This document establishes that an individual seeking shelter is literally homeless and determines their eligibility for the shelter program.

Shelter Support Staff will ensure that the client has completed the top portion of the form by checking at least one box that is applicable to their experience of homelessness to complete the self-certification requirement. In order to complete the requirement of a verified oral statement of homelessness documented by an intake worker, Shelter Support Staff will ask the client where they slept last night and why they are seeking shelter now and write down the client's response. An electronic copy of the document will be uploaded into the client's HMIS profile.

Clients with Service/Emotional Support Animals

Clients with a service/emotional support animal(s) must provide staff with evidence of having a Maricopa County license and proof of a recent rabies vaccination. Additionally, clients must follow all CASS guidelines by reading and signing the CASS Service Animal Shelter Stay Agreement. Clients who do not follow the guidelines will be given verbal and written warnings, and if the violations continue client can be asked to locate other placement for their animal.

Review copies of each of these documents at the shelter front desk.

Client Grievance Procedure

Any client of CASS may file a grievance at any time.

A client may ask to speak directly to the department Lead or Supervisor at the time of the incident if they are available. If a supervisor is unavailable, the client will be given a grievance form to express their concerns in writing. Clients will place the completed grievance form in the locked box located in the shelter intake area.

Grievances must include the following information:

- The name and bed number of the client filing the grievance.
- The nature of the action(s) which resulted in the complaint.
- Date(s) and time(s) of the event.
- The staff member, client name, or policy the grievance concerns.

Grievance Process

- Once "Grievance Form" is turned in CASS staff will respond within 24 hours with a received receipt.
- Receipt will include time and date for follow up by client with management.
- Time and date for follow ups include;

- Monday, Wednesday and Fridays between 5pm and 7pm.

Any grievances placed in the locked box will be reviewed within three (3) business days, and will be directed to the appropriate supervisor or lead for review. The supervisor or lead will attempt to contact the client and the resolution of the concern will be documented on the form.

If the client is not comfortable submitting a grievance form as described above, he or she may mail a written grievance to the Shelter Manager (SPM) at:

Central Arizona Shelter Services

230 S 12th Avenue

Phoenix, AZ 85007

Grievances may also be phoned in to the Director of Programs at

(602) 256-6945 ext.: 1402

Upon receipt of a grievance, the Director of Programs will investigate the stated concerns within three (3) business days. The DOP will take any necessary corrective actions.

Appeals:

If the client is not satisfied with the handling of the grievance, the client may appeal directly to CASS' Chief Operating Officer (COO).

Appeals with the Chief Operating Officer can be scheduled by calling the receptionist for CASS Administrative Services at 602-256-6945. Appeals will be scheduled and heard within three (3) business days of receipt of the phone call. The Chief Operating Officer (COO) will review the handling of the grievance, meet with the client, and take any further action that is deemed appropriate. The Chief Operating Officer (COO) will respond in writing to the client within three (3) working days of the meeting. The decision of the Chief Operating Officer is the final level of appeal within CASS.

All clients have the right, at any time and for any reason, to present to the Community Services Administration (CSA) of the Department of Economic Security (DES) any grievances arising from the delivery of client and/or shelter services. Grievances can include but are not limited to ineligibility determination, service reduction, suspension or termination, or quality of services. DES determines jurisdiction over the grievance. DES can be contacted at:

Department of Economic Security

Community Services Administration

1789 W. Jefferson

Phoenix, AZ 85005

602-542-6600

Anyone filing a grievance against CASS is assured that they will not face retaliation. This includes loss or reduction of any client or shelter services that are not warranted by the facts of the case.

Bus Pass Logs

- Review the bus pass distribution log for specific information on circumstances in which bus passes may or may not be issued.
- All fields of the bus pass log must be filled out completely, in legible print.
- Shelter Support Staffs will scan in bus pass logs on a weekly basis for quality assurance and monitoring purposes.

Wake Up Lists

The Wake-Up Lists for all levels are kept at the Intake Desk.

Wake-Up service begins at 12:00am (midnight) and continues until 5:00am at hourly intervals.

Clients may not place themselves on the Wake-Up List for multiple times throughout the night. If a client appears on the Wake-Up List more than once, staff will wake the client up at the earliest listed time only.

When waking up clients, do not turn on the lights; use a flashlight if necessary. Go to the client's bed, and wake them up by gently tapping at their bunk or calling their name. Do not make physical contact with clients.

When a staff member awakens a client, the client will be required to initial by his or her bed number on the Wake-Up List. This will reduce complaints and confusion on whether a person was awakened or not.

Staff should stay by the client until he or she acknowledges the wake-up call. If the client refuses to wake up, staff will make a notation on the Wake-Up List. Continued failure to acknowledge the wake-up call may result in loss of this service.

Staff will perform a dorm-wide wake-up call for all clients at 6:00am daily. Staff should check each dorm area at ten minute intervals in order to verify that everyone is awake and getting ready to vacate the dormitories at the proper time.

Shelter staff will create a new Wake-Up List for the next day after 3:00am each morning.

Substance Use

Substance use includes alcohol, illicit drugs, and prescription drugs.

Intoxication:

- Clients who are intoxicated will not be asked to leave the shelter solely due to being under the influence. If the client does not appear to pose a danger to themselves or to others, the client will be allowed to go to bed.

- If a client exhibits signs of overdose (such as vomiting, dizziness or loss of balance, drowsiness, slowed breathing, etc.), this person's life may be at risk. Staff must contact the EMT or 911 for medical evaluation, even if the client declines services.
- If a client exhibits disruptive behaviors (such as unwillingness to comply with security protocol or violence), staff may attempt to discuss desired behavior changes with the client. If it is not safe to approach the client, staff must contact a campus intervention team consisting of an EMT, Mental Health Navigator and Security, or the Police if necessary.

Possession of alcohol within the shelter:

Possession of alcohol within the shelter is prohibited. Any alcoholic beverages must be discarded before entering the shelter. Clients who are found to have alcohol in the shelter will lose their bed for the evening.

Possession of drugs within the shelter:

- Possession of illicit drugs within the shelter is prohibited. Any drugs must be discarded before entering the shelter. Clients who are found to have drugs in the shelter will lose their bed for the evening.
- Medical marijuana in an appropriately labeled container will NOT be confiscated, but must be stored off-site, in accordance with the CASS and Human Services Campus policies on drugs.

Written Reminders: Policy & Consequences

Clients who are not in accordance with certain aspects of shelter guidelines may be given a reminder by staff. See the "Client Consequences for Failure to Follow CASS Guidelines" for details on when reminders are issued.

All written reminders must be reviewed with the client and signed by both the client and the staff member issuing the reminder. If the client refuses to sign, the staff member will request another staff member to "witness" the refusal and indicate "Refused" on the client signature line.

All written reminders must be scanned and uploaded to the client's HMIS profile.

Incident Report Procedure

An Incident Report (IR) is a written account of an event which has occurred within CASS. Staff will be required to create an Incident Report (IR) immediately after the incident occurs.

Review the "Consequences for Failure to Follow CASS Guidelines" document for a quick reference to common situations that necessitate an Incident Report.

The following types of events must be documented by writing an IR:

- Injury (to anyone)
- Threats or Verbal Abuse
- Medical Emergencies
- Police Involvement
- Phoenix Fire Involvement
- Assault (on anyone)
- Weapons Policy Violation
- Discrimination/Harassment
- Drug/Alcohol Policy Violation
- 911 Call
- DTS/DTO Ideations
- Death
- Hazmat/Biohazard Situation
- Theft
- Duty To Warn
- Property Damage
- Media Presence
- Client Transport to Hospital (any reason)

An Incident Report (IR) is a *legal document*, and should be treated as a written testimony of the facts of an event which has taken place. Only facts should be recorded in an IR. Hearsay, opinions, guesses, and biases must be left out of an IR. Client witness statements may be made on a Comment/Grievance Form, and should be passed on to the appropriate supervisor.

The staff member(s) involved in or who witnessed the event must complete an Incident Report. In the circumstance where several staff members witnessed or were involved in an event, a single Staff member should be chosen to write the primary report. When reporting a situation involving multiple staff or security persons, the writer must include statements from other of the witnessing parties. Supplemental reports may be requested by the Director of Programs or Chief Operations Officer.

Incident reports are entered into HMIS in the "CASS Incident Report" section and are available to view in real-time by supervisors. Complete all required fields. Spelling, grammar, and information should be reviewed before the IR is considered complete.

If the incident primarily involves security staff, they must be instructed to also write an Incident Report following the above guidelines. Incident Reports completed by security staff will be reviewed and entered into HMIS by the Security Manager.

Serious incidents should be communicated to the Client Care Supervisor immediately, who will notify the Director of Programs, Chief Operations Officer, and/or Facility Manager, as appropriate.

Suspension Procedure:

Staff may stop providing services to clients for behavior that presents risk of harm to other clients or staff or seriously interferes with shelter operations. These incidents should be rare, staffed with a supervisor prior to suspension (if possible), and documented.

In the rare circumstances that clients are suspended from shelter services, it is due to serious safety concerns such as violent threats, physical assault, hygiene/health issues, or the need for police involvement for behavioral intervention. Review the "Client Consequences for Failure to Follow CASS Guidelines" document for additional information.

1. Notify the client that his or her shelter privileges are being suspended for behavior that is in violation of CASS guidelines.
    i. Staff must inform the client of the specific reason his or her shelter services are being suspended, as well as the consequence. In most cases, a client is given a verbal warning, which is documented in the client's profile. A written warning is issued at least two times, indicating the consequences if the behavior is repeated, and clients are asked to sign. Whether they choose to sign or not, the form is uploaded in the client's HMIS profile.
    ii. Staff must inform the client that they may return to speak to a supervisor.
    iii. The supervisor who meets with the client will establish the consequence based on the severity of the situation.

2. Complete an Incident Report (IR), providing a detailed account of the serious events which led up to suspension.
    i. Staff must cite any previously documented violations found within the client's profile, using times, dates, and the name(s) of the staff member(s) who documented the violations.
    ii. The IR must be completed before the end of the staff member's shift.

3. A condensed version of the incident must be noted in the client's profile, under "General Client Notes". For example: "06/01/17 Client suspended for Verbal Abuse/Threats toward Staff; issued 1NO/LOB. See IR. ZZ[]"

Single Adult Shelter

Consequences for Failure to Follow CASS Guidelines

Failure to act responsibly / respectfully:	1st Violation:	Repeated Violation:
8:30 PM No-show - Violation of curfew *(document in HMIS, no IR required)*	1 NO/LOB	1 NO/LOB
Late List violation *(document in HMIS, no IR required)*	Written warning	2: Written warning 3+: 1 NO/LOB
Cubical violation: excessive belongings, improper storage of items, food or drink *(document in HMIS, no IR required)*	Written warning	2: moved to L1 3: 1 NO/LOB
Exiting shelter before 12AM (midnight) *(document in HMIS, no IR required)*	1 NO/LOB Client forfeited bed	1 NO/LOB Client forfeited bed
Verbal abuse involving gender, sexual orientation, racial, or other slurs	1 NO/LOB	2: 7 day suspension 3: 30 day suspension
Verbal abuse: staff will enforce when abuse continues or is excessive	Verbal warning	2: Written warning 3+: 1 NO/LOB
Disrespectful behavior: exposure, nudity in the dorms, sexual behavior	Verbal warning	2: Written warning 3+: 1 NO/LOB
Disrespectful behavior: disruption, discrimination, harassment	Verbal warning	2: 1 NO/LOB 3+: 7-day suspension
Failure to comply with assistive animal agreement (animal unattended, aggressive behavior, feces/urine indoors)	Written warning	Animal must leave

Jeopardizing safety of others:	1st Violation:	Repeated Violation:
Security: refusal to comply with property search	1 NO/LOB	2: 1 NO/LOB 3+: 7-day suspension
Entering opposite dorm than assigned	7-day suspension	2: 30-day suspension 3: 1-year suspension
Entering a restricted area (employee area, smoking area, bathroom, dorm outside of assigned level)	Written warning	1 NO/LOB or transfer levels
Unauthorized use of emergency exit doors	Written warning	1 NO/LOB
Verbal threats: when threats do NOT include bodily harm	1 NO/LOB	1 NO/LOB
Possession: illegal drugs, drug paraphernalia, alcohol - inside shelter	1 NO/LOB	2: 1 NO/LOB 3: 7-day suspension
Possession: (or deliberate concealment) any non-firearm weapon	1 NO/LOB	2: 7 day suspension 3: 30 day suspension
Theft (verified)	1 NO/LOB	2: 7 day suspension 3: 30 day suspension
Smoking inside shelter	1 NO/LOB	2: 7-day suspension 3: 30-day suspension

Revised 4.21.21

Serious safety concerns:	1st Violation:	Repeated Violation:
Police involvement, criminal activity, damage to CASS property - Violent	7-day suspension	2: 30-day suspension 3: 1-year suspension
Possession: (or deliberate concealment) firearms or explosives	30 day suspension	1-year suspension
Physical Assault	30-day suspension	1-year suspension

Notes

- Incident Reports must be completed in HMIS unless otherwise noted
- All violations must be verified/witnessed by staff/security
- 1 NO/LOB = One night out and loss of bed - client must leave immediately with belongings and return the next day after 3PM, if beds are available
- All Verbal Warnings are documented in HMIS
- All Written Warnings are signed by client and uploaded to HMIS
- Campus suspensions supersede CASS suspensions (a client is not allowed in CASS if they are not allowed on Campus)
- Consequences more severe than 1 NO/LOB are based on supervisor or manager approval
- Suspensions can be overturned with manager approval

All consequences are subject to manager discretion and can escalate/de-escalate based the aggravating or mitigating factors of the individual circumstances.

