

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to section 901 to Chapter 9, of Title 29 of the District of Columbia Municipal Regulations entitled, "Medically Needy Income Levels". The rules would modify the medically needy income levels to 50% of the federal poverty level (FPL) and facilitate implementation of the Medical Assistance Expansion Program Act of 1999, effective October 20, 1999 (D.C. Law 13-38; D.C. Official Code §1-307.03), which requires the Mayor to establish a program to expand medical assistance to traditionally non-Medicaid eligible populations.

A Notice of Proposed Rulemaking governing medically needy income levels was published in the *D.C. Register* on April 18, 2003 (50 DCR 3053). No comments on the proposed rules were received. No substantive changes have been made. The Council of the District of Columbia and the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services have approved the corresponding amendment to the District of Columbia State Plan for Medical Assistance.

Amend Chapter 9, Title 29 DCMR by deleting subsection 901.1 (Medically Needy Income Levels) in its entirety and replacing it with the following:

- 901.1 The medically needy income levels (MNILs), for each household size in the District of Columbia, shall be based on 50% of the respective amounts of the Federal poverty guidelines published each year by the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. The current MLIN calculations, based on the FY 2003 Federal poverty guidelines shall be as follows::

| HOUSEHOLD SIZE | MONTHLY INCOME |
|----------------|----------------|
| 1 | \$ 479.75 |
| 2 | 505.00 |
| 3 | 635.83 |
| 4 | 766.67 |
| 5 | 897.50 |
| 6 | 1,028.33 |
| 7 | 1,159.17 |
| 8 | 1,290.00 |
| 9 | 1,420.83 |
| 10 | 1,551.67 |

| | |
|----|----------|
| 11 | 1,682.50 |
| 12 | 1,813.33 |
| 13 | 1,944.17 |
| 14 | 2,075.00 |
| 15 | 2,205.83 |
| 16 | 2,336.67 |
| 17 | 2,467.50 |
| 18 | 2,598.33 |
| 19 | 2,729.17 |
| 20 | 0 |

DEPARTMENT OF HEALTH
NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 774; D.C. Official Code, § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to Chapter 9 of Title 29 DCMR "Public Welfare," by adding a new section 937. These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for preventive, consultative and crisis support services provided by health care professionals to participants with mental retardation in the Home and Community Based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver). These rules also establish reimbursement rates for preventive, consultative and crisis support services.

A notice of emergency and proposed rulemaking was published in the *D.C. Register* on August 15, 2003 (50 DCR 6725). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective one day after publication of this notice in the *D.C. Register*.

Amend Chapter 9 (Medicaid Program) of Title 29 DCMR by adding the following new section 937 to read as follows:

**SECTION 937 PREVENTIVE, CONSULTATIVE AND CRISIS SUPPORT
 SERVICES**

- 937.1 Preventive, consultative, and crisis support services shall be reimbursed by the Medicaid Program for each participant with mental retardation in the Home and Community Based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.
- 937.2 Preventive, consultative, and crisis support services are services that are designed to support and encourage the client in his or her decision to reside within the community, to decrease the impact of the crisis event and to assist the individual to mobilize resources and regain equilibrium through the development of effective adaptive and coping mechanisms. These services shall be available to all Waiver eligible clients to prevent any unnecessary change in placement, or placement to a more restrictive environment, or to prevent a psychiatric hospitalization. Services shall be delivered under two venues-Crisis Intervention and Stabilization and Preventive and Consultative.

- 937.3 Crisis intervention and stabilization services eligible for reimbursement include, but are not limited to the following services:
- (a) An on-site assessment of the crisis situation, the client's strength and resources;
 - (b) The development of intervention strategies, including person-specific intervention strategies, which address environmental and emotional issues that may affect the client's behavior;
 - (c) Training on proactive strategies and behavioral interventions by guiding the client through exploration and identification of the problem and interpretation and resolution thereof;
 - (d) Crisis supervision or expanded supervision and monitoring to stabilize the client;
 - (e) Formulate a constructive plan and mobilize the client's resources; and
 - (f) Follow-up services which include a review of the client's progress.
- 937.4 The provider shall develop a written plan for crisis intervention which shall include all of the following information:
- (a) The names of individuals to be contacted in the event of a crisis;
 - (b) The process of responding to a crisis or emergency;
 - (c) A list of appropriate referrals;
 - (d) Conflict resolution counseling and problem solving;
 - (e) Training of informal caregivers for emergency and crisis stabilization;
 - (f) A written evaluation, including diagnosis and proposed treatment; and
 - (g) Goals of the proposed treatment.
- 937.5 Development of the required plan set forth in section 937.4 shall be based on the following activities:
- (a) Interview of the client;
 - (b) Observation of the client at his/her residence or in the community;
 - (c) Conversations with family members, friends and other professionals;
 - (d) Interpreting results of lab or other medical diagnostic studies; and
 - (e) Medical and psychiatric history.
- 937.6 Preventive and consultative services eligible for reimbursement include, but are not limited to the following services:

