NOTICE OF PRIVACY PRACTICES

(Effective Date: July 2011)

THIS NOTICE TELLS HOW MEDICAL AND OTHER PRIVATE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ARROWHEAD HOUSE PROGRAMS PRIVACY POLICY addresses the collection, use, and disclosure of information about recipients to the extent necessary to provide services while maintaining reasonable safeguards to protect the integrity and confidentiality of the information consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and the federal regulations implementing the Act (collectively referred to as "HIPAA"), as well as other applicable federal and state laws and regulations.

ARROWHEAD HOUSE PROGRAMS NOTICE OF PRIVACY PRACTICES AND SAFEGUARDING OF INFORMATION

Arrowhead House will inform recipients about its privacy practices. The Recipient, will be provided with a copy of the Notice of Privacy Practices at the time of their pre-screening/intake process or first service and to any person who requests information on Arrowhead House privacy practices. The recipient will acknowledge receipt in writing by signing the Consents Form signature sheet. The Arrowhead House Notice of Privacy Practices shall contain all information required under federal regulations. Arrowhead House will safeguard health information about recipients, inform recipients about its privacy practices and respect recipient privacy rights.

MINIMUM NECESSARY ACCESS, USE & DISCLOSURE

Arrowhead House will use or disclose only the minimum amount of information necessary to provide services to recipients. Arrowhead House staff may, in the course of their job duties, need to use/disclose information on a variety of recipients. This will only be done in the course of providing services to a recipient and only those staff members needing to use and disclose a particular recipient's information will have access to that information. Staff employed in the areas of Operations, Human Resources, Accounting, and Support Staff will only have access to recipient information necessary to carry out the duties of their job. Under HIPAA, a covered entity may voluntarily choose, but is not required, to obtain the individual's consent for it to use and disclose information about him or her for treatment, payment, and health care operations. These areas following fall under the minimum necessary rule when providing health information.

WHY DO WE ASK FOR THIS INFORMATION?

FOR TREATMENT:

- Information you give to our health care team will be written in your medical record. The health care team may read, discuss, or share your health information to provide quality care and to help decide what care may be best for you.
- We may share health information with another provider if you are transferred to inform them about the care you have received at Arrowhead House, including current medications.

FOR PAYMENT:

- We may share your health information to determine eligibility or coverage under a plan and to decide which services you are eligible for.
- To collect money from other agencies, like insurance companies, if they should pay for your care; or to collect money from the state or federal government, or any other party responsible for payment.

FOR REGULAR HEALTH OPERATIONS:

- Members of the staff may use information in your case record to assess the care and outcomes in your case. The information may be used in program evaluation studies to assess the care provided and to measure effectiveness of different program models.
- Arrowhead House may obtain, collect, maintain, use, transmit, share and/or disclose information about recipients in the administration of its programs, services and activities, and as necessary to assist recipients in accessing and receiving services.
- To make reports, do research, do audits, and evaluate our staff and programs.

WITH WHOM MAY WE SHARE THIS INFORMATION?

We will only share information about you as needed and as allowed or required by law. We may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agency.
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, vulnerable adult protection and fraud investigators
- Human services offices
- Governmental agencies administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with power of attorney
- Coroners and medical investigators in the event of death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Anyone else to whom the law says we must or can give the information.

    - **We may talk about your health information to a friend or family member who helps with your medical care, who helps pay for your care, who you ask to be told, or in an emergency situation. We will tell them only what they need to know to help you. You have the right to say "no" to this use or to sharing your information. If you say "no," we will not use or share your health information with your family or friends.**

RECIPIENT PRIVACY RIGHTS:

- You and people you have given permission to may see and copy medical or other private information we have about you. You may have to pay for the copies.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- You have the right to ask us in writing to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information.
- You have the right to get a record of some of the people or organizations with whom we have shared your information. You must ask for a copy of this record in writing.
- You may revoke your authorization to use or disclose health information except to the extent that action has already been taken.

