

**METROPOLITAN ST. LOUIS PSYCHIATRIC CENTER (MPC)
EMERGENCY DEPARTMENT (ED) AND 25-BED ACUTE CARE CLOSURE**

EMERGENCY RESPONSE, CAPACITY AND COMMUNICATIONS PLAN

Prepared by MPC Short-term Crisis Team and Approved by MPC Planning Group

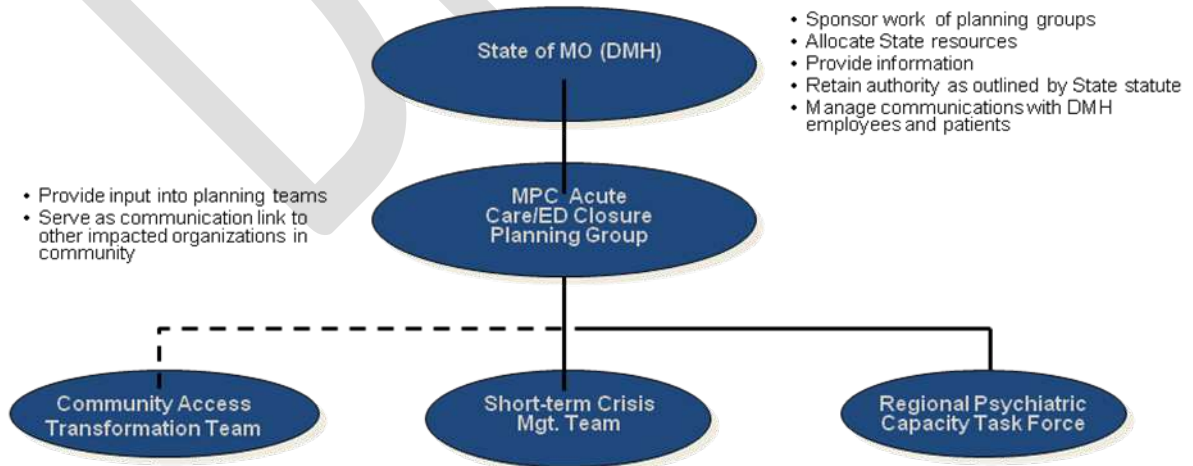
RHC Commissioners approved this document on 7/21/10. Since that time, members of the Short-Term Crisis Team and MPC Planning Group have suggested some changes. Additions are highlighted in the following document. Those items removed are represented by strikethrough text. The document is still in process and is expected to be finalized 8/16/10 at the last meeting of the Short-Term Crisis Team.

August 13, 2010

Background

In April 2010, the State of Missouri Department of Mental Health (DMH) announced its intent to close the Emergency Department (ED) and acute care beds at Metropolitan St. Louis Psychiatric Center (MPC). On May 19, 2010, the state made a formal request to the St. Louis Regional Health Commission (RHC) to create a local plan to address issues created by the closure. In response to the state's request, the RHC convened a regional Planning Group on May 27, 2010, and a Short-Term Crisis Management Team on June 3, 2010. These groups have been meeting regularly since to understand the scope and scale of the closure and its impact on the community and to identify and address the key issues the closure creates. During that time, DMH announced the ED and 25 acute care beds will close at MPC on July 15, 2010, leaving 25 acute care beds open until May 2011. After this time, MPC will provide competency restoration services for individuals who are court-ordered.

Planning Team Structure



The short-term crisis planning has been conducted in two phases: (1) emergency response; (2) capacity related issues.

The following document details the Short-term Crisis Team and Planning Groups' recommendations. Members of the Short-term Crisis Team include representatives from community hospitals, community mental health centers, city and county jails, and first responders (police and EMS). (See Appendix I, complete team roster.) This work has been conducted in coordination with the Community Access Transformation Team (CATT). Hospital representatives have attended CATT meetings and members of CATT have participated in Short-term Crisis Team and Planning Group meetings, which prompted recommendations from the Short-term Crisis Team to the CATT team. These recommendations are detailed in the following document.

This plan addresses the immediate issues presented by the closure of the emergency department (ED) and acute care beds at Metropolitan St. Louis Psychiatric Center (MPC), recognizing that MPC will continue to provide psychiatric services to forensic patients after the closure of the ED and acute care beds. The Planning Group further recognizes the need to address the significant care shortfalls in the aftermath of the ED closure.

The individuals and organizations participating in the planning process have worked together to develop the best possible solutions in the short time provided to the challenges created by this closure. As representatives of DMH have publicly stated, the closure of MPC's ED and acute care beds deteriorates the behavioral health system in the St. Louis region and has been precipitated solely by significant revenue shortfalls in the state of Missouri in 2011 and 2012. Combined with the reduction in psychiatric services by the eastern region community hospitals over the past five years, the changes at MPC will continue to strain existing health care providers, and especially EDs, which will create challenges for patients and families. The recommendations and solutions presented in this document are designed to mitigate negative impacts as much as possible; however, the team members believe it is important to note that these solutions are sub-optimal vis-à-vis maintaining or enhancing acute care and emergency services for psychiatric patients in the eastern region.

Not addressed in the existing analysis is the impact of the collective closing of multiple agencies and resources in the St. Louis area and Southeast Missouri area. The closing of multiple agencies will create a ripple effect for patients and facilities throughout the area thus limiting quick access within one's own community and forcing individuals to seek services outside their community. It is well documented that receiving behavioral health services outside one's support system and community reduces the chances of integration and effective care. Such fragmented care does not allow for cohesive inclusion of community resources and family to determine the most effective wrap around services within the community to support the individual. By leaving one's community to receive care, it will further stretch the remaining resources to care for individuals outside of the region.

The Short-term Crisis Team and Planning Group's anticipate the greatest impact to be on those patients who are uninsured. In 2008, 61 percent of MPC patients were uninsured. While hospitals expect to be able to enroll many of those patients in Medicaid, there is an expectation that the number of uninsured

psychiatric patients that community hospitals will treat will increase with the closure of MPC. The RHC's previous recommendation to DMH for expedited Medicaid determination in the eastern region for psychiatric diagnosis will be important to implement in 2010 given MPC's recent reduction in services to alleviate the financial strain on community providers.

Issues Identified to Address

The Short-term Crisis Team worked to identify the immediate issues created by the closure of MPC services by first understanding the scope and impact of the situation on the following stakeholders: patients and families, police, EMS, courts, jails, community hospitals, community mental health centers, other behavioral health providers and homeless shelters. Through conversations with representatives of each stakeholder and analysis of critical data, the Short-term Crisis Team identified the following issues to address in the Emergency Response and Capacity plan:

- Protocols for police and EMS to bring patients to community hospitals instead of MPC.
- Best practices for community hospitals to manage an increasing number of involuntary admissions, both civil and court ordered.
- Best practices for conducting an increasing number of "fit for confinement" evaluations in community hospital EDs.
- Identification of providers for patients coming from jails, who traditionally would go to MPC.
- Protocols for securing admission of patients in need of maximum security at Fulton State Hospital or in need of long-term care, either in an inpatient setting at St. Louis Psychiatric Rehabilitation Center or in an Intensive Residential Treatment Service maintained by a Community Mental Health Center. (Individuals detained in jail settings awaiting transfer to Fulton State Hospital for hospitalization need not be screened for admission by any provider in the St. Louis region and can be admitted directly to Fulton State Hospital.)
- Identification of a service provider to assign attorneys to patients from St. Louis City or St. Louis County admitted involuntarily to a local community hospital.
- Identification of a service provider to assign a drug and alcohol substance abuse provider to patients committed to involuntary treatment.
- Identification of tools that could help facilitate transfers between hospitals.
- Identification of community-based resources that would help community hospitals transition patients from acute hospital beds to more appropriate care settings.
- Services MPC provides for its patients that may need to be replicated by other organizations.

The following recommendations represent the collective input of the Short-term Crisis Team and should be reviewed and considered by each individual entity's staff and legal counsel before implementing. These recommendations are not intended to serve as legal advice.

The Short-term Crisis Team also recommends a task force be assembled by DMH, community providers and the Missouri Hospital Association to oversee the implementation of the following recommendations and to ensure collaboration among all the psychiatric providers in the region continues. It is the Short-term Crisis Team's intent that this task force would help ensure a coordinated system of care that would enable patients to be served in their own communities when possible. The task force would provide a vehicle for providers to continue to identify the best processes, procedures and protocols for patients and their families.

Additionally, not adequately addressed in this plan are mentally ill individuals who are in the custody of jails. The Short-term Crisis Team advocates for a safe, secure and supportive environment where evidence-based medicine is practiced for optimal outcomes for this specialized population.

Key Data

Since 2006, MPC has operated at 100 staffed beds or fewer. Over the last several years, this number has steadily declined, reducing access to vitally needed inpatient mental health care in the community. Since December 2009, MPC has been staffing only 50 inpatient beds. This decline has reduced the annualized discharges from about 1,500 discharges in fiscal year 2009 to about 1,200 discharges in fiscal year 2010.

The MPC ED also has experienced declining volumes due to reductions in service. The ED treated about 4,000 patients in fiscal year 2009, down to an annualized 2,800 patients for fiscal year 2010.

Recent statistics represent an average of about seven to eight patient visits per day at MPC's emergency department, resulting in two to three inpatient admissions per day.

Other key statistics and facts include:

- From December 2009 to May 2010, MPC admitted 389 involuntary patients, or about 65 involuntary patients per month, which represents 78 percent of all admissions.
- Of these 65 involuntary patients per month served by MPC since December 2009, about 31 per month are court-ordered patients. In addition, about nine involuntary patients per month are brought in by law enforcement.
- St. Louis City EMS reports transporting about one patient per day to MPC. If EMS psychiatric patients are presenting any other medical conditions, they are taken to a community hospital that can handle both the behavioral and physical health needs of the patient.

- In the past year (June 15, 2009 to June 15, 2010), MPC treated 38 patients from jails, an average of about three to four patients per month.
- Psychiatric patients on average spend six to eight hours in busy community hospital emergency departments, and sometimes as long as 20 hours waiting for an inpatient bed placement. The average wait times for patients in the MPC Emergency Department was 2.6 hours.
- Community hospitals currently do not have the physical plant or capacity to safely manage the increase in volume and acuity of psychiatric patients.

For additional analysis and data regarding MPC, please refer to the Impact Statement created by the Short-term Crisis Planning Team and available at www.stlrhc.org.

EMERGENCY RESPONSE RECOMMENDATIONS

Stabilization unit(s) and/or services for psychiatric patients with increased linkages from acute care to outpatient services is in the best interest of patients, staff, and community stakeholders. While that plan is being formulated, the following protocols are recommended.

Police and EMS Protocol

Police report they would be able to better serve the community if area hospitals followed the same standard protocol for managing patients brought by police. As a result, the Short-term Crisis Team developed a flowchart of recommended protocol for community hospitals and standard forms that community hospitals may review and consider using with the input of their staff and legal counsel. These forms will be available on the website of Behavioral Health Response (www.bhrstl.org) for hospitals to easily access and customize.

Police report that standard protocols and forms throughout the community will help officers return to the streets sooner and enable police and ED staff to easily manage patient flow and information under HIPAA guidelines. (See Appendix II, Mental Health Admission Process: ED Patients Brought by Police Flowchart and ED Patient Brought in by Family, Friends or Self.)

The standard protocol and forms also will help facilitate patient transfers among hospitals. With an increasing number of patients expected to receive care at community hospitals due to MPC's closure, transfers will be more common than they are today.

The Short-term Crisis Team consulted with Commissioners Patrick Connaghan and Kimberly Coon in St. Louis City and St. Louis County respectively to determine if certain forms required notarized signatures or two signatures by witness nurses. Both judges advised hospitals to obtain notarized signatures for these forms. The community hospitals may take this information into consideration as their staff and legal counsel determine their own course of action.

Some community hospitals report requiring all ED charge nurses receive notary certification to ensure a notary is always present in the ED.

Involuntary Admissions

From December 2009 to May 2010, MPC admitted 389 involuntary patients, representing 78 percent of all admissions. This volume equates to about two additional involuntary admissions per day that the community hospitals across the region will collectively need to manage in the future. Generally speaking, about 50 percent of MPC's involuntary patients go before a judge who considers MPC's request for a 21-day commitment.

To help community hospitals manage these additional involuntary admissions, it is recommended that community hospitals consider the following:

- Integrate auto-complete worksheets (currently used at MPC and Barnes-Jewish Hospital) into electronic health record systems to facilitate the court application for an involuntary admission. A psychiatrist, psychiatric social worker with one year of experience, or psychiatric nurse with three years of experience may complete the forms, which then are sent to the community hospital's review team before submitted to the courts. These forms are accepted in both St. Louis City and St. Louis County. (See Appendix III, Involuntary Admission Form.)
- Provide remote courtrooms with teleconferencing capabilities in community hospitals. MPC and Barnes-Jewish Hospital currently have these facilities, which were developed under the guidance of Commissioner Connaghan in St. Louis City. The Short-term Crisis Team recommends that St. Louis County courts begin facilitating hearings via remote courtrooms. Members of the Short-term Crisis Team will conduct a meeting with Commissioner Coon in St. Louis County to discuss this recommendation. MPC and Barnes-Jewish Hospital both report that the patients prefer to remain in the hospital for these proceedings. (When MPC and Barnes-Jewish Hospital built these courtrooms about two years ago, they did so at a cost of about \$25,000 per courtroom. It is anticipated that the cost would be lower today due to the decreasing cost of the technology employed.)

Of the about 65 involuntary admissions per month at MPC, about 31 are court ordered. DMH is developing a complete list of hospitals with psychiatric units for judges in the eastern region to consult as they determine where to send court-ordered patients. The Short-term Crisis Team recommends that judges send court-ordered patients to the hospital nearest the patient's residence for evaluation.