- (a) Training on creating positive environments and coping mechanisms, developing interventions, teamwork, and developing evaluation strategies to assess the effectiveness of interventions;
 - (b) Consultative services to assist in the development of person-specific strategies;
 - (c) Development and implementation of functional assessment techniques and strategies; and
 - (d) Development of an effective strategy for crisis prevention.
- 937.7 Preventive, consultative, and crisis support services are available to family members, service providers, or other individuals that provide support and/or services to the client.
- 937.8 Preventive, consultative, and crisis services may be provided to supplement traditional medical and clinical services available under the District of Columbia State Plan for Medical Assistance.
- 937.9 Preventive, consultative, and crisis support services shall be authorized and provided in accordance with each client's individual habilitation plan (IHP) or individual support plan (ISP).
- 937.10 Each provider of preventive, consultative and crisis support services shall:
- (a) Be a non-profit organization, home health agency, social service agency or other business entity;
 - (b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for preventive, consultative and crisis support services under the Waiver;
 - (c) Maintain a copy of the most recent IHP or ISP approved by the Department of Human Services, Mental Retardation and Developmental Disabilities Administration (MRDDA);
 - (d) Ensure that all preventive, consultative, and crisis support services staff are qualified and properly supervised;
 - (e) Ensure that the service provided is consistent with the client's IHP or ISP;
 - (f) Offer the Hepatitis B vaccination to each person providing services pursuant to these rules and maintain a copy of the acceptance or declination of the vaccine; and

- (g) Provide training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor, as set forth in 29 CFR 1910.1030.

937.11 Persons authorized to provide preventive, consultative, and crisis support services are as follows:

- (a) Psychologist;
- (b) Graduate Social Worker;
- (c) Independent Clinical Social Worker;
- (d) Registered Nurse; or
- (e) Paraprofessional working under the supervision of the psychologist, graduate social worker, independent clinical social worker or registered nurse.

937.12 Each psychologist shall have a Masters degree from an accredited institution and have at least three (3) years of experience in a setting providing habilitation and crisis support services to persons with mental retardation and other developmental disabilities.

937.13 Each psychologist shall possess professional knowledge of psychological principles, theories and methods with an ability to develop and implement treatment plans.

937.14 Each social worker shall have a Masters degree from a school of social work accredited by the Council in Social Work Education and have at least three (3) years of experience in a setting providing habilitation and crisis support services to persons with mental retardation and other developmental disabilities.

937.15 Each social worker shall possess knowledge of human behavior and of public and private human service systems in the District of Columbia.

937.16 Each registered nurse shall have at least three (3) years of experience in a setting providing habilitation and crisis support services to persons with mental retardation and other developmental disabilities.

937.17 Each psychologist, social worker and registered nurse shall have a minimum of one year's experience developing, implementing and monitoring behavior intervention plans, and developing effective interventions in response to crisis situations.

937.18 Each paraprofessional shall receive training on the ISP and IHP and meet all of the following qualifications:

- (a) Have a high school diploma or general educational development certificate;

- (b) Have basic training and education in mental health;
- (c) Have a minimum of one year experience working with persons with challenging behaviors; and
- (d) Have a minimum of three years experience working with persons with mental retardation and developmental disabilities.

937.19 Each person providing preventive, consultative, and crisis support services shall meet all of the following requirements:

- (a) Be at least eighteen (18) years of age;
- (b) Be acceptable to the client;
- (c) Demonstrate annually that he or she is free from communicable disease, as confirmed by an annual PPD Skin Test or provide documentation from a physician, stating that he or she is free from communicable disease;
- (d) Be able to communicate with the client;
- (e) Have a minimum of one year experience developing, implementing, and monitoring behavior intervention plans, and developing effective interventions in response to crisis situations;
- (f) Be able to read and write the English language;
- (g) Have completed training in crisis intervention and positive behavioral interventions;
- (h) Complete pre-service and in-service training required by MRDDA;
- (i) Have the ability to provide preventive, consultative and crisis support services consistent with the client's IHP or ISP; and
- (j) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002, (D.C. Laws 12-238 and 14-98; D.C. Official Code § 44-551 et seq.) and implementing rules.

937.20 Preventive, consultative, and crisis support services shall be made available twenty-four (24) hours a day, seven days a week. Services may be accessed during regular work hours through the client's case manager. In the event of an after hours emergency, authorization for services may be obtained by contacting MRDDA.

937.21 The reimbursement rate for preventive, consultative and crisis support services shall be \$150.00 for an initial assessment and \$45.00 per hour for a follow-up visit. The rate paid for the initial assessment includes the duration of time that it takes for each provider to complete a thorough assessment of the client and develop the written plan for crisis intervention.

937.22 Preventive, consultative and crisis support services shall be limited to 104 hours per client during any one year period, which shall commence on the date that the services are authorized.

937.99

DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Client—An individual with mental retardation who has been determined eligible to receive services under the Home and Community-Based Waiver for Persons with Mental Retardation and Developmental Disabilities.

Communicable Disease—Shall have the same meaning as set forth in section 201 of Chapter 2 of Title 22, District of Columbia Municipal Regulations.

Crisis—A situation where the client is exhibiting threatening behavior, or appears to be capable of causing physical harm or damage to another individual, personal property, or themselves.

Crisis Intervention and Stabilization Services—Services that are designed to provide an immediate on-call crisis support at the client's home due to an emergency or unpredicted crisis to assist the client to mobilize resources, regain equilibrium and develop effective adaptive and coping mechanisms.

Crisis Supervision/Expanded Supervision—Supervision of the client during the crisis by professionals or a paraprofessional consistent with the requirements of this section.