ARROWHEAD HOUSE PROGRAMS RESPONSIBILITIES:

- We must protect the privacy of your medical and private information according to the terms of this notice
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. Changes to our privacy rules will be posted as of September 2011 on our website at: http://www.ahprograms.com.

RETENTION OF MEDICAL AND PRIVATE INFORMATION:

- Unless otherwise required by law, your medical/mental health record including reports and information from outside providers is the physical property of the Arrowhead House program that compiled it. Your record is kept by Arrowhead House and its contents are protected and confidential. Your private record will be kept for seven years upon your discharge date, at which time it will be destroyed.
- If private information is taken during a pre-screening/intake process and you chose not to participate in an Arrowhead House Program, your private information will be destroyed after 30 days.

- **NOTICE OF PRIVACY PRACTICES AVAILABILITY:** This notice will be prominently posted in the main office. Recipients will be provided a hard copy at the intake/screening process. As of September 2011 a copy will be posted on our website at http://www.ahprograms.com.

- **FOR MORE INFORMATION OR TO REPORT A PROBLEM:**
  If you have questions and would like additional information, you may contact the privacy officer of Arrowhead House at (218)-728-8977. If you believe your privacy rights have been violated, you can also file a complaint with the U.S. Department of Health and Human Services or to the MN Department of Human Services. There will be no retaliation for filing a complaint.

ARROWHEAD HOUSE PROGRAMS

ACKNOWLEDGEMENT AND CONSENT OF NOTIFICATION OF PRIVACY PRACTICES

NAME: _____

GUARDIAN/PERSONAL
REPRESENTATIVE: _____

PROGRAM NAME: _____

_____I acknowledge that I have been provided a copy of the Arrowhead House Notice of Privacy Practices and have therefore been advised of how private information about me may be used and disclosed. I have also been advised about how I may obtain access to this information.

_____ I acknowledge that by signing below I have been informed of and consent to receiving Treatment from Arrowhead House.

_____ _____

Signature of Recipient or Guardian/Personal Representative Date

_____

Print Name of Recipient or Guardian/Personal Representative

THIS FORM WILL BE PLACED IN YOUR CASE RECORD

Recipient Name:		Date of Birth:	

ARROWHEAD HOUSE PROGRAMS

EMERGENCY DISCHARGE PLAN

If Arrowhead House cannot meet the recipient's health and safety needs, or determines that a particular recipient presents an imminent danger to themselves or others, Arrowhead House must arrange to transfer the recipient to a provider who or setting that has the capacity to meet the recipient's needs.

The following actions are considered to be health and/or safety hazards that will result in an Emergency discharge. The Treatment Team, including the Recipient's case manager will be consulted in the below instances:

- assault of another recipient or staff person
- any action that puts themselves or others in serious danger.
- alcohol or drugs brought into the house or onto the property
- alcohol or drugs used in the house or on the property
- being under the influence of a mood altering substance and refusing to go to Detox. (see Recipient Mood Altering Substance Use / Abuse Policy)

In the event of a violation, Arrowhead House will immediately contact my Case Manager to arrange for a more appropriate setting for me.

In the case of emergency discharge I would I would like to be discharged to (check one):

	Hospital
	Detox
	Birch Tree Center
	Incarceration

Signature of Recipient: _____ Date: _____

Signature of Case Manager: _____ Date: _____

Signature of Arrowhead House Staff: _____ Date: _____

01/2013; revised 01/2016

ARROWHEAD HOUSE PROGRAMS

RECIPIENT MOOD ALTERING SUBSTANCE USE / ABUSE POLICY

Mood Altering Substances include, but are not limited to: Alcohol, Illegal Drugs, all Synthetic drugs, herbs and chemicals used for the purpose of mood-altering side effects.