COPA HEALTH	# 309 (HR .11)	HIPAA Disciplinary Guidelines ☐ Policy ☐ Standard Operating Procedure					
Date of Inception:		3/1/2016	**CEO Approval:**				
Current Approval Date:		10/01/2017	**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☐	HR ☒	CC / QM ☐	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☐	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☐

Policy Statement

Protected health information (PHI) is confidential and protected from access, use, or disclosure except to authorized individuals requiring access to such information. Attempting to obtain or use, actually obtaining or using, or assisting others to obtain or use PHI, when unauthorized or improper, will result in counseling and/or disciplinary action up to and including termination. This policy also applies to the PIR electronic health record and third party health databases such as the health information exchange (HealthCurrent).

Purpose

To establish standards for disciplinary actions related to violations of privacy and security standards under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the "Omnibus Rule" (78 FR 5565) and Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2).

Scope

Partners In Recovery Campuses and administrative locations.

Procedure

I. General Requirements

A. All staff and personnel members are responsible for ensuring an environment of confidentiality for verbal, written, physical and technology-based protected health information of PIR employees and service participants. Employees who observe or are aware of a breach or impermissible disclosure must immediately report it to their Supervisor. The Supervisor will report the breach to the PIR Privacy Officer.

B. Failure to report a breach of which one has knowledge will result in appropriate disciplinary action.

C. Co-located providers are considered personnel members for the purposes of this policy. Violations of PIR privacy standards and policies will result in notifications to the agency supervisor and may result in termination of access to PIR protected health information.

D. Prior to imposing any disciplinary steps, the PIR Privacy Officer will initiate an investigation to substantiate the alleged impermissible disclosure, including a risk assessment consistent with PIR Policy *REC .08 Breach Notification*.
   a. An investigation, even when not substantiated, may result in recommendations for additional staff training and/or additional physical, administrative and technical safeguards to mitigate risk of future breaches.
   b. Failure to cooperate in any investigation or disciplinary intervention is itself grounds for discipline.

E. PIR will implement disciplinary interventions consistent with the frequency and severity of a substantiated incident:
   a. Verbal Counseling/Re-Training: The manager/supervisor is to notify the employee that a minor offense has occurred and appropriate documentation has been placed in employee's file.
   b. Written Warning: The employee is asked to sign the written counseling document for acknowledgement of receipt of notification.
   c. Final Written Warning: Final notice will be given.
   d. Termination: An employee who fails to comply with corrective action as prescribed may be terminated. In certain circumstances, immediate discharge is appropriate and recommended.

II. Disciplinary Guidelines

Level of Violation	**Examples**	**Minimum Disciplinary Action**
Level I – Improper or Unintentional Disclosures	Unintentional or careless access, review or disclosure of PHI. • Misdirected faxes, e-mails & mail. • Failing to log-off or close or secure a computer with PHI displayed. • Failing to verify identity and authority prior to providing PHI • Leaving a copy of PHI in a non-secure area. • Dictating or discussing PHI in a non-secure area (lobby, hallway, cafeteria, elevator). • Failing to redact patient information for non-PIR uses • Leaving detailed PHI on an answering machine. • Improper disposal of PHI. • Transmission of PHI using an unsecured method. • Unsecured transport of PHI	• First offense: verbal counseling and re-training on PIR policy • Second offense within one year: written warning. • Third offense within two years: termination.
Level II – Purposeful / Intentional Disclosures	Access, review or disclosure of PHI in a manner that is inconsistent with PIR policies but not for reasons of personal gain.	• First offense: Written warning. • Second offense within two years: Final written warning • Third offense within two years.

	• Requesting another individual to inappropriately access patient information. • Inappropriate sharing of ID/password with another coworker or encouraging coworker to share ID/password. • Failure to secure data on mobile devices through encryption/password. • Taking photographs or recordings without patient consent	Termination
Level III – Willful or Intentional Disclosure for Personal Gain or Malicious Intent	Access, review or disclosure of PHI for personal gain or use • Releasing or using aggregate patient data without written PIR approval for research, publications, etc. • Marketing a personal business to PIR service participants • Accessing or allowing access to PHI without having a legitimate reason. • Giving an individual access to your electronic signature. • Accessing patient information due to curiosity or concern, such as a family member, friend, co-worker, "public" person, etc. • Posting PHI to social media or distribution of photographs, recordings without company authorization. • Use of the HIE to access personal health data	• First offense: Final written warning. • Second offense within three years: termination.
Level IV – Civil / Criminal Liability	• Releasing or using data for personal gain • Compiling a mailing list to be sold for personal gain or for some personal use • Disclosure or abusive use of PHI • Tampering with or unauthorized destruction of information.	• Termination. • Violation will be reported to appropriate licensing boards and third party agencies when required.

Cross Reference(s)

REC .08 Breach Notification

REC .02 General Rules for the Use and Disclosure of PHI

REC .03 Authorization to Use and Disclose PHI

REC .06 Verbal, Electronic, Written and Physical Transmission of PHI

COPA HEALTH	# 818 (PRG .40)	Re-Engagement, Transition and Closure ☐ Policy ☐ Standard Operating Procedure					
Date of Inception:		9/23/09	**CEO Approval:**				
Current Approval Date:		5/1/2018	**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☐	HR ☐	CC / QM ☐	Rights ☒	RCM ☐	ERS ☒
H/S ☐	IHS ☒	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☐

Policy Statement

Partners In Recovery ensures that all appropriate outreach and re-engagement strategies are implemented prior to closing a participant from PIR services or transitioning from active treatment.

Purpose

To establish PIR Campus standards for closure and re-engagement activities prior to disenrollment.

Scope

PIR Campuses

Procedure

I. Closure and Transition

A. Closure from active treatment.

Situations in which participants are closed from active treatment include the following:

1. Deceased participants;
2. Move of a participant out of the geographic region served by PIR
   a. If the person moves within the state of Arizona, but outside of Maricopa County, an Inter-RBHA transfer is initiated. Coordination of care with the receiving agency to ensure continuity of appropriate care is expected. Proper documentation of contact with the receiving agency and the details of the participant's transfer to a new care provider are completed prior to the closure and consistent with *PIR Policy PRG .21 Transfer of Care*.
   b. If the person moves out of state, the Case Manager shall assist the participant in locating a behavioral health service agency in the applicable geographic area if the persons agrees to this assistance.

3. Conviction and sentencing to the Department of Corrections (prison) for a period exceeding 3 months; the Clinical Care team must continue to provide coordination of care for the first 3 months of the sentence prior to closure.
4. Transfer of care to the Arizona Long Term Care System (ALTCS);
5. If a participant chooses to enroll with another outpatient provider for his or her outpatient behavioral health services and case management; and
6. Completion of the SMI decertification process.

B. Transitioning out of active treatment

1. Unless a participant is closed, he/she will be transitioned into the PIR Navigator Outreach Program.
2. A person may request a transition from active treatment into the PIR Navigator Outreach Program. There will be a higher threshold for transition when the transition involves medication or symptom escalation needs or frequent hospitalization and ED utilization. PIR will not initiate transition for persons who lack capacity to make treatment decisions as evidenced by:
    a. Under active Court Order Treatment or meeting clinical standards for initiating pre-petition screening or petition for treatment process
    b. Requires Special Assistance
    c. Receives DDD services
    d. Lacking decisional capacity as evidenced by active psychiatric symptoms that significantly impair the thought process or
    e. A person on the PIR High Risk Registry.
3. Transition to the PIR Navigator Outreach Program shall not occur:
    a. Due to failure to comply with policies or Clinical Care Team recommendations as a direct result of mental health symptoms, and
    b. Prior to notification of the Clinical Care Team's plan to transition care by sending PRG FRM 40.01 Notice *of Intent to Transition Active Treatment* Letter.

II. Re-Engagement Activities for Participants in Active Treatment

A. PIR will attempt re-engagement on any person who has withdrawn from participation in the treatment process OR if the person declines services OR if the person fails to appear for a scheduled service(s).

B. Re-engagement following appointment no-show:

1. Attempt telephone contact within 24 hours
2. If the Clinical Care team is unable to make telephone contact, a face to face or home visit is completed within 72 hours following the missed appointment.
3. If the Clinical Care team is unable to locate the participant at home (or other face to face contact), active outreach and re-engagement is initiated.
4. All no show and re-engagement efforts are documented in the person's Electronic Health Record.

C. Active outreach and re-engagement

The Clinical Care team will document a minimum of 8 weeks of re-engagement/outreach activity with a minimum of two outreach attempts per week or more assertive efforts if clinically indicated. Outreach attempts includes, but are not limited to, the following:

1. Communicating in the person's preferred language;
2. Contacting the person or legal guardian by phone at times when the person may reasonably be expected to be available
3. Whenever possible, contacting the person or the person's guardian face to face, if telephone contact is insufficient to locate the person or determine acuity and risk; and
4. Contacting the person's emergency contact(s), if applicable
5. Searching databases such as Care Unify and the Health Current HIE to determine if the person is inpatient
6. Contacting the Jail Hotline or checking the Maricopa County Sheriff Office Website to see if the person has been arrested
7. Contacting the Maricopa County Medical Examiner's Office
8. Conducting a home visit or other face to face contact opportunity in the community
9. Sending a "Notice of Intent to Transition from Active Treatment" letter (PRG FRM 40.01) to the current or most recent address requesting contact, only if all attempts at personal contact are unsuccessful
10. For persons who are receiving Special Assistance, the Clinical Care Team will also contact the person designated to provide Special Assistance for his/her involvement in re-engagement efforts.

D. **Notice of Intent to Transition Active Treatment Letter**

Unless closure is due to the participant's documented request or death, the participant shall be notified of the Care Team's plan to transition to Navigator Outreach no less than 30 days prior to the date of transition by sending PRG FRM 40.01 *Notice of Intent to Transition Active Treatment Letter*.

A copy of the "Notice of Intent to Transition from Active Treatment Letter" is filed with the participant's medical record.

IV. Documentation Required for Closure or Transition Out of Active Treatment

A. Within ten (10) days of the eligible closure or transition date, PIR will complete:

1. A demographic update (EA1013) in the EHR;
2. Documented coordination with other involved providers/stakeholders;
3. Primary Care Physician Communication form*;* and
4. A documented note containing the Discharge Summary:
   a. Reason for Discharge from active treatment, identifyng the specific reason the participant is being closed or transitioned from services, i.e. participant requested transition to Outreach; death of a participant; move of participant from geographic area served by PIR; lack of contact or declined services.
   b. Brief Review of Services Provided, , identifying services and major supports provided or coordinated by PIR, such as:

i. Crisis Services

ii. Inpatient Psychiatric Hospitalization;

iii. Residential Treatment Services, Housing Subsidies;

iv. Vocational Services;

v. Counseling Services;

vi. Primary Care Services;

vii. Case Management level of service.

viii. Medications Prescribed: Detail the medications and dates of prescriptions by the Behavioral Health Medical Practitioner (BHMP) and/or PCP at the time of closure or transition. If the participant is placed in the Outreach program, the record will provide a statement explaining why medications were not prescribed at the time of transition.

c. For transitions to the PIR Navigator Outreach program, information regarding referrals provided to the participant that address ongoing treatment needs shall be documented. If the Clinical Care team is unable to contact a participant at the time of transition, the team shall indicate why no referrals were provided.

d. Referrals for closures:

i. No referrals should be indicated for participants who are deceased or incarcerated.

ii. For all other closures, referrals will be made according to participant need and request, and will be noted in the EHR.