Functional Assessment—Includes (1) indirect assessment techniques such as interviews, written record reviews and questionnaires; (2) direct assessment techniques such as observation of the client, documentation of the frequency, duration and intensity of problem behaviors; and (3) the evaluation of the relationship between the environmental and emotional variables and the occurrence of problem behaviors.

Graduate Social Worker—A person who is licensed as a graduate social worker pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 et seq.) or licensed as a graduate social worker in the jurisdiction where the services are being provided.

Independent Clinical Social Worker—A person who is licensed as an independent clinical social worker pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 et seq.) or licensed as an independent clinical social worker in the jurisdiction where the services are being provided.

Individual Habilitation Plan (IHP)—That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (ISP)—The successor to the individual habilitation plan (IHP) as defined in the court-approved Joy Evans Exit Plan.

Paraprofessional—A trained worker who is not a member of a given profession but who assists a professional.

Psychologist— A person who is licensed to practice psychology pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 et seq.) or licensed as a psychologist in the jurisdiction where the services are being provided.

Preventive and Consultative Services—Services that are designed as an ongoing, preventive service to improve and maintain outcomes in the health, attitude and behavior of the client.

Registered Nurse— A person who is licensed to practice registered nursing pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 et seq.) or licensed as a registered nurse in the jurisdiction where the services are being provided.

Regular Work Hours—Shall mean the hours of 9:00 AM to 5:00 PM, Monday through Friday, except days determined to be holidays by the District of Columbia government.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code, § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to Chapter 9 of Title 29 DCMR, "Public Welfare," a new section 942. The Director took final action to adopt these rules on October 2, 2003. These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for family training services provided by qualified professionals to participants with mental retardation in the Home and Community Based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver). These rules also establish Medicaid reimbursement rates for family training services. Notices of emergency and proposed rulemaking were published February 21, 2003, at 50 DCR 1780, and August 22, 2003, at 50 DCR 7017. No comments have been received, and no changes have been made since the latter publication. These final rules will become effective upon publication of this notice in the *D.C. Register*.

The Centers for Medicare and Medicaid Services (CMS), formerly the federal Health Care Financing Administration has advised the District that the maintenance and expansion of family training services to persons with mental retardation and developmental disabilities is essential to the continuation of the Waiver. These rules establish standards governing the provision of family training services.

Title 29 DCMR is amended by adding a new section 942, to read as follows:

942 FAMILY TRAINING SERVICES

- 942.1 The Medicaid Program shall reimburse for family training services for each participant with mental retardation in the Home and Community Based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.
- 942.2 Family training services are training and counseling services for the families of clients.
- 942.3 Family training services eligible for reimbursement shall include the following services:
- (a) Instruction about treatment regimens;
 - (b) Training on the use of equipment specified in the individual habilitation plan (IHP) or the individual support plan (ISP);

- (c) Training on understanding the needs of the client;
 - (d) Counseling to address the psychosocial needs of the family;
 - (e) Training to prepare a family to make informed choices and to coordinate services for its family member; and
 - (f) Follow-up training necessary to safely maintain the client at home.
- 942.4 Family training services shall not exceed fifty-two (52) training or counseling sessions per year.
- 942.5 Family training services shall be authorized by the client's interdisciplinary team and provided in accordance with each client's IHP or ISP.
- 942.6 Each provider of family training services shall:
- (a) Be a non-profit organization, home health agency, social service agency, or other business entity;
 - (b) Have a current District of Columbia Medicaid Provider Agreement for the provision of services that authorizes the provider to bill for family training services under the Waiver;
 - (c) Maintain a copy of the most recent IHP or ISP approved by the Department of Human Services, Mental Retardation and Developmental Disabilities Administration (MRDDA);
 - (d) Ensure that all family training services staff are qualified and properly supervised;
 - (e) Ensure that the service provided is consistent with the client's IHP or ISP;
 - (f) Offer the Hepatitis B vaccination to each person providing direct care services pursuant to these rules;
 - (g) Provide training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor as set forth in 29 CFR 1910.1030;
 - (h) Provide training to the families in the frequency and duration of care as delineated in the IHP/ISP; and
 - (i) Maintain documentation in each client's clinical record regarding the initial assessment of the family's training needs, the goals to be accomplished, the training provided on each visit, and the outcome of each

training.

- 942.7 Each person providing family training services shall:
- (a) Be licensed to practice independent social work, independent clinical social work, professional counseling, occupational therapy, physical therapy, psychology, or registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*); or
 - (b) Be licensed to practice his or her profession within the jurisdiction where services are provided; or
 - (c) Be a special education teacher with a Master's Degree in Special Education with an emphasis in developmental disabilities from an accredited college or university and experience working with persons with mental retardation and developmental disabilities.
- 942.8 Each person providing family training services shall meet all of the following requirements:
- (a) Be at least eighteen (18) years of age;
 - (b) Be acceptable to the client;
 - (c) Demonstrate annually that he or she is free of communicable diseases as confirmed by an annual PPD Skin Test or documentation from a physician stating that the person is free of communicable diseases;
 - (d) Be able to communicate with the client;
 - (e) Be able to read and write the English language;
 - (f) Complete required training;
 - (g) Have the ability to provide family training services consistent with the client's IHP or ISP; and
 - (h) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238; D.C. Official Code § 44-551 *et seq.*), and the rules implementing the act.
- 942.9 The billable unit of service shall be one (1) hour. The reimbursement rate for family training services shall be sixty dollars per hour (\$60.00/hr.) for the initial service and fifty dollars per hour (\$50.00/hr.) for any follow-up services.