It is the team's recommendation that all hospitals with inpatient psychiatric units provide services for involuntary patients.

Fit for Confinement Evaluations

When police arrest someone who exhibits mental or physical illness, they take them to a hospital for assessment to determine if they are fit for confinement. The hospital assesses the patient to determine if he or she meets the criteria for inpatient admission. MPC currently conducts a number of psychiatric fit for confinement evaluations for both police and jails.

With the closure of MPC's ED, it is anticipated that community hospitals will perform an increasing number of these evaluations. The Short-term Crisis Team has developed a recommended form for these evaluations that community hospitals may review and consider using with the input of their staff and legal counsel.

Members of the Short-term Crisis Team recommend a standard form and approach throughout the community to help better facilitate these evaluations for police and jails. (See Appendix IV, Fit for Confinement Evaluation Form.)

~~St. Louis City and St. Louis County jails currently reimburse hospitals \$150 for a medical fit for confinement evaluation. There is no budget set aside in these departments to provide psychiatric fit for confinement evaluations, which historically have been conducted by MPC at no cost to the jails.~~

Providers for Jail Patients

Community hospitals currently treat very similar patients to those seen at MPC with one exception. Patients who are in jail and need acute inpatient psychiatric care rarely are treated in community hospital psychiatric units. Historically, in the St. Louis region, county and city jails have sent individuals who they are unable to treat in their own facilities to MPC at no cost to the county or city. The Department of Mental Health (DMH) has covered the cost of these services.

In a recent call with providers from Springfield and Columbia, the Short-term Crisis Management Team ascertained that other community hospitals throughout the state do provide services for jail patients. While they are compensated for medical care, they are not compensated for mental health services.

During fiscal year 2010, MPC treated 49 hold prisoners. Analysis of a subset of that data reveals a median length of stay of seven days at a total cost of \$291,834. At least 14 of these patients were from St. Louis City jails and at least four were from St. Louis County. The remaining patients were sent from a number of municipalities. It is important to note that patients from jails are commingled with other psychiatric inpatients; the number of these patients is not sufficient to require a separate treatment unit.

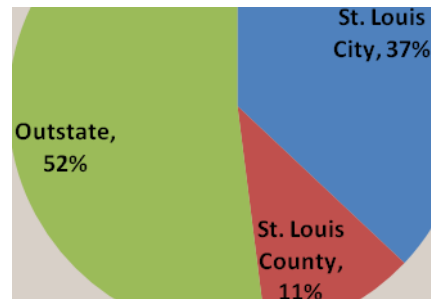
**Subset of Hold Prisoners Court Committed to MPC
June 15, 2009 – June 15, 2010**

City	Frequency	
	Count	%
ST LOUIS	14	37%
CLAYTON*	4	11%
KAHOKA	2	5%
WARRENTON	2	5%
WAYNESVILLE	2	5%
DESOTO	1	3%
DIXON	1	3%
GRANITE CITY	1	3%
HANNIBAL	1	3%
LAKE ST LOUIS	1	3%
LOUISIANA	1	3%
PARK HILLS	1	3%
PILOT KNOB	1	3%
POTOSI	1	3%
RICHLAND	1	3%
SALEM	1	3%
ST JAMES	1	3%
TROY	1	3%
WASHINGTON	1	3%

38

(Total does not equal 49
due to data discrepancies)

*St. Louis County Jail



MPC medical staff report that the patients who come from jail settings are similar to the other patients they treat in terms of diagnosis and length of stay. Outlined below is a summary provided by MPC that describes the most typical clinical profiles of patients who were admitted from jails.

Group 1: Patients with personality disorder diagnoses and behavioral disturbances

This group is usually comprised of young males with a lifelong history of impulsivity, behavioral disturbance and anger problems. Extremely primitive personality functioning with mixed borderline and antisocial traits. Many of these patients will carry a plethora of old diagnoses, typically ADHD and bipolar, but in most cases these traits are secondary to personality issues. They usually present from jail with behavioral outbursts that the jail has problems managing. The outbursts are multi-factorial in nature and represent a combination of manipulation and frustration with their incarceration. Most often present from rural jails. Length of stay is very short, usually 96-hour observation, then out.

Group 2: Patients with antisocial personality disorder, who are malingering to avoid jail

This group typically consists of patients with a long history of criminality, deviancy and antisocial behaviors. Has typically had sparse treatment for mood complaints and/or impulsivity and aggression. These individuals often present after having self-injurious behavior or verbalizing suicide. Length of stay is very short, usually 96-hour observation, then out.

Group 3: Patients in acute psychotic or manic episode

These patients usually have a history of schizophrenia or bipolar disorder. They often times present in the context of psychosis or mania in the context of medication refusal. Often times index crimes are relatively minor and likely represent psychotic behaviors that happened to be illegal in nature. A significant amount of these will represent the migratory psychotic patient, who has no ties to the immediate geographic area and was detained by police while wandering across the country. Length of stay is bimodal and depends upon the level of dangerousness. If the patient is dangerous, length of stay can be long – on the order of several weeks. If the patient is not dangerous the course of treatment is 96-hour observation, then out. This is the typical scenario from St. Louis County jails that have in-house treatment services.

Psychiatric patients who have committed major felonies (rape, murder, arson, etc.) are eligible for admission to Fulton State Hospital (See Appendix V, Major Crime Exclusion List.)

The Short-term Crisis Team discussed potential solutions for treating jail patients not eligible for care at Fulton State Hospital, including:

- DMH uses a portion of the \$2 million allocated to the region to fund services for individuals from the eastern region's jails.
- Community hospitals with appropriately secure facilities provide inpatient psychiatric care for a contracted per diem fee.
- Jails build capacity to provide services in house. One jail could perhaps build this capacity and offer services to other regional jails for efficiency.

MPC may still be able to serve some of this patient population through May 2011 depending on availability in the remaining 25-bed unit. To further evaluate potential solutions and determine a recommended course of action, the Short-term Crisis Team recommends the following:

- St. Louis City and St. Louis County jails consult legal counsel to determine how custody of these patients can be managed. Current understanding is that these patients need to be supervised by an armed officer of the jail for the jail to maintain legal custody. Community hospitals report that armed or uniformed officers are not allowed on psychiatric units. Weapons of any kind are not allowed on these units and uniformed officers create difficulty in providing appropriate care to the other mental health patients.

- St. Louis City and St. Louis County jails consult legal counsel to determine their ability to administer involuntary medications – one of the primary reasons these jails seek hospital care for their inmates. Currently, the jails do not administer involuntary medications. The jails may study this issue further to understand the legal, ethical and licensure considerations.
- Community hospitals identify psychiatric units that offer patient environments that may be secure enough to serve this patient population.

No regional solution to provide inpatient psychiatric care for inmates has yet been identified, and individual hospitals are assessing their skills, security and experience to care for this population. Some community hospitals have stated they will not admit jail patients for psychiatric care. ~~It should be noted that while community hospitals often contract for reimbursement for providing medical services to jail patients. No plan has been identified to provide reimbursement for providing psychiatric services.~~

Protocols for DMH Admissions

Historically, St. Louis area patients who need to be admitted either to Fulton State Hospital or to a DMH long-term care facility have gone to MPC first. DMH reports that patients can be admitted directly to either Fulton or a DMH long-term care facility. (See Appendix VI, Protocols for Transfers to Fulton State Hospital.)

In the near term, MPC will be providing admissions only for scheduled patients from community hospitals, consumers who need revocation and for clients committed pursuant to Chapter 552 RSMo for restoration of competency. St. Louis Psychiatric Rehabilitation Center (SLPRC) will only admit clients transferred from other DMH facilities and some consumers who need revocation. At a later date, DMH with the community will develop an admission protocol for those in need of long-term care, either in an inpatient setting at SLPRC or in an Intensive Residential Treatment Service maintained by a Community Mental Health Provider.

Other MPC Services

MPC currently assigns attorneys to involuntary psychiatric patients in St. Louis City and St. Louis County. The ED at MPC manages this process because the assignment needs to happen as soon as possible after an admission decision. Behavioral Health Response (BHR) has indicated that through its 24/7 call center it could manage this service for hospitals in St. Louis City and St. Louis County. BHR will work with MPC immediately to understand the full scope of the service and its associated costs.

MPC also facilitates the assignment of substance abuse providers for those patients in the region committed to 30-day alcohol and drug involuntary treatment. At this time, very few community hospitals seek drug and alcohol involuntary commitments. In fiscal year 2010, MPC did 153 drug and alcohol commitments. At MPC, these patients experience very brief lengths of stay (less than 96 hours)

before they are admitted into one of the alcohol and drug treatment programs, assigned on a rotating basis. MPC anticipates that families and patients will begin presenting in community hospital emergency departments seeking involuntary commitments for drug and alcohol abuse. Each hospital will have to determine how they will handle these patients. Bridgeway has established an alcohol and drug abuse residential treatment rotation accessible through (314) 226-9030, extension 253, for 30-day alcohol and drug commitments.

MPC provides free medications to patients committed to these treatment programs. This is at an average retail equivalent cost of \$175 per client.

CAPACITY ISSUES RECOMMENDATIONS

Facilitating Patient Transfers Between Hospitals

As psychiatric inpatient capacity continues to tighten in the St. Louis region, hospitals will more frequently need to transfer patients to facilities that have available beds.

In 2005, the Missouri Hospital Association worked with community hospitals to develop a web-based tool that enabled hospitals to share information about bed availability. Every two hours, hospital staff would update the number of beds available. The system also provided up-to-date contact information for hospitals to use when trying to find an available bed for a patient. The hospitals report they quit using the system because not all hospitals were updating the information, and hospitals did not trust that all participants were sharing accurate information.

The Short-term Crisis Team discussed how frequently their bed availability changes and that information, even an hour old, may be inaccurate. They also noted that bed availability fluctuates depending on the medical acuity of patients in the unit at the time. If patients require isolation for medical reasons or because of psychiatric acuity, semi-private rooms become private, making some beds unavailable.

For illustration purposes, when the web-based system was operating, the following was a typical situation: Hospital A would show they had beds available in the system; Hospital B would call Hospital A to try to place a patient; Hospital A would report they had no beds available; Hospital B did not trust the information in the system, nor the information provided when staff called Hospital A.

The Short-term Crisis Team recommends investigating a redeployment of this tool. The team believes it could be effective in more easily facilitating transfers between hospitals if: (1) hospital staff understood that the numbers reported in the system were merely for guidance and would not be 100 percent accurate, and (2) all hospitals participated. It also may be helpful if the system only tracked adult acute care beds.

The Short-term Crisis Team has asked the Missouri Hospital Association to provide information about activities and associated costs to redeploy the tool. **After consideration, members of the Short-term**

Crisis Team have determined the system would not be helpful due to lack of interest from the entire hospital community.

Managing Increased Volume in Emergency Departments

It is estimated that the region's community hospitals treat about 1,500 psychiatric patients in their emergency departments each month. With MPC's closure, the hospitals in the region can expect a total of about 80 additional psychiatric patients each month, most of whom are likely to be involuntary patients.

The Short-term Crisis Team recommends the consideration of development of community-wide psychiatric/substance abuse intake and stabilization unit(s) and/or services, which could:

- Ensure that appropriate mental health and behavioral services are provided to patients in a setting that has been developed and staffed to deliver the specialized care necessary for these patients.
- Ensure that EMS providers, police and community members are aware of where to take patients who are suffering only from psychiatric issues and/or substance abuse.
- Establish and follow protocols that provide clarity on when and under what conditions psychiatric/substance abuse patients are to be transferred to community hospital emergency departments.
- Establish a potential 23-hour observation unit to manage patients (typically intoxicated or with less severe suicidal thoughts) that don't require inpatient psychiatric hospitalization.
- Allow judges to court order patients for evaluation to this site(s).
- Integrate with the existing community system of care.

The Short-term Crisis Team has evaluated ways to manage increased volumes in emergency departments using non-hospital treatment options. The group believes that the ability to secure next day, urgent care appointments at community mental health centers (CMHCs) may enable emergency departments to discharge a small but significant number of patients rather than admitting them.

The Short-term Crisis Team recommends that the Community Access Transformation Team (CATT) consider how CMHCs may be able to provide these next-day appointments specifically to hospitals with psychiatric units treating involuntary patients.

