or intervention); or
- 5) An employer generally in those situations where there are work-related injuries or workplace medical surveillance. Agencies, who make disclosures to employers, must provide notice to individuals that they do.

Victims of Abuse, Neglect or Domestic Violence: (other than child abuse, see above) When Davis Behavioral Health reasonably believes an individual is a victim of abuse, neglect, or domestic violence, disclosures of PHI may be made without individual authorization to a legally appointed governmental authority when:

- 1) It is required by law and the disclosure complies with and is limited to the requirements of the law, and Davis Behavioral Health informs the individual (victim) that the report has been made;
- 2) The individual (victim) agrees to the disclosure; or
- 3) It is expressly authorized by statute or regulation and either
 - a. Davis Behavioral Health, in the exercise of its professional judgment, believes that disclosure is necessary to prevent serious harm to the individual or other potential victims; or
 - b. The individual is unable to agree due to incapacity and the official who is to receive the information represents that he/she does not intend to use the PHI against that individual, and that an immediate enforcement activity depends upon the PHI and would be materially and adversely affected by waiting for the individual to recover.

In each of these cases, the individual must be notified that the disclosure was made. There are two exceptions:

- a. If Davis Behavioral Health believes, in the exercise of its professional judgment, that informing the individual would place the individual at risk of serious harm or
- b. If the person to be informed, as a personal representative, is the one believed responsible for the abuse, neglect, or other injury and that it would not be in the individual's best interest as determined Davis Behavioral Health, exercising professional judgment, to inform the personal representative.

Health Oversight: Disclosures of PHI may be made by Davis Behavioral Health without individual authorization to health oversight agencies. Disclosures must be for the purpose of oversight of the health care system.

Judicial and Administrative Proceedings: Disclosures of PHI may be made by Davis Behavioral Health without individual authorization when the request for PHI is made through or pursuant to an order from a court or administrative tribunal, or in response to a subpoena or discovery request, or other lawful process, by a party to the proceeding. Any staff member receiving a subpoena must consult with the Privacy Officer or his designee, who will determine in consultation with legal counsel, the appropriateness of our response. In this process, Davis Behavioral Health must ensure that the client's privileged communication is protected and that the client has the opportunity to assert that privilege.

Prior to delivering the subpoenaed records, Davis Behavioral Health should review the record and identify and redact any "sensitive information", such as HIV status or other information limited by state law, unless they have obtained a specific authorization of the individual to disclose such information. If there is information regarding substance abuse, Davis Behavioral Health must comply with the policies and procedures below regarding substance abuse records.

Law Enforcement Purposes: Disclosures of PHI may be made by Davis Behavioral Health, without individual authorization, to law enforcement officers for law enforcement purposes when disclosure of the PHI is required by law or the PHI is made in compliance with:

- a. A court order or court-ordered warrant or a subpoena or summons issued by a judicial officer;
- b. A grand jury subpoena;
- c. A civil investigative demand, administrative subpoena or summons or similar process if the request meets certain conditions related to the nature of the information sought.

Davis Behavioral Health may also disclose limited identifying information in response to a request from law enforcement for the purpose of identifying a suspect, fugitive, material witness, or missing person, but only if the individual agrees to the disclosure or Davis Behavioral Health determines that the law enforcement purpose is to meet a serious danger to the individual or other persons.

Davis Behavioral Health may also disclose PHI about an individual who is a victim of a crime, without a court order or without being required to do so by law. However, Davis Behavioral Health may do so only if the disclosure has been requested by a law enforcement official and the victim agrees to the disclosure or, in the case of the victim's incapacity, the following occurs:

- a. The law enforcement official represents to Davis Behavioral Health that (i) the victim is not the subject of the investigation and (ii) an immediate law enforcement activity to meet a serious danger to the victim or others depends upon the disclosure; and
- b. Davis Behavioral Health determines, exercising professional judgment, that the disclosure is in the victim's best interest.

Davis Behavioral Health may also disclose to law enforcement officials, PHI about an individual who has died for the purpose of alerting law enforcement to the death of the individual if Davis Behavioral Health suspects that the death may be the result of criminal conduct.

About Decedents: Disclosures of PHI, including psychotherapy notes, may be made by Davis Behavioral Health, without individual authorization, to the medical examiners for identification of a deceased person or to determine the cause of death provided that the chief medical examiner or his designee has deemed the PHI relevant to establishing the cause and manner of death. PHI may also be disclosed to funeral directors as necessary to carry out their legal duties.

Cadaveric Donation of Organs, Eyes, or Tissues: Disclosures of PHI may be made by Davis Behavioral Health, without individual authorization, to organ procurement and similar organizations.

Research Purposes: Disclosures of PHI may be made by Davis Behavioral Health, without individual authorization, as long as Davis Behavioral Health obtains:

1. Certain representations from the researcher;
2. Documentation identifying the IRB or privacy board and the date on which the alteration or waiver of authorization has been approved;
3. A statement that the IRB or privacy board has determined that the alteration or waiver, in whole or in part, of authorization satisfies the following criteria:
 - a. That the use or disclosure of PHI involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:
 - 1) An adequate plan to protect the identifiers from improper use and disclosure;
 - 2) An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and
 - 3) Adequate written assurances that the PHI will not be reused or disclosed to any other person or entity, except as required by law for oversight purposes or for other research that would be permitted under the Privacy Rule.
 - b. The research could not be conducted without the waiver or alteration; and
 - c. The research could not be conducted without access to and use of the PHI.

4. A brief description of the PHI that is determined to be necessary;
5. A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures, as follows:
 - a. An IRB must follow the requirement of the Common Rule;
 - b. A privacy board must review the proposed research at convened meetings at which a majority of members are present (at least one of whom is not affiliated with Davis Behavioral Health, the research sponsor, or related to any person who is affiliated with such entities);
 - c. With respect to a privacy board, an expedited review procedure can be used if the research involves no more than minimal risk to the privacy of individuals who are subject of the PHI for which use or disclosure is sought. The review and approval may be carried out by the chair of the privacy board or by a member designated by the chair; and
 - d. The documentation of the waiver or alteration must be signed by the chair or designated member.

To Avert a Serious Threat to Health or Safety: Disclosures of PHI may be made by Davis Behavioral Health, without individual authorization, when Davis Behavioral Health believes, in good faith, that PHI:

- a. Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and that the disclosure is to a person(s) reasonably able to prevent or lessen the threat, including the target of the threat; or
- b. Is necessary for law enforcement authorities to identify or apprehend an individual who has made a statement admitting participation in a past violent crime that Davis Behavioral Health reasonably believes may have caused serious physical harm or where the individual appears to have escaped from a correctional institution or lawful custody.

PHI may not be disclosed if it was learned in the course of treatment provided to affect the propensity to commit the crime, or counseling or therapy or through a request for such treatment, counseling, or therapy.

Specialized government functions: Disclosures of PHI may be made by Davis Behavioral Health, without individual authorization, to military authorities typically for the purpose of assuring proper execution of the military mission or for the purpose of determining eligibility for benefits. PHI may also be disclosed to authorized federal authorities for the conduct of lawful intelligence or other lawful national security activities authorized by the National Security Act.

Correctional institutions: Disclosures of PHI may be made by Davis Behavioral Health, without individual authorization, to a correctional institution, or an official having lawful custody of an inmate, if it is necessary for the provision of healthcare, for health and safety purposes, or for maintenance of good order of the correctional institution.

Workers' Compensation: Disclosures of PHI may be made by Davis Behavioral Health, without individual authorization, as authorized by and to the extent necessary to comply with the state's Workers' Compensation law.

Substance Abuse Providers

Federal Regulations governing the confidentiality of substance abuse information (42 CFR, Part 2) are generally more restrictive than HIPAA and should be followed when PHI of any client in a federally-assisted alcohol or drug abuse (“substance abuse”) program is disclosed. The Federal Regulations prohibit the disclosure of records or other information concerning any client in a federally-assisted substance abuse program without the specific consent of the client, except:

- a. For internal program communication purposes. Under this exception, program staff may disclose information to other staff within the program, or to an entity having direct administrative control over that program, if the recipient needs the information in connection with the provision of substance abuse diagnosis, treatment or referral for treatment.
- b. For medical emergencies posing an immediate threat to health and requiring immediate medical intervention. Under this exception, disclosures may be made to public or private medical personnel to the extent necessary to meet a bona fide medical emergency of the client or any other person.
- c. In response to court-ordered disclosures where the court order has been issued in accordance with procedures specified by the Federal Regulations. Court-ordered disclosures must be limited to the information essential to fulfill the purpose of the order, and they must be restricted to those persons who need the information.

If the order is sought by law enforcement officials or prosecutors, there are five additional criteria that must be met:

- i. The crime must be extremely serious,
- ii. The records requested must be likely to have information of significance to the investigation or prosecution;
- iii. There is no other practical way to obtain the information;
- iv. The public interest in disclosure outweighs any actual or potential harm to the patient or the client-patient relationship and the ability of the program to provide services to other patients; and
- v. When law enforcement personnel seek the order, the program has had an opportunity to be represented by counsel.

A federally-assisted substance abuse program is prohibited from disclosing PHI about clients in response to subpoenas unless:

- i. The client has signed a proper consent form for the disclosure or
 - ii. A court has ordered the program to release the PHI after giving the client and the program an opportunity to be heard and after making a “good cause” determination.
- d. When a client has committed or threatened to commit a crime on the program premises or against program personnel. Under these circumstances the program may report the crime to a law enforcement agency or seek its assistance. The program may disclose the circumstances of the incident, including the suspect’s name, address, last known whereabouts, and the suspect’s status as a client at the program.
 - e. When the disclosure is for research purposes. Under this exception the program may release PHI to researchers the program director determines are qualified.

- f. When a government agency that funds or regulates the program, a third-party payor or a peer review organization requests access to program records. The auditor or evaluator must agree in writing that it will re-disclose identifying information only:
 - i. Back to the program;
 - ii. Pursuant to a court order to investigate or prosecute the program (not a client), or
 - iii. To a government agency that is overseeing a Medicare or Medicaid audit or evaluation.

Records may be removed only upon a promise in writing to safeguard the records, not to re-disclose the records in violation of law, and to destroy all client-identifying information when the audit or evaluation is completed.

- g. When the program is reporting under state law incidents of suspected child abuse and neglect to appropriate authorities.
- h. When the disclosure is to a “qualified service organization” (QSO). A QSO is a person or entity that provides services to the program.

If the program receives a request for disclosure of a client’s record that is not permitted under the Federal Regulations, the program must refuse to make the disclosure and must ensure that the refusal is accomplished in a way that does not reveal the individual has ever been diagnosed or treated for an alcohol or drug problem.

Any PHI disclosed without authorization of a client in a federally-assisted substance abuse program authorization, may only be made in consultation with the Privacy Officer.

Uses and Disclosures

Policy 5 Uses and Disclosures: Business Associates

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rule of HIPAA's Administrative Simplification provisions, sets out, in this policy, the nature of the third party relationships that will be considered to be Business Associates and the requirements for contracting with them.

Policy

Any vendor or independent contractor who proposes to do business with Davis Behavioral Health will be subjected to procedures that will determine if the vendor or subcontractor is a Business Associate. We will consider any vendor or independent contractor to be a Business Associate if they have the following characteristics:

1. they perform a function or activity on our behalf that involves the use or disclosure of PHI or provide any legal, actuarial, accounting, consulting, data aggregation or management, administrative, accreditation, or financial services to or for us;
2. they are not involved in the treatment of a client; and
3. they are not providing consumer-conducted financial transactions.

Any vendor or independent contractor (but not any member of our workforce) who qualifies as a Business Associate will be required to sign a Business Associate Agreement or an Agreement that includes Business Associate provisions. The Agreement will be attached to this policy (see page ____).

Amendments to the Business Associates Agreement may not be made without the approval of legal counsel.

Protection of our client's health information is important to us, therefore we require our employees to be sensitive to the behavior of our Business Associates and to report any conduct that appears inappropriate.

Form 1 – Business Associate Agreement – New Contracts

BUSINESS ASSOCIATE AGREEMENT
With [Full Legal Name of Business Associate]
Effective Date: [Insert Effective Date of this Agreement]

This **Business Associate and Chain of Trust Agreement** (the "Agreement") is made as of the Effective Date set forth above, by and between **Davis Behavioral Health, Inc.** ("Health Care Provider") with a principal office at **291 South 200 West, Farmington, UT 84025** and **[Insert full legal name of Business Associate]** ("Business Associate") with a principal office at **[Insert address of Business Associate]**.

Whereas, Health Care Provider desires to disclose, and Business Associate desires to use, disclose, create, and/or receive, Individually Identifiable Health Information (i) on behalf of the Health Care Provider in the performance of certain functions or activities involving Individually Identifiable Health Information, or (ii) while providing certain designated services (including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services) to or for the Health Care Provider;

Whereas, Health Care Provider and Business Associate wish to comply with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. §1320(d)) ("HIPAA") including without limitation the Standards for Privacy of Individually Identifiable Health Information (42 C.F.R., Part 160 and 164), the Standards for Electronic Transactions (45 C.F.R., Part 160 and 162) and the Security Standards (45 C.F.R., Part 142) (collectively, the "Standards") promulgated or to be promulgated by the Secretary of Health and Human Services (the "Secretary").

I. Definitions.

The following terms, as used in this Agreement, shall have the meanings set forth below:

- 1.1 **"Data Aggregation"** means, with respect to Protected Health Information created or received by Business Associate in its capacity as the business associate of Health Care Provider, the combining of such Protected Health Information by Business Associate with the Protected Health Information received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.
- 1.2 **"Designated Record Set"** means a group of records maintained by or for Health Care Provider that is (i) the medical records and billing records about individuals maintained by or for Health Care Provider, (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for Health Care Provider to make decisions about individuals. As used in this Agreement, the term "Record" means any item, collection, or grouping of information that includes Protected Health information and is maintained, collected, used, or disseminated by or for the Health Care Provider.
- 1.3 **"Electronic Media"** means the mode of electronic transmissions. It includes the internet, extranet (using internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.
- 1.4 **"Individually Identifiable Health Information"** means information that is a subset of health information, including demographic information collected from an individual, and

(a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (i) identifies the individual, or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

- 1.5 **"Protected Health Information" or "PHI"** means Individually Identifiable Health Information that is (a) transmitted by electronic media, (b) maintained in any medium constituting Electronic Media; or (c) transmitted or maintained in any other form or medium. "Protected Health Information" does not include (a) education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. §1232g and (b) records described in 20 U.S.C. §1232g(a)(4)(B)(iv).

II. Obligations of Business Associate With Respect to PHI.

- 2.1 **Use and Disclosure of PHI.** Business Associate shall use and disclose PHI only as required to satisfy its obligations under this Agreement or as required by law and shall not otherwise use or disclose any PHI. Health Care Provider shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Standards for Individually Identifiable Health Information (hereinafter, the "Privacy Standards") if done by Health Care Provider **[Optional:** except with respect to uses and disclosures of PHI for data aggregation or management and administrative activities of Business Associate, as provided in Sections 2.12 and 2.13 of this Agreement, respectively].

2.2 Purposes and Limitations on Use or Disclosure of PHI.

- 2.2.1 **Purposes.** Except as otherwise provided in this Agreement, Business Associate may use or disclose PHI on behalf of, or to provide services to, Health Care Provider only for the following purposes, so long such use or disclosure of PHI would not violate the Privacy Standards if used or disclosed by the Health Care Provider:

[List specific purposes for Business Associate's use or disclosure of PHI] i.e., to conduct a survey and determine the accreditation status of Health Care Provider; to provide accounting services to Provider; to conduct research services using patient medical records for XYZ purposes, etc.

- 2.2.2 **Property Rights in PHI.** Business Associate hereby acknowledges that, as between Business Associate and Health Care Provider, all PHI shall be and remain the sole property of Health Care Provider, including any forms of PHI developed by Business Associate in the course of fulfilling its obligations under this Agreement.

- 2.2.3 **Minimum Necessary.** Business Associate further represents that, to the extent Business Associate requests Health Care Provider to disclose PHI to Business Associate, such request is only for the minimum necessary PHI for the accomplishment of Business Associate's purposes.

2.3 Safeguards and Security.

- 2.3.1 **Safeguards.** Business Associate agrees to use all appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement or as required by law.
- 2.3.2. **Security.** Business Associate shall establish security policies, processes and procedures in compliance with the Security Standards including without limitation administrative procedures, physical safeguards, technical security

services, and technical security mechanisms, in order to protect the integrity and confidentiality of PHI exchanged electronically. Business Associate acknowledges and agrees that the legal, technical or business requirements for security of PHI may change and that, at any time during the term of this Agreement, Health Care Provider shall have the right to require Business Associate to adopt new policies, processes and procedures, or to require modifications to existing policies, processes and procedures. Health Care Provider shall communicate in writing such new or altered requirements to Business Associate, and Business Associate agrees to promptly implement such requirements. Business Associate shall supply a written copy of its security policies and procedures to Health Care Provider upon the execution of this Agreement.

2.4 Reporting Disclosures of PHI: Mitigation. Business Associate shall report any use or disclosure in violation of this Agreement within two business days of learning of such violation by Business Associate or its officers, directors, employees, contractors or other agents or by any third party to which Business Associate has disclosed PHI. Business Associate agrees to mitigate promptly at the direction of Health Care Provider any harmful effect of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement. Health Care Provider may, at its sole discretion, access records of Business Associate, direct an investigation of a use or disclosure by Business Associate, and determine the appropriate method of mitigation; Business Associate agrees to cooperate fully with Health Care Provider in any such investigation or mitigation.

2.5 Employees, Subcontractors, and Agents. Business Associate hereby represents and warrants that its employees and agents will be specifically advised of, and shall comply in all respects with, the terms and conditions of this Agreement. Business Associate shall obtain and maintain, in full force and effect, a binding contract with each of its agents including without limitation subcontractors who will have access to PHI and whose PHI is received from, or created or received by, Business Associate on behalf of the Health Care Provider. Business Associate shall further ensure that any such agent agrees in such contract to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI.

2.6 Accounting of Disclosures.

2.6.1 Accounting by Business Associate. Business Associate agrees to document any disclosures of PHI made by Business Associate, as well as other information related to such disclosures, as would be required for Health Care Provider to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528. Business Associate also agrees to provide Health Care Provider, in a time and manner designated by Health Provider, information collected in accordance with this section of the Agreement, to permit Health Care Provider to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.

2.6.2 Recordkeeping. Business Associate agrees to implement an adequate record keeping process to enable it to comply with the requirements of this section of the Agreement.

2.7 Privacy Practices. Business Associate hereby acknowledges and agrees that Health Care Provider has provided it with a copy of its Notice of Privacy Practices. Business Associate agrees to comply with the practices identified in the Notice of Privacy Practices, to the extent that such practices would apply to Health Care Provider if it were performing Business Associate's functions, and will utilize as appropriate Health Care Provider's form documents. Health Care Provider hereby reserves the right to change the applicable privacy practices and related documents at any time. To the extent that such

changes affect the duties and obligations of Business Associate under this Agreement, Business Associate will implement such changes within 10 days of receipt of notice of the change.

- 2.8 **Revocation or Modification of Consumer Permission.** Health Care Provider shall provide Business Associate with any changes in, or revocation of, permission by an individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.
- 2.9 **Consumer Restrictions on Uses and Disclosures.** Health Care Provider shall notify Business Associate of any restriction to the use or disclosure of PHI that Davis Behavioral Health has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.
- 2.10 **Availability of Books and Records.** Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, created, or received by Business Associate (on behalf of Health Care Provider) available to Health Care Provider, or at the request of Health Care Provider to the Secretary, in a time and manner designated by the Health Care Provider or the Secretary, for purposes of the Secretary determining Health Care Provider's compliance with the Privacy Standards. The provisions of this section shall survive termination of this Agreement.
- 2.11 **Notice of Request for PHI.** Business Associate agrees to notify Health Care Provider within two business days of receipt of any request, subpoena or other legal process to obtain PHI or an accounting of PHI. Health Care Provider in its discretion shall determine whether Business Associate may disclose PHI pursuant to such request, subpoena, or other legal process. Business Associate agrees to cooperate fully with Health Care Provider in any legal challenge initiated by Health Care Provider in response to such request, subpoena, or other legal process. The provisions of this section shall survive the termination of this Agreement.

[Optional: Include the following section only if you intend Business Associate to be able to use PHI in its own management or administration functions.]

2.12 Proper Management and Administration of Business Associate.

- 2.12.1 **Permissible Uses.** Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- 2.12.2 **Permissible Disclosures.** Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are required by law, or that Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

[Optional: Include the following section only if you intend Business Associate to perform Data Aggregation functions.]

- 2.13 **Data Aggregation.** Except as other limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Health Care Provider as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

[Optional: Include the following section only if Business Associate will receive PHI in Designated Record Sets.]

- 2.14 **Access to Records in a Designated Record Set.** At the request of Health Care Provider and in the time and manner designated by Health Care Provider, Business Associate agrees to provide access to PHI in a Designated Record Set to Health Care Provider (and its employees and agents) or, as directed by Health Care Provider, to an individual in order to meet the requirements under 45 C.F.R. § 164.524.

[Optional: Include the following section only if Business Associate will receive PHI in Designated Record Sets.]

- 2.15 **Amendment of Records in a Designated Record Set.** At the request of Health Care Provider and in the time and manner designated by Health Care Provider, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Health Care Provider (or its employees or agents) directs or agrees to pursuant to 45 C.F.R. § 164.526.

III. Other Obligations of Business Associate.

[Insert Duties and Obligations of Business Associate Not Related to HIPAA]

IV. Other Obligations of Health Care Provider.

[Insert Duties and Obligations of Health Care Provider Not Related to HIPAA]

V. Term and Termination.

5.1 Term.

[Insert provisions relating to term of this Agreement – the Term to commence with the Effective Date. If Business Associate functions are the only activities to be performed under this Agreement, you may use the following provision:]

The term of this Agreement shall commence upon the Effective Date and continue thereafter for a period of **[Insert period (in days, months or years) that contract is in effect]** or until earlier terminated in accordance with Section 5.2 below.

5.2 Termination.

5.2.1 General Termination Provisions.

[Insert general provisions relating to the termination of this Agreement. If Business Associate functions are the only activities to be performed under this Agreement and you wish to permit Business Associate to terminate this Agreement without cause, you may use the following provision:]

Either Health Care Provider or Business Associate may terminate this Agreement at any time without cause with **[Insert number of days of required notice – typically 30 to 120 days, depending upon the time period needed for a transition]** day's prior written notice.

- 5.2.2 **Termination Upon Breach.** Any other provision of this Agreement notwithstanding, this Agreement may be terminated by Health Care Provider upon five business days written notice to Business Associate in the event that the Business Associate breaches any provision (including any covenant, representation, warranty, or condition) contained in Article II of this Agreement or any other such provision of this Agreement that relates to PHI and such breach is not cured within the five day notice period; provided, however, that in the event that termination of this Agreement is not feasible in Health Care Provider's sole discretion, Business Associate hereby acknowledges that Health Care Provider shall have the right to report the breach to the Secretary.

5.2.3 Return or Destruction of PHI upon Termination.

- 5.2.3.1 **General Provisions.** Upon termination of this Agreement, Business Associate shall either return or destroy, at the option of Health Care

Provider, all PHI received from the Health Care Provider, or created or received by Business Associate on behalf of the Health Care Provider and which Business Associate still maintains in any form. Business Associate shall not retain any copies of such PHI.

5.2.3.2 **Alternative Arrangement.** Notwithstanding the foregoing, to the extent that the Health Care Provider agrees that it is not feasible to return or destroy such PHI, Business Associate shall provide Health Care Provider with a written acknowledgement and notification of the conditions that make return or destruction infeasible. Business Associate hereby agrees to (a) extend the protections of this Agreement to such PHI only for those purposes that make the return or destruction infeasible, (b) limit further uses and disclosures of such PHI to such purposes, and (c) extend any term or provision of this Agreement relating to PHI so that such term or condition shall survive termination of this Agreement. Thereafter, such PHI shall be used or disclosed solely for such purpose or purposes, which prevented the return or destruction of such PHI.

5.2.3.3 **Applicability of Provisions.** The provisions of this section of the Agreement shall apply, to the same extent that it applies to Business Associate, to PHI that is in the possession of agents of Business Associate.

5.2.4 **Health Care Provider's Right to Cure.** At the expense of Business Associate, Health Care Provider shall have the right to cure any breach of Business Associate's obligations under this Agreement with respect to PHI. Health Care Provider shall give Business Associate notice of its election to cure any such breach and Business Associate shall cooperate fully in the efforts by the Health Care Provider to cure Business Associate's breach. All requests for payment for such services of the Health Care Provider shall be paid within 30 days of Business Associate's receipt of the request for payment.

VI. Miscellaneous.

6.1 Indemnification.

[Insert an indemnification provision for this Agreement. If the only purpose of this Agreement is to comply with HIPAA's business associate requirements, you may use the following indemnification provision.]

Business Associate hereby agrees to indemnify and hold Health Care Provider and its employees and agents harmless from and against any and all loss, liability, or damages, including reasonable attorneys' fees, arising out of or in any manner occasioned by a breach of any provision of this Agreement by Business Associate, or its employees or agents.

6.2 Insurance.

[Insert insurance provision for this Agreement. If the only purpose of this Agreement is to comply with HIPAA's business associate requirements, you may use the following insurance provision.]

Business Associate shall obtain and maintain, at its sole expense, during the term of this Agreement liability insurance on an occurrence basis with responsible insurance companies covering claims based upon a violation of any of the Standards or any applicable state law or regulation concerning the privacy of patient information and claims based upon its obligations pursuant to Section 6.1 of this Agreement in amount not less than **[Insert minimum amount of required coverage; for high risk business**

associates – suggest \$1,000,000 per claim.] [Optional, suggest inserting for high or medium risk business associates: Such insurance policy shall name Health Care Provider as an additional named insured and shall provide for 30 days prior written notice to Health Care Provider in the event of any decrease, cancellation, or non-renewal of such insurance.] A copy of such policy or a certificate evidencing the policy shall be provided to Health Care Provider upon written request.