942.99 **DEFINITIONS**

When used in this section, the following terms and phrases shall have the meanings ascribed:

Client -an individual with mental retardation who has been determined eligible to receive services under the Home and Community-Based Waiver for Persons with Mental Retardation and Developmental Disabilities.

Communicable disease- that term as set forth in section 201 of Chapter 2 of Title 22, District of Columbia Municipal Regulations.

Family- one or more persons related to a client by blood, marriage, or some other legal relationship, such as a foster family, who live with or provide care to a client, and may include parents, spouse, children, relatives, foster family, or in-laws. This term does not include individuals who are employed to care for the client.

Individual Habilitation Plan or IHP-that plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan or ISP-the successor plan to the individual habilitation plan as defined in the court-approved Joy Evans Exit Plan.

DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Mental Health, pursuant to the authority set forth in section 114 of the District of Columbia Department of Mental Health Service Delivery Reform Act of 2001, effective December 18, 2001 (D.C. Law 14-56; D.C. Official Code §§ 7-1131.01 *et seq.*) (Act), hereby adopts the following new Chapter 3, of Title 22A of the D.C. Code of Municipal Regulations, entitled "Consumer Grievance Procedures." Chapter 3, Title 22A, DCMR sets forth the rules regarding the resolution of complaints and grievances regarding violations of the rights or protections guaranteed to consumers of mental health services and supports.

Earlier versions of these rules were published as proposed rules on February 22, 2002 at 49 D.C. Reg. 1681, on July 26, 2002 at 49 D.C. Reg. 7205, and on January 31, 2003 at 50 D.C. Reg. 1008. Clarifying revisions have been made to the rules since their last publication as proposed rulemaking. These final rules will be effective upon publication in the D.C. Register.

Title 22A DCMR is amended by adding the following new Chapter 3:

CHAPTER 3

**DEPARTMENT OF MENTAL HEALTH
CONSUMER GRIEVANCE PROCEDURES**

300 PURPOSE AND APPLICATION

300.1 The purpose of these rules is to protect and enhance the rights and protections of consumers by establishing the specific procedure for response to and impartial resolution of grievances.

300.2 The rules in this Chapter are applicable to each mental health provider (MH provider) and the Department of Mental Health (DMH). References to DMH may refer to DMH when it is acting in its capacity as the Mental Health Authority for the District of Columbia.

301 CONSUMER RIGHTS AND PROTECTIONS PROCEDURE

301.1 Each MH provider shall establish and adhere to a Consumer Rights Policy. The MH provider's Consumer Rights Policy must be approved by the MH provider's governing authority and DMH, and contain, at a minimum, the following:

- (a) A Consumer Rights Statement published by DMH;
- (b) A copy of the MH provider's Grievance Procedure established in accordance with § 306;
- (c) The telephone number for any independent peer advocacy programs established in accordance with § 302.1; and
- (d) The following statement: "You may also have the option to initiate a grievance with any or all of several outside entities, including but not limited to the Office of Administrative Review and Appeals at the Department of Human Services, the U.S. Department of Health and Human Services, and the District of Columbia's program for the protection and advocacy for persons with mental illness. For further information, contact the Department of Mental Health's Access Hotline or its web site."

301.2 Within one hundred eighty (180) days of the effective date of these rules, each MH provider shall submit to DMH its written Consumer Rights Policy, including the MH Provider Grievance Procedure, for approval. DMH must approve the Consumer Rights Policy of each MH provider in order for the MH provider to be certified and licensed by DMH.

- (a) A MH provider shall submit subsequent substantive changes to its Consumer Rights Policy or MH Provider Grievance Procedure to DMH for approval before implementation of the changes by the MH provider.
- (b) A MH provider may continue to utilize existing consumer grievance policies approved by DMH in the certification process for MH providers, until the MH provider adopts a new procedure consistent with §§ 304 through 306 and approved by DMH as required by this section 301.2.

301.3 Each MH provider shall disseminate its Consumer Rights Policy in ways designed to foster consumer understanding, including, at a minimum:

- (a) A MH provider shall provide a copy of its Consumer Rights Policy to each consumer at his or her initial appointment with the provider or at the next appointment. At the same time the MH provider shall also offer a verbal explanation of the Policy to the consumer and provide such explanation upon request.
- (b) The consumer, and his or her legal guardian if present, shall sign a DMH-approved form acknowledging receipt of the Policy and any

verbal explanation. The receipt form shall be placed in the consumer's clinical record.

- (c) If the consumer elects not to sign the receipt form, the reasons given for not signing shall be recorded on the form.
- (d) In the event of a crisis or other emergency at the initial or next appointment that prevents a written and verbal explanation of the Consumer Rights Policy, the consumer shall be verbally advised of, at a minimum, the consumer's immediately pertinent rights and protections, such as the right to consent to or to refuse the offered treatment and the consequences of that consent or refusal. In such cases, distribution and explanation of the Consumer Rights Policy shall be accomplished at the consumer's next appointment and the reason for the delay shall be documented on the receipt form.
- (e) Each MH provider shall post a copy of the Consumer Rights Policy in strategic and conspicuous locations in each building operated by the provider, and shall make additional copies of the Consumer Rights Policy available to consumers, parents, guardians, family, designated personal representatives and staff upon request.
- (f) Each MH provider shall ensure that every current staff member, including administrative, clerical, and support staff, is knowledgeable about its Consumer Rights Policy when its grievance procedure goes into effect. Each MH provider shall also establish a means of ensuring that all new staff members who are hired in the future are knowledgeable about its Consumer Rights Policy.