The Short-term Crisis Team recognizes that DMH has provided the following guidelines for patient populations eligible for funding available from the \$2 million allocated to the eastern region by DMH:

Target Population:

- *Individuals discharged from a community hospital acute psychiatric unit or emergency room, who are Medicaid eligible and have a CPRC qualifying diagnosis.*
- *Existing DMH consumers, Mental Health 4 consumers (individuals with serious mental illness) discharged from correctional settings, consumers discharged from long-term care state-operated facilities.*
- *Other individual exceptions can be made based on the acuity of the crisis and the limits of each CMHC's allocation.*

Desired Plan Elements:

The following elements are intended more as guidance than as strict requirements:

- **The Front End:** *The FIRST priority is attending to the replacement of the ED function, meaning services intended to engage people in existing community-based services, managing crises and minimizing use of community ED services and serving as an alternative to inpatient admission. All such services enhance access and connectivity, focus on high utilizers (frequent users) of ED and inpatient services. This include such services as:*
 - *Mobile Outreach (scrambling BHR or agency staff to the scene of a crisis including a community ED, with or without existing psychiatric beds and expertise, or staffing community ED units (with BHR or CMHC staff).*
 - *Urgent Care (i.e., at least "next-day," if not "same-day" appointments).*
 - *Crisis/respite beds in sub-acute settings (which can be a part of an intensive residential treatment service (See */IRTS below with shorter lengths of stay.)*
- **The Back End:** *A SECONDARY priority is attending to the needs of consumers who have been admitted into community hospital acute inpatient beds:*
 - *It is NOT the department's intention for the regional plans to spend all, or even the majority of their dollars, on operating EDs, purchasing inpatient days, capital improvement efforts to build beds, etc. However, should a region submit a plan in which such features predominate, and it is has broad support across the regional planning group, such a plan will receive serious consideration.*
 - *The department DOES encourage the use of service/residential support options that facilitate release from inpatient care and continuity of care with our community providers. Such services/supports mitigate excessive lengths of stay in high dollar inpatient beds, enhance opportunities for coordination of care with community providers and facilitate effective community reintegration. The following are examples of the department:*

- *Processes for staffing acute care consumers in the community hospitals to facilitate discharge planning.*
- **Intensive residential treatment service options (IRTs) in sub-acute residential settings with intermediate- to long-term lengths of stay.*
- *Other Desirable Features*
 - *Coordination with law enforcement (including CIT officers) and the courts.*
 - *Strategies for involving peer specialists in the provision of care.*

It is acknowledged in the brief planning window of the Short-term Crisis Team that the full details of the stabilization unit(s) and/or services have not been developed to date. If the details are reasonable and agreeable to all parties, the Short-term Crisis Team and MPC Planning Group would like DMH to consider directing the funds to stabilize emergent psychiatric patients and support outpatient care for uninsured psychiatric patients. Outpatient care would be directed to patients coming from: (1) an inpatient stay at a community hospital, or (2) an ED visit that does not require immediate hospitalization. If possible, priority could be given to "high utilizers" of inpatient or ED services. Patients who have been incarcerated may be considered part of the "high utilizer" priority group. In addition, patients with a first psychosis or who are delusional and possibly homicidal or suicidal could also be considered as part of the priority group.

The teams believe that funds should be available to coordinate stabilization and outpatient care from those hospitals with adult, locked acute psychiatric units and those hospitals that accept involuntary patients. The intent is to leverage the \$2 million from DMH with local, state and/or federal dollars in order to provide both stabilization and outpatient care.

Increasing Inpatient Capacity by Facilitating Timely Discharge and CMHC Capacity

It has been noted by members of the MPC Planning Group that MPC's lengths of stay are longer than those of community hospitals, enabling patients and families to better plan for care after a hospital stay. MPC reports a median length of stay of seven days in fiscal year 2009. When outliers are accounted for, the average length of stay is 17.56 days. For comparison, hospitals in the region report a range of about five to eight days as an average length of stay on an adult psychiatric acute unit.

Hospitals are scrutinized by Medicare and other payers to ensure all patient days are medically necessary, making it impossible to keep patients longer than medically necessary.

With the closure of the MPC ED and acute care beds and the continued tightening of psychiatric inpatient beds in the St. Louis region, the Short-term Crisis Team has worked to identify ways to improve discharge planning, possibly enabling more patients to discharge earlier with better care plans. These earlier discharges will make more psychiatric beds available to the community.

Capacity is a critical issue within the CMHC system. All avenues of public and private services should be examined to determine where capacity can be increased. Moreover, it is critical to review capacity

within the CMHC system to ensure new patients may access services. The Short-term Crisis Team recommends studying the ability of CMHCs to advance patients beyond public mental health services. It is recommended that the long-term team (Regional Psychiatric Capacity Task Force) develop recommendations for increasing capacity for DMH clients in CMHCs.

The team evaluated several potential solutions, including:

- Priority CMHC appointments (within one week of discharge).
- Coordination with community case managers.
- Discharge to crisis beds.
- Short-term housing support.
- Substance abuse treatment.
- Intensive residential treatment.
- Access to medication at discharge.
- Resources for discharging developmentally disabled patients.
- Increasing capacity at CMHCs.

After evaluating each of these options within the context of the \$2 million available to the eastern region from the state of Missouri, the Short-term Crisis Team recommends community hospitals and CMHCs work more closely to facilitate effective and timely discharges. This could involve mobile care coordination, enabling CMHC staff to visit patients in hospitals, work with hospital social workers and help facilitate discharge. Some CMHCs already provide this service for their current patients. To help with the MPC closure, this service would need to be extended to new patients.

It is the recommendation of the Short-term Crisis Team that the CATT evaluate the viability, scope and scale that this service could be offered in order to determine if it would help alleviate some of the pressures on the system created by the closure of MPC.

One of the challenges identified is the ability of community hospitals and CMHCs to share patient information under HIPAA guidelines. As an option, DMH has provided a template for a Business Associate Agreement (See Appendix VII, Business Associate Agreement) that the department uses with providers to enable the sharing of information. Hospitals and CMHCs can use this as a basis to draft their own agreements between each other.

It was also noted that access to affordable medication is an issue for some patients at discharge. The Short-term Crisis Team will provide hospitals with a list of places to receive affordable medications that MPC currently provides its patients.

Key MPC Relationships

MPC provides services to its patients that community hospitals may want to consider offering. Examples include family education provided in cooperation with the National Alliance on Mental Illness (NAMI) and promotion of patient rights via the Missouri Protection and Advocacy Services. MPC is conducting an inventory of these types of relationships for community hospitals to review.

CONCLUSION

Summary of Recommendations

As a result of the Short-term planning process, several recommendations have been made for area hospitals and other providers to consider with their staff and legal counsel. These include:

- A standard process and protocol in community hospitals for handling involuntary patients.
- Standard fit for confinement and police hold forms.
- Notarized signatures on affidavits instead of two witness signatures.
- Auto-complete forms (currently used by MPC and Barnes-Jewish Hospital) for court applications for involuntary admissions).
- Additional tele-courtrooms in community hospitals.

These changes in the process are designed to help hospitals handle more involuntary patients than they currently treat, to help facilitate transfers of patients between hospitals and to help police officers leave hospitals and return to the streets sooner.

In addition, the group identified services MPC provides the community that other organizations will need to absorb or that different protocol will need to be addressed. The resolution to these issues follows:

- Behavioral Health Response will manage the rotational assignment of attorneys for involuntary psychiatric patients.
- Bridgeway will manage the rotational assignment of alcohol and drug abuse treatment programs for drug and alcohol involuntary commitments.
- Jails and law enforcement will follow DMH procedures for direct transfers to Biggs Forensic Center at Fulton State Hospital. (Traditionally, patients would come to MPC before going to Biggs.

The group also recommended solutions for the Community Access Transformation Team to consider in their recommendations to DMH:

- Next-day urgent care appointments at Community Mental Health Centers (CMHCs) for emergency department patients, enabling some patients to discharge rather than admit.
- Facilitated inpatient discharge coordinated between community hospitals and CMHCs, enabling more patients to access outpatient care.

It is acknowledged in the brief planning window of the Short-term Crisis Team that the full details of the stabilization unit(s) and/or services have not been developed to date. If the details are reasonable and agreeable to all parties, the Short-term Crisis Team and MPC Planning Group would like DMH to consider directing the funds to stabilize emergent psychiatric patients and support outpatient care for uninsured psychiatric patients. Outpatient care would be directed to patients coming from: (1) an inpatient stay at a community hospital, or (2) an ED visit that does not require immediate hospitalization. If possible, priority could be given to "high utilizers" of inpatient or ED services. Patients who have been incarcerated may be considered part of the "high utilizer" priority group. In addition, patients with a first psychosis or who are delusional and possibly homicidal or suicidal could also be considered as part of the priority group.

The teams believe that funds should be available to fund coordinated stabilization and outpatient care from those hospitals with adult, locked acute psychiatric units and those hospitals that accept involuntary patients. The intent is to leverage the \$2 million from DMH with local, state and/or federal dollars in order to provide both stabilization and outpatient care.

The teams further recommend consideration of a stabilization unit(s) and/or services.

Unresolved Issues

The Short-term Crisis Team has spent considerable time understanding the issue of treating patients from jails. At this time, no regional solution to provide inpatient psychiatric care for inmates has yet been identified, and individual hospitals are assessing their skills, security and experience to care for this population. Some community hospitals have stated they will not admit jail patients for psychiatric care. It should be noted that while community hospitals often contract for reimbursement for providing medical services to jail patients, no plan has been identified to provide reimbursement for providing psychiatric services.

Issues for Long-term Team's Consideration

The following long-term issues have been identified by the Short-term Crisis Team for the Long-term Team's consideration:

System of Care Coordination

- Limited availability of slots in Community Mental Health Centers, especially for the uninsured, develop recommendations for increasing capacity.
- Shrinking inpatient psychiatric capacity in the region with longer waits in EDs as patients wait for beds.
- Lack of 24/7 alternatives other than EDs for psychiatric care.
- Lack of availability of a range of housing options for psychiatric patients, including long-term care and residential facilities. Identify a range of housing options for psychiatric patients that would include everything from individual living facilities through residential care and long-term care facilities.
- Lack of capacity of substance abuse providers, especially for those without insurance.
- Lack of employment opportunities for psychiatric patients.

Unique Patient Populations

- With DMH's closure of the MPC ED and acute care beds, lack of provider for patients from jails.

Reimbursement

- Typically, 90 days from application for patients to become enrolled in Medicaid.

Workforce

- Lack of psychiatrists and other licensed staff.

COMMUNICATIONS RECOMMENDATIONS

Executive Summary of Metropolitan St. Louis Psychiatric Center (MPC) Emergency Response Plan for Community Distribution

The Missouri Department of Mental Health (DMH) has announced it is closing the emergency department and 25 acute care beds at MPC July 15, 2010, leaving 25 beds in operation until May 2011. Next spring, MPC will convert its operations to a 50-bed forensic pre-trial program.

The Planning Group assembled by the St. Louis Regional Health Commission, at DMH's request, has developed a short-term crisis planning process that has developed cross-organizational recommendations to address: (1) emergency response issues, and (2) capacity issues of inpatient psychiatric units.

In developing the Emergency Response and Capacity Plan, the MPC Planning Group has determined that community hospitals already treat many of the same kinds of patients as MPC. While the community hospitals' behavioral health units already are taxed, they believe they will be able to continue to absorb most of MPC's remaining patients, which account for seven to eight emergency department visits per day and two to three inpatient admissions per day. Patients can expect to experience longer waits in emergency departments as hospitals treat more patients and psychiatric inpatient beds become scarcer.

To help manage the increased volume, the MPC Planning Group has developed a series of recommended protocols, procedures and forms to help all area hospitals with behavioral health services more easily serve former MPC patients and clients. Each hospital may review these recommendations with their staff and legal counsel to determine if they are appropriate for their own organization. With greater patient demand, it is expected that hospitals will frequently transfer patients to other hospitals where beds are available. These standard protocols, procedures and forms are intended to better manage patient flow and information.

Hospitals in the St. Louis area that provide emergency and adult acute psychiatric services include:

- Barnes-Jewish Hospital
- CenterPointe Hospital
- Christian Hospital Northeast/Northwest
- Forest Park Community Hospital
- Jefferson Memorial Hospital
- MPC (25 beds after July 15, 2010)
- St. Alexius Hospital – Broadway Campus
- St. Anthony's Medical Center
- St. John's Mercy Medical Center
- St. Louis University Hospital*
- SSM DePaul Health Center
- SSM St. Joseph Health Center (Wentzville & St. Charles)
- SSM St. Mary's Hospital

*Note: St. Louis University Hospital will not accept involuntary psychiatric patients, which account for 78 percent of MPC's current admissions.

Community hospitals currently do not typically serve one type of MPC patient: those who come from jails. In the last year (June 15, 2009 – June 15, 2010), MPC admitted 38 patients from jails. The Planning Group has evaluated several options and is conducting additional research to determine the best approach. MPC may be able to serve some of this patient population through May 2011, depending on availability in the remaining 25-bed unit.

In order to address capacity-related issues, the Short-term Crisis Team will investigate the viability of restoring a web-based solution that enables hospitals to share information about bed availability. This will help facilitate transfers between hospitals, which will be necessary as inpatient beds become scarcer.

The Short-term Crisis Team also has requested that the Community Access Transformation Team consider developing a proposal for DMH that may include next-day urgent care appointments for patients seen and discharged from EDs and greater coordination of discharge planning between hospitals and CMHCs. Hospitals report significantly better outcomes when patients meet a representative from a CMHC prior to discharge.

Audiences for Emergency Response Communications

First Responders

- St. Louis City Police
- St. Louis Fire Department (EMS)
- St. Louis County Police/Municipal and University Police Departments
- St. Louis-area EMS
- 911 Dispatchers

Courts

Jails

- St. Louis City Jails
- St. Louis County Jails
- Municipal Jails

Community Hospitals

Primary Care Physicians

Patients and Families

Other Referral Sources

- Community Mental Health Centers and Affiliates
- Homeless Shelters
- Social or Community Agencies

Communications Strategies

- I. Hospital representatives of Short-term Crisis Team and Planning Group to share recommended protocols, procedures and forms with hospital staff.
- II. EMS, police, Crisis Intervention Team (CIT), Short-term Crisis Team and Planning Group to distribute protocols, procedures and forms to officers, 911 dispatchers and EMS.
- III. DMH to distribute a letter to courts, communicating their options for services.
- IV. DMH to distribute a letter to jails (those who have used MPC services in last two years) communicating their options for services.
- V. DMH to distribute a letter to MPC patients/guardians (of last two years) communicating their options for services.
- VI. DMH to distribute a letter to MPC referral sources (of last two years) communication options for services.
- VII. DMH to distribute a letter to associations representing primary care physicians to communicate options for care (examples: Missouri State Medical Association and Missouri Academy of Family Physicians).