- 6.3 **Injunction.** Business Associate hereby agrees that Health Care Provider will suffer irreparable damage if Business Associate breaches this Agreement and that such damages will be difficult to quantify. Business Associate hereby agrees that Health Care Provider may file an action for an injunction to enforce the terms of this Agreement against Business Associate, in addition to any other remedy Health Care Provider may have.
- 6.4 **Independent Contractor.** Under this Agreement, Business Associate shall at all times be acting and performing in the status of independent contractor to Health Care Provider. Business Associate shall not by virtue of this Agreement be deemed a partner or joint venturer of Health Care Provider. No person employed by Business Associate will be an employee of Health Care Provider, and Health Care Provider shall have no liability for payment of any wages, payroll taxes, and other expenses of employment for any employee of Business Associate. Business Associate is constituted the agent of Health Care Provider only for the purpose of, and to the extent necessary to, carrying out its obligations under this Agreement.
- 6.5 **Authorization for Agreement.** Business Associate represents and warrants that the execution and performance of this Agreement by Business Associate has been duly authorized by all necessary laws, resolutions and corporate action, and this Agreement constitutes the valid and enforceable obligations of the Business Associate in accordance with its terms.
- 6.6 **Governing Law and Choice of Forum.** The parties agree that this Agreement shall be construed in accordance with the laws of the State of Utah, without regard to conflict of laws principles. The parties further agree that any litigation concerning this Agreement shall only be brought in a court of competent jurisdiction within the State of Utah. To the extent that the Privacy Standards apply to any provision in this Agreement, any ambiguity shall be resolved in favor of a meaning that permits Health Care Provider to comply with the Privacy Standards.
- 6.7 **Binding Agreement: Assignment.** This Agreement shall inure to the benefit and be binding upon the parties hereto and their respective successors and assigns; provided, however, that Business Associate may not assign any rights or obligations under this Agreement without the prior written consent of Health Care Provider.
- 6.8 **Notices.** Any notice, request, demand, report, approval, election, consent or other communication required or permitted under the terms of this Agreement (collectively, “Notice”) shall be in writing and either delivered personally, by registered or certified mail, return receipt requested, postage prepaid, or by reputable overnight courier, addressed as follows:

To Health Care Provider:

**Davis Behavioral Health, Inc.
291 South 200 West
Farmington, UT, 84025**

With a copy to:

To Business Associate:

[Insert Full Legal Name of Entity]
[Street Address]
[City or Town, State, Zip Code]
Attn: [Insert Title of Officer in Business Associate's
Organization, i.e., President]

With a copy to: [If copy is desired, insert name and address of person to
whom copy should be sent.]

or at such other address as either party may designate by Notice. Notice shall be deemed to have been given when received if delivered personally, three days after postmarked if sent by certified mail, or one day after deposited with an overnight courier.

- 6.9 **Integration.** This Agreement constitutes the sole and only agreement of the parties hereto with respect to the subject matter herein. Any and all prior agreements, promises, proposals, negotiations or representations, whether written or oral, which are not expressly set forth in this Agreement are hereby superseded and are of no force or effect.
- 6.10 **Amendment.** This Agreement may not be amended, modified or terminated orally, and no amendment, modification, termination or attempted waiver shall be valid unless in writing signed by the party against whom the same is sought to be enforced.
- 6.11 **Severability.** Should any provision of this Agreement or application thereof be held invalid, illegal or unenforceable for any reason whatsoever, then notwithstanding such invalidity, illegality or unenforceability, the remaining terms and provisions of this Agreement shall not be affected and shall continue to be valid and enforceable to the fullest extent permitted by law unless to do so would defeat the purposes of this Agreement.
- 6.12 **Survival.** All matters that (a) expressly survive the termination of this Agreement including without limitation the provisions of Sections 2.10, 2.11, 5.2.3, and 5.2.4, (b) relate to the termination of this Agreement, or (c) in the normal course would not occur or be effectuated until after any such termination, as well as all rights and obligations of the parties pertaining thereto, shall survive any termination and be given full force and effect notwithstanding any termination of this Agreement.
- 6.13 **Waiver.** The failure at any time by either party to require or demand performance of any provision of this Agreement shall not constitute a waiver by such party of such provision and shall not affect such party's full right to require performance at any later time.
- 6.14 **Legislative, Regulatory or Administrative Changes.** In the event of a change in federal, state or local law, any of which could, in Health Care Provider's reasonable judgment, materially and adversely affect the manner in which either party may perform services under this Agreement, the parties shall immediately amend this Agreement to comply with the law, regulation, or policy and approximate as closely as possible the arrangements set forth in this Agreement as it existed immediately prior to the change in law, regulation or policy.
- 6.15 **Joint Notices.** If applicable, in this Agreement the term "covered entity" shall include all entities covered by a joint Notice of Privacy Practices.
- 6.16 **Business Associates That Are Covered Entities.** In the event a Business Associate is a "covered entity" under the Privacy Standards, Business Associate may designate a

“health care component” of that entity, pursuant to 45 C.F.R. § 164.504(a) as the Business Associate for purposes of this Agreement.

- 6.17 **No Third Party Beneficiary.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties to this Agreement and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
- 6.18 **Headings.** The headings to the various paragraphs of this Agreement have been inserted for convenient reference only and shall not modify, define, limit or expand the provisions of this Agreement.
- 6.19 **Counterparts.** This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same instrument.

In Witness Whereof, Health Care Provider and Business Associate have caused this instrument to be duly executed by their authorized representatives as of the Effective Date.

Davis Behavioral Health, Inc.

By: [Insert “President” or Title of Other Authorized Officer]

[Insert Full Legal Name of Business Associate]

By: [Insert “President” or Title of Other Authorized Officer]

Form 2 – Business Associate Addendum – Amendment to Existing Contract

BUSINESS ASSOCIATE ADDENDUM **With [Full Legal Name of Business Associate]** **Effective Date: [Insert Effective Date of this Addendum]**

This **Business Associate and Chain of Trust Addendum** (the “Addendum”) is made as of the Effective Date set forth above, by and between **Davis Behavioral Health, Inc.** (“Health Care Provider”) and **[Insert full legal name of Business Associate]** (“Business Associate”) as a duly executed amendment to **[Insert name of original contract]** originally effective as of **[Insert effective date of original contract]** (the “Agreement”).

Whereas, Health Care Provider and Business Associate desire to amend the Agreement with this Addendum in order to permit the use or disclosure of Individually Identifiable Health Information between Health Care Provider and Business Associate and to permit Business Associate as necessary to use, disclose, create and/or receive Individually Identifiable Health Information (i) on behalf of the Health Care Provider in the performance of certain functions or activities involving Individually Identifiable Health Information, or (ii) while providing certain designated services (including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services) to or for the Health Care Provider;

Whereas, Health Care Provider and Business Associate wish to comply with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. §1320(d)) (“HIPAA”) including without limitation the Standards for Privacy of Individually Identifiable Health Information (42 C.F.R., Part 160 and 164), the Standards for Electronic Transactions (45 C.F.R., Part 160 and 162) and the Security Standards (45 C.F.R., Part 142) (collectively, the “Standards”) promulgated or to be promulgated by the Secretary of Health and Human Services (the “Secretary”).

I. Definitions.

The following terms, as used in this Addendum, shall have the meanings set forth below:

- 1.1 **"Data Aggregation"** means, with respect to Protected Health Information created or received by Business Associate in its capacity as the business associate of Health Care Provider, the combining of such Protected Health Information by Business Associate with the Protected Health Information received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.
- 1.2 **"Designated Record Set"** means a group of records maintained by or for Health Care Provider that is (i) the medical records and billing records about individuals maintained by or for Health Care Provider, (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for Health Care Provider to make decisions about individuals. As used in this Agreement, the term "Record" means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for the Health Care Provider.
- 1.3 **"Electronic Media"** means the mode of electronic transmissions. It includes the internet, extranet (using internet technology to link a business with information only

accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.

- 1.4 **"Individually Identifiable Health Information"** means information that is a subset of health information, including demographic information collected from an individual, and:

- (a) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- (b) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (i) identifies the individual, or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

- 1.5 **"Protected Health Information" or "PHI"** means Individually Identifiable Health Information that is (a) transmitted by electronic media, (b) maintained in any medium constituting Electronic Media, or (c) transmitted or maintained in any other form or medium. "Protected Health Information" does not include (a) education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. §1232g and (b) records described in 20 U.S.C. §1232g(a)(4)(B)(iv).

II. Integration of Addendum.

- 2.1 **Effect of this Addendum.** The terms and provisions of this Addendum shall supercede any other conflicting or inconsistent terms and provisions in the Agreement to which this Addendum is attached, including all exhibits or other attachments to, and all documents incorporated by reference in, the Agreement. Without limitation of the foregoing, any limitation or exclusion of damages provisions contained in the Agreement shall not be applicable to this Addendum.

III. Obligations of Business Associate With Respect to PHI.

- 3.1 **Use and Disclosure of PHI.** Business Associate shall use and disclose PHI only as required to satisfy its obligations under the Agreement or as required by law and shall not otherwise use or disclose any PHI. Health Care Provider shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Standards for Individually Identifiable Health Information (hereinafter, the "Privacy Standards") if done by Health Care Provider [**Optional:** except with respect to uses and disclosures of PHI for data aggregation or management and administrative activities of Business Associate, as provided in Sections 3.12 and 3.13 of this Addendum, respectively].

- 3.2 **Purposes and Limitations on Use or Disclosure of PHI.**

- 3.2.1 **Purposes.** Except as otherwise provided in this Addendum, Business Associate may use or disclose PHI on behalf of, or to provide services to, Health Care Provider only for the following purposes, so long such use or disclosure of PHI would not violate (a) the minimum necessary policies and procedures of Health Care Provider and (b) the Privacy Standards if used or disclosed by the Health Care Provider:

[List specific purposes for Business Associate's use or disclosure of PHI]
i.e., to conduct a survey and determine the accreditation status of Health Care Provider; to provide accounting services to Provider; to conduct research services using patient medical records for XYZ purposes, etc.

- 3.2.2 **Property Rights in PHI.** Business Associate hereby acknowledges that, as between Business Associate and Health Care Provider, all PHI shall be and remain the sole property of Health Care Provider, including any forms of PHI developed by Business Associate in the course of fulfilling its obligations under this Agreement.
 - 3.2.3 **Minimum Necessary.** Business Associate further represents that, to the extent Business Associate requests Health Care Provider to disclose PHI to Business Associate, such request is only for the minimum necessary PHI for the accomplishment of Business Associate's purposes.
- 3.3 **Safeguards and Security.**
 - 3.3.1 **Safeguards.** Business Associate agrees to use all appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Addendum or as required by law.
 - 3.3.2 **Security.** Business Associate shall establish security policies, processes and procedures in compliance with the Security Standards including without limitation administrative procedures, physical safeguards, technical security services, and technical security mechanisms, in order to protect the integrity and confidentiality of PHI exchanged electronically. Business Associate acknowledges and agrees that the legal, technical, or business requirements for security of PHI may change and that, at any time during the term of this Agreement, Health Care Provider shall have the right to require Business Associate to adopt new policies, processes and procedures, or to require modifications to existing policies, processes and procedures. Health Care Provider shall communicate in writing such new or altered requirements to Business Associate, and Business Associate agrees to promptly implement such requirements. Business Associate shall supply a written copy of its security policies and procedures to Health Care Provider upon the execution of this Agreement.
- 3.4 **Reporting Disclosures of PHI; Mitigation.** Business Associate shall report any use or disclosure in violation of this Addendum within two business days of learning of such violation by Business Associate or its officers, directors, employees, contractors or other agents or by any third party to which Business Associate has disclosed PHI. Business Associate agrees to mitigate promptly at the direction of Health Care Provider any harmful effect of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum. Health Care Provider may, at its sole discretion, access records of Business Associate, direct an investigation of a use or disclosure by Business Associate, and determine the appropriate method of mitigation; Business Associate agrees to cooperate fully with Health Care Provider in any such investigation or mitigation.
- 3.5 **Employees, Subcontractors, and Agents.** Business Associate hereby represents and warrants that its employees and agents will be specifically advised of, and shall comply in all respects with, the terms and conditions of this Addendum. Business Associate shall obtain and maintain, in full force and effect, a binding contract with each of its agents including without limitation subcontractors who will have access to PHI and whose PHI is received from, or created or received by, Business Associate on behalf of the Health Care Provider. Business Associate shall further ensure that any such agent agrees in such contract to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI.
- 3.6 **Accounting of Disclosures.**
 - 3.6.1 **Accounting by Business Associate.** Business Associate agrees to document any disclosures of PHI made by Business Associate, as well as other information

related to such disclosures, as would be required for Health Care Provider to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528. Business Associate also agrees to provide Health Care Provider, in a time and manner designated by Health Provider, information collected in accordance with this section of the Addendum, to permit Health Care Provider to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.

- 3.6.2 **Record keeping.** Business Associate agrees to implement an adequate record keeping process to enable it to comply with the requirements of this section of the Addendum.
- 3.7 **Privacy Practices.** Business Associate hereby acknowledges and agrees that Health Care Provider has provided it with a copy of its Notice of Privacy Practices. Business Associate agrees to comply with the practices identified in the Notice of Privacy Practices, to the extent that such practices would apply to Health Care Provider if it were performing Business Associate's functions, and will utilize as appropriate Health Care Provider's form documents. Health Care Provider hereby reserves the right to change the applicable privacy practices and related documents at any time. To the extent that such changes affect the duties and obligations of Business Associate under this Agreement, Business Associate will implement such changes within 10 days of receipt of notice of the change.
- 3.8 **Revocation or Modification of Consumer Permission.** Health Care Provider shall provide Business Associate with any changes in, or revocation of, permission by an individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.
- 3.9 **Consumer Restrictions on Uses and Disclosures.** Health Care Provider shall notify Business Associate of any restriction to the use or disclosure of PHI in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.
- 3.10 **Availability of Books and Records.** Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Health Care Provider available to Health Care Provider, or at the request of Health Care Provider to the Secretary, in a time and manner designated by Health Care Provider or the Secretary, for purposes of the Secretary determining Health Care Provider's compliance with the Privacy Standards. The provisions of this section of the Addendum shall survive the termination of this Agreement.
- 3.11 **Notice of Request for PHI.** Business Associate agrees to notify Health Care Provider within two business days of receipt of any request, subpoena or other legal process to obtain PHI or an accounting of PHI. Health Care Provider in its discretion shall determine whether Business Associate may disclose PHI pursuant to such request, subpoena, or other legal process. Business Associate agrees to cooperate fully with Health Care Provider in any legal challenge initiated by Health Care Provider in response to such request, subpoena, or other legal process. The provisions of this section shall survive the termination of this Agreement.

[Optional: Include the following section only if you intend Business Associate to be able to use PHI in its own management or administration functions.]

3.12 Proper Management and Administration of Business Associate.

- 3.12.1 **Permissible Uses.** Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

- 3.12.2 **Permissible Disclosures.** Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are required by law, or that Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

[Optional: Include the following section only if you intend Business Associate to perform Data Aggregation functions.]

- 3.13 **Data Aggregation.** Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Health Care Provider as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

[Optional: Include the following section only if Business Associate will receive PHI in Designated Record Sets.]

- 3.14 **Access to Records in a Designated Record Set.** At the request of Health Care Provider and in the time and manner designated by Health Care Provider, Business Associate agrees to provide access to PHI in a Designated Record Set to Health Care Provider (and its employees and agents) or, as directed by Health Care Provider, to an individual in order to meet the requirements under 45 C.F.R. § 164.524.

[Optional: Include the following section only if Business Associate will receive PHI in Designated Record Sets.]

- 3.15 **Amendment of Records in a Designated Record Set.** At the request of Health Care Provider and in the time and manner designated by Health Care Provider, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Health Care Provider (or its employees or agents) directs or agrees to pursuant to 45 C.F.R. § 164.526.

IV. Termination.

- 4.1 **Termination Upon Breach.** Any other provision of this Agreement notwithstanding, this Agreement may be terminated by Health Care Provider upon five business days written notice to Business Associate in the event that the Business Associate breaches any provision (including any covenant, representation, warranty, or condition) contained in Article III of this Addendum or any other such provision of this Addendum that relates to PHI and such breach is not cured within the 5 day notice period; provided, however, that in the event that termination of this Agreement is not feasible in Health Care Provider's sole discretion, Business Associate hereby acknowledges that Health Care Provider shall have the right to report the breach to the Secretary, notwithstanding any other provision of this Agreement to the contrary.
- 4.2. **Return or Destruction of PHI upon Termination.**
- 4.2.1 **General Provisions.** Upon termination of this Agreement, Business Associate shall either return or destroy, at the option of Health Care Provider, all PHI received from the Health Care Provider, or created or received by Business Associate on behalf of the Health Care Provider and which Business Associate still maintains in any form. Business Associate shall not retain any copies of such PHI.
- 4.2.2. **Alternative Arrangement.** Notwithstanding the foregoing, to the extent that the Health Care Provider agrees that it is not feasible to return or destroy such PHI, Business Associate shall provide Health Care Provider with a written acknowledgement and notification of the conditions that make return or destruction infeasible. Business Associate hereby agrees to (a) extend the

protections of this Agreement to such PHI only for those purposes that make the return or destruction infeasible, (b) limit further uses and disclosures of such PHI to such purposes, and (c) extend any term or provision of this Agreement relating to PHI so that such term or condition shall survive termination of this Addendum. Thereafter, such PHI shall be used or disclosed solely for such purpose or purposes, which prevented the return or destruction of such PHI.

4.2.3 **Applicability of Provisions.** The provisions of this section of the Addendum shall apply, to the same extent that it applies to Business Associate, to PHI that is in the possession of agents of Business Associate.

4.2.4 **Health Care Provider's Right to Cure.** At the expense of Business Associate, Health Care Provider shall have the right to cure any breach of Business Associate's obligations under this Addendum. Health Care Provider shall give Business Associate notice of its election to cure any such breach and Business Associate shall cooperate fully in the efforts by the Health Care Provider to cure Business Associate's breach. All requests for payment for such services of the Health Care Provider shall be paid within 30 days of Business Associate's receipt of the request for payment.

1.2.5 **Survival.** The provisions of this Article IV of the Addendum shall survive the termination of this Agreement.

V. Miscellaneous.

5.1 **Indemnification.** Business Associate hereby agrees to indemnify and hold Health Care Provider and its employees and agents harmless from and against any and all loss, liability, or damages, including reasonable attorneys' fees, arising out of or in any manner occasioned by a breach of any provision of this Addendum by Business Associate, or its employees or agents, without regard to any limitation or exclusion of damages provision otherwise set forth in this Agreement.

5.2 **Insurance.** Business Associate shall obtain and maintain, at its sole expense during the term of this Agreement, liability insurance on an occurrence basis with responsible insurance companies covering claims based on a violation of any of the Standards or any applicable state law or regulation concerning the privacy of patient information and claims based on its obligations pursuant to Section 5.1 of this Addendum in amount not less than **[Insert minimum amount of required coverage; for high risk business associates – suggest \$1,000,000 per claim.] [Optional, suggest inserting for high or medium risk business associates:** Such insurance policy shall name Health Care Provider as an additional named insured and shall provide for 30 days prior written notice to Health Care Provider in the event of any decrease, cancellation, or non-renewal of such insurance.] A copy of such policy or a certificate evidencing the policy shall be provided to Health Care Provider upon written request.

5.3 **Injunction.** Business Associate hereby agrees that Health Care Provider will suffer irreparable damage if Business Associate breaches this Addendum and that such damages will be difficult to quantify. Business Associate hereby agrees that Health Care Provider may file an action for an injunction to enforce the terms of this Addendum against Business Associate, in addition to any other remedy Health Care provider may have.

5.4 **Authorization for Addendum.** Business Associate represents and warrants that the execution and performance of this Addendum by Business Associate has been duly authorized by all necessary laws, resolutions and corporate action, and this Addendum constitutes the valid and enforceable obligations of the Business Associate in accordance with its terms.

- 5.5 **Legislative, Regulatory or Administrative Changes.** In the event of a change in federal, state or local law, any of which could, in Health Care Provider's reasonable judgment, materially and adversely affect the manner in which either party may perform services under this Addendum, the parties shall immediately amend this Addendum to comply with the law, regulation, or policy and approximate as closely as possible the arrangements set forth in this Addendum as it existed immediately prior to the change in law, regulation or policy.
- 5.6 **Interpretation.** Notwithstanding any other provision of this Agreement, any ambiguity in a provision of this Agreement that may require an interpretation of the Standards, shall be resolved in favor of a meaning that permits Health Care Provider to comply with the Standards including without limitation those standards relating to preemption of state laws.

In Witness Whereof, Health Care Provider and Business Associate have caused this instrument to be duly executed by their authorized representatives as of the Effective Date.

Davis Behavioral Health, Inc.

By: [Insert "President" or Title of Other Authorized Officer]

[Insert Full Legal Name of Business Associate]

By: [Insert "President" or Title of Other Authorized Officer]

Policy 6 The Designated Record Set and PHI

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the elements of the designated record set and the creation and maintenance of data sources that contain PHI. This Policy mandates that Davis Behavioral Health maintain accurate and complete medical and billing records for each of our clients so that they can exercise their rights to access, review, and amend their PHI maintained in a designated record set as required under HIPAA.

Policy

Davis Behavioral Health will maintain the following items in its designated record set:

The Medical Record (including all of the items listed below, and any other records of care that would be appropriate):

- a. The clinical diagnostic assessment
- b. The psychiatric diagnostic assessment
- c. The treatment plan
- d. Consents for treatment
- e. Reports/information from indirect treatment providers
- f. Functional status assessments
- g. Medication profiles
- h. Progress notes and documentation of care provided, for both treatment and reimbursement purposes. .
- i. Multidisciplinary progress notes/documentation
- j. Content of any consultation with internal or external individuals regarding the client's care
- k. Nursing assessments
- l. Orders for diagnostic tests and diagnostic study results
- m. Practice guidelines that imbed patient data
- n. Records of physical history, examinations, respiratory therapy, physical therapy, speech therapy, occupational therapy, and any other records of services provided by specialty providers
- o. Telephone consultation records
- p. Telephone orders

- q. Discharge instructions
- r. Discharge summaries
- s. Legal Documents and correspondence between the agency and the client or others involved in the client's care
- t. utilization management or utilization review forms that are used to determine or review level of care decisions including admission, continuing stay, and discharge

The Billing Record

- a. Signature on file
- b. Consent to bill third parties
- c. Individual Financial Assessment (i.e., Income Affidavit)
- d. Copies of any insurance cards and other data on insurance coverage
- e. Fee Agreement
- f. Requests for prior authorization of services
- g. Authorizations for services or other written acknowledgements of client eligibility for services
- h. Billing records including dates, services provided, provider, billing and payment records, and other information used to bill or to record and report encounters or services.

PHI is kept in many forms throughout Davis Behavioral Health. Each of the existing repositories of PHI have been identified, documented, and approved for usage. It is our policy that any new need for creation of an additional repository of PHI must follow the same process. Unsanctioned maintenance of PHI in any form will lead to disciplinary action.

Policy 7 Privacy Notice

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for providing notice to clients of our privacy practices.

Policy

Davis Behavioral Health will post a copy of our Privacy Notice, in English, in a prominent position at the Intake area of each service delivery site. In addition, copies of the Notice, in English and Spanish, will be available at the Front Desks for those who wish to have them. Any individual who is unable to read can request that the Notice be read to him/her.

Davis Behavioral Health will obtain a written acknowledgment of receipt of the Privacy Notice from each new client (other than in emergency situations) no later than their first service. Should we fail to obtain the written acknowledgment, we will document the good faith effort we made to obtain the acknowledgment and the reason why we were unable to obtain it. We will mail the Privacy Notice to all current clients, prior to April 14, 2003.

The Privacy Notice that is in effect will be the Notice that is attached to this Policy. This version of the Notice reflects the privacy practices in place at this time in our Agency.

It is our policy to conform our Privacy Notice to the content specified in the Privacy Rule. At the present time, this content is as follows and any version of our Privacy Notice must contain all of these items:

1. Header:

“THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.”

2. A description, including sufficient detail to place the individual on notice, and at least one example of the types of uses and disclosures for each of the following purposes: treatment, payment, and health care operations.

3. A description, including sufficient detail to place the individual on notice, of each of the other purposes a covered entity is either required or permitted to use or disclose PHI without the individual's written consent or authorization.
4. A description of any prohibitions or material limitations required by more stringent law.
5. A statement that other uses and disclosures will be made only with the individual's written authorization and that such authorization may be revoked.
6. If Davis Behavioral Health intends to do any of the following, there must be a separate statement that:
 - a. It will contact the individual to provide appointment reminders or information about treatment alternatives, or other health-related benefits and services that may be of interest;
 - b. It may contact the individual to raise funds on its behalf.
7. A statement of the individual's rights with respect to uses and disclosures of PHI and a description of how those rights may be exercised including:
 - a. The right to request restrictions, including a statement that Davis Behavioral Health is not required to agree to such a restriction;
 - b. The right to receive confidential communications of PHI;
 - c. The right to inspect and copy PHI;
 - d. The right to amend PHI;
 - e. The right to receive an accounting of disclosures of PHI; and
 - f. The right to obtain a paper copy of the notice upon request.
8. A statement about Davis Behavioral Health's duties to:
 - a. Maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices relative to PHI;
 - b. Abide by the terms of the privacy notice currently in effect; and
 - c. When retroactively applying a change in the notice, to provide a statement that it reserves the right to change the terms of its notice and to make the new notice effective for all PHI it maintains; and how it intends to provide individuals with a revised notice.
8. A statement that individuals may complain (to Davis Behavioral Health or the Department of Health and Human Services) if he/she believe their rights have been violated; a brief description of how to file a complaint with the covered entity; and a

statement that there will be no retaliation against the individual if a complaint is made.

9. The name, title, and telephone number of the person or office designated as responsible for receiving complaints and providing additional information.
10. The date on which the notice is first in effect which may not be earlier than the date on which the privacy notice is printed or otherwise published.

Davis Behavioral Health requires that revision of our privacy practices may only occur after deliberation by the ELT or its designated group and the Privacy Officer. Any changes arising from the revision process will be incorporated into the Privacy Notice and distributed to clients before those practices are effective.

DAVIS BEHAVIORAL HEALTH NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective: 04/14/2003

Davis Behavioral Health is required by law to maintain the privacy of your medical information, to provide this notice to you, and to abide by the terms of this notice.