302 INDEPENDENT PEER ADVOCACY PROGRAMS

- 302.1 DMH shall facilitate and provide funding to establish one or more peer advocacy programs independent of all MH providers to assist consumers throughout the grievance process, including filing a grievance, accompanying consumers to meetings, helping consumers gather relevant information, and presenting the information in any subsequent proceedings. A peer advocacy program may provide services to consumers in addition to assistance with grievances.
- 302.2 The responsibilities of a peer advocacy program established under § 302.1 shall include:
 - (a) Recruit and collaborate with DMH to train independent peer advocates;

- (b) Ensure that independent peer advocates abide by all federal and local requirements for the confidentiality of consumer information;
- (c) Ensure that each independent peer advocate continues to provide services in a satisfactory manner;
- (d) Provide an intake function that permits consumers to submit requests for assistance twenty-four (24) hours per day, seven (7) days per week; and
- (e) Ensure that an independent peer advocate is available for individual consultation no later than twenty-four (24) hours after a consumer has submitted a request for assistance pursuant to § 302.2 (d) above.

302.3 An independent peer advocate shall not assist a consumer with a grievance against a MH provider from which the peer advocate is currently receiving mental health services or supports, unless the consumer consents in writing to such assistance.

302.4 The existence of an independent peer advocacy program is not intended to replace or discourage the use of any consumer advocacy programs a MH provider may offer.

303 CORE SERVICES AGENCY TRANSITIONAL PEER ADVOCACY PROGRAM

303.1 Within thirty (30) days from the effective date of these rules and until such time as DMH notifies MH Providers that an Independent Peer Advocacy Program has been established in accordance with § 302, each Core Services Agency (CSA) shall maintain an internal peer advocacy program.

303.2 Each CSA shall appoint one or more peer advocates who shall be available to provide information and advice to consumers and to act as representatives of consumers who have filed or contemplate filing a grievance.

303.3 Each CSA shall make consumers aware of the availability of peer advocates and shall ensure that consumers have reasonable access to peer advocacy services.

303.4 Each CSA peer advocate shall complete a training course provided by DMH.

303.5 A CSA may elect to establish a permanent peer advocacy program at any time.

304 GRIEVANCE PROCEDURE – GENERAL PROVISIONS

- 304.1 A grievance is the expression by any individual of his or her dissatisfaction with either DMH or a MH provider, including the denial or abuse of any consumer right or protection provided by applicable federal and District laws and regulations. A grievance will not be entertained if it complains of a specific action that occurred more than six (6) months prior to the filing of the grievance, absent extenuating circumstances.
- 304.2 DMH shall establish a grievance procedure (Grievance Procedure) that complies with applicable federal and District laws and regulations and that is available to all consumers and other interested parties. As part of the Grievance Procedure, each MH provider shall establish and adhere to an internal grievance procedure for its consumers (MH Provider Grievance Procedure) that has been approved by DMH according to § 301.2.
- 304.3 Consumers are not required to utilize the Grievance Procedure. Consumers may pursue other legal, administrative, or informal relief in lieu of or concurrently with filing a grievance.
- 304.4 Any consumer who believes he or she has been denied a service for which the consumer is eligible under Medicaid may file a grievance with the Office of Fair Hearings at the Department of Human Services, pursuant to D.C. and federal law. A Medicaid consumer who has a grievance regarding the receipt, termination, amount, kind, or conditions of Medicaid services is not required to go through DMH or MH Provider Grievance Procedures before filing a grievance with the Office of Administrative Review and Appeals, which is part of the Department of Human Services.
- 304.5 A MH provider's continuing obligations to safeguard the welfare of consumers, including the filing of Unusual Incident reports and other reports of allegations of abuse or neglect, are not affected by the Grievance Procedure.
- 304.6 Mental health services and mental health supports shall continue without limitation, reduction, or termination pending resolution of grievances regarding such mental health services and mental health supports.
- 304.7 Neither DMH nor a MH provider shall retaliate against the consumer or his or her representative in any way because the consumer filed a grievance. An allegation of retaliation shall be treated and filed as a new grievance against the MH provider or DMH.
- 304.8 DMH may institute proceedings to revoke or suspend a MH Provider's certification and/or licensure or to impose other sanctions if:

- (a) DMH substantiates an allegation that the MH provider retaliated against a consumer, or his or her representative, for filing a grievance;
- (b) The MH provider fails to obtain approval of either its MH Provider Grievance Procedure or changes to its MH Provider Grievance Procedure as required by § 301.2;
- (c) The MH provider fails to abide by or implement a final decision by DMH in response to a grievance;
- (d) The MH provider fails to take actions identified to rectify situations that have lead to abuse or neglect of consumers; or
- (e) The MH provider evidences a pattern of untimely or incomplete responses to consumer grievances, or fails to complete action promised by the MH provider in response to a grievance.

304.9 The written explanation of the DMH Grievance Procedure and of each MH Provider Grievance Procedure shall include the language in § 304.7 in a type size and style that stands out from the surrounding text.