Appendices

Appendix I: Short-term Crisis Team Roster

Appendix II: Mental Health Admission Process: ED Patients Brought by Police Flowchart and ED Patient Brought in by Family, Friends or Self

Appendix III: Involuntary Admission Form

Appendix IV: Fit for Confinement Evaluation Form

Appendix V: Major Crime Exclusion List

Appendix VI: Protocols for Transfers to Fulton State Hospital

Appendix VII: Business Associate Agreement



Metropolitan St. Louis Psychiatric Center (MPC) Acute Care/ED Closure
Short-Term Crisis Management Team

Charge:

Determine short-term, cross-organizational activities to prepare for and to manage the closure of MPC's acute care/ED services in summer or autumn 2010.

Key Deliverables:

- Impact statement describing the likely impact of MPC's acute care/ED closure across the region
- Procedures and protocols between courts/law enforcement/community hospitals (*as allowed by anti-trust law*) for review by the State of Missouri Department of Mental Health (DMH)
- Recommendations to DMH regarding acute care/ED closure in the short-term
- Public communications plan

Current Membership:

John Eiler, Chair

Executive Vice President for Behavioral Health and Senior Services
SSM Healthcare – St. Louis

James Hoerchler

Social Work Manager
Barnes-Jewish Hospital

Sergeant Barry Armfield

St. Louis Area CIT Police Coordinator
St. Louis County Police Department

Lynne Jones

Health Services Administrator
St. Louis County Department of Health

Tony Cuneo

Chief Operating Officer
Metropolitan St. Louis Psychiatric Center

Sue Lindenbusch

St. John's Mercy Medical Center

Kenneth McCain

Health Service Administrator – St. Louis City Jails
CMS St. Louis

Dr. Tim Dalaviras

Executive Director, Hyland Behavioral Health
St. Anthony's Medical Center

Daniel Poupard

Director of Behavioral Health
St. Louis University Hospital

Al Fressola

Vice President, Community Affairs/Quality
Behavioral Health Response

Dr. Nick Nguyen

Acting Medical Director
Metropolitan St. Louis Psychiatric Center

Mary Ann Hampton

Chief Nursing Officer
St. Alexius / Forest Park Hospitals

Captain Mary Warnecke

St. Louis City Police Department

Laura Heebner

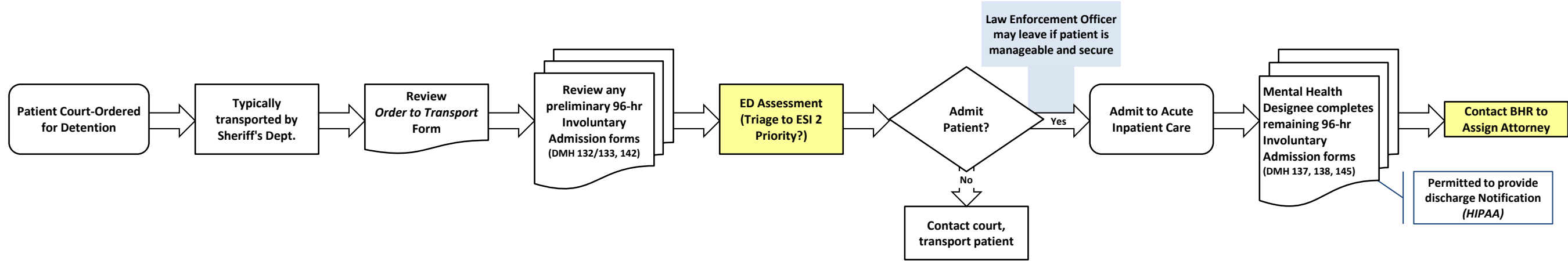
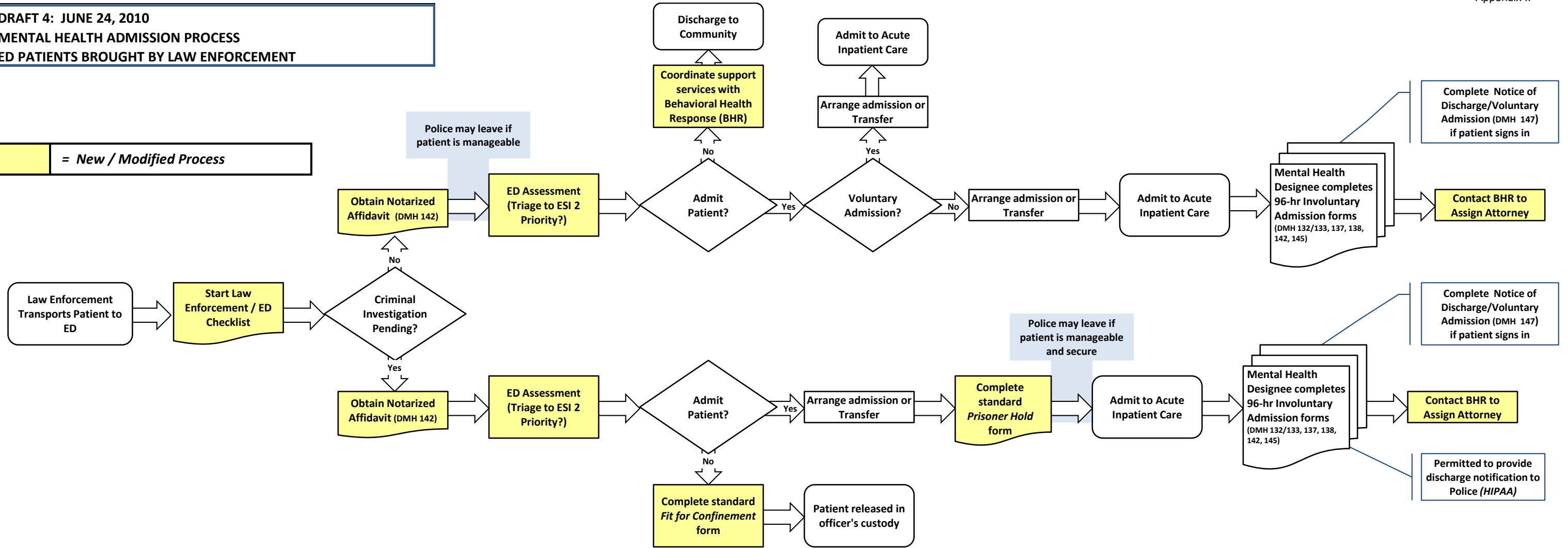
Senior Vice President and Chief Operating Officer
Crider Health Center

Monroe Yancie

St. Louis Fire Department

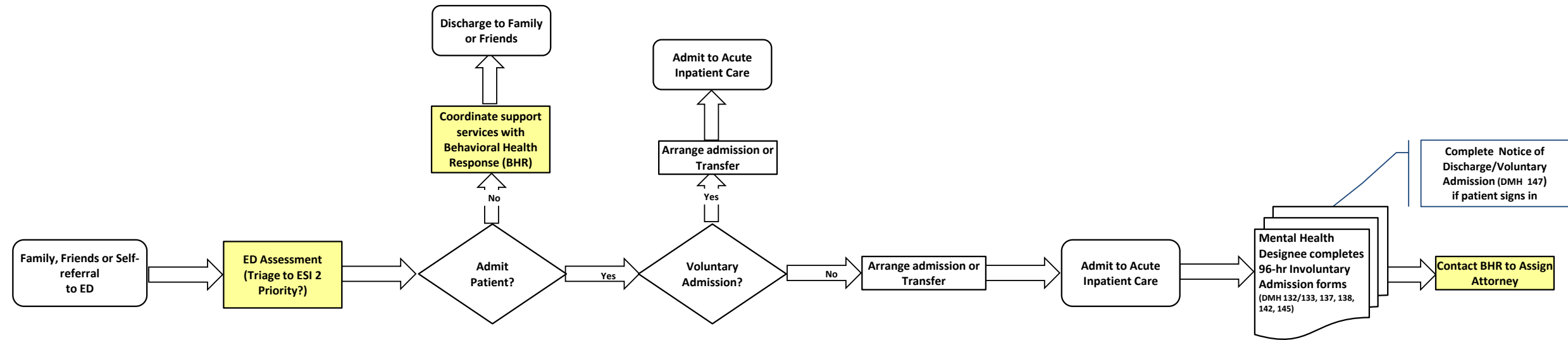
DRAFT 4: JUNE 24, 2010
MENTAL HEALTH ADMISSION PROCESS
ED PATIENTS BROUGHT BY LAW ENFORCEMENT

[Yellow Box] = *New / Modified Process*



DISCLAIMER: These recommendations represent the collective input of the MPC Short-term Crisis Team and should be reviewed and considered by each individual entity's staff and legal counsel before implementing. These recommendations are not intended to serve as legal advice.

DRAFT 1: JULY 7, 2010
MENTAL HEALTH ADMISSION PROCESS
ED PATIENTS BROUGHT IN BY FAMILY,
FRIENDS OR SELF



[Yellow Box] = *New / Modified Process*

DISCLAIMER: These recommendations represent the collective input of the MPC Short-term Crisis Team and should be reviewed and considered by each individual entity's staff and legal counsel before implementing. These recommendations are not intended to serve as legal advice.



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
**APPLICATION FOR 96 HOUR IMMINENT HARM ADMISSION
 TO A MENTAL HEALTH OR ALCOHOL AND DRUG ABUSE FACILITY**

(A MENTAL HEALTH FACILITY/ALCOHOL OR DRUG ABUSE FACILITY)

The applicant is a _____ who may complete this application under Section 632.305.4, RSMo. or Section 631.120.1 RSMo.

The applicant herein states that _____ he has reason to believe that the respondent, _____, age _____, birthdate _____, gender Male Female, who resides at

STREET CITY COUNTY STATE ZIP CODE

is mentally disordered/abuses alcohol or drugs or both as defined by law and presents an imminent likelihood of serious harm to himself or others, and thus is in need of detention, evaluation and treatment/rehabilitation in a mental health/alcohol or drug abuse facility. Such belief is based upon the facts which have been derived from the applicant's personal observation and/or investigation.

1. The facts that support the applicant's belief that the respondent is mentally disordered/abuses alcohol or drugs or both are:

2. The facts that support the applicant's belief that the respondent presents an imminent likelihood of serious harm are:

Attached hereto and incorporated herein are the names and addresses of persons known to the applicant to have personal knowledge of said facts.

WHEREFORE, the applicant requests the mental health/alcohol or drug abuse facility to admit _____ for detention, evaluation and treatment/rehabilitation for a period not to exceed 96 hours pursuant to Chapter 632 RSMo. or Chapter 631, RSMo.

APPLICANT		DATE
		10/11/2007
ADDRESS		TELEPHONE
NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE OF	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS	
	DAY OF	YEAR
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
NOTARY PUBLIC NAME (TYPED OR PRINTED)		USE RUBBER STAMP IN CLEAR AREA BELOW.

MO 650-0182N (8-07)

DMH 132



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
**APPLICATION FOR 96 HOUR DETENTION, EVALUATION AND TREATMENT/
 REHABILITATION OF A VOLUNTARY PATIENT REQUESTING RELEASE**

NO. _____

TO: _____
MENTAL HEALTH FACILITY/ALCOHOL OR DRUG ABUSE FACILITY

The applicant herein states the following:

1. The respondent is a voluntary patient who has requested h_____ release from _____ a mental health facility/alcohol or drug abuse facility.
2. The applicant is a _____ who may complete this application pursuant to Sections 632.150 or 632.155, RSMo/Section 631.120 RSMo.
3. The head of the facility, _____, has determined that _____ is mentally disordered/abuses alcohol or drugs or both and as a result a likelihood of serious harm to h_____self or others and therefore has refused the patient's request for release.
4. The applicant herein states that _____ he has reason to believe that the respondent, _____, age _____, birthdate _____, gender Male Female, who is presently a patient at _____, a mental health/alcohol or drug abuse facility is suffering from a mental disorder/abuses alcohol or drugs or both and presents a likelihood of serious harm to h_____self or others and thus is in need of detention, evaluation and treatment in a mental health/alcohol or drug abuse facility. Such belief is based upon facts derived from the applicant's personal observation and/or investigation.
5. The facts that support the applicant's belief that the respondent is mentally disordered/alcohol or drug abuser are:

6. The facts that support the applicant's belief that the respondent presents a likelihood of serious harm are:

Attached hereto and incorporated herein are the names and addresses of persons known to the applicant to have personal knowledge of said facts.

WHEREFORE, the applicant requests the mental health/alcohol or drug abuse facility to admit _____ for detention, evaluation and treatment/rehabilitation for a period not to exceed 96 hours pursuant to Chapter 632 RSMo/Chapter 631, RSMo.

APPLICANT			TELEPHONE	
STREET	CITY	COUNTY	STATE	ZIP CODE
NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE OF		COUNTY (OR CITY OF ST. LOUIS)	
	SUBSCRIBED AND SWORN BEFORE ME, THIS			USE RUBBER STAMP IN CLEAR AREA BELOW.
	DAY OF	YEAR		
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES		
NOTARY PUBLIC NAME (TYPED OR PRINTED)				

MO 650-0148N (8-07)

DMH 133



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
NOTICE OF ADMISSION OF INVOLUNTARY PATIENT

NO. _____

IN THE CIRCUIT COURT OF _____ COUNTY, MISSOURI
 PROBATE DIVISION
 IN THE MATTER OF _____
 RESPONDENT, A PERSON ALLEGED TO BE MENTALLY DISORDERED.