B. All paperwork, including documentation of 8 weeks for outreach, is forwarded to the Clinical Director for review and approval of transition or closure.

C. Within three (3) business days of receiving transition or closure paperwork, the Clinical Director will review the documentation in the HER, including 8 weeks of documented outreach, prior to approving the transition and closure. It is the responsibility of the Clinical Director to ensure that the processes leading to the point of transition and closure of the case are consistent with PIR policy.

Cross Reference(s)

PRG .80	Patient Navigator Program
PRG FRM 40.01	Notice of Intent to Transition Active Treatment Letter
PRG 4.1	SMI Decertification Process

COPA HEALTH	# 405 (RM .02)	Campus Safety and Welfare ☐ Policy ☐ Standard Operating Procedure					
Date of Inception:		9/23/09	**CEO Approval:**				
Current Approval Date:		6/1/2016	**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☒	HR ☐	CC / QM ☒	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☐	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☐

Policy Statement

Partners In Recovery is committed to maintaining a safe work environment for employees and a safe experience for participants, both at the facility and on facility outings. Safety policies and practices are addressed during new employee orientation and updated as appropriate during educational activities.

Purpose

This policy is intended to review steps that each employee should take to help assure his or her own safety while at any of the campuses as well as to outline requirements to protect participant safety at outings.

Scope

Partners In Recovery Campuses

Procedure

I. Property and Staff Safety

Campuses put in place security mechanisms and activities to protect the welfare of employees and participants including educating employees about steps to take to promote their safety and the safety of participants. These steps include but are not limited to the following:

A. Parking

1. Park in well lit areas after dark

B. Entering and Exiting the Campus

1. Campuses provide master keys and/or information about the access code to alarm systems to a limited number of essential staff.
2. Campuses may provide security guards after hours that control access to the campus.
3. When it is dark, employees are encouraged to leave together, not alone.

C. Daily Operations

1. During business hours, all exits are locked with the exception of the main entry and those exits that must remain unlocked per safety code.
2. Any suspicious activity witnessed by any person while at the campus is immediately reported to a supervisor.

D. Weapons

1. Weapons may include, but are not limited to stun guns, tasers, firearms, knives, bow and arrow or other archery-type devices, slingshots, objects capable of firing a projectile such as a pellet and BB rifles/ handguns, martial arts devices, blackjacks, and so forth.
2. Employees, direct care staff members and participants shall not possess weapons on any Partners In Recovery (PIR) campuses or property. Notices to that effect are posted at each site.
3. Under no circumstances will it be deemed appropriate for a PIR staff member to possess a weapon while conducting business for PIR. This includes holding on to a weapon for a participant or touching a weapon for any reason. (The police should be notified to remove all weapons onsite or offsite if there is DTO and/or DTS situation, see 5a and 5b below).
4. Any concerns about safety shall be immediately brought to the attention of a supervisor and those concerns shall be addressed and documented appropriately.
    a. Participants who display a weapon while on site shall be asked to either vacate the facility and surrounding property or surrender the weapon.
    b. The police shall be notified if the participant refuses to leave the facility or surrender the weapon.
    c. Police may also be notified to have any weapon confiscated if the situation poses a danger to self or danger to others on site.

E. Home Visits

1. Home visits shall be conducted as set forth in the Participant Contact Guidelines Policy, or as determined necessary by the clinical team.
2. The following safety strategies are recommended for employees when making a visit to a participant's home:
    a. Always try to maintain personal space of 3 feet; and there shall be no touching of any kind that can lead to a misunderstanding, such as hugging or hand-holding.
    b. Staff members shall possess and practice the basic personal safety techniques as taught in Crisis Prevention/ Intervention (CPI). No staff member should make a home visit without having first successfully completed CPI.
    c. Be aware of your surroundings at all times—look in each direction before leaving the premises and while walking.
    d. Staff members shall not conduct a home visit after dark, unless accompanied by another team member, or as directed by the clinical team.
    e. Do not confront a participant's beliefs or perceptions if it appears to upset the participant.
    f. Encourage the participant to calm themselves if the participant begins to demonstrate that he or she is upset.

g. Speak in a low, soothing voice.

h. Maintain an appropriate, non-threatening, but confident posture.

i. If a staff member begins to feel threatened, he/she shall leave. The meeting should be brief, and the staff member shall avoid taking unnecessary risks.

j. If the participant appears to possess a weapon or an object that could be used as a weapon, the visit shall be terminated.

k. When feeling uncomfortable about entering a participant's home, ask the participant if he or she can meet outside or arrange to meet at a neutral location.

l. Always know who is present at the participant's home when conducting a home visit.

m. If a staff member suspects criminal activity is occurring in the participant's home, the staff member shall leave immediately.

n. Wear appropriate professional attire.

o. If at any time during the home visit, it appears to the staff member that the participant may be a danger to self or others, the staff member shall leave the participant's home and notify the clinical team and other authorities if appropriate.

p. Do not let your guard down; stay alert no matter how comfortable you may feel with the participant.

q. If the situation begins to escalate, stay calm.

r. Be prepared to provide information to others that may be needed to assist you.

s. If the participant's behavior makes an employee feel uncomfortable in any way, the staff member shall leave.

3. If it is necessary to terminate a home visit or leave the participant's home out of a concern for safety, contact a clinical supervisor immediately upon leaving the participant's home. The clinical team will review the case with the staff member and determine the appropriate intervention to assure the participant's safety and safety of others.

4. When a home visit must be made, but there is reason to believe that the environment may not be safe, contact local law enforcement to request assistance using the non-emergent police telephone number.

II. Responding to Threats and Emergencies

A. Each campus is responsible for the development and posting of an emergency evacuation plan.

B. If the campus is notified that there may be a bomb present, the building is vacated immediately and the police (911) are contacted.

C. If a hostage situation occurs at the campus, employees are to contact the police immediately by calling 911.

1. The building should immediately be evacuated and no one will be permitted to enter the building.
2. Employees shall not take action (other than vacating the premises and following this policy) that might jeopardize the safety of the hostages.
3. As appropriate, the site administrator or designee will contact the Deputy CEO or Chief Information Officer to request that the telephones be forwarded to another campus.

D. Other Threats of Harm

911 shall be called immediately if there is a life-threatening emergency or an immediate risk of harm to a participant or to any PIR staff member. In situations where the person making the threats is present at the location or is threatening to harm a PIR staff member, the procedures outlined in the *On Site Emergencies and Crisis* and *Duty To Warn* policies are followed.

III. Assuring Participant Safety

A. Campuses assure participant safety through employment of qualified and well-trained staff. Prior to employment, an extensive screening and credentialing of professional staff occurs. All staff report to supervisors and managers who are accountable for staff performance of their responsibilities. PIR trains its staff and supports their continued professional development including a focus on working with people and responding to the needs of persons with serious mental illness.

B. Under the direction of the medical, clinical, and operations leadership, the campus staff is trained on and understand the scope of their responsibilities to ensure the health, safety and welfare of participants at the sites and during activities and outings. If incidents occur, PIR have internal procedures in place to report and review procedures to address the immediate situation and to mitigate the changes of a repeat occurrence in the future.

C. If a participant believes it is necessary for their treatment to have an individual accompany them to treatment, an evaluation takes place based on the individual participant's clinical needs. A decision on the request will be made after an assessment of the individuals' circumstances including their ability to function independently (including a review of their transportation needs).

IV. Participant Safety on Activities and Outings

A. An outing as defined R9-10-101 is a planned activity sponsored by an agency that occurs off the premises, is not part of the agency's regular program or daily routine, and lasts for more than four (4) hours.

B. Campus staff are responsible for ensuring participant safety is protected on outings and activities organized by the outpatient campuses through the following procedures:

1. Participants are given advanced notice of the date, time, and destination of all activities. Participants who are interested and able to attend, sign up to attend these activities and transportation is arranged, as applicable.
2. Contact information is provided to the Site Administrator and/or Clinical Director before the outing, including the date, time, location and staff on site at the activity.
3. If participants take medications they are responsible for bringing them on the outing. Staff will prompt participants to bring and self-administer their medications.

C. A clinical director (or designee) ensures that for outings:

1. An outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each participant participating in the outing; and
2. Probable hazards, such as weather conditions, adverse participant behavior, or medical situations that may occur during the outing are identified and staff members participating in the outing are prepared and have the supplies necessary to prevent or respond to each probable hazard.
3. A minimum of two staff members are present and a sufficient number of staff members are present to ensure each participant's health, safety, and welfare on an outing.
   a) Each staff member on the outing has documentation of current training in CPR and first aid in accordance with the campus licensing requirements.
4. A staff member remains at the location of the outing until all PIR service participants have been picked up for transportation home.
5. Emergency information for each participant participating in the outing is available and includes:
   a) The participant's name;
   b) The name and telephone number of the individual to notify in case of medical emergency or other emergency.

V. Smoking

There is no smoking permitted on campuses or in PIR vehicles. The campuses have designated smoking areas outside the buildings that are clearly marked.

VI. Fire Drills

A. Fire drills are conducted for staff members and participants at the campuses once every three months and on each shift. Documentation of each fire drill is created using PIR RM FRM 02.01 and includes:

1. The date and time of the drill;
2. The amount of time taken for all participants and staff members to evacuate the facility;
3. Any problems encountered in conducting the drill; and
4. Recommendations for improvement, if any

B. Documentation of a fire drill is available for review for 12 months after the date of the drill.

VII. First Aid Kit/Emergency Treatment Supplies

A. A first aid kit is maintained on the premises and is accessible to staff members.

B. First aid kits are also available in vehicles that transport participants.

C. The first aid kit contains the following supplies in a quantity sufficient to meet the needs of all participants:

1. Adhesive bandages;
2. Gauze pads;
3. Antiseptic solution;
4. Tweezers;
5. Scissors;
6. Tape;
7. Disposable medical grade latex and non-latex gloves that are marked and distinct; and
8. Re-sealable plastic bags of at least one gallon size.

Cross Reference(s)

- RM .05 Emergency Preparedness Plan
- RM .06 Transportation
- RM FRM 02.01 Fire/ Evacuation Drill
- ENV .04 Routine and Emergency Supplies
- PRG .07 Duty to Warn
- PRG .09 On Site Emergencies and Crisis

COPA HEALTH	# 806 PRG .07	Duty to Warn ☐ Policy ☐ Standard Operating Procedure					
Date of Inception:		9/23/09	**CEO Approval:**				
Current Approval Date:		10/1/2018	**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☐	HR ☐	CC / QM ☐	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☒	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☐

Policy

Partners In Recovery establishes and supports best clinical practices for managing threats of harm and duty to warn potential victims as required by law.

Purpose

To establish the process for warning an identified or identifiable individual if a service participant communicates to a staff member a threat of imminent serious physical harm or death to the individual and the client has the apparent intent and ability to carry out the threat

Scope

Partners In Recovery Campuses

Key Terms

Duty to Warn

Disclosure of a confidential communication made by or relating to a service participant when the participant has communicated an explicit threat of imminent, serious harm to a clearly identifiable victim, and has the apparent intent and ability to carry out such a threat. A duty to warn disclosure is for the purpose of reducing the risk of harm to others or the public.

Procedure

I. Managing Threats of Harm and Duty to Warn

A. If a participant has communicated to a staff member an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the participant has the apparent intent and ability to carry out the treat, the staff member shall notify the Site Administrator or designated leader for assistance in carrying out the following interventions:

1. The staff member shall gather as much information from the threatening person as possible.

2. If the threat presents an *immediate* risk to the health or safety of anyone (not just Partners In Recovery staff members) and immediate police intervention is required, the staff member shall call 911 and shall discuss the case with the highest ranking clinician on site.
3. In the absence of an immediate risk to the health or safety of another person, the decision to call the police shall be approved by the highest ranking clinician present or Site Administrator.
    a) The highest ranking clinician, Administrator or the Behavioral Health Medical Practitioner on site shall make the call to the police.
    b) The call shall be made using a non-emergent phone number.
4. The highest ranking clinician, Administrator, or the Behavioral Health Medical Practitioner shall confirm that a "duty to warn" exists and the staff member who witnessed/received the threat shall:
    a) Communicate when possible the threat to all identifiable victims;
    b) Notify a law enforcement agency in the vicinity where the participant or any potential victim resides;
    c) Take reasonable steps to initiate proceedings for voluntary or involuntary hospitalization if appropriate; and
    d) Take any other precautions that a reasonable and prudent behavioral health care provider would take under the circumstances.