305 FILING A GRIEVANCE

305.1 All consumers shall have the right to file a grievance with DMH. If a consumer's grievance involves a specific MH provider, DMH shall ensure that the MH provider has responded to the grievance in a timely manner, before initiating its prompt and impartial review of the grievance. All grievances involving a specific mental health professional shall be treated as involving the MH provider that employs or contracts with the mental health professional.

305.2 Grievances may be expressed orally or in writing. Oral grievances shall be reduced to writing. Each MH provider shall ensure consumers have access to all assistance they need or request in filling out any forms necessary for filing grievances.

- (a) A grievance may be filed by the consumer or the consumer's personal representative, legal guardian, or other party acting on behalf of the consumer, when the consumer is an adult.
- (b) A grievance may be filed by the consumer or the consumer's family member or legal guardian on behalf of the consumer, when the consumer is a child.

- (c) The consumer, or the consumer's family member or legal guardian, when the consumer is a child, must consent to the filing of a grievance by another person in his or her behalf unless the grievance involves an allegation that the consumer is being abused or neglected.

305.3 Each consumer may be assisted throughout the grievance process, by any person chosen by the consumer. If the consumer chooses to be assisted by a peer advocate or personal representative, the consumer must designate the advocate or representative in writing and specify what protected mental health information, if any, may be released to the peer advocate or personal representative.

305.4 Peer advocates and personal representatives are subject to the requirements of federal and District laws regarding the confidentiality of protected mental health information.

305.5 A MH provider shall release information regarding a grievance to any organization or individual upon receipt of a valid authorization for disclosure from the consumer.

306 MH PROVIDER GRIEVANCE PROCEDURE

306.1 Consumers with grievances concerning a MH provider from whom they are receiving services shall file the grievances with their provider. Consumers with grievances concerning rules, policies, or actions of employees that are the sole responsibility of DMH may file them with their MH provider but are not required to do so.

306.2 Each MH Provider Grievance Procedure shall incorporate, at a minimum, the following elements:

- (a) Consumers shall have the opportunity to file a grievance at any time during the MH provider's normal hours of operation;
- (b) Consumers shall be protected against having to file or present a grievance to the person complained about in the grievance;
- (c) Consumers shall have access to peer advocates and shall have the right to representation during each stage of the grievance procedure by a peer advocate or personal representative;
- (d) The consumer or his or her designee shall receive written acknowledgment of a filed grievance;
- (e) Time limits shall be set the completion of each step of the Procedure, consistent with § 306.5;

- (f) Prompt steps shall be specified to insure the immediate physical safety of a consumer if the circumstances surrounding a grievance raise a reasonable belief that the consumer's safety is threatened;
- (g) If informal attempts to resolve a grievance are unsuccessful, the chief executive officer of the MH provider shall review the grievance and write a decision in response. The written decision shall be transmitted, with oral explanation, to the consumer or his or her designee along with a reminder of the consumer's right to appeal the grievance to DMH for external review.

306.3 Each MH provider shall establish a permanent group composed of equal numbers of consumers and staff members who shall be responsible for responding to inquiries regarding the grievance process, for attempting to resolve grievances consensually, and for assisting the chief executive officer of the MH provider in providing a response to grievances.

- (a) The group or individual group members may look into individual grievances and work with the consumer filing the grievance and other parties to resolve the grievance consensually, using mediation or other dispute resolution techniques.
- (b) If the grievance cannot be resolved informally, the group or individual group members may fact-find or make advisory recommendations to the chief executive officer of the MH provider.
- (c) Grievances containing allegations of physical or sexual abuse may be forwarded directly to the chief executive officer of the MH provider without action by the group.

306.4 Each MH Provider shall demonstrate that consumers have played a meaningful role in the final design of the Grievance Procedure, and that consumers will be meaningfully consulted in future efforts to monitor and evaluate its effectiveness and decide upon needed modifications. The consumer/staff group required by § 306.3 may be utilized for these functions, or the MH Provider may use other means.

306.5 The chief executive officer of each MH provider shall review, investigate, and provide a substantive response to grievances within the following time frames:

- (a) Within five (5) business days of the date the grievance is filed if it alleges abuse or neglect of a consumer or a denial of service to a consumer; or

- (b) Within ten (10) business days of the date the grievance is filed for all other grievances.

The chief executive officer of a MH provider may request an extension of the time set by paragraph (b) above for a specific number of days. The consumer filing the grievance shall have the option to grant or deny such a request.

- 306.6 If a consumer is dissatisfied with the response to a grievance by the chief executive officer of the MH provider or his or her designee, the consumer shall have ten (10) business days from the date of verbal notification and explanation of the response within which to appeal the grievance to DMH for external review in accordance with §§ 308 and 309.
- 306.7 Each MH provider shall submit a copy of each grievance to DMH on the day it is filed and shall submit a copy of any subsequent action concerning the grievance within 24 hours of the action's occurrence. Providers shall submit the information in a manner to be specified by DMH.
- 306.8 Each MH provider shall ensure that every staff person, including administrative, clerical, and support staff, has a clearly understood responsibility to immediately advise any consumer or other person who is articulating a grievance on behalf of a consumer, of the right to file a grievance and of the means of contacting the peer advocate program.
- 306.9 Each MH provider may accomplish its responsibilities with regard to implementing the MH Provider Grievance Procedure through utilization of its own staff or board members, as appropriate, or through agreement with outside staff, agencies, or organizations. The utilization of outside persons in the MH Provider Grievance Procedure shall be clearly explained to each consumer filing a grievance and to other parties filing a grievance on behalf of a consumer.