NOTICE OF ADMISSION OF INVOLUNTARY PATIENT

TO: JUDGE, PROBATE DIVISION, CIRCUIT COURT OF _____ COUNTY, MISSOURI
 _____, RESPONDENT, WHO RESIDES AT,

(STREET, CITY, COUNTY)

_____ COUNTY, MISSOURI, WAS ADMITTED TO _____
 ON THE _____ DAY OF _____, 20____, AT _____ O'CLOCK ____ .M.
 ON AN INVOLUNTARY BASIS.

ENCLOSED HERewith IS A COPY OF THE APPLICATION FOR RESPONDENT'S ADMISSION, A COPY OF THE NOTICE GIVEN TO RESPONDENT AS REQUIRED BY CHAPTER 632 OR 631, RSMO, AND PROOF OF SERVICE OF SUCH NOTICE.

THE ATTORNEY REPRESENTING THE RESPONDENT IS _____, WHO IS DESIGNATED FROM THE LIST PROVIDED BY THE COURT.

DATED: _____, 20____.

MENTAL HEALTH COORDINATOR OR HEAD OF FACILITY

ADDRESS		CITY
STATE	ZIP CODE	TELEPHONE NUMBER



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
**AFFIDAVIT IN SUPPORT OF APPLICATION FOR DETENTION, EVALUATION
 AND TREATMENT/REHABILITATION - ADMISSION FOR 96 HOURS**

IN THE MATTER OF _____, RESPONDENT,
 A PERSON ALLEGED TO BE MENTALLY DISORDERED.
 _____, HEREBY AFFIRMS AN OATH AS FOLLOWS:
 (Describe the behavior which respondent exhibits which supports the conclusion that respondent is mentally disordered or
 an alcohol or drug abuser and presents a likelihood of serious harm to himself or others.)

NAME (SIGNATURE)			
STREET ADDRESS			
CITY	STATE	ZIP CODE	TELEPHONE
NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE OF	COUNTY (OR CITY OF ST. LOUIS)	
	SUBSCRIBED AND SWORN BEFORE ME, THIS		
	DAY OF	YEAR	USE RUBBER STAMP IN CLEAR AREA BELOW.
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
NOTARY PUBLIC NAME (TYPED OR PRINTED)			

MO 650-0173N (8-00)

DMH 142

Fit for Confinement Form

REQUESTOR INFORMATION: (To be filled in by Requestor)

Requesting Agency Name: _____

Name of Agency Representative: _____ Phone# _____

Type of Confinement Assessment Requested: **Medical** **Psychiatric**

PATIENT INFORMATION: (To be filled out by Hospital)

Patient Name _____ D.O.B _____

Current Medical Problems: _____

Current Medications:

1. _____ 3. _____

2. _____ 4. _____

NAME OF PERSONAL PHYSICIAN: _____ LAST SEEN: _____

PHYSICAL FINDINGS:

T _____ P _____ R _____ B/P _____ ALLERGIES _____

EXAMINATION SUMMARY (Copies of labs, medications given, reports, needed appointments attached? _____)

Is patient **MEDICALLY** fit for confinement? YES NO NOT EVALUATED

Is patient **PSYCHIATRICALY** fit for confinement? YES NO NOT EVALUATED

- Patient does not require inpatient medical treatment
- Patient does not require inpatient psychiatric treatment
- Outpatient Referral/Treatment Recommendation:
- Medical Treatment
- Psychiatric Treatment

Medications/treatment details:

Suicidal/Assault Precautions-If checked, provide precaution details. _____

FACILITY/DOCTOR INFORMATION

Facility Name: _____ Phone Number: _____

Physician Name (Printed): _____ Date/Time of Evaluation: _____

Physician, M.P. or P.A. Signature

Date

Law Enforcement Emergency Department Checklist

This form is intended to provide a standardized guide for ED staff when providing services to patients escorted by Law Enforcement and Jail Personnel.

Officer Name/Rank/Title: _____

Officer's Department or Facility: _____

District/Precinct Name _____

Phone Number: _____

Patient Name: _____

Patient DOB: _____

ED Staff Name: _____

Reason for Visit (check all that apply):

- Medical Needs
- Behavioral Health Needs
- Fit for Confinement Evaluation

- Is officer presenting affidavits for Involuntary Detention? YES NO

If Yes:

- 1) Review affidavit with officer
- 2) Have affidavit notarized

- Is officer requesting hold to release? YES NO

If Yes:

- 1) Review reasons for hold with officer
- 2) Have Officer begin completion of DETAINEE HOLD ORDER FORM

- Is officer requesting Fit for Confinement Evaluation? YES NO

If Yes

- 1) Review reason for evaluation request
- 2) Have officer complete top portion of FIT FOR CONFINEMENT FORM

- Is officer staying until evaluation is complete? YES NO

If NO:

- 1) Does officer require follow-up on disposition/transfer? YES NO

If YES,

Contact Phone Number: _____

Contact Name: _____

Detainee Hold Order Form

Date: _____, 20__

REQUESTOR INFORMATION

Officer Name/Rank/Title: _____
Officer's Department or Facility: _____
District/Precinct Name _____
Phone Number: _____

DETAINEE INFORMATION

Detainee Name _____ DOB _____
Reason for Detention (Choose One):
 Warrant Issued, Charges: _____

 Warrant Pending, Charges: _____

 Convicted, serving sentence on following charges: _____

ADMITTING FACILITY INFORMATION

Facility Name _____
Facility Phone Number _____
Admitting Doctor: _____

DISPOSITION OF HOLD ORDER (Choose One)



Discharged to Officer
Officer Name: _____
Officer Phone Number _____
Time/Date of Discharge _____

Released from Hold by Officer
Officer Name: _____
Officer Phone Number: _____
Time/Date of Release _____

Major Crimes or Attempts thereof

Major Crimes include crimes (and attempted crimes) statutorily (556.061.8) defined as a Dangerous Felony plus Murder 1st and Sexual Assault. Major Crimes are:

- Abuse of a Child
 - pursuant to subdivision (2) of subsection 3 of section 568.060, RSMo ((2) A child dies as a result of injuries sustained from conduct chargeable pursuant to the provisions of this section)
- Arson 1st
- Assault
 - Assault 1st
 - Assault of a Law Enforcement Officer 1st
 - Domestic Assault 1st
- Elder Abuse 1st
- Kidnapping
 - Kidnapping
 - Child Kidnapping
 - Parental Kidnapping committed by detaining or concealing the whereabouts of the child for not less than one hundred twenty days under section 565.153, RSMo
- Murder
 - Murder 1st
 - Murder 2nd
- Rape
 - Forcible Rape
 - Statutory Rape 1st when the victim is a child less than twelve years of age at the time of the commission of the act giving rise to the offense
- Robbery 1st
- Sexual Assault
- Sodomy
 - Forcible Sodomy
 - Statutory Sodomy 1st when the victim is a child less than twelve years of age at the time of the commission of the act giving rise to the offense

					DOR 4.533
		RON DITTEMORE, DEPARTMENT DIRECTOR			
CHAPTER Program Implementation and Records	SUBCHAPTER Transfer Procedures	EFFECTIVE DATE 10-1-06	NUMBER OF PAGES 4	PAGE NUMBER 1 of 4	
SUBJECT Transfer to Biggs Forensic Center		AUTHORITY Federal Consent Decree Section 630.050.RSMo		HISTORY See below	
PERSON RESPONSIBLE Director, CPS			SUNSET DATE 7/1/10		

PURPOSE: Prescribes procedures for transfer to the Fulton State Hospital, Biggs Forensic Center (Excludes pretrial evaluations under Sections 552.020 and 552.030, RSMo.).

APPLICATION: Applies to the entire department.

(1) The Biggs Forensic Center has as its primary mission the evaluation, care, and treatment of clients committed under Chapter 552, RSMo. However, the department may admit to the Biggs Forensic Center (forensic center) under the provisions of this DOR any client committed or admitted to the department with the following exceptions:

(A) Competent adults admitted voluntarily under Chapter 632 RSMo, shall not be admitted to the forensic center unless they are Department of Corrections transfers.

(B) Minors under the age of eighteen (18) years, unless they are committed under Chapter 552, RSMo, and transfer to a non-maximum security adult ward has been determined inadequate under DOR 4.563 to provide the necessary security.

(2) All clients committed pursuant to section 552.020 or 552.030, RSMo, for a pretrial evaluation shall not be entitled to a pre or post transfer hearing as set out in this DOR. The director's authority to set the time, place, and conditions of these pretrial evaluations is pursuant to sections 552.020 and 552.030, RSMo.

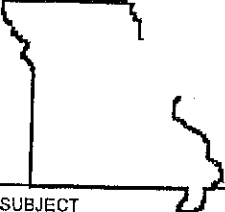

(3) All clients admitted from a county jail who are charged with Murder 1st degree, Sexual Assault, any dangerous felony as defined by section 556.061(8), RSMo, or the attempts of any of these crimes shall be admitted to Biggs Forensic Center and shall not be entitled to a pre or post transfer hearing as set out in this DOR.

(4) A pre or post transfer hearing as set out in this DOR shall not be necessary if written consent to the transfer is received from the client or guardian. A copy of the written consent shall be maintained in the client's file.

PRE-TRANSFER HEARING

(5) Clients considered for transfer to the forensic center shall be given a hearing before the transfer, except as set out in section (8), to determine the necessity and appropriateness of the proposed transfer to the forensic center.

(6) The following procedures shall apply to hearings held before transfer:

				DOR 4.533	
SUBJECT Transfer to Biggs Forensic Center		EFFECTIVE DATE 10-1-06		NUMBER OF PAGES 4	
				PAGE NUMBER 2 of 4	

(A) The head of the transferring facility shall notify the client, and any guardian on the Notice of Hearing on Transfer Request Form, of the hearing at least forty-eight (48) hours, excluding weekends and legal holidays, before the hearing and a copy of the notice shall be placed in the client's file. The notice shall contain:

1. The purpose, time and place of the hearing;
2. A specific account of the statements, occurrences, facts and conditions that are the basis for request for transfer;
3. A list of witnesses who may testify on behalf of the head of the transferring facility and a statement that the client or advocate shall have access to the witnesses prior to the hearing;
4. The client's rights, as set out in subsection (D) of this section.

(B) If the client needs assistance in understanding the notice, facility staff shall explain the notice and the client's rights regarding the hearing. The date and name of the person giving the oral explanation to the client shall be documented in the progress notes of the client's record.

(C) Clients shall have the right to be represented by an advocate of choice (e.g., attorney, Missouri Protection and Advocacy, facility patient advocate, parent, spouse, minister, guardian) at the hearing at no cost to the department. The advocate may meet with the client before the hearing, investigate the basis for the request for transfer, and attend the hearing. DMH staff will assist the client in arranging for an advocate if requested to do so by the client.

(D) Clients and their advocates shall have the following rights at the hearing:

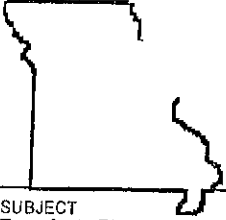

1. To be given a reasonable delay in holding the hearing for good cause shown to the DMH hearings administrator;
2. To present witnesses (e.g., family members, staff members, or other clients who are willing to testify);
3. To confront and cross-examine witnesses;
4. To appeal the decision of the hearing administrator as set out in section (10).

(E) The hearing administrator shall decide whether confinement in the forensic center is necessary and appropriate for the client.

1. The transfer is "necessary" if the client is dangerous and cannot be safely treated in a less restrictive setting than the forensic center;
2. The transfer is "appropriate" if the client can receive treatment at the forensic center that is reasonably appropriate for the client's needs;

(F) A hearing administrator appointed by the director of Department of Mental Health from among the staff of the central office of the department shall conduct the hearing.

1. The hearing shall be tape recorded and the tapes kept for at least one year. Upon appeal or good cause shown, a transcription of the proceedings shall be given to the client and/or the client's advocate.
2. The head of the transferring facility shall have the burden to show that confinement in the forensic center is necessary and appropriate for the client. The

		RON DITTEMORE, DEPARTMENT DIRECTOR			DOR 4.533
		SUBJECT Transfer to Biggs Forensic Center	EFFECTIVE DATE 10-1-06		NUMBER OF PAGES 4

superintendent of the facility requesting a transfer shall designate a staff member to present the facility's position.

3. At the discretion of the hearing administrator, in consultation with the facility and the client or his representative, witnesses may either remain in the hearing room or be called in as they are needed to testify.

4. The hearing administrator's decision shall be based solely on the evidence introduced at the hearing and is restricted to either sending the client to the Biggs Forensic Center or retaining the client in the referring facility.

(7) Within five (5) working days after the hearing, the hearing administrator shall give a written order for or against transfer.

(A) The order shall contain the facts presented at the hearing, the specific reasons for the hearing administrator's decision, especially stating why the proposed transfer is or is not necessary and appropriate and, if the order is for transfer, a statement of the procedures for appealing the hearing administrator's order.

(B) A copy of the order shall be placed in the client's file and a copy given to the client, client advocate, any guardian, the heads of the transferring and proposed receiving facilities and the division director within forty-eight (48) hours after the order is issued.

POST TRANSFER HEARING

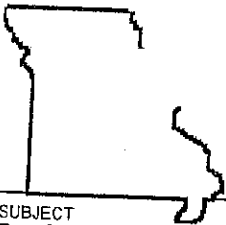

(8) If a facility head decides there is imminent danger that a client will cause serious harm to others, the client may be transferred to the forensic center before a hearing. Before any transfer shall occur, the head of the transferring facility shall contact the superintendent of Fulton State Hospital to obtain approval for immediate admission to the forensic center. Prior to the post transfer hearing, the sending facility shall state, in writing, to the client, the specific reasons for a post transfer hearing and that such a hearing shall be conducted within five (5) working days of transfer. A copy of the statement shall be placed in the client's file and a copy given to the client, any guardian, and the division director.