HOW WE USE YOUR HEALTH INFORMATION

When you receive care from Davis Behavioral Health, we may use your health information for treating you, billing you for services, and conducting our normal business (known as health care operations).

Examples of how we use your information include:

Treatment – We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment. Some health records, including confidential communications with a mental health professional, substance abuse treatment records, and genetic test results, may have additional restrictions for use and disclosure under state and federal laws.

Payment – We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. For example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company (i.e., Medicaid) or to the State Division of Mental Health and Substance Abuse.

Health Care Operations – We use health information to improve the quality of care, train staff and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, therapists, nurses, and other health care workers.

Health Related Benefits – We may use and disclose information to tell you about health related benefits. For example, we may disclose information about insurance benefits to others.

OTHER SERVICES WE PROVIDE

We may also use your health information to recommend treatment alternatives, tell you about health services and products that may benefit you, share information with family or friends involved in your care or payment for your care, share information with third parties who assist us with treatment, payment, and health care operations, and remind you of an appointment (optional, notify the front desk staff if you do not wish to be reminded).

YOUR INDIVIDUAL RIGHTS

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. When it is not in your best interest, we may deny you access to a portion of your health information and you may request a review of the denial.*
- Request changes or additions to your health information.*
- Request an accounting of certain disclosures of your health information made by Davis Behavioral Health. The accounting does not include disclosures made for treatment, payment, and health care operations, disclosures subject to your signed authorization, and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free, but a fee will apply if more than one request is made in a 12-month period. *

- Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star () must be made in writing. Contact Abel Ortiz at 773-7060, the Davis Behavioral Health Privacy Officer, for the appropriate form for your request.

SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization and without notice to you. These situations include activities necessary to administer the Medicaid program and the following:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices
- To protect victims of abuse, neglect, or domestic violence and emergencies
- For health oversight activities such as investigations, audits, and inspections
- For legal proceedings
- When otherwise required by law
- When requested by law enforcement as required by law or court order
- To coroners, medical examiners, and funeral directors
- For organ and tissue donation
- For research approved by our review process under strict federal guidelines
- To reduce or prevent a serious threat to public health and safety
- For worker's compensation or other similar programs if you are injured at work
- For specialized government functions such as intelligence and national security
- To the armed forces when requested if you are a member of the armed forces

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

OUR PRIVACY RESPONSIBILITIES

Davis Behavioral Health is required by law to:

- Maintain the privacy of your health information
- Provide this notice that describes the ways we may use and share your health information
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in all Davis Behavioral Health offices. You may also request a copy of any notice (including an 11-page document explaining this notice in greater detail) from Abel Ortiz, the Davis Behavioral Health Privacy Officer.

CONTACT US

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, contact Abel Ortiz, the Davis Behavioral Health Privacy Officer.

Abel Ortiz
2250 N 1700 W
Layton, UT 84041
(801) 773-7060
aortiz@davisbh.org

You may also file a written complaint with the following:

Office of Civil Rights
200 Independence Avenue
S.W. Room 509F
HHH Bldg.
Washington, DC 20201

We will investigate all complaints and will not retaliate against you for filing a complaint.

NOTICE OF PRIVACY PRACTICES

Davis Behavioral Health

291 South 200 West

Farmington, UT 84025

(801) 451-7799

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Privacy Notice, please contact Abel Ortiz @ 773-7060, the Davis Behavioral Health Privacy Officer.

I. Introduction

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care (health care refers to mental health, behavioral health, substance abuse, and related medical care) operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your health information.

“Protected health information” means health information (including identifying information about you) we have collected from you or received from your health care providers, health plans, your employer, or a health care clearinghouse. It may include information about your past, present, or future behavioral health or condition, the provision of your health care, and payment for your health care services.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are also required to comply with the terms of our Notice of Privacy Practices.

II. How We Will Use and Disclose Your Health Information

We will use and disclose your health information as described in each category listed below. For each category, we will explain what we mean, in general, but not describe all specific uses or disclosures of health information.

A. Uses and Disclosures for Treatment, Payment, and Operations.

1. **For Treatment.** We will use and disclosure your health information, without your authorization, to provide your behavioral health care and any related services. We will also use and disclose your health information to coordinate and manage your health care and related services. For example, we may need to disclose information to a case manager who is responsible for coordinating your care. We may also disclose your health information among our clinicians and other staff (including clinicians other than your therapist or principal clinician), who work at or contract with Davis Behavioral Health. For example, our staff may discuss your care at a case conference. In addition, we may disclose your health information to another health care provider (such as your primary care physician, a hospital, a pharmacy, or a laboratory) working outside of Davis Behavioral Health for purposes of your treatment.

2. **For Payment.** We may use or disclose your health information, without your authorization, so that the treatment and services you receive are billed to, and payment is collected from, your health plan or other third party payer. By way of example, we may disclose your health information to permit your health plan to take certain actions before your health plan approves or pays for your services. These actions may include:

- Deciding if you qualify or have coverage for health insurance;
- Reviewing your services to determine if they were medically necessary;
- Reviewing your services to determine if they were appropriately authorized or certified in advance of your care; or
- Reviewing your services for purposes of utilization review, to ensure the appropriateness of your care, or to justify the charges for your care.

For example, your health plan may ask us to share your health information in order to determine if the plan will approve additional visits to your therapist. We may also disclose your health information to another health care provider so that provider can bill you for services they provided to you, such as an ambulance service that transported you to the hospital.

3. For Health Care Operations. We may use and disclose health information, without your authorization, about you for our health care operations. These uses and disclosures are necessary to run our organization and make sure that our consumers receive quality care. These activities may include quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training students in clinical activities, licensing, accreditation, business planning and development, and general administrative activities.

We may combine the health information of many of our consumers to decide what additional services we should offer, what services are no longer needed, and whether certain new treatments are effective. We may also provide your health information to other health care providers or to your health plan to assist them in performing certain of their own health care operations. We will do so only if you have or have had a relationship with the other provider or health plan. For example, we may provide information about you to your health plan to assist them in their quality assurance activities. We may also use and disclose your health information to contact you to remind you of your appointment. Finally, we may use and disclose your health information to inform you about possible treatment options or alternatives that may be of interest to you.

4. Health-Related Benefits and Services. We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. If you do not want us to provide you with information about health-related benefits or services, you must notify Abel Ortiz, DBH Privacy Officer, in writing at 291 South 200 West, Farmington, UT 84025. Please state clearly that you do not want to receive materials about health-related benefits or services.

5. Fundraising Activities. It is not our practice to release identifiable health information that would allow a fundraiser to directly contact you. However, we may use or disclose non-identifiable health information to assist us in raising money for our programs, services, and operations. We may disclose identifiable health information to potential fundraising entities, to assist us in raising money. We will only disclose identifiable information, if we first obtain your consent. We will only release basic contact information, such as your name and address and the dates you were provided service, but we will not provide information about your treatment.

B. Uses and Disclosures That May be Made Without Your Authorization, But For Which You Will Have an Opportunity to Object.

1. **Facility Directory.** We do not maintain a facility directory at any of our units. If asked, we will not confirm orally, in writing, or through any other medium that you are our current or former client, with the exceptions listed below under “Person’s Involved in an Individual’s Care.”

2. **Persons Involved in Your Care.** We may provide health information about you to someone who helps pay for your care. We may use or disclose your health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. We may also use or disclose your health information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures for this purpose to family or other individuals involved in your health care. In limited circumstances, we may disclose health information about you to a friend or family member who is involved in your care. If you are physically present and have the capacity to make health care decisions, your health information may only be disclosed with your agreement to persons you designate to be involved in your care. However, if you are in an emergency situation, we may disclose your health information to a spouse, a family member, or a friend so that person may assist in your care. In this case, we will determine whether the disclosure is in your best interest and, if so, only disclose information that is directly relevant to participation in your care. If you are not in an emergency situation but are unable to make health care decisions, we will disclose your health information to:

- A person designated to participate in your care in accordance with an advance directive validly executed under state law,
- Your guardian or other fiduciary if one has been appointed by a court, or
- If applicable, the state agency responsible for consenting to your care.

C. Uses and Disclosures That May be Made Without Your Authorization or Opportunity to Object.

1. **Emergencies.** We may use and disclose your health information in an emergency treatment situation. By way of example, we may provide your health information to a paramedic who is transporting you in an ambulance. We will attempt to obtain your Consent as soon as reasonably practicable after we provide you with emergency treatment. If a clinician is required by law to treat you and your treating clinician has

attempted to obtain your Consent but is unable to do so, the treating clinician may nevertheless use or disclose your health information to treat you.

2. **Research.** We may disclose your health information to researchers when the research has been approved by an Institutional Review Board or a similar privacy board who has reviewed the research proposal and established protocols to ensure the privacy of your health information.
3. **As Required By Law.** We will disclose health information about you when required to do so by federal, state, or local law.
4. **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious and imminent threat to your health or safety or to the health or safety of the public or another person. Under these circumstances, we will only disclose health information to someone who is able to help prevent or lessen the threat.
5. **Organ and Tissue Donation.** If you are an organ donor, we may release your health information to an organ procurement organization or to an entity that conducts organ, eye or tissue transplantation, or serves as an organ donation bank, as necessary to facilitate organ, eye or tissue donation and transplantation.
6. **Public Health Activities.** We may disclose health information about you as necessary for public health activities including, by way of example, disclosures to:
 - Report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
 - Report vital events such as birth or death;
 - Conduct public health surveillance or investigations;
 - Report child abuse or neglect;
 - Report elderly abuse or neglect;
 - Report disabled abuse or neglect;
 - Report to the Food and Drug Administration (FDA) or to a person subject to the jurisdiction of the FDA to report certain events including information about defective products or problems with medications;
 - Notify consumers about FDA-initiated product recalls;
 - Notify a person who may have been exposed to a communicable disease or who is at risk of contracting or spreading a disease or condition;
 - Notify the appropriate government agency, if we believe you have been a victim of abuse, neglect or domestic violence. We will only notify an agency if we obtain

your agreement or if we are required or authorized by law to report such abuse, neglect or domestic violence.

7. **Health Oversight Activities.** We may disclose health information about you to a health oversight agency for activities authorized by law. Oversight agencies include government agencies that oversee the health care system, government benefit programs such as Medicare or Medicaid, other government programs regulating health care, and civil rights laws.
8. **Disclosures in Legal Proceedings.** We may disclose health information about you to a court or administrative agency when a judge or administrative agency orders us to do so. We also may disclose health information about you in legal proceedings without your permission or without a judge or administrative agency's order when:
 - We receive a subpoena for your health information. We will not provide this information in response to a subpoena without your authorization if the request is for records of a federally-assisted substance abuse program.
9. **Law Enforcement Activities.** We may disclose health information to a law enforcement official for law enforcement purposes when:
 - A court order, subpoena, warrant, summons, or similar process requires us to do so; or
 - The information is needed to identify or locate a suspect, fugitive, material witness or missing person; or
 - We report a death that we believe may be the result of criminal conduct; or
 - We report criminal conduct occurring on the premises of our facility; or
 - We determine that the law enforcement purpose is to respond to a threat of an imminently dangerous activity by you against yourself or another person; or
 - The disclosure is otherwise required by law.

We may also disclose health information about a client who is a victim of a crime, without a court order or without being required to do so by law. However, we will do so only if the disclosure has been requested by a law enforcement official and the victim agrees to the disclosure or, in the case of the victim's incapacity, the following occurs:

- The law enforcement official represents to us that (i) the victim is not the subject of the investigation and (ii) an immediate law enforcement activity to meet a serious danger to the victim or others depends upon the disclosure; and
- We determine that the disclosure is in the victim's best interest.

10. **Medical Examiners or Funeral Directors.** We may provide health information about our consumers to a medical examiner. Medical examiners are appointed by law to assist in identifying deceased persons and to determine the cause of death in certain circumstances. We may also disclose health information about our consumers to funeral directors as necessary to carry out their duties.
11. **Military and Veterans.** If you are a member of the armed forces, we may disclose your health information as required by military command authorities. We may also disclose your health information for the purpose of determining your eligibility for benefits provided by the Department of Veterans Affairs. Finally, if you are a member of a foreign military service, we may disclose your health information to that foreign military authority.
12. **National Security and Protective Services for the President and Others.** We may disclose health information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or so they may conduct special investigations.
13. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official.
14. **Workers' Compensation.** We may disclose health information about you to comply with the state's Workers' Compensation Law.

III. Uses and Disclosures of Your Health Information with Your Permission.

Uses and disclosures not described in Section II of this Notice of Privacy Practices will generally only be made with your written permission, called an "authorization." You have the right to revoke an authorization at any time. If you revoke your authorization, we will not make any further uses or disclosures of your health information under that authorization, unless we have already taken an action relying upon the uses or disclosures you have previously authorized.

IV. Your Rights Regarding Your Health Information.

A. Right to Inspect and Copy.

You have the right to request an opportunity to inspect or copy health information used to make decisions about your care, whether they are decisions about your treatment or

payment of your care. Usually, this would include clinical and billing records, but not psychotherapy notes.

You must submit your request in writing to Abel Ortiz, DBH Privacy Officer, at 291 South 200 West, Farmington, UT 84025. If you request a copy of the information, we may charge a fee for the cost of copying, mailing and supplies associated with your request. We may deny your request to inspect or copy your health information in certain limited circumstances. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access. We will inform you in writing if the denial of your request may be reviewed. Once the review is completed, we will honor the decision made by the licensed health care professional reviewer.

B. Right to Amend.

For as long as we keep records about you, you have the right to request us to amend any health information used to make decisions about your care, whether they are decisions about your treatment or payment of your care. Usually, this would include clinical and billing records, but not psychotherapy notes. To request an amendment, you must submit a written document to Abel Ortiz, DBH Privacy Officer, at 291 South 200 West, Farmington, UT 84025 and tell us why you believe the information is incorrect or inaccurate. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend health information that:

- Was not created by us, unless the person or entity that created the health information is no longer available to make the amendment;
- Is not part of the health information we maintain to make decisions about your care;
- Is not part of the health information that you would be permitted to inspect or copy; or
- Is accurate and complete.

If we deny your request to amend, we will send you a written notice of the denial stating the basis for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of

disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the health information that is the subject of your request.

If you choose to submit a written statement of disagreement, we have the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal (as well as the original request and denial) to all future disclosures of the health information that is the subject of your request.

C. Right to an Accounting of Disclosures.

You have the right to request that we provide you with an accounting of disclosures we have made of your health information. An accounting is a list of disclosures. But this list will not include certain disclosures of your health information, by way of example, those we have made for purposes of treatment, payment, and health care operations. To request an accounting of disclosures, you must submit your request in writing to Abel Ortiz, DBH Privacy Officer, at 291 South 200 West, Farmington, UT 84025. For your convenience, you may submit your request on a form called a "Request For Accounting," which you may obtain from our Privacy Officer. The request should state the time period for which you wish to receive an accounting. This time period should not be longer than six years and should not include dates before April 14, 2003.

The first accounting you request within a 12-month period will be free. For additional requests during the same 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge, and you may choose to withdraw or modify your request before we incur any costs.

D. Right to Request Restrictions.

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. To request a restriction, you must request the restriction in writing addressed to Abel Ortiz, DBH Privacy Officer, at 291 South 200 West, Farmington, UT 84025. The Privacy Officer will ask you to sign a request for restriction form, which you should complete and return to the Privacy Officer. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency treatment.

E. Right to Request Confidential Communications.

You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. For example, you may request that we contact you only at work or by e-mail. We will accommodate all reasonable requests. You do not need to give us a reason for the request; but your request must specify how or where you wish to be contacted.

F. Right to a Paper Copy of this Notice.

You have the right to obtain a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice of Privacy Practices electronically, you may still obtain a paper copy. To obtain a paper copy, contact Abel Ortiz, DBH Privacy Officer, at 291 South 200 West, Farmington, UT 84025.

V. Confidentiality of Substance Abuse Records

For individuals who have received treatment, diagnosis, or referral for treatment from our drug or alcohol abuse programs, the confidentiality of drug or alcohol abuse records is protected by federal law and regulations. As a general rule, we may not tell a person outside the programs that you attend any of these programs, or disclose any information identifying you as an alcohol or drug abuser, unless:

- You authorize the disclosure in writing; or
- The disclosure is permitted by a court order; or
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation purposes; or
- You threaten to commit a crime either at the drug abuse or alcohol program or against any person who works for our drug abuse or alcohol programs.

A violation by us of the federal law and regulations governing drug or alcohol abuse is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. Federal law and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to appropriate state or local authorities. Please see 42 U.S.C. § 290dd-2 for federal law and 42 C.F.R., Part 2 for federal regulations governing confidentiality of alcohol and drug abuse patient records.

VI. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, contact Abel Ortiz at 291 South 200 West, Farmington, UT 84025. All complaints must be submitted in writing. Abel Ortiz, who can be contacted at 291 South 200 West, Farmington, UT 84025 (801-451-7799) will assist you with writing your complaint, if you request such assistance. Davis Behavioral Health will not retaliate against you for filing a complaint.

VII. Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We will post a copy of the current Notice of Privacy Practices at our main office and at each site where we provide care. You may also obtain a copy of the current Notice of Privacy Practices by calling us at 801-451-7799 and requesting that a copy be sent to you in the mail or by asking for one any time you are at our offices.

VIII. Who will follow this Notice

This Notice of Privacy Practices will be followed by us and by our contracted entities. In addition, these entities, sites, or locations may share health information with each other for treatment, payment or health care operation purposes.

Policy 8 Minimum Necessary

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out in this policy, the process for applying the minimum necessary standards to uses, disclosures, and requests for PHI.

Policy

Davis Behavioral Health will apply the minimum necessary standards to all uses, disclosures, and requests for PHI, except for:

1. Disclosures to, or requests, by, a healthcare provider for the purpose of treatment;
2. Disclosures to the client;
3. Disclosures pursuant to the client's authorization;
4. Disclosures required to comply with the Privacy Rule; and
5. Uses and disclosures required by law to the extent that such disclosure complies with and is limited to the relevant requirements of the law.

Any request made for entire medical records, other than for treatment purposes, must be justified in writing and made part of the medical record as documentation of that justification.

Our policy for uses of PHI by our employees will be to use PHI in accordance with the matrix of classes of persons, categories of access, and conditions appropriate to such access. The operative version of the Role-based Access to PHI matrix will be appended to this Policy and Procedure. Changes to the matrix will require notification of Human Resources for inclusion in subsequent training of direct service personnel.

Our policy for routine and recurring disclosures of PHI will be to disclose PHI in accordance with the matrix of type of PHI, types of persons eligible to receive PHI, and the conditions that would apply to such access. The operative version of the Routine Disclosures Matrix will be appended to this Policy and Procedure. Changes to the matrix will require notification of Human Resources for inclusion in subsequent training of direct service personnel.

Non-routine, non-recurring disclosures of PHI will be reviewed, prior to release of PHI, by an authorized clinical person as identified in current procedures below. This person will make a determination that the minimum necessary PHI is being used or disclosed in accordance with our criteria for non-routine, non-recurring disclosures.

When we receive requests for PHI from external sources, we will generally rely upon the written representation of the requestor that it is requesting the minimum PHI necessary for its purpose. We will rely on the representation of the following person(s), only when reliance is reasonable:

1. Public officials for a disclosure not requiring any legal permission;
2. Other covered entities;
3. A professional who is either a member of our workforce or a business associate and the request is for the purpose of providing professional services on our behalf and the professional has asserted that the PHI requested is the minimum necessary for their stated purpose; and
4. Researchers as long as we have received documentation from an IRB or privacy board and we have determined the PHI that minimally necessary to achieve the scope of the use or disclosure.

However, if reliance on the representation of the requestor is not reasonable, we may disregard the representation and make our own determination of the minimum amount of PHI that is necessary for the purpose.

Policy 9 De-identification and Limited Data Sets

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out in this policy, the process for creating and using de-identified health information and limited data sets.

Policy

Davis Behavioral Health will create de-identified health information for use or disclosure in any circumstance where that information can be used, effectively and efficiently, in place of PHI.

Davis Behavioral Health will consider PHI to be de-identified health information if it meets one of the two following criteria:

1. A qualified statistician (a person with appropriate knowledge and experience with generally accepted statistical and scientific principles and methods), applying such principles and methods has determined that the risk is very small that the information could be used alone, or in combination with other reasonably available information, by an anticipated recipient to identify an individual and documents the methods and results of the analysis that justify such determination.
2. All of the following identifiers have been removed, and Davis Behavioral Health does not have actual knowledge that the remaining information could be used, alone or with other information, to identify an individual who is the subject of the information:
 - a. Names of individual, relatives, or household members
 - b. Geographic subdivisions smaller than a state, except for the initial three digits of a zip code for geographic area with more than 20,000 people;
 - c. All elements of dates (including birth, admission and discharge dates, and dates of death), except for the year, for all individuals under 89, and all elements of dates for those over 89 except for presentation as a single over-90 category;
 - d. Telephone or fax numbers or e-mail addresses, URLs, or IP addresses;
 - e. Social security numbers;
 - f. Medical record numbers;
 - g. Health plan beneficiary numbers;
 - h. Account numbers;
 - i. Certificate or license numbers;

- j. Vehicle identifiers and serial numbers;
- k. Device identifiers and serial numbers;
- l. Biometric identifiers such as finger or voice prints;
- m. Full face photographic images and the like; or
- n. Any other unique identifying number, code, or characteristic except for a re-identification code.

The re-identification code may not be derived from or related to information about the individual and may not be otherwise translatable to identify the individual. We will not use or disclose the code for any purpose, nor the means of re-identification.

Davis Behavioral Health will create limited data sets for use or disclosure in any circumstance where that information can be used, effectively and efficiently for research, public health or health care operations.

Davis Behavioral Health will consider PHI to be in the form of a limited data set if it excludes the following direct identifiers of our clients, their relatives, employers, or household members:

- 1. Names;
- 2. Postal address information, other than town or city, state, and zip code;
- 3. Telephone numbers;
- 4. Fax numbers;
- 5. Electronic mail addresses;
- 6. Social security numbers;
- 7. Medical record numbers;
- 8. Health plan beneficiary numbers;
- 9. Account numbers;
- 10. Certificate/license numbers;
- 11. Vehicle identifiers and serial numbers, including license plate numbers;
- 12. Device identifiers and serial numbers;
- 13. Web Universal Resource Locators (URLs);
- 14. Internet Protocol address numbers;
- 15. Biometric identifiers, including finger and voice prints; and
- 16. Full face photographic images and any comparable images.

Any use or disclosure that we make of a limited data set must take place pursuant to a data use agreement. This data use agreement must include the following requirements:

1. That the limited data set recipient(s) will use or disclose information for the limited purposes described in the agreement and not further disclose the information in a way that would be inconsistent with the privacy regulation as it would apply to our Agency itself;
2. That only the recipient(s) specified in the agreement may use or receive the limited data set;
3. That the recipient(s) will not use or further disclose the information in a manner that violates the data use agreement or the law and will use appropriate safeguards to prevent any uses or disclosures other than the permitted uses or disclosures;
4. That the recipient(s) will report to Davis Behavioral Health any use or disclosure of PHI in the limited data set, which is not included in the data use agreement, of which it becomes aware;
5. That the recipient(s) will assure that any subcontractor who is provided with a limited data set agrees to the same restrictions and conditions as apply to the recipient(s); and
6. That the recipient(s) will not identify the information or contact the individuals.

Should Davis Behavioral Health become aware of a pattern of activity or practice by a recipient that constitutes a material breach of the data use agreement, we will discontinue disclosure to that recipient and report the problem to the Secretary of Health and Human Services.

Policy 10 Individual's Right to Access

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out in this policy, the processes for requesting, granting, denial of, and review of denial, of client requests for access to PHI.

Policy

Davis Behavioral Health will consider all requests from our clients, or previous clients, for access to their PHI that is maintained in their designated record set and that is dated after April 14, 2003. (See policy on Designated Record Set.) Davis Behavioral Health will consider client requests to either inspect or obtain a copy of their PHI for as long as we maintain their PHI in the designated record set.

Davis Behavioral Health will require that clients make their request in writing using the form that has been designed for that purpose (i.e., the Access Request Form). At a minimum, the form will contain:

1. Identification of the specific PHI that the client wishes to access;
2. The reason for their request (this is optional for the client);
3. Whether they wish to inspect or obtain copies of the PHI;
4. Notification of the cost we will charge for copying and postage; and
5. Notification of their right to obtain a summary or explanation of their information, along with the cost of that service.

Davis Behavioral Health will deny a client access to PHI, and that denial will not be subject to review if:

1. The PHI requested is contained in:
 - a. Psychotherapy notes;
 - b. Records or documents compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or
 - c. Records or documents from clinical laboratories subject to or exempt from the Clinical Laboratory Improvement Act.
2. The PHI is subject to the Federal Privacy Act;

3. The information was obtained under the promise of confidentiality from another person (not a healthcare provider), and the access requested would be reasonably likely to reveal the source of that information;
4. The information was created or obtained in the course of research that involves treatment when the individual agreed to the denial of access for the duration of the research (that includes treatment) when consenting to participate in the research and the client has been informed that access will be reinstated upon completion of the research; or
5. An inmate requests a copy of PHI, and it is determined that such a copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or other inmates or the safety of an officer or other person responsible for transporting the inmate. Davis Behavioral Health will provide an inmate with the right to inspect his PHI unless other grounds for denial exist.

Davis Behavioral Health will deny access to any PHI that a licensed healthcare professional determines:

1. Exercising professional judgment, is reasonably likely to endanger the life or physical safety of the client or another person;
2. Exercising professional judgment, makes reference to another person (not a health care provider) and access is reasonably likely to cause substantial harm to that other person; or
3. Has been requested by a personal representative and access by that person is reasonably likely to cause substantial harm to the client or another person.

When denying a client access for any of these three reasons, these denials will be subject to review as described below. In addition, if access to the entire record is denied and the client requests a review of the decision, we will make the entire record available to the client's attorney, with the consent of the client, or to a psychotherapist designated by the individual.

It is the policy of Davis Behavioral Health to deny clients access to their PHI only infrequently and in unusual circumstances and, when access is denied, it must be for one of the specific reasons listed above. Furthermore, Davis Behavioral Health will provide access, to the extent possible, to any other requested PHI that is not part of the PHI to which access has been denied. Davis Behavioral Health will make an effort to redact the denied PHI from the designated record set and allow inspection or copying of any remaining information.