B. Clinical staff reporting a duty to warn in a situation where a participant has explicitly threatened to cause serious harm to a person or where the clinician has reasonably concluded that a patient is likely to do so, and the clinician discloses a confidential communication made by or relating to the patient for the purpose of reducing the risk of harm, will not experience liability for the disclosure.

II. Reporting and Follow-Up After an Emergency

A. Documentation

1. Once a duty to warn notification process is complete, the Clinical Director or designee completes an Incident/Accident/Death report and submits to PIR Quality Management.
2. Clinical staff and BHMP (as applicable) complete a Progress Note in the medical record of the involved participant.
3. The Clinical Director shall de-brief the incident with any involved staff and the Clinical Team.

Cross Reference(s)

RM .01 Incident/Accident/Death Reporting
RM .02 Campus Safety and Welfare

COPA HEALTH	# 808 PRG .09	On Site Emergencies and Crisis ☐ Policy ☐ Standard Operating Procedure					
Date of Inception:		9/23/09	**CEO Approval:**				
Current Approval Date:		10/01/2018	**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☐	HR ☐	CC / QM ☐	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☒	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☐

Policy

Partners In Recovery establishes and supports best clinical practices for management of psychiatric and medical emergencies in campus settings, including provision of crisis services.

Purpose

To establish standards for identifying and responding to medical and psychiatric emergencies/crisis in campus settings.

Scope

Partners In Recovery Campuses

Key Terms

Crisis Services
"Crisis services" means immediate and unscheduled behavioral health services provided to a service participant to address an acute behavioral health issue affecting the person.

Emergency
“Emergency” means an immediate threat to the life or health of a patient.

Medical Emergency
Any sudden, severe change in a participant’s physical well being, including serious injury, loss of consciousness, loss of physical function or severe pain. “Emergency” means an immediate threat to the life or health of a patient.

Psychiatric Emergency

A situation in which a participant presents as an imminent danger to self, danger to others or exhibits behavior requiring immediate intervention beyond that routinely provided by the clinical team.

Procedures

I. Standards

A. PIR provides crisis services during clinical hours of operation at each campus location. Crisis intervention services may also be provided off-site by ACT Teams during team hours of operation and consistent with PIR ACT Desktop Protocols.

B. PIR direct care staff receive crisis prevention and intervention training consistent with PIR policy on new employee and ongoing training.

C. During clinical hours of operation, the following staff are present and available at each campus location:

1. A behavioral health technician;
2. A registered nurse;
3. A behavioral health professional (available); and
4. A medical practitioner (available).

D. Staff certified in CPR are present in each campus during all clinical hours of operation.

E. Each PIR campus maintains campus-specific emergency response protocols consistent with the policy and standards.

F. All medical and/or psychiatric emergencies and crisis events are reported to PIR Quality Management consistent with PIR policy on Incident/Accident/Death reporting.

II. Medical Emergency/Crisis

B. In the case of a medical emergency on site:

1. Any employee assessing that an emergency exists shall:

a) Call for help, notifying the highest ranking medical staff member on site (Behavioral Health Medical Practitioner (BHMP), Nurse, individuals trained and certified in CPR and First Aid);

b) Apply aid to the best of his/her abilities; and

c) Remain with the participant until the BHMP or Nurse arrives.

2. The BHMP or Nurse shall triage the situation to determine if immediate life-sustaining intervention is required, if the local emergency response system shall be notified, or if the situation can be managed on site through administering first aid. No medical evaluations or treatment, other than first aid, shall be carried out on site.

3. If the situation requires immediate intervention due to a life or health-threatening emergency, only staff members trained in CPR and first-aid shall administer the emergency intervention while directing another employee to call 911, or, if no one else is available, the staff member shall call 911 prior to initiating emergency measures.

a) Only licensed medical staff or staff members trained in CPR and first-aid shall determine appropriate emergency interventions required to sustain the participant until the local emergency response system arrives. Life-sustaining measures provided by Partners In Recovery trained employees shall be limited to basic CPR and management of severe bleeding.

b) The staff member(s) available at the scene of the medical emergency shall also contact the Site Administrator for assistance in determining the appropriate response, other notifications to be made, and any other decision requiring administrative authority.

I. Psychiatric Emergencies/Crisis

A. In the case of a Psychiatric Emergency occurring on site, any staff member assessing that an emergency exists shall:

1. Notify the highest-ranking clinical staff member on site for assistance (Nurse, Site Administrator, Clinical Director, Clinical Coordinator).

2. The employee shall initiate actions that are directed towards:

a) Protecting the safety and security of participants in the immediate vicinity, including the participant experiencing the emergency;

b) Managing and determining appropriate clinical intervention to diffuse the emergency situation and provide for appropriate follow up;

c) Interventions shall be administered according to the participant's presenting problem under the guidance of the highest-ranking medical professional or clinician, and are designed to calm the participant and stop or reduce the behavior.

3. If the participant is unable to control his or her behavior while at the Campus, and there is *no threat of immediate physical harm to self or others*, the participant shall be asked to leave the Campus until he or she is able to control their behavior.

B. Campus Warnings and Notifications

1. Working Hours: If an emergency situation involves a serious threat of physical harm to others, staff members shall immediately notify others at the campus of the danger.

a) Campus leadership shall use Dr. Strong or Red Folder for notifying employees at the campus.

b) As needed, as many staff that are available will report to the area of Dr. Strong/Red folder.

c) The highest ranking campus leader at the area of incident shall:

i. Designated a staff member to call 911.

ii. Designate staff members as appropriate, to vacate the area where the participant is located to assure the safety of all participants until emergency personnel arrive.

d) The designated staff member available at the scene shall also contact the Site Administrator for assistance in determining the appropriate response, other notifications to be made, and any other decision requiring administrative authority.

2. After Hours: PIR maintains a current log of all employee phone numbers and conducts annual testing of the PIR Emergency Phone Tree consistent with the PIR Emergency Preparedness Plan.

Cross Reference(s)

RM .01 Incident/Accident/Death Reporting
RM .02 Campus Safety and Welfare
HR .03 New Employee Verification, Orientation and Ongoing Training

COPA HEALTH	# 602 Member Rights	Grievances, Appeals and Complaints

Date of Inception:	5/18/2020	Previous Approval Date(s):	
Current Approval Date:		Approved by: Chief Executive Officer	
		Chief Medical Officer	

Operational Scope:	BD ☐	Admin ☐	HR ☐	Corp Comp / QM ☒	ERS / DP ☐	Member Rights ☒	Medical Manage/ Medication ☐
IHS ☐	IT ☐	Sec / Safety ☐	H/R Services ☒	Infectious Control ☐	Facilities ☐	Emergency Ops ☐	Agency ☐

602 PURPOSE:

Individuals have the right to prompt treatment and supportive services appropriate to their needs. All individuals served by Housing/Residential (H/R) Services have basic human rights and specific legal rights (R9-10) that they do not forfeit when they receive services from H/R.

602.1 POLICY:

All individuals served by Marc Community Resources H/R Services have basic human rights and specific legal rights (R9-10) that they do not forfeit when they receive services from Marc Community Resources H/R. Individuals have the right to prompt treatment and supportive services appropriate to their needs.

At the time of admission, the program staff member shall review rights of individual served with the individual and document this in the individual clinical record in keeping with RBHA and accrediting guidelines. All individuals and/ or their representatives are informed of the grievance and appeals procedure and receive a copy of the same at the time of admission. All individuals served, their guardian(s), and significant others are encouraged to discuss any questions or concerns with the program staff as the need arises.

H/R shall not discharge or discriminate in any way against any individual by whom or on whose behalf a formal complaint has been submitted to AHCCCS, or who has participated in a complaint investigation process against Marc Community Resources H/R. Unresolved grievances may be raised to succeeding levels of review in keeping with AHCCCS and RBHA/Managed Care Organization (MCO) guidelines.

Individuals receiving services shall be provided notice of any changes to the level, frequency or duration of services that are being provided when H/R has initiate a process that will result in changes to the services being provided to the individual/family.

Appeals of decisions made by Marc Community Resources H/R or the RBHA/MCO regarding eligibility for services and/or funding types will be addressed to the RBHA in keeping with AHCCCS and RBHA/MCO policy. BHS will assist the individual to file appeals on his/her behalf. H/R will abide by the decisions made by the RBHA/MCO and will assist the individual in complying with the decision made by the RBHA/MCO to ensure continuity of care in the most appropriate treatment environment.

602.2 SCOPE:

All Copa Health Employees

602.3 DEFINITIONS:
Reference list of BHS Definitions and Abbreviations.

602.4 PROCEDURE:

- At time of admission, the program staff member shall review rights of individual served with the individual and document this in the individual clinical record in keeping with RBHA/MCO and accrediting guidelines. All individuals and/or their representatives are informed of the grievance and appeals procedure and receive a copy of the same at the time of admission. All individuals served, their guardian (s), and significant others are encouraged to discuss any questions or concerns with the program staff as the need arises.

- Informal complaints should be verbally directed to the program staff member. Discussion and remedial action shall take place immediately if time and the situation permit. If immediate actions are not possible, a specific time for discussion will be set. This process shall in no way circumvent the formal grievance and appeal process. (Reference BHS SOP #RI.06.03, Complaints.)

- Individuals receiving services shall be provided notice of any changes to the level, frequency or duration of services that are being provided when H/R has initiated a process that will result in changes to the services being provided to the individual/family.

- Appeals of decisions made by H/R or the RBHA/MCO regarding liability of services and/or funding types will be addressed to the RBHA/MCO in keeping with AHCCCS and RBHA/MCO policy. H/R will assist the individual to file appeals on her/his behalf. H/R will abide by the decision made by the RBHA/MCO and will assist the individual in complying with the decision made by the RBHA/MCO to ensure continuity of care in the most appropriate treatment environment. (Reference BHS SOP #RI.06.01, Grievance, Appeal and Notice Procedures.)

602.5 REFERENCES:

- AAC R9-10
- AHCCCS Policy and Procedures Manual

COPA HEALTH	# 603 Member Rights	Grievance, Appeal, Notice Procedure					
Date of Inception:		5/18/2020	**Previous Approval Date(s):**				
Current Approval Date:			**Approved by:** **Chief Executive Officer**				
			Chief Medical Officer				
Operational Scope:	BD ☐	Admin ☐	HR ☐	Corp Comp / QM ☒	ERS / DP ☐	Member Rights ☒	Medical Manage/ Medication ☐
IHS ☐	IT ☐	Sec / Safety ☐	H/R Services ☒	Infectious Control ☐	Facilities ☐	Emergency Ops ☐	Agency ☐

603 PURPOSE:

To ensure that individuals served by Housing/Residential (H/R) Services have appropriate information and guidance to file a complaint or grievance, and/or to be notified of or respond to anticipated changes in service authorization.

603.1 POLICY:

All individuals served by H/R Services have basic human rights and specific legal rights (R9-10) that they do not forfeit when they receive services from H/R Services. Individuals have the right to prompt treatment and supportive services appropriate to their needs.

603.2 SCOPE:

All Copa Health Employees.

603.3 DEFINITIONS:

Reference list of BHS Definitions & Abbreviations.

603.4 PROCEDURE:

- **At the time of admission for services, all individuals served or their representatives will receive a copy of the BHS Program Handbook in keeping with BHS policy, licensing and accrediting standards. A copy of the BHS Grievance and Appeals policy is included in the Program Handbook. This document outlines the rights and procedures for each individual regarding the filing of a complaint, grievance or appeal.**

- **BHS staff members are expected to facilitate the process by which each individual served may execute his/ her rights associated with these procedures. Staff members are prohibited from taking any retaliatory action against any individual who files a complaint, grievance or appeal regarding services delivered by BHS or against a staff member who assists in that process.**

- Complaint: **A complaint is a written expression of dissatisfaction about any matter other than an "action" and allegations of a violation of rights of an individual with a Serious Mental Illness. The procedure is the same for all populations. The individual will be asked to discuss his/her complaint with the appropriate staff member or therapist depending upon the program. The individual may register his/her complaint verbally or in writing. The in services or his/her legal representative may file complaints.**

  In general H/R will attempt to resolve all complaints internally before initiating the following procedure for external resolution of complaints. However, the individual may file the oral or written complaint with the RBHA at any time during the complaint resolution process.