(9) All of the provisions of sections (6) and (7) shall apply to hearings after transfer except that the hearing shall be arranged by Fulton State Hospital and held within five (5) working days after the transfer. Notice shall be made on the Notice of Hearing on Transfer Form.

APPEAL PROCESS

(10) A client, the client's advocate, guardian or the head of the transferring or receiving facility may appeal the decision of the hearing administrator as set out below:

(A) Within fifteen (15) days after receipt of the hearing administrator's order, the client or representative may appeal the hearing administrator's order in writing to the department director. Within five (5) working days after receipt of the hearing

		RON DITTEMORE, DEPARTMENT DIRECTOR			DOR 4.533
		SUBJECT Transfer to Biggs Forensic Center	EFFECTIVE DATE 10-1-06		NUMBER OF PAGES 4

administrator's order, the head of the transferring or receiving facility may appeal the hearing administrator's order in writing to the department director. If either the facility or the client appeals the decision, they shall include in the appeal the basis for such appeal. The department director shall send a copy of the letter of appeal to the client, the client's advocate, and the heads of the transferring and receiving facilities.

(B) Upon receipt of the letter of appeal, the department director shall order a transcription of the hearing and such transcription shall be prepared and delivered to the department director within fifteen (15) working days after the order.

(C) The department director shall review the client's records and transcription of the hearing and shall, within five (5) working days after receiving the records and transcription, affirm or overrule the hearing administrator's decision.

(D) While the department director is reviewing the decision, the client, the client's representative, the heads of the transferring and receiving facilities may review the hearing administrator's order and submit comments to the department director. Such comments, shall be submitted to the department director within fifteen (15) working days after the date of the order to be considered as part of the appeal.

(E) Copies of the department director's written order shall be given to the client, the client's advocate, guardian, the heads of the transferring and receiving facilities and a copy shall be placed in the client's file.

(11) Failure to comply or assure compliance with the provisions of this DOR may be cause for disciplinary action, up to and including dismissal.

HISTORY: Original DOR effective July 1, 1986 replacing Operating Regulations 138 and 188. Amendment effective May 30, 1989. Amendment effective September 1, 1994. Amendment effective February 15, 2001. Amendment effective June 1, 2004. Amendment effective October 1, 2006.

PRE-TRANSFER HEARING PROCESS

(Non-Emergency)

Purpose:

To afford a fair hearing for clients referred for transfer to the Maximum Security unit at Fulton State Hospital (Biggs Forensic Center).

Requirements: On Whom and When:

All non-emergency transfer hearings must be held within ten working days of referral by Superintendent of the sending facility.

By Whom:

Hearings Officer of Missouri Department of Mental Health (Central Office).

Procedure:

1. Treatment team submits Transfer to Maximum Security Unit Request Form to the Superintendent. If the Superintendent concurs, the Superintendent or designee contacts the Hearing Officer to set a date and time for the Pre-Transfer Hearing.
2. At least 48 hours prior to the hearing, the client is given written notice of the hearing. If the person has a guardian, that person shall also be notified (see attached notification letter).
3. Such notice shall be signed by the Superintendent or designee and shall contain the following:
 - A. Date, time, place, and purpose of the hearing.
 - B. Specific incidents and statements which are the basis for consideration of transfer.
 - C. A list of witnesses who may be called to testify at the hearing. The client or advocate shall have access to the witnesses prior to the hearing.
 - D. Client's rights at hearing.
 1. To be present at the hearing, and to present witnesses (e.g., family members, staff members, or other clients who are willing to testify);
 2. To have a representative at the hearing to help the client represent his or her position;
 3. To be confronted with the reason why such a transfer is necessary;
 4. To cross-examine facility's witnesses; and
 5. To appeal the decision of the Hearing Officer.
4. The hearing may be postponed for good cause by contacting the Hearing Officer.
5. Within five working days after the Transfer Hearing, the Hearing Officer shall notify the client and the Superintendent of the referring facility of the Hearing Officer's recommendation as to whether the client should be transferred to Maximum Security or remain in the present facility. Included in this notification will be the appeal process should the client be transferred to Maximum Security. A copy of the order shall be placed in the client's file and copies given to the client, client advocate, and the client's guardian.
6. Factors to be considered regarding transfer:
 - A. The nature of the crime, if any, which caused the client to be committed to the Department, if any;
 - B. The current behavior of the client which indicates a need for a maximum security setting;

- C. What less restrictive alternatives have been used to try to control the behavior of the client;
 - D. Whether the client presents an escape risk and would pose a danger if in a less restrictive setting.
7. If the Hearing Officer's decision is to send the client to Maximum Security, the client has 15 days after receipt of the Hearing Officer's order to appeal the decision to the Director of the Missouri Department of Mental Health. The head of the transferring or receiving facility has five working days after receipt of the Hearing Officer's decision to appeal that decision to the Department Director.
 8. While the Department Director is reviewing the decision, the client, the client's representative and/or advocate, the heads of the transferring and receiving facilities may review the Hearing Officer's order and submit comments to the Department Director.

Authority:

Consent decree (Williams v. Hill)
DOR 4.533

POST-TRANSFER PROCESS

(Emergency)

Purpose:

To afford a fair hearing for clients who have been transferred to the Maximum Security Unit of Fulton State Hospital (Biggs Forensic Center) on an emergency basis.

Requirements: On Whom and When:

All clients transferred to Maximum Security on an emergency basis. Notice of the hearing must be given within five working days of transfer. The hearing must be held within five working days of the notice.

By Whom:

Hearing Officer in the Department of Mental Health (Central Office).

Procedure:

1. Superintendent of Fulton State Hospital or designee contacts Hearing Officer to set a date for a Post-Transfer Hearing.
2. At least 48 hours prior to the hearing, the client receives written notice of the hearing from the Superintendent or designee of the Maximum Security unit of Fulton State Hospital (see notification letter in Appendix). If the client has a guardian, the guardian shall also be notified.
3. Such notice shall be signed by the Superintendent or designee and shall contain the following:
 - A. Date, time, and place of the hearing.
 - B. Incidents and statements which are the basis for the emergency transfer.
 - C. A list of witnesses who may be called to testify at the hearing. The client or advocate shall have access to the witnesses prior to the hearing.
 - D. Client's rights at hearing.
 1. To be present at the hearing, and to present witnesses (e.g. family members, staff members, or other clients who are willing to testify);
 2. To have a representative at the hearing to help the client represent his or her position;
 3. To be confronted with the reason why such a transfer is necessary;
 4. To cross-examine facility's witnesses; and
 5. To appeal the decision of the Hearing Officer.
4. The hearing may be postponed for good cause by contacting the Hearing Officer.
5. Within five working days after the Transfer Hearing, the Hearing Officer shall notify the client and the Superintendent of Fulton State Hospital of the Hearing Officer's recommendation as to whether the client should be retained in Maximum Security or be returned to the sending facility. Included in this notification will be the appeal process should the client be retained in Maximum Security. A copy of the order shall be placed in the client's file and copies given to the client, client advocate, and the client's guardian.
6. Factors to be considered regarding continued treatment in a Maximum Security setting:
 - A. The nature of the crime, if any, that caused the client to be committed to the Department.

- B. The current behavior of the client which indicates a need for a Maximum Security setting.
 - C. What less restrictive alternatives have been used to try to control the behavior of the client.
 - D. Whether the client presents an escape risk and would pose a danger if in a less restrictive setting.
7. If the Hearing Officer's decision is to retain the client in Maximum Security, the client has fifteen days after receipt of the Hearing Officer's order to appeal the decision to the Director of the Department of Mental Health. The head of the transferring or receiving facility has five working days after receipt of the Hearing Officer's decision to appeal that decision to the Department Director.
 8. While the Department Director is reviewing the decision, the client, the client's representative and/or advocate, or the heads of the transferring and receiving facilities may review the Hearing Officer's order and submit comments to the Department Director.

Authority:

Consent decree (Williams v. Hill)
DOR 4.533

SENDING FACILITY'S NOTICE OF TRANSFER/EMERGENCY

(Date)

(Client's Name)

(Unit and Ward)

Dear _____:

You are being transferred on an emergency basis to the maximum security unit of Fulton State Hospital on _____ . The reason for this transfer was because of your behavior as described below:

As a result of your transfer to the maximum security unit, you are entitled to a hearing within five (5) working days of transfer to see if you need to remain in maximum security. The staff of Fulton State Hospital will notify you of the specific time of the hearing and your rights at the hearing.

Sincerely,

Superintendent

cc: CPS Division Director
Guardian (if any)
Client File
DMH Assistant General Counsel

TRANSFER LETTER/NON-EMERGENCY

(Date)

(Client name)
(Facility)
(Facility address)
(City, State, Zip)

Dear (Client name):

This is to inform you that I am recommending that you be transferred to the maximum security facility at Fulton State Hospital. I have taken this action because of your behavior described below:

Since your admission to (facility name) on (date), you have shown increased threatening and aggressive behavior. During this time you have engaged in numerous harmful and potentially harmful acts, have been verbally and physically intimidating towards clients and staff, have threatened serious harm to clients and staff, and have created a danger to yourself and others. Specifically, on (date), you assaulted staff (initials) while being escorted to seclusion, on (date) you assaulted and provoked a fight with another client (initials), and on (date) you intentionally stomped on a staff member's (initials) foot.

(ADD ANY ADDITIONAL INCIDENTS HERE)

In accordance with Missouri Department of Mental Health Operating Regulation Number 4.533, a hearing has been set for (DATE) at (TIME) in (Facility name) in Room (NUMBER).

At this hearing, the appropriate hospital staff will present the facts that they feel necessitate your transfer to the maximum security facility. You have the right to attend this hearing and to call your own witnesses to contradict or otherwise show that your transfer to the maximum security facility is not necessary or unduly restrictive. You also have the right to request someone of your choice to represent you, such as an attorney, parent, spouse, or legal guardian. However, any expenses incurred in obtaining witnesses, and/or representatives must be borne by you. The hearings officer may call additional witnesses as he or she sees fit, and, upon your request, may call witnesses on your behalf. You and/or your representative have a right to question any witness on any point you feel is important so that all the facts are fully developed.

The following persons may be called during the hearing as witnesses for (Facility name):

Fill in names, degrees & titles, if known, here

If the time set for the hearing is not suitable to you, you should notify me in writing within twenty-four (24) hours of receipt of this letter and suggest a time more convenient for you. You are entitled to a reasonable delay of the time of hearing if you have a good reason.

After the hearing, the following procedures will be followed:

- 1) Within five (5) working days following the hearing, the hearings officer will make a decision regarding his or her findings and recommendations. Within 48 hours, a copy of this notice will be placed in your medical file and a copy will be sent to me, the Superintendent of Fulton State Hospital, the Director of the Division of Comprehensive Psychiatric Services of the Department of Mental Health, and any representative you have designated.
- 2) Within five (5) working days after I receive notice from the hearings officer, I will notify you in writing as to my decision to affirm or appeal his or her recommendation. If I appeal, I must make that appeal in writing to the Director of the Department of Mental Health.
- 3) If the transfer request is granted by the Hearings Officer, you will have fifteen (15) days after receipt of his/her notice to appeal my decision in writing to the Director of the Department of Mental Health.
- 4) If you do not understand any part of this letter, you should have you social worker or other mental health professional staff person explain it to you so that you will be fully informed of your rights and the procedures to be followed.

Sincerely yours,

Name of Facility CEO/Supt/Director
Title

I (do/do not) desire to designate a representative to assist me at the hearing.

I (do/do not) desire an extension of time for the hearing. If so, why?

(client signature)

Original presented to client on *(DATE)* at *(TIME)*.

By: _____

(Name)

cc: Hearings Officer

Client's Medical Record

PRE- AND POST-TRANSFER HEARINGS FROM MENTAL HEALTH FACILITIES TO THE BIGGS FORENSIC CENTER

Purpose:

Pre- and post-transfer hearings shall be conducted when a mental health facility has a client for whom it is believed that a transfer to the Biggs Forensic Center (Biggs) is *both necessary and appropriate*. Such a transfer is *necessary* if the client is dangerous and cannot be safely treated in a less restrictive setting. The transfer is *appropriate* if the client can receive treatment at Biggs that is reasonably appropriate for the client's needs. The hearings for such transfers are required by Federal Consent Decree, a court order, which mandates certain due process requirements be met in order to justify the move into a maximum security setting. Such transfers cannot be agreed upon nor can the hearings waived; the procedures outlined in this section must be followed.

While pre-transfer hearings are recommended (meaning that the client is **NOT** transferred to Biggs prior to a determination by the Hearings Administrator approving the transfer), clients may be transferred on an emergency basis to Biggs when circumstances dictate that there is imminent danger that a client will cause serious harm to others. Such emergency transfers are negotiated between the transferring facility's chief operating officer and the chief operating officer of Fulton State Hospital, or their respective designees. Any questions staff from the transferring facility may have regarding whether the circumstances rise to an emergency level should be addressed to the Assistant General Counsel assigned to the transferring facility and any questions staff from the receiving facility may have on this matter should be addressed to the Assistant General Counsel assigned to the receiving facility. **A post-transfer hearing must then take place within five (5) working days of the transfer, and will be conducted at Fulton State Hospital.** The fact that staff may have to travel to Fulton to testify should not be the deciding factor on whether the transfer is of an emergency nature. Nor should it be a factor in the determination of whether transfer to maximum security or intermediate security is most appropriate.