When a client has been denied access for one of the reasons that is subject to review, Davis Behavioral Health will respond in writing giving the basis for denial in plain language within the time period set forth below. Davis Behavioral Health will also inform the client of their right to request a review of the denial of access and provide a description of how the client may file a complaint with us or with the Secretary of Health and Human Services.

In any case where the client requests a review, Davis Behavioral Health will promptly refer the denial to another licensed healthcare professional, who has not been directly involved in the denial, for their review. Davis Behavioral Health will also promptly inform the client, in writing, if the reviewer upholds the denial. In those cases where the reviewer permits access, the client will be informed.

When Davis Behavioral Health agrees to grant access to PHI, Davis Behavioral Health will notify the client and arrange for access within 30 days from the date of the request. Should the PHI requested be maintained off-site, Davis Behavioral Health can take longer to respond, but no more than 60 days from the date of the request. In either case, Davis Behavioral Health can obtain a single, 30-day extension of time in those rare cases where we are unable to respond in the initial time period. Davis Behavioral Health will notify the client of the reasons for delay and the date of completion by means of a written statement.

When Davis Behavioral Health has agreed to inspection of the designated record set, a mutually agreeable time and place will be arranged for the inspection.

When Davis Behavioral Health has agreed to provide copies of the requested PHI, we will confer with the client and determine their preference for the media in which to receive it (i.e., paper or electronic, where available). If we cannot agree on how the PHI will be produced then we will produce the PHI in readable hard copy. We will charge a fee for copying the material and for postage, if the copies are to be mailed, and the client will be notified of that charge in the Access Request Form. However, if the individual is requesting the PHI for the purpose of supporting a claim or appeal under the Social Security Act or any Federal or state financial need-based benefit program, we will furnish the PHI within 30 days of the request at no charge to the individual.

It will be the policy of Davis Behavioral Health to charge for the cost of making the copies (i.e., the labor, machine, and paper cost) but we will not include in our charges the cost of the retrieval and handling of information nor will the client be charged for the costs of processing the request.

Davis Behavioral Health will provide summaries of PHI in those cases where the individual has requested them. Davis Behavioral Health will charge for the costs associated with producing the summary, and the client will be notified of that charge in the Access Request Form.

In those cases where Davis Behavioral Health receives a request for PHI that we do not maintain, but we know where it is maintained, we will inform the client of the location of the PHI.

CLIENT'S REQUEST FOR HIS/HER OWN RECORDS

HIPAA regulations allow our clients the right to view, inspect, amend and request a copy of their health information. Although we have the right, under certain circumstances to deny such requests, our general practice, at Davis Behavioral Health, will be to comply with and grant such requests. A client must show picture identification before his/her records will be released.

Name:
Address:
Birth date:
Social Security Number:
Reason for requesting records (optional):

Information that you would like released:	
☐ Complete Record	☐ Treatment Plan
☐ Progress Notes	☐ Discharge Summary
☐ Initial Assessment	☐ Substance Abuse Treatment Notes
☐ Psychiatric Evaluation	☐ Treatment Summary
☐ Diagnosis	☐ Dates of Service
☐ Other-please specify:	

Signature:	Date:
Witness:	Date:

By signing this document, I agree to the following conditions as outlined by the HIPAA regulations: (Please see reverse side for details).

Records will be provided in paper format unless you would prefer that you receive your records in another manner.

☐ I would like my information in another manner. Please explain: _____

Prior to release of records, your chart will be reviewed a licensed mental health professional at Davis Behavioral Health.

DBH shall respond to all written requests for PHI within thirty (30) days, unless the information is not stored on a DBH site, then DBH shall respond to the request within sixty (60) days. If DBH is unable to respond within the time frames stated, then DBH shall respond within an additional 30 days, provided that the Privacy Officer gives you a statement in writing of the reasons that DBH is unable to respond within these time frames.

If your request for information is denied, the Privacy Officer shall give written notice to the requester of its denial of the request for PHI.

DBH shall arrange to allow the client to inspect or obtain a copy of the PHI at a convenient time and place. DBH may discuss the scope, format, and other aspects of the request for access with the client to facilitate timely provision of the information.

If you request copies of your record, or you agree to pay for a summary of your record, DBH shall **charge fees** as follows:

***\$.05 per page copied;**

***\$10.00 per hour to copy or scan the information, which is the approximate cost of the staff who will take the time to copy or scan the chart;**

***postage, when the client asks for the PHI to be mailed; and**

***\$ 18-45 (range) per hour to prepare a summary of the information, which is the approximate cost of the staff who will be preparing the summary.**

If DBH denies access, in whole or in part, to your record, DBH shall:

Provide a written denial, which states: the basis of the denial; the client's rights to have a review of the denial; and how the client may appeal the denial (where applicable) or appeal to the Secretary of Health and Human Services

Upon receipt of a request for review of denial, DBH shall appoint Abel Ortiz, the DBH Privacy Officer, who was not involved in the initial denial to review the request. The reviewing professional shall promptly give a written response to the client's request to review.

Dates and Number of hours to copy or scan the record:
Dates and Number of hours to prepare a summary:
Total Number of pages copied:
Cost of preparation time (Hours X Rate Per Hour):
Cost of the paper record (Number of Pages Copied X .05):
Total Cost:

Policy 11 Individual's Right to Amendment of PHI

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out in this policy, the process for providing clients with an opportunity to amend their PHI that is maintained in a designated record set.

Policy

Davis Behavioral Health will consider all requests from clients, or former clients, to amend their PHI that is maintained in a designated record set for as long as it is maintained. Davis Behavioral Health will require that all requests for amendment be in writing and be prepared using the Request for Amendment form. In any case where that form cannot be obtained, Davis Behavioral Health will provide the client or former client with the information needed to submit in lieu of the form. Davis Behavioral Health will require that the individual inform us, in writing, as to the reason for the amendment. Davis Behavioral Health will notify our clients of our policies for requesting amendments in our Privacy Notice.

Davis Behavioral Health will respond to requests for amendment within 60 days from the date of the request. Should, in rare circumstances, Davis Behavioral Health be unable to respond within 60 days, the individual will be notified prior to the expiration of the 60-day period, in writing, and he/she will be provided with the reason additional time is needed. At that time, a date will be set (no more than 30 days beyond the original 60 days) by which Davis Behavioral Health expects to complete action on the request.

In those instances where the request for amendment is granted, Davis Behavioral Health will do the following:

1. Inform the client in writing;
2. Obtain the client's agreement about the list of people or organizations that the client and Davis Behavioral Health believe should be informed of the amendment; and
3. Notify the agreed-upon list (identified above in number 2. of the amendment).

(Note: it is the policy of Davis Behavioral Health to identify anyone who we know may have relied upon the subject PHI in the past, or who might reasonably be expected to rely upon it in the future and attempt to obtain agreement from the client regarding their notification.)

In those instances where the request for amendment is denied, Davis Behavioral Health will do the following:

1. Provide the client with a written denial that is in plain language and that:
 - a. Contains the basis for the denial; and
 - b. Notifies the individual that he/she has the right to provide a written statement disagreeing with the denial and how he/she might file such a statement.
2. Describe to the client the procedure for filing a complaint either with:
 - a. The Department of Health and Human Services or
 - b. With the person or office in Davis Behavioral Health who is responsible for receiving complaints, including the name, title, and telephone number.
3. Inform the individual that he/she may file a statement of disagreement with the denial that does not exceed 250 words.
4. Inform the individual that he/she may request, should he/she not file a statement of disagreement, that the request for amendment and the related denial be attached to all future disclosures of the subject PHI.

Davis Behavioral Health will prepare rebuttals in those instances, where a licensed healthcare professional determines that a rebuttal is necessary, to add clarity to the other material created around this request for amendment.

Designated Record Set

It is the policy of Davis Behavioral Health to take the following actions with respect to the designated record set in amendment situations:

1. When the amendment request has been granted:
 - a. Identify the subject PHI in the designated record set; and
 - b. Append the amendment to the PHI or
 - c. Provide a link to the location in the file of the amendment.
2. When the amendment request has been denied and the client requests it:
 - a. Identify the subject PHI in the designated record set; and
 - b. Append the request for amendment and the denial to the PHI or
 - c. Provide a link to the location in the file of the request and the denial.
3. When the amendment request has been denied, and the client has filed a statement of disagreement, and Davis Behavioral Health has or has not prepared a rebuttal:

- a. Identify the subject PHI in the designated record set; and
- b. Append the request for amendment, the denial, the statement of disagreement, and, if prepared, our rebuttal to the PHI or
- c. Provide a link to the location in the file of all of the items listed in b.

CLIENT'S REQUEST FOR AMENDMENT TO RECORD

HIPAA regulations allow our clients the right to view, inspect, amend, and request a copy of their health information. At Davis Behavioral Health, our standard is accurate documentation; therefore requests to amend records will be given serious consideration. Under certain circumstances, these requests may be denied. A client must show picture identification before his/her records will be released and/or amended.

Date of Request:
Date Received by Privacy Officer:

Name:
Address:
Birth date:
Social Security Number:
Information to be amended:
Reason for amending records (not optional):

Treatment Coordinator:

Signature:	Date:
Witness:	Date:

By signing this document, I agree to the following conditions as outlined by the HIPAA regulations: (Please see reverse side for details).

Prior to amending of records, your chart will be reviewed a licensed mental health professional at Davis Behavioral Health.

DBH shall respond to all written requests for amendment within sixty (60) days from the date of the request. In rare circumstances, DBH be unable to respond within sixty (60) days. In such cases, DBH shall provide a written response explaining the reason for the delay and setting a date within an additional thirty (30) days to complete an action on the client's request.

If your request for amendment is denied, the Privacy Officer shall give written notice to the requester of its denial of the request and the basis for that denial.

If your request for amendment is denied, you have the right to file a complaint either with: the Department of Health and Human Services or Davis Behavioral Health. If you would like to file a complaint with Davis Behavioral Health, please contact Todd A. Soutor, Ph.D. at 451-7799.

If your request for amendment is denied, you have the right to file a statement of disagreement with the denial that does not exceed 250 words. If you would like to file a statement of disagreement, please contact Todd A. Soutor, Ph.D., at 451-7799. Should you choose not to file a statement of disagreement, you may request that your original request for amendment and the related denial be attached to all future disclosures of the specific PHI.

If your request for amendment involves copying your record, DBH shall **charge fees** as follows:

***\$.05 per page copied;**

***\$10.00 per hour to copy or scan the information, which is the approximate cost of the staff who will take the time to copy or scan the chart;**

***postage, when the client asks for the PHI to be mailed; and**

Dates and Number of hours to copy or scan the record:
Total Number of pages copied:

Cost of preparation time (Hours X Rate Per Hour):
Cost of the paper record (Number of Pages Copied X .05):
Total Cost:

Policy 12 Individual's Right to an Accounting of Disclosures of PHI

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out in this policy, the process for providing clients with an opportunity to receive an accounting of the disclosures made of their PHI.

Policy

Davis Behavioral Health will consider all requests from clients, or former clients, to receive an accounting of certain disclosures of their PHI that have occurred in the six year period prior to their request, or from the effective date of the Privacy Rule, whichever is shorter. Davis Behavioral Health will require that all requests for an accounting be in writing using the Request for Accounting form. Should a client need assistance in completing the form, Davis Behavioral Health will provide that assistance. Davis Behavioral Health will notify our clients of the policies for requesting an accounting in our Privacy Notice.

Davis Behavioral Health will respond to requests for an accounting within 60 days from the date of the request. Should, in rare circumstances, Davis Behavioral Health be unable to respond within 60 days, the individual will be notified, in writing during the initial 60-day period and he/she will be provided with the reason(s) that Davis Behavioral Health needs additional time. Additionally, Davis Behavioral Health will identify a date (no more than 30 days beyond the original 60 days) by which we expect to complete action on the request.

Davis Behavioral Health will account for all uses and disclosures of our clients' PHI except for those in the following categories:

1. Disclosures made to carry out treatment, payment, or operations (this includes disclosures made by business associates for these purposes as well);
2. Disclosures made to the individual;
3. Disclosures made incident to a use or disclosure that is otherwise permitted or required;
4. Disclosures made pursuant to an authorization;
5. For disclosures made to the Secretary of Health and Human Services for compliance purposes and for any other disclosures allowed to be made without the individual's permission;

6. Disclosures for national security or intelligence purposes; and
7. Disclosures to correctional institutions or law enforcement officials when individual is an inmate;
8. Disclosures made as part of a limited data set. See Policy 9, De-identification;
9. Those disclosures that occurred prior to April 14, 2003.
10. Disclosures to persons involved in the individual's care or other permitted notification purposes. See Policy 4, No Permission.

In those situations where Davis Behavioral Health has made disclosures to a health oversight or law enforcement agency (as permitted by the No Permission Policy) and the particular agency has provided Davis Behavioral Health with a written statement that inclusion of such disclosures would be reasonably likely to impede with their activities (within a specific time period provided by the agency), our policy will be to exclude those disclosures from any accounting requested by the client. At the end of that period, Davis Behavioral Health will include, in any future accountings, any disclosures made to the agency during that period in any future accountings.

Should the health oversight or law enforcement agency provide Davis Behavioral Health with an oral statement that a disclosure would be reasonably likely to impede their activities, Davis Behavioral Health will withhold disclosures for a 30 day period. After the 30 day period, Davis Behavioral Health will include the disclosures in requested accountings unless a written statement requesting a longer time period has been provided during the 30 day period.

Davis Behavioral Health will include the following items in every accounting:

1. The date of the disclosure;
2. The name and address of the person or organization receiving the PHI;
3. A brief description of the PHI disclosed; and
4. A brief statement that reasonably informs the client of the purpose for the disclosure.

Davis Behavioral Health's policy with respect to multiple disclosures of a client's PHI to the same person or entity (for the same purpose) will be to present all of the information listed above for the first disclosure in the accounting period. In addition, we will present the frequency, periodicity, or number of disclosures made during the accounting period and the date of the most recent disclosure.

Davis Behavioral Health's policy, with respect to disclosures of PHI for a particular research purpose with 50 or more individuals participating, is that the accounting will provide:

1. The name of the protocol or other research activity;
2. A description, in plain language, of the research protocol or other research activity, including the purpose and criteria for selection of particular records;
3. A description of the type of PHI that was disclosed;
4. The date or period of time during which such disclosure occurred, or may have occurred, including the date of the last disclosure during the accounting period;
5. The name, address, and telephone number of the entity that sponsored the research and of the researcher to whom the information was disclosed; and
6. A statement that the PHI may or may not have been disclosed.

In the event that it is reasonably likely that the PHI of a particular client has been disclosed for such a protocol or research activity, Davis Behavioral Health will, if requested by the client, assist him/her in contacting the entity that sponsored the research and the researcher.

Davis Behavioral Health will provide the first accounting in each 12 month period, beginning with the client's first request for an accounting, at no charge. Any additional request for accounting from the same client during that 12 month period will be made subject to the client's agreement to pay a reasonable, cost-based fee for the additional accounting. Davis Behavioral Health will inform the client of the fee on the Request for Accounting form and obtain their written agreement to pay the fee prior to preparing the accounting. Davis Behavioral Health will offer the client an opportunity to withdraw or modify their request in order to avoid or reduce the fee.

Request for Accounting of PHI Disclosed by Davis Behavioral Health

I request an accounting of all PHI disclosed by Davis Behavioral Health pursuant to the requirements of the Privacy Rule. I understand that this accounting will not include disclosures that were:

1. Made to me or my health care representatives.
2. Made to carry out the treatment, payment or operational activities of the organization.
3. For facility directory purposes or to discuss my healthcare with a family member or other individuals involved in my care or for other permitted notification purposes
4. Made for national security and intelligence purposes
5. Made to a correctional institution or to law enforcement and I am currently an inmate
6. Made incident to a use or disclosure that is otherwise permitted by the Agency
7. Made pursuant to an authorization
8. Made as part of a limited data set
9. Occurred prior to April 14, 2003

The period of time I am requesting the accounting for is from:

_____ to _____

I understand that this period of time can be for no longer than six years and cannot include any time period before April 14, 2003, the date the Privacy Rule became effective. I also understand that the first accounting I request in any 12 month period will be given to me for no charge.

Signed: _____

Date: _____

Print Name Below

For a client requesting more than one accounting in a 12 month period the following additional signature should be obtained:

I understand that because I have requested more than one accounting in a 12 month period that I will be charged the cost to Davis Behavioral Health for completing this accounting. I understand that this cost will be *\$.05 per page copied; *\$10.00 per hour to process, copy, or scan the information, which is the approximate cost of the staff who will take the time to copy or scan the chart; and *postage, when the client asks for the PHI to be mailed. Payment must be made at the time I receive the accounting or prior to the accounting being mailed to me.

Agreed and accepted: _____ Date: _____

Print Name Below

PHI Disclosure to be Included in Client's Accounting

If this disclosure was made:

1. To the client or their personal representative;
2. To carry out our treatment, payment or operational activities;
3. For facility directory purposes, to discuss their healthcare with a family member or other individual involved in their care, or for other permitted notification purposes;
4. For national security or intelligence purposes; or
5. To a correctional institution or to law enforcement and the client is currently an inmate;
6. Incident to a use or disclosure that is otherwise permitted;
7. Pursuant to an authorization;
8. As part of a limited data set;
9. Prior to April 14, 2003

STOP – DO NOT COMPLETE THIS FORM!

For all other disclosures:

Date of disclosure: _____ Staff ID Number: _____

Name of person and organization receiving disclosure:

Address of person/organization receiving this disclosure:

Description of what information was disclosed:

Brief statement of purpose of disclosure:

Signature of staff person making disclosure: _____

Date of Disclosure: _____

Uses and Disclosures

Policy 13 Other Individual Rights – Right to Restrict Uses and Disclosures of PHI

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for agreeing to client-requested restrictions on the use and disclosure of PHI for treatment, payment, and operations.

Policy

Davis Behavioral Health will consider a client's request for restriction of the uses and disclosures of PHI that are made for purposes of treatment, payment, and operations. Davis Behavioral Health will discuss with the client the potential difficulties that are inherent in the restrictions that the client requests, such as those that might interfere with the client's ability to obtain appropriate treatment.

Davis Behavioral Health will use the Request for Restrictions form to document the request and, ultimately, the restriction that has been granted to the client. While Davis Behavioral Health is not required by the Privacy Rule to agree to client-requested restrictions, it will be our policy to grant those restrictions that we believe, in our judgment, to be in the best interests of our clients. Davis Behavioral Health will abide by all of the restrictions that are granted, except as described below.

When the individual is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the policy will be to make disclosure of the PHI that is required for treatment and to send along with the PHI the requirement that there be no further uses or disclosures of the restricted PHI.

In non-emergency situations, when Davis Behavioral Health receives a request for PHI that is restricted but required for appropriate treatment, Davis Behavioral Health will discuss with the client the need to send the PHI and attempt to obtain their agreement. Should the client agree to the request, this agreement will be documented by a note in the medical record.

In any case where Davis Behavioral Health believes that the client's restriction can no longer be honored, the restriction will be terminated. Davis Behavioral Health will discuss the change of

circumstance with the client, will ask for their agreement, and will document that agreement on the Request for Restrictions form that is in the medical record.

Should the client refuse to agree to the termination of the restriction, Davis Behavioral Health will implement a unilateral termination. This will also be documented on the Request for Restrictions form. The PHI that was created or received during the term of the restriction will be flagged to assure that future uses and disclosures of it are made in accordance with the restrictions in place for that period.

Davis Behavioral Health

Client Restriction on the Uses and Disclosures of PHI for Treatment,
Payment or Operations

Client Name: _____

Client Number: _____

Social Security Number: _____

Address: _____

Telephone Number: _____

Restriction

requested: _____

This restriction reviewed with client:

Date: _____

By: _____

(Name and Position of Individual Reviewing Restriction with Client)

Face to Face: _____

Phone call: _____

Restriction Approved: Yes ☐

No ☐

Date: _____

Signature of employee approving/denying restriction: _____

Name of employee approving/denying restriction: _____

Signature of Client (required): _____

Signature of Privacy Officer: _____ Date: _____

Uses and Disclosures

Policy 14 Other Individual Rights – Confidential Communications

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for accommodating a client's request for confidential communications.

Policy

Davis Behavioral Health will consider a client's request for confidential communications upon request, for example, at intake.

Davis Behavioral Health will document the alternative information and the approval on the intake/demographic form or equivalent electronic field. It will be our policy to grant reasonable requests. Reasonableness will be judged by the administrative difficulty of complying with the request.

Davis Behavioral Health will not ask the client to explain why he/she wishes to have us communicate with them by alternative means or to alternative locations.

Davis Behavioral Health will not comply with the client's request unless he/she has provided us with complete information to enable us to communicate with them (i.e., a complete address or other method of contact).

Davis Behavioral Health will provide adequate notice of the request to those employees who may need to contact the client by flagging the medical record and, where possible, other client databases.

Policy 15 Administrative Requirements -- Documentation

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the standards it will maintain to fulfill the documentation retention requirements.

Policy

Davis Behavioral Health will retain all documentation as described in the Privacy Rules for a period of six years from its creation or from the date it was last in effect, whichever is later. The six-year period does not apply to the retention of the medical record itself.

The Privacy Officer will assure that all documentation is preserved for the appropriate retention period in whatever medium is considered appropriate for each required item.

The material subject to documentation retention requirements is set out in each individual Privacy Policy. The list that follows summarizes these requirements:

1. The notice of privacy practices, with copies of the notices maintained by implementation dates by version;
2. All policies and procedures, with copies of each policy and procedure maintained through each of its iterations;
3. Workforce training efforts;
4. Restrictions to uses and disclosures of PHI that were granted;
5. The designated record set;
6. Personnel roles related to Privacy Rules (i.e., the Privacy Officer, the person or office designated to receive complaints, the titles of person(s) or office(s) who are responsible for receiving and processing requests for access by individuals, the titles of person(s) or office(s) responsible for receiving and processing requests for amendments and accountings of PHI);
7. For each accounting provided to an individual – the date of disclosure, the name and address of entity or person who received the PHI, a description of the PHI disclosed, a briefly stated purpose for the disclosure, and the written accounting that was provided;

8. All signed, written acknowledgements of receipt of the Privacy Notice or documentation of good faith efforts made to obtain such acknowledgement in those cases where a signed, written acknowledgement could not be obtained;
9. Any signed authorization;
10. All complaints received and their disposition;
11. Any sanctions against members of the workforce that have been applied as a result of non-compliance; and
12. Any of PHI for research made without the individual's authorization and any approval or alteration or waiver of PHI for research in accordance with the requirements of §164.512(i)(2).

Policy 16 Administrative Requirements – Complaint Process

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the process it will establish to receive complaints from clients.

Policy

Davis Behavioral Health will appoint a person to receive and be responsible for complaints about:

1. Privacy policies and procedures required by the Privacy Rule;
2. Compliance with such policies and procedures; and
3. Compliance with the Privacy Rule.

All privacy complaints, as defined above, received by Davis Behavioral Health will be directed to this individual for proper processing and handling.

When any privacy complaint is received, the Complaint Officer will:

1. Retain the original copy of every complaint,
2. Enter the complaint in a log book maintained chronologically;
3. Request the complainant to submit the complaint in writing and, if requested, promptly refer the complainant to the Privacy Officer who will assist the complainant in writing a complaint.
4. Send a letter to or make a telephone contact with the complainant within five-days of receipt of complaint acknowledging receipt of the complaint, thanking him/her for their assistance in strengthening Davis Behavioral Health's privacy practices, providing a copy of the procedures for processing the complaint, establishing the time frame for responding, providing an address for correspondence, and describing that the complainant always has the right to complain to the Secretary of Health and Human Services as well as the information needed to make that contact;
5. Review the complaint;
6. Investigate the complaint;
7. Report results of the investigation to the appropriate individuals; and
8. Periodically submit a summary report of activity to the designated persons (for example, a risk management committee, the Privacy Officer, the Board, the CEO, Counsel).

Davis Behavioral Health will inform clients either orally or in writing at the time of the complaint of his/her right to complain directly to the Secretary of Health and Human Services and will give the client the contact information.

Any complaint that deals with a breach of privacy practices must be reported to the Privacy Officer for appropriate follow-up.

Policy 17 Administrative Requirements – Training of the Workforce

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the requirements for workforce training in our privacy practices.

Policy

Davis Behavioral Health will train all of our workforce members (full time employees, part time employees, interns, and volunteers) in our privacy practices. All members will be trained on or before the effective date of the Privacy Rules. Davis Behavioral Health will train employees in accordance with his/her role in the Agency and his/her functions with regard to PHI. All workforce members who join the Agency subsequent to the effective date will receive privacy training as part of their orientation to the Agency.

Whenever there are material changes to the privacy practices, the Privacy Officer will determine the workforce groups affected by the changes and coordinate the training of those groups.

All trainings presented will be documented as to content and attendance. Workforce members who fail to attend their assigned trainings will be subject to sanction for breach of privacy practices.

Policy 18 Administrative Safeguards – Personnel

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the requirements for safeguarding PHI in all media.

Policy

Davis Behavioral Health will assign responsibility for all safeguarding matters to a Security Officer. This position will be responsible for assuring that all PHI, whether in oral, written, or electronic form, is reasonably secure from accidental or intentional uses and disclosures that violate the Privacy Rules and from inadvertent disclosures to other than the intended recipient.

The Security Officer will maintain the Policies and Procedures, for all media, around security measures to protect PHI. The Security Officer will also be responsible for monitoring the appropriate and consistent implementation of the policies and procedures that control the conduct of the workforce, subcontractors, and business associates with regard to the protection of data. The Security Officer will assure that breaches of security are investigated and that members of the workforce who are responsible for those breaches will be subject to the appropriate sanctions. In addition, the Security Officer will assure that any system weakness uncovered during such investigations will be corrected.

Policy 19 Administrative Safeguards – Chain of Trust Agreements

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the requirements for safeguarding PHI in electronic media.

Policy

Chain of Trust Agreements

Davis Behavioral Health will obtain agreements, commonly referred to as "Chain of Trust Agreements" with any third party through whom it processes electronic data. This agreement will assure that at least the same level of security present within our Agency will be maintained at all points in the movement of PHI to ensure its security, accuracy, and authentication.