Individuals entering the program that are evaluated with a history of mood altering substance use, abuse, or dependency will be expected to participate in a curriculum known as Integrated Dual Diagnosis Treatment (IDDT). Recipients involved in this treatment program will be randomly tested for alcohol or drug use using an on-site breathalyzer and/or drug screening equipment. Recipients have the right to refuse alcohol or drug screenings; however, refusal will threaten their continued placement and their case manager will be contacted to discuss the appropriateness of this placement and other possible treatment options. Weekly UA's will also be collected.

I understand that I may be randomly tested for drug or alcohol use and that my room, and personal belongings may be searched for possession of contraband. _____ Recipient Initials

It is the policy of Arrowhead House IRTS to treat suspected use/abuse of mood altering substances in a uniform manner for recipients struggling with a dependency. The treatment philosophy encourages reduction of use (harm reduction model) as part of mental health treatment and discourages using for anyone taking prescribed medications. If there is a relapse, continued use will be addressed according to the unique needs of the individual through the treatment plan and case manager involvement.

However, within the house or on the property, Arrowhead House has a zero tolerance policy for being under the influence of, or in the possession of a mood altering substance. In the event a recipient is suspected of being under the influence of a mood altering substance, the recipient will agree to have Arrowhead House personnel transport them to Detox. If the recipient refuses to go to Detox, the police may be called to escort based on presenting symptomology such as threatening or disorderly behavior. If a recipient refuses to go to Detox, the case manager will be contacted immediately to begin discharge for a more appropriate treatment option. Recipients who refuse to go to Detox but are not threatening or disorderly, will remain on the main floor of the house within eyesight of the staff, and be placed on a Health Status Check requiring blood pressure and pulse readings every 15 minutes.

It is the expectation that recipients will respect themselves, other recipients that they live with, and the program staff by not being under the influence of, bringing in, or sharing any mood altering substances.

I agree that if I am under the influence of a mood altering substance, I will allow Arrowhead House personnel to take me to Detox. My refusal to do so will result in a discharge from the program for a more appropriate treatment option. _____ Recipient Initials

I understand that possession of and/or sharing of any of the listed substances with other recipients will result in a discharge from the program for a more appropriate treatment option. _____Recipient Initials

I _____, have reviewed, understand and have been given a copy of the Recipient Mood Altering Substance Use/Abuse Policy:
(print name of recipient)

_____
Recipient Signature Date

I, _____, have provided both the Recipient and their Case Manager a copy of this Mood Altering Substance Use/Abuse Policy:
(print name of staff person)

_____
Staff Signature Date

Patient Name:		DOB:	
Allergies:			

STANDING ORDERS / OVER THE COUNTER MEDICATIONS

Fever / Pain / Discomfort:

Yes No

☐ ☐ Acetaminophen 650 mg. (po) (may be packaged as one 650 mg tablet or if a 325 mg tablet amount to administer would be two tablets by mouth every 4 hours PRN for pain relief or for temperature above 101 (o) or 102 (r). Not to exceed 4 doses in 24 hours unless by MD order.

☐ ☐ Ibuprofen 400 mg. (po) every 4-6 hours PRN for elevated temp. or discomfort. Not to exceed 1200 mg in 24 hours.

Colds/Sore Throats/Coughs: Please specify decongestant, dose, frequency if okay to have.

Yes No

☐ ☐ Chloraseptic spray or lozenges (po) NOTIFY RN IF SORE THROAT LASTS LONGER THAN 48 HRS.

☐ ☐ Decongestant, *(please indicate)*_____

☐ ☐ Guaifenesin syrup (**without dextromorphan hydrobromomide-DM**) 2 tsp. every 4 hours (po) PRN for cough. Not to exceed 2400 mg in 24 hours.

Bowels

Yes No

☐ ☐ Milk of Magnesia 30 ml. (po) If no BM in 2 days or showing signs of constipation.