Department of Mental Health Clients Entitled to Pre or Post-Transfer Hearings:

- 1) The pre-and post-transfer hearing process applies to forensic clients committed pursuant to Chapter 552 of the Revised Statutes of Missouri, clients civilly committed pursuant to Chapter 632 of the Revised Statutes of Missouri, and/or any client who has a legal guardian.
- 2) Transfers may **NOT** be made for voluntary clients who do **NOT** have a guardian. Transfers may also **NOT** be made for minors under eighteen (18) years of age who have not been certified to stand trial as an adult.
- 3) Transfer hearings are **NOT** required for those clients committed by court order for inpatient pretrial evaluations. Pursuant to Section 552.020.2 of the Revised Statutes of Missouri, the Director of the Department of Mental Health has the discretion to set the time, place, and conditions of the pretrial evaluation.
- 4) Transfer hearings are **NOT** required for those clients who received a pre-transfer hearing and are transferred to Biggs on an emergency basis before a decision is issued from the pre-transfer hearing that supports the transfer.
- 5) Transfer hearings are **NOT** required for those clients who are directly admitted to Biggs pursuant to the major crimes list.

**HEARINGS PROCESS: TRANSFER OF ADULTS
TO BIGGS FORENSIC CENTER**

- 1) Missouri Department Operating Regulation 4.533 sets forth the process for both pre-and post-transfer hearings.

- 2) At the hearing it is not required that the transferring facility be represented by legal counsel. The transferring facility will designate an individual to appear at the hearing and present evidence to support the transferring facility's position that the transfer is both necessary and appropriate. This person may be the facility's transfer hearings coordinator. In any event, at the hearing this person serves as the Facility Representative for the transferring facility. This is allowed by Department Operating Regulation 4.533 (4) (F) 2.
 - A) The only exception to this is if the client obtains an attorney to represent him/her. If there is an attorney representing the client, the transferring facility must have an Assistant General Counsel present the case at the hearing. As soon as staff from the transferring facility, Biggs, or the transferring facility hearings coordinator learns that an attorney will represent the client, the Assistant General Counsel's office for the region the transferring facility is located in shall be immediately contacted. A list of the Assistant General Counsels assigned to each facility is contained in the Appendix section of this manual.

- 3) When a decision is made to transfer a client to Biggs on an emergency basis, prior to the transfer taking place, the transferring facility must provide the client with a letter informing him/her of the transfer, the reasons for the transfer, that the client is entitled to a hearing, and that staff at Biggs will inform the client of the specific time of the hearing, and the client's rights at the hearing. A sample of this letter is included in the Appendix section of the manual.

- 4) In the case of a pre-transfer hearing, the transferring facility **must** provide the client with notice of the hearing at least forty-eight (48) hours prior to the hearing date and time which outlines:

- the purpose, time, and place of the hearing,
- a specific account of the statements, occurrences, facts, and conditions that are the basis for the transfer request (think of this as the what, where, when, why, and how of the pre-transfer hearing notice); and
- a list of witnesses who would testify at the hearing. This list should include all prospective witnesses.

At the hearing, the Pre-Transfer Hearing Notice should be offered as an exhibit by the Facility Representative.

5) In the case of a post-transfer hearing, the receiving facility **must** provide the client with notice of the hearing at least forty-eight (48) hours prior to the hearing date and time which outlines:

- the purpose, time, and place of the hearing;
- a specific account of the statements, occurrences, facts, and conditions that are the basis for the transfer request (think of this as the what, where, when, why, and how of the post-transfer hearing notice); and
- a list of witnesses who would testify at the hearing. This list should include all prospective witnesses.

At the hearing, the Post-Transfer Hearing Notice should be offered as an exhibit by the Facility Representative.

6) **If a witness is not listed on the notice of transfer hearing provided to the client, the Hearings Administrator will not allow the witness to testify at the hearing.** Therefore, it becomes very important to place all names of prospective witnesses on the notice of transfer hearing. If after the notice has been served on the client, the Facility Representative determines he/she needs to add or substitute a witness, the Facility Representative must contact the Hearings Administrator and obtain approval for the proposed witness to testify. If the Hearings Administrator agrees to allow the witness to testify, prior to the commencement of the hearing, the receiving facility in post-transfer cases and the transferring

facility in pre-transfer cases shall provide the client, his/her guardian, and/or advocate with written notice of the new or substituted witness.

7) The notice of transfer hearing is to be presented to the client and the client's guardian, if any. The client should sign the acknowledgement receipt which may be a separate page that is attached to the notice or contained at the bottom of the notice. If possible, the client's guardian should sign the acknowledgement receipt. If the client refuses to sign the acknowledgement receipt, the individual who presented the notice to the client shall have a witness note on the acknowledgement receipt that the client refused to sign. At the hearing, the notice of transfer hearing and the acknowledgement of receipt shall be offered as an exhibit by the Facility Representative. If the client's guardian agrees with the transfer, then the Facility Representative should have the guardian state his/her position in a notarized written statement. A sample consent to transfer is included in the Appendix section of this Manual.

8) The date and time of the hearing in pre-transfer cases is determined by the transferring facility's hearings coordinator contacting the Department of Mental Health's Hearings Administrator (currently Debra M. Miles) **by telephone (not e-mail)** to arrange a mutually convenient date and time for the hearing. **The telephone number of the Hearings Administrator is (573)751-8097.** The transferring facility's hearings coordinator shall arrange for a room at the facility in which to conduct the hearing. That room number or name should be included in the notice of transfer hearing that is presented to the client.

9) In post-transfer cases the admissions clerk at Biggs contacts the Hearings Administrator to schedule the hearing and is responsible for ensuring that the hearing notice is prepared, served on the client and/or guardian and providing a copy of the notice to the hearings coordinator for the transferring facility. **In both pre- and post-transfer hearings, a copy of the hearing notice must be provided to the Hearings Administrator immediately after it is served on the client.** The Hearings Administrator reviews the hearing notice prior the hearing to give her an overview of the allegations that are the subject of the hearing. **The fax number for the Hearings Administrator is (573) 522-6259.**

10) In all post-transfer cases, the Department Operating Regulation sets forth a specific time period in which a post-transfer hearing shall be held. After discussing the matter with the Hearings Administrator and the Assistant General Counsel for the transferring facility and a determination

has been made that it is not practical to conduct the hearing within the time period specified, the Facility Representative may ask the client to consent to waiving the timeline for the hearing. **However, in no circumstances is the client required to waive the timeline.** A sample waiver of timeline for transfer hearing is included in the Appendix section of the manual.

11) Once the hearing is set:

- The Facility Representative should review and become familiar with the Guidelines or Standards of Practice in Administrative Hearings held before the Missouri Department of Mental Health. Copies of the Guidelines may be obtained by contacting the Hearings Administrator at (573) 751-8097. A copy of the Guidelines is included in the Appendix section of this manual. The Guidelines outline the procedures for all Department of Mental Health administrative hearings, which include but is not limited to transfer hearings.
- The Facility Representative should meet with each of the witnesses who will be testifying to review their knowledge of or role in any event(s) that are the basis for the transfer as well as to review any information they may have regarding the appropriateness of the transfer. This meeting should occur before the date of the hearing. If the Facility Representative intends to call as a witness a staff member from Biggs, he/she should make arrangements to speak with that witness before the hearing. The Facility Representative may make arrangements to speak with any witness, including a witness from Biggs, by telephone or in-person prior to the hearing. The Facility Representative is expected to have spoken with all of his/her witnesses prior to the commencement of the hearing and should not expect the Hearings Administrator to delay the hearing for him/her to speak with any witnesses, including but not limited to those from Biggs.
- If a potential witness completed a statement, made an entry into the progress notes, wrote restraint/seclusion or other medical orders, or completed an Incident and Injury Report, copies of the document(s) should be made and submitted at the hearing. Each document should be marked with an alphabetical or numerical designation such as a "Facility Exhibit A" or "Facility Exhibit 1". The Facility

Representative should be consistent in his/her designation. In other words, all exhibits are marked alphabetically or numerically, not both.

- The Facility Representative shall also present witnesses and other evidence regarding all least restrictive steps that have been taken with no success while the client resided at the transferring facility. The Hearings Administrator will want to know what was tried, what failed, and why other treatment options are not appropriate for this client. Examples would include what medications were tried, what medications may not be appropriate, what verbal interventions or redirections were attempted without success, and how long and how often the person has had to be in restraint/seclusion, etc. Again, these are only examples. The testimony in each case will need to be tailored to that specific fact situation.
- After meeting with the witnesses, the Facility Representative should organize the presentation to the Hearings Administrator. It is important to determine how many witnesses to each incident will be necessary. It may not be necessary to present twenty (20) witnesses to the same incident. The Hearings Administrator **will not** allow the presentation of repetitive or duplicative witnesses or documents.
- Questions for a variety of witnesses/professions are included in the Appendix section of this manual as sample questions. These are to be considered sample only and should be tailored to the individual circumstances involved in each hearing. When reviewing the attached sample questions, in no way should the Facility Representative assume that the Chief Executive Officer, Chief Operating Officer, or the Medical Director should be called to testify in every case, but should only be called if absolutely necessary.
- The Facility Representative should obtain a copy of the original commitment order for the client and if there has been a change in the client's commitment status, a copy of the current commitment order should also be obtained. This document(s) should be offered as an exhibit(s) at the transfer hearing.
- The Facility Representative should make contact with, or assign another facility staff to make contact with, a representative of Fulton State Hospital to learn what security measures are available and what treatment is available there that is appropriate for the client for whom

transfer is being requested. The Facility Representative should have a witness testify who will provide that information the Hearings Administrator during the transfer hearing. **It is the responsibility of the Facility Representative to present all evidence that the transfer is necessary in that only Biggs can provide needed security and appropriate in that Biggs can provide needed treatment. The Facility Representative should not expect or rely upon the Hearings Administrator to call or question witnesses to ascertain information that is relevant to determining whether the transfer is necessary and appropriate.**

- The Facility Representative may choose to organize his/her presentation using an exhibit list. A sample exhibit list is included in the Appendix section of this manual.

12) At the hearing:

- The Facility Representative should have a witness list prepared and ready to present to the Hearings Administrator. A form witness list is included in the Appendix section of this manual. This witness list is different from the list of witnesses in the notice of transfer hearing. The witnesses stated on the witness list are the people who **will** testify at the hearing. The list of witnesses in the notice of transfer hearing are the people who may testify.
- The client has specific rights, as set forth in Department Operating Regulation 4.533. The Facility Representative should be familiar with these rights.
- After reading the introductory script, the Hearings Administrator will ask both parties if they have any preliminary matters. This is the time to advise the Hearings Administrator of any stipulations the parties have reached. Also, at this time, if the Facility Representative chooses to do so, he/she could request that the client or his/her advocate stipulate that the witnesses who will testify at the hearing for the transferring facility have the appropriate education and credentials. If the client so stipulates, then the Hearings Administrator will note this on the record. It may also include a stipulation as to which documents can be admitted into evidence. During this time, the Hearings Administrator will officially admit into evidence any

documents that the parties have stipulated may be admitted into evidence.

- The Facility Representative may make an opening and closing statement to the Hearings Administrator. Opening and closing statements are not required. The Hearings Administrator reviews the notice of transfer hearing prior to the hearing and is aware of the allegations prior to the commencement of the hearing; therefore, an opening statement may not be necessary. The Hearings Administrator has listened to the testimony of the witnesses; therefore, a closing statement may not be needed.
- The Facility Representative will first present witnesses as to why the transfer is (was) necessary and appropriate. The Facility Representative should bring copies of his/her proposed exhibits for the client. If possible, the Facility Representative should provide copies of his/her proposed exhibits to the client's advocate or guardian (if the guardian will be participating in the hearing either by telephone or in person) prior to the hearing. In any event, the Hearings Administrator will ask the client's advocate or guardian if he/she will stipulate or agree to the transferring facility's exhibits being admitted into evidence. If an agreement is obtained, then the Hearings Administrator will admit the stipulated exhibit(s) into evidence and such exhibit(s) do not need to be introduced with a witness. **If the client's advocate or guardian does not stipulate to the admission of an exhibit, then the Facility Representative must offer that exhibit with the appropriate witness.** The following questions should be asked by the Facility Representative to the appropriate witness in order to properly request the introduction of an exhibit into evidence:
 1. Have you received any correspondence or made any record concerning (client's name)?
 2. I hand you what has been what has been marked for identification as Facility Exhibit _____.
 - Do you recognize this document?
 - Is the information recorded in this document recorded at or near the time of the occurrence?

- Is it a regular part of the duties of (employee who recorded the information or in the course of business for the facility) to record such information in the records?
- What is the document?
- What is the document used for?
- Is this document a true and accurate copy of the document as it appears in the client's chart?

After this series of questions has been answered, the Facility Representative requests a document be admitted into evidence by stating to the Hearings Administrator at this time "I offer Facility Exhibit ___ into evidence". The Hearings Administrator will ask the client or his/her advocate or guardian if he/she has any objection(s) to the exhibit. The Hearings Administrator determines if the Facility's exhibit will be admitted into evidence.

- After the Facility Representative is done questioning each of his/her witnesses, before the witness is excused from the hearing room, the client and his/her advocate or guardian has the opportunity to ask questions of each of the Facility's witnesses.
- After the Facility Representative presents its case for the transferring facility, the client will have an opportunity to present information such as witness testimony and/or written documents to the Hearings Administrator. The Facility Representative will have the opportunity to question any witnesses the client presents as well as the client if the client chooses to testify.
- If the client testifies or offers evidence, the Hearings Administrator will give the Facility Representative the opportunity to present rebuttal witnesses. The purpose of a rebuttal witness is to present testimony or evidence to contradict testimony or evidence presented by the client. The rebuttal witness may be selected from the list of prospective witnesses set forth in the notice of hearing and /or the Facility's witness list that was presented to the Hearings Administrator at the beginning of the hearing. The Facility Representative is not required to present rebuttal witnesses.
- After all the witnesses have testified and the exhibits admitted into evidence, **the Hearings Administrator concludes the hearing and then has five (5) working days after the hearing to make her**

decision regarding the transfer. A copy of the decision will be sent to the parties required to be notified by Department Operating Regulation 4.533 (5) (B).