The Chain of Trust Agreement is a form of Business Associate Agreement and will be in the form attached to this policy. Note: Chain of Trust provisions are incorporated in Section 3.3 of the model Business Associates Addendum and Section 2.3 of our Model Business Associates Agreements that are attached to the Business Associates Policy.

Davis Behavioral Health will identify the specific attributes that we will require from our electronic data vendors and the steps that will be taken in performing due diligence with these vendors. The process in the Business Associates Policy and Procedure is the guidance for minimum procedures around electronic data vendors.

Policy 20 Administrative Safeguards – Contingency Planning

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rule of HIPAA's Administrative Simplification provisions, sets out, in this policy, the requirements for safeguarding PHI through contingency planning.

Policy

Davis Behavioral Health will maintain contingency plans in accordance with the five required plans set forth in the proposed Security Rule.

It will be our policy to maintain, in a timely manner, documentation of our applications and data criticality that includes:

1. Network architecture diagrams and systems flowcharts showing current structure, equipment addresses, communication providers and system interdependencies;
2. Critical business processes surrounding PHI;
3. Key applications and systems used to support critical business processes;
4. Key applications and systems and their recovery time objectives;
5. Internal and external interfaces with key applications and systems;
6. The adequacy of redundancies within the network infrastructure; and
7. Mitigating controls, in place and tested, for any single points of failure for which redundancies cannot be established.

Davis Behavioral Health will assure, by means of a Data Backup Plan that we have adequate (regular and periodic) backup of critical information as prioritized in the data criticality analysis. Backup and restore procedures will be updated regularly to reflect changes within the organization for the documentation listed above. In addition, Davis Behavioral Health will assure that the backup data can be accessed quickly. We will maintain offsite storage of critical documentation and assure access to those materials.

Davis Behavioral Health will maintain a Disaster Recovery Plan that documents all elements of the Plan and that is updated on a regular basis. The Plan will cover the full range of information and activities needed to assure that the Plan will function smoothly in situations where it is needed.

Davis Behavioral Health will maintain an Emergency Mode Operation Plan that will enable us to operate effectively in emergency conditions. The Plan will include any information, activities, and assignments that are needed such as: identification of crisis management team members, a command center for emergency purposes, a process for acquiring additional personnel with needed skill sets, alternate processing and work space, and health and safety issues.

Davis Behavioral Health will test and revise procedures as necessary to assure that they function as planned and that they are effective.

Policy 21 Administrative Safeguards – Audit Controls and Internal Audit

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rule of HIPAA's Administrative Simplification provisions, sets out, in this policy, the requirements for safeguarding PHI through audit controls and internal auditing.

Policy

Davis Behavioral Health will establish and maintain ongoing processes to review records of systems activity, such as log-ins, file accesses, and security incidents, for PHI in all media. We will establish documented procedures for auditing this information for the purpose of identifying security breaches and for assuring that users comply with access controls. We will assign specific individuals or job functions that will be responsible for such internal audit activity.

Davis Behavioral Health will also establish audit controls that will define users, data sources, data accessed, the client, the date and time of the access, and other information we consider appropriate.

Davis Behavioral Health will also establish procedures to audit configuration management practices that have been established to assure that changes to hardware and software systems do not contribute to, or create, security weaknesses.

Access to audit logs will be limited to those assigned to the internal audit and control function as described above.

Policy 22 Administrative Safeguards – Workforce-related Security Measures

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rule of HIPAA's Administrative Simplification provisions, sets out, in this policy, the requirements for safeguarding PHI. This Policy recognizes that our workforce is the foundation for our security environment.

Policy

Davis Behavioral Health will create and maintain procedures directed toward the behavior of our workforce that promote an environment for PHI that is reasonably secure from accidental, intentional, or inadvertent disclosures that violate the Privacy Rule.

Davis Behavioral Health will create and maintain guidelines on workstation use that are documented. These guidelines will address:

1. The proper functions to be performed;
2. The manner in which those functions are to be performed (i.e., the documentation of the actual function and how it is to be performed); and
3. The attributes of the physical environment in which the workstations, including laptops and other portable devices, are to be located – the attributes will vary based on the sensitivity of information that typically is accessed from that environment. Attributes include such things as physical access to the workstation itself and to the area in which the workstation is located, the removable media, such as diskettes, CD-ROMs, etc., and the practices around writing down passwords where others can find/use them.

The Security Officer will oversee this process and assure that the workforce is trained on these guidelines prior to being given access to the system.

It will be our policy to provide security awareness training to all members of the workforce and to any independent contractors who have access to our workplace and systems. Awareness training will be directed at all of these individuals, regardless of their roles or access to PHI – its purpose will be to provide education around such things as: password maintenance, security incident

reporting, virus and other forms of destructive software. Awareness training will also be accomplished by periodic environmental reminders such as: screen savers, posters, etc. The Security Officer will oversee the development of awareness training in conjunction with Human Resources.

It will also be our policy to provide training to all users of electronic systems. User training will be required prior to any user receiving access to the system. User training will focus specifically on the actual usage of security features such as: virus protection practices, addition of unauthorized hardware or software to the system, password management, login practices, automatic logoffs, etc. The Security Officer will oversee the development of awareness training in conjunction with Human Resources.

We will establish procedures in conjunction with Human Resources for terminated workforce members and for members of the workforce whose positions and work assignments have changed. These procedures will cover security for PHI in all media. We will address:

1. Physical access combinations – for locks and alarm systems;
2. Removal of access privileges – both general access and user levels of access; and
3. The collection of keys, tokens, or other objects that allow access.

Policy 23 Administrative Safeguards – Access Control

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rule of HIPAA's Administrative Simplification provisions, sets out, in this policy, the requirements for safeguarding PHI by controlling access to our facilities and electronic systems.

Policy

Davis Behavioral Health will create and maintain procedures to safeguard all of our locations from unauthorized physical access and to safeguard hardware and other equipment from unauthorized physical access, theft, and interference.

Davis Behavioral Health will limit and control physical access to any and all parts of the designated record set. Our paper medical record files will be placed in limited access spaces and access to those records will be controlled by medical records or other appropriate staff.

Electronic files will be subject to access controls that will limit user access to that PHI for which they have clearance. See Minimum Necessary Policy and Procedures. Controls for access to non-PHI data will be established and maintained in accordance with either context, role, or user-based criteria. These controls will include a process for setting criteria for granting access and for modification of the criteria.

Our systems will maintain an access authorization record to document and review the level of access granted to a user, program, or procedure.

Davis Behavioral Health will assure that systems maintenance personnel have proper access authorization.

Davis Behavioral Health will not transmit PHI over the Internet (open network) without some form of encryption intended to limit access to information.

Policy 24 Administrative Safeguards – Data and Entity Authentication

Purpose

Davis Behavioral Health, in an effort to be compliant with the Privacy Rule of HIPAA's Administrative Simplification provisions, sets out, in this policy, the requirements for safeguarding PHI by assuring that PHI is going to, or coming from, the appropriate person or entity and that the data being processed or transmitted has not been modified intentionally or inadvertently.

Policy

Davis Behavioral Health will establish and maintain procedures for assuring that recipients of PHI via electronic or other means are the intended recipients.

Davis Behavioral Health will also establish and maintain procedures for data authentication. These procedures will assure that PHI contained in messages or files has not been altered or modified.

INFORMED
CONSENT

SECTION:	Clinical Policies
PAGE:	1 of 1
SUBJECT:	Informed Consent
EFFECTIVE DATE:	12/2005
REVISION DATE:	5/2013

Policy

Clients of Davis Behavioral Health will be given information about their medical/psychiatric condition. Clients will be given enough information to understand the proposed treatment options. Clients will be instructed as to the risks and benefits of treatment, and the risks and benefits of non-treatment. Clients will be informed that they may, to the extent allowed by their legal status, be allowed the freedom to accept or refuse treatment.

Purpose

To ensure that clients in a voluntary treatment status, or those responsible for treatment decisions for the client, have the information that they need to make informed, free decisions about their care.

Procedure

- 1) Clients will be given explanations, in language comprehensible to them based upon level of development, education, and comprehension, of the:
 - a) nature of the mental health condition;
 - b) the nature of proposed diagnostic steps and/or treatment(s) and the probability of their success;
 - c) the existence and nature of the risks involved; and the existence, potential benefits, and risks of recommended alternative treatments (including the choice of no treatment).
- 2) The client's understanding of the above information will be clinically assessed, including an assessment, if only tacit, of the capacity of the client or responsible party, to make the necessary decision(s).
- 3) The client will be assured, to the degree that it is legally possible, that the he/she has the freedom to choose among the medical alternatives without coercion or manipulation.
- 4) Employees of Davis Behavioral Health will be encouraged to advocate for the client to receive appropriate medical care or treatment options.

MANAGEMENT OF INFECTIOUS WASTE

Policies & Procedures



SECTION:	Administrative Policies
PAGE:	1 of 1
SUBJECT:	Management of Infectious Waste
EFFECTIVE DATE:	12/2005
REVISION DATE:	11/2013

POLICY

Davis Behavioral Health Inc will recognize and dispose of all infectious waste in accordance with recognized community standards such as in accordance with guidelines from the Centers for Disease Control (CDC), State Code and the Environmental Protection Agency

PURPOSE

Due to the inherent risk of working with our population of clients in mental health, alcohol and Addiction therapy, wherein there exists an increased incidence of blood borne pathogens, the following procedures are to be followed for the safe disposal of infectious waste, in accordance with guidelines from the Centers for Disease Control (CDC), State Code and the Environmental Protection Agency.

PROCEDURE

- 1.0 All infectious waste will be contained in color coded (red bags) and biohazard labeled containers in the area it is generated. The biohazard containers will be transported from the Davis Behavioral Sites to be picked up through BFI.
- 2.0 At no time will infectious waste be flushed in sinks where hands are washed.
- 3.0 Items contaminated with small amounts of blood or body substances (dressings, bandaids) are deemed ordinary waste and may go to a landfill.

Large volumes of blood, or saturated bandages that could drip if squeezed, may be disposed of in toilets or red bagged.

References:

Hedrick, Eddie "Infectious waste management – Will Science prevail? Infection Control: Hospital Epidemiology 1988/ Vol9, No.11

Bouk, Ron "Medical Waste- Task Force results" Utah Hospital Association, July 20, 1990

MEDICALLY NECESSARY SERVICES

SECTION:	Clinical Policies
PAGE:	1 of 1
SUBJECT:	Medically Necessary Services
EFFECTIVE DATE:	12/2005
REVISION DATE:	5/2013

Policy

Treatment services at Davis Behavioral Health will be provided according to an assessment of the medical necessity of those services. The medical necessity will be documented in the assessment and treatment plan, and will be reflected in the ongoing assessment in the progress notes.

Purpose

“Medical Necessity” is a concept that delineates what services qualify for reimbursement from medical plan payors. The concept is useful in appraising what services DBH will provide as a behavioral health system, and is essential for complete corporate compliance.

Procedure

1. Services provided at Davis Behavioral Health will be those which have been assessed to be medically necessary.
2. A treatment is defined as medically necessary if there is adequate information in the clinical record so that it can be determined that:
 - a. There is a billable ICD 9/10 diagnosis;
 - b. A functional impairment has been determined to exist;
 - c. The prescribed level of care addresses:
 - i. Prevention, diagnosis and treatment of behavioral health impairments,
 - ii. The ability of the client to achieve age-appropriate growth and development,
 - iii. The ability to attain, maintain or regain functional capacity.
 - d. The prescribed treatment could not be provided as effectively in a less costly manner;
 - e. The services are not provided merely for the convenience of the client or service provider;
 - f. The services are consistent with professional standards of practice.
3. The medical necessity of a service is determined based on a clinical assessment. The functional impairment must be clinically determined, and the indicated service must be part of a prescribed treatment plan.
4. Progress notes will be based on an evaluation of the client’s response to the medically necessary service. These notes will reflect an ongoing assessment of the absence or presence of the medical necessity of the service based on the client’s response to the services and the client’s functional status.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ **See page 2** for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ **See page 3** for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ **See pages 3 and 4** for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

***Example:** A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

***Example:** We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

***Example:** We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Other Information:

If you seek or receive treatment for substance abuse at Davis Behavioral Health, we do not share your information without your written permission unless otherwise permitted or required by state or federal law.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

Davis Behavioral Health, Privacy Office
934 S Main Street, Layton, UT 84041
(801) 773-7060 or shellyt@dbhutah.org

NOTICE OF
PROVIDER TERMINATION

SECTION:	Clinical
PAGE:	1 of 1
SUBJECT:	Notice of Provider Termination
EFFECTIVE DATE:	11/2009
REVISION DATE:	2/2019

Purpose

To ensure that Medicaid enrollees receive timely written notification of the termination of employment of a provider whom the enrollee has been seeing on a regular basis.

Policy

In the event of a contractor or employee's death or employment termination, Davis Behavioral Health will provide its consumers written notification of the event.

Procedure

1. Within 15 working days of receipt or issuance of termination notice, Davis Behavioral Health will provide a written letter to each consumer and/or family member who was seen regularly by the terminated provider.
2. The Human Resources department will develop a letter that will include the name and contact information of the new primary service provider, if applicable, as well as instructions for scheduling a new appointment.

PEER REVIEW

SECTION:	<u>Clinical Policies</u>
PAGE:	<u>1 of 2</u>
SUBJECT:	<u>Peer Review</u>
EFFECTIVE DATE:	<u>6/2009</u>
REVISION DATE:	<u>4/2014</u>

PURPOSE

To assess through clinical records and other data sources the accessibility, quality, adequacy and outcomes of clinical services provided by Davis Behavioral Health.

POLICY

1. DBH will maintain a Peer Record Review process that is governed by the QAPI committee and that adheres to the regulatory demands of its contractors.
 - a. Peer reviews will be conducted on therapists 2 times yearly.
 - b. Peer review results for individual therapists are reviewed by supervisors.
 - c. Any necessary immediate changes to ensure compliance are directed by the supervisor.
 - d. The QAPI committee will analyze findings and make recommendation for improvement; and
 - e. The findings and recommendations of this committee will be kept on file and be subject to review by State and Federal officials.

PROCEDURE

1. Peer Reviews are conducted by assigned staff and consist of a rotating peer review chairperson.
 - a. The chairperson may be the Program Director or someone assigned by the Program Director who coordinates peer review activities with the Program Director.
 - b. All therapists will participate in a peer review.
2. Records to be reviewed will be randomly selected by the following method:
 - a. Random selections from the therapists active caseload are selected for peer reviews.

- b. If the selected records have insufficient information to be reviewed, the records specialist will make note of the missing elements and this information will be added to the peer review analysis. The next record on the caseload list will be pulled for review.
 - c. In some instances the Program Director may pull specific records to be used for auditing and teaching purposes. These reviews will be included in the peer review process and data analysis.
- 3. A minimum of two (2) charts per clinicians will be reviewed each year. Peer reviews are conducted by assigned peer review committees, in staff meetings, or individually by assigned staff.
- 4. Peer Reviews include a review of Medicaid and State Division of Substance Abuse and Mental Health requirements as well as any area of practice targeted by DBH.
- 5. Peer Reviews include qualitative comments as well as documentation of elements reviewed.
- 6. Written reports are reviewed with each therapist and areas of strength or areas of improvement are noted.

PRACTICE GUIDELINES

SECTION:	Clinical
PAGE:	1 of 1
SUBJECT:	Practice Guidelines
EFFECTIVE DATE:	4/2009
REVISION DATE:	4/2015

POLICY

As preferred practice guidelines are developed (by the Division of Substance Abuse and Mental Health, National Clearinghouse Guidelines and/or internally at DBH), Davis Behavioral Health will formally review, update and adopt/amend said guidelines periodically. DBH will also disseminate these guidelines to clinical staff, subcontractors, and upon request, to Enrollees.

Preferred Practice Guideline's adopted by DBH will be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field and consider the need of DBH clients.

PURPOSE

Davis Behavioral Health recognizes the need for formal review and adoption of practice guidelines as its treatment members implement preferred practices in its recovery focused treatment of mental illness.

PROCEDURE

1. As part of DBH's policy review process, clinical leadership will review, and where needed modify, all existing practice guidelines.
2. Clinical leadership will submit recommendations for formal adoption or revision to the CEO and/or designee.
3. If internal practice guidelines are developed, clinical leadership will review and forward recommendations to the CEO and/or designee for formal approval an adoption/amendment.
4. All practice guidelines will have adoption/revision dates.
5. Annual training will be provided to service providers by clinical leadership. Training will be documented in the provider's personnel record, supervision log or subcontract file. Subcontractors are notified of practice guideline changes and invited to provide feedback.
6. Review and Development of practice guidelines may result out of QAPI request, clinical need, adverse incidents or other means.

DAVIS BEHAVIORAL HEALTH PROFESSIONALISM STANDARDS

SECTION A CONDUCT

Paragraph 1. General Provisions. DBH employees are prohibited from engaging in activities that might have an unfavorable effect upon the DBH. Every employee has a duty to safeguard DBH facilities, equipment, and supplies and to help ensure that DBH Work sites are safe and free of illegal and other activities, which might reflect negatively upon the DBH or its employees. Each employee has an obligation to report incidents, accidents, wrong doing, and any other activity, which might have a negative impact upon the DBH, to their immediate supervisor, or Program Director as soon as possible but at least within 48 hours of occurrence. If further action is needed or if the employee is unable to reach immediate supervisor, the employee shall report the information to the President/CEO, her/his administrative assistant or the Human Resource Director. Each employee shall read and sign a Professionalism Standards upon hire.

Paragraph 2. Violations. Violation of any of the provisions of DBH policies or standards shall constitute just cause for disciplinary action, including dismissal. No employee shall be excused from the provisions of this standard or any DBH policies.

SECTION B STANDARDS OF CONDUCT

Paragraph 1. Employees are expected to apply themselves fully to their assigned duties during the work schedule for which they are being compensated.

Paragraph 2. Employees shall meet the performance standards established for their positions and shall report to their supervisors conditions or circumstances that would prevent them from performing their jobs effectively or from completing their assigned duties. Employees shall also bring to their supervisors' attention any unclear instructions or procedures that are not completely understood.

Paragraph 3. Employees are expected to make prudent and frugal use of DBH funds, equipment, vehicles, buildings, and supplies.

Paragraph 4. Employees shall observe all work rules and comply with all policies and regulations.

Paragraph 5. Unprofessional behavior such as horseplay, grabbing, and tickling are not allowed in any form.

Paragraph 6. Racial or other slurs or actions will not be tolerated.

Paragraph 7. Appropriate titles and names of staff members are to be used when talking to clients in reference to another staff member.

Paragraph 8. Loud talking and joking are not allowed in waiting room areas. Inappropriate jokes, swearing, and profanity are not allowed in any DBH facility or at any DBH function.

Paragraph 9. Children of staff are not allowed in DBH facility or meetings without prior approval.

Paragraph 10. No employee shall receive or take any equipment, property, or supplies for personal benefit regardless of whether item is considered to have value or to be surplus without permission of the President/CEO.

Paragraph 11. Personal use of the telephone for long-distance and toll calls is not permitted. Employees should practice discretion when making local personal calls and may be required to reimburse DBH for any charges resulting from their personal use of the telephone.

Paragraph 12. Employees shall refrain from using their work address for personal mail. DBH stationery and letterheads shall not be used for personal or unauthorized correspondence. DBH postage meters shall not be used for the mailing of personal correspondence.

Paragraph 13. To maintain a safe and productive work environment, DBH expects employees to be reliable and to be punctual in reporting for scheduled work. Absenteeism and tardiness place a burden on other employees and on DBH. In the rare instances when employees cannot avoid being late to work or are unable to work as scheduled, they should notify their supervisor as soon as possible in advance of the anticipated tardiness or absence. Poor attendance and excessive tardiness are disruptive. Either may lead to disciplinary action, up to and including termination of employment. Timely attendance is an essential job function of all DBH employment positions.

Paragraph 14. Computers, computer files, the e-mail system, and software furnished to employees are DBH property intended for business use. Employees should not use a password, access a file, or retrieve any stored communication without authorization. DBH prohibits the use of computers and the e-mail system in ways that are disruptive, offensive to others, or harmful to morale. For example, the display or transmission of sexually explicit images, messages, and cartoons is not allowed. Other such misuse includes, but is not limited to, ethnic slurs, racial comments, off-color jokes, or anything that may be construed as harassment or showing disrespect for others. E-mail may not be used to solicit others for commercial ventures, religious or political causes, outside organizations, or other non-business matters. DBH purchases and licenses the use of various computer software for business purposes and does not own the copyright to this software or its related documentation. Unless authorized by the software developer, DBH does not have the right to reproduce such software for use on more than one computer. Employees may only use software on local area networks or on multiple machines according to the software license agreement. DBH prohibits the illegal duplication of software and its related documentation.

Paragraph 15. If employees eat food prepared for clients, they should pay for the food they consume.

Paragraph 16. Legal questions are to be directed to the President/CEO with appropriate detail. The President/CEO will obtain legal counsel to questions.

Paragraph 17. Employees cannot work hours in excess of their approved status without approval from their supervisor.

SECTION C EMPLOYEE CONDUCT

Paragraph 1. Communication. Each employee shall keep unit secretaries and receptionists informed all times of his/her: location, travel destination, time leaving and time returning. Employees unable to be contacted during regular office hours may be placed on leave-without-pay.

Paragraph 2. Involvement with Clients. Relationships between employees and clients must be developed and maintained at a professional level and in accordance with professional ethics and

standards. Sexual contact is prohibited. All dual relationships with clients are prohibited. Employees shall disclose all relationships with ex-clients whose therapy ended within previous three years. Employees shall not hug or otherwise inappropriately touch clients.

Paragraph 3. Therapists cannot accept gifts from a client, enter into business with a client, or write a contract with a client without the written permission of the President/CEO. A client is someone who is a current client of the DBH or within two years after the formal documented termination of the professional client relationship.

Paragraph 4. Working Evenings. Evening clients (groups and individuals) need to be made aware that there are others in the building during evening hours. Employees need to leave the building at the same time as the individuals in the group (s)he is conducting if there is no other staff in building. Employees should not provide services to clients unless there is another employee or authorized volunteer in the building.

SECTION D – EMPLOYEE CONDUCT IN COMMUNITY

Paragraph 1. Convictions. Conviction of a felony will be grounds for dismissal. Conviction of a misdemeanor may also result in termination.

SECTION E – APPEARANCE

Paragraph 1. Dress Standards. During business hours or when representing DBH, you are expected to present a clean, neat, and tasteful appearance. You should dress and groom yourself according to the requirements of your position and accepted social standards. This is particularly true if your job involves dealing with clients or visitors in person.

Your supervisor or department head is responsible for establishing a reasonable dress code appropriate to the job you perform. If your supervisor feels your personal appearance is inappropriate, you may be asked to leave the workplace until you are properly dressed or groomed. Under such circumstance, you will not be compensated for the time away from work. Consult your supervisor if you have questions as to what constitutes appropriate appearance. Where necessary, reasonable accommodation may be made to a person with a disability.

SECTION F CONTROLLED SUBSTANCES

Paragraph 1. Drug Free Workplace It is DBH's desire to comply with the Drug Free Workplace Act of 1988 and the Omnibus Transportation Employee Testing Act of 1991 and provide a drug-free, healthful, and safe workplace. This applies to all applicants, employees, and volunteers. To promote this goal, employees are required to report to work in appropriate mental and physical condition to perform their jobs in a satisfactory manner.

No employee having an illegal substance in their system; possessing alcohol, or have used alcohol within the last four hours, shall be allowed to start or remain on duty.

While on DBH premises and while conducting business-related activities off DBH premises, to include off duty on call paid status, no employee may use, possess, distribute, sell, or be under the influence of alcohol or illegal drugs. The legal use of prescribed drugs is permitted on the job only if it does not impair

an employee's ability to perform the essential functions of the job effectively and in a safe manner that does not endanger other individuals in the workplace. Abuse of a prescription drug and unauthorized use without a prescription from a licensed physician is prohibited.

Employees shall pursue and complete rehabilitation, if the employee has an alcohol or drug abuse problem; report to his/her immediate supervisor any use of prescription medication which may affect the employee's judgment, performance or behavior before beginning the work shift; and not refuse to take any test which is requested in accordance with current policy.

Violations of the drug free policy may lead to disciplinary action, up to and including immediate termination of employment, and/or required participation in a substance abuse rehabilitation or treatment program. Such violations may also have legal consequences. Any conviction by a law enforcement agency for illegal drug or substance activity may be cause for immediate dismissal from employment.

SECTION G CONFIDENTIALITY

The protection of confidential client information and employee information is vital to the interests and the success of DBH. Such confidential information includes, but is not limited to, the following examples:

- * compensation data
- * computer processes
- * computer programs and codes
- * client lists
- * client information
- * financial information
- * privileged information

Employees who improperly use or disclose confidential information will be subject to disciplinary action, up to and including termination of employment and legal action, even if they do not actually benefit from the disclosed information.

In addition, DBH has a legitimate interest in insuring that the integrity of its services and client base is protected from others. Accordingly, DBH employees may not be employed by or provide services for any person, entity or organization that provides mental health services during the term of employment with DBH without written permission from the CEO or HR Director to do so. Violation of this provision shall be considered a material breach of the contract of employment and shall justify immediate termination of employment for cause.

SECTION H OUTSIDE EMPLOYMENT AND OUTSIDE COMPENSATION

Paragraph 1. Employees may hold outside jobs as long as they meet the performance standards of their job with DBH. All employees will be judged by the same performance standards and will be subject to DBH's scheduling demands, regardless of any existing outside work requirements. Any outside employment shall be disclosed to ELT representative and H.R. Office.

If DBH determines that an employee's outside work interferes with performance or the ability to meet the requirements of DBH as they are modified from time to time, the employee may be asked to terminate the outside employment if he or she wishes to remain with DBH.

Outside employment that constitutes a conflict of interest is prohibited. Employees may not receive any income or material gain from individuals outside DBH for materials produced or services rendered while performing their jobs.

Paragraph 2. Employees shall not accept outside compensation including cash, gifts, favors, gratuities, special accommodations, or any other similar benefits for performance of their duties without approval of the President/CEO.

SECTION I WORKPLACE SAFETY AND ON-THE-JOB INJURIES

DBH provides information to employees about workplace safety and health issues through regular internal communication channels such as supervisor-employee meetings, bulletin board postings, memos, or other written communications.