  - **At any time during the process, the individual may wish to file his/ her complaint with the ADHS Office of Human Rights. (800-421-2124). Staff members will assist individuals in filing a complaint, if so requested, and will not impede this process. The RBHA/ ADHS process for reviewing complaints or grievances are independent of the H/R process. Anyone may file a complaint/grievance. Written complaints must be filed within 12 months of the alleged event according to ADHS procedures.**

- **If the problem is not satisfactorily resolved internally (using form BHS-ADM-040) with the clinician, the individual will be directed to file a written complaint with the Program Manager/Director as soon as possible. In most cases, the Program manager/Director will schedule a face-to face appointment with the individual within 48 hours of receipt of the written complaint.**

- **If the individual feels that the issue is not satisfactorily resolved, complaints may be raised to succeeding levels of authority within H/R: Program Director, Vice President (VP) of H/R Services. H/R will conduct a review at each level within 7 working days of receipt of the written complaint and will attempt to resolve the matter within 30 days of the origination of the complaint. Individuals whose complaints have not been substantiated by the internal H/R process may wish to elevate the complaint to the RBHA for further review.**

- **In Maricopa County, individuals may be directed to the RBHA Customer Service Department at 800-564-5465 to request assistance. Hearing impaired individuals may contact 800-424-9831.**

- **Staff members will assist individuals to file a complaint in writing, as necessary.** When an individual has submitted a written complaint, the staff member will also file an Incident Report.

- **The RBHA must respond to all complaints, conduct an investigation of the events and circumstances surrounding the complaint and resolve the matter within 90 days of notification. The RBHA may act as an advocate for the individual but, during an investigation, the RBHA representative is considered a neutral party.**

- **H/R may be asked to provide various types of documentation to facilitate the investigation. Staff members may be asked to participate in the investigation. In all cases, H/R staff members may do so with the knowledge of their supervisor.**

- **Investigations that substantiate the complaint may result in H/R being required to complete corrective actions to resolve the complaint. The QM Department shall be informed of any substantiated complaint and any need for a corrective action.**

- Grievance and Request for Investigation: **The process by which an individual determined to have a Serious Mental Illness may resolve issues related to an alleged violation of his/her rights, alleged abuse or mistreatment or the individual has died while in treatment.**

- **Documentation of the filing of a complaint or grievance should be maintained in both the clinical record and by the Risk Management Department.** Grievances require staff members to complete an Incident Report

- **Staff members are expected to assist the individual, if requested, to file a written or oral grievance or request an investigation. Failure to file the grievance or assist in the filing of a grievance may be grounds by disciplinary action.**

- **The grievance form is forwarded to the RBHA Customer Service Office as noted in #4 above.**

- **Staff members are expected to participate during the investigative process by providing information requested by the RBHA or ADHS/ DBHS and implementing immediate, reasonable action required to protect the health and safety of any individual involved.**

- Appeal: **The process by which an individual challenges a treatment or eligibility decision. An appeal may be filed when a service has been reduced, denied, suspended, or terminated.**

  - **The individual or his/ her legal guardian may file appeals within 60 days of the decision.**

  - **Appeals must be filed with the RBHA Customer Service/ Grievance & Appeals Office. The phone numbers are the same as noted in #4 above. The RBHA has 60 days to resolve a standard appeal. The RBHA must provide the individual with a written Notice of Appeal Resolution.**

  - **An "Expedited Appeal" may be conducted, if requested, and there is supporting documentation from H/R indicating that the wellbeing of the individual served is jeopardized if the standard appeal timeframe is followed. Expedited appeals, if approved, must be resolved within three working days after the RBHA has received the appeal. The timeframe may be extended up to 14 days under extenuating circumstances.**

  - **The State Fair Hearing may follow the appeal resolution issued by the RBHA, if requested by the individual. It must take place within 30 days of the RBHA decision.**

- **The individual's case manager, whether an employee of H/R or PNO, should be apprised of the filing of an appeal and should be an active participant during the appeal process. In general, H/R staff members may be involved in all levels of appeals until final resolution.**

- **Services for the individual served can continue during the appeal or state fair hearing process if the appeal has been filed in a timely fashion, the individual has requested that the services continue, the appeal addresses previously authorized services that are being terminated, suspended or reduced and the services were ordered by an authorized provider.**

- **Individuals who are determined to be Seriously Mentally Ill have additional rights concerning criteria for filing an appeal. These include:**

  - ✓ **Decisions regarding SMI eligibility determination;**

  - ✓ **Sufficiency or appropriateness of assessment;**

  - ✓ **Goals, objective or timelines in the Individual Service Plan;**

  - ✓ **Recommended services identified in the assessment or service plan;**

  - ✓ **Actual services to be provided, as described in the service plan;**

  - ✓ **Access to or prompt provision of services;**

  - ✓ **Findings of the clinical team with regard to competency, need for guardianship or other protective services or special assistance;**

  - ✓ **Denial of request for review of, outcome of, modification/ termination of service plan;**

  - ✓ **Decisions regarding fee assessment or denial of request for waiver of fees;**

  - ✓ **Denial of payment of a claim; and**

- ✓ **Failure of the RBHA or ADHS to act within the timeframes regarding an appeal.**

- **Staff members should include copies of all documentation related to the appeal process in the clinical record.**

- **Staff members are expected to provide all requested documentation to the RBHA or ADHS as part of the appeal process.**

- Notice of Action: **All Title 19 and Title 21 eligible individuals must be provided written notice of any denial, reduction suspension or termination of prior authorized services initiated by behavioral health provider. BHS staff members must provide notices to individuals in services at H/R. If the Individual is enrolled in a PNO, then the PNO should be notified.**

  - **An** "action" **occurs when a treatment decision has been made by the provider such as a discharge from a particular program or service. (e.g.: leaving 24-hour residential and moving into 16-hour residential services). This does not apply when there is a change in a service plan or intervention strategy within a program (e.g.: reducing the frequency of counseling session from weekly to biweekly).**

  - **Notice of Action must be given directly to the individual served or his/her guardian. The Program manager is responsible to provide the Notice prior to the anticipated change in services (See timeframes below). Notice of Action need not be provided when the individual has agreed to the "action" or when the individual (or his/her legal representative) has requested or initiated the action.**

  - **Notice of Action must be provided to each individual served when there is disagreement between the individual and the practitioner that will result in a denial, suspension, reduction or termination of Title19/ 21 services.** Note: When the item on the Service Plan is checked indicating that the individual disagrees with the plan, the practitioner should alert the Program manager to the possibility of providing a Notice of Action.

  - **In the case of an individual receiving prior authorized services, which leaves treatment without prior notification, H/R will send the "30-day letter" and Notice of Action to inquire about the individual's plan for continuing treatment.**

  - **A Notice of Action from the receiving agency/ department is not required for people who have been referred to a H/R program/ service but have been denied admission. These individuals have never received the service being requested and, therefore, do not fall under the definition of "denial" of services.**

- **People who are neither Title19/ 21 eligible service recipients nor Seriously Mentally Ill do not receive formal notice. However, each individual should receive information about alternative services that might be available to him/ her. For those individuals leaving services, each individual is provided with a copy of his/ her discharge plan/ instructions per H/R policy.**

- **Disagreement with a service plan is not considered an "action" as defined by Medicaid, but is considered to be noticeable by ADHS for individuals with Serious Mental Illness only, regardless of Title 19 status.**

- **Notices of Action must be provided within the approved timeframes.**

  - ✓ **For an authorization decision related to a service requested by or on behalf of an individual served, the notice of action must be mailed within 14 days. The timeframe may be adjusted downward under circumstances where the well being of the individual may be jeopardized, but no later than three working days after receipt of the request for services.**
  - ✓ **For service terminations, the notice must be sent at least 30 days before the date of the action except:**

    - ➢ **H/R has factual information concerning the death of the individual served,**

    - ➢ **The individual served has clearly stated (preferably in writing) that he/she no longer wants services**

    - ➢ **The individual can not be located and there is no forwarding address,**

    - ➢ **The individual has been accepted by Medicaid in another state.**

- **Notices must be hand delivered or provided via certified mail.**

- **Staff members must retain copies of all notices in the clinical record.**

603.5 FORMS: ***(Available on the H/R Intranet or ADHS)***

- **ADHS Notice of Action**
- **ADHS Appeal or SMI Grievance Form**
- **ADHS Notice of Decision & Right to Appeal (For SMI Individuals)**

603.6 REFERENCES:

- **AAC R9-10**
- **ADHS Provider Manual Section 5**
- **ARS 36-113**
- **42 CFR 431.200**
- **45 CFR 160-164 (HIPAA)**

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical, drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to maintain the privacy and confidentiality of information about you, your health and health care, and payment for the services we provide you. Information regarding your health care, including payment for your care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Confidentiality Law, 42 C.F.R. Part ("Part 2").[1] There are additional state law protections.

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 10 working days of your request. We may charge a reasonable, cost-based fee.
- You may also access your records through PIR's "patient portal." Ask us about this free service and how we might assist you to register to use it.

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.

[1] HIPAA can be found at 42 U.S.C. § 1320d *et seq.*, 45 C.F.R. Parts 160 & 164. HIPAA protects your health information whether or not you receive services for drug or alcohol services. Part 2 can be found at 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. Part 2 does not allow us to acknowledge to anyone outside our program that you receive services for drug or alcohol treatment except under certain circumstances.

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. If you receive drug or alcohol treatment services from us, you must give us permission to bill for those services. Only in the case of alcohol or drug treatment services, if you decide not to let us share information for billing purposes, we could deny those services to you.

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 our Privacy Officer who is Andrew Terech at (602) 449-3942 or Andrew.Terech@copahealth.org
- 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 **ww.hhs.gov/ocr/privacy/hipaa/complaints/.** A violation of the Confidentiality Law (Part 2) is a crime and any suspected violations should be reported to the United States Attorney for Arizona.

- We will not retaliate against you for filing a complaint.

Right to receive a notice from us if we think your personal health information has been improperly disclosed (often called a "breach")

We will notify you in accordance with state and federal law if we discover a breach has occurred such that your protected health information has been compromised. If we decide this notice is necessary, it will happen after we do an investigation according to the state and federal laws.

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

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
- If you are applying for or receiving services for drug or alcohol abuse, we may not acknowledge to a person outside of our program that you attend our program or in any way that identifies you as attending our program

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 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**.**

To provide you services and treatment

Without your consent we can use your health information and share it with other professionals who are treating you unless we provide you with drug or alcohol services and then we need your consent to share information. Even if you are not in active treatment with us, but your health plan has asked us to try to maintain contact with you, we may share your information.

To operate our business

Sometimes we have agreements with other organizations that either help us with services or help us with running our business and our agreements allow us to share information. These agreements comply with federal law and require these organizations to treat information the same way we do.

To bill for our services

Without your consent, we may use your information to bill for our services that we have provided but only with your consent for drug and alcohol services.

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, respond to audits, investigations or evaluations

We can use or share your information for health research, audits, investigations or evaluations of our programs.

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
- These general rules change if your health information includes anything about alcohol or drug abuse treatment services, and we will tell you about these differences.

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.

Working with a health information exchange

We also share information with a health information exchange ("HIE"). An HIE is a big database that allows us to coordinate with other providers and improve your care. We will talk with you about the HIE, and you can tell us if you don't want your information shared.

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.

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My Permission (Consent) for Treatment

This is a first person permission statement. This means that this form uses "I, me, mine" to indicate a person's permission, consent for treatment, and consent to disclose substance use disorder patient records (if applicable) as described below. I agree that the word "permission" means to give my formal consent.

I, _____, give my permission for treatment with Copa Health and its affiliated organizations: Partners in Recovery and Marc Community Resources (Copa Health, Partners in Recovery, and Marc Community Resources are collectively referred to in this form as "Copa Health"). My consent is fully described in this form. I recognize that there are two parts when I grant permission for treatment: one is for behavioral health care specifically and the other is for physical health care. Behavioral and physical health care delivered together is often called integrated care.