13) At any time prior to the hearing, the Facility Representative may ask questions of the Assistant General Counsel in order to facilitate the preparation for the hearing. If the Facility Representative or admissions clerk at Biggs has any questions regarding preparing the appropriate notices, who should serve as witnesses, what questions to ask witnesses, or how to question witnesses as well as what documents to present at the hearing as evidence, he/she should discuss these matters with the Assistant General Counsel assigned to his/her facility.

Business Associate Agreement
Between the Missouri Department of Mental Health
and _____

This Agreement between the Missouri Department of Mental Health and _____ is being entered into in order to plan and participate in a data exchange to facilitate and coordinate treatment to adults and their families.

WHEREAS, both the Missouri Department of Mental Health and _____ are covered entities under the Privacy Rule and Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, and 45 CFR 160.103(3) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) (collectively, and hereinafter, HIPAA) and all regulations promulgated pursuant to authority granted therein;

WHEREAS, the Missouri Department of Mental Health is committed to the prevention, treatment, and promotion of public understanding for Missourians with mental illnesses, developmental disabilities, and addiction;

WHEREAS _____, will work with the Missouri Department of Mental Health in furthering its mission and commitments under this Agreement;

WHEREAS, the work under this agreement is to begin in ____ 2010 and end in ____ 2010.

THEREFORE, the undersigned participants agree that the following describes in part the roles and responsibilities of the participants as it relates to this Agreement:

- 1.1.1 Health Insurance Portability and Accountability Act of 1996, as amended - The Department of Mental Health (hereinafter “state agency”), and _____ are both subject to and must comply with provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) (collectively, and hereinafter, HIPAA) and all regulations promulgated pursuant to authority granted therein. The contractor constitutes a “Business Associate” of the state agency as such term is defined in the Code of Federal Regulations (CFR) at 45 CFR 160.103. Therefore, the term, “contractor” as used in this section shall mean “Business Associate.”
- a. The contractor shall agree and understand that for purposes of the Business Associate Provisions contained herein, terms used but not otherwise defined shall have the same meaning as those terms defined in 45 CFR parts 160 and 164 and 42 U.S.C. §§ 17921 *et. seq.* including, but not limited to the following:
- 1) “Access”, “administrative safeguards”, “confidentiality”, “covered entity”, “data aggregation”, “designated record set”, “disclosure”, “hybrid entity”, “information system”, “physical safeguards”, “required by law”, “technical safeguards”, “use” and “workforce” shall have the same meanings as defined in 45 CFR 160.103, 164.103, 164.304, and 164.501 and HIPAA.
 - 2) “Breach” shall mean the unauthorized acquisition, access, use, or disclosure of Protected Health Information which compromises the security or privacy of such information, except as provided in 42 U.S.C. § 17921. This definition shall not apply to the term “breach of contract” as used within the contract.
 - 3) “Electronic Protected Health Information” shall mean information that comes within paragraphs (1)(i) or (1)(ii) of the definition of Protected Health Information as specified below.

- 4) “Enforcement Rule” shall mean the HIPAA Administrative Simplification: Enforcement; Final Rule at 45 CFR parts 160 and 164.
 - 5) “Individual” shall have the same meaning as the term “individual” in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502 (g).
 - 6) “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.
 - 7) “Protected Health Information” as defined in 45 CFR 160.103, shall mean individually identifiable health information:
 - (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; or (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
 - (2) Protected Health Information excludes individually identifiable health information in (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity (state agency) in its role as employer.
 - 8) “Security Incident” shall be defined as set forth in the “Obligations of the Contractor” section of the Business Associate Provisions.
 - 9) “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 164, subpart C.
 - 10) “Unsecured Protected Health Information” shall mean Protected Health Information that is not secured through the use of a technology or methodology determined in accordance with 42 U.S.C. § 17932 or as otherwise specified by the secretary of Health and Human Services.
- b. The contractor agrees and understands that wherever in this document the term Protected Health Information is used, it shall also be deemed to include Electronic Protected Health Information.
 - c. The contractor must appropriately safeguard Protected Health Information which the contractor receives from or creates or receives on behalf of the state agency. To provide reasonable assurance of appropriate safeguards, the contractor shall comply with the Business Associate Provisions stated herein.
 - d. The state agency and the contractor agree to amend the contract as is necessary for the parties to comply with the requirements of HIPAA and the Privacy Rule, Security Rule, Enforcement Rule, and other rules as later promulgated (hereinafter referenced as the regulations promulgated thereunder).

1.1.2 Permitted uses and disclosures of Protected Health Information:

- a. The contractor may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the state agency as specified in the contract, provided that such use or disclosure would not violate HIPAA and the regulations promulgated thereunder.
- b. The contractor may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1) and shall notify the state agency by no later than ten (10) calendar days after the contractor becomes aware of the disclosure of the Protected Health Information.
- c. If required to properly perform the contract and subject to the terms of the contract, the contractor may use or disclose Protected Health Information if necessary for the proper management and administration of the contractor’s business.
- d. If the disclosure is required by law, the contractor may disclose Protected Health Information to carry out the legal responsibilities of the contractor.

- e. The contractor may use Protected Health Information to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B).

1.1.3 Obligations of the Contractor:

- a. The contractor shall not use or disclose Protected Health Information other than as permitted or required by the contract or as otherwise required by law, and shall comply with the minimum necessary disclosure requirements set forth in 45 CFR § 164.502(b).
- b. The contractor shall use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by the contract. Such safeguards shall include, but not be limited to:
 - 1) Workforce training on the appropriate uses and disclosures of Protected Health Information pursuant to the terms of the contract.
 - 2) Policies and procedures implemented by the contractor to prevent inappropriate uses and disclosures of Protected Health Information by its workforce.
 - 3) Any other safeguards necessary to prevent the inappropriate use or disclosure of Protected Health Information.
- c. With respect to Electronic Protected Health Information, the contractor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that contractor creates, receives, maintains or transmits on behalf of the state agency.
- d. The contractor shall require that any agent or subcontractor to whom the contractor provides any Protected Health Information received from, created by, or received by the contractor pursuant to the contract, also agrees to the same restrictions and conditions stated herein that apply to the contractor with respect to such information. *Note: Although HIPAA requires these paragraphs to be included, 42 C.F.R. Section 2.11 requires qualified service organizations to abide by the federal drug and alcohol regulations which prohibit such organizations from redisclosing any patient identifying information even to an agent or subcontractor.*
- e. By no later than ten (10) calendar days of receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the contractor shall make the contractor's internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by, or received by the contractor on behalf of the state agency available to the state agency and/or to the Secretary of the Department of Health and Human Services or designee for purposes of determining compliance with the Privacy Rule.
- f. The contractor shall document any disclosures and information related to such disclosures of Protected Health Information as would be required for the state agency to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 42 USCA §17932 and 45 CFR 164.528. By no later than five (5) calendar days of receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the contractor shall provide an accounting of disclosures of Protected Health Information regarding an individual to the state agency. If requested by the state agency or the individual, the contractor shall provide an accounting of disclosures directly to the individual. The contractor shall maintain a record of any accounting made directly to an individual at the individual's request and shall provide such record to the state agency upon request. *Note: Although HIPAA requires these paragraphs to be included, 42 C.F.R. Section 2.11 requires qualified service organizations to abide by the federal drug and alcohol regulations which prohibit such organizations from redisclosing any patient identifying information even to an agent or subcontractor.*

- g. In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, the contractor shall, within five (5) calendar days following a state agency request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, provide the state agency access to the Protected Health Information in an individual's designated record set. However, if requested by the state agency, the contractor shall provide access to the Protected Health Information in a designated record set directly to the individual for whom such information relates.
- h. At the direction of the state agency, the contractor shall promptly make any amendment(s) to Protected Health Information in a Designated Record Set pursuant to 45 CFR 164.526.
- i. The contractor shall report to the state agency's Security Officer any security incident immediately upon becoming aware of such incident and shall take immediate action to stop the continuation of any such incident. For purposes of this paragraph, security incident shall mean the attempted or successful unauthorized access, use, modification or destruction of information or interference with systems operations in an information system. This does not include trivial incidents that occur on a daily basis, such as scans, "pings," or unsuccessful attempts that do not penetrate computer networks or servers or result in interference with system operations. By no later than five (5) days after the contractor becomes aware of such incident, the contractor shall provide the state agency's Security Officer with a description of any remedial action taken to mitigate any harmful effect of such incident and a proposed written plan of action for approval that describes plans for preventing any such future security incidents.
- j. The contractor shall report to the state agency's Privacy Officer any unauthorized use or disclosure of Protected Health Information not permitted or required as stated herein immediately upon becoming aware of such use or disclosure and shall take immediate action to stop the unauthorized use or disclosure. By no later than five (5) calendar days after the contractor becomes aware of any such use or disclosure, the contractor shall provide the state agency's Privacy Officer with a written description of any remedial action taken to mitigate any harmful effect of such disclosure and a proposed written plan of action for approval that describes plans for preventing any such future unauthorized uses or disclosures.
- k. The contractor shall report to the state agency's Security Officer any breach immediately upon becoming aware of such incident and shall take immediate action to stop the continuation of any such incident. By no later than five (5) days after the contractor becomes aware of such incident, the contractor shall provide the state agency's Security Officer with a description of any remedial action taken to mitigate any harmful effect of such incident and a proposed written plan for approval that describes plans for preventing any such future incidents.
- l. The contractor's reports specified in the preceding paragraphs shall include the following information regarding the security incident, improper disclosure/use, or breach, (hereinafter "incident"):
 - 1) The name, address, and telephone number of each individual whose information was involved if such information is maintained by the contractor;
 - 2) The electronic address of any individual who has specified a preference of contact by electronic mail;
 - 3) A brief description of what happened, including the date(s) of the incident and the date(s) of the discovery of the incident;
 - 4) A description of the types of Protected Health Information involved in the incident (such as full name, Social Security Number, date of birth, home address, account number, or disability code) and whether the incident involved Unsecured Protected Health Information; and
 - 5) The recommended steps individuals should take to protect themselves from potential harm resulting from the incident.

- m. Notwithstanding any provisions of the Terms and Conditions attached hereto, in order to meet the requirements under HIPAA and the regulations promulgated thereunder, the contractor shall keep and retain adequate, accurate, and complete records of the documentation required under these provisions for a minimum of six (6) years as specified in 45 CFR part 164.
- n. Contractor shall not directly or indirectly receive remuneration in exchange for any protected health information without a valid authorization.
- o. If the contractor becomes aware of a pattern of activity or practice of the state agency that constitutes a material breach of contract regarding the state agency's obligations under the Business Associate Provisions of the contract, the contractor shall notify the state agency's Security Officer of the activity or practice and work with the state agency to correct the breach of contract.
- p. Contractor, as a Qualified Service Organization/Business Associate acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the state agency about the patients in the state agency, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 AND by HIPAA.

1.1.4 Obligations of the State Agency:

- a. The state agency shall notify the contractor of limitation(s) that may affect the contractor's use or disclosure of Protected Health Information, by providing the contractor with the state agency's notice of privacy practices in accordance with 45 CFR 164.520.
- b. The state agency shall notify the contractor of any changes in, or revocation of, authorization by an Individual to use or disclose Protected Health Information.
- c. The state agency shall notify the contractor of any restriction to the use or disclosure of Protected Health Information that the state agency has agreed to in accordance with 45 CFR 164.522.
- d. The state agency shall not request the contractor to use or disclose Protected Health Information in any manner that would not be permissible under HIPAA and the regulations promulgated thereunder.

1.1.5 Expiration/Termination/Cancellation - Except as provided in the subparagraph below, upon the expiration, termination, or cancellation of the contract for any reason, the contractor shall, at the discretion of the state agency, either return to the state agency or destroy all Protected Health Information received by the contractor from the state agency, or created or received by the contractor on behalf of the state agency, and shall not retain any copies of such Protected Health Information. This provision shall also apply to Protected Health Information that is in the possession of subcontractor or agents of the contractor.

- a. In the event the state agency determines that returning or destroying the Protected Health Information is not feasible, the contractor shall extend the protections of the contract to the Protected health Information for as long as the contractor maintains the Protected Health Information and shall limit the use and disclosure of the Protected Health Information to those purposes that made return or destruction of the information infeasible. If at any time it becomes feasible to return or destroy any such Protected Health Information maintained pursuant to this paragraph, the contractor must notify the state agency and obtain instructions from the state agency for either the return or destruction of the Protected Health Information.

1.1.6 Breach of Contract – In the event the contractor is in breach of contract with regard to the Business Associate Provisions included herein, the contractor shall agree and understand that in addition to the requirements of the contract related to cancellation of contract, if the state agency determines that cancellation of the contract is not feasible, the State of Missouri may elect not to cancel the contract, but

the state agency shall report the breach of contract to the Secretary of the Department of Health and Human Services.

- 1.1.7 Amendment -- The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for state agency and contractor to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 and/or the Alcohol and Drug Confidentiality law within 42 C.F.R. Part 2.
- 1.1.8 State Law -- In addition to HIPAA and the HIPAA Regulations and the Alcohol and Drug Confidentiality law within 42 C.F.R. Part 2, contractor and state agency shall comply with all applicable state and federal privacy and security laws.

By: _____

By: _____

Date: _____

Date: _____