Each employee is expected to obey safety rules and to exercise caution in all work activities. Employees must immediately report any unsafe condition to the appropriate supervisor. Employees who violate safety standards, who cause hazardous or dangerous situations, or who fail to report or, where appropriate, remedy such situations, may be subject to disciplinary action, up to and including termination of employment.

In the case of accidents that result in injury, regardless of how insignificant the injury may appear, employees should immediately notify their supervisor who will then notify the Human Resources Director. Such reports are necessary to comply with laws and initiate insurance and workers' compensation benefits procedures.

SECTION J – SEXUAL HARASSMENT

DBH is committed to providing a work environment that is free from all forms of discrimination and conduct that can be considered harassing, coercive, or disruptive, including sexual harassment. Actions, words, jokes, or comments based on an individual's sex, race, color, national origin, age, religion, disability, sexual orientation, or any other legally protected characteristic will not be tolerated.

Sexual harassment is defined as unwanted sexual advances, or visual, verbal, or physical conduct of a sexual nature. This definition includes many forms of offensive behavior and includes gender-based harassment of a person of the same sex as the harasser

If you experience or witness sexual or other unlawful harassment in the workplace, report it immediately to your supervisor. If the supervisor is unavailable or you believe it would be inappropriate to contact that person, you should immediately contact the Human Resources Director or any other member of management. You can raise concerns and make reports without fear of reprisal or retaliation.

All allegations of sexual harassment will be quickly and discreetly investigated. To the extent possible, your confidentiality and that of any witnesses and the alleged harasser will be protected against unnecessary disclosure. When the investigation is completed, you will be informed of the outcome of the investigation.

Sexual harassment as set forth in DBH Policy 703 is a cause, which may warrant immediate termination of employment.

SECTION K – OVERTIME

When operating requirements or other needs cannot be met during regular working hours, employees will be given the opportunity to volunteer for overtime work assignments. All overtime work must receive the supervisor's prior authorization. Overtime assignments will be distributed as equitably as practical to all employees qualified to perform the required work.

Overtime compensation is paid to all nonexempt employees in accordance with federal and state wage and hour restrictions. Overtime pay is based on actual hours worked. Time off on sick leave, vacation leave, or any leave of absence will not be considered hours worked for purposes of performing overtime calculations.

Compensatory time for exempt employees shall be approved in advance. Exempt compensatory time shall accrue at the rate of 1 for 1 - straight hour for hour.

CERTIFICATE OF UNDERSTANDING AND COMPLIANCE.

I understand there is a copy of DBH Policies and Procedures (Handbook) available in my unit and/or on the DBH website, which I may consult.

I agree to submit to a physical examination, if required. I agree that no contract exists between David Behavioral Health and myself with respect to length of employment, salary ranges, movement within salary ranges, employee benefits, or other conditions of employment.

I acknowledge that I have read and understand the DBH Professionalism Standards (revision 03/01/02) and I agree to comply with all of its provisions. I agree to be responsible for DBH property and equipment issued to me and to pay for property and equipment not returned.

Employee Signature

Date

This signed "Certificate of Understanding and Compliance" will be placed in the signer's personnel file.

PROVIDER NETWORK

Policies & Procedures



SECTION:	<u>Administrative</u>
PAGE:	<u>1 of 3</u>
SUBJECT:	<u>Provider Network</u>
EFFECTIVE DATE:	<u>5/2018</u>
REVISION DATE:	<u> </u>

PURPOSE

Davis Behavioral Health, Inc. (DBH) will maintain and monitor a provider network that is supported by written agreements, which is consistent with the scope of its contracted services and provides adequate access to all services covered under the contract.

POLICY

DBH will consider the following criteria when maintaining and monitoring its provider network:

The anticipated Medicaid enrollment.

The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area.

The numbers, types, and specialties of providers required to furnish the contracted Medicaid services.

The number of network providers accepting/not accepting new Medicaid members.

The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members.

The ability of providers to communicate with limited English proficient members in their preferred language.

The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities.

The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and or other technology solutions, when available.

DBH will ensure that it does not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment.

DBH will also ensure that it does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on the basis of that license or certification.

If DBH chooses to decline to include individual or groups of providers in its network, DBH will give the affected providers written notice of the reason for its decision.

This is not construed to:

Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members.

Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

DBH will not knowingly have a relationship of the type described above with any of the following:

- An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12649 and 1128 or section 1128A of the Social Security Act
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

Adequacy of DBH's provider network will be evaluated at least annually by the executive team at DBH. This team (or its designee) will use a combination of the following as measures in determining network adequacy.

- 1) Access to care (initial and follow-up)
- 2) On-going utilization review of clinician caseload
- 3) Caseload size
 - a. 50 – 70 for outpatient MH therapist
 - b. 25 – 50 for IOP/OP substance abuse therapist
 - c. 250 – 400 for a prescriber

In the event of overpayment, the contractor must return the overpayment to DBH within 60 days and notify DBH in writing of the reason for the overpayment. DBH will report all recoveries of overpayments to the State on an annual basis.

Provider Network Retention

In an attempt to retain members of its provider network, DBH has implemented the following strategies for employees:

- A comprehensive compensation plan has been approved by the Board of Directors to include efforts specifically focused on maintaining competitive wages and benefits
- Opportunities for professional growth and development, including brown bag luncheons, off-site conferences, and other training activities.
- A Wellness Committee responsible for promoting overall wellness at the agency through physical, social, and other areas of well-being.
- When beneficial to the agency and its clients, DBH allows employees to apply for and work a flexible schedule.

- Multiple staff activities organized by the agency throughout the year to express appreciation and promote comradery among co-workers.
- Improved efforts to acknowledge exceptional work by employees.
- Numerous incentives for employee, including discounted memberships, access to a perks website with discounted goods and services, onsite laundry service pickup, weekly yoga classes for staff, etc.

Efforts to retain subcontractor providers include:

- Participation in agency trainings with CEU certificates provided.
- Case staffings with the DBH Corporate compliance officer or other clinicians working in a leadership capacity.

When DBH is unable to supply a client with a qualified in-house clinician to provide the medically necessary service(s) it will refer the client to a contracted, qualified, outside provider. DBH may elect to allow a client to be treated by an outside provider under other circumstances, but is not required to do so by the PMHP Medicaid contract between Medicaid and DBH when it has a qualified in-house provider.

Subcontract for Administrative Functions

DBH will ensure that the following actions are taken when seeking subcontractors for administrative functions (i.e. electronic health record, human resources information system, etc.):

- Evaluate prospective subcontractor's ability to perform the activities to be delegated.
- Maintain copies of each approved and active contract
- Determine if any individual is disbarred, suspended, or otherwise excluded from participating in procurement activities or from participating in non-procurement activities by:
 - Conducting LEIE and EPLS database searches and/or
 - Obtaining attestations for individuals performing administrative functions

In addition, DBH will see that verbiage specifying the activities and report responsibilities is contact in the contract language. Further, DBH will require language that provides for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate.

PURCHASING CARD (P-CARD)

Policies & Procedures



SECTION:	<u>Financial Policies</u>
PAGE:	<u>1 of 2</u>
SUBJECT:	<u>Purchasing Card (P-Card)</u>
EFFECTIVE DATE:	<u>12/2007</u>
REVISION DATE:	<u>3/2016</u>

PURPOSE

To more efficiently pay for programmatic goods and services and to reduce the costs associated with procurement, DBH will use Purchasing Cards (P-Cards) to make payment on purchases that are not easily planned for in advance.

POLICY

Employees given authority to purchase program materials and services will be issued a purchasing card. The P-Card is the preferred method of paying for purchases that are not purchased using an established vendor account.

Except in limited circumstances [e.g. an emergency, travel or other occasional situations that dictate immediate action] purchases for DBH should NOT be made with an employee's personal credit card.

PROCEDURES

1. P-Card purchases must be made in accordance with the DBH procurement policy. Examples of purchases that may be made with a program P-Card are: subscriptions, seminars, books, video tapes, activities and entertainment.
2. The P-Card may not be used for the following purchases:
 - a. Any merchant, product, or service normally considered to be an inappropriate use of DBH funds
 - b. Personal items
 - c. Any items that are subject to the centralized procurement procedure, unless the P-Card holder is the centralized procurement agent
 - d. Purchases above the P-Card's credit limit
3. Obtaining a P-Card

P-Cards will be issued with the approval of the Chief Financial Officer, upon written request from a Program Director. The Program Director's request shall include the following:

- a. The employee's name
- b. The program the charges are to be billed to

- c. The reason the employee needs a P-Card
- d. The recommended amount of credit available to the employee
- e. Prior to being issued the P-Card, the employee must sign an acknowledgement that they have read and understand the DBH Procurement Policy

4. Using a P-Card

- a. Each P-Card holder is personally responsible for every transaction associated with the P-Card. Keep it safe.
- b. To transfer financial responsibility to DBH, each transaction must be supported by an itemized receipt and documented on a DBH P-Card Log.
- c. The P-Card holder will be e-mailed a monthly statement identifying all transactions charged to the card during the previous monthly billing cycle. The e-mailed statement should be attached to the Log along with original receipts for each transaction. These documents must be approved by the cardholder's supervisor and forwarded to the accounts payable employee responsible for processing payments for P-Card transactions within 3 working days of the cardholder receiving the mailed statement. [For cardholder protection, it is suggested that a copy of the statement, Log and associated attachments be retained by the cardholder until the next billing cycle as backup for the submission to Finance].

5. Termination of P-Card

- a. The employee is responsible for the security of the P-Card as well as each transaction made with the card. The card is issued in their name and all purchases made with the card must be made solely by that employee. Failure to comply with this policy and enumerated procedures may result in disciplinary action, which may, in extreme circumstances, include termination of employment.
- b. Failure to follow DBH P-Card procedures regarding timely submission of monthly support documentation may result in loss of the card.
- c. When an employee is terminated or transferred to another job assignment within DBH, the card must be retrieved by the cardholder's supervisor and the card sent to the Chief Financial Officer for destruction.

RECIPIENT FRAUD

SECTION:	Corporate Compliance
PAGE:	1 of 2
SUBJECT:	Recipient Fraud
EFFECTIVE DATE:	8/2012
REVISION DATE:	

I. PURPOSE

Davis Behavioral Health is obligated to report potential recipient fraud related to the recipient's eligibility for Medicaid. And to describe the measures that will be taken when recipient fraud is suspected

II. POLICY

Any employee or agent with knowledge or suspicion of recipient fraud, waste or abuse or becomes aware of any misrepresentation of facts by recipients in order to become or remain eligible for Medicaid shall report his/her knowledge or suspicion to either a supervisor or the Compliance Officer. In addition, anyone within or outside the organization can contact the Compliance Officer directly with questions or concerns.

III. PROCEDURES

- A. All employees responsible for enrolling Medicaid recipients for services will take reasonable efforts to ensure that the individual requesting/receiving services is in fact the individual that is insured by Medicaid.
- B. During the intake process, staff will request State or Federal issued photo identification to verify the name and date of birth with the information available in the Medicaid MMCS system.
- C. If the individual requesting services does not have any State or Federally issued photo identification, staff will request any form of identification (ie., credit card, student ID card) to at a minimum verify the individual's name.
- D. If the individual requesting services does not have any form of identification (such as a child), staff will attempt to verbally verify the Enrollee information available in the Medicaid MMCS system.
- E. If any employee or provider suspects or becomes aware of (ie., a child being called by a different name than reported, an individual reluctant to verify information, unreported

income, assets or marital status) any misrepresentation of facts or identity related to Medicaid eligibility, those suspicions or knowledge should be immediately reported to the Compliance Officer.

- F. No purported Medicaid eligible individuals will be denied covered services based on suspicions of recipient fraud related to the recipient's eligibility for Medicaid. The individuals will be enrolled in services until otherwise notified by the Compliance Officer.
- G. The Compliance Officer will complete a preliminary review of the suspicions within 2 business days of receiving the information from the employee or agent.
- H. Within 15 days after the detection of any incidents of potential Medicaid fraud by clients related to the clients' Medicaid Eligibility, the Compliance Officer, will contact the Department of Workforce Services at 1-800-955-2210. All other types of potential recipient fraud and all types of potential recipient waste or abuse related to the Medicaid program shall be reported to the Utah Office of Inspector General of Medicaid Services.
- I. The Compliance Officer will maintain records of all reports of compliance concerns, investigations, findings and corrective actions.

RECORDS RETENTION

SECTION:	<u>Administrative Policies</u>
PAGE:	<u>1 of 3</u>
SUBJECT:	<u>Records Retention Policy</u>
EFFECTIVE DATE:	<u>4/2009</u>
REVISION DATE:	<u>5/2014</u>

Policy Statement:

Davis Behavioral Health will retain all records in accordance with the following standards:

All records shall be retained for the period required by applicable state and federal laws and regulations.

All records necessary for business reasons shall be retained for a period of time that will reasonably assure the availability of those records when needed.

Records vital to the ongoing operation of the business shall be identified and appropriately safeguarded.

In order to reduce the high cost of storing, indexing, and handling the vast number of documents that would otherwise accumulate and to maximize the performance of the computer systems, all records not necessary for legal or business reasons and not required to be retained by law or regulation shall be destroyed at the end of the calendar year in which the applicable retention period set forth in the attached Record Retention Schedule expires.

Destruction of records shall take place only in compliance with DBH's written policy.

Documents that are not otherwise subject to retention for business reasons may need to be retained because of unusual circumstances, such as litigation or a government investigation. If for any reason it is felt that an unusual circumstance exists or arises, legal counsel and the corporate compliance officer shall be notified immediately. When litigation or investigations occur, legal counsel or the corporate compliance officer will notify the appropriate departments and direct that relevant categories of documents be labeled for retention until further notice.

Procedures:

- 1) All department heads, program supervisors and records maintenance personnel will be aware of and follow the approved retention schedule and record naming conventions.
- 2) Files will be prepared for storage in accordance with the retention schedule on an ongoing basis or fiscal year as needed.
- 3) File names will include the following:
 - a. Origination date
 - b. Document name or content

- 4) A catalog of all stored records will be maintained and available for search requests.
- 5) Requests for stored information must be approved by authorized administrative and records custody personnel.
- 6) A record of checked out records noting requestor and location for use must be maintained.
- 7) Files checked out of storage must be secured at all times and returned to storage as soon as possible.
- 8) Records with expiration dates will be destroyed in a timely manner using appropriate destruction methods.

DAVIS BEHAVIORAL HEALTH, INC.
RECORDS RETENTION SCHEDULE

DESCRIPTION	YEARS
Correspondence, general	2
Correspondence, routine with customers/vendors	2
Employment applications (recruitment process)	6 months
Bank statements	PERMANENT
Employee personnel records (after termination) Hard Copy Electronic Copy	1 PERMANENT
Internal audit reports	7
Accounts payable ledgers and schedules	7
Cash receipt copies	3
Contracts and leases (expired)	7
Explanation of benefits/cash payments from insurance companies	5
Inventory records	3
Invoices to customers or from vendors	5
Subsidiary ledgers	5
Time cards	5
Vouchers for payments to vendors, employees, etc (includes allowances and reimbursement of employees, officers, etc, for travel and expense reimbursement)	5
Accounts receivable ledgers and schedules	7
Clinical records adult substance abuse and medical records except for discharge summary	10 years after discharge date if no legal actions pending

Discharge Summary from clinical record of adult substance abuse and/or mental health	PERMANENT
Clinical records children & youth substance abuse and medical records except for discharge summary	Longer of 10 years or 4 years after age of 18, but not less than 7 years from date of discharge if no legal actions pending
Discharge Summary from clinical record of children & youth substance abuse and/or mental health	PERMANENT
Documents relating to uses and disclosures of protected health information: authorization forms, notices of information practices, responses to clients who want to amend or correct their information, client statements of disagreement, and complaint records	6
Independent Financial and Legislative Audit reports	PERMANENT
Chart of accounts	PERMANENT
Contracts and leases in force	PERMANENT
Correspondence on legal and regulatory matters	PERMANENT
Deeds, mortgages and bills of sale	2 years after disposal of the property
Depreciation schedules	PERMANENT
Financial statements (year-end, other months optional)	PERMANENT
General ledgers, year-end trial balances	7
Insurance records, accident reports, claims, policies, etc.	7
IRA and Keogh plan contributions, rollovers, transfers and distributions	PERMANENT
Legal entity organizational documents, bylaws and board minutes	PERMANENT
Payroll records	7
Property records, including costs, depreciation reserves, year-end trial balances, depreciation schedules, blueprints, and plans	2 years after disposal of the property
Tax returns, revenue agents' reports, and other documents relating to determination of income tax liability	PERMANENT

REFERRALS / TRANSFERS / DISCHARGES

SECTION:	Clinical
PAGE:	1 of 2
SUBJECT:	Referrals/ Transfers/ Discharges
EFFECTIVE DATE:	12/2005
REVISION DATE:	5/2013

Policy

DBH will assist clients to obtain services that are needed but not available within the DBH service array. The treatment plan will include a transition plan and assistance will be given in identifying resources for the transition process.

Purpose

Comprehensive mental healthcare must include coordination with other human service providers and physical healthcare providers. Because these systems are often very difficult to navigate, the client may need case management assistance from DBH.

Procedure

1. Based on the results of the Individual Assessment, identified needs specific to the client's age, gender, disability/disorder or other special circumstances will be addressed. If the identified needs cannot be addressed with services within DBH, referrals/ transfers may be made. Transfers may be made by the primary service coordinator or by a case manager to primary care, recovery support services, or other service organizations.
2. A discharge plan will be developed as part of the treatment planning process.
3. Discharge from services is indicated when:
 - a. The client no longer meets medical necessity for treatment.
 - b. The client no longer desires treatment, and does not meet criteria for involuntary commitment.
 - c. No direct services have been received by the client within 90 days, and appropriate outreach has occurred to invite the client into services. Exceptions to this will be made when the treatment plan includes provision for services to be provided less often than every 90 days.
4. When discharge occurs the service coordinator will:
 - a. Complete a DBH discharge summary.
 - b. Review the discharge plan with the client. The discharge plan will:

- i. Reflect the client's preferences
 - ii. Include family participation when appropriate.
 - iii. Include other community services when appropriate.
 - iv. Identify the support systems that will assist in the client's continuing recovery.
 - v. Include referral information, such as contact name, telephone number, locations, hours, and days of service.
- c. Because mental illness and substance use disorders are non-linear and on-going conditions, discharge from treatment does not mean DBH no longer has a shared responsibility for the client's recovery needs. Therefore, recovery support services are documented to the extent required for clinical continuity.

REIMBURSABLE EXPENSES WHILE HOSTING A GUEST

SECTION:	Finance
PAGE:	1 of 2
SUBJECT:	Reimbursable Expenses While Hosting Guests
EFFECTIVE DATE:	5/11/05
REVISION DATE:	10/1/11

PURPOSE

To provide guidelines and limits on charges, including reimbursable expenses incurred by Davis Behavioral Health while hosting officials and guests of the agency on a recurring or one-time basis.

POLICY

Davis Behavioral Health will, in special circumstances, reimburse employees/guests' expenses for meals purchased while conducting official business.

PROCEDURES

1.0 Functions for which meal cost reimbursement is permissible are:

- 1.1 Meetings of the Board, Committees of the Board, or Local Authority.
- 1.2 Functions of an exigent nature that could not be anticipated, where food costs must be incurred in the line of duty.
- 1.3 Meetings at conventions, conferences and seminars where an employee is representing the agency.
- 1.4 Other functions or situations specifically authorized by the CEO and CFO, such as meetings involving food costs with individuals who are or are not paid agency employees.

2.0 Specific approval criteria for functions incurring charges:

2.1 The meeting must have an agency purpose and be authorized by the Executive Leadership Team (ELT) for the benefit of Davis Behavioral Health.

2.1.1 The primary purpose may not be merely good will.

2.1.2 The nature must be of a clear agency nature and not for the purpose of furthering personal or social relationships between the employee(s) and guest(s) or the agency and guest(s).

2.1.3 Expenditures will not be paid when the meeting between Davis Behavioral Health and guest(s) or the employee(s) and guest(s) occurs where there is a little or no probability of engaging in the active conduct of agency business, such as meetings at nightclubs, sporting events or other essentially social gatherings.

2.2 On-going authorized Boards, Local Authority, or Committees where food is provided and where expenditures will be requested must receive prior approval from the ELT to provide food. The organization staffing said Board, Council, Task Force, or Committee will be responsible for requesting approval (See 5.0.).

3.0 Specific approval criteria for guests/employees incurring charges include:

3.1 All Board, Local Authority members, or committee members must be serving without compensation or per diem expense that would normally cover meals.

3.2 Employees attending conferences, seminars, or conventions must not be receiving per diem expenses that would normally cover meal costs.

4.0 Limits on Expenditures:

4.1 Unless otherwise approved as an exception by the ELT, the allowable cost of meals will be consistent with agency guidelines.

4.2 No charges relating to serving or consumption of alcoholic beverages may be included in payment requests.

5.0 Procedures to obtain prior approval:

5.1 To obtain prior approval (as specified in 2.2) the requesting individual should submit an explanation of the function at which food will be made available including frequency of the meetings, locations, type of meeting (breakfast, lunch, dinner), purpose, attendees, and the agency organization responsible for arranging the meeting. Once ongoing functions are approved in concept, payment requests will be submitted directly to the Purchasing Coordinator.

5.2 If the requesting organization cannot anticipate the charge before the function takes place, "after the fact" approval will be subject to the policy requirements as explained in 6.1.

6.0 Processing payment requests:

6.1 All requests for payment, including reimbursements from petty cash accounts, will be submitted to Personnel/Purchasing for ELT approval with a check request that contains:

1. The date of the meeting
2. The location of the meeting
3. The type of meeting, i.e., breakfast, lunch or dinner
4. The purpose of the meeting
5. A list of the agency employees and guests attending
6. The total number of attendees
7. The total payment amount requested
8. The signature of the person submitting the request
9. The date the request was signed
10. The signature of the manager or executive approving the request
11. The date approved by the official
12. A copy of the bill or receipt

6.2 If the group of guests is large, the names of the officers of the group will be considered adequate identification.

RISK ASSESSMENT

Policies & Procedures



SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Risk Assessment
EFFECTIVE DATE:	12/2005
REVISION DATE:	6/2013

Policy

Davis Behavioral Health clinical staff will perform reasonable and prudent assessments of client risk to self and others. Clinical decision-making will be documented in each of these situations. When a significant risk is identified, the risk will be specifically addressed in treatment and adequate actions will be taken to assure the safety of the client and others.

Purpose

The primary purpose of this policy is to ensure that clients who may be at increased risk for suicide or may represent a risk to others are identified and treated according to professional standards of care. Secondly, compliance with this policy provides for a reduced risk of liability to the agency and the individual practitioner.

Procedure

1. Clinicians will conduct an assessment of client risk to self and others that is within standards of reasonable and prudent care
 - A. During the initial mental health assessment,
 - B. Whenever suicidal ideation or behavior is detected, or
 - C. When there is a significant change in the client's condition.
2. The risk assessment will include consideration of:
 - A. Long-term demographic risk factors (age, gender, marital status, and race)
 - B. Client factors that elevate suicide/violence risk (drug abuse, impulsivity)
 - C. Current level of situational and psychosocial stress
 - D. History of suicidal/ violent thought or behavior and degree of lethality of previous attempts
 - i. if client has a plan or identified target
 - ii. if steps have been taken to implement the plan
 - iii. if there is evidence of rehearsal or preparation for implementation
 - E. Current suicidal ideation
 - i. frequency and intensity of ideation
 - ii. if client has a suicide plan
 - iii. if client has access to lethal means
 - F. Protective factors (family support, expressed hopefulness)
 - G. Mental status

3. A summary of the risk assessment will be documented in the clinical record.
4. Neither suicide nor violence is predictable. The goal of the risk assessment is not to predict but to assess the level of risk.
5. When the level of risk is assessed to be clinically significant, a clinical decision will be made about the best level of care for the client.
 - A. Hospitalization may be indicated if:
 - i. the risk of harm to self or others is produced by an acute condition which is likely to respond to treatment in an inpatient setting;
 - ii. no other reasonable safety plan can be arranged;
 - iii. the client meets commitment criteria and is not treatment compliant;
 - B. Outpatient treatment may be indicated if:
 - i. a reasonable safety plan can be developed in the outpatient setting;
 - ii. the risk of harm to self or others is produced by a chronic condition which is not expected to improve (or may be worsened) with inpatient hospitalization;
 - iii. the strength of the treatment alliance provides clinician confidence that the client will communicate any increasing suicide risk.
 - C. Consultation from clinical colleagues or supervisors will be sought when indicated.
6. The clinician will document in the clinical record the decision-making process. Consistent with duty to warn guidelines, the clinician will make the necessary notifications when an immediate and viable threat has been made or when there is reason to suspect abuse or neglect of children, the elderly, or a vulnerable adult.

SAFETY PLAN

SECTION:	Administrative
PAGE:	1 of 5
SUBJECT:	Safety Plan
EFFECTIVE DATE:	11/2017
REVISION DATE:	

Davis Behavioral Health promotes a safe and secure environment and does not tolerate aggressive or threatening behaviors. This policy covers how to deal with aggressive or threatening behavior on the part of clients, people associated with clients or the public. Staff, clients and others do not have to tolerate such behavior and should report it immediately. Zero tolerance of aggressive or threatening behavior extends to all Davis Behavioral Health locations including school, home and community settings.

Policy Objectives:

- To ensure adequate processes are in place for the protection of staff, clients and others participating in treatment or in the vicinity of aggressive or threatening behavior at DBH locations.
- To ensure staff are fully aware of their responsibilities when dealing with violent or aggressive patients.
- To ensure that staff are fully aware of their rights when dealing with such incidents.

A series of steps can be taken to ensure a safe and secure work environment including:

- Physical precautions in the work setting to prevent or safeguard against aggressive or threatening behavior
- Safety precautions in advance of problems including minimum coverage and case review in advance of an interaction with a high-risk client
- Limiting, refusing or withdrawing service in the face of aggressive or threatening behavior
- Using co-leadership for groups where there may be safety issues
- Implementing Credible alerts or email alerts for clients who pose a safety concern
- Managing aggressive or threatening behavior.

Every effort will be made to ensure that clients are not stigmatized by inaccurate information. However, in ambiguous situations the safety needs of staff, volunteers, clients and others must take precedence.