I give Copa Health my permission to provide me with routine behavioral health evaluation and treatment when this care is determined to be medically necessary and authorized. If I withdraw my permission and consent, Copa Health will stop my care as soon as possible. However, I know that my treatment may not stop immediately because if it did it might hurt me. Even after I withdraw from care and treatment, Copa Health will continue outreach to me to ensure that I am safe and healthy. I know that Copa Health will be there during this time, to help me if I request, even after I stop my permission for care and treatment. I know Copa Health will ask me if I would like to give permission to start my care and treatment again. Copa Health will continue outreach after I withdraw from treatment or until I enroll with another provider.

I give Copa Health my permission to provide me with routine behavioral health evaluation and treatment and physical health examinations, testing and treatment. I know this means integrated care.

I am giving Copa Health my permission for its medical professionals (doctors, nurses, physician assistants, etc.) to examine me for the purposes of diagnosis, testing, and treatment. I know that if there are tests that require more explanation because of the type of test, Copa Health will review the procedure and ask me to give my permission for these other tests.

I know that Copa Health has a philosophy of care, and during the time I am reviewing this permission statement, a Copa Health staff person explained to me that Copa Health believes in an idea called "least restrictive environment" which is free from physical, mechanical and chemical restraints. I know that if I feel agitated or if I am threatening in any way, Copa Health staff will try to work with me to calm the situation, and Copa Health may call the police if warranted by the circumstances.

My rights and what to expect as a patient (a person receiving services) with Copa Health: I know I must be informed about my care, my tests, and my possible course of treatment and care. I know that when I sign this consent I agree to participate in my care once a care plan is developed, and that I may say whether I want a particular treatment or procedure. I know that any treatment or procedure will be explained to me, including the risks, benefits, and any alternatives. I know that I may not have a care or treatment plan yet, but because I am giving my permission to start, Copa Health and I will develop or update my integrated care plan together.

Consent to disclose substance use disorder records (if applicable): If I receive substance use disorder diagnosis, treatment, or referral for treatment from Partners In Recovery, I give my permission to Partners In Recovery to disclose the minimum amount necessary of my substance use disorder ("SUD") records to its parent company, Copa Health, and its affiliated substance use disorder program, Marc Community Resources, for treatment and care coordination purposes. If I do not already have a treatment relationship with Marc Community Resources or Copa Health, my SUD records will be disclosed to Marc Community Resources and/or Copa Health.

Additionally, I give my permission to Partners In Recovery and/or its affiliated and subsidiary entities to disclose the minimum amount necessary of my SUD records to achieve the following purposes/functions to Partners In Recovery's contractors, subcontractors, and/or legal representatives (including, but not limited to, any applicable third-party payor) for:

- Payment and/or collection purposes for SUD treatment, diagnosis, and/or referral services rendered to me, including claims management, submission, and related health care data processing activities
- Healthcare operations purposes, including, but not limited to:
    - Provider performance assessment and/or staff training purposes
    - Compliance related and/or auditing functions

- Clinical professional support services
- Patient safety activities
- Accreditation, certification, credentialing, and/or licensing activities

I understand that my SUD records are protected under federal law, including the federal regulations governing the confidentiality of SUD patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may revoke my consent to disclose SUD records as provided in this form at any time except to the extent that action has been taken in reliance on this consent. This consent will remain effective so long as I am receiving services from Partners In Recovery.

I understand that I may be denied services if I refuse to consent to the disclosure of my SUD records for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been given the opportunity to request more specific information about my rights and the Copa Health Notice of Privacy Practices that have been provided to me, and I understand my rights and Copa Health's practices regarding the confidentiality, access, and disclosure of my protected health information. Additionally, I received a notice explaining federal confidentiality requirements for SUD records under 42 C.F.R. Part 2. I have also received a copy of Copa Health's Digital Communication Consent Addendum and understand its content.

Please indicate if you consent to digital communication: ___YES ____NO

Please indicate if you consent to sharing Part 2 SUD Information between Copa Health entities: Partners in Recovery and Marc Community Resources

____**YES,** I consent

____**NO,** I do not consent. I understand that by declining to consent to share SUD data as part of this consent form, I may be asked to give my consent at a later date if I am referred for services within Copa Health.

My signature below means:

I consent to the disclosure of my SUD records between Copa Health entities (if applicable) as described above.

I attest that I have been provided a copy of my rights as set forth in Arizona Administrative Code, Title 9, Chapter 10, and have been offered an opportunity to ask questions about these rights.

I agree that I have had this consent explained to me to my satisfaction and that I give my permission to become a person receiving evaluation, testing, treatment and care from Copa Health.

_____ _____
Participant's Name Date of Birth

_____ _____
Participant's Signature Date signed

_____ _____
(or Parent, Legal Guardian, Custodian or Agent) Date signed

Describe authority to sign on behalf of the Participant: _____

_____

Date Revoked (if applicable): _____ Staff Initials: _____

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Digital Communication Consent Addendum

This consent authorizes Copa Health and its affiliated health care providers (Partners in Recovery and Marc Community Resources) to communicate with me via digital communication. As a part of this agreement, I understand that I will need to agree to the terms and conditions, and the privacy practices of digital tools or solutions used in my care. Although Copa Health has entered into agreements with digital providers, I understand that my protected health information may be stored on a system that is not controlled by Copa Health or its affiliated health care providers. By agreeing to opt into digital communication, I also have received a copy of Copa Health's Privacy Practices and understand that my protected health information will be kept secure and confidential in accordance with these practices.

Digital communication is a widely accepted form of communication. While it cannot replace personal encounters between you and your health care provider, it can be a convenient way to exchange information. I understand that using digital communication will enhance my ability to communicate with my healthcare provider. However, these communications are not to take the place of regular healthcare visits as required by my healthcare provider in order to prescribe medications, make medical recommendations, or diagnose a medical condition. Although digital communication is meant to increase accessibility to my healthcare provider, I understand there may be circumstances that cause a delayed response from Copa Health (i.e. holidays, afterhours, etc.).

If you are experiencing a medical emergency or behavioral health crisis PHONE 911 immediately.

I understand that my participation in digital communication is voluntary and I may refuse to participate or decide to stop participation at any time. I understand that my refusal to participate will not result in any delay in my care, treatment, or services.

I understand and agree that:

- Digital communication is not to be used in emergencies, or when I need information or advice urgently.
- Digital communication is not an appropriate substitute for "in-person", clinical examinations. I am responsible for following up on any digital communication and for scheduling appointments where warranted.
- Digital communication may be accessed by medical office staff or ancillary members of my treatment team in the course of their duties, and only for the purposes of providing or coordinating care.
- Digital communication may be accessed by my health care provider's medical colleagues while caring for me when my health care provider is absent.
- Digital communication will use respectful language.
- I will not send pictures via digital communication unless I have been asked by my healthcare provider to do so.
- Digital communication will not be used for non-treatment related or commercial purposes. Or any purpose outside the context of my direct patient-health care provider relationship.
- Digital communication between me and Copa Health will become part of my confidential patient record.
- Copa Health may use digital communication to send me alerts, health promotion material and other educational resources.
- Although Copa Health will ensure all appropriate safeguards are in place, I understand that the use of digital communication to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Copa Health is not responsible for information loss due to technical failures.
- The use of digital communication or digital solutions or tools is not part of my client rights and the service may be withdrawn at the discretion of Copa Health. I acknowledge Copa Health's right to withdraw the option of digital communication.

I understand that for quality assurance and/or training purposes, communications may at times be monitored by other Copa Health staff members, including members of the Copa Health leadership team who must also protect my confidentiality as required by state and federal law. Viewing of any information by any Copa Health employee will align with Copa Health privacy practices.

I have been informed of my current diagnosis and treatment plan and understand that Copa Health and its affiliated providers may have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug use, HIV/AIDS diagnosis and/or treatment, and any additional behavioral health records.

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Notice to SUD Patients of Federal Confidentiality Requirements Under 42 CFR Part 2

If you are a substance use disorder ("SUD") program ("Part 2 Program") participant at Copa Health or any of its affiliated organizations: Partners in Recovery or Marc Community Resources, federal law and regulations protect the confidentiality of your SUD patient records. Below is a summary of those federal law and regulations, known as the "Part 2 Regulations."

1. **SUD Patient Identification Restriction:** In limited circumstances, an organization with Part 2 programs like Copa Health, Partners in Recovery or Marc Community Resources may acknowledge that an individual is present or disclose outside of the organization's information identifying a patient as having or having had a SUD with a SUD patient's express consent. For example, patient consent is not required for a Part 2 Program to acknowledge the presence of a patient if the Part 2 Program is not publicly identified as a place where only SUD services are provided, and if the acknowledgement of a patient's presence does not reveal that the patient has a SUD. Similarly, in responding to record requests from third parties, including other treatment providers, a Part 2 Program may provide a copy of the Part 2 Regulations, but may not affirmatively reveal that the patient has or is being treated for a SUD at the Part 2 Program.

2. **Criminal Law Violation**: A violation of the Part 2 Regulations by a Part 2 Program is a crime, and suspected violations may be reported to appropriate authorities, including the United States Attorney for the District of Arizona, and the Substance Abuse and Mental Health Services Administration ("SAMHSA"), at:

To U.S. Attorney's Office:

U. S. Attorney Michael G. Bailey
Two Renaissance Square
40 N. Central Avenue, Suite 1800
Phoenix, AZ 85004-4449
602-514-7500

To SAMHSA:

Substance Abuse and Mental Health Services Administration
Attn: Opioid Treatment Program Oversight Division
5600 Fishers Lane
Rockville, MD 20857
SAMHSAInfo@samhsa.hhs.gov
877-SAMHSA-7 (726-4727)
TTY: 800-487-4889

3. **Criminal Behavior Not Confidential**: Information related to a patient's commission of a crime or threat to commit a crime on the premises of Copa Health, Partners in Recovery or Marc Community Resources or against Copa Health, Partners in Recovery or Marc Resources' personnel is not protected under Part 2 Regulations.

4. **Suspected Child Abuse or Neglect Not Confidential**: Reports of suspected child abuse and/or neglect made under state law by Copa Health, Partners in Recovery or Marc Community Resources are not protected by Part 2 Regulations.

For more information or to review the federal law and regulations yourself, go to:

Statute: 42 USC § 290dd-2, available at https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE-2010-title42-chap6A-subchapIII-A-partD-sec290dd-2/summary

Regulations: 42 CFR § 2.1 *et seq*., available at https://www.ecfr.gov/cgi-bin/text-idx?SID=8731ee1a1b0ada4cc6c961ae4f0dc82b&mc=true&node=pt42.1.2&rgn=div5

Rights of Behavioral Health Participants

At Copa Health our commitment is to support and protect your fundamental human rights. Copa Health will ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity; or
   k. Misappropriation of personal and private property by a recovery care center's medical staff. personnel members, employees, volunteers, or students; and

You Have The Following Rights Under Title 9 Chapter 10 Medical Licensing

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects your individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To have access to a telephone;
5. To be advised of the recovery care center's policy regarding health care directives;
6. To associate and communicate privately with individuals of the patient's choice;
7. To review, upon written request, your own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
8. To receive a referral to another health care institution if the Copa Health is not authorized or not able to provide physical health services or behavioral health services for you;
9. To participate or have your representative participate in the development of, or decisions concerning treatment;
10. To participate or refuse to participate in research or experimental treatment; and
11. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising your rights.

You or your representative have the following rights:

1. Except in an emergency, to consents to or refuses treatment.
2. To refuse or withdraw consent to treatment before treatment is initiated;
3. Except in an emergency, is informed of proposed treatment alternatives associated risks, and possible complications; ;
4. To be informed of the following:
   a. Copa Health's policy on health care directives, and
   b. Copa Health's complaint process;
5. To consent to a photograph before a photograph is taken, except that a patient may be photographed when admitted to a recovery care center for identification and administrative purposes; and
6. Except as otherwise permitted by law, to provide written consent to the release of information in your:
   a. Medical records, and

b. Financial records.