☐ ☐ Bisacodyl suppository 10mg. Rectally – Day 3 without BM

☐ ☐ Fleet enema rectally if no results from suppository

☐ ☐ Other _____

Minor Wounds and Burns:

Yes No

☐ ☐ Mild soap and water washes to clean minor wounds.

☐ ☐ Bacitracin ointment applied topically to clean, minor wounds, up to TID until healed

☐ ☐ Other:_____

Mild Sunburn / Itching:

Yes No

☐ ☐ 1% Benadryl Cream-apply topically sparingly 3-4 times daily PRN-clean area before and between applications.

☐ ☐ ½-1% Hydrocortisone cream-apply topically sparingly 3-4 times daily PRN. If symptoms persist after 7 days,notify MD.

Misc

Yes No

☐ ☐ Debrox drops by ear, Use per manufacturer's instructions.

☐ ☐ Maalox or equivalent- 2 Tsp. (po) PRN for upset stomach. No more than 4 doses in 24 hrs.

☐ ☐ Other: _____

Additional Orders: _____

Printed Name: _____

Physicians Signature:_____ **Date:**_____

Patient Name:		DOB:	
Allergies:			

Standing Order Medications Info

The following list briefly describes each medication/treatment. Please refer to a drug reference book for more detailed information on each.

Acetaminophen: Analgesic and antipyretic
Use: give for discomfort, aches, pains, fever
Side effects: Diaarhea, stomach upset, sore throat, bruising, rash
HIGH DOSES MAY LEAD TO LIVER FAILURE

Ibuprofen:Anti-inflammatory ,analgesic and antipyretic
Use: Mild to moderate pain, arthritis, fever
Side effects: headache, dizziness, nausea, diaarhea, constipation, rash, gastric bleeding
Advise: Should always be taken with food or antacid

Chloraseptic Spray or Lozenges.
Use: Relief from throat irritation.
Side effects: hive/like swelling of the skin-call poison control immediately. Minor skin irritation, causing mild burning, stinging.
Advise: Notify RN if sore throat lasts longer than 48 hours. If giving lozenges, instruct to suck on lozenges until it dissolves.

Guaifenesin: Expectorant
Use: Liquify and reduce thickness of lung/ nasal secretions
Side effects: dizziness, headache, vomiting, nausea, rash
Advise to take with one full glass of water.

Bacitracin: Anti-infective
Use: to treat or prevent skin infection
Side effects: redness, rash, irritation
Advise: Apply only a thin layer or small amount. If condition persists and/ or worsens have seen by MD.

Benadryl Cream: Anti-histamine topical
Use: relief of itching from bug bites or allergies
Side effects: redness, irritation, rash
Advise: Apply over affected area and rub in slowly

Hydrocortisone Cream: Topical steroid
Use: relief inflammation and itching
Side effects: redness, irritation, rash
Advise: If condition persists or worsens refer person to MD, urgent care or ER

Milk of Magnesia: Laxative
Use: to relieve constipation
Side effects: loose stool, abdominal cramping, nausea
Advise to give adequate fluids SHAKE WELL before dispensing.

Bisacodyl Suppository : Laxative
Use: chronic constipation, prep for procedures
Side Effects: dizziness, faintness, abdominal cramps, nausea, vomiting, diaarhea
Advise: to lie on side during administration

Fleet Enema: Laxative
Use: chronic constipation, prep for procedures
Side Effects: dizziness, faintness abdominal cramps, nausea, vomiting, diarrhea
Advise: If no results from enema, contact physician, urgent care or ER

Maalox : antacid
Use: relieve heartburn or stomach upset, reduce stomach acid
Side effects: loose stools
Advise: do not give at the same time as other medications. SHAKE WELL

Debrox drops (carbamide peroxide): ear drops
Use: soften or dissolve ear wax
Side effects: dark ear drainage, itching, burning
Advise: Do not use if experiencing ear pain, irritation or rash in the ear or are dizzy. Do not use if there is an injury or perforation (hole) of the eardrum or after ear surgery unless directed by a physician.