DEFINITION

Aggressive or threatening behavior can include:

- Menacing, angry, loud and/or abusive language

- Communicating a threat of bodily harm or injury to property, either verbally or through physical behavior
- Brandishing any object as a weapon
- Any threat, real or implied
- Any behavior that makes a staff person, client or volunteer feel unsafe
- Destruction of property or theft

The aggressive or threatening behavior may be exhibited by the client or by someone associated with the client (e.g., a partner, relative or friend).

SCOPE

All Davis Behavioral Health staff, volunteers and clients are covered by this policy.

PROCEDURES

1. Precautions to take PRIOR to interacting with individuals or groups who pose a safety risk or concern

1.1 Review client file and determine which safety precautions to take, including:

- Using an alternative interview room rather than personal office
- Reviewing the phone alert System at your location. If you're not sure of which button on your phone requests assistance, be sure to contact the office manager for assistance.
- Speaking with the referral source in advance of the initial meeting with the client
- Scheduling the appointment with the client or group session at peak staffing level periods to ensure the availability of support and back-up
- Advising your supervisor, support staff or administration of the time and location of the appointment with the client or group session
- Preparing the room for safety (e.g., clear out objects that could be used as weapons, leave the door ajar)
- Arranging to have staff colleagues monitor the interview room
- Bringing a second staff member to assist in the interview.

1.2 Provide service, to the greatest extent possible, in a safe interview room that:

- Does not have objects that can be thrown or used as weapons
- Provides the option of leaving the door and/or window blinds open
- Allows staff to easily leave the room.

1.3 Ensure minimum staff coverage for any service provided to a client who poses a safety risk (i.e., Service Alert on his/her file related to problematic behavior, concern based on clinical experience). A supervisor or one other staff must be in close proximity to the office location while the interview is underway and aware of the situation.

1.4 Develop a support plan with your supervisor to include alternate safety strategies such as utilizing the phone alert system, notifying the front desk to alert staff to a specific client, having the supervisor or support staff "call-in" during the service, have a co-worker participate in the service with you, etc.

2. Precautions to take DURING and AFTER an interaction with individual client or group session

- Staff should position themselves/furniture so that they may easily exit the room if required.
- Negotiate a contract with the client at the beginning of the service regarding unwanted behaviors and resulting consequences.
- Utilize the phone alert system.
- Escort client out of the building if possible.
- Request to be observed or accompanied when leaving the building.

3. WHEN the client is aggressive or threatening

- If staff, clients or volunteers feel they are not safe at any point in providing service, follow the principle of **safety first**. Do not minimize a situation that may be getting out of control. Trust your gut feelings.
- Terminate the interview and ask the individual to leave the office.
- If the person is willing to do so, escort him/her out of the building (if possible).
- If the person is unwilling to leave, becomes volatile, disruptive or unpredictable, leave the room immediately (if possible).
- Activate the phone alert system to summon help from other staff.
- If necessary, create noise and disturbance to attract the attention of other staff.
- If necessary, secure the building by asking support staff to lock the entrances if the aggressive client has left the building.

4. ONCE the Phone Alert System has been activated

4.1 Staff directly involved in the incident must advise the program manager of the situation. If the program manager is not available, assume the role of crisis manager or find another staff person to do so.

4.2 Upon hearing the safety alert system:

- Staff who are not directly involved in the incident should follow the safety alert system for their location (e.g., stay in office or leave their office and proceed to the predefined area).
- If there are other patients/clients in the vicinity, then there is a duty to protect them. If possible, remove them to another part of the building away from the situation.

4.3 Those receiving the phone alert message must immediately determine the location of the disruption and whether any contact has been made with the staff who activated the system. Responders are identified for each location and should immediately respond to the notification.

4.4 If no contact has been made, the responder:

- Knocks on the door and asks the therapist to step into the hallway
- If no answer at the door, phones into the office where the incident is occurring. If possible and if it makes sense, ask the staff to pick up the phone then ask if they're safe.
- If there is still no answer, listens to what is happening in the office to determine what to do (may need to use a key to open the office, or call 911).

4.5 Once contact has been made, the responder will determine the best course of action. Arrange to call 911 as needed.

5. Call 911 (if necessary)

- Dial 911 and request police, fire, ambulance or a combination.
- Inform the 911 operator if there is an immediate threat of harm. Such calls are higher priority and receive a fast police response.
- Identify yourself and the office location where the incident is occurring.
- Advise administrative staff at the first available opportunity.

6. AFTER the aggressive or threatening behavior

6.1 Staff involved should document the behavior in the client chart.

6.2 The aggressive or threatening incident should be reported within the "Alert" tab in the electronic record.

6.3 If there is reason to believe the aggressive or threatening behavior will continue, an organization-wide alert should be issued by email (DBH-AII).

6.4 Debrief on the situation with your supervisor and administration. Determine whether follow-up or support is required (e.g. EAP debriefing services etc.).

If other clients/patients witness the event, debrief this with them as soon as possible. Offer additional supports as appropriate.

6.5 If required, obtain additional supports for staff, volunteers, students and/or clients involved in the aggressive or threatening incident (e.g., EAP debriefing, outside counselling, legal assistance, financial reimbursement or time off). *A one to one discussion with the staff member that was affected should be done in private and as informally as possible.*

- The staff member should be encouraged to talk about the incident from their perspective and encouraged to write it down. When appropriate, this can be used to complete an incident report.
- Ask the staff member what support they feel they need to help them deal with the situation.
- When appropriate, a group session should be provided to those affected by the situation. This can be for clients together, staff together or combination when appropriate.

6.6 Complete an *Incident Report* once the situation has abated and submit to your supervisor. Supervisor reports to administration.

6.7 Determine if service to the client should be limited or withdrawn.

A determination regarding the continuation of services for a client who has been aggressive, violent or threatening will be made by the clinical directors committee. Incident reports should be made/presented to the clinical committee. This committee will decide the conditions of continued care, if any, and will communicate that decision to the client in writing (see example letter at the end of this policy).

If there are repeated incidents from a particular client, then the agency should provide written communication to let them know that no other incidents will be tolerated and the patient will be no longer be able to be treated at DBH.

When appropriate, efforts will be made to assist the client to find another agency or provider that is willing to provide treatment.

7. Criminal Charges

7.1 In cases of aggressive and/or threatening behavior, the police may decide to press charges against the client. In such cases, staff are expected to cooperate fully.

7.2 Affected managers and staff may ask the Corporate Compliance Officer, Shelly Tanner, for approval to seek legal counsel through the organization's legal counsel.

Example letter:

Dear Tom,

This letter is to remind you about our policy of zero tolerance of both verbal and physical acts of aggression and violence. At DBH we take this policy very seriously for your safety, the safety of our staff and others in our clinic.

On your visit to our clinic on Thursday, July 27, 2017, you became very upset about the denial of a medication script and threatened staff. Your behavior was witnessed by several other staff members and clients in the waiting room. Your behavior caused fear and anxiety for several people that were in the vicinity.

If you desire to continue receiving treatment at DBH, you will need to meet with your provider to discuss the matter in a calm and respectful manner.

You will develop a written plan and contract for how you are going to deal with future frustration and anger.

It may be that a decision will be made that you will need to seek treatment from another clinic or agency. If this is the case, we can assist you in trying to find other resources that are willing to treat you.

If a decision is made that you are authorized to continue with treatment at DBH, an important part of your plan may include writing an apology letter to staff members that were witness to this behavior. It may also include writing an apology letter that will be given confidentially to others that witnessed your behavior.

We are sure that you can understand the need to keep yourself and others safe

It is our hope that you are able to continue to be seen at DBH.

Sincerely,

SECURITY OF PHI:
ADMINISTRATIVE SAFEGUARDS

SECTION:	HIPAA
PAGE:	1 of 4
SUBJECT:	Security of PHI: Administrative Safeguards
EFFECTIVE DATE:	8/2017
REVISION DATE:	9/2018

POLICY

Administrative safeguards shall be implemented to secure protected health information (PHI) and patient identifying information (PII) in all formats from unauthorized access at all times and to protect the information from damage, loss, alteration, tampering, and fraudulent use or disclosure.

PROCEDURES1. Workforce Security (*45 CFR 164.308(3)(a)(i) and (ii)(A – C); 164.308(4)(a)(i) and (ii)(B – C)*)

A. New employees

- 1) Upon hiring, the new employee's supervisor will submit a signed Personnel Action Form (PAF) to the Human Resources Office, requesting job-specific access to the network. Human Resources will complete the approval of the PAF and will generate a support ticket for IT staff to complete the action.
- 2) Job-specific access will be locked down to information that is relevant to the employee's position, including access to department information, shared folders, email distribution lists, and medical records.

B. Change of Position or Termination of Employment

- 1) Upon change of position within DBH or termination of employment from DBH, the employee's supervisor will fill out and sign the relevant section of the PAF and submit it to Human Resources which will then complete the form and generate a support ticket for IT staff to take the following action:
 - a. For change of position, IT will terminate the employee's access to any information that is no longer relevant to the new job position and will initiate job-specific access to relevant information.
 - b. For termination of employment, IT will immediately terminate the employee's access to the network. Supervisors are also required to collect keys and other access devices if the employee's job duties included authorized access to any area where health information is stored or used.

2. Access Authorization (*45 CFR 164.308(a)(4)(i) and (ii)(B – C)*)

A. Password Protection

- 1) Access to the network is limited by password protected personal accounts assigned to individuals who are specifically identified and authenticated by the supervisor and Human Resources staff on the PAF. Access is granted for defined work-related purposes and for defined periods of time. The PAF shall provide information of individuals who have been given access to any data and shall include, at minimum:

- a) The individual's name and work responsibilities
 - b) The date access was given and the reason access was given to the data
 - c) The individual's assigned account information
 - d) The date access was terminated and the reason for termination
- 2) Employees shall log in to the network with a protected password. Three incorrect password attempts will result in the person being locked out from another attempt for 15 minutes. IT staff may be contacted if earlier login is necessary.

B. Network Protection

- 1) As a new employee is issued a computer, it is automatically updated upon connection to the system network. The connection includes Unified Threat Management (UTM) which provides, but is not limited to, security functions such as:
- a) Port blocking
 - b) Content Filter
 - c) Deep packet inspection
 - d) Intrusion Prevention

3. Access establishment and modification *(45 CFR 164.308(a)(4)(ii)(C))*

A. Review and modification of user's right to access

- 1) A user's right to access a workstation, transaction, program or process is established, reviewed, and documented through the Human Resources Personnel Action Form and process described in Sections 1 and 2 above.

4. Security Incidents *(45 CFR 164.308(a)(6)(i))*

A. Preventing, detecting, containing, and correcting security breaches and violations.

- 1) Security incidents include viruses, worms, hoax e-mails, hacking, altered data, deliberate disruptions of service, and other unauthorized use of computer accounts and systems.
- 2) Quarterly, IT staff will run a HIPAA-compliance audit tool (such as "Network Detective" by Rapid Fire Tools) and will provide the results of the audit to the DBH Executive Leadership Team (ELT).
- 3) Security incidents involving inappropriate use or disclosure of protected health information shall be reported to the Security Officer immediately.
 - a) The Security Officer will report known and suspected security incidents to the appropriate Program Manager for investigation, repair, restoration, and disciplinary action, as necessary.

b) The Security Officer will document the outcome and report results to ELT.

5. Contingency Plan (45 CFR 164.308(a)(7)(i) and (ii)(A – E))

A. Data Backup Plan

- 1) DBH maintains two identical data centers, including servers and storage devices, in separate locations on the DBH campus. These data centers continually replicate to each other. Damage or malfunction in one center is backed up by the other without disruption in system function or service.
- 2) All data maintained in the above two centers shall also replicate to a third-party cloud service, such as Microsoft Azure.
- 3) All user account information and permissions are replicated to a 3rd location on the DBH campus.

B. Disaster Recovery Plan

- 1) As described in *Section 5(A)(1)* above, in the event of damage or malfunction in one of the two data centers, the other data center will continue to perform without disruption to function or service.
- 2) In the event that both data centers maintained on campus are damaged or otherwise rendered unusable (e.g. fire, flood, earthquake), data shall be recovered through the use of third-party cloud service.

C. Emergency Mode Operation Plan

- 1) In addition to the back-up procedures described above, email service shall be hosted by an off-site third-party service, such as Microsoft 365, to enable continuation of business processes.
- 2) Medical records shall be supported by an off-site, third-party vendor, such as Credible, to enable continuation of business processes.

D. Testing and revision procedures

- 1) At least monthly, IT staff shall re-boot servers to test and demonstrate continuity. Any issues and a plan of corrective action shall be reported to ELT.

E. Data Criticality Analysis –

In the event of system failure, IT staff will prioritize the following based on their level of importance for continued business operations:

- 1) Power/Internet. DBH shall have two lines, such as Comcast and Centricom, to provide continual access. Access may also be gained via the LTE Broadband Card or “mobile hotspot.” The two data centers will continue to operate on battery backup as IT staff works to restore power. In the event of failure of the data center battery backup, laptop computers may also be used on battery, as needed, to provide emergency access to medical records and email, operated by off-site, third-party providers.

- 2) Medical Records and Email. Once power is restored, all medical records and email shall be again available to all staff.
- 3) Servers. IT staff shall then restore server functionality, which will once again provide staff access to documents, shared folders, etc.

6. Sanctions *(45 CFR 308(a)(1)(ii)(C))*

A. Any member of the workforce who fails to comply with DBH Security policies and procedures shall be referred by his/her supervisor to Human Resources for investigation.

References: *HIPAA Regulations cited above*

SECURITY OF PHI:
PHYSICAL SAFEGUARDS

SECTION:	HIPAA
PAGE:	1 of 2 Security of PHI: Physical Safeguards
SUBJECT:	
EFFECTIVE DATE:	8/2017
REVISION DATE:	9/2018

POLICY

Physical safeguards shall be implemented to secure protected health information (PHI) and patient identifying information (PII) in all formats from unauthorized access at all times and to protect the information from damage, loss, alteration, tampering, and fraudulent use or disclosure.

PROCEDURES1. Facility Access Controls (*45 CFR 164.310(a)(1) and (2)(i – iv)*)

A. Contingency Operations

- 1) Job-specific authorization (by key, badge or biometrics) shall be approved by Human Resources to enable such authorized individuals, in the event of an emergency and/or to restore lost data, to immediately access the secured, locked rooms where servers and units are maintained.

B. Facility Security Plan

- 1) In the absence of job-specific authorization described above, no individual shall access the secure storage areas.
- 2) No items other than approved IT equipment shall be stored in the secure areas. Any request to store items in these areas must be approved by ELT.

C. Access Control and Validation Procedures

- 1) Facilities. Access to the secure storage areas shall be limited to the job-specific authorization described above. No visitors shall enter the secure area unless accompanied at all times by an individual with approved access.
- 2) Software. Any new piece of software shall be test controlled first. Once testing is complete, the software is rolled out to all users. Only administrators have rights to install software.

D. Maintenance Records

- 1) A request for maintenance to the facility may be generated by any staff member via the support ticket system. IT staff forwards the ticket to the Maintenance Department to take action. Upon completion of repairs or modifications, the ticket is closed and the results documented.

2. Workstation Use (*45 CFR 164.310(b)*)

A. Physical attributes of workstation

- 1) For employees who work in private offices, each computer and work station shall be positioned in a manner that PHI and PII are not viewable by visitors if possible. When the employee is away from the office, access shall be protected by password and automatic logoff as described in the Administrative Safeguards policy.
 - 2) For employees who work in common areas, such as front desk staff and medical assistants, the supervisor shall generate a support ticket to request IT staff to place a physical screen/barrier around the monitor which will inhibit viewing by any individual other than the employee seated directly in front of the screen.
3. Device and Media Controls (*45 CFR 164.310(c)(2)(i – iv)*)
- A. Disposal
- 1) DBH shall contract with a certified destruction facility to provide the service of destroying hard drives. The company shall provide documentation of the destruction.
- B. Media re-use
- 1) When an employee desires to change office and computer or other device, the supervisor will fill out the relevant section of the Personnel Action Form (PAF) and submit it to Human Resources. Upon completion and approval of the PAF, Human Resources will generate a support ticket for IT staff to take the following action:
 - a. Remove the device from the employee's former office.
 - b. Verify and complete backup of any data on the device.
 - c. Utilize data destruction software, such as DriveWipe, that is certified by the U.S. Department of Defense.
- C. Accountability
- 1) See "Purchasing, Inventory & Installation of IT Equipment" policy.
 - 2) DBH shall implement software approved by IT and the Executive Leadership Team (ELT) to track security and location of assets.
- D. Data backup and storage
- 1) See Contingency Plan section of "Security of PHI: Administrative Safeguards" policy.

References: *HIPAA Regulations incorporated above*

SECURITY OF PHI:
TECHNICAL SAFEGUARDS

SECTION:	HIPAA
PAGE:	1 of 2 Security of PHI: Technical Safeguards
SUBJECT:	
EFFECTIVE DATE:	8/2017
REVISION DATE:	11/01/2018

POLICY

Technical safeguards shall be implemented to secure protected health information (PHI) and patient identifying information (PII) in all formats from unauthorized access at all times and to protect the information from damage, loss, alteration, tampering, and fraudulent use or disclosure.

PROCEDURES1. Access Control (*45 CFR 164.312(a)(1) and (2)(i – iv)*)

A. Unique user identification

- 1) They said to just repeat this line. DBH shall assign a unique name and/or number for identifying and tracking user identity.

B. Emergency Access procedure

- 1) See Contingency Plan section of “Security of PHI: Administrative Safeguards” policy.

C. Automatic Logoff

- 1) Access to the network is limited by password protected personal accounts assigned to individuals who are specifically identified and authenticated by the supervisor and Human Resources staff on the Personnel Action Form (PAF). Access is granted for defined work-related purposes and for defined periods of time.

D. Encryption and Decryption

- 1) Email. The user has an option to select an alternate signature block to encrypt the message as soon as email goes outside of DBH. Any subsequent conversation with the recipient in that email chain is also encrypted. Further, an algorithm searches emails being sent outside the agency for PHI. The algorithm may include PHI indicators such as key words, social security numbers, etc. If indicators are located, the system flags the email and submits it to IT. The email is not released until reviewed and approved by IT reviews.
- 2) Medical records. PHI is encrypted by the third-party vendor. The vendor is accountable to DBH via its Business Associate Agreement.
- 3) Text messaging. DBH staff shall only communicate via text or instant messaging if the communication in no way shares PHI or otherwise identifies an individual as a client of Davis Behavioral Health.

2. Audit Controls (*45 CFR 164.312 (b)*)

A. Procedural mechanisms that record and examine activity

- 1) In the electronic medical records system, every click is logged and tracked to the user. Assigned administrators, such as the Security Officer have been given rights to view reports on user activity.
- 2) The firewall provides tracking of any attempted breaches.

3. Integrity (*45 CFR 164.312(c)*)

A. Authentication

- 1) Each client of DBH is assigned to a program in the electronic medical records system. Users are granted job-specific access and do not have rights to view PHI of clients in other programs. Users have read/write access for their own clients but, once data is saved, they do not have rights to alter or destroy data. If a user needs to correct an input error, the user shall contact the assigned administrator to make the correction.

4. Person or Entity Authentication (*45 CFR 164.312(d)*)

Each user has a unique name and/or number and each login is password-protected.

References: *HIPAA Regulations incorporated above*

SERVICE AUTHORIZATION

Policies & Procedures



SECTION:	Clinical Policy
PAGE:	1 of 6
SUBJECT:	Service Authorization Policy
EFFECTIVE DATE:	2/16/07
REVISION DATE:	5/2018

POLICY

Services provided by Davis Behavioral Health are prioritized as to population and scope according to statutory and contractual requirements. The delivery of services by an appropriate provider is prioritized as to 1) employee providers, 2) subcontracted providers, and 3) alternative (non-panel) providers, respectively. Requests for the delivery of services are subject to authorization as specified in the following procedures.

PROCEDURES

A. Authorization for service delivery – employee providers

1. Initial Requests for Service (internal intake system) – non-client
 - a. The service authorization process relative to employee providers is initiated by a formal request for service (RFS). Requests for service are received by the DBH reception desk. Requests clearly stated to be for routine service scheduled for initial intake and assessment within 15 days. Those requests for emergent services are immediately forwarded to the Triage /On-call crisis worker who will evaluate for an initial determination of level of service need (i.e., emergency, urgent, or non-urgent). For urgent and non-urgent determinations, the Triage Worker will offer and schedule, as available, an initial face-to-face appointment for clinical assessment within five and fifteen working days respectively.
 - b. Requests for emergency (crisis) services will be forwarded immediately to the Center's Triage/On-call Crisis Worker currently on rotation to conduct a crisis screening. Crisis staff will respond to the request for emergency services within 30 minutes and determine the level of service need (i.e., emergency, urgent, non-urgent).
 - c. Upon determination of a need for emergency services, the crisis coordinator will facilitate an initial face-to-face contact with the prospective client within one hour following the crisis screening for initial assessment and delivery of crisis service. For urgent and non-urgent determinations, the crisis coordinator will offer and schedule, as available, an initial face-to-face appointment for clinical assessment within five and fifteen working days respectively.
 - d. As indicated above, the request for service is followed by an initial face-to-face clinical assessment to determine the specific services needed. The completion of the assessment and documentation of service need constitutes a service authorization. Once services are assessed and authorized, an individualized treatment plan is formulated to address the amount, duration, and scope of service delivery particular to the client. Amount, duration and scope of service are authorized based on clinical need and benefit coverage. The client is then scheduled for follow-up service appointments as expeditiously as the client's

health condition may require. Services requested but not available within the scope of the Center's covered services are not the obligation of DBH and cannot be authorized.

- e. Failure to provide the first face-to-face service within the time frames specified above for emergency, urgent, and non-urgent service determinations will constitute an Action (to include a Notice of Action to be provided at the time it is determined the time frame will not be met) only when:
 - i. The reason is due to the Center's limitations; and
 - ii. The client is dissatisfied with waiting beyond the required time frame.
 - f. Any decision to deny a *service authorization request* or to authorize a *service* in an amount, duration, or scope that is less than requested, including the type or level of service (with the exception of services that are not "covered" under the DHCF contract), constitutes an Action and requires the Center to provide a written Notice of Action to the client
 - g. If the Center terminates suspends, or reduces previously authorized services, and the client informs the Center that he or she disagrees with the change in his or her treatment plan, the Center will mail a notice of action to the client.
2. Additional service requests – existing client
- a. Requests by an existing client for additional services not previously authorized (i.e., ECT, residential treatment, etc.) may be made orally or in writing. These requests will first be evaluated by the client's current treatment coordinator to determine medical necessity.
 - b. If considered medically necessary, the treatment coordinator will amend the client's treatment plan to authorize and include the requested service as expeditiously as the health condition of the client requires.
 - c. If the requested service is not within the scope of the treatment coordinator's practice and/or licensure, the request will be forwarded to appropriate clinical and/or administrative staff with clinical expertise and credentialing necessary to make a determination of medical necessity and provide authorization for service delivery.
 - d. If authorization is denied, the Center will provide a written Notice of Action to the client. If approved, the client will be notified in writing, and service delivery will be coordinated by the authorizing clinician or designee.
 - e. Any decision to deny a service authorization or to authorize a service in an amount, duration, or scope that is less than requested will be made by appropriately credentialed staff having clinical expertise in treating the client's diagnosed condition.
3. A continuation of service delivery beyond any limits that may be specified must be re-authorized following the procedures outlined above, following a written request for continued authorization.

4. A “second opinion” related to the authorization of services, initial assessment, diagnosis, and/or available treatment options will be provided upon request at no cost to the enrollee.

B. AUTHORIZATION FOR SERVICE DELIVERY – SUBCONTRACTED PROVIDERS

1. Requests for authorization and service delivery by a subcontracted provider must be submitted to the Utilization Management Coordinator (UMC) either verbally or in writing. Prior to the authorization of service delivery by a subcontracted provider, an initial clinical assessment (or reassessment for existing clients) must be completed by the requesting provider who must forward the evaluation and a treatment plan to the UMC. The UMC will present the documentation to the Clinical Services Administrator (CSA), or designee, who must be a licensed mental health provider, for review and authorization. Individuals who refuse assessment or reassessment will be denied authorization for service provision by the subcontracted provider.
2. The Center will also mail the client a written Notice of Action at the time of the action affecting a claim if the denial reason is that: (1) the service was not authorized by the Center, as the client could be liable for payment if the client gave advance written consent that he or she would pay for the specific service; (2) the client requested continued benefits (services) during an appeal or State fair hearing and the appeal or State fair hearing decision was adverse to the client; or (3) the client was not eligible for Medicaid when the services were provided.
3. The CSA or designee will review the assessment in consultation with the assessing clinician, consult with the requested provider if necessary, and determine the appropriateness of an alternative provider based upon the following review criteria:
 - a. Type of service requested;
 - b. Amount, duration, and scope of service requested;
 - c. Credentials, expertise, and capacity of Center staff;
 - d. Credentials, expertise, and capacity of requested provider;
 - e. History of previous treatment;
 - f. Extenuating circumstances.
4. DBH will make a service authorization determination and provide notice of the decision to the subcontractor and the client as expeditiously as the client's condition may require, but no later than 14 calendar days from the date of receipt of the subcontractor's request for service authorization. This will be tracked on the off-panel request form.
5. The Center may extend the time frame for making a service authorization decision by up to 14 calendar days if the client or subcontractor requests an extension, or upon request by the Department of Health and the Center justifies that there is a need for additional information and that the extension is in the best interest of the client.
6. If the time frame for making a service authorization decision is extended, the Center will:
 - a. Give the client written notice of the reason for the decision;
 - b. Inform the client of his or her right to file a Grievance, and how to do so, if the client disagrees with the decision, and

- c. Carry out the service authorization determination as expeditiously as may be required by the client's health condition, however, no later than the date the extension expires.
7. The above time frames will apply unless the client's health or safety (as indicated by the subcontractor or determined by DBH) requires an expedited decision, in which case the assessment and authorization must be accomplished and notice provided as expeditiously as the client's health condition requires, but no later than 3 working days from receipt of the request for service by the subcontractor.
8. The time frame for an expedited decision may be extended by up to 14 calendar days if the client or subcontractor requests an extension, or upon request by the Department of Health and the Center justifies that there is a need for additional information and that the extension is in the best interest of the client.
9. Failure to reach a service authorization decision within the time frames as indicated above will constitute an Action and require the Center to provide a Notice of Action to the client (written) as well as provide notice to the subcontractor (oral or written) by or on the date the time frame expires.
10. Any decision to deny a service authorization or to authorize a service in an amount, duration, or scope that is less than requested will be made by appropriately credentialed staff having clinical expertise in treating the client's diagnosed condition.
11. Any decision to deny a *service authorization request* (not a request for services from a specific provider), or to authorize a *service* in an amount, duration, or scope that is less than requested, including the type or level of service (with the exception of services that are not "covered" under the DHCF contract), constitutes an Action and requires the Center to provide a Notice of Action to the client (written) as well as provide notice to the subcontractor (orally or in writing).
12. A continuation of service delivery beyond any limits that may be specified must be re-authorized following the procedures outlined above, following a written request for continued authorization.
13. A "second opinion" related to the authorization of services, initial assessment, diagnosis, and/or available treatment options will be provided upon request.