You may file a complaint with the Arizona Department of Health Services 150 N. 18th Ave., 4th Floor, Phoenix, AZ 85007; telephone #602-364-2536

COPA HEALTH	# 201	Service Animals ☒ Policy ☐ Standard Operating Procedure					
Date of Inception:		09-01-2018	**CEO Approval:**				
Current Approval Date:			**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☒	HR ☐	CC / QM ☐	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☐	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☒

201 Policy:

The purpose of this policy is establish Copa Health (Copa) standards for the presence of service animals, while committed to maintaining a safe work environment for employees and a safe experience for members, while respecting the rights of individuals under state and federal law.

201.1 Scope:

This policy applies to all employees, interns, volunteers and supervisors.

201.2 Definitions

Emotional Support /Comfort Animals (ESA) - A pet that provides comfort, support and companionship but is not trained to do work or perform tasks for a person with a disability. ESA are not service animals under the ADA, but may be considered a reasonable accommodation for purposes of housing, employment and education.

Pet - A domestic or tamed animal kept for companionship or pleasure.

Psychiatric Service Dog (PSD) – A service dogs that provide assistance to people with psychiatric disabilities, such as severe depression, anxiety disorders, and post-traumatic stress disorder (PTSD).

Service Animal - Any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual or other mental disability.

Therapy Dog - means a service delivered by a registered therapy dog agency that is scheduled by Copa for the comfort and well-being of service members or employee.

201.3 Access

Service animals are granted access rights in public facilities under the Americans with Disabilities Act (ADA). This policy includes any member or employee.

201.3.1 Standards

Pets are not permitted in any Copa facility.

Copa provides signage and member notices to ensure service members with emotional support/comfort animals are aware that these pets may not enter the campus.

A working service animal must be under the control of their handler at all times.

Staff may request that a service animal be removed from a Copa facility should the animal behave in an unacceptable way and the handler does not take effective action to control the animal's behavior.

201.3.2.1 Examples of Unacceptable Behavior Include:

- Uncontrolled barking, jumping on other people, or running away from the handler;
- Behavior that poses a direct threat to the health or safety of others, such as growling, snapping, baring teeth, pest infestation (fleas, ticks, etc.) and other behaviors that disrupt the campus environment;
- An animal that is not housebroken.

201.3.2 Proof or Documentation

Copa employees <u>may not</u> request evidence, proof or documentation that a service animal has been certified, trained, or licensed as a service animal.

The following questions may be asked by designated staff:

- Is the animal required because of a disability?
- What work or task has the animal been trained to perform?
- Is the dog licensed in the county?

201.3.3 Handler Liability:

Copa and its owners, employees and agents are not responsible for damage caused by a service animal or an unidentified emotional support animal, including providing for the care or supervision of the animal or cleaning up after the animal.

201.3.4 Transportation:

Copa will advise transportation and referral agencies when arranging transportation that a service animal will be accompanying its handler.

Employees are not required to transport a member with a service animal, but will be responsible to arrange appropriate transportation for the member and their service animal.

201.3.5 Prohibited Spaces:

Per Arizona Department of Health Rules & Regulations 2.403.11, Service Animals are not allowed within any facility kitchen, where food is prepared.

- This does not include a residential property where the member resides.

201.3.6 Fitness Center Access:

Service animals are allowed to accompany their handlers when utilizing the fitness center.

201.4 Fair Housing Act:

The Fair Housing Act (FHAct), Section 504 protects a person with a disability from discrimination in obtaining housing. Under this law, a landlord or homeowner's association must provide reasonable accommodation to people with disabilities so that they have an equal opportunity to enjoy and use a dwelling.

Housing providers and landlords must evaluate requests for reasonable accommodations in a timely fashion and under the same general standards used for all accommodations requests, including Service and Emotional Support Animals.

201.5 Assessing for Reasonable Accommodations:

Copa may assist by providing documentation for reasonable accommodations.

When a member requests documentation for reasonable accommodations, it is required to be accompanied by a signed Consent to Release Protected Health Information.

When evaluating reasonable accommodations, the person with the disability must demonstrate the following:

- Does the person seeking to use and live with the animal have a disability — i.e., a physical or mental impairment that substantially limits one or more major life activities?
- Does the person making the request have a disability-related need for an assistance animal? In other words, does the animal work, provide assistance, perform tasks or services for the benefit of a person with a disability, or provide emotional support that alleviates one or more of the identified symptoms or effects of a person's existing disability?

Documentation in the form of a Reasonable Accommodation Letter for Emotional Support Animals should identify the person, confirm a disability-related condition, symptom or effect and support that use of the animal in question will provide some type of disability-related assistance or emotional support.

201.6 Employment Settings (Service Animals Only):

Federal law prohibits employment discrimination because of a disability and requires employers to provide reasonable accommodations for disability-related conditions.

If the disability is not obvious and/or the reason the animal is needed is not clear, an employer may request documentation to establish the existence of a disability and how the animal helps the individual perform their job.

Copa may provide documentation in the form of a letter that establishes the disability-related condition, symptom or effect and includes a description or statement of support that the animal would help the employee in performing job tasks.

201.7 Service and Emotional Support Animals Transportation:

Copa may provide documentation in the form of a letter to establish that the member has a disability and the disability-related need for the animal during travel.

201.7.1 Ground Transportation:

Only service animals have rights of access on public and private transportation, including subways, fixed-route buses, rail, light-rail, taxicabs, shuttles and limousine services.

- Must have a completed and signed Release of Information form from the member.

201.7.2 Air Transportation:

Due to regulatory changes from the U.S. Department of Transportation (USDOT), airlines have stopped accepting emotional support animals on flights in 2021.

- That means an ESA letter can no longer be submitted to an airline for special accommodation of an emotional support animal.
- Some ESA owners may, however, be able to train their dogs to become psychiatric service dogs.

Under these new rules, psychiatric service dogs are the only type of assistance animal that must be accommodated in the cabin of the airplane free of charge and exempt from size and weight restrictions.

To fly with a psychiatric service dog, you must submit a special form from the USDOT to the airline before departure.

USDOT Service Animal Relief Attestation Form requires PSD owners to certify that their dog is trained to perform tasks relating to their mental health disability.

201.8 General Guidance on Service Animals Specific Tasks:

The ADA makes a distinction between a service animal, PSD and ESA as defined under section 201.2 of this policy.

Other specific tasks may include the following, but not limited to:

- Alert a person when their blood sugar is low;
- Alert a person to detect the onset of seizure;
- Alert a person suffering from depression to take their medication;
- Bring Medication to Alleviate Symptoms;

- Bring a Beverage So Human Partner Can Swallow Medication;
- Bring the Emergency Phone During a Crisis;
- Answer the Doorbell;
- Call 911 or Suicide Hotline on K-9 Rescue Phone;
- Bring Help Indoors and Provide Speech Impairment Assistance;
- Provide Balance Assistance on Stairs;
- Assist Person to Rise & Steady that Person;
- Respond to Smoke Alarm if Partner Unresponsive;
- Medication Reminder at Certain Time of Day;
- Wake up Human Partner for Work or School;
- Assist with vision or hearing impaired;

Re:

American Disabilities Act
Fair Housing Act, Section 504
Arizona Revised Statutes § 11-1024
Arizona Department of Health Rules & Regulations 2.403.11
Consent to Release Protected Health Information
Request for Reasonable Accommodation in Housing Form
USDOT Service Animal Relief Attestation Form

COPA HEALTH	# 303	Drug & Alcohol Policy ☒ Policy ☐ Standard Operating Procedure					
Date of Inception:		05-01-2021	**CEO Approval:**				
Current Approval Date:			**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☐	HR ☒	CC / QM ☐	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☐	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☐

303 Policy Statement

Copa Health (Copa) is committed to a safe, healthy, and productive work environment for all employees free from the effects of substance misuse and abuse.

303.1 Scope

This policy applies to all employees, interns, volunteers and supervisors. All employees have been issued, upon initiation of this policy or upon hire (whichever is later), a copy of the company policy that describes what substances will be tested for and under what conditions employees will be tested.

303.2 Definitions

Controlled Substances - Include alcohol, medical marijuana, recreational marijuana, illegal drugs, and any drug that has not been legally obtained or is not being used for its intended purpose.

Safety-Sensitive Position - Refers to a job in which the employee is responsible for his or her own or other people's safety, or to a job where an impairment, such as drug or alcohol use, can put a worker or others at risk of harm.

Interactive Process – Used to determine the appropriate accommodation should the employee have a prescription that may affect their ability to perform their job functions safely.

Medical Review Officer (MRO) – A Copa-designated provider who has knowledge of substance abuse disorders and the appropriate medical training to evaluate positive results, medical histories, and any other relevant biomedical information.

303.3 Copa Employee Handbook

This policy is intended to incorporate and work in tandem with the Copa Employee Handbook, and intends to comply with all applicable laws. Copa will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, marital status,

national origin or ancestry, citizenship status, age, disability, military status or an unfavorable discharge from military service, or any other basis protected by applicable local, state or federal law.

303.4 Drug Free Work Environment

To ensure a safe and productive work environment, Copa prohibits the use, sale, dispensation, manufacture, distribution or possession of Controlled Substances or drug paraphernalia, as follows:

- On any company premises or work sites.
- Company owned vehicles or personal vehicles being used for company business or parked on company property.
- Forbids the illegal (under federal and/or state law) off-duty use, sale, dispensation, manufacture, distribution, or possession of Controlled Substances, or drug paraphernalia.

303.4.1 Arizona Medical Marijuana Cardholders

An Arizona medical marijuana registered cardholder may not possess, use or be impaired by medical marijuana while performing work.

- If Copa would lose a monetary or licensing benefit under federal law or regulation, Copa will refuse to hire or keep employed an Arizona medical marijuana registered cardholder.
- Medical marijuana is considered the equivalent of a prescription drug and use by an employee must be pursuant to a valid prescription.
- Employees are prohibited from being impaired by medical marijuana while performing work on behalf of Copa during working hours, or in or on Company property.
- Any employee testing positive for marijuana, who lawfully possesses a medical marijuana card at the time of the drug test, must produce his/her medical marijuana card to Human Resources.
- Privacy will be maintained to the extent possible.
- Policy remains that an employee may not be impaired by medical marijuana during work, as detailed above.
- Legalized recreational marijuana is not permitted to be used, possessed, or distributed by employees while performing work on behalf of Copa, during work hours, or in or on Company property.

303.4.2 Prescription or Over the Counter Medications

When an employee must take prescription or over-the-counter drugs, the employee must ask the prescribing medical professional or pharmacist if the drug has any side effects which may impair the employee's ability to safely or productively perform the employee's job duties.

- If there is potential impairment of the employee's ability to work safely or productively, the employee must report this information to the supervisor or designee
- Copa may conduct an interactive process with the employee regarding the impact of the employee's work and safety in the workplace.

303.5 Safety Sensitive Positions

If Copa designates a position as safety-sensitive and has a good faith belief the employee is using any Controlled Substance, whether legal, decriminalized, or prescribed by a physician, that could cause an impairment while working, or otherwise impact the employee's job performance or ability to perform job duties adequately and safely, then Copa may take appropriate action to remove the employee from the safety-sensitive position.

- Employees who work in positions classified as safety-sensitive may be subject to disciplinary action, up to and including termination, if they test positive for alcohol or drugs, including but not limited to marijuana, even if they have a valid medical marijuana license.
- Copa may also refuse to hire applicants for safety-sensitive positions who test positive for alcohol or drugs, including but not limited to marijuana as part of a pre-employment drug test, even if those applicants can produce a valid medical marijuana patient license/card.

303.5.1 Safety Sensitive Legal Application

Copa follows guidelines and laws established by Occupational Safety and Health Administration (OSHA) and A.R.S. § 23-493 et seq.

Pursuant to A.R.S. § 23-493 et seq. a "safety-sensitive position" includes any position that is:

- Designated by the employer as "safety-sensitive" (e.g., employees who work with members, patients, customers); or
- Recognized as a safety-sensitive position under Arizona Revised Statute § 23-493, because it requires the performance of tasks or duties that Copa in good faith believes could affect the safety or health of the personnel performing the task or others. Examples of safety-sensitive positions include but are not limited to:
    - Operating a motor vehicle, other vehicle, equipment, machinery or power tools.
    - Repairing, maintaining or monitoring the performance or operation of any equipment, machinery or manufacturing process, the malfunction or disruption of which could result in injury or property damage.
    - Performing duties in the residential or commercial premises of a customer, supplier or vendor.
    - Preparing or handling food or medicine.
    - Working in any occupation regulated pursuant to **T**itle 32.3

303.6 Employee and Applicant Drug and Alcohol Testing

To promote a safe and productive workplace, Copa will conduct the following types of Drug and Alcohol Testing for all employees:

Pre-Employment Testing:

- All persons seeking employment with Copa shall undergo post-offer, pre- employment drug testing. Applicants will be informed that as a condition of employment they must pass a drug screening test.