307 DMH REVIEW OF GRIEVANCES

- 307.1 The Mental Health Authority of DMH shall review grievances that concern:
 - (a) The actions of employees of DMH in its capacity as Mental Health Authority for the District of Columbia; or
 - (b) Rules or policies that are the sole responsibility of DMH; or
 - (c) Grievances involving a MH provider not resolved to the consumer's satisfaction.

- 307.2 Consumers may first file grievances concerning rules or policies that are the sole responsibility of DMH with their MH provider but are not required to do so.
- 307.3 All consumers shall have the right to file a grievance with DMH. If a consumer's grievance involves a specific MH provider, DMH shall ensure that the MH provider has responded to the grievance in a timely manner before initiating its prompt and impartial review of the grievance.
- 307.4 DMH shall refer appeals of consumers' grievances against MH providers to external review as described in § 308 within five (5) business days of receipt of the grievance by DMH.
- 307.5 The Director of DMH or the Director's designee shall respond orally and in writing to the consumer or the consumer's designee within ten (10) business days of receipt of the grievance by DMH, in grievances not involving the appeal of a consumer's grievance against a MH provider. If a consumer is dissatisfied with the DMH response to a grievance, the consumer shall have ten (10) business days from the date of verbal notification and explanation of the response within which to exercise the right to external review of the grievance according to § 308.
- 308 EXTERNAL REVIEW OF GRIEVANCES**
- 308.1 DMH shall contract with one or more external reviewer(s) to provide timely, neutral, and impartial review of grievances that have not been resolved to the consumer's satisfaction. The Director or his or her designee shall select the external reviewer. External reviewers shall serve at the pleasure of the Director of DMH. DMH shall provide consumers with written notice of the method, date, and time of external review, a list of participants, and contact information for the independent peer advocacy program.
- (a) A consumer has the right to representation by a peer advocate, an attorney or a person of the consumer's choice throughout the external review process but DMH shall not appoint, assign or compensate a consumer's representative.
- (b) A consumer, employees or representatives of providers, witnesses, or other participants in a grievance proceeding shall not be compensated by DMH for their time.
- 308.2 All external reviewers shall have experience or appropriate training in mediation, arbitration, and/or alternative dispute resolution.

- 308.3 The external reviewer may manage an assigned grievance in one of the following ways:
- (a) The external reviewer may attempt to mediate a consensual resolution to the grievance. Mediation may be conducted via individual telephone calls or meetings with interested parties or via a joint meeting. The consumer has the right to representation during mediation. Necessary representatives from the MH provider, as determined by the external reviewer, shall be required to attend the mediation. The consumer may terminate the mediation at any time. If mediation is unsuccessful at resolving the grievance to the consumer's satisfaction, an external reviewer shall prepare a written advisory opinion at the request of any party to the mediation. The external reviewer who prepares a written advisory opinion pursuant to this subsection may or may not be the mediator.
 - (b) The external reviewer may conduct a fact-finding hearing and issue a written advisory opinion. Necessary representatives from the MH provider, as determined by the external reviewer, shall be required to attend the hearing. The consumer has the right to representation during the hearing, and may call witnesses. The MH provider also has the right to representation during the hearing at its expense, and may call witnesses. In some instances, and with the consent of the parties, the external reviewer may attempt to mediate a consensual resolution to a grievance prior to issuing an advisory opinion.
 - (c) The external reviewer may conduct a fact-finding process and issue a written advisory opinion without a hearing, if the consumer elects not to have one. In this case the external reviewer may request written information from the consumer or the MH provider to supplement the record. The external reviewer shall prepare a written advisory opinion based upon the information submitted and any informal conversations held with parties to the grievance.
- 308.4 Within five (5) business days of receipt of a consumer's request for external review, DMH shall assign an external reviewer and secure the earliest practicable date for a mediation or hearing. If a hearing is held, the external reviewer shall submit a written advisory opinion within five (5) business days of the completion of the hearing. An external reviewer may extend the time period for submission of an opinion with the express consent of all parties to the hearing.
- 308.5 Any written advisory opinion prepared by an external reviewer shall include:

- (a) A summary of the evidence gathered during the hearing or document review;
- (b) Applicable federal or District laws and regulations;
- (c) Findings of Fact; and
- (d) Conclusions and recommendations.

308.6 A written advisory opinion prepared by the external reviewer shall be forwarded to the Director of DMH, the chief executive officer of the MH provider (if the grievance originated at or involved the MH provider), and the consumer. A copy of the written advisory opinion shall be provided to the consumer's representative, if authorized pursuant to the Mental Health Information Act of 1978, D.C. Official Code §§ 7-1201.01 *et seq.* Any party to the external review, including the chief executive officer of the MH provider, may, within five (5) business days of receipt of the written advisory opinion, communicate their reaction to the opinion to the Director. The Director shall, in writing, accept in full, accept in part, or reject the recommendations of the external reviewer and set time limits and responsible parties for carrying out any accepted recommendations, within ten (10) business days of receipt of the advisory opinion.