C. AUTHORIZATION FOR SERVICE DELIVERY - NON-SUBCONTRACTED OR NON-PANEL (ALTERNATIVE) PROVIDERS

1. Requests for authorization and service delivery by a non-subcontracted or non-panel provider (alternative provider) must be made to the Center's UCM either verbally or in writing, prior to the authorization of service delivery by an alternative provider, an initial clinical assessment (or reassessment for existing clients) must be completed as specified in section A, 1, d above, to determine the relevant treatment issues and service need. Individuals who refuse assessment will be denied authorization for service provision by an alternative provider.
2. Within a reasonable period of time following the clinical assessment, but not to exceed 30 days, the CSA or designee will review the assessment in consultation with the assessing clinician, consult with the requested provider if necessary, and

determine the appropriateness of an alternative provider based upon the following review criteria:

3. Clients will be notified either orally or in writing as to the determination for service delivery by an alternative provider and such determination will be documented in the clinical record using an approved form.
4. Clients denied a request to see an alternative provider shall be contacted directly to discuss options and alternatives. Clients approved for delivery of services by an alternative provider will be subject to that provider's service delivery schedule in which case performance standards relative to initial face-to-face contact shall not apply.
5. If approved, the alternative provider will be required to enter into a written subcontract with the Center and must meet all established guidelines for subcontractors as set by the local authority and as specified by Center contract with the Division of Health Care Financing.
6. Items 4 through 13 of Section B pertaining to subcontractor will apply to Section C for non-subcontractors or non-panel alternative providers.

D. GENERAL POLICIES AND PROCEDURE

1. DBH will produce and distribute a handbook to all enrollees who seek services. The handbook will provide information pertaining to the amount, duration, and scope of benefits available in sufficient detail to ensure that enrollees understand the benefits covered by DBH and how to access those services. Enrollee information will include the extent to which, and how, enrollees may obtain benefits from out-of-network providers and how, after hours and emergency coverage are provided, including what constitutes emergency medical condition, emergency services and post stabilization services.
2. DBH provides information on its process and procedures for obtaining emergency services, including use of the emergency telephone system. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract. DBH will inform enrollees of their right to use any hospital or other setting for emergency care.
3. DBH will notify the Health Department of any intended change that would mean the information contained in the Medicaid Member Handbook would no longer be accurate and up-to-date.
4. The Health Department will determine if the change is a significant change.
5. DBH will give each enrollee written notice of any change that the Health Department defines as significant. The written notice will be 30 days before the intended effective date of the change.
6. DBH will make a good faith effort to give written notice of termination of a Subcontractor within 15 days of receipt or issuance of the termination notice, to each enrollee who was seen on a regular basis by the terminated Subcontractor.

7. If DBH is unable to provide necessary services covered under the contract to a particular enrollee, DBH will adequately and timely cover these services by using other out-of-network providers that offer the same level of care for as long as DBH is unable to provide them.
8. DBH will ensure compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue Medically Necessary Covered Services to any enrollee.
9. Regular meetings will occur on at least a monthly basis involving UM staff and the DBH Intensive Services Director to review and approve payments and denials of inpatient billing requests.
10. Davis Behavioral Health will provide Medically Necessary Covered Services in a manner that addresses:
 - a. Prevention, diagnosis and treatment of mental health impairments.
 - b. The ability of the client to achieve age-appropriate growth and development, and
 - c. The ability to attain, maintain or regain functional capacity.
11. Davis Behavioral Health will provide, at a minimum, all appropriate Medically Necessary Covered Services in terms of amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. Services at DBH are available for CHEC enrollees.
12. Davis Behavioral Health may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition. Davis Behavioral Health may place appropriate limits on a service on the basis of medical necessity, or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

SMOKE & TOBACCO-FREE ENVIRONMENT

SECTION: Clinical

PAGE: 1 of 2

SUBJECT: Smoke & Tobacco-Free Environment

EFFECTIVE DATE: 1-1-12

REVISION DATE: _____

PLEASE NOTE: This policy supersedes all agency policies referencing tobacco or smoking.

PURPOSE:

As a healthcare provider, DBH is committed to health and safety. To promote this commitment, all DBH facilities, campuses, company-owned vehicles, and properties are to be tobacco-free environments as of January 1, 2012. No smoking, use of tobacco products in any form, or e-cigarettes will be permitted in facilities or on properties of DBH on or after that date.

A ban on tobacco does not take away an individual's rights as there is no "right to smoke" in Utah. DBH does not require staff, consumers or visitors to stop using tobacco. It is required that people do not smoke or use other tobacco products on any of DBH's physical properties, except for client housing.

POLICY:

This policy is applicable to all persons on DBH properties and is effective immediately for the Main Street Clinic in Layton Utah. All other DBH properties are to be tobacco-free on or before January 1, 2012.

DEFINITIONS:

Tobacco or Nicotine Delivery Products – Cigarettes, pipes, pipe tobacco, tobacco substitutes (e.g. clove cigarettes), chewing tobacco, cigars, e-cigarettes.

Tobacco Paraphernalia – combustible material is contraband unless authorized

Nicotine Paraphernalia – e.g., gum, patches, lozenges, inhalers

Workplace – workplace means facilities or properties including but not limited to patient care buildings, clinics, facilities, office buildings, parking lots, DBH-owned vehicles, or property leased or rented out to other entities. This policy applies regardless of whether a DBH facility or property is owned and whether or not the other tenants follow similar guidelines. Employees and clients at off-site patient activities shall not use tobacco products.

ACCOUNTABILITY:

It is the responsibility of all staff members to enforce the organization's tobacco-free environment policy by encouraging their colleagues, clients, visitors and others to comply with the policy. Supervisors are more particularly responsible for implementing and enforcing DBH Smoke & Tobacco-Free Environment Policy.

PROCEDURE:

The community, staff, clients and visitors will be informed of the policy through a variety of communication methods.

GENERAL POLICY PROVISIONS

1. No tobacco products or related paraphernalia such as lighters and matches shall be used, sold or bartered anywhere on a DBH campus.
 2. Signs declaring this campus “tobacco free” shall be posted at the DBH campus entrances and other conspicuous places.
 3. DBH employees and other employees who work on the DBH campus will be advised of the provisions of this policy during New Employee Orientation.
 4. DBH will post this policy in employee common areas and in the DBH Employee Handbook.
- A. Employees, Volunteers, Physicians, Students and Contracted Workers
1. Respectful enforcement of this policy is the responsibility of all DBH employees.
 2. Employees, students, medical staff, volunteers, vendors, lessees and contractors are expected to comply with this policy.
 3. Job announcements for all positions on the DBH campus will display a notice that DBH has a tobacco-free work environment policy.
 4. Employees who encounter tobacco policy violators are encouraged to politely explain the policy to the violator.
 5. Staff who fail to adhere to this policy or supervisors who fail to hold their employees accountable are subject to disciplinary action as defined in DBH Human Resources policy.
- B. Clients or Consumers
1. Residential and outpatient clients are prohibited from smoking or using tobacco on campus.
 2. All clients admitted to DBH will be assessed for history of tobacco use and the need for interventions related to tobacco addiction including nicotine replacement and cessation education.
 3. Employees who encounter clients who are violating the tobacco policy are encouraged to politely explain the policy, and report the violation to the client’s treatment team.
 4. Violation of this policy by clients is a treatment issue to be addressed by the treatment team.
- C. Visitors
1. Signs will be posted at campus entrances and in selected locations inside and outside the facility.
 2. Employees who encounter a visitor who is violating the tobacco policy are encouraged to politely explain the policy to the visitor.
 3. Visitors who become agitated or unruly or repeatedly refuse to comply when informed of the tobacco-free campus policy may be reported to DBH administration. Administrators will respond to the situation as appropriate, according to their professional judgment and need to maintain a safe environment.
- D. Outside Groups
- Outside groups who use DBH facilities for meetings will be advised of this policy. Violation of the policy will result in the rescinding of approval for the group to meet on this campus.

DBH CLIENT EMPLOYMENT

SECTION:	Clinical Policy
PAGE:	1 of 4
SUBJECT:	Rep Payee – Clinical Indications
EFFECTIVE DATE:	10/2008
REVISION DATE:	6/2013

POLICY STATEMENT:

A person's recovery journey must include acquiring or returning to social roles in the community – including that of being a worker. Some clients of DBH qualify for employment at DBH. They have the same status as any other full or part time employee. They perform valuable services. From time to time, the nature of his/her illness may require reasonable accommodations that DBH may provide as the situation indicates. Supervisors will coordinate with mental health and substance abuse staff to provide thee appropriate accommodations.

PURPOSE:

The best evidence, compiled from an exhaustive review of available research, reflects that supported employment far surpasses all other vocational rehabilitation approaches for people with severe mental illnesses. Studies have shown that 7 out of 10 consumers are interested in finding paid and useful employment, and that 6 out of 10 consumers are able to work if the right type of supports and services are easily accessible. Because research demonstrates that supported employment is responsible for greater numbers of consumers getting and maintaining jobs than any other approach, it has been praised as a worthy approach toward a successful and therapeutic employment outcome.

The public behavioral health system of care and benefits has institutionalized people's poverty status and lack of information on the impact of shifting from the system of benefits to an income based on employment contribute to people's hesitancy to return to the workforce.

Studies have clearly demonstrated the many positive personal and economic effects of working including:

- Improvement in employment status results in higher levels of self-esteem, morale, self-efficacy, and overall life satisfaction
- Working consumers contribute to our country's tax base. In a California study, for each consumer who became employed, \$239 was paid each month in federal, state, local and sales taxes.
- Helping consumers to work reduced the number of people on the SSI/SSDI rolls and saves taxpayer money. In the same study noted above, an average of \$200 per month was saved in general assistance, TANF and SSI payments. In

addition, an average of \$187 was saved in public behavioral health services costs.

- Employment for consumers can reduce the use of costly behavioral health services.

Overall goal:

To significantly increase the number of persons served by the Davis Behavioral Health who are employed.

Terminology:

DBH employed clients participate in competitive work in integrated work settings. DBH employed clients may provide assistance transportation, assistive technology, specialized job training, and individually tailored supervision with clinical consultation as needed.

Definitions:

Natural supports are support from supervisors and co-workers, such as mentoring, friendships, socializing at breaks and/or after work, providing feedback on job performance, or learning a new skill together at the invitation of a supervisor or co-worker. These natural supports are particularly effective because they enhance the social integration between the employee with a disability and his/her co-workers and supervisor. In addition, natural supports may be more permanent, consistently and readily available, thereby facilitating long-term job-retention. DBH employed clients are people who work full or part time at DBH and who also receive services from DBH.

Basic Components:

DBH employed clients should achieve the following outcomes: opportunity to earn equitable wages and other employment-related benefits, development of new skills, increased community participation, enhanced self-esteem, increased consumer empowerment, and quality of life. The types of reasonable accommodations provided depend on the needs of individual consumers. The following are the basic components of DBH employed clients:

Paid Employment--Wages are a major outcome. Work performed must be compensated with the same benefits and wages as other workers in similar jobs receive. This includes sick leave, vacation time, health benefits, bonuses, training opportunities, and other benefits.

Integrated Work Sites--Integration is one of the essential. Individuals with disabilities should have the same opportunities to participate in all activities in which other employees participate and to work alongside other employees who do not have disabilities.

Ongoing Support--A key characteristic which distinguishes supported employment from other employment programs is the provision of ongoing, reasonable accommodations for individuals with severe disabilities to maintain employment.

Client Employment Models:

DEO will utilize as many of the following supported employment models and resources to provide the benefits of work for people with severe disabilities.

Individual Placement Model--A person with a disability is placed in a job in a community business which best suits his/her abilities and preferences. Training is provided on the job site in job skills and work related behaviors, including social skills, by a job coach. As the employee gains skills and confidence, the job coach gradually spends less time at the worksite. Support is never completely removed. The private or public vocational rehabilitation agency furnishing the job coach is always available to the employer for retraining for new assignments, assisting in dealing with challenging behaviors, supplying periodic consultations with co-workers and employer, giving orientation and training for co-workers.

Enclave Model--A small group of people with disabilities (generally 5-8) is trained and supervised among employees who are not disabled at the host company's work site. Persons in the enclave work as a team at a single work site in the host company, a community business or industry. Initial training, supervision, and support are provided by a specially trained on-site supervisor, who may work for the host company or the placement agency. Another variation of the enclave approach is called the "dispersed enclave." This model is used in service industries (e.g., universities, restaurants, and hotels). Each person works on a separate job, and the group is dispersed throughout the company.

Mobile Work Crew--A small crew of persons with disabilities (up to 6) works as a distinct unit and operates as a self-contained business that generates employment for their crew members by selling a service. The crew works at several locations within the community, under the supervision of a job coach.

Integration Model—Individuals are placed in employment settings at regular full and part time jobs. Accommodations may or may not be needed.

Therapeutic Modalities:

Milieu Therapy: Environmental sensitivity is a huge component of mental illness; therefore, our environments are set up to support wellness.

Communication: Staff have extensive training in the art of therapeutic interaction. The three components of therapeutic communication are boundary, nurturance and play.

Cognitive-Behavioral Therapy: Each client receives cognitive-behavioral therapy as part of their treatment plan. Behavioral dis-control can be one of the greatest barriers to success. These behaviors range from obsessive compulsive disorder components to eating habits, lack of impulsivity control, motivation issues, and the inability to link things to purpose.

Admission Criteria:

- 1) eligibility of the consumer is based on the consumer's choice, and therefore no one is prevented from participating;
- 2) job placement begins at the time of referral. Job placement may be in any of the modalities offered by DEO based on the consumer's interests and abilities.
- 3) competitive employment is the goal, focusing on local full-time or part-time employment that pays at least minimum wage and is open to anyone;
- 4) follow-up support systems work on a steady basis, and individualized provisions continue until the consumer no longer wants assistance; and
- 5) the preferences of the consumer are essential, and the options and choices regarding work are founded on the consumer's requirements and skills.

TRANSPORTATION

PURPOSE

To meet its contractual obligations, DBH is required to provide transportation services to eligible Medicaid clients to and from medically necessary mental health related treatment appointments.

POLICY

Davis Behavioral Health will make provisions to provide transportation to Medicaid eligible consumers receiving mental health services directly or by referral from DBH when they have no resources or third party means for transportation. Further, DBH may transport non-Medicaid clients for programmatic reasons. The following procedures apply to all DBH employees when transporting clients in a DBH vehicle or in their own vehicle.

PROCEDURE

1. DBH Driver Requirements:
 - a. All drivers must wear their seatbelts.
 - b. Drivers will not have used alcohol for at least 12 hours prior to transporting passengers or operating a DBH vehicle.
 - c. Drivers will not operate company vehicles when taking medications that will impair their ability to drive.
 - d. Drivers will not be permitted to smoke or use tobacco products in any company vehicle.
 - e. Drivers shall have a valid driver's license with a safe driving record that will allow DBH purchased insurance to cover them in the course of their employment.
 - f. Drivers shall treat all passengers with dignity and respect. They will be courteous and follow driving rules and safe practices.
 - g. No texting or use of cell phones while driving, including 'hands free' devices.
 - h. All drivers must pass a BCI and meet all requirements listed in DBH 'Vehicle Operations' Policy.
 - i. Drivers will fill in the forms showing the usage of vehicles as needed by the Transportation Office each time they use a vehicle.
 - j. The Transportation Coordinator will ensure that all drivers have met all the requirements to drive a DBH vehicle listed in the 'Vehicle Operations' Policy.
2. Passenger Requirements:
 - a. Consumer Transportation will only be provided for medically necessary purposes or for supported employment. Determination for what meets medical necessity, programmatic or supported employment needs will be determined by program directors.
 - b. Passengers will be respectful and courteous to the driver and other passengers
 - c. Passengers will meet scheduling requirements by;
 1. Scheduling 24 hours in advance or when requested by a clinical provider
 2. Being ready at the appointed time and place
 3. Giving advance notice when canceling

- d. DBH is not liable for any personal property transported or left in vehicles.
- e. All passengers will wear seatbelts.

Non-compliance of this policy or any rules could result in losing transportation privileges.

3. Transportation of Children:

- a. Children under 13 years of age will not be transported without a guardian or other authorized adult in attendance
- b. Small children will only be transported in appropriately sized and correctly installed and adjusted restraint devices.
- c. Children ages 12 or younger may not sit in front passenger seat.

4. Education:

Drivers shall successfully meet the required Driver Qualifications and safety training as outlined in the Vehicle Operations Policy before using DBH vehicles.

5. Scheduling Vehicles:

The scheduling and allocation of vehicles should be done by the campus coordinator or online where available. Vehicles shall be allocated first to provide services for clients of DBH, and second to act in the financial and other interests of DBH.

6. Record Keeping:

- a. The Transportation Office shall keep records of all transportation using DBH owned or leased vehicles including;
 - 1. Driver
 - 2. Passengers
 - 3. Dates & Times
 - 4. Program
 - 5. Mileage
 - 6. Purpose
- b. The Transportation Office shall submit utilization reports to DBH management when requested.

7. Maintenance:

The Transportation Coordinator will assure that DBH vehicles are maintained to recommended manufacturer's standards to ensure longevity of use and safe operations.

TRAVEL POLICY

Policies & Procedures



SECTION:	Finance
PAGE:	1 of 4
SUBJECT:	Travel
EFFECTIVE DATE:	4/2007
REVISION DATE:	12/2018

Summary

All travel and training must be approved in advance. The specific guidelines which follow this paragraph must be complied with in order to receive reimbursement for travel. Only actual, economical transportation and lodging expenses will be reimbursed. A per diem amount for meals will be paid for authorized meals. Reimbursement will be made within fifteen days of the submission of an approved Travel Reconciliation Report. Travel expenses for a companion are not reimbursed. Questions concerning the interpretation of the DBH travel policy should be addressed by the Controller.

Travel Approval

All travel must be pre-approved by the employee's immediate supervisor and their program director. Incidental travel and non-overnight travel required to perform the employee's day-to-day duties does not require prior approval.

A completed Travel Request Form must be submitted to the travel coordinator for all travel/training 15 days prior to the date of travel/training. Travel requiring airfare purchase should be to the travel coordinator 30 days in advance of departure. Exceptions must be approved by the Executive Leadership Team.

Most Economical Form of Travel

The most economical form of travel is the DBH standard. DBH may limit total reimbursement amounts for travel and training in order to stay within budgeted amounts. Employees may be reimbursed a set amount for specific travel and training as determined by the Executive Leadership Team prior to the travel.

Travel Arrangements

Travel Coordinator Arranged Travel:

All travel arrangements listed below may be made by the travel coordinator. Once a Travel Request Form has been approved, the travel coordinator will make arrangements for the following areas on the DBH travel credit card:

- Conference Registration
- Hotel, Condo, House Rental Accommodations
- Airfare (Coordinator will provide employee flight time options)
- Car Rental

Employee Arranged Travel:

Employees are allowed to make their own travel arrangements and pay for their travel with a personal credit card. If an employee wishes to make their own travel arrangements, they should first check with the travel coordinator to determine reimbursement rates paid by DBH. After the travel has been completed, the employee must submit receipts for reimbursement on the travel reconciliation form.

While an employee is allowed to make their own travel arrangements with a personal credit card, they may not make travel arrangements for other employees with their personal credit card.

Meal Reimbursement

Meals are reimbursed for 1) business oriented overnight travel, and 2) business related entertainment (employee meal purchases made when business is being conducted throughout the meal).

Meals that are provided complimentary of the conference, hotel or association are not considered reimbursable.

Overnight travel meal reimbursement is determined by the time of day the traveler leaves "home base" (the location the employee leaves from and/or returns to), the number of days at the location, and the time of day the traveler returns the home base. Tips and tax on meals are included in the per diem.

Leave Home Base:

1st quarter: Leaves between 12:01am and 7am
2nd quarter: Leave between 7:01am and 1pm
3rd quarter: Leaves between 1:01pm and 6pm
4th quarter: Leave between 6:01pm and midnight

Per Diem Reimbursement for:

B-L-D
L-D
D
0

Returns to Home Base:

1st quarter: Arrives between 12:01am and 6am
2nd quarter: Arrives between 6:01am and noon
3rd quarter: Arrives between 12:01pm and 6pm
4th quarter: Arrives between 6:01pm and midnight

Per Diem Reimbursement for:

\$0
B
B-L
B-L-D

Lodging

DBH reimburses for lodging if the conference is more than 75 miles from the DBH offices at 934 South Main Street, Layton Utah.

Hotel room service, movies and other charges are the responsibility of the employee.

If a traveler stays with friends or relatives rather than in a hotel, uses a personal camper/trailer, or rents a home/condo the travel is reimbursed as follows:

- \$25 per day (stays with family or friends, no receipt required)
- Actual cost up to \$50 per day with receipt (campground, trailer park)
- Home/Condo rental (rental will be reimbursed for actual cost up to the amount of hotel lodging costs determined by the travel coordinator).

Transportation

Mileage reimbursement will be the lesser of mileage or airfare. Mileage is calculated at the IRS approved business travel reimbursement rate. For travel/training budget reasons, DBH may reduce the amount reimbursed for mileage for specific conferences prior to the conference. Rental cars are not reimbursable for in-state travel; however, an employee can use the mileage reimbursement to pay for the rental car. Travel time taken for driving or flying during the employee's normal work week may count as time worked, but cannot be considered overtime.

- Use of private vehicle: IRS or DBH rate for business travel
- Private motorcycle: ½ the IRS or DBH rate for business travel

Incidental Travel Expenses

Travelers will be reimbursed for actual out-of-pocket expenses for incidental items such as baggage, baggage tips, taxi's/tips, shuttle service, other ground transportation, long term

airport parking and toll fees.

A receipt is required for each incidental travel expense over \$25. For incidental travel expenses under \$25 the traveler must indicate on the travel reimbursement form the type of incidental expense and dollar amount.

Fall Substance Use Conference

Each year ELT will determine the total reimbursable amount allowed for this conference. This amount will cover hotel, transportation/mileage and food costs per diem. Employees are responsible to check with the travel coordinator to determine the reimbursable amount allowed by ELT prior to the conference.



POLICIES & PROCEDURES

SUBJECT: VEHICLE OPERATIONS

SECTION: Administrative

PAGES: 2

EFFECTIVE DATE: 12/2005

REVISION DATE: 10/2011

POLICY

All Davis Behavioral Health Vehicles are to be operated in a safe and proper manner. All persons driving Davis Behavioral Health Vehicles will meet the standards set forth by our insurance carrier and Davis Behavioral Health.

SCOPE

All Davis Behavioral Health Staff and Volunteers

OVERSIGHT

- A. Unit Responsibility: The Transportation Coordinator will ensure that all staff and volunteers who operate cars or vans belonging to Davis Behavioral Health are in compliance with this policy.
- B. Administrative Responsibility: The Transportation Coordinator will cause a list to be kept of all drivers, approved by our insurance carrier, that have completed all necessary training requirements.
- C. Vehicle Use: The Transportation Office will develop and maintain records that track the use of DBH vehicles; see that vehicles are serviced in accordance with manufacturer recommendations; keep vehicles fueled when possible; and schedule the use of vehicles not assigned to a Program.

PROCEDURES

A. Driver Qualifications

- 1. Must be at least 22 years of age or have 6 years of driving experience.
- 2. Have a current valid Utah Driver's license.
- 3. As verified by a Department of Motor Vehicles Driver's Record Service Report through our insurance carrier
 - a. Have *no* record of DUI, Reckless Driving, or license suspension in the last five years,
 - b. Have not been involved in more than two *at fault* accidents in the past three years,
 - c. Have no more than two moving citations in the past three years.
- 4. Prior to assuming driving duties, new drivers must receive orientation from the Transportation Coordinator regarding the use of the vehicles and the policies and procedures relating to vehicles and drivers.

B. Driver Disqualifications

- 1. Failure to maintain qualifications as described above.
- 2. Driver's License Suspension by any state Department of Motor Vehicles.
- 3. A driver may re-qualify for driving status in some instances by attending the *Defensive Driving Course* offered by the County. [does not apply to disqualification for a DUI citation]

C. Accident Procedures

- 1. The police must be called and an accident report obtained.

2. The driver's supervisor should be notified.
3. Within two working days of the accident, an incident report must be filed with Human Resources regardless of the amount of damages or injury.
4. All vehicle related incidents must be reported to the Chief Operations Officer by Human Resources.

D. Limits on Use

1. Drivers will be advised that permission from the Davis Behavioral Health Executive Committee must be received prior to overnight trips, and trips exceeding the mileage limit imposed by our insurance carrier.
2. Insurance extensions must be obtained for each van traveling more than 300 miles from Salt Lake City, and for each truck traveling more than 150 miles from Salt Lake City.
3. Each program assigned a vehicle must notify the Transportation Office within 24 hours of any damage or observable vehicle deficiencies. Each Program will also make assigned vehicles available for servicing when notified of scheduled maintenance.

E. Records

1. A current list of all authorized drivers including their driver's license number, birth date, and status. [HR]
2. A current list of all vehicles including the License Plate number, purchase date, Vehicle Identification Number (VIN), and assigned program. [Finance, Transportation Office]
3. Each program assigned vehicles will keep records of vehicle use, a trip log, and a passenger log in a format requested by the Transportation Office. Copies of trip records must be submitted to the Transportation Office within one week of each month end date. A summary of trip records is to be submitted to Finance quarterly. [Transportation Office and Program Directors; Finance]