- Applicants who test positive will be notified that they have not met the standards for employment and will be informed they can have the confirmed positive test re-tested by a government certified lab selected by the applicant.

Reasonable Suspicion Testing:

- An employee will be asked to submit to drug and alcohol testing when Copa reasonably suspects the employee is impaired or is under the influence of a Controlled Substance.
- The employee will be place on paid/unpaid leave pending receipt of the test. Reasonable suspicion testing may result from one of the following examples, and is not limited to the following:
    - Specific, personal, and articulable observations concerning the employee's speech, walking, standing, physical dexterity, agility, coordination, actions, movement, demeanor, appearance, clothing, odor, or irrational or unusual behavior;
    - The employee's negligence or carelessness in operating equipment, machinery or production or manufacturing processes; disregard for the safety of the employee or others; involvement in an accident that results in serious damage to equipment, machinery or property, disruption of a production or manufacturing process, or any injury to the employee or others;
    - Violation of a safety rule or other unsafe work incident which, after further investigation of the employee's behavior, leads the supervisor/manager to believe that the employee's functioning is impaired;
    - Other physical, circumstantial, or contemporaneous indicators of impairment.

- When a supervisor/manager has reasonable suspicion to request testing, the supervisor/manager will arrange to transport the employee to the collection site and will arrange for the employee's transport home.
- Copa will place the employee on a paid leave pending the receipt of drug testing.

Random Testing:

- Employees will be subject to drug and alcohol testing at any time on a random basis asa term and condition of continuing employment.
    - Random testing will be spread reasonably throughout the year, will be unannounced to ensure that no employee receives advanced knowledge of the time of testing, and will be on paid time.
    - All employees will have an equal chance of being selected each time a random selection ismade.

Post-Accident Testing:

- An employee must submit to drug and alcohol testing whenever such use is possible to have contributed to the accident.

- An employee who is involved in an accident must immediately report the accident to his

or her supervisor/manager.

- Whenever a supervisor/manager observes or is notified of an accident where employee drug or alcohol use is possible to have contributed to the accident, the supervisor/manager will initiate drug and alcohol testing.
    - The supervisor/manager will order the employee to submit to a urine and/or breath test.
    - The supervisor/manager will arrange to transport the employee to the collection site and will arrange for the employee's transport home.

- Copa will place the employee on a paid/non-paid leave pending the receipt of drug testing.

Return to Duty/Follow-up Testing:

- If the employee is permitted to return to work following a positive test result; the employee must first pass a drug and alcohol test and subsequently submit to a program of unannounced testing for a period of not more than 12 months from the date of return to duty.

303.7 Substances Tested and Their Metabolites

- Marijuana
- Cocaine
- Opiates including Codeine and Morphine
- Methadone
- Phencyclidine (PCP)
- Amphetamines including Methamphetamine
- Barbiturates such as Mephobarbital (Mebaral) and Pentobarbital Sodium (Nembutal)Alcohol
- Benzodiazepines
- Methaqualone
- Propoxyphene such as Darvon
- Alcohol

303.7.1 Positive Test for Marijuana with Medical Card

- Any employee testing positive for marijuana, who lawfully possesses a medical marijuana card at the time of the drug test, must produce his/her medical marijuana card to Human Resources.
    - Privacy will be maintained to the extent possible.
    - However, the policy remains that an employee may not be impaired by medical marijuana during work, as detailed herein.

303.8 Safeguards/Confidentiality

Drug screen analysis is accomplished through the person's blood, breath, urine or other bodily substance.

Samples will be collected in a sanitary environment designed to maximize employees' privacy while minimizing the possibility of sample tampering.

All drug tests are performed by a government-certified outside laboratory.

- All government-certified outside laboratories strictly follow chain of custody guidelines to ensure the integrity of the testing process.
- The company shall use a Medical Review Officer (MRO) who will receive the laboratory results of the testing procedure.
- The MRO shall review all medical records made available by the tested individual when a confirmed positive test could have resulted from legally prescribed medication.

303.8.1 Negative Test Results

If the results of the initial test are negative, the testing laboratory will report the results to the MRO retained by Copa. The MRO or the testing laboratory reports the negative results to Copa. In this instance, no additional tests on the specimen will be done.

303.8.2 Positive Drug and/or Alcohol Result

If there is a positive drug and/or alcohol result on the initial screening test, the laboratory or blood alcohol technician will automatically do a second test to confirm the results.

- The second drug test will be performed using gas chromatography/mass spectrometry or other scientifically accepted method.
- A positive breath alcohol test will be confirmed by a second breath test.
- In the event the drug and alcohol test result is dilute, the applicant or employee will be required to re-test if the test result is a negative dilute.

A second confirmatory test shall be performed if the results of the initial test are positive, that is, if the results exceed the permitted levels for any of the seven drugs tested or for alcohol.

Only specimens that are confirmed positive on the second (confirmatory) test are reported positive to the MRO for review and analysis.

- The MRO will contact the employee personally, in the case of a positive test result.
- The MRO has the responsibility of reporting to Copa whether the test results are positive or negative.

303.9 Inspections and Searches

Copa may conduct unannounced inspections and searches for violations of this policy in the workplace, work sites, or company premises.

- Employees are expected to cooperate during any inspection.
- The inspections and searches may include, but not limited to, vehicles, lockers, desks, workstations, containers, bags, briefcases, packages, etc.
- Private vehicles parked on Copa's physical premises are included in this policy.
- Refusing to submit to a search or inspection when requested by management will be cause for immediate discharge from employment.

Any drugs found on Copa property may be turned over to appropriate law enforcement authorities for investigation and possible criminal enforcement action.

303.10 Voluntary Treatment

Copa supports sound treatment efforts. Whenever practical, Copa will assist employees in overcoming drug and/or alcohol problems, as long as this policy has not already been violated.

If an employee seeks treatment for drug and/or alcohol use, the employee may be eligible to go into a drug and/or alcohol treatment program either through Copa's medical insurance program or at his or her own expense.

If the employee enters an appropriate treatment program, Copa may place the employee on unpaid status, and the employee is permitted to use any accrued PTO while participating in the program, so long as the employee is complying with the conditions of treatment.

Prior to reinstatement of paid status, Copa will require a release to work and/or verification of treatment from the health care provider as described in the company's medical leave policies in the Employee Handbook.

- For reinstatement to paid status, Copa will require a negative test result pursuant to Return to Duty Testing.

More information regarding availability of treatment resources and possible insurance coverage for treatment services is available from the Human Resources Department.

303.11 Disciplinary Actions

Disciplinary action, including and up to termination, against an employee will be taken for violation of this policy, inclusive of the following reasons:

- Testing Positive:
  - Employees who test positive for drugs and/or alcohol are in violation of this policy;

- Refusal to Comply:
  - Employees who refuse required testing are in violation of this policy;

- Interference with Testing:
  - Employees who adulterate, tamper with, or otherwise interfere with accurate testing are in violation of this policy; or
  - Any employee who has been observed using or possessing Controlled Substances during work time, including breaks, or on Copa premises is in violation of this policy.

[Acknowledgement Form To Be Signed on Next Page]

Drug and Alcohol Policy
Acknowledgement

I have received a copy of Copa's Drug and Alcohol Policy and understand that, in order to continue my employment with Copa, I must abide by the terms of the policy. I agree to notify Copa of any violation of this policy.

I understand that this policy in no way modifies my status as an at-will employee and in no way implies, infers, or guarantees my continued employment for any definite term and that I may be dismissed at the discretion of Copa for other reasons than failing to follow the terms of the policy.

_____ _____

Employee Signature Date

_____

Print Name

Re: Occupational Safety and Health Administration (OSHA)
A.R.S. § 23-493 et seq

Policy Number:	**PRG .41 Administrative and Clinical Decertification of the Seriously Mentally Ill**		
Date of Inception:	6/8/2009	Previous Approval Date(s):	6/8/09, 5/31/11, 5/30/2013; 7/1/2015
Current Approval Date:	01/07/2020		
Approved by:	Stacy Garner Chief of Integrated Health Solutions Copa Health	Darwyn Chern, MD Chief Medical Officer, Integrated Health Solutions	

Operational Scope:	Medical	QM	Network	Customer Service	Claims	Rights	Admin	HR	Records
	☒	☐	☐	☐	☐	☒	☐	☐	☐

Policy Statement

Partners in Recovery may assist and support requests to decertify from participants designated as Seriously Mentally Ill (SMI) according to best clinical practice in accordance with the rights of the participant and in compliance with the Regional Behavioral Health Authority (RBHA) requirements.

Purpose

To identify the processes and workflow in assisting SMI patients in pursuit of SMI decertification in accordance with community standard of care and safe practices of care transitions.

Scope

Integrated Health Solutions of Copa Health

Procedures

Serious Mental Illness Clinical Decertification is a determination that an individual who has a SMI designation no longer meets diagnostic and/or functional SMI criteria.

A person with SMI regardless of treatment status (active/ enrolled or inactive/ disenrolled) remain in the RBHA roster of SMI patients indefinitely unless he undergoes the process of decertification. There are two ways of decertifying from the roster namely administrative decertification and clinical decertification.

I. Administrative decertification applies to SMI patients who has not received behavioral health services for a continuous period of two or more years. They are not enrolled or connected to any active treatment with any clinic. Patients seeking to decertify through this process should be referred to AHCCCS/ DHCM, Clinical Resolution Unit. AHCCCS confirms the claim of not having any need for services for the stated period by verifying claims records. The person should never be required to open a new treatment episode unless there is a clinical need. AHCCCS performs this decertification following receipt of required paperwork from patient (Attachment C) and confirmation of stability based on lack of claim or records. Clinical staff is not involved in this process other than directing the patient to access.

In the event that AHCCCS database shows the last behavioral health encounter was less than 2 years, the individual will be advised that decertification should be done through a clinical process involving a review and evaluation of whether the patient continues to fulfill the diagnostic and/or functional criteria for SMI designation.

II. Clinical decertification is the process followed when a person in an active treatment relationship with a clinic requests to be dropped from the state roster of persons with SMI. The basis for approval of this is clinical stability for the past year. Documents are prepared by the clinical team to either support or deny the request of the patient requesting decertification. The process and requirements are described in the succeeding section.

III. The patients assigned clinical team is responsible for submitting the following documentation to the Crisis Response Network through its portal.

A. Decertification attestation
B. Decertification notice signed by provider and patient
C. CRN Assessment/ SMI form
D. Recent Comprehensive Psychiatric Assessment (done within the past 6 months)
E. One year of Behavioral Health Medical Practitioner Progress Notes
F. Original SMI determination

IV. PIR Review and Approval Process

A. All requests for SMI decertification must be reviewed by the Behavioral Health Medical Practitioner (BHMP) and the BHMP must then sign the Request for SMI Decertification and Decertification Attestation.
B. The completed SMI Decertification packet from Section III above and the BHMP signed Request for SMI Decertification form must be submitted to the Campus Chief Psychiatrist and Clinical Director (CD) for a 2nd level review and approval before submission to the RBHA for final approval. Any disagreement between the CD and Chief Psychiatrist should be elevated to the Chief Medical Officer.

V. The RBHA SMI Eligibility Reviewer from the Crisis Response Network will render a decision on the request based on the following:

A. The participant no longer meets diagnostic and/or functional criteria for SMI status based on available information; or

B. The participant is receiving treatment on a voluntary basis and is requesting decertification.

VI. Pending the outcome of the review and the individual is decertified from SMI services, the care team will provide a referral for General Mental Health and Substance Abuse services through a network provider and will coordinate the transition of care, to include a transfer staffing between the PIR campus clinical team and the provider agency.

A. The Eligibility Department at the RBHA will provide the participant with written notice of the reason for the decertification and the right to appeal.

B. The RBHA will ensure that services are continued depending on Title XIX eligibility.

Attachments

Attachment 1: AHCCCS Medical Policy Manual Policy 320-P, Attachment C Administrative Serious Mental Illness Decertification Form.

Attachment 2: Decertification Attestation

Attachment 3: Workflow for Serious Mental Illness. Decertification