308.7 Any agreement reached in mediation shall be forwarded to the Director of DMH and/or the chief executive officer of the MH provider where the grievance originated, according to which entity has authority over the actions specified in the agreement. The Director or chief executive officer shall set any necessary time limits and responsible parties for carrying out the actions specified by the agreement, within ten (10) business days of receipt of the agreement.

308.8 The external reviewer shall report such information on each grievance as DMH may require and shall provide such information within the time limits and in the manner that DMH requires, except that statements made by parties to mediation shall not be reported.

308.9 Any party to a grievance dissatisfied with the grievance's final determination by DMH may request a fair hearing, pursuant to the D.C. Administrative Procedure Act and federal regulations.

309 DMH MONITORING AND REPORTING

309.1 DMH shall periodically review the implementation of the Consumer Rights Policy, including each MH Provider Grievance Procedure.

- 309.2 DMH shall ensure that grievances are tracked and that responsible parties carry out actions mandated or agreed to be performed in response to grievances within prescribed time limits.
- 309.3 DMH shall make publicly available a semi-annual report summarizing the types and dispositions of all grievances filed during the reporting period, including noteworthy trends and patterns and any other statistical information it believes would be helpful in evaluating the operation of the Grievance Procedure.

399 DEFINITIONS

“Abuse” - any knowing, reckless, or intentional act or omission by a provider that causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to, physical or emotional injury, death, or financial exploitation of a consumer.

“Consumer” – an adult, child or youth who seeks or receives mental health services or mental health supports funded or regulated by DMH. For purposes of this chapter, references to a child or youth consumer include the child’s or youth’s family or legal guardian.

“Consumer Rights Statement” - a document prepared and distributed by DMH to all MH providers which describes all the consumer rights and protections available under federal and District laws and regulations.

“Core Services Agency” - a community-based provider of mental health services and mental health supports that is certified by DMH in accordance with rules published in the D.C. Register, and acts as the clinical home for consumers of mental health services by providing a single point of access and accountability for mental health rehabilitation services.

“CSA peer advocate” – a person appointed by a core services agency to assist consumers and others in filing a grievance and throughout the grievance process, who

- (a) is a current or former consumer of mental health services or supports; and
- (b) has been trained by DMH.

“DMH” - the Department of Mental Health, the successor in interest to the District of Columbia Commission on Mental health Services.

“Director” - the Director of DMH.

“External reviewer” – a person or organization with extensive experience in mediation, arbitration and/or alternative dispute resolution, selected by

the Director, that contracts with DMH to provide neutral and impartial review and resolution of grievances.

“Governing Authority” – the designated individuals or governing body legally responsible for conducting the affairs of the MH provider.

“Grievance” – a description by any individual of his or her dissatisfaction with either DMH or a MH provider, including the denial or abuse of any consumer right or protection provided by applicable federal and District laws and regulations.

“Independent Peer advocate” – a person designated by an independent peer advocacy office established by or with the assistance of DMH to assist consumers and others in filing a grievance and throughout the grievance process, who

- (a) is a current or former consumer of mental health services in the District of Columbia or elsewhere or, in the case of children and youth consumers, a guardian or family member of a current or former child or youth consumer;
- (b) meets minimum qualifications established by DMH; and
- (c) demonstrates knowledge about the Grievance Procedure and relevant MH Provider Grievance Procedures, and District laws and regulations regarding consumer rights and protections.

“Mental Health Authority” – the divisions, offices and employees of DMH involved in the regulatory, administrative, policy, planning, and fiscal responsibilities for the Department, and the Access Helpline or central intake functions of the Department. The Mental Health Authority is not directly involved in providing mental health services or supports and is separate from St. Elizabeths Hospital and the public core services agency. Mental Health Authority offices and divisions include the Director and Director’s office, Chief Compliance Officer and Regulatory Counsel, General Counsel, Chief Financial Officer, Public Affairs, Consumer and Family Affairs, Chief Clinical Officer, Organizational Development, Office of Fiscal and Administrative Services, Office of Accountability, and Office of Delivery Systems Management.

“Mental health services” - the services funded or regulated by DMH for the purpose of addressing mental illness or mental health problems.

“Mental health supports” - the supports funded or regulated by DMH for the purpose of addressing mental illness or mental health problems.

“Mental Illness” - a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

"MH provider" – (a) any entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports, (b) any entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports, or (c) St. Elizabeths Hospital or the public core services agency.

"Neglect" - any act or omission by a MH provider that causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to, injury or death of a consumer.

"Peer advocate" – see "Independent peer advocate" and "CSA peer advocate."

"Personal representative" – a person designated by a consumer as the consumer's personal representative. A personal representative may be a family member, significant other, guardian or attorney.

"Policy" – a written statement developed by a MH Provider that gives specific direction regarding how the MH provider shall operate administratively and programmatically.

"Procedure" – a written set of instructions describing the step-by-step actions to be taken by MH provider staff in implementing a policy of the MH provider.

"Protected mental health information" - means information regulated by the District of Columbia Mental Health Information Act of 1978 effective March 3, 1979 (D.C. Law 2-136, D.C. Official Code §7-1201.1 *et seq.*).

"Service plan" - either the individual recovery plan (IRP) for adults or the individual service plan for children and youth (IPC).

"St. Elizabeths Hospital" – the inpatient psychiatric hospital operated by